STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL046020	A. BUILDING: _____ B. WING _____	R-C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHOSKIE ASSISTED LIVING	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(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 000}	Initial Comments The Adult Care Licensure section conducted a follow-up survey and a complaint investigation on 03/26/24 and 03/27/24.	{D 000}		
{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 observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#1, #4) including errors with a medication used to treat chronic obstructive pulmonary disease (COPD) (#4) and a medication used to control high blood sugars for a diabetic resident (#1). The findings are: 1. Review of Resident #4's current FL-2 dated 01/12/24 revealed: -Diagnoses of chronic obstructive pulmonary disease (COPD), dementia, and schizophrenia. -The resident's level of care was Special Care Unit (SCU). -There was an order for Ventolin HFA-108 mcg/actuation aerosol inhaler, inhale 2 puffs	{D 358}	The facility's care coordinator(s) will ensure that Medication Aides are reordering medications prior to running out. Completed 4/1/24. In the event a medication does run out such as these events, the facility will have the medications sent into the back-up pharmacy and communicate with the prescribing provider to discuss ability to administer when received. Completed 3/28/24 Care coordinator(s) will also ensure during monthly batch placement and cart audit that any medications that are not on a batch system will be reordered if close to running out. Completed 4/1/24 Care coordinator(s) will meet with each MA to discuss the importance of not leaving any medications in resident's rooms. Also monitoring to ensure resident has taken the medication as ordered. Completed 4/1/24.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Catie A Puhl, BHS-G,CDP	Administrator	4/16/2024

Reviewed and Acknowledged 05/05/24-MB

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{D 358}	Continued From page 1	{D 358}		

every four hours as needed (Ventolin HFA is a rescue inhaler used to treat and prevent breathing problems, shortness of breath and wheezing).
-There was an order for oxygen concentrator and portable oxygen concentrator at 3 liters per minute continuous.

Observation of Resident #4's room on 03/26/24 at 9:08am revealed:
-The resident was lying in her bed with her oxygen.
-There was a bedside table to the right of the resident's bed with a plastic prescription bag with a prescription label for Ventolin HFA-108 mcg/actuation with the resident's name, date dispensed of 03/14/24, inhale 2 puffs via inhaler every 4 hours as needed for wheezing.
-The Ventolin HFA inhaler was on the bedside table to the right of the plastic prescription bag.
-There was a counter on the back of the Ventolin HFA inhaler that showed 3 puffs were left in the inhaler.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/27/24 at 9:23am revealed Resident #4's Ventolin HFA-108 mcg/actuation aerosol inhaler had a total of 200 puffs on the back counter prior to usage.

Interview with Resident #4 on 03/26/24 at 9:08am revealed:
-She had a difficult time breathing most days due to her COPD.
-She used the inhaler "a lot" for shortness of breath and difficulty breathing.

Review of Resident #4's January 2024 electronic medication administration record (eMAR) revealed:

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{D 358}	Continued From page 2 -There was an entry for Ventolin HFA-108 mcg/actuation with instructions to inhale 2 puffs via inhaler every 4 hours as needed for wheezing. -There was no documentation that Ventolin HFA-108 mcg/actuation was administered from 01/14/24 to 01/31/24. Review of Resident #4's February 2024 eMAR revealed: -There was an entry for Ventolin HFA-108 mcg/actuation with instructions to inhale 2 puffs via inhaler every 4 hours as needed for wheezing. -There was no documentation that Ventolin HFA-108 MCG/ACT was administered from 02/01/24 to 02/29/24. Review of Resident #4's March 2024 eMAR revealed: -There was an entry for Ventolin HFA-108 MCG/Actuation (ACT) with instructions to inhale 2 puffs via inhaler every 4 hours as needed for wheezing. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/07/24 at 5:32am. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/09/24 at 5:51am. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/11/24 at 1:30am and 5:32am. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/12/24 at 5:34am. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/13/24 at 5:44am. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/14/24 at 1:56am, 6:14am, 12:35pm, 4:18pm, and	{D 358}		

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{D 358}	Continued From page 3 11:46pm. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/15/24 at 9:40am and 4:39pm. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/16/24 at 4:51pm and 10:14pm. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/17/24 at 5:37am, 3:54pm, and 7:18pm. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/18/24 at 5:15am and 3:40pm. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/20/24 at 4:22pm. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/21/24 at 3:52pm. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/22/24 at 5:00pm. -Ventolin HFA-108 mcg/actuation was documented as administered on 03/25/24 at 9:48am and 1:13pm. Observation of Resident #4's medications on hand on 03/26/24 revealed: -There was a Ventolin HFA inhaler in a plastic bag with printed instructions on a label to inhale 2 puffs via inhaler every 4 hours as needed for wheezing, dispensed on 03/14/24 with 200 puffs available. -There was a counter on the back of the Ventolin HFA inhaler that showed 3 puffs were left in the inhaler. -There was a Ventolin HFA inhaler in the manufacturers box with instructions on the label to inhale 2 puffs via inhaler every 4 hours as needed for wheezing, dispensed on 03/26/24 with	{D 358}		

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{D 358}	Continued From page 4 200 puffs available. Based on observations, interviews and record reviews the Ventolin HFA inhaler dispensed on 03/14/24 with 200 puffs available should have lasted until 03/30/24 or 03/31/24 if administered per PCP orders for 2 puffs every 4 hours as needed. Review of Resident #4's facility progress notes revealed: -The Special Care Unit Coordinator (SCUC) documented on 03/26/24 at 11:01am the resident reported shortness of breath after smoking, asked for her Ventolin HFA inhaler, and her oxygen saturation was 94%. -There was documentation that there were not any doses of the resident's Ventolin HFA inhaler, and a refill prescription was called into the facility's back up pharmacy. -The primary care provider (PCP) was notified that the resident was experiencing shortness of breath. -The PCP ordered Lorazepam 0.5mg STAT (immediately) and to monitor oxygen saturation each shift until the resident's Ventolin HFA inhaler arrived at the facility (Lorazepam is used to treat anxiety). -On 03/26/24 at 2:38pm Resident #4's oxygen saturation was 88%, and the resident was sent to the local ED. -The resident's Ventolin HFA inhaler was delivered to the facility after the resident was transported by EMS to the local ED. Review of a local emergency medical services (EMS) report dated 03/26/24 revealed: -EMS was dispatched to the facility for Resident #4 due to acute respiratory distress, COPD, shortness of breath, and wheezing.	{D 358}		

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{D 358}	Continued From page 5 -When EMS arrived, the resident was sitting on the edge of her bed with labored breathing and retractions on 4 liters per minute of oxygen via nasal canula (retractions are a sign that a person is working hard to breathe; the area between the ribs and in the neck sink in when a person attempts to breathe). -The resident was hypoxic on 4 liters per minute of oxygen (Hypoxia is when there is not a sufficient amount of oxygen). -Facility staff reported that the resident went outside to smoke earlier, and when she came back in the facility she complained of shortness of breath, and that she needed her inhaler. -The resident reported to EMS staff that she had "trouble breathing." -EMS administered 5mg of Albuterol and 0.5mg Atrovent via nebulizer mask with no improvement to lung sounds. (Albuterol is used to treat wheezing and difficulty breathing and Atrovent is used to treat shortness of breath and difficulty breathing). -EMS reassessed the resident's vital signs and the resident remained hypoxic on oxygen via nebulizer mask. -The resident was placed on CPAP (continuous positive airway pressure) for the treatment of COPD with moderate to severe respiratory distress. -EMS administered 0.3mg of Epinephrine injection in the resident's right arm. -Vitals were reassessed upon arrival at the hospital and were within clinically acceptable limits. Review of an after visit summary for Resident #4 from the local emergency department (ED) dated 03/26/24 revealed: -Resident #4 was diagnosed with COPD exacerbation and respiratory distress.	{D 358}		

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{D 358}	Continued From page 6 -Resident #4 was administered Methylprednisolone Sodium Succinate (SOLU-MEDROL) (Methylprednisolone Sodium Succinate is a medication used to treat breathing or lung problems) at 1:21pm. -Resident #4 was administered Ipratropium-Albuterol (DuoNeb) on 03/26/24 at 1:25pm (Ipratropium-Albuterol DuoNeb is a medication used to relax muscles in the airways and increase air flow to the lungs). -Resident #4 was administered Ventolin HFA at 2:43pm. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/27/24 at 9:23am revealed: -Ventolin HFA-108 mcg/actuation was last dispensed for Resident #4 on 03/26/24 for a quantity of 18 which was 200 puffs available for 16 to 17 days if the resident was administered 2 puffs every 4 hours each day. -Ventolin HFA-108 mcg/actuation was dispensed for Resident #4 on 03/14/24 for a quantity of 18 which was 200 puffs available for 16 to 17 days if the resident was administered 2 puffs every 4 hours each day. Interview with a medication aide (MA) on 03/27/24 at 1:15pm revealed: -She told the SCUC that the Ventolin HFA inhaler for Resident #4 was out of doses. -She did not realize that there were three doses of the Ventolin HFA inhaler still available per the counter on the back of the inhaler. -She usually ordered the resident's refill from the facility's contracted pharmacy once there were 10 doses on the counter on the back of the inhaler. -She was not sure why she and other MAs had not ordered the medication refill from the pharmacy.	{D 358}		

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{D 358}	Continued From page 7 -When she administered the resident the Ventolin HFA inhaler, she observed the resident take 2 puffs from her inhaler. Interview with the SCUC on 03/26/24 at 12:45pm revealed: -Resident #4 was transported by EMS to the local ED due to difficulties breathing and an oxygen saturation of 88%. -The EMS responders were still at the facility attempting to improve the resident's breathing and low oxygen saturation. -The resident's Ventolin HFA inhaler was not available, because there were not any additional puffs available on the inhaler. -She contacted the facility's back up pharmacy to have the Ventolin HFA inhaler delivered on 03/26/24. -She did not know why the resident's Ventolin HFA inhaler had not been ordered before the resident's breathing difficulties earlier today. Interview with the SCUC on 03/27/24 at 10:44am revealed: -Resident #4 went outside to smoke a few times a day and was always accompanied by a personal care aide (PCA). -Resident #4 usually asked for her Ventolin HFA inhaler after she came back inside from smoking. -On 03/26/24, a PCA walked back into the facility with the resident after the resident had a cigarette outside; the PCA informed the SCUC that Resident #4 complained that she was unable to breathe and needed her inhaler. -The SCUC asked the MA if Resident #4's Ventolin HFA inhaler was available to administer. -The MA informed the SCUC that there were no doses remaining on the resident's Ventolin HFA inhaler. -She checked the medication cart and thought	{D 358}		

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{D 358}	Continued From page 8	{D 358}		

she observed zero doses available on the resident's Ventolin HFA inhaler.
-She contacted the facility's back up pharmacy to order the Ventolin HFA inhaler and called 911.

Interview with the Administrator on 03/27/24 at 1:50pm revealed:
-Resident #4 usually requested her Ventolin HFA inhaler after she smoked outside.
-The SCUC and MA thought that there were no doses of the resident's Ventolin HFA inhaler, they did not realize that there were three doses left based on the counter on the back of the inhaler.
-A MA should have contacted the facility's contracted pharmacy once there were 10-20 doses left on the Ventolin HFA inhaler to ensure the resident had the inhaler available.
-The resident's oxygen saturation dropped to 88% and the SCUC called 911.

Telephone interview with Resident #4's PCP on 03/27/24 at 4:57pm revealed:
-She first saw the resident on 03/29/24, the resident was seen by another PCP prior to her visit to the facility.
-The resident's Ventolin HFA inhaler should have been available for staff to administer as needed every 4 hours as ordered.
-The SCUC and MA should have checked closer to see that there were three doses of the resident's Ventolin HFA inhaler available.
-Staff should be able to read the counter number on the back of the inhaler, when the inhaler had 15-20 doses remaining staff should contact the facility's contracted pharmacy to refill the inhaler.
-Resident #4 had COPD, difficulty breathing at times with shortness of breath and needed her Ventolin HFA inhaler available if needed.
-The resident had increased anxiety due to her inhaler not being available for staff to administer

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{D 358}	Continued From page 9 when she had difficulties breathing. -When the resident had increased anxiety, it made her shortness of breath and breathing difficulties worse. -Overuse of the Ventolin HFA inhaler could cause the resident to have an increased blood pressure, increased heart rate which could lead to a panic attack. -Staff would benefit from education on the correlation between anxiety and how that impacts the resident's breathing difficulties and shortness of breath. -The increased pollen count impacted the resident's breathing difficulties and shortness of breath. -The ultimate goal for Resident #4 was to prevent any ED visits or hospitalizations; if the SCUC and MA had looked more closely to the resident's Ventolin HFA inhaler she may not have experienced oxygen saturation at 88, increased anxiety, and a visit to the local ED. 2. Review of Resident #1's current FL-2 dated 10/12/23 revealed: -Diagnoses of type 2 diabetes, other seizures, hypothyroidism, mild intellectual disabilities, legal blindness, gastro-esophageal reflux disease, and anxiety disorder due to known physiological condition. -There was an order for Humalog KWIK INJ 100/ML INJ sliding scale (SS) SUBQ 0-149=0units (U), 150-199 =2U, 200-249=4U, 250-299=6U, 300-349 =8U 350-400=10U; Greater than 400 notify primary care provider (PCP). Review of Resident #1's February 2024 medication administration record (MAR) revealed: -Instructions were to check finger stick blood sugar (FSBS) before meals & at bedtime:150-199	{D 358}		

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{D 358}	Continued From page 10 =2U, 200-249=4U, 250-299=6U, 300-349 =8U 350-400=10U; Greater than 400 notify the PCP. -There was an entry on 02/03/24 at 7:30pm FSBS was documented as 163 and 1U was documented as administered. -There was an entry on 02/05/24 at 7:30pm FSBS was documented as 160 and 0U was documented as administered. -There was an entry on 02/10/24 at 7:00pm FSBS was documented as 246 and 0U was documented as administered. -There was an entry on 02/24/24 at 7:00pm FSBS was documented as 226 and 2U was documented as administered. -There was an entry on 02/25/24 at 7:00pm FSBS was documented as 171 and 4U was documented as administered. Review of Resident #1's March 2024 MAR revealed: -Instructions were to check finger stick blood sugar (FSBS) before meals & at bedtime:150-199 =2U, 200-249=4U, 250-299=6U, 300-349 =8U 350-400=10U; Greater than 400 notify the PCP. -There was an entry on 03/05/24 at 7:00pm FSBS was documented as 268 and 4U was documented as administered. -There was an entry on 03/10/24 at 7:00pm FSBS was documented as 228 and 4U was documented as administered. -There was an entry on 03/13/24 at 4:30pm FSBS was documented as 205 and 2U was documented as administered. -There was an entry on 03/14/24 at 4:30pm FSBS was documented as 169 and 3U was documented as administered. -There was an entry on 03/15/24 at 4:30pm FSBS was documented as 186 and 3U was documented as administered. -There was an entry on 03/15/24 at 7:00pm FSBS	{D 358}		

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{D 358}	Continued From page 11	{D 358}		

was documented as 176 and 3U was documented as administered.
-There was an entry on 03/18/24 at 7:00pm FSBS was documented as 196 and 3U was documented as administered.
-There was an entry on 03/19/24 at 7:00pm FSBS was documented as 197 and 3U was documented as administered.

Interview with the Resident Care Coordinator (RCC) on 03/27/24 at 3:05pm revealed:
-She was unaware of the inconsistency of documentation such as documenting 3U when it should have been 2U.
-It appeared that staff needed to be retrained on sliding scale units.
-During training the MA worked with a seasoned MA on how to administer medication and checked off by a registered nurse when he/she was ready to administer medication without supervision.
-The quality improvement (QI) team reviewed the MARs at least quarterly, but she did not know the date of the last QI review.
-She did not know why the QI team did not catch the error during their review.
-Resident #1 could have gone into a diabetic coma and died if her blood glucose bottomed out when given the wrong units.

Interview with the Special Unit Care Coordinator on 03/27/24 at 3:45pm revealed:
-The MA were to read the order as written by the PCP three times and then administered correctly.
-The process when find documentation errors was to pull the MA for retraining.
-Notified the PCP about the medication and documentation errors and waited for what to do next.
- The Quality Improvement team reviewed the MARs at least quarterly, and the last one was

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AHOSKIE ASSISTED LIVING	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(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 12 done in December 2023. Interview with Resident's #1 Primary Care Provider (PCP) on 03/27/24 at 5:20pm revealed: -She recently became the PCP for this facility and had not seen Resident #1. -The sliding scale made it easy to determine the correct dosage, not to give too much or too little. -The importance of the MAR was to implement the order. -Wrong doses of insulin could put her into a coma, damage her organs, and could send her to the emergency room. The facility failed to administer medications as ordered for 2 of 5 sampled residents, Resident #4 who was diagnosed with COPD, resided on the SCU and had a history of requesting a breathing treatment after she smoked. The resident had a rescue inhaler dispensed on 03/14/24 to be administered as needed every 4 hours which was found at the residents beside with 3 doses remaining. The resident returned from smoking and requested the inhaler and staff thought the resident did not have any doses left in her inhaler causing the resident's oxygen saturation to drop to 88%, resulting in the resident being treated at the local ED. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of Resident #4 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/27/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 11, 2024.	{D 358}		

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{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 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 record reviews and interviews, the facility failed to ensure that 1 of 5 sampled residents (#1) had medication record accuracy. The findings are: Review of Resident #1's current FL-2 dated 10/12/23 revealed: -Diagnoses of type 2 diabetes, other seizures, hypothyroidism, mild intellectual disabilities, legal blindness, gastro-esophageal reflux disease, and anxiety disorder due to known physiological condition.	{D 367}	Care coordinator(s) will work with contracted long-term care pharmacy to determine why the EMAR did not have consistency with insulin orders. Completed 4/8/24. Contracted long-term care pharmacy's pharmacist representative reviewed the EMARs and communicated with their QA team to determine what the cause of inconsistency was. It was determined that it did not show unit amounts, it showed solution amount. Which lead to a misunderstanding for the staff. Pharmacy's QA team corrected the issue 4/8/2024.	

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{D 367}	Continued From page 14 -There was an order for Humalog KWIK INJ 100/ML INJ sliding scale (SS) SUBQ 0-149=0units (U), 150-199 =2U, 200-249=4U, 250-299=6U, 300-349 =8U 350-400=10U; Greater than 400 notify primary care provider (PCP). Review of Resident #1's March 2024 MAR revealed: -Record review showed inappropriate documentation of MAR for the following dates. - There was an entry on 03/08/24 at 7:30am finger stick blood sugar (FSBS) was documented as 152 and it was documented as 100U was documented as administered. - There was an entry on 03/14/24 at 7:00pm FSBS was documented as 223 and it was documented as 100U was documented as administered. - There was an entry on 03/20/24 at 4:30pm FSBS was documented as 158 and it was documented as 100U was documented as administered. - There was an entry on 03/20/24 at 7:00pm FSBS was documented as 198 and it was documented as 100U was documented as administered. - There was an entry on 03/22/24 at 4:30pm FSBS was documented as 180 and it was documented as 100U was documented as administered. - There was an entry on 03/22/24 at 7:00pm FSBS was documented as 217 and it was documented as 100U was documented as administered. - There was an entry on 03/23/24 at 11:30am FSBS was documented as 187 and it was documented as 100U was documented as administered. - There was an entry on 03/23/24 at 7:00pm	{D 367}		

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{D 367}	Continued From page 15 FSBS was documented as 210 and it was documented as 100U was documented as administered. - There was an entry on 03/24/24 at 7:30am FSBS was documented as 137 and it was documented as 100U was documented as administered. - There was an entry on 03/24/24 at 11:30am FSBS was documented as 248 and it was documented as 100U was documented as administered. - There was an entry on 03/24/24 at 7:00pm FSBS was documented as 230 and it was documented as 100U was documented as administered. Interview with the medication aide (MA) on 03/27/24 at 02:41pm revealed: -Checked Resident's #1 finger stick blood sugar (FSBS) number then administered the unit per the sliding scale. -She had no idea why on 03/13/24 if the FSBS was 205 why she documented 2U when it should have been 4U. -She believed that she gave the correct dosage because she always showed Resident #1 where the pen was set before administering the units. -She believed her finger hit the number 2 key on the keyboard instead of the number 4 key, but she was not sure. -Documenting 100U was an error and she believed the instructions were not read correctly. -If she did not give the dosages correctly it could make things worse and be devastating causing the resident to become very sick such as affecting the resident's liver, kidneys, or causing a stroke or a heart attack. Interview with the Resident Care Coordinator (RCC) on 03/27/24 at 3:05pm revealed:	{D 367}		

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{D 367}	Continued From page 16 -She was unaware of the typos and the inconsistency of documentation such as documenting 3U when it should have been 2U. -The 100U documentation was a typo because the resident could have gone into a coma or died if administered. -It appeared that staff needed to be retrained on documentation. -During training the MA worked with a seasoned MA on how to administer medication and checked off by a registered nurse when he/she was ready to administer medication without supervision. -The quality improvement (QI) team reviewed the MARs at least quarterly, but she did not know the date of the last QI review. -She did not know why the QI team did not catch the error during their review. -Resident #1 could have gone into a diabetic coma and died if her blood glucose bottomed out when given the wrong units. Interview with the Special Unit Care Coordinator on 03/27/24 at 3:45pm revealed: -She was unaware of the typos and the inconsistency of documentation such as documenting 100U. -The 100U documentation was a typo because the resident could have gone into a hypo or hyperglycemia distress depending on what was given. -The MAs were to read the order as written by the PCP three times and then administer the insulin according to the order. -When documentation errors were identified the MA would be retrained. -When an error was identified the PCP should be notified. - The Quality Improvement team reviewed the MARs at least quarterly, and the last one was done in December 2023.	{D 367}		

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{D 367}	Continued From page 17 Interview with Resident's #1 Primary Care Provider (PCP) on 03/27/24 at 5:20pm revealed: -She recently became the PCP for this facility and had not seen Resident #1. -No PCP would prescribe a 100U because it would be detrimental to her health. -The sliding scale made it easy to determine the correct dosage, not to give too much or too little. -The importance of the MAR was to implement the order. -Wrong doses of insulin could put her into a coma, damage her organs, and could send her to the emergency room.	{D 367}		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure medications were safely secured on the Special Care Unit (SCU) for 1 of 3 sampled residents who resided on the SCU, and were not accessible to residents on the SCU including a rescue inhaler was found on a bedside table in Resident #4's room. The findings are: Review of Resident #4's current FL-2 dated	D 378	Care coordinator(s) will meet with each MA to discuss the importance of not leaving any medications in resident's rooms. Also monitoring to ensure resident has taken the medication as ordered. Completed 4/1/24.	

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01/12/24 revealed:
-Diagnoses of chronic obstructive pulmonary disease (COPD), dementia, and schizophrenia.
-The resident's level of care was Special Care Unit (SCU).
-There was an order for Ventolin HFA 90 mcg/actuation aerosol inhaler, inhale 2 puffs every four hours as needed (Ventolin HFA is a rescue inhaler used to treat and prevent breathing problems, shortness of breath and wheezing).

Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 01/11/24.

Review of Resident #4's care plan dated 01/24/24 revealed:
-The resident was sometimes disoriented, forgetful, and needed reminders.
-Resident #4 required limited assistance with eating.
-The resident required extensive assistance with toileting, ambulation, bathing, dressing, grooming and transfer.

Observation of Resident #4's room on 03/26/24 at 9:08am revealed:
-The resident was lying in her bed with oxygen from an oxygen concentrator.
-There was a bedside table to the right of the resident's bed with a plastic prescription bag with a prescription label for Ventolin HFA-108 MCG/ACT with the resident's name, date dispensed of 03/14/24, inhale 2 puffs via inhaler every 4 hours as needed for wheezing.
-The Ventolin HFA inhaler was on the bedside table to the right of the plastic prescription bag.
-There was a counter on the back of the Ventolin HFA inhaler that showed 3 puffs were left in the

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D 378	Continued From page 19 inhaler. Interview with Resident #4 on 03/26/24 at 9:08am revealed: -She had a difficult time breathing most days due to her COPD. -The person that administered her medication "left it here for me" referring to the inhaler on her bedside table. -She was not able to remember the medication aides (MAs) name that left the inhaler on her bedside table or when a MA left the inhaler in her room. -She used the inhaler "a lot" for shortness of breath and difficulty breathing. -Staff assisted her when she needed to use an inhaler. Observation of the Special Care Unit Coordinator (SCUC) on 03/26/24 at 9:10am revealed: -She entered Resident #4's room and asked how she was doing. -She did not remove the Ventolin HFA inhaler from the resident's bedside table. Interview with a medication aide (MA) on the SCU on 03/26/24 at 9:11am revealed: -Resident #4 had a self-administer order for her Ventolin HFA inhaler. -A minute later she reported that Resident #4 did not have orders to self-administer any of her medications. -She was confused and thought that Resident #4 had a self-administer order for her Ventolin HFA inhaler. -She was asked if she knew that there was a Ventolin HFA inhaler on Resident #4's bedside table. -The MA was not aware that there was a Ventolin HFA inhaler in Resident #4's room.	D 378		

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D 378	Continued From page 20 Observation of a MA on the SCU on 03/26/24 at 9:12am revealed: -She observed the Ventolin HFA inhaler in Resident #4's room on her bedside table. -She took the plastic prescription bag and the Ventolin HFA inhaler to the medication cart; she unlocked the medication cart, and she placed the inhaler in the plastic bag and returned the inhaler to the top drawer of the medication cart. Second interview with a MA on 03/26/24 at 9:15am revealed: -The Ventolin HFA inhaler should not have been in Resident #4's room because the MAs were responsible to administer the resident her medications. -The Ventolin HFA inhaler in Resident #4's room placed Resident #4 at risk and other residents at risk since it was the SCU, and some residents wandered and picked up items during the day. -If another resident took the Ventolin HFA inhaler from Resident #4's room and inhaled the medication could have an allergic reaction to the inhaler, it could cause problems with a resident's breathing, and cause a resident to go to the local emergency department (ED). -Medications were supposed to be secured on the medication cart so residents and staff that were not qualified to administer medications did not have access to medications. Interview with the Special Care Unit Coordinator on 03/26/24 at 9:45am revealed: -She was not aware that there was a Ventolin HFA inhaler in Resident #4's room on her bedside table until the MA informed her around 9:15am. -Staff were expected to keep all medication locked and in a secure location on the SCU to ensure residents' safety.	D 378		

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-Residents on the SCU would wander, some would pick up items and when all medications were in a secure location it protected residents on the SCU from taking a medication.
-MAs knew to keep medications secured on the locked medication cart.
-She was not sure how the Ventolin HFA inhaler was left in Resident #4's room, but it should have been locked on the medication cart.

Interview with the Administrator on 03/27/24 at 1:50pm revealed:
-MAs knew the importance of keeping medications locked on the medication cart to ensure medications were not accessible to residents on the SCU.
-A staff person made a mistake when they left the resident's inhaler in her room, the resident did not have an order to self-administer her inhaler.
-The incorrect use of the Ventolin HFA inhaler by Resident #4 or any resident on the SCU could have caused harm to any of the residents.

Telephone interview with Resident #4's primary care provider on 03/27/24 at 4:57pm revealed:
-Resident #4 was a resident on the SCU and had a diagnosis of dementia.
-Resident #4 was administered medications by the MAs and the SCUC.
-She was not aware that staff had left the resident's Ventolin HFA inhaler in the resident's room.
-If the resident used the Ventolin HFA inhaler herself, the resident was at risk of using the inhaler excessively which could cause an increased blood pressure, increased heart rate and could cause a panic attack.
-If the resident used the Ventolin HFA inhaler too much, it placed the resident at risk of the inhaler not being as effective if the inhaler was not used

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D 378	Continued From page 22 as ordered, which could cause shortness of breath, increased wheezing, and exasperation of the resident's COPD.	D 378		