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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 10/13/21 to 10/15/21.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 residents sampled (#2) related to not coordinating podiatry care for a resident with diabetes; implementing referrals for physical therapy and a gastrointestinal provider; obtaining a urine sample and getting a urinalysis with culture and sensitivity on one occasion and a delay on another occasion including failing to notify the primary care provider of the delay or the results; and failure to coordinate to have an antipsychotic injection available in the facility when the home health nurse was scheduled to administer it. The findings are: Review of Resident #2's current FL-2 dated 11/18/20 revealed diagnoses included diabetes type 2, fall risk, cervical degeneration (discs in the cervical spine start to break down due to wear and tear), and clavicular fracture (broken collarbone). Review of Resident #2's current assessment and	D 273		11/29/21

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care plan dated 03/30/21 revealed:
-The resident was ambulatory and used a walker.
-The resident was oriented and had adequate memory.
-The resident was independent with eating.
-The resident required limited assistance by staff with toileting, ambulation, and transferring.
-The resident required extensive assistance by staff with bathing, dressing, and grooming.

a. Observations of Resident #2 on 10/13/21 at 9:36am and 10/15/21 at 11:00am revealed:
-The resident's toenails on both feet were yellowish brown, long, and thick.
-The great toenails on both feet were approximately 1 inch long and jagged.
-The 2nd, 3rd, and 4th toenails on both feet curved over the top of the toes and pressed into the skin under each of the toes.
-There were no open areas on the skin around the toenails.

Interview with Resident #2 on 10/13/21 at 9:36am and 10/15/21 at 11:00am revealed:
-Her toenails were long and needed trimming.
-She told the facility's Transporter that she wanted to see a podiatrist (could not recall when) but the Transporter told her it would cost $50 to see the podiatrist.
-She did not recall if or when she had seen a podiatrist.
-Her toenails sometimes pushed into her shoes and it hurt sometimes.

Review of Resident #2's progress notes and provider visit notes revealed no documentation of the resident being seen by a podiatrist.

Interview with a personal care aide (PCA) on 10/15/21 at 2:53pm revealed:

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-Resident #2 was scheduled for showers three times a week on first shift.
-She assisted the resident with toileting, dressing, and bathing.
-She had not noticed the resident's toenails needed to be trimmed.
-If she had noticed the resident's toenails needed to be trimmed, she would have reported it to the medication aide (MA), who was her supervisor.
-Resident #2 had diabetes and she was not allowed to trim or clip the toenails of residents with diabetes.

Interview with a second PCA on 10/15/21 at 3:05pm revealed:
-Resident #2 was scheduled for showers three times a week on first shift.
-She usually gave the resident a shower if she was assigned to that hall.
-When giving showers, she was supposed to observe any issues with skin, fingernails, and toenails.
-She had not noticed the resident's toenails needed to be trimmed.
-The resident's diagnosis included diabetes.
-Residents with diabetes were usually sent out to a podiatrist for their fingernails and toenails to be trimmed.
-If she had noticed any issues with the resident's toenails, she would have documented it in the activities of daily living (ADL) progress notes and notified the MA.

Interview with the Resident Care Coordinator (RCC) on 10/15/21 at 9:33am revealed:
-She saw Resident #2's toenails on 10/14/21 and the resident needed to see a podiatrist because her toenails were long and thick and she had diabetes.
-No one had reported any concerns about the

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resident's toenails to her.
-Facility staff were not allowed to trim toenails of residents with diabetes.
-The facility was in the process of getting a mobile podiatrist to come to the facility to provide services to the residents.

Interview with the Executive Director (ED) on 10/15/21 at 11:24am revealed:
-Facility staff could not trim toenails of residents with diabetes but they could file them.
-The PCAs were responsible for reporting toenail issues to the MAs.
-The MAs would be responsible for reporting to the Transporter so she could set up an appointment with podiatry.
-The facility was going to have a mobile podiatrist to start at the facility on 10/20/21.

Telephone interview with the Resident #2's primary care provider (PCP) on 10/15/21 at 4:16pm revealed:
-She saw Resident #2's toenails during her visit on 10/13/21.
-No one had made her aware of the condition of Resident #2's toenails prior to 10/13/21.
-She wrote a referral request for podiatry on 10/13/21.

b. Review of Resident #2's visit notes from a spine and pain center provider dated 03/11/21 revealed:
-The resident's diagnosis was radiculopathy (compression of a spinal nerve) of the lumbar region.
-The provider ordered physical therapy (PT) to assist in the current diagnosis and treatment.
-The provider noted delay in PT may lead to poor outcomes.

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Review of Resident #2's progress notes and provider notes revealed no documentation the resident received PT as ordered on 03/11/21.

Review of Resident #2's hospital discharge instructions dated 04/29/21 revealed the resident was seen in the emergency room (ER) and diagnoses included a fall, low back pain, chronic pain syndrome, and pain in lower leg.

Review of Resident #2's accident / incident report dated 07/12/21 at 10:56am revealed:
-The resident fell in her bedroom on 07/12/21 at 10:35am with injuries.
-The resident was re-educated on the importance of using the call bell.

Review of Resident #2's hospital discharge instructions dated 07/12/21 revealed the resident was seen in the ER and diagnoses included a fall, effusion (excess fluid in the joint) of the right knee, contusion (bruise) of the right lower leg, and pain in the right lower leg.

Review of Resident #2's primary care provider (PCP) visit progress note dated 07/14/21 revealed:
-There was an order for x-ray of the right hip and right knee due to pain.
-There was an order to refer the resident to physical therapy / occupational therapy (PT/OT) for evaluation of generalized muscle weakness.

Review of Resident #2's x-ray report dated 07/16/21 revealed:
-The resident's right knee and right hip were x-rayed.
-There was no acute fracture or dislocation of the right knee or right hip.
-There was moderate osteoarthritis of the right

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hip and right knee.

Review of Resident #2's Wellness Observation form by the facility's in-house PT provider dated 07/26/21 revealed the resident was evaluated but there was no documentation indicating if the resident would receive PT services.

Review of Resident #2's progress notes and provider notes revealed no documentation the resident received PT as ordered on 07/14/21.

Review of Resident #2's visit notes from a spine and pain center provider dated 08/27/21 revealed:
-The resident's diagnosis was radiculopathy (compression of a spinal nerve) of the lumbar region.
-The provider ordered PT to assist in the current diagnosis and treatment.
-The provider noted delay in PT may lead to poor outcomes.

Review of Resident #2's progress notes and provider notes revealed no documentation the resident received PT as ordered on 08/27/21.

Interview with Resident #2 on 10/13/21 at 9:36am and 10/15/21 at 11:00am revealed:
-She had some falls and her last fall was in July 2021.
-She recently had fluid removed from her knee and she had chronic pain in her right knee and leg.
-She did not remember having PT services.

Interview with the Resident Care Coordinator (RCC) on 10/15/21 at 9:33am revealed:
-She did not know why the PT referrals had not been done for Resident #2.
-Any PT orders or referrals were usually put in the

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folder for the in-house PT provider by her or the MAs.
-Resident #2 did not qualify to use the in-house PT provider because she was receiving other services from an outside home health agency so she would have to use that same agency for PT services.
-She or the MAs would be responsible for contacting the HH provider about the PT referrals.
-She did not recall the resident having any PT services and she did not know if the resident's orders for PT had been done.

Interview with the Executive Director (ED) on 10/15/21 at 11:24am revealed:
-She did not know why Resident #2's PT orders/referrals in March 2021 and August 2021 were not done.
-The facility's in-house PT provider did an evaluation of Resident #2 on 07/26/21 but did not pick her up for services due to insurance issues.
-The PT orders should have been faxed to the resident's home health provider by the Lead Supervisor or the RCC.
-She did not follow-up on PT orders and she did not know if there was a system to follow-up on PT orders.
-Resident #2 had another order for PT from the spine and pain center provider dated 10/11/21.
-She got an updated order for PT to be done through the resident's HH provider on 10/13/21 after PT was ordered again on 10/11/21.
-She was concerned the resident did not receive PT as ordered because PT could help the resident get to a higher level of self care.

Review of Resident #2's order from a spine and pain center provider dated 10/11/21 revealed the resident needed PT for knee.

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Review of Resident #2's PCP order dated 10/13/21 revealed an order for home health physical therapy to evaluate and treat.

Attempted telephone interview with Resident #2's home health provider on 10/15/21 at 4:59pm was unsuccessful.

Telephone interview with the Resident #2's PCP on 10/15/21 at 4:16pm revealed:
-She was concerned the resident's PT order from 07/14/21 had not been done.
-PT was usually ordered to help decrease further deconditioning and debilitation.

Telephone interview with a representative from Resident #2's spine and pain center provider on 10/15/21 at 3:55pm revealed:
-PT services were ordered as part of the resident's treatment plan to decrease pain.
-They expected the resident to have some moderate improvement in her pain management from receiving PT.
-The facility had not notified their office the resident had not received PT services.

c. Review of Resident #2's order dated 06/17/21 by a hospital provider revealed:
-The resident had a history of chronic diarrhea.
-The resident had constipation for 2 days.
-The provider ordered an enema
-The provider ordered a referral for the resident by a gastrointestinal (GI) provider.

Review of Resident #2's progress note dated 06/17/21 at 3:24pm revealed:
-An order was faxed for an appointment with a GI provider.
-The Transporter documented waiting on a referral from a GI provider.

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D 273	Continued From page 8 Review of Resident #2's letter from a GI provider dated 08/05/21 revealed a reminder for an appointment on 09/21/21 at 1:30pm with a GI provider. Review of Resident #2's progress notes and provider visit notes revealed no documentation Resident #2 had been seen by a GI provider as ordered on 06/17/21. Interview with Resident #2 on 10/13/21 at 9:36am and 10/15/21 at 11:00am revealed: -She had been having problems with diarrhea for a month or longer. -She was supposed to see a GI provider back when she was having abdominal pain (could not recall the date) but she never saw the GI provider. -The Transporter took her to see the GI provider on one occasion (could not recall date) but they were unable to locate the GI provider's office so they came back to the facility. -Her abdominal pain was better but she still had problems with diarrhea. Interview with the Resident Care Coordinator (RCC) on 10/15/21 at 9:33am revealed: -She reviewed any referral orders and appointments with the facility's Transporter. -The facility's Transporter was responsible for making appointments and documenting the appointments in the transportation planner and reporting them verbally to the RCC. -Appointment forms were filled out a week in advance and put at the nurses' station to remind staff when a resident needed to be ready to go out for an appointment. -She implemented a new form in mid-September 2021 that noted the resident's name, provider's	D 273		

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name, date of visit, and had a comment section for the transporter could document information such as refusals.
-She reviewed the transportation forms weekly.
-She did not know if Resident #2's referral to see a GI provider dated 06/17/21 had been done.
-The resident had problems with diarrhea and indigestion "off and on".
-The resident had not complained of abdominal pain to her knowledge.

Telephone interview with a patient service associate at Resident #2's GI provider's office on 10/15/21 at 9:05am revealed:
-Resident #2 was a new patient and had never been seen by the GI provider.
-Their office received a copy of the 06/17/21 referral on 06/25/21.
-She called the facility on 06/25/21 to set up an appointment but no one answered.
-An appointment was made for 08/06/21 but she was not sure who set up the appointment.
-The appointments for 08/06/21 and 09/21/21 were canceled by the facility.
-The resident's appointment had been rescheduled for 11/05/21 at 10:30am.

Interview with the facility's Transporter on 10/15/21 at 3:48pm revealed:
-The RCC or the Lead Supervisor usually gave her orders for referrals.
-She called the referral providers, made sure residents' insurance was taken, and made the appointments.
-She documented appointments in her planner and she let the Executive Director (ED) and RCC know verbally when appointments were made.
-On 06/17/21, Resident #2 went to the hospital because she was having diarrhea and that was when she got the referral to see a GI provider.

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-The facility had issues with the transportation van on 08/06/21 so she rescheduled that appointment to 09/21/21.
-The van was in disrepair for at least 3 to 4 days in August 2021 and there was no alternate transportation available.
-She had 3 residents with appointments on 09/21/21 and the appointments may have run overtime which could have caused Resident #2 to miss her appointment.
-She rescheduled the GI appointment for 11/05/21.

Interview with the ED on 10/15/21 at 11:24am revealed:
-When an order for a referral was received, the Lead Supervisor or the RCC reviewed the orders and made the facility's Transporter aware.
-The Transporter was responsible for calling and making appointments and documenting it on the planner.
-The Transporter was responsible for taking residents to appointments unless the resident needed handicap access and then a transportation service was set up to take the resident.
-She did not know if there was a system to check to make sure referral appointments were made and to make sure the residents were taken to the appointments.
-She was not sure why Resident #2 missed the GI appointment on 08/06/21.
-Resident #2's GI appointment in September 2021 was canceled because another resident's appointment ran late that day and the facility only had one Transporter.
-The resident was rescheduled to see the GI provider on 11/05/21.
-Resident #2 complained of acid reflux and she took prn (as needed) medication for diarrhea.

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-The resident should have been seen by GI to make sure there were no major medical issues.

d. Review of Resident #2's current FL-2 dated 11/18/20 revealed there was an order for Risperdal Consta 50mg/2ml inject 2ml intramuscularly (IM) every 2 weeks for psychosis; for home health nurse (HHN) to administer every 2 weeks. (Risperdal Consta is used to treat schizophrenia and mood disorders.)

Review of Resident #2's mental health provider (MHP) visit progress note dated 05/18/21 revealed:
-The resident had chronic schizoaffective disorder, depressive type and was benefiting from Risperdal Consta injections every 2 weeks and oral medication for ongoing hallucinations.
-No behavioral concerns were reported.
-No medication adjustments were indicated.

Review of Resident #2's MHP visit progress note dated 06/15/21 revealed:
-The resident had a history of schizoaffective disorder, depressive type.
-There were no reports of worsening psychosis, delusional thoughts, or agitation.
-The resident remained on Risperdal Consta injections every 2 weeks and oral medications for ongoing hallucinations.

Review of Resident #2's MHP visit progress note dated 08/04/21 revealed:
-The resident had a history of schizoaffective disorder, depressive type.
-The resident's anxiety was improved and controlled.
-The resident continued to benefit from Risperdal Consta injections every 2 weeks and oral medications.

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D 273	Continued From page 12 Review of Resident #2's MHP visit progress note dated 09/07/21 revealed: -The resident had a history of schizoaffective disorder, depressive type. -The resident reported no auditory or visual hallucinations or delusions. -No bizarre behavior was reported by staff. -The MHP noted the resident was compliant with Risperdal Consta injections and oral medications. Review of Resident #2's August 2021 - October 2021 electronic medication administration records (eMARs) revealed: -There was an entry for Risperdal Consta 50mg/2ml inject 2ml IM every 2 weeks for psychosis; for home health nurse to administer every 2 weeks on each eMAR. -There was no Risperdal Consta documented as administered from August 2021 - October 2021. Review of Resident #2's handwritten and computer printed home health note reports revealed: -On 08/10/21, the HHN noted the resident's Risperdal Consta had been unavailable that week on 2 attempts. -On 08/19/21, Risperdal Consta was unable to be administered because the medication was not available; the resident nor the facility staff had any complaints or concerns. -There was no Risperdal Consta documented as administered since 07/19/21 until 08/24/21, over 5 weeks later. -No Risperdal Consta was documented as administered after 09/23/21 (due to be administered again on 10/07/21). -On 10/04/21, attempted visit to administer Risperdal Consta but the medication was not available.	D 273		

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-On 10/08/21, arrived to the facility but Risperdal Consta was not on site; the MA contacted the pharmacy twice while in the HHN's presence that week to try to obtain the medication.

Interview with Resident #2 on 10/13/21 at 9:36am and 10/15/21 at 11:00am revealed:
-She was supposed to get Risperdal Consta injections every 2 weeks.
-She was not sure if they had run out of her Risperdal Consta or if she had missed any injections.
-The Risperdal Consta made her mood a little better and her mood had been the same for a while.

Telephone interview with the medication aide (MA) / Lead Supervisor on 10/15/21 at 4:50pm revealed:
-Resident #2's Risperdal Consta injection had been unavailable at times when the HHN came to administer it (could not recall dates).
-She had called the pharmacy when it was unavailable (could not recall date) and they were supposed to send it.
-The pharmacy used to just send one Risperdal Consta but then they started sending 2 at a time.
-The resident's behavior had been stable.

Interview with the Resident Care Coordinator (RCC) on 10/15/21 at 9:33am revealed:
-She was not aware Resident #2's Risperdal Consta had been unavailable and not administered.
-The MAs were responsible for ordering medications and the MAs should let her know if a medication was unavailable.
-The MAs were responsible for doing medication cart audits once a week.
-She had not done any medication cart audits or

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checked behind the MAs because she had been busy with other tasks.
-Resident #2 was not having any behavior issues currently.
-The resident had not complained of any hallucinations or paranoia.

Interview with the Executive Director (ED) on 10/15/21 at 11:24am revealed:
-When the HHN came to the facility to administer Risperdal Consta and it was not available, the HHN should notify the MA.
-The MAs should call the pharmacy to find out why the medication was not available.
-The MAs should report to the RCC if they were unable to obtain the medication.
-She was not aware Resident #2 had missed doses of the Risperdal Consta.
-The MAs or the RCC should notify the PCP and MHP of any missed doses of Risperdal Consta.
-The Risperdal Consta was currently in the medication refrigerator in the medication room.
-She was not sure when the Risperdal Consta was delivered to the facility.
-Resident #2 got a little agitated at times but her behavior had been stable.
-She was concerned missing doses of the Risperdal Consta could cause the medication to wean out of the resident's system and cause her behaviors to return.

Observation of Resident #2's medications on hand on 10/15/21 at 3:17pm revealed:
-There was a box of Risperdal Consta 50mg/2ml with 2 syringes dispensed on 10/09/21.
-The instructions were to inject 2ml every 2 weeks for psychosis, for home health nurse to administer every 2 weeks.
-The box was sealed and had not been opened.

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D 273	Continued From page 15 Telephone interview with the facility's contracted pharmacy on 10/15/21 at 3:39pm revealed: -Resident #2's Risperdal Consta 50mg was an active order. -The medication was dispensed on 5/24/21, 06/22/21, and 10/09/21. -Risperdal Consta was not automatically refilled so the facility staff had to request the medication be refilled by facsimile or electronically when needed. -There was no documentation in the pharmacy electronic system that Risperdal Consta was requested to be refilled at any other times than when it was dispensed. Telephone interview with the Resident #2's primary care provider (PCP) on 10/15/21 at 4:16pm revealed: -Resident #2's Risperdal Consta was managed by a MHP in their practice. -Missing a dose of Risperdal Consta by more than a few days could increase the resident's behavior or likelihood of self-harm. -A provider could change a resident's medications without knowing the resident was not actually receiving the medication. Telephone interview with Resident #2's MHP on 10/15/21 at 4:15pm revealed: -The order for Risperdal Consta injection was written to prevent the resident from hallucinating and having delusions. -She expected the facility to notify her and home health if the resident had missed any doses of her Risperdal Consta injection. -She was not aware the resident had missed doses of her Risperdal Consta injection. -Missing doses of the Risperdal Consta injection placed the resident a risk of having a psychotic break.	D 273		

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-A psychotic break consisted of delusions and paranoia.

Attempted telephone interview with Resident #2's HHN on 10/15/21 at 4:59pm was unsuccessful.

e. Review of Resident #2's primary care provider (PCP) visit progress note dated 07/06/21 revealed there was an order to collect urine and send for urinalysis (UA) with culture and sensitivity (C & S).

Review of Resident #2's lab reports and progress notes revealed no documentation of a urine sample being collected and tested for UA with C & S.

Review of Resident #2's PCP visit progress note dated 09/02/21 revealed:
-The resident's urinary frequency was worsening, causing interrupted sleep.
-The PCP was unsure if it was a urinary tract infection (UTI) or overactive bladder (OAB).
-The resident had no signs or symptoms of UTI except frequency.
-The PCP ordered a UA to see if OAB management medications should be started.

Review of Resident #2's lab report dated 09/27/21 revealed:
-The resident's urine was collected and tested on 09/27/21.
-There was a handwritten note by the PCP dated 10/06/21 to notify her when the urine culture result was finalized.

Review of Resident #3's lab reports on 10/13/21 revealed no documentation of a final urine culture result for the urinalysis on 09/27/21.

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Interviews with Resident #2 on 10/13/21 at 9:36am and 10/15/21 at 11:00am revealed:
-She recently gave staff a urine sample (could not recall date).
-She had not refused to give a urine sample.
-She was having problems with urinating a lot but no burning when she urinated.

Interview with the Resident Care Coordinator (RCC) on 10/15/21 at 9:33am revealed:
-For orders for urinalysis, the lab came to the facility once a week or as needed.
-The medication aides (MAs) usually obtained a resident's urine sample and the MA would call the lab to have them collect the urine the same day it was collected.
-A resident's urine should be collected when an order for a urinalysis was received.
-The MAs should document in the progress notes when they collect urine for a urinalysis.
-She did not know why Resident #2's urinalysis was not done when ordered in July 2021.
-She did not know why Resident #2's urinalysis ordered on 09/02/21 was not done until 09/27/21.
-The facility's contracted PCP usually came to the facility on Wednesdays but they may not receive orders from the visit until the following Monday.
-She had not seen the PCP's handwritten note on the urinalysis results dated 10/06/21 about notifying her when the culture and sensitivity results were received.
-The MAs should have notified her of the PCP's written note on the lab results.
-She would check with the PCP regarding the PCP and whether the PCP wanted to start the resident on medications for OAB.

Interview with the Executive Director (ED) on 10/15/21 at 11:24am revealed:
-The facility's contracted lab came to the facility

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on Mondays.
-Third shift staff should look through lab orders and try to collect urine for urinalysis on Monday mornings when residents were being gotten up for the day.
-It was her understanding the lab was not contracted to come more than once a week.
-She did not know if resident's providers were aware the lab only came once a week.
-If a resident was symptomatic, they could check with the local hospital to seek if the urine sample could be taken to the hospital lab for processing.
-She was not aware Resident #2's urinalysis ordered in July 2021 was not done.
-It should not have taken until 09/27/21 to collect a urine sample for the urinalysis ordered on 09/02/21.
-The MAs should document when they collect urine in the progress notes.
-She was concerned if a urinalysis was not done as ordered or was delayed, a resident could become symptomatic and could possibly become septic (infection in blood).
-She just received a referral order by the PCP on 10/13/21 for the Resident #2 to be seen by urology for recurrent bacterial UTIs and the PCP ordered a daily course of prophylactic antibiotics for UTIs.

Telephone interview with the Resident #2's PCP on 10/15/21 at 4:16pm revealed:
-She did not work with the contracted PCP's office in July 2021 so she was not sure why a urinalysis was ordered at that time.
-She ordered the UA on 09/02/21 because the resident was having frequent urination so she was trying to determine if the resident had UTI or OAB.
-She expected a urine specimen to be collected for testing within 3 days of the order unless it was

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D 273	Continued From page 19 urgent and needed to be done the same day. -She thought she was notified by staff around 09/05/21 that the resident refused to give a urine sample. -If the resident continued to refuse to give a urine sample past a few days from the initial refusal, she expected the facility staff to notify her. -She was not aware it took 3 weeks to get the resident's urine sample for the UA with C & S ordered on 09/02/21. -She would want to know so she could keep a close eye on the resident because a delay in doing the UA could result in pyelonephritis (inflammation of the kidney due to bacterial infection). -She had not received the C & S results from the order on 09/02/21. _____ The facility failed to ensure the acute and routine health care needs were met for Resident #2. Resident #2 had diabetes and had long thick toenails that were jagged and the 2nd, 3rd, and 4th toenails on each foot curved over the top of the toes and pressed into the skin on the bottom of the resident's toes which caused the resident pain. Resident #2 experienced chronic pain and weakness related to spinal nerve pain, right knee, and right leg pain and did not receive physical therapy as ordered on 03/10/21, 07/14/21, or 08/27/21. Resident #2 had abdominal pain and bouts with diarrhea and constipation on 06/17/21 with a referral to a GI provider but had not been seen as of 10/15/21 due to two missed appointments. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 10/15/21 for this violation.	D 273		

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D 273	Continued From page 20 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 29, 2021.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#6, #7) observed during the medication passes evidenced by errors with a medication to treat chronic obstructive pulmonary disease (#7) and a medication to treat anemia (#6); and for 2 of 5 residents sampled (#2, #5) for record review including errors with a medication used to lower blood pressure and heart rate (#2), a diuretic for swelling (#5), and a potassium supplement (#5). The findings are: 1. The medication error rate was 6% as evidenced by the observation of 2 errors out of 29 opportunities during the 8:00am medication pass on 10/14/21. a. Resident #6's current FL-2 dated 04/15/21	D 358		11/29/21

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revealed:
- Diagnoses included anemia, mental retardation, and dementia.
-There was an order for Ferrous Sulfate 325mg take 1 tablet by mouth once a day at 8:00am. (Ferrous Sulfate is a medication to treat anemia.)

Interview with the medication aide (MA) on 10/14/21 at 7:39am revealed:
-Resident #6's bubble card with Ferrous Sulfate tablets was empty.
-There was no Ferrous Sulfate available to administer to the resident.
-The refill sticker had been removed from the label of the Ferrous Sulfate but she was not sure when it was reordered.

Observation of the 8:00am medication pass on 10/14/21 revealed Ferrous Sulfate was not offered to Resident #6 when he received his other morning medications at 7:45am.

Review of Resident #6's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Ferrous Sulfate 325mg take 1 tablet by mouth every day scheduled to be administered at 8:00am.
-The medication was documented as not administered on 10/14/21 due to the medication being unavailable.

Interview with Resident #6 on 10/14/21 at 1:04pm revealed:
-He took medications that were offered to him.
-He was not sure what medications he received.
-The medications did not cause any stomach upset.
-He felt "alright."

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D 358	Continued From page 22 Second interview with the MA on 10/14/21 at 10:52am revealed: -The facility kept overstock medications in a cabinet in the medication room. -She just found some Ferrous Sulfate in the overstock supply for Resident #6. -She was going to administer the Ferrous Sulfate to the resident now because it was "normal" procedure. Observation on 10/14/21 at 10:56am revealed the MA administered the Ferrous Sulfate 325mg tablet to Resident #6. Review of a diagnostic laboratory report dated 04/05/21 revealed: -There was an order for a complete blood count (CBC) used to detect a wide range of disorders including anemia. -There was an entry for a red blood count (RBC) of 3.99 that was less than the normal range of 4.7-6.1 M/ul. -There was an entry for a hemoglobin (HGB) of 12.3 that was less than the normal range of 14.0-18.0 g/dl. -There was an entry for a hematocrit (HCT) of 37.5 that was less than the normal range of 42.0-52.0 %. Third interview with the MA on 10/14/21 at 1:40pm revealed: -Her morning routine was to check incoming medications from the pharmacy which were supposed to be placed in an open white basket on the countertop in the medication room. -She checked the basket before the 8:00am medication pass on 10/14/21 but it was empty. -If a medication was ordered once a day she thought the policy was to administer it even if it was out of the timeframe.	D 358		

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D 358	Continued From page 23 -If a medication was ordered more than once a day, she would have to contact the primary care provider (PCP) and follow instructions from the PCP. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/15/21 at 9:20am revealed: -Resident #6's Ferrous Sulfate was last dispensed on 10/11/21 and included a 30-day supply. -The medication was delivered to the facility on 10/11/21 by the pharmacy. Interview with the Resident Care Coordinator (RCC) on 10/14/21 at 2:19pm revealed: -She expected the MA to check the medication cart twice to determine if the medication was on the cart. -Then, her expectation was that the MA should have locked the cart and looked in the "overstock cabinet" in the medication room for the medication at that time. -If the medication was not there, then pharmacy should have been called. -If it was beyond the 1-hour timeframe when the MA found the medication the MA should have contacted the PCP and followed instructions by the PCP. Interview with the Executive Director (ED) on 10/14/21 at 2:47pm revealed: -The MA should have checked the medication cart twice to determine if the medicine was there. -The MA should have locked the cart and gone to the "overstock cabinet" in the medication room to see if the medicine was there. -She should have contacted the PCP if the medication was going to be administered out of the timeframe for instructions.	D 358		

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D 358	Continued From page 24 Telephone interview with Resident #6's PCP on 10/15/21 at 4:15pm revealed: -Ferrous Sulfate was scheduled in the morning for Resident #6 because it was better tolerated when given with a meal. -There usually were items on the breakfast menu that contained Vitamin C which helped with the absorption of the medication. -She was not concerned of harm to the resident if the medication was administered late on 10/14/21. b. Resident #7's current FL-2 dated 10/08/20 revealed: -Diagnoses included chronic obstructive pulmonary disease, hypertension and dementia. -There was an order for Advair Diskus 500-50 mcg inhale 1 puff by mouth twice daily at 8:00am and 8:00pm, rinse mouth and spit out after each use. (Advair Diskus is a dry powder inhaler used to deliver medication deep into the lungs. These types of inhalers are breath activated requiring a deep, fast breath to release the medication from the device and into the lungs. According to the manufacturer, Advair Diskus requires the Diskus to be held in a level, flat position to slide the lever until it clicks. The number on the counter will count down by 1 and the Diskus is ready to use. The Diskus should not be tilted. Before breathing in a dose from the Diskus, exhale (breathe out) as long as you can. Put the mouthpiece to your lips while the Diskus is held flat and breathe in quickly and deeply. Remove the Diskus from your mouth and hold your breath for about 10 seconds. Breath out slowly as long as you can. Close Diskus and rinse mouth.) Review of Resident #7's October 2021 electronic medication administration record (eMAR)	D 358		

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revealed:
-There was an entry for Advair Diskus 500-50 mcg inhale 1 puff by mouth twice daily.
-Advair Diskus was scheduled to be administered at 8:00am and 8:00pm.

Observation of the medication pass on 10/14/21 at 7:54am revealed:
-The medication aide (MA) held the Advair Diskus to the resident's mouth in a tilted position and slid the lever until it clicked.
-The resident took one quick shallow puff while the MA held the Diskus in a tilted position to the resident's mouth.
-Resident #7 was not instructed to exhale before inhaling the medication, to inhale deeply, to hold her breathe for 10 seconds after inhaling the medication, or to exhale slowly after receiving the medication.
-The Advair Diskus was not held in a level, flat position during the administration of the medication.
-The resident rinsed her mouth with water afterwards.

Observation of Resident #7's medications on hand on 10/14/21 at 2:08pm revealed
-There was an Advair Diskus stored in the manufacturer's box.
-There were instructions for the use of the Advair Diskus printed on the back of the box.
-Hold the Diskus in a level flat position with the mouthpiece toward you.
-Breathe out (exhale) as long as you can while holding the Diskus away from the mouth.
-Do not breathe into the mouthpiece.
-Put the mouthpiece to the lips.
-Breathe in quickly and deep through the Diskus.
-Remove the Diskus from your mouth and hold your breath about 10 seconds or as long as

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comfortable.
-Breathe out slowly as long as you can.
-Rinse your mouth with water.

Interview with Resident #7 on 10/15/21 at 12:55pm revealed:
-She received the Advair Diskus medication in the morning and at night.
-She normally took 1 puff.
-She held the Diskus sometimes and sometimes the MA held it during the administration of the medication.
-The MA did not instruct her on how to breathe when taking the medication.
-Sometimes she had shortness of breath when she was engaged in a physical activity such as walking.
-She did not have shortness of breath when she was sitting or resting.

Interview with the MA on 10/15/21 at 1:4 pm revealed:
-She received no training on how to position the Advair Diskus when administering the medication.
-She normally held the Diskus for Resident #7 when administering the medication.
-She received no training on instructing the resident how to breathe before and after the administration of the medication.
-She had not noticed the instructions on the back of the box containing the Advair Diskus.
-She recalled being trained on other types of inhalers when being checked off as a MA.

Interview with the Resident Care Coordinator (RCC) on 10/15/21 at 2:19pm revealed:
-The MAs had been trained on the use of different types of inhalers by a registered nurse when they became MAs.
-She expected the MAs to follow the

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manufacturer's instructions for proper technique for administering inhalers.
-She expected the MAs to instruct the residents on how to use the inhalers.
-Resident #7 should have been instructed to inhale prior to taking a puff with a deep breath and holding her breath prior to slowly breathing out.

Interview with the Executive Director (ED) on 10/14/21 at 2:47pm revealed:
-She did not know if the MAs were trained on how to use dry powder inhalers when they took the MA training course.
-She expected the MAs to know the proper technique to administer Advair Diskus to Resident #7.
-She expected the MAs to instruct the resident on how to breathe before and after receiving the Advair Diskus.

Telephone interview with the primary care provider (PCP) on 10/15/21 at 4:15pm revealed:
-Resident #7 had not had any recent acute respiratory "flare ups".
-Her expectation was for the MAs to follow the manufacturer's instructions when administering the Advair Diskus to ensure the resident received the best benefit of the medication by getting a full dose of the medication.

2. Review of Resident #2's current FL-2 dated 11/18/20 revealed:
-Diagnosis included diabetes, type 2.
-There was an order for Propranolol 10mg 1 tablet 3 times a day for anxiety / palpitations (racing or pounding heart beat), hold if blood pressure is less than (<) 110/60 or pulse (heart rate) < 60. (Propranolol slows down heart rate and lowers blood pressure and may be used to

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D 358	Continued From page 28 treat anxiety and rapid heart beat.) Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Propranolol 10mg 1 tablet 3 times daily for anxiety / palpitations, hold if blood pressure is < 110/60 or pulse rate < 60. -Propranolol was scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Propranolol was documented as administered from 08/01/21 - 08/20/21 and 08/25/21 - 08/31/21. -Propranolol was documented as being on hold from 08/21/21 - 08/24/21. -There were no blood pressures or pulses documented as being checked prior to the administration of Propranolol 3 times a day from 08/01/21 - 08/31/21. -Propranolol was documented as being administered without the resident's blood pressure and pulse being checked prior to the administration of Propranolol as ordered. -There was an entry for blood pressure to be checked once weekly and the resident's weekly blood pressure ranged from 133/67 - 148/78. Review of Resident #2's September 2021 eMAR revealed: -There was an entry for Propranolol 10mg 1 tablet 3 times daily for anxiety / palpitations, hold if blood pressure is < 110/60 or pulse rate < 60. -Propranolol was scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Propranolol was documented as administered from 09/01/21 - 09/30/21. -There were no blood pressures or pulses documented as being checked prior to the administration of Propranolol 3 times a day from 09/01/21 - 09/30/21.	D 358		

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-Propranolol was documented as being administered without the resident's blood pressure and pulse being checked prior to the administration of Propranolol as ordered.
-There was an entry for blood pressure to be checked once weekly and the resident's weekly blood pressure ranged from 120/61 - 129/70.

Review of Resident #2's October 2021 eMAR dated 10/01/21 - 10/13/21 revealed:
-There was an entry for Propranolol 10mg 1 tablet 3 times daily for anxiety / palpitations, hold if blood pressure is < 110/60 or pulse rate < 60.
-Propranolol was scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-Propranolol was documented as administered from 10/01/21 - 10/13/21 at 8:00am.
-There were no blood pressures or pulses documented as being checked prior to the administration of Propranolol 3 times a day from 10/01/21 - 10/13/21 at 8:00am.
-Propranolol was documented as being administered without the resident's blood pressure and pulse being checked prior to the administration of Propranolol as ordered.
-There was an entry for blood pressure to be checked once weekly and the resident's weekly blood pressure ranged from 135/70 - 136/75.

Observation of Resident #2's medications on hand on 10/15/21 at 2:56pm revealed:
-There was a multidose pack (MDP) with a fill date of 10/06/21 and a start date of 10/09/21.
-The MDP included Propranolol 10mg 1 tablet 3 times a day for anxiety/palpitations, hold if blood pressure is < 110/60 and/or pulse <60.

Interview with Resident #2 on 10/13/21 at 9:36am and 10/15/21 at 11:00am revealed:
-The facility staff usually checked her blood

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pressure and pulse only once a week.
-Sometimes her blood pressure may be a little high.
-If her blood pressure was low, she felt "bad".

Telephone interview with the medication aide (MA) / Lead Supervisor on 10/15/21 at 4:50pm revealed:
-She did not check Resident #2's blood pressure and pulse prior to administering the Propranolol to the resident because she thought the parameters had been discontinued at some point.
-She had not noticed the instructions on the eMAR and the medication label still included the parameters to be checked prior to administering the medication.

Interview with the Resident Care Coordinator (RCC) on 10/15/21 at 9:33am revealed:
-Resident #2's blood pressure and pulse should be checked 3 times a day before the MAs administered Propranolol to the resident.
-She was not aware the MAs were not checking and documenting the parameters for administration of the Propranolol.
-The MAs were supposed to do medication cart audits weekly that included audits of the eMARs.
-The MAs had not reported any issues with the resident Propranolol on the eMAR.
-Resident #2's parameters not being on the eMAR must have been overlooked during the audits.
-The pharmacy usually entered orders into the eMAR systems and either she, the Lead Supervisor, or the Executive Director approved orders before they became active on the eMAR.
-The parameters not being on the eMAR must have been overlooked when the order was approved on the eMAR.

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Interview with the Executive Director (ED) on 10/15/21 at 11:24am revealed:
-She expected the MAs to check Resident #2's blood pressure and pulse prior to administering the Propranolol 3 times a day as ordered.
-She was concerned administering the Propranolol without checking the parameters to see if the medication needed to be held could result in low blood pressure and low pulse which could lead to increased risk for falls.

Telephone interview with the Resident #2's primary care provider (PCP) on 10/15/21 at 4:16pm revealed:
-Resident #2's blood pressure and pulse should be checked prior to staff administering the medication.
-If Propranolol was administered when it should have been held, it could cause a slow heart rate or low blood pressure.

3. Review of Resident #5's current FL-2 dated 01/06/21 revealed diagnoses included hypertension (HTN) and cerebrovascular accident (CVA).

Review of Resident #5's primary care provider's (PCP) progress note dated 09/09/21 revealed an order to start Furosemide 40mg every day (Furosemide is used to treat fluid retention (edema) and swelling) with Potassium Chloride 10mEq (Potassium Chloride is used to prevent or treat low potassium levels in the body caused by certain medications) until PCP was able to follow up.

Review of Resident #5's PCP's progress note dated 09/17/21 revealed:
-An order to discontinue Furosemide 40mg tablet.
-An order to discontinue Potassium Chloride

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10mEq tablet.

Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed:
- Furosemide 40mg tablet was administered from 09/18/21 to 09/30/21.
- Potassium Chloride 10mEq tablet was administered from 09/18/21 to 09/30/21.

Review of Resident #5's October 2021 eMAR revealed:
- Furosemide 40mg tablet was administered on 10/01/21.
- Potassium Chloride 10mEq tablet was administered on 10/01/21.

Interview with a medication aide (MA) on 10/14/21 at 11:23am revealed:
-She contacted the pharmacy on 10/05/21 to verify the Furosemide 40mg tablet and Potassium Chloride 10mEq tablet had been discontinued.
-She discontinued the medications in the eMAR system on 10/05/21.
-She notified the PCP on 10/06/21 the medications were administered to Resident #5 from 09/18/21 to 09/30/21 and on 10/01/21.

Interview with the Resident Care Coordinator (RCC) on 10/14/21 at 8:10am revealed:
-She and a MA reviewed the eMAR for errors once per week.
-She was not aware Resident #5 had orders to discontinue Furosemide 40mg tablet and Potassium Chloride 10mEq tablet.

Telephone interview with Resident #5's PCP on 10/14/21 at 9:40am revealed:
-The orders for Furosemide 40mg tablet and Potassium Chloride 10mEq were ordered as a

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D 358	Continued From page 33 short-term therapy related to the resident's edema. -The orders for Furosemide 40mg tablet and Potassium Chloride 10mEq were written with an open-ended date. -The facility notified her last week (not sure of date) the medications were never discontinued. -She ordered lab work to ensure there was no effect to the resident continuing the medications after they were discontinued but the labs were not back when she came to the facility on 10/13/21. -There was no concern the medications were continued after they were discontinued because the edema had been resolved. Interview with the Executive Director on 10/14/21 at 7:42am revealed: -She and the RCC were responsible for verifying medications were discontinued in the eMAR. -She was not aware Resident #5 had orders to discontinue Furosemide 40mg tablet and Potassium Chloride 10mEq tablet.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations	D912		11/29/21

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D912	Continued From page 34 as related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 residents sampled (#2) related to not coordinating podiatry care for a resident with diabetes; implementing referrals for physical therapy and a gastrointestinal provider; obtaining a urine sample and getting a urinalysis with culture and sensitivity on one occasion and a delay on another occasion including failing to notify the primary care provider of the delay or the results; and failure to coordinate to have an antipsychotic injection available in the facility when the home health nurse was scheduled to administer it. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		