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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 10/19/22 and 10/20/22.	D 000		
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 interviews, and record reviews, the facility failed to ensure implementation of an order for 1 of 5 sampled residents (#2) related to not notifying the primary care provider (PCP) that the resident's diastolic pressure was less than (<) 60. The findings are: Review of Resident #2's current FL-2 dated 05/09/22 revealed diagnoses included chronic obstructive pulmonary disease (COPD), hypertension and atrial fibrillation. Review of Resident #2's primary care provider (PCP) order dated 05/09/22 revealed an order to obtain monthly vital signs and weight; notify the PCP if the diastolic pressure was less than (<) 60. (Diastolic pressure is the bottom number of a blood pressure and is the amount of pressure in the arteries between beats). Review of Resident #2's August 2022 electronic medication administration record (eMAR)	D 276		

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revealed:
-There was an entry to obtain vital signs daily, notify PCP for diastolic blood pressure was less than (<) 60 related to hypertension.
-The resident's diastolic blood pressure was documented as <60 on 3 occasions ranging from 51 to 58.
-The diastolic blood pressure was 55 on 08/09/22, 51 on 08/11/22, and 58 on 08/22/22.
-There was no documentation the resident's PCP was notified on 08/09/22, 08/11/22, or 08/22/22.

Review of Resident #2's September 2022 electronic medication administration record (eMAR) revealed:
-There was an entry to obtain vital signs daily, notify PCP for diastolic blood pressure was less than (<) 60 related to hypertension.
-The resident's diastolic blood pressure was documented as <60 on 5 occasions ranging from 49 to 59.
-The diastolic blood pressure was 54 on 09/02/22, 58 on 09/08/22, 49 on 09/11/22, 53 on 09/15/22, and 59 on 09/29/22.

-There was no documentation the resident's PCP was notified on 09/02/22, 09/08/22, 09/11/22, 09/15/22, or 09/29/22.

Review of Resident #2's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry to obtain vital signs daily, notify PCP for diastolic blood pressure was less than (<) 60 related to hypertension.
-The resident's diastolic blood pressure was documented as <60 on 5 occasions ranging from 47 to 59.
-The diastolic blood pressure was 47 on 10/07/22, 50 on 10/10/22, 56 on 10/13/22, 48 on

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10/14/22, and 59 on 10/16/22.
-There was no documentation the resident's PCP was notified on 10/07/22, 10/10/22, 10/13/22, 10/14/22, or 10/16/22.

Review of Resident #2's facility progress notes revealed there was no documentation that the PCP was notified of 13 times the resident's diastolic blood pressure was <60 as ordered.

Interview with a medication aide (MA) on 10/20/22 at 2:42pm revealed:
-MAs were expected to follow physician orders.
-She was not sure why the PCP was not contacted when Resident #2's diastolic blood pressure was <60.
-MAs were expected to document in the facility progress note when the PCP was notified.

-MAs were expected to notify the Resident Care Coordinator (RCC) after they contacted the PCP.
-She must have forgotten to document that she notified the PCP when Resident #2's diastolic blood pressure was <60.

Interview with the RCC on 10/20/22 at 2:48pm revealed:
-MAs should have notified the PCP when Resident #2's diastolic blood pressure was <60.
-Staff had been trained on the importance of documentation and were expected to document any communication with the PCP.
-She expected the MAs to follow PCP orders to ensure the resident did not have increased health problems or a health emergency.
-The PCP may have changed medications if the MAs had informed him that Resident #2's diastolic blood pressure was <60.

Interview with the Director of Assisted Living on

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D 276	Continued From page 3 10/20/22 at 3:40pm revealed she expected MAs to follow PCP orders to ensure the resident did not have a fall or have a decline in their health. Telephone interview with Resident #2's primary care provider (PCP) on 10/20/22 at 3:27pm revealed: -He expected the MAs to follow orders. -The MAs should have informed him that Resident #2's diastolic blood pressure was <60. -He was concerned that he was not notified because it put Resident #2 at an increased risk of falls and a possible fracture.	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: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 1 of 2 residents (#4) observed during the medication pass including errors with a medication used to increase vitamin D levels, a nasal spray used to treat seasonal allergies, and a nasal spray used for dry nose. The findings are: The medication error rate was 9% as evidenced	D 358		

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by the observation of 3 errors out of 33 opportunities during the 8:00am medication pass on 10/19/22.

Review of Resident #4's current FL-2 dated 07/29/22 revealed diagnoses included acute respiratory failure with hypoxia (low oxygen levels).

a. Review of Resident #4's current FL-2 dated 07/29/22 revealed there was an order for vitamin D 50mcg (2000IU) daily (Vitamin D is a supplement used to increase vitamin D levels).

Review of Resident #4's physician progress notes dated 10/12/22 revealed:
-Resident #4's vitamin D level was low at 31.17.
-The primary care provider (PCP) would increase Resident #4's vitamin D to 4000IU daily and repeat a vitamin D level in 6 weeks.

Review of Resident #4's physician orders dated 10/12/22 revealed there was an order to increase vitamin D to 4000IU daily.

Observation of the 8:00am medication pass on 10/19/22 revealed the medication aide (MA) administered vitamin D 2000IU to Resident #4 at 9:46am.

Review of Resident #4's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for vitamin D 2000IU give one tablet by mouth one time a day scheduled for administration at 8:00am.
-Vitamin D 2000IU was documented as administered at 8:00am on 10/19/22.
-There was no entry for vitamin D 4000IU.

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Interview with Resident #4 on 10/19/22 at 11:15am revealed lately she had been more tired than usual.

Interview with the MA on 10/19/22 at 2:13pm revealed:
-She was not aware that Resident #4's vitamin D had been increased to 4000IU.
-When a resident received new medication orders either the MA or the Resident Care Coordinator (RCC) put the new medication order onto the eMAR.
-The new medication order was then reviewed by another MA and the new medication order was faxed to the facility's contracted pharmacy.

Interview with the RCC on 10/19/22 at 2:21pm revealed:
-She usually retrieved a resident's chart from the clinic at the facility and looked through the orders.
-If she was not available to look at resident's charts the 3-11 supervisor would look at them for new orders.
-She reviewed the new medication orders and put them on the eMAR for the residents.
-The medication orders were then verified by a MA.
-MAs could also put new medication orders on the eMAR.
-When a new order was received, she signed off on the order to show that it had been noted and the changes had been made.
-She or another staff member had not signed off on Resident #4's 10/12/22 physician orders so they must have gotten missed.
-She was not sure why the medication orders to increase vitamin D were missed for Resident #4.

Interview with the Director of Assisted Living on 10/19/22 at 2:44pm revealed:

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-Resident charts were retrieved from the clinic at the facility by either the RCC, the 3-11 supervisor, or a MA.
-Whoever retrieved the chart from the clinic was responsible for checking for new orders, entering any new medication orders on the eMAR, and faxing new medication orders to the facility's contracted pharmacy.
-New medications orders should be checked by a second person as well.
-She expected Resident #4's vitamin D orders to be followed and increased to 4000IU on the same day the order was received.

Interview with Resident #4's PCP on 10/20/22 at 3:25pm revealed:
-Resident #4's vitamin D level was not very low, and he did not think any harm came from not increasing the vitamin D dosage right away.
-He expected Resident #4's vitamin D to be increased as ordered.

b. Review of Resident #4's current FL-2 dated 07/29/22 revealed there was an order for Flonase 50mcg 1 spray in both nostrils in the morning (Flonase is a nasal spray used to treat seasonal allergies).

Review of Resident #4's physician orders dated 10/17/22 revealed:
-There was an order to hold Flonase 1 spray to both nostrils daily for 7 days.
-There was an order for Flonase 2 sprays to both nostrils twice daily for 7 days.

Observation of the 8:00am medication pass on 10/19/22 revealed the medication aide (MA) administered 1 spray of Flonase in each of Resident #4's nostrils at 10:05am.

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Review of Resident #4's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Flonase 50mcg 1 spray in both nostrils one time a day scheduled for administration at 8:00am.
-There was a "H" recorded for 10/18/22 to 10/25/22.
-There was an entry for Flonase 50mcg 2 sprays in each nostril two times a day scheduled for administration at 9:00am and 4:00pm.
-Flonase 2 sprays was documented as administered at 9:00am on 10/19/22.

Interview with Resident #4 on 10/19/22 at 11:15am revealed:
-Her nose had been more congested lately.
-She received her Flonase in each nostril, and she thought she was only supposed to receive one spray.

Interview with the medication aide (MA) on 10/19/22 at 2:13pm revealed:
-She administered 1 spray of Flonase in each of Resident #4's nostrils on 10/19/22.
-During the medication pass she looked at the label on Resident #4's Flonase and the eMAR and the orders did not match.
-Since the orders did not match, she should have looked at Resident #4's chart to verify the correct order before administering Flonase to Resident #4.
-The "H" on Resident #4's eMAR indicated that the medication was being held.
-She documented that she administered 2 sprays of Flonase to Resident #4 because that was the only place she could document it on the eMAR.

Interview with the Resident Care Coordinator (RCC) on 10/19/22 at 2:21pm revealed she

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expected the MA to read the eMAR and administer Resident #4's Flonase as it was ordered on the eMAR.

Interview with the Director of Assisted Living on 10/19/22 at 2:44pm revealed:
-She expected MAs to administer the correct dosage of medication to residents.
-She expected the MA to read the eMAR and administer 2 sprays of Flonase to Resident #4 because that is what was ordered.

Interview with Resident #4's primary care provider (PCP) on 10/20/22 at 3:25pm revealed:
-Resident #4 was experiencing an increase in her allergy symptoms and that was why her Flonase was increased.
-He expected Resident #4 to receive 2 sprays of Flonase because that is what was ordered.

c. Review of Resident #4's current FL-2 dated 07/29/22 revealed there was an order for sodium chloride solution (a saline solution used to treat dry nose) 0.65% 1 spray to both nostrils every morning 1 hour before Flonase (a nasal spray used to treat symptoms of seasonal allergies).

Observation of the 8:00am medication pass on 10/19/22 revealed:
-The medication aide (MA) administered 1 spray of Flonase to each of Resident #4's nostrils at 10:05pm.
-The MA administered 1 spray of sodium chloride solution to each of Resident #4's nostrils at 10:09am.

Review of Resident #4's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for sodium chloride solution

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0.65% 1 spray in both nostrils in the morning one hour before Flonase scheduled for administration at 7:30am.
-Sodium chloride 0.65% was documented as administered at 7:30am on 10/19/22.

Interview with Resident #4 on 10/19/22 at 11:15am revealed:
-She was not sure if she usually received her saline nasal spray before her Flonase or not.
-She knew she received 2 nasal sprays, and she usually received them at the same time.

Interview with the MA on 10/19/22 at 2:13pm revealed:
-She did not notice that Resident #4's eMAR stated to administer her saline nasal spray 1 hour before her Flonase.
-She would have to click further on the eMAR to see the complete order for Resident #4's saline nasal spray and she did not do so.
-Since Resident #4's saline nasal spray was scheduled for administration at 7:30am that is when it should have been administered.

Interview with the Resident Care Coordinator (RCC) on 10/19/22 at 2:21pm revealed:
-She expected MAs to click further on the eMAR so they could see the complete order for residents.
-She expected Resident #4 to receive her saline nasal spray at least 1 hour before her Flonase because that was how it was ordered.
-Since Resident #4's saline nasal spray was scheduled for administration at 7:30am it should not have been administered any later than 8:30am.

Interview with the Director of Assisted Living on 10/19/22 at 2:44pm revealed Resident #4 should

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D 358	Continued From page 10 have received her saline nasal spray at least 1 hour before she received her Flonase because that was how it was ordered. Interview with Resident #4's primary care provider (PCP) on 10/20/22 at 3:25 pm revealed he was not sure why Resident #4's saline nasal spray was ordered to be administered 1 hour before receiving her Flonase, but he expected her to receive her saline nasal spray 1 hour prior to her Flonase because it was ordered to be administered that way.	D 358		