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THE ADDISON OF INDIAN TRAIL	5306 SECREST SHORT CUT ROAD MONROE, NC 28110

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D 000	Initial Comments The Adult Care Licensure Section completed an Annual survey on 11/02/21, 11/03/21, 11/04/21 with a telephone exit on 11/05/21.	D 000		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to respond immediately and in accordance with the facility's established policy and procedures for 1 of 5 sampled residents (Resident #1) who was complaining of chest pain, and was pale, clammy and short of breath which required an immediate emergency response. Review of Resident #1's previous FL2 dated 10/25/21 revealed: -Diagnoses included diabetes mellitus II (DM II), increased cholesterol, high blood pressure, hyperglycemia chronic kidney disease and dementia. Review of the facility's Community Emergency	D 271		

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Procedures Policy dated 12/14/11 revealed:
-This standard applies in the event of a resident emergency situation such as, but not limited to, complaints of pain the community shall recommend calling 911/Emergency Medical Services (EMS) for evaluation, treatment and potential transportation to a hospital.
-If a personal representative declines EMS, the personal representative must complete a Declination of EMS Release.
-Call the resident's primary care physician (PCP).
-Complete and incident/accident report.
-Document the incident in the resident's progress notes.

Review of Resident #1's progress notes revealed:
-A late entry documented on 10/28/21 at 12:06pm for 10/25/21 at 7:45am by the Special Care Director (SCD) documented, upon arriving to work on 10/25/21, the medication aide (MA) informed her Resident #1 was pale, clammy and in great pain.
-As the SCD entered the Special Care Unit (SCU) she heard Resident #1 screaming "help me".
-Resident #1 informed her, his "chest hurt" and he "couldn't breathe".
-She called Resident #1's Power of Attorney (POA) and was told "not to call the ambulance" and the POA would come and pick Resident #1 up.
-The POA did not want Resident #1 to sit in the emergency room (ER) and the POA would make an appointment with the PCP.
-On 10/25/21, after 2:00pm the SCD received a call from POA informing them Resident #1 had a heart attack and a stent was placed in Resident #1's heart.

Review of Resident #1's hospital discharge summary dated 10/29/21 revealed:

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-There was an admission date of 10/25/21.
-The admission diagnoses included heart attack, elevated brain natriuretic peptide level (BNP, a test to indicate heart failure), and diabetic ketoacidosis (a life-threatening complication of diabetes) without coma associated with type 2 diabetes.

Interview with SCD on 11/02/21 at 10:39am revealed:
-On 10/25/21, Resident #1 informed her he was having chest pain (CP) and was short of breath.
-She did not call 911 because she called Resident #1's POA first and the POA not to call 911.
-She called Resident #1's POA and informed the POA Resident #1 was complaining of short of breath, body aches, not feeling well and was pale and clammy.
-She could not remember if she said Resident #1 was having CP.
-Resident #1's POA did not want Resident #1 to wait in the ER lobby so the POA would come pick up Resident #1 and take Resident #1 to his PCP.
-She considered Resident #1 was having a heart attack because of his symptoms of CP, but she could not go against the POA, so she did not call 911.
-Before the POA arrived at the facility, Resident #1 complained of heaviness in his chest and she did not call 911 at that point.
-Resident #1's POA #2 did not arrive until an hour later.
-The policy for CP was to call 911 but she did not do so even when Resident #1 continued to complain of CP, heaviness and short of breath because Resident #1's POA said not to.
-She could not override a POA decision to not call 911.

Telephone interview with a Nurse from Resident

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#1's PCP office on 11/02/21 at 4:14pm revealed:
-On 10/25/21, the facility staff did not call them and report Resident #1's symptoms of CP, pale, clammy or body aches and fever.
-On 10/25/21, Resident #1's POA called the office and reported the facility staff informed her Resident #1 complained of fever and body aches and scheduled a virtual visit for that day at 2:30pm.
-On 10/25/21, she received a call from Resident #1' POA informing her Resident #1 was admitted to the hospital due to a heart attack and required stent placement.
-It was the expectation of Resident #1's PCP to call 911 when Resident #1 complained with any one or more of the following; CP, short of breath, heaviness in his chest or was pale or clammy.

Telephone interview with Resident #1's POA #1 on 11/03/21 at 9:30am revealed:
-On 10/25/21, he and a family member received a phone call from the facility staff informing him Resident #1 was cold, clammy and had a fever and was complaining of hurting all over.
-It was their impression from the facility it was the flu or blood sugar issues and they would just take Resident #1 to the PCP so Resident #1 did not have to wait in the ER waiting room before being seen.
-The POA, went to the facility and picked Resident #1 up to take him to the PCP.
-The POA notified the PCP after receiving the call from the facility stating Resident #1 was cold, clammy and had a fever and was hurting all over.
-The PCP made a "virtual visit" appointment for 10/25/21 at 2:30pm but he did not make the appointment because Resident #1 stated he was having CP about 45 minutes after being at home with them.
-The facility staff did not inform her Resident #1

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complained of CP.
-If the staff had told her Resident #1 complained of CP, she would have had the staff call 911 and not wait on her.
-CP, heaviness on chest, shortness of breath, pale and clamminess required 911, but body aches and fever could wait until seen by PCP.
-She expected the staff to inform her of the correct symptoms and call 911 for CP, shortness of breath, pale and clamminess.

Interview with a medication aide (MA) on 11/03/21 at 10:11am revealed:
-She was not the MA on duty on 10/25/21.
-When a resident complained of CP or heaviness in the chest, she was responsible as the MA for calling 911.
-The SCD could also call 911.
-Once emergency personnel arrived then she could call the resident's POA and the POA could refuse at that point.

Telephone interview with a representative from Resident #1's Cardiac Physician's office on 11/04/21 at 10:30am revealed:
-After review of Resident #1's hospital records, office notes and consulting cardiologist, she stated Resident #1 presented to the ER on 10/25/21 complaining of severe CP.
-Resident #1 was diagnosed with heart attack.
-The signs and symptoms of a heart attack were chest pain or pressure, heaviness in the chest, shortness of breath, paleness and clamminess.
-The delay in treatment of a heart attack could cause a significant loss of heart muscle and death.
-It was the cardiologist expectation when Resident #1 complained of any of the signs or symptoms, 911 was called.

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D 271	Continued From page 5 Interview with the Administrator on 11/02/21 at 12:48pm revealed: -On 10/25/21, between 7:00am and 8:00pm she received a call from the facility informing her the staff was "sending" resident #1 out to the hospital because Resident #1 complained of CP, shortness of breath and was pale and clammy. -She instructed the facility to make sure they contacted Resident #1's POA. -She was informed by the SCD and Sales and Marketing Director (SMD) Resident #1's POA refused transport to the hospital and would take Resident #1 to his PCP. -The facility policy for a resident complaining of CP was to call 911 and send to the hospital for evaluation. -The MA or SCD was responsible calling 911. -It was her understanding 911 was called and she did not find out Resident #1 was still in the facility until the POA arrived around 9:30am. -Resident #1's POA gave a verbal refusal over the phone to not send Resident #1 out to the hospital for evaluation. -She could not override the POA's decision. -It was her understanding the POA knew Resident #1 complained of CP and refused transport to the hospital. -Later on, 10/25/21, the staff were called by the POA, and were informed Resident #1 had a heart attack. -She did not find out the POA was told Resident #1 only complained of body aches and a fever. -It was her expectation the staff call 911, let the emergency personnel evaluate and give the correct information to the POA so that an informed decision could be made to send to the hospital or not. _____ The staff failed to respond in accordance with the facility's policy and procedures to call	D 271		

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D 271	Continued From page 6 911/Emergency Medical Services (EMS) for evaluation, treatment and potential transportation to a hospital. The staff failed to call 911 in regard to a resident complaining of chest pain, heaviness in the chest, clamminess, and pallor resulting in a 4 hour delay of treatment. Resident #1 experienced a heart attack and required a stent placement with a 5 day hospitalization. This failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/02/21. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 6, 2021.	D 271		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 5 sampled residents (Resident #1) regarding finger stick blood sugar (FSBS) check.	D 276		

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D 276	Continued From page 7 The findings are: Review of Resident #1's previous FL2 dated 10/25/21 revealed diagnoses included diabetes mellitus II (DM II), increased cholesterol, high blood pressure, hyperglycemia, chronic kidney disease and dementia. Review of Resident #1's hospital discharge summary dated 10/29/21 revealed: -There was an admission date of 10/25/21. -The admission diagnoses included heart attack, and diabetic ketoacidosis (a life-threatening complication of diabetes) without coma associated with type 2 diabetes. -Resident #1 was discharged on 10/29/21. -A discharge order for finger stick blood sugars (FSBS) every day before meals. Review of Resident #1's October 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check and record FSBS before meals with a start date of 10/29/21 scheduled at 8:00am, 12:00pm and 4:00pm. -On 10/30/21, at 8:00am and 12:00pm the FSBS was documented as "leave of absence" (LOA) at hospital. -On 10/31/21, at 8:00am and 12:00pm the FSBS was documented as "did not give" glucometer not available. Review of Resident #1's November 2021 electronic eMAR revealed: -There was an entry to check and record FSBS before meals with a start date of 10/29/21 documented at 8:00am, 12:00pm and 4:00pm. -On 11/01/21, at 8:00am and the FSBS was documented as "did not give", "blood glucose not available".	D 276		

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-On 11/01/21, at 12:00pm the FSBS was documented as "refused".

Review of Resident #1's glucometer on 11/03/21 at 12:44pm revealed there were no FSBS results recorded between 10/29/21 at 4:30pm to 10/31/21 at 5:22pm.

Interview with the Special Care Director (SCD) on 11/02/21 at 10:39am revealed:
-Resident #1 returned from the hospital on 10/29/31 after high blood sugar and a heart attack.
-There were orders on the discharge summary to check and document Resident #1 FSBS before meals and administer insulin according to the sliding scale.
-Resident #1 did not receive a glucose meter from the pharmacy on 10/29/21 with the insulin.
-She and the Health and Wellness Director (HWD) notified the POA to bring one to the facility.
-On 10/30/21, the HWD came to the facility in the evening and found an unused glucometer to use.
-It was the staff's responsibility to obtain a blood glucose monitor to check the FSBS if the pharmacy or POA did not supply one.

Telephone interview with a Nurse from Resident #1's primary care physician (PCP) office on 11/02/21 at 4:14pm revealed:
-Resident #1 began having episodes of low blood sugar so 10/01/21 Resident #1's FSBS and diabetic medications were discontinued.
-Resident #1's office notes indicated on 10/01/21 if Resident #1 blood sugars started moving up above or A1C was greater than 8, he would start FSBS checks and sliding scale insulin.
-The POA notified the PCP on 10/25/21, Resident #1 was in the hospital 10/25/21 to 10/29/21 due to

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high blood sugars above 500, A1C of 9.0 and diabetic ketoacidosis (DKA, a life-threatening problem that affects people with diabetes).
-There was an order in the hospital discharge summary to monitor Resident #1's FSBS before meals and administer insulin according to a SSI.
-It was the PCP's expectation to check Resident #1's FSBS once returned from the hospital as ordered in order to help prevent complications of diabetes like diabetic ketoacidosis and heart attack which could be detrimental and lead to death.

Telephone interview with Resident #1's Power of Attorney (POA) on 11/03/21 at 9:50am revealed:
-From August 2021 to end of September 2021, Resident #1 has episodes of low blood sugars.
-On 10/01/21, Resident #1's PCP discontinued Resident #1's diabetic medication and FSBS and stated if the FSBS increased or A1C increased to 8 or above the plan would be to put on FSBS and sliding scale insulin (SSI).
-When Resident #1 was discharged from the hospital after having a heart attack and dealing with DKS during the hospitalization, Resident #1 was ordered FSBS and SSI.
-The HWD notified him on 10/31/21, to bring a glucometer because they did not have one.
-He did not get one to the facility because he was told on 11/01/21 the staff was checking the blood sugars.
-He though the staff was checking the FSBS all along.

Interview with the HWD on 11/03/21 at 11:55am revealed:
-Resident #1 returned from the hospital on 10/29/21 around supper time.
-The hospital discharge orders included an order to check Resident #1's FSBS and administer SSI.

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-The pharmacy sent the SSI but did not send a glucose monitor, so she contacted Resident #1's POA and asked him to bring one.
-She did not look for one at the facility until 10/31/21 when she came in the evening to do some paperwork and Resident #1 was not getting his blood sugars checked and SSI was not being administered.
-After she spoke to Resident #1's POA on 10/31/21, she checked in the facility and found an unused glucometer to use.
-It was the MA responsibility to notify her a monitor was not delivered by Resident #1's POA on 10/29/21.
-It was the staff's responsibility to provide a monitor on 10/29/21 if Resident #1's POA did not bring one.

Telephone interview with a representative from Resident #1's cardiologist office on 11/02/21 at 4:14pm revealed:
-Resident #1 hospital discharge orders on 10/29/21 included FSBS before meals and administer SSI.
-The purpose of checking FSBS in a resident with diabetes and after having a heart attack and DKA was reduce the damage to the blood vessels in the heart caused by high blood sugars which could lead to another heart attack.
-This damage increased the risk of heart disease.
-The higher the A1C, the more damage to the heart vessels which could significantly increase the risk of a heart attack or stroke which could cause death.
-Diabetes, specifically hyperglycemia, is detrimental to the vascular health and plays an integral role in the development of vascular disease.
-The likelihood of the development of a subsequent myocardial or vascular event is most

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D 276	Continued From page 11 likely moderate give the comorbidities such as Type 2 Diabetes, prior coronary artery disease and age. Telephone interview with the Administrator on 11/05/21 at 4:30pm revealed: -The MA, SCD or HWD or who ever was present at the time Resident #1 arrived back to the facility was responsible for faxing all orders to the pharmacy for processing. -The HWD was responsible for audits to check for orders not implemented. -She was unsure how often the HWD performed the audits. -It was her understanding the family was brining in a glucometer. -She was told there was one in the facility. -It was her expectation if the glucometer did not arrive on 10/29/21, the staff obtained one from inside the facility or go and purchase one.	D 276		
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: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to administer medications as	D 358		

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ordered for 2 of 5 sampled residents related to sliding scale insulin before meals (Resident #1) and administering blood pressure medications (Resident #2).

The findings are:

1. Review of Resident #1's FL2 dated 10/25/21 revealed:
-Diagnoses included diabetes mellitus II (DM II), increased cholesterol, high blood pressure, hyperglycemia chronic kidney disease and dementia.

Review of Resident #1's hospital discharge summary dated 10/29/21 revealed:
-There was an admission date of 10/25/21.
-The admission diagnoses included heart attack, elevated brain natriuretic peptide level (BNP, a test to indicate heart failure), and diabetic ketoacidosis (a life-threatening complication of diabetes) without coma associated with type 2 diabetes.
-A cardiac catherization was performed on 10/26/21 with stent placement in the left anterior descending artery (LAD, is the largest coronary artery of the heart).
-A discharge order for finger stick blood sugars (FSBS) ever day 15 minutes before meals and lispro sliding scale insulin (SSI is a rapid acting insulin) as follows; 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 201-350 = 8 units, and 351-400 = 10 units.

Review of Resident #1's October 2021 electronic Medication Administration Record (eMAR) revealed:
-An entry for lispro (a fast-acting insulin) SSI as follows; 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 201-350 = 8 units, and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 351-400 = 10 units to start on 10/29/21 scheduled to be administered at 8:00am, 12:00pm and 4:30pm. -Lispro SSI was documented as not administered on 10/29/21 at 4:30pm, 10/30/21 at 8:00am, 12:00pm and 4:30pm and on 10/31/21 at 8:00am and 12:00pm because there was no blood glucose meter available. Observation during medication pass on 11/02/21 at 10:39am revealed: -The medication aide (MA) did not obtain Resident #1's FSBS at 8:00am on 11/02/21 and the Special Care Director (SCD) obtained it herself. -The SCD obtained a FSBS from Resident #1 at 10:39am was 385 and required 10 units of lispro SSI insulin. -The SCD administered 10 units of lispro SSI to Resident #1 at 10:40am and instructed the MA to document the SSI in Resident #1's eMAR. Review of Resident #1's November 2021 eMAR revealed: -An entry for lispro SSI as follows; 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 201-350 = 8 units, and 351-400 = 10 units to start on 10/29/21 scheduled to be administered at 8:00am, 12:00pm and 4:30pm, documented as administered 11/01/21 at 12:00pm and 4:30pm. -On 11/01/21, at 8:00am, the lispro was documented as, not administered, "no blood glucose meter". -On 11/02/21, the 8:00am entry was documented as lispro 10 units administered at 11:28am. -On 11/02/21, the 12:00pm, entry was documented as 8 units administered at 1:37pm. Interview with a MA on 11/02/21 at 1:45pm revealed:	D 358		

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D 358	Continued From page 14 -On 11/02/21, at 10:40am, the SCD obtained a FSBS from Resident #1 and administered 10 units of lispro SSI as she watched. -The SCD told her to document the FSBS and SSI administered as soon as possible. -She was busy and did not document the FSBS and SSI administered until around 11:30am, but she documented it in the 8:00am slot. -She checked Resident #1 FSBS after lunch around 1:30pm and it was 308 and she administered 8 units of SSI. -She did not know she was to check Resident #1's FSBS within 15 minutes of a meal and administer the SSI or make sure that Resident #1 ate his meal. -She saw Resident #1 in the dining room on 11/02/21 at 12:00pm but did not see that he ate the meal. -She checked Resident #1's FSBS and administered more SSI after lunch and she knew he did not eat anything else. Interview with a pharmacy technician from the facility's contracted pharmacy on 11/03/21 at 10:53am revealed: -On 10/29/21, the pharmacy received a discharge summary from the facility with an order check and record FSBS before meals and inject lispro insulin 15 minutes before a meal per SSI; 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 201-350 = 8 units, and 351-400 = 10 units to start on 10/29/21. -The facility staff was responsible for the administration times per Resident #1's meal schedules. -Lispro 100units/ml, 10ml bottle was dispensed to the facility on 10/29/21 to start on 10/29/21 before evening meal. -Lispro fast acting insulin that needed to be administered 15 minutes before a meal and was	D 358		

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to be held if Resident #1 was not going to eat.

Interview with the Health and Wellness Director (HWD) on 11/03/21 at 11:55am revealed:
-Resident #1's FSBS and SSI administration was to be completed within 30 minutes before eating a meal.
-She did not know Resident #1 was receiving FSBS and SSI at the wrong times.
-The MAs were responsible for following the physician's order as it was written.
-She was responsible for running a report daily to audit for missed, or late medications.
-She did not run a report on Resident #1 on or after 10/29/21 because of other duties.

Telephone interview with a Nurse from Resident #1's cardiologist's office on 11/04/21 at 10:30am revealed:
-Resident #1 hospital discharge orders dated 10/29/21 included FSBS before meals and administer SSI.
-Resident #1's lispro SSI was a fast-acting insulin and required him to eat within 30 minutes after receiving the insulin or it could cause him to have low blood sugar which could require medical intervention.

Interview with the SCD on 11/04/21 at 11:30am revealed:
-On 11/02/21, she obtained Resident #1's FSBS and administered the SSI because the MA did not know how to administer insulin using a syringe.
-Resident #1's FSBS and SSI was to be completed 30 minutes before Resident #1 ate a meal.
-She did not know the MA obtained another FSBS and administered SSI after lunch.
-She was responsible for eMAR audit on a monthly basis and she did not complete and

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eMAR audit on Resident #1 since he returned from the hospital on 10/29/21.

Telephone interview with the Administrator on 11/05/21 at 4:30pm revealed:
-It was the MAs responsibility to administer the medications as ordered.
-Resident #1's insulin was to be administered 30 minutes before his meal.
-She did not know the MA administered insulin after a meal.
-The HWD was responsible for audits to check for medications not administered as ordered.
-She was unsure how often the HWD performed the audits.

2. Review of Resident #2 's current FL2 dated 06/28/21 revealed a diagnosis for rheumatoid arthritis.

Review of a physician order for Resident #2 dated 09/15/21 revealed:
-An order for change blood pressure medication to 1:00pm on Tuesday, Thursday and Saturday after dialysis.
-There was no clarification as to which blood pressure medication should be changed or if all three blood presure medications were to be changed to 1:00pm on Tuesday, Thursday and Saturday after dialysis.

Review of Resident #2's electronic medication administration record (eMAR) for September 2021 revealed:
-A computer generated entry for Coreg 25mg (for high blood pressure) one tablet twice daily, scheduled for administration at 8:00am and 8:00pm.
-A computer generated entry for Cozaar 100mg (for high blood pressure) one tablet daily,

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scheduled for administration at 8:00am.
-A computer generated entry for Procardia XL 90 mg extended release (ER) (for high blood pressure) one tablet daily, scheduled for administration at 8:00am.

Review of Resident #2's electronic medication administration record (eMAR) for October 2021 revealed:
-A computer generated entry for Coreg 25mg one tablet twice daily, scheduled for administration at 8:00am and 8:00pm.
-A computer generated entry for Cozaar 100mg one tablet daily, scheduled for administration at 8:00am.
-A computer generated entry for Procardia XL 90 mg extended release (ER) one tablet daily, scheduled for administration at 8:00am.
Review of Resident #2's electronically signed physician orders dated 09/15/21 revealed an order for change blood pressure medication to 1:00pm after dialysis.

Review of Resident #2's electronic medication administration record (eMAR) for 11/01/21-11/03/21 revealed:
-A computer generated entry for Coreg 25mg one tablet twice daily, scheduled for administration at 8:00am and 8:00pm.
-A computer generated entry for Cozaar 100mg one tablet daily, scheduled for administration at 8:00am.
-A computer generated entry for Procardia XL 90 mg extended release (ER) one tablet daily, scheduled for administration at 8:00am.

Observation of Resident #2's medications on hand on 11/04/21 at 3:35pm revealed:
-A blister pack with a medication labeled Coreg 25mg with instructions to take one tablet twice

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daily.
-A blister pack with a medication labeled Cozaar 100mg with instructions to take one tablet daily.
-A blister pack with a medication labeled Procardia XL 90 mg extended release (ER) with instructions to take one tablet daily.

Interview with Resident #2 on 11/03/21 at 4:07pm revealed:
-His blood pressure was high when he arrived at dialysis.
-On the days he went to dialysis he did not get his blood pressure medications in the morning.
-He only received Coreg 25mg at 8pm on his dialysis days.
-He had asked the Health and Wellness Director (HWD) to get his blood pressure medications changed to 1:00pm when he comes back from dialysis to keep his blood pressure down.
-His blood pressure medication times had not changed.

Interview with the HWD on 11/04/21 at 9:30am revealed:
-She had a conversation with Resident #2 in September 2021 about his concerns related to receiving his blood pressure medications after he returned from dialysis.
-She had asked the Resident Care Coordinator (RCC) to get an order form the physician to have Resident #2's blood pressure medications changed from 8:00am until Resident #2 returned from dialysis on Tuesday, Thursday and Saturday.
-The RCC had told her she had obtained the order for the blood pressure medications to be changed to 1:00pm on dialysis days.
-She was not aware the order change for Resident #2's blood pressure medication had not been updated on the eMAR and Resident #2 was

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not receiving his blood pressure medication when he returned from dialysis.

Interview with the Resident Care Coordinator (RCC) on 11/04/21 at 10:15am revealed:
-She assisted the HWD in obtaining and verifying physician orders, ensuring the eMAR's were correct and chart audits, putting together resident records upon admission and other duties.
-She would send the new orders or change in orders she received by fax to the pharmacy and then the pharmacy would enter the order into the eMAR system.
-She would also place a copy of the order in the resident record.
-She or the HWD would verify the orders.
-She was not aware the order from 09/15/21 for a change in times for Resident #2's blood pressure medication was not on the eMAR.
-Either she or the HWD were responsible for ensuring orders were correct and on the eMAR.
-She was not sure what had happened with the order on 09/15/21 for Resident #2.

Interview with a medication aide (MA) on 11/04/21 at 10:50am revealed:
-Resident #2 was compliant taking his medications and did not refuse them.
-Resident #2 received a medication when he returned from his dialysis, but it was not any of his blood pressure medications.
-Resident #2 did not get any of his morning medications before he went to dialysis as he would only receive the 8:00pm dose of one of his blood pressure medications.

Interview with the facility contract pharmacy technician on 11/04/21 3:32pm revealed:
-The facility faxes the new orders or changes in orders to the pharmacy and the pharmacy will

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enter the order on the eMAR.
-The pharmacy had never received the order for the change in blood pressure medications on 09/15/21 so the order was never changed for Resident #2.

Interview with Resident #2's clinical manager at the local dialysis center on 11/04/21 at 11:36am revealed:
-The nurse practitioner (NP) had met with Resident #2 on 11/02/21 while he was at dialysis.
-Resident #2's blood pressure had remained elevated each time Resident #2 came in for dialysis.
-The NP had shared those concerns with Resident #2.
-If Resident #2 was missing scheduled doses of his blood pressure medications on the morning he came to dialysis this could contribute to his blood pressure being elevated.
-Dialysis patients with continued high blood pressure have an increased chance of worsening kidney function and heart problems.

Interview with the Administrator on 11/05/21 at 4:30pm revealed:
-She was not aware Resident #2 had asked for his blood pressure medications to be given after he returned from dialysis.
-She was not aware there was an order for the change in times for Resident #2's blood pressure medication.
-She expected staff to follow physician orders.

Attempted telephone interview with Resident's #2 physician was unsuccessful on 11/04/21 at 11:35am and 11/05/21 at 1:23pm.

The facility failed to ensure medications were administered as ordered for 2 of 5 sampled

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D 358	Continued From page 21 residents including a diabetic resident with a recent hospitalization after a heart attack and DKA with orders to check and record FSBS before meals and inject lispro insulin 15 minutes before a meal per SSI, who received the SSI after a meal was eaten (#1); a dialysis resident who did not receive a change in times for three blood pressure medications which resulted in higher blood pressures which could lead to worsening kidney function and heart problems.(#2). This failure was detrimental to the health of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/04/21 for this violation. CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2021	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the	D 367		

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omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 1 of 5 sampled residents including medications for diabetes (Resident #1) and a blood pressure medication (Resident #2).

The findings are:

1. Review of Resident #1's previous FL2 dated 09/12/21 revealed:
-Diagnoses included diabetes mellitus II (DM II), increased cholesterol, high blood pressure, hyperglycemia chronic kidney disease and dementia.

Review of Resident #1's October 2021 eMAR revealed:
-A computer generated entry for lispro (a fast-acting insulin) SSI as follows; 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 201-350 = 8 units, and 351-400 = 10 units to start on 10/29/21 scheduled to be administered at 8:00am, 12:00pm and 4:30pm.
-Lispro documented as not administered on 10/29/21 at 4:30pm, 10/30/21 at 8:00am, 12:00pm and 4:30pm and on 10/31/21 at 8:00am and 12:00pm.
-Lispro documented as 4 units administered on 10/31/21, at 4:30pm.

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Observation during medication pass on 11/02/21 at 10:39am revealed:
-The medication aide (MA) did not obtain Resident #1's FSBS at 8:00am on 11/02/21 and the SCD obtained it herself on 11/02/21 at 10:39am.
-The SCD obtained a FSBS from Resident #1 at 10:39am was 385 and required 10 units of lispro SSI insulin.
-The SCD administered 10 units of lispro SSI to Resident #1 at 10:40am and instructed the MA to document the SSI in Resident #1's eMAR.

Review of Resident #1's November 2021 eMAR revealed:
-An entry for lispro SSI as follows; 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 201-350 = 8 units, and 351-400 = 10 units to start on 10/29/21 scheduled to be administered at 8:00am, 12:00pm and 4:30pm, documented as administered 11/01/21 at 12:00pm and 4:30pm.
-On 11/02/21, the 8:00am entry was documented as lispro 10 units administered at 11:28am.
-On 11/02/21, the 12:00pm, entry was documented as 8 units administered at 1:37pm.

Interview with a MA on 11/02/21 at 1:45pm revealed:
-On 11/02/21, at 10:40am, the SCD obtained a FSBS from Resident #1 and administered 10 units of lispro SSI as she watched.
-The SCD told to document the FSBS and SSI administered as soon as possible.
-She was busy and did not document the FSBS and SSI administered until around 11:30am, but she documented it in the 8:00am slot.
-She checked Resident #1 FSBS after lunch around 1:30pm and it was 308 and she administered 8 units of SSI in the 12:00pm slot.
-When she entered the lispro SSI information in

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the eMAR, she changed the time to correlate the time the medication was supposed to be administered.
-She was trained to check the eMAR with the resident's medications, administer the medications according to the order and document after she administered the medications.
-She was busy and did not get to the medications as ordered so she changed the time.

Interview with the Health and Wellness Director (HWD) on 11/03/21 at 11:55am revealed:
-Resident #1 FSBS and SSI was to be administered at 8:00am, 12:00pm and 4:30pm.
-She did not know Resident #1 was receiving FSBS and SSI at the wrong times.
-The MA were responsible for following the physician's order as administer the medications at the correct time and document the correct time it was administered.
-She did not know the MA's could change the times on the eMAR.
-She was responsible for running a Time Variance Report (TVR) daily to audit for the actual times the medications were documented.
-She did not run a TVR on Resident #1 on or after 10/29/21 because of other duties.

Interview with the SCD on 11/04/21 at 11:30am revealed:
-Resident #1 FSBS and SSI was to be administered at 8:00am, 12:00pm and 4:30pm.
-She did not know Resident #1 was receiving FSBS and SSI at the wrong times.
-The MA were responsible for documenting the medications at the correct time they were administered.
-She did not know the MA's could change the times on the eMAR.
-She was responsible for monthly eMAR audits to

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check for late administered medications which would include the actual time stamp of each medication administered.

Telephone interview with the Administrator on 11/05/21 at 4:30pm revealed:
-The MA responsibility to administer the medications and documenting the medications as soon as the medications were administered before moving to the next resident.
-The HWD was responsible for audits to check for medications administered at the incorrect times.
-She was unsure how often the HWD performed the audits.

2. Review of Resident #2 's current FL2 dated 06/28/21 revealed a diagnosis for rheumatoid arthritis.

Review of Resident #2's Care Plan revealed there was no care plan for Resident #2.

Review of the electronic medication administration record (eMAR) summary revealed diagnoses of rheumatoid arthritis, dependence on renal dialysis, end stage renal disease, gastrophageal reflux disease, hyperkalemia, hypertensive chronic kidney disease stage 5, muscle weakness and dysphagia.

a. Review of Resident #2's electronic medication administration record (eMAR) for September revealed:
-A computer generated entry for Coreg 25mg (for high blood pressure) one tablet twice daily, scheduled for administration at 8:00am and 8:00pm.
-Coreg 25mg was documented as administered at 8:00am on 09/04/21, 09/14/21, 09/16/21,

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D 367	Continued From page 26 9/21/21, 9/23/21, 09/28/21. Review of the blood pressure seating time log from the dialysis center for Resident #2 revealed: -On 09/04/21 it was documented at 7:16am. -On 09/14/21 it was documented at 7:20am. -On 09/16/21 it was documented at 7:21am. -On 09/21/21 it was documented at 7:14am. -On 09/23/21 it was documented at 7:28am. -On 09/28/21 it was documented at 7:28am. Review of Resident #2's eMAR for October revealed: -A computer generated entry for Coreg 25mg one tablet twice daily, scheduled for administration at 8:00am and 8:00pm. -Coreg 25mg was documented as administered at 8:00am on 09/04/21. Review of the seating time at the dialysis center for Resident #2 revealed on 09/04/21 was documented at 7:16am. Review of Resident #2's eMAR for 11/01/2021-11/03/21 revealed: -A computer generated entry for Coreg 25mg one tablet twice daily, scheduled for administration at 8:00am and 8:00pm. -Coreg 25mg was documented as administered at 8:00am on 09/04/21, 09/09/21, 09/14/21, 09/16/21, 09/21/21, 09/23/21, 09/28/21. Review of the blood pressure seating time log from the dialysis center for Resident #2 revealed: -On 09/04/21 it was documented at 7:16am. -On 09/09/21 it was documented at 7:19am. -On 09/14/21 it was documented at 7:20am. -On 09/16/21 it was documented at 7:21am. -On 09/21/21 it was documented at 7:14am. -On 09/23/21 it was pressure documented at	D 367		

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7:28am.
-On 09/28/21 it was documented at 7:28am.

Refer to interview with Resident Care Coordinator (RCC) on 11/04/21 at 10:15am.

Refer to interview with a medication aide (MA) on 11/04/21 at 10:50am.

Refer to interview with Health and Wellness Director (HWD) on 11/04/21 at 9:30am.

Refer to interview with Administrator on 11/05/21 at 4:30pm.

b. Review of Resident #2's electronic medication administration record (eMAR) for September revealed:
-A computer generated entry for Cozaar 100mg (for high blood pressure) one tablet daily, scheduled for administration at 8:00am.
-Cozaar 100mg was documented as administered at 8:00am on 09/04/21.

Review of the seating time at the dialysis center for Resident #2 revealed on 09/04/21 was documented at 7:16am.

Review of Resident #2's eMAR for October revealed:
-A computer generated entry for Cozaar 100mg one tablet daily, scheduled for administration at 8:00am.
-Cozaar 100mg was documented as administered on 10/07/21 at 2:46pm, 10/12/21 at 8:12am, 10/16/21 at 2:29pm and 10/23/21 at 12:39pm.

Review of the blood pressure seating time log from the dialysis center for Resident #2 revealed:

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-On 10/07/21 it was documented at 7:23am.
-On 10/12/21 it was documented at 7:24am.
-On 10/16/21 it was documented at 7:19am.
-On 10/23/21 it was documented at 7:15am.

Review of Resident #2's eMAR for 11/01/2021-11/03/21 revealed:
-A computer generated entry for Cozaar 100mg one tablet daily, scheduled for administration at 8:00am.
-Cozaar 100mg was documented as administered at 8:00am on 11/02/21.

Review of the seating time at the dialysis center for Resident #2 was documented at 7:24am.

Refer to interview with Resident Care Coordinator (RCC) on 11/04/21 at 10:15am.

Refer to interview with a medication aide (MA) on 11/04/21 at 10:50am.

Refer to interview with Health and Wellness Director (HWD) on 11/04/21 at 9:30am.

Refer to interview with Administrator on 11/05/21 at 4:30pm.

c. Review of Resident #2's electronic medication administration record (eMAR) for September revealed:
-A computer generated entry for Procardia XL 90 mg extended release (ER) (for high blood pressure) one tablet daily, scheduled for administration at 8:00am.
- Procardia XL 90 mg ER was documented as administered at 8:00am on 09/04/21, 09/09/21, 09/14/21, 09/16/21, 09/21/21, 09/21/21, 09/28/21.

Review of the blood pressure seating time log

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from the dialysis center for Resident #2 revealed:
-On 09/04/21 it was documented at 7:16am.
-On 09/09/21 it was documented as 7:19am.
-On 09/14/21 it was documented at 7:20am.
-On 09/16/21 it was documented at 7:21am.
-On 09/21/21 it was documented at 7:14am.
-On 09/23/21 it was documented at 7:28am.
-On 09/28/21 it was documented at 7:28am.

Review of Resident #2's eMAR for October revealed:
-A computer generated entry for Procardia XL 90 mg extended release (ER) one tablet daily, scheduled for administration at 8:00am.
- Procardia XL 90 mg ER was documented as administered on 10/05/21 at 12:35pm, 10/09/21 at 12:31pm, 10/23/21 at 12:39pm, 10/26/21 at 12:21pm.

Review of the blood pressure seating time log from the dialysis center for Resident #2 revealed:
-On 10/05/21 it was documented as 7:23am.
-On 10/09/21 it was documented as 7:30am.
-On 10/23/21 it was documented as 7:15am
-On 10/26/21 it was documented as 7:09am

Review of Resident #2's eMAR for 11/01/2021-11/03/21 revealed:
-A computer generated entry for Procardia XL 90 mg extended release (ER) one tablet daily, scheduled for administration at 8:00am.
- Procardia XL 90 mg ER was documented as administered on 11/02/21 at 9:52am.

Review of the seating time at the dialysis center for Resident #2 was documented on 11/02/21 at 7:24am.

Refer to interview with Resident Care Coordinator (RCC) on 11/04/21 at 10:15am.

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D 367	Continued From page 30 Refer to interview with a medication aide (MA) on 11/04/21 at 10:50am. Refer to interview with Health and Wellness Director (HWD) on 11/04/21 at 9:30am. Refer to interview with Administrator on 11/05/21 at 4:30pm. _____ Interview with the Resident Care Coordinator (RCC) on 11/04/21 at 10:15am revealed: -She assisted the HWD in obtaining and verifying physician orders, ensuring the eMAR's were correct and chart audits, putting together resident records upon admission and other duties. -She expected staff to document accurately. -She was not aware staff were documenting medications as administered when Resident #2 was not in the facility. Interview with a medication aide (MA) on 11/04/21 at 10:50am revealed: -Resident #2 did not get any of his morning medications before he went to dialysis. -She could not recall documenting administration of medications after Resident #2 was out of the facility. -She must have documented it by mistake. Interview with the Health and Wellness Director (HWD) on 11/04/21 at 9:30am revealed: -She expected staff to document medications when they were given. -She was not aware staff were documenting any medications when Resident #2 was not in the facility. -She had not completed a chart audit for accuracy on the eMARS.	D 367		

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D 367	Continued From page 31 Interview with the Administrator on 11/05/21 4:30pm revealed: -She expected staff to document when they gave the resident a medications as they had been taught to. -She was not aware staff had documented the administration of medication when Resident #2 was not in the facility.	D 367		
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 related to personal care and supervision and medication administration. The findings are: 1. Based on record reviews and interviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents related to sliding scale insulin before meals (Resident #1) and administer blood pressure medications (Resident #2). [Refer to Tag D 271 10A NCAC 13F .0901(C) Personal Care and Supervision (Type A1 Violation)].	D912		

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D912	Continued From page 32 2. Based on record reviews and interviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents related to not administering sliding scale insulin before meals (Resident #1) and administering blood pressure medications (Resident #2). [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program	D935		

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developed by the Department that includes training and instruction in all of the following:
1. The key principles of medication administration.
2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (staff C) who administered medications had completed the state approved 5-hour and 10-hour medication aide training course as required and 2/3 sampled Medication Aides (staff A and C) had successfully completed the clinical skills validation portion of the competency evaluation prior to the administration of medications..

The findings are:

1. Review of Staff C's medication aide (MA), personnel file revealed:
-Date of hire was 06/13/21.
-Her position title was MA.
-She was an agency MA.
-She passed the written medication exam on 08/24/05.
-There was no documentation of completion of the 5, 10 or 15-hour medication aide training.

Interview with a Staff C on 11/03/21 at 4:00pm revealed:
-She was a second shift MA for the facility for 5

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months.
She received all her training from the staffing agency.
-She completed her medication aide training at the agency.

Interview with the Administrator on 11/05/21 at 4:30pm revealed:
-Most of the MAs were agency.
-The agency sent over the personnel file for each MA.
-She did not know she was to have a copy of the clinical skills checklist in their folder at the facility.

2. Observation during the medication pass on 11/02/21 from 10:00am to 10:50am revealed she administered 25 different medications to 4 different residents.

Review of Staff A's MA, personnel file revealed:
-Date of hire was 07/23/21.
-Her position title was Medication Aide (MA).
-She was an agency MA.
-She passed the written medication exam on 07/12/21.
-There was no documentation of completion of clinical skills validation.

Interview with Staff A on 11/02/21 at 10:38am revealed:
-She was a first and second shift MA for the facility for 4 months.
She received all her training from the staffing agency.
-She completed her medication aide training and clinical skill checklist at the agency.

Refer to interview with the Administrator on 11/05/21 at 4:30pm.

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D935	Continued From page 35 3. Review of Staff C's MA, personnel file revealed: -Date of hire was 06/13/21. -Her position title was MA. -She was an agency MA. -She passed the written medication exam on 08/24/05. -There was no documentation of completion of clinical skills validation. Interview with a Staff C on 11/03/21 at 4:00pm revealed: -She was a second shift MA for the facility for 5 months. She received all her training from the staffing agency. -She completed her medication aide training and clinical skill checklist at the agency. Refer to interview with the Administrator on 11/05/21 at 4:30pm. _____ Interview with the Administrator on 11/05/21 at 4:30pm revealed: -Most of the MAs were agency. -The agency sent over the personnel file for each MA. -She did not know she was to have a copy of the clinical skills checklist in their folder at the facility.	D935		