

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/22/2024
NAME OF PROVIDER OR SUPPLIER NAVION OF NEW BERN			STREET ADDRESS, CITY, STATE, ZIP CODE 1336 SOUTH GLENBURNIE ROAD NEW BERN, NC 28562		
(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 an Annual and Follow up survey on 08/21/24 through 08/22/24.	D 000			
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 3 sampled residents (#2 and #3) related to not scheduling a referral for physical therapy (#2) and for failing to send a fingerstick blood sugar reading log to the provider as requested (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 05/21/24 revealed diagnoses included chronic kidney disease, myelodysplastic syndrome and Type 2 diabetes and she was ambulatory. Review of Resident #2 current assessment and care plan dated 02/19/24 revealed Resident #2 was ambulatory with the aide of an assistive device and used a wheelchair and rollator. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation dated 05/14/24 revealed: -LHPS tasks were identified as collecting and testing of fingerstick blood sample, ambulation with assistive devices that required physical assistance from staff and transferring	D 273	DSC/RCC or designee to audit New Order Tracking audits 2xdaily (1st and 2nd shift) x 4 weeks then ongoing daily.	10/6/24	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Tony Cade Executive Director

TITLE

(X6) DATE

9/27/24

STATE FORM

6999

T6UV11

If continuation sheet 1 of 54

Reviewed and Acknowledged KC 09/30/24

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D 273	Continued From page 1 semi-ambulatory or non-ambulatory residents. -There was documentation Resident #2 was able to ambulate and transfer independently using her wheelchair/walker, but requested assistance from staff due to history of falls. Review of Resident #2's physician's order dated 05/02/24 revealed there was a referral for physical therapy (PT) to evaluate for gait training. Review of Resident #2's record revealed there was no documentation of a PT evaluation. Interview with Resident #2 on 08/21/24 at 8:21am revealed: -She used a rollator or pushed her wheelchair for ambulation. -She fell prior to admission to the facility and was afraid of falling again. -She was not receiving PT and did not remember being evaluated by PT. Interview with the Director of Clinical Services on 08/22/24 at 10:57am revealed: -The referral for PT was not completed as it should have been for Resident #2. -When new orders come into the facility, the medication aide (MA) on duty was responsible for initiating a new order tracking form and she thought the order for PT was placed on Resident #2's chart without the tracking form being put in place. -A copy of the order, along with the new order tracking form, should have been placed in a binder that was kept in the medication room. -The new order tracking process was discussed in monthly MA meetings and she had conducted an inservice with the MAs when the form changed after the ownership of the facility changed. -There had been no change in the process and	D 273			

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D 273	Continued From page 2 she did not know why the process was not followed. Interview with the Administrator on 08/22/24 revealed a new order tracking form should have been initiated so the referral would not be missed and she did not know why it was not done. 2. Review of Resident #3's current FL-2 dated 12/21/23 revealed diagnoses included type 2 diabetes. Review of Resident #3's record revealed there was an order dated 05/10/24 to continue fingerstick blood sugar (FSBS) as needed, check the FSBS before giving insulin twice daily for 2 weeks, then every morning; "fax log to the provider." Review of Resident #3's physician's order dated 05/24/24 revealed there was an order to check blood glucose every morning and as needed. Review of Resident #3's record revealed there was an order dated 04/25/24 for the facility to send a copy of the FSBS for review. Review of Resident #3's record revealed there was an order dated 05/08/24 in which the primary care provider stated, "I had previously asked for FSBS log but have not received it." Review of Resident #3's record revealed there was an order dated 08/02/24 to continue blood glucose checks every morning and as needed for low blood sugar symptoms. Review of Resident #3's August 2024 medication administration record (MAR) revealed there was an order to check blood glucose every morning at	D 273			

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D 273	Continued From page 3 6:00am and as needed. Interview with the Certified Medical Assistant (CMA) at Resident #3's primary care provider (PCP) office on 08/22/24 at 12:15pm revealed: -Resident #3 was last seen on 05/10/24 due to hypoglycemic concerns. -Notes and phone calls were received from the facility regarding Resident #3 having really low blood sugar levels in the middle of the night and not eating properly. -The FSBS log was sent by the facility prior to 05/10/24 but the low blood sugar levels were not showing as low as the facility staff had stated. -The facility sent observation notes prior to 05/10/24 showing low blood sugar levels and what had been done. -The FSBS log was not sent after the 05/10/24 PCP visit. -The FSBS log for Resident #3 was needed by the PCP for possible reduction of insulin. Interview with the Resident Care Coordinator (RCC) on 08/22/24 at 2:54pm revealed: -She also worked as the medication aide (MA). -When a resident returned with new orders, the MA transferred the orders to observation charting. -The Director of Clinical Services (DCS) was responsible for reviewing and approving all orders. -Orders could not be seen until the DCS approved them. -The MA was responsible for reviewing the orders after they were approved by the DCS. -The MA was responsible for sending the FSBS log to the PCP after Resident #3's 05/10/24 PCP visit. -She was not aware the FSBS log needed to be sent to the PCP. -She was not aware the FSBS log was not sent to	D 273			

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D 273	Continued From page 4 the PCP. -She did not know why the FSBS log was not sent to the PCP. Interview with the Administrator on 08/22/24 at 3:53pm revealed: -She was not familiar with Resident #3's orders. -She was not aware the FSBS log needed to be sent to the PCP. -She was unsure how the order to send the FSBS log was missed since it was on the same visit as other orders. -She was unsure how staff would document carrying out this order as a reminder. -The MA and the DCS were responsible for reviewing new orders. -A new order tracking form should be completed when new orders are received. Interview with the Director of Clinical Services (DCS) on 08/22/24 at 4:37pm revealed: -She was aware of the order to send the FSBS log to the PCP. -She sent the FSBS log after the PCP said the log was not received. -The MA was responsible for faxing the FSBS log to the PCP. -When new orders came into the facility, the medication aide (MA) on duty was responsible for initiating a new order tracking form. -A copy of the order, along with the new order tracking form, should have been placed in a binder and she should have been informed.	D 273			
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support	D 280			

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D 280	Continued From page 5 (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS) reviews and evaluations for 3 of 3 sampled residents (#1, #2, #3) included a physical assessment, evaluation of care provided, and recommendations based on the physical assessment and evaluation of the residents. The findings are: 1. Review of Resident #1's current FL-2 dated 06/05/24 revealed: -Diagnoses included chronic kidney disease, diabetes mellitus, benign essential hypertension, diabetic peripheral neuropathy and impaired	D 280	DCS/ED or designee will complete 100% LHPS Audit x1. DCS/ED or designee will perform exit meeting with LHPS nurse monthly x 3 months, then ongoing quarterly to ensure compliance	9/18/24	

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D 280	Continued From page 6 cognition. -There was an order semaglutide (semaglutide is used to help lower blood sugar levels) 1mg/0.75ml, injection pen 3ml, inject 1 mg under the skin each week. -There was an order for insulin glargine (insulin glargine is a long-acting insulin injected once daily and provides a basal insulin level throughout the day), inject 15 units daily at bedtime. Review of Resident #1's Licensed Health Professional Support (LHPS) evaluation dated 06/13/24 revealed: -The LHPS evaluation was performed within the first 30 days of admission. -The resident's primary diagnoses were chronic kidney disease, diabetes mellitus, hypertension, debilitating peripheral neuropathy, impaired cognition, glaucoma and paroxysmal dyspnea. -The nurse noted the resident was a new admit to the facility. -He was independent with ambulation. -No LHPS tasks were identified at this time. -Additional comments and notifications included "Continue to follow the current POC". -There was no task identified for medications administered by injection. Interview with Resident #1 on 08/22/24 at 10:57am revealed: -Before he came to the facility, he administered his own insulin injections. -The facility staff administered his daily insulin injections for him currently. Interview with a medication aide (MA) on 08/22/24 at 4:00pm revealed: -He performed insulin injections and preformed finger stick blood sugars for the residents with orders.	D 280			

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D 280	Continued From page 7 -He administered insulin injections to Resident #1. Attempted telephone interview with the facility's current contracted LHPS nurse on 08/22/24 at 2:12pm was unsuccessful. Refer to interview with the Resident Care Coordinator (RCC) on 08/22/24 at 2:54pm. Refer to interview with the Director of Clinical Services (DCS) on 08/22/24 at 4:37pm. Refer to interview with the Administrator on 08/22/24 at 3:53pm. 2. Review of Resident #3's current FL-2 dated 12/21/23 revealed: -Diagnoses included type 2 diabetes. -The resident was ambulatory. Review of Resident #3's Resident Register dated 12/09/22 revealed: -The resident was admitted to the facility on 12/10/22. -The resident used a walker and a cane. Review of Resident #3's assessment and care plan dated 02/15/23 revealed: -The resident was ambulatory with aide or device and used a cane and rollator. -The resident was independent with ambulation and transferring. -The resident was independent with dressing and grooming. -The resident was independent with toileting. Review of Resident #3's physician's order dated 05/24/24 revealed: -There was an order to check blood glucose	D 280			

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D 280	Continued From page 8 every morning. -There was an order to check blood glucose as needed. -There was an order for Humulin N injection U-100 KWP Inject 20 units subcutaneously every morning with breakfast at 8am. -There was an order for Humulin N injection U-100 KWP Inject 15 units subcutaneously every night at bedtime at 8pm. Observation of Resident #3 on 08/21/24 at 4:00pm revealed the resident was ambulating to the common area using a rollator. Interview with Resident #3 on 08/21/24 at 8:55am revealed: -Staff administered her insulin in the morning and at night. -The staff ordered the medication from the facility's contracted pharmacy for her. -She always used her rollator for assistance with ambulation. -She was independent with her activities of daily living (ADLs). Review of Resident #3's current Licensed Health Professional Support (LHPS) review dated 05/14/24 revealed: -The nurse noted that the resident was alert and pleasant in the physical assessment section of the LHPS form. -The nurse noted that there were no LHPS tasks identified at this time in the physical assessment section of the LHPS form. -There was no physical assessment documentation related to the LHPS tasks medication through injection or testing of fingerstick blood samples. -Additional comments/notifications included "Continue to follow the current POC."	D 280		

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D 280	Continued From page 9 Interview with the Resident Care Coordinator (RCC) on 08/22/24 at 2:54pm revealed: -She also worked as the medication aide. -Resident #3 received finger stick blood sugar (FSBS) and Humalin N injections. -The facility's contracted pharmacy's registered nurse (RN) completed the LHPS. -The Director of Clinical Services (DCS) was responsible for reviewing the LHPS. -She has been the RCC for 1 month. Interview with the DCS on 08/22/24 at 4:37pm revealed: -The LHPS were completed quarterly. -The facility's contracted pharmacy's registered nurse (RN) completed the LHPS. -She told the RN who needed an LHPS and updated her on the tasks each resident needed. -FSBS was considered a task. -She was unsure if injections were considered a task. -She reviewed the LHPS and made sure they were accurate, all tasks were there, and no resident that needed an LHPS was missed. -She had not come across any resident LHPS with missing tasks. -If tasks were missing from the LHPS, she would have had the RN re-do the LHPS. -She was not aware Resident #3 had no task identified on her LHPS. -The MA did FSBS for Resident #3. -She did not know why FSBS was not identified as a task for Resident #3. - The MA gave Resident #3 Humalin N injections. -She was not aware injections were considered a task. -She did not know why Resident #3 had no task identified on her LHPS.	D 280		

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D 280	Continued From page 10 Interview with the Administrator on 08/22/24 at 3:53pm revealed: -The facility's contracted pharmacy's RN completed the LHPS. -The DCS was responsible for reviewing the LHPS for accuracy. -The DCS and the Administrator were responsible for making sure the LHPS was done quarterly. -She was not aware Resident #3 had no tasks identified on her LHPS. Attempted telephone interview with Resident #3's responsible person (RP) on 08/22/24 at 8:52am was unsuccessful. Attempted telephone interview with the facility's current contracted LHPS nurse on 08/22/24 at 2:12pm was unsuccessful. Refer to interview with the Resident Care Coordinator (RCC) on 08/22/24 at 2:54pm. Refer to interview with the Director of Clinical Services on 08/22/24 at 4:37pm. Refer to interview with the Administrator on 08/22/24 at 3:53pm. 3. Review of Resident #2's current FL-2 dated 05/21/24 revealed: -Diagnoses included chronic kidney disease and Type 2 diabetes. -There was an order for finger stick blood sugar checks to be completed twice daily. -There was an order for Lantus solostar 100 units/ml, 34 units to be administered each night at bedtime. Review of Resident #2 current assessment and care plan dated 02/19/24 revealed.	D 280			

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D 280	Continued From page 11 -Resident #2 was ambulatory with the aide of an assistive device and used a wheelchair and rollator. -Resident #2 was diagnosed with diabetes and was dependent on insulin injections. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation dated 05/14/24 revealed: -LHPS tasks were identified as collecting and testing of fingerstick blood sample, ambulation with assistive devices that required physical assistance from staff and transferring semi-ambulatory or non-ambulatory residents. -There was documentation Resident #2 was able to ambulate and transfer independently using her wheelchair/walker, but requested assistance from staff due to history of falls. -She had an order for FSBS checks. -She received Lantus 34 units each night at bedtime. -Additional comments/notifications included "Continue to follow the current POC." -LHPS tasks did not include medications administered by injection. Interview with Resident #2 on 08/21/24 at 8:21am revealed: -Staff checked her FSBS three to four times each day. -She received an insulin injection every night from the medication aide (MA). Attempted telephone interview with the facility's current contracted LHPS nurse on 08/22/24 at 2:12pm was unsuccessful. Refer to interview with the Resident Care Coordinator (RCC) on 08/22/24 at 2:54pm.	D 280		

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D 280	Continued From page 12 Refer to interview with the Director of Clinical Services on 08/22/24 at 4:37pm. Refer to interview with the Administrator on 08/22/24 at 3:53pm. Interview with the Resident Care Coordinator (RCC) on 08/22/24 at 2:54pm revealed: -The facility's contracted pharmacy's registered nurse (RN) completed the LHPS. -The Director of Clinical Services (DCS) was responsible for reviewing the LHPS. -She has been the RCC for 1 month. Interview with the DCS on 08/22/24 at 4:37pm revealed: -The LHPS were completed quarterly. -The facility's contracted pharmacy's RN completed the Licensed Health Professional Support (LHPS). -She told the RN who needed an LHPS and updated her on the tasks each resident needed. -Finger stick blood sugar (FSBS) was considered a task. -She was unsure if injections were considered a task. -She reviewed the LHPS and made sure they were accurate, all tasks were there, and no resident that needed an LHPS was missed. -She had not come across any resident LHPS with missing tasks. -If tasks were missing from the LHPS, she would have had the RN re-do the LHPS. -She was not aware injections were considered a task. Interview with the Administrator on 08/22/24 at 3:53pm revealed: -The facility's contracted pharmacy's RN completed the LHPS.	D 280			

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D 280	Continued From page 13 -The DCS was responsible for reviewing the LHPS for accuracy. -The DCS and the Administrator were responsible for making sure the LHPS was done quarterly.	D 280		
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 ensure medications were administered as ordered for 3 of 5 residents (#1,#4, and #5) observed during the medication pass including errors with a medication used to treat yeast infections, a medication to used lower high triglyceride and cholesterol levels (#1), a medication used to treat bacterial infections (#4) and a supplement used to treat low bone density (#5), and errors for 2 of 3 sampled residents (#2 and #3) including a medication used to treat high phosphorous levels (#2), and a medication used to treat high blood sugar (#3), The findings are: Review of the facility's Medication Agreement dated 03/25/24 revealed: -Purpose to ensure that residents receive medications and treatments in accordance with	D 358	RCC/DCS or designee to perform weekly med cart audits x 4 weeks, then DCS monthly ongoing	9/23/24

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D 358	Continued From page 14 physician's orders. -Procedure, upon admission of a resident, the community will have written physician's orders for any medications to be administered, to include over the counter medications, only the medications listed on the physician's orders will be administered to the residents. -Procedure, medications will be ordered in a timely manner by the community, all necessary information regarding the medication will be faxed to the pharmacy with delivery in a timely manner, any STAT orders will be ordered from the backup pharmacy for an expedited delivery. Review of the facility's undated Medication/Treatment Administration Policy revealed: -Policy, to ensure that residents receive medication and treatments in accordance with the physician's orders. -Procedure, each medication/treatment will be compared with the electronic medication administration record (eMAR) verifying the medication/treatment is being administered to the right resident, right medication/treatment, right dose, right time and right route. -Procedure, documentation will be completed at the time of the administration. -Procedure, the resident has the right to refuse to refuse any medications or treatments. -Procedure, documentation of administration or refusal will be completed immediately following. -Procedure, discontinued medications will be returned to the pharmacy per state regulations or destroyed using the community's destruction system with appropriate documentation. -Procedure, when an error has occurred, appropriate documentation/follow-up will be completed to include, an incident report will be completed following guidelines including	D 358			

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STATE FORM

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D 358	Continued From page 15 notification of the resident, healthcare provider, responsible party, community management, and appropriate follow-up as indicated to emergency treatment if needed. 1. The medication error rate was 11% as evidenced by 4 errors out of 34 opportunities during the 8:00am medication pass on 08/21/24. a. Review of Resident #1's current FL-2 dated 06/05/24 revealed diagnoses included chronic kidney disease, diabetes mellitus, benign essential hypertension, diabetic peripheral neuropathy and impaired cognition. Observation of the 8:00am medication pass on 08/21/24 revealed: -The medication aide (MA) prepared Resident #1's morning medications for administration which included one fluconazole 200mg tablet. -The MA administered Resident #1's morning oral medications which included the fluconazole 200mg tablet at 9:12am. Review of Resident #1's primary care provider (PCP) triage note dated 07/19/24 revealed: -He had a urinalysis and urine culture that was positive for a urinary tract infection and required an antibiotic for treatment. -An order was sent for antibiotics. -The urine culture also showed a moderate amount of candida (yeast). -Fluconazole (fluconazole is used to treat yeast or fungal infections) was ordered to take daily with the antibiotics. -There was an order for fluconazole 200mg, take one tablet daily once a day for 14 days. Review of Resident #1's July 2024 eMAR revealed:	D 358			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAVION OF NEW BERN

1336 SOUTH GLENBURNIE ROAD

NEW BERN, NC 28562

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D 358	Continued From page 16 -There was an entry for fluconazole 200mg, take one tablet every day for yeast infection and urinary tract infection for 14 days scheduled at 8:00am. -Fluconazole 200mg was documented as administered at 8:00am on 07/23/24 through 07/31/24. Review of Resident #1's August 2024 eMAR revealed: -There was an entry for fluconazole 200mg, take one tablet every day for yeast infection and urinary tract infection for 14 days, scheduled at 8:00am. -Fluconazole 200mg was documented as administered at 8:00am on 08/01/24 and 08/02/24. -Fluconazole 200mg was not documented as administered at 8:00am on 08/21/24. -The entry for fluconazole 200mg was grayed out from 08/03/24 through 08/31/24. Observation of Resident #1's medications on hand on 08/21/24 at 2:29pm revealed: -There was a bubble package of fluconazole 200mg tablets, labeled to take one tablet every day for yeast infection and urinary tract infection for 14 days, for a quantity of 14 tablets dispensed on 07/22/24. -The was one tablet of fluconazole 200mg remaining in the bubble package. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 08/22/24 at 10:23am revealed: -An order was received for Resident #1 for fluconazole 200mg, take one tablet daily for yeast infection and urinary tract infection for 14 days on 07/19/24. -The 07/19/24 fluconazole 200mg order was	D 358		

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D 358	Continued From page 17 "profiled" for Resident #1 and not sent out until 07/22/24. -Fluconazole 200mg was dispensed for Resident #1 on 07/22/24 for 14 tablets to take one daily for a 14-day supply. Interview with the MA on 08/21/24 at 2:07pm revealed: -She always compared the residents' medication label to the order on the eMAR when she prepared their medications. -She did not think she administered fluconazole to Resident #1 during the 8/21/24 medication pass. -She did not know why Resident #1 had fluconazole remaining on the medication cart if he was only supposed to receive the medication for 14 days. -Resident #1 occasionally refused his medications. -Resident #1 also received fluticasone nasal spray and she thought maybe she confused the names. -She did not know why she administered fluconazole to Resident #1. Interview with the Resident Care Coordinator (RCC) on 08/21/24 at 2:12pm revealed: -She was not sure why Resident #1 had fluconazole remaining on the medication cart. -He had been to the hospital, but she was not sure of the dates or that he had possibly refused the medications. -The MAs compared the medication labels to the order on the eMAR. -It was possible the MA confused the fluconazole with fluticasone that he also received. -Resident #1 should not have received fluconazole at the morning medication pass. -She was responsible for medication cart audits.	D 358		

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D 358	Continued From page 18 -Medication cart audits were performed monthly. -Medication cart audits involved looking for expired medications, discontinued medications, and making sure medications were available for the residents. -She had been the RCC for one month and had not had time to perform the medication cart audits. Interview with the Director of Clinical Services (DCS) on 08/21/24 at 2:54pm revealed: -The MAs were always to compare the medication label to the eMAR when medications were administered to the residents. -The MAs were never to administer a medication that did not appear on the eMAR. -She did not know why Resident #1 had fluconazole remaining on the medication cart. -Resident #1 should have received the full 14 days of fluconazole. Interview with the Administrator on 08/21/24 at 3:27pm revealed: -The MAs were expected to administer medications to the residents following the seven rights of medication administration, the right person, the right medication, the right dose, the right time, the right route, the right reason and the right documentation. -The MAs were to always compare the medication label to the eMAR. -Resident #1 should have completed the 14-day course of fluconazole as ordered. -She was not sure why Resident #1 had fluconazole remaining on the medication cart. -The RCC was responsible for performing the medication cart audits. -The medication cart audits were done monthly and consisted of reviewing for expired or discontinued medications, making sure	D 358			

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D 358	Continued From page 19 medications were available for the residents. -She expected the MAs to administer medications as ordered. Interview with Resident #1's PCP on 08/22/24 at 12:07pm revealed: -She ordered fluconazole 200mg for Resident #1 for yeast in a urinalysis. -If the fluconazole was not administered consecutively for the full 14 days, it could be less effective at treating the urinary tract infection. -She was not aware that Resident #1 had not received the full consecutive 14 days of fluconazole. -She expected medications to be prescribed to the residents as ordered. b. Review of Resident #1's current FL-2 dated 06/05/24 revealed: -Diagnoses included chronic kidney disease, diabetes mellitus, benign essential hypertension, diabetic peripheral neuropathy and impaired cognition. -There was an order for fenofibrate (fenofibrate is used to lower high triglyceride and cholesterol levels) 145mg, take a half tablet every day. Review of Resident #1's signed physicians order sheet dated 07/11/24 revealed an order for fenofibrate 145mg, take a half tablet every day. Review of Resident #1's hospital discharge summary dated 08/17/24 revealed under the discharge medications heading, fenofibrate 145mg take one tablet daily was listed. Observation of the 8:00am medication pass on 08/21/24 revealed: -The medication aide (MA) prepared Resident #1's morning medications for administration	D 358			

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D 358	Continued From page 20 which included a half tablet of fenofibrate 145mg. -The MA administered Resident #1's morning oral medications which included the half tablet of fenofibrate 145mg tablet at 9:12am. Review of Resident #1's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for fenofibrate 145mg, take one tablet daily scheduled at 8:00am. -Fenofibrate 145mg, one tablet was documented as administered at 8:00am on 08/20/24 and 08/21/24. Observation of Resident #1's medication on hand on 08/21/24 at 2:18pm revealed: -There was a medication bottle labeled with the resident's name for fenofibrate 145mg, take one half tablets daily, dispensed from the Veterans Affairs (VA) pharmacy on 06/05/24 for a quantity of 45 tablets. -There were seven whole tablets and one-half tablet of fenofibrate remaining in the medication bottle. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 08/22/24 at 10:23am revealed: -Resident #1's FL2 dated 06/05/24 was received on 06/06/24. -Resident #1's FL2 dated 06/05/24 included an order for fenofibrate 145mg, take one half tablet every day. -The fenofibrate 145mg order was "profiled", which meant it was entered into the eMAR system for Resident #1 but not dispensed from their pharmacy. -A hospital medication discharge list was received for Resident #1 on 08/16/24 included an order for fenofibrate 145mg, take one tablet daily.	D 358			

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D 358	Continued From page 21 -The new fenofibrate order from 08/16/24 for Resident #1 was "profiled" and not dispensed to the facility. Attempted telephone interview with the VA pharmacy on 08/22/24 at 11:07am was unsuccessful. Interview with the MA on 08/21/24 at 2:07pm revealed: -Resident #1 used the VA pharmacy for most of his medications. -He brought a lot of outside medication with him when he was admitted to the facility in June 2024. -The MAs compared the residents' medication label to the eMAR entry. -She did not realize Resident #1's fenofibrate order had changed from one half tablet daily to one tablet daily. -She was nervous during the morning medication pass and must not have read the fenofibrate entry thoroughly. -When a resident had new medication orders, the MAs, Resident Care Coordinator (RCC) or the Director of Clinical Services (DCS) faxed the new orders to the pharmacy. -The pharmacy entered the new order into the eMAR system and when the new medication arrived at the facility, the MA compared the medication to the eMAR entry. Interview with the RCC on 08/21/24 at 2:12pm: -Resident #1 had been admitted the hospital recently but was not aware his fenofibrate order had changed. -The MAs compared the medication labels to the order on the eMAR. -Resident #1 should have received fenofibrate one tablet at the morning medication pass instead of a half tablet.	D 358			

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D 358	Continued From page 22 -She was responsible for medication cart audits. -Medication cart audits were performed monthly. -Medication cart audits involved looking for expired medications, discontinued medications, and making sure medications were available for the residents. -She had been the RCC for one month and had not had time to perform the medication cart audits. Interview with the Director of Clinical Services (DCS) on 08/21/24 at 2:57pm revealed: -She, the RCC or the MAs were responsible for faxing new medication orders to the pharmacy. -The pharmacy entered the new medication orders into the eMAR system. -Once the new medication was received from the pharmacy, it was compared to the eMAR. -She reviewed the hospital discharge paperwork for the residents to look for new medication orders, referrals or new diagnosis. -She faxed Resident #1's 8/16/24 hospital discharge medication list to the facility's contracted pharmacy provider. -Resident #1's new fenofibrate order was profiled by the pharmacy but not dispensed since he received his medications from the VA. -Resident #1's 08/16/24 hospital discharge medication list should have been faxed to his primary care provider for review and a prescription, but she was unable to tell if it had been sent to his PCP. -The MAs were always to compare the medication label to the eMAR when medications were administered to the residents. -The MAs were never to administer a medication that did not appear on the eMAR. Interview with the Administrator on 08/21/24 at 3:27pm:	D 358		

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D 358	Continued From page 23 -The MAs were expected to administer medications to the residents following the seven rights of medication administration, the right person, the right medication, the right dose, the right time, the right route, the right reason and the right documentation. -The MAs were to always compare the medication label to the eMAR. -She expected the MAs to administer medications as ordered. Interview with Resident #1's PCP on 08/22/24 at 12:07pm revealed: -She prescribed fenofibrate for Resident #1 for elevated cholesterol and triglycerides. -Resident #1 had been recently admitted and discharged from the hospital for pancreatitis. -She was not aware until today that Resident #1's fenofibrate had been changed by the provider at the hospital. -She was provided with his 08/16/24 hospital discharge medication list today while she was in the facility. -She clarified for the facility to administer fenofibrate 145mg, one tablet every day to Resident #1. -Not administering the recommended whole tablet of fenofibrate for Resident #1 could result in the medication being less effective at treating his elevated cholesterol and triglyceride levels. c. Review of Resident #4's current FL2 dated 01/24/24 revealed diagnoses included osteoarthritis, coronary artery disease, hypertension and vertigo. Review of Resident #4's primary care provider (PCP) triage note dated 8/07/24 revealed: -The facility reported the resident complained of a stye (a red painful lump near the edge of the	D 358		

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D 358	Continued From page 24 eyelid) and a skin tear with odor. -Antibiotics were sent to the pharmacy ahead of tomorrow's face to face visit. -The resident would be seen tomorrow for assessment to evaluate for additional medications or needs. -Doxycycline (doxycycline is an anti-biotic used to treat bacterial infections) hyclate 100mg, take one tablet twice a day for 7 days for skin infection and eye infection was sent to the facility's contracted pharmacy provider. Observation of the 8:00am medication pass on 08/21/24 revealed: -The medication aide (MA) prepared Resident #4's morning medications which included one doxycycline hyclate 100mg tablet. -The MA administered Resident #4's morning oral medication which included one tablet of doxycycline hyclate 100mg at 8:26am. Review of Resident #4's August 2024 electronic medication administration record revealed: -There was an entry for doxycycline hyclate 100mg, take one tablet twice a day, scheduled at 8:00am and 8:00pm. -Doxycycline hyclate 100mg was documented as administered at 8:00am on 08/08/24 through 08/21/24. -Doxycycline hyclate 100mg was documented as administered at 8:00pm on 08/08/24 through 08/20/24. Observation of Resident #4's medication on hand on 08/21/24 at 2:08pm revealed: -There were 2 bubble packages labeled with Resident #4's name, of doxycycline hyclate 100mg tablets, for a quantity of 28 tablets in each bubble package, dispensed on 08/08/24. -There were 10 tablets of doxycycline hyclate	D 358			

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D 358	Continued From page 25 remaining in the 1st bubble package. -There were 28 tablets of doxycycline hyclate remaining in the 2nd bubble package. Interview with Resident #4 on 08/22/24 at 9:45am revealed: -Staff administered her medications. -She was not sure what medications she took. -She denies gastrointestinal upset or any other side effects with her medications. Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/22/24 at 10:09am revealed: -An order was received on 08/07/24 for Resident #4 for doxycycline hyclate 100mg, take one tablet twice a day for 7 days. -A second order was received on 08/08/24 for Resident #4 for doxycycline hyclate 100mg, take one tablet twice a day for 7 days. -Doxycycline hyclate 100mg was dispensed on 08/07/24 for quantity of 10 tablets to take twice a day for a 5-day supply. -Doxycycline hyclate 100mg was dispensed on 08/08/24 for a quantity of 56 tablets to take twice a day for a 28-day supply. -She did not know why doxycycline hyclate was dispensed on 08/08/24 for a 28-day supply. -Taking an antibiotic for longer than the prescribed number of days could disrupt the normal gut bacteria and lead to the growth of a bacteria called clostridioides difficile (c. diff) which could cause diarrhea and colitis (colitis is an inflammation of the colon). Interview with the MA on 08/21/24 at 2:07pm: -She was not aware that Resident #4 was only to receive the doxycycline hyclate for 7 days. -There was not a stop date noted on the eMAR. -She had not seen the original order from the	D 358			

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D 358	Continued From page 26 PCP. -The pharmacy entered orders into the eMAR system and when the medications arrived, they were compared to the entry in the eMAR system. Interview with the RCC on 08/21/24 at 2:12pm: -She was responsible for medication cart audits. -Medication cart audits were performed monthly. -Medication cart audits involved looking for expired medications, discontinued medications, and making sure medications were available for the residents. -She had been the RCC for one month and had not had time to perform the medication cart audits. -The pharmacy did not provide a stop date for Resident #4's doxycycline. -The MAs were responsible to compare the medications when received to the medication order. Interview with the Director of Clinical Services (DCS) on 08/21/24 at 2:45pm revealed: -The pharmacy did not put a stop date on Resident #4's doxycycline hyclate order. -Resident #4 should have received doxycycline hyclate for 7 days only. -The MA should have compared the Resident #4's doxycycline to the original order. -She was told by the pharmacy that they failed to uncheck the "cycle fill" (which meant medications were automatically filled for a 28-day supply) box for Resident #4's doxycycline hyclate. Interview with the Administrator on 08/21/24 at 3:27pm revealed: -The MAs were expected to administer medications to the residents following the seven rights of medication administration, the right person, the right medication, the right dose, the	D 358			

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D 358	Continued From page 27 right time, the right route, the right reason and the right documentation. -The pharmacy made an error when Resident #4's doxycycline was entered into the eMAR system without a stop date. -The pharmacy should have unchecked the "cycle fill" box for Resident #4's doxycycline. -Resident #4's doxycycline hyclate medication should have been compared to the original order by the MA, RCC or the DCS. Interview with Resident #4's PCP on 08/22/24 at 12:03pm revealed: -She prescribed doxycycline hyclate for Resident #4 for a sty on the right eye and a skin tear on the left arm. -Doxycycline hyclate was prescribed for Resident #4 for seven days only. -She was not aware until yesterday that Resident #4 received doxycycline twice daily since 08/08/24. -The overuse of antibiotics could lead to antibiotic resistance. -The prolonged use of doxycycline by Resident #4 could have caused stomach upset, diarrhea, and gastrointestinal distress. -She expected medications to be administered to the residents as ordered. d. Review of Resident #5's current FL2 dated 07/30/24 revealed: -Diagnoses included moderate vascular dementia, basal cell carcinoma of the lateral side of the nose, vitamin B12 deficiency, and osteopenia (lower than average bone density, but not low enough to be considered osteoporosis). -There was an order for Oyster Shell Calcium-Vitamin D3 500mg-200U, take one tablet 2 times daily with meals.	D 358			

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D 358	Continued From page 28 Review of Resident #5's signed physician's order sheet dated 08/08/24 revealed there was an order for Oyster Shell Calcium-Vitamin D 500mg-200U, take one tablet twice a day with meals. Observation of the 8:00am medication pass on 08/21/24 revealed: -The medication aide (MA) prepared Resident #5's morning medications which included one tablet of Oyster Shell Calcium-Vitamin D 500mg-200U and took them to Resident #5's room, where Resident #5 was sitting on the side of her bed. -The MA administered Resident #5's morning oral medications which included one tablet of Oyster Shell Calcium-Vitamin D 500mg-200U at 8:32am. -There was no meal tray in Resident #5's room. -Resident #5 was not offered a snack. Review of Resident #5's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Oyster Shell Calcium-Vitamin D 500mg-200U, take one tablet twice a day with meals. -Oyster Shell Calcium-Vitamin D 500mg-20U was documented as administered at 8:00am on 08/01/24 through 08/21/24 and at 8:00pm on 08/01/24 through 08/20/24. Observation of Resident #5's medication on hand on 08/21/24 at 2:14pm revealed: -There were two bubble packages, labeled with the Resident #5's name, for Oyster Shell Calcium-Vitamin D 500mg-200U, take one tablet twice a day with meals, for a quantity of 28 tablets in each bubble package, dispensed on 08/12/24. -There were 10 tablets of Oyster Shell Calcium-Vitamin D remaining on the 1st bubble	D 358			

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D 358	Continued From page 29 package and 28 tablets of Oyster Shell Calcium-Vitamin D remaining in the 2nd bubble package. -Each bubble package of Oyster Shell Calcium-Vitamin D had an additional label in the top left corner to take with food. Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 08/21/24 at 10:19am revealed: -The pharmacy received Resident #5's FL2 dated 07/30/24 on 07/30/24, with an order for Oyster Shell Calcium-Vitamin D 500-200U, take one tablet twice daily with meals. -Oyster Shell Calcium-Vitamin D 500mg-200U, take one tablet twice daily with meals was dispensed on 08/12/24 for a quantity of 56 tablets for a 28-day supply. -Taking Oyster Shell Calcium-Vitamin D on an empty stomach could potentially affect the absorption of the medication and cause gastric upset. Interview with Resident #5 on 08/22/24 at 2:44pm revealed: -Staff administered her medications. -She often skipped breakfast. -Snacks were usually offered around 10:00am. -She denied stomach upset or issues after receiving her medications. Interview with the MA on 08/21/24 at 2:07pm revealed: -The MAs compared the residents' medication labels to the eMAR prior to administering medications. -If a medication was ordered to be given twice a day with meals, then it was given with breakfast and dinner. -She knew Resident #5's Oyster Shell	D 358			

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D 358	Continued From page 30 Calcium-Vitamin D was to ordered to be given with meals but Resident #5 did not like to go to breakfast. -It never occurred to her to offer Resident #5 a snack with her morning medications. Interview with the RCC on 08/21/24 at 2:12pm: -The MAs compared the medication labels to the order on the eMAR. -A medication ordered to be given with meals, twice a day, then it should be administered at breakfast and dinner. -A snack should be offered to Resident #5 with her morning medications when she does not go to breakfast. Interview with the Director of Clinical Services (DCS) on 08/21/24 at 2:57pm revealed: -The MAs were always to compare the medication label to the eMAR when medications were administered to the residents. -If a medication was ordered to be given with meals, it should be administered within 30 minutes of the meal. -When Resident #5 skipped breakfast, she should have been offered a snack with her morning medications. Interview with the Administrator on 08/21/24 at 3:27pm revealed: -The MAs were expected to administer medications to the residents following the seven rights of medication administration, the right person, the right medication, the right dose, the right time, the right route, the right reason and the right documentation. -The MAs were to always compare the medication label to the eMAR. -If a medication was ordered to be given twice a day with meals, then it should be administered	D 358			

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D 358	Continued From page 31 with breakfast and dinner. -If a medication was ordered with meals and the resident refused or did not want to eat then a snack should always be offered. Interview with Resident #5's PCP on 08/22/24 at 12:06pm revealed: -She prescribed Oyster Shell Calcium with Vitamin D for Resident #5 to promote bone health and to treat osteopenia. -Administering Oyster Shell Calcium with Vitamin D on an empty stomach could cause gastric distress. -She expected the facility to administer medications as ordered. 2. Review of Resident #2's current FL-2 dated 05/21/24 revealed: -Diagnoses included chronic kidney disease, Type 2 diabetes, atrial fibrillation and myelodysplastic syndrome. -There was an order for Velphoro 500mg, one-half tablet, to be administered three times each day when the patient eats. (Velphoro is used to control phosphorus levels in the blood for adults with chronic kidney disease on hemodialysis.) Review of Resident #2's laboratory results on 05/21/24 revealed her phosphorus level was 5.6. (Normal range is 3.5 to 5.1) Review of Resident #2's physician's order dated 05/31/24 revealed Velphoro 500mg chew was to be administered three times a day with meals and snacks with instructions that half may be administered at the beginning of the meal and the	D 358			

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D 358	Continued From page 32 other half mid-meal. Review of Resident #2's electronic medication administration record (eMAR) for June 2024 revealed: -There was an electronic entry for Velphoro 500mg chew to be administered with meals and snacks with instructions that half may be administered at the beginning of the meal and the other half mid-meal and scheduled for 8:00am, 12:00pm and 5:00pm beginning 06/02/24. -There was documentation Velphoro 500mg was administered at 8:00am on 06/02/24 to 06/16/24 and on 06/18/24 to 06/30/24. -There was documentation Velphoro 500mg was not administered at 8:00am on 06/17/24 because she was out of the building for dialysis. -There was documentation Velphoro 500mg was administered at 12:00pm on 06/02/24 to 06/03/24, 06/05/24, 06/07/24, 06/09/24 to 06/10/24, 06/12/24, 06/19/24, 06/21/24, 06/23/24 to 06/24/24, 06/26/24, 06/28/24 and on 06/30/24. -There was documentation Velphoro 500mg was not administered at 12:00pm on 06/01/24, 06/04/24, 06/06/24, 06/08/24, 06/11/24, 06/13/24, 06/15/24, 06/17/24, 06/18/24, 06/22/24, 06/25/24, 06/27/24 and on 06/29/24 because she was at dialysis. -There was documentation Velphoro 500mg was not administered at 12:00pm on 06/14/24 because she was out of the building and took the medication with her. -There was documentation Velphoro 500mg was not administered at 12:00pm on 06/16/24 and 06/20/24 because she was out of the building (no destination documented). -There was documentation Velphoro 500mg was administered at 5:00pm on 06/02/24 to 06/03/24, 06/05/24 to 06/08/24, 06/10/24 to 06/13/24, 06/16/24 to 06/28/24 and on 06/30/24.	D 358			

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D 358	Continued From page 33 -There was documentation Velphoro 500mg was not administered on 06/04/24, 06/15/24 and 06/9/24 because she was at dialysis. -There was documentation Velphoro 500mg was not administered at 5:00pm on 06/09/24 and 06/14/24 because she was out of the building (no destination documented). - There was documentation 23 out of 90 doses were not administered as ordered. Review of Resident #2's eMAR for July 2024 revealed: -There was an electronic entry for Velphoro 500mg chew to be administered with meals and snacks with instructions that half may be administered at the beginning of the meal and the other half mid-meal and scheduled for 8:00am, 12:00pm and 5:00pm. -There was documentation Velphoro 500mg was administered at 8:00am on 07/01/24 to 07/18/24 and on 07/23/24 to 07/31/24. -There was documentation Velphoro 500mg was not administered at 8:00am on 07/19/24 to 07/22/24 because she was out of the facility. -There was documentation Velphoro 500mg was administered at 12:00pm on 07/01/24, 07/03/24, 07/05/24 to 07/09/24, 07/12/24, 07/14/24 to 07/15/24, 07/17/24, 07/24/24, 07/26/24, 07/28/24 to 07/29/24 and on 07/31/24. -There was documentation Velphoro 500mg was not administered at 12:00pm on 07/02/24, 07/04/24, 07/10/24, 07/11/24, 07/13/24, 07/16/24, 07/23/24, 07/27/24 and on 07/30/24 because she was at dialysis. -There was documentation Velphoro 500mg was not administered at 12:00pm on 07/18/24 and 07/25/24 because she was out of the building (no destination documented). -There was documentation Velphoro 500mg was not administered at 12:00pm on 07/19/24 to	D 358		

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D 358	Continued From page 34 07/22/24 because she was out of the facility. -There was documentation Velphoro 500mg was administered at 5:00pm on 07/01/24 to 07/16/24 and on 07/23/24 to 07/31/24. -There was documentation Velphoro 500mg was not administered at 5:00pm 07/17/24 and 07/27/24 because she was out of the building (no destination documented). -There was documentation Velphoro 500mg was not administered at 5:00pm on 07/18/24 to 07/22/24 because she was out of the facility. -There were 13 of 81 doses were not administered as ordered. Review of Resident #2's eMAR for August 2024 revealed: -There was an electronic entry for Velphoro 500mg chew to be administered with meals and snacks with instructions that half may be administered at the beginning of the meal and the other half mid-meal and scheduled for 8:00am, 12:00pm and 5:00pm. -There was documentation Velphoro 500mg was administered at 8:00am on 08/01/24 to 08/21/24. -There was documentation Velphoro 500mg was administered at 12:00pm on 08/02/24, 08/04/24 to 08/05/24, 08/07/24, 08/09/24, 08/11/24 to 08/12/24, 08/14/24, 08/16/24, 08/18/24 to 08/19/24 and on 08/21/24. -There was documentation Velphoro 500mg was not administered at 12:00pm on 08/08/24 08/10/24 08/13/24, 08/15/24, 08/17/24 and 08/20/24 because she was at dialysis. -There was documentation Velphoro 500mg was not administered at 12:00pm on 08/01/24, 08/03/24 and 08/06/24 because she was out of the building (no destination documented). -There was documentation Velphoro 500mg was administered at 5:00pm on 08/01/24 to 08/02/24, 08/04/24 to 08/05/24, 08/07/24 to 08/09/24,	D 358			

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D 358	Continued From page 35 08/11/24, 08/13/24 to 08/15/24 and on 08/18/24 to 08/19/24. -There was documentation Velphoro 500mg was not administered at 5:00pm on 08/10/24 and 08/17/24 because she was at dialysis. -There was documentation Velphoro 500mg was not administered at 5:00pm on 08/03/24, 08/06/24, 08/16/24 and on 08/20/24 because she was out of the building (no destination documented). -There was documentation Velphoro 500mg was not administered at 5:00pm on 08/12/24 because Resident #2 refused. - There was documentation 16 out of 63 doses were not administered as ordered. Interview with Resident #2 on 08/22/24 at 8:12am revealed: -She spent 4-5 days with family in July 2024 and her medications were sent with her, but she was unsure of the dates. -She went to dialysis every week on Tuesday, Thursday and Saturday. -She took a transportation bus to dialysis on Tuesdays and Thursdays, but her family member would take her on Saturdays -She did not take any medications during the day when she went to dialysis and no medications were sent with her. -Facility staff made sure she received her medications in the morning before she left on days, she had dialysis. Telephone interview with Resident #2's pharmacist on 08/22/24 at 10:07am revealed: -Resident #2 was ordered Velphoro 500mg to be administered three times a day with meals and snacks. -Velphoro was to be administered with food to block the absorption of phosphorus since dialysis	D 358			

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D 358	Continued From page 36 can increase phosphorus levels in the blood. -Increased phosphorus levels could cause numbness, cramps and joint pain. Interview with the Director of Clinical Services on 08/22/24 at 10:57am revealed: -She reviewed an exception report daily for missed doses of medications and the reason the medication was missed. -She was aware Resident #2 missed doses of Velphoro when she was at dialysis. -She had not contacted Resident #2's provider regarding the missed doses because she thought the provider would know since they were aware Resident #2 received dialysis 3 times each week. -Resident #2 went to dialysis on 06/17/24 early due to increased fluid. -The staff administering medications that day should have contacted the provider regarding guidance on administering medications, but she did not think that was done since she was the one administering medication that day. -She assumed dialysis would have reached out to the provider about the medications, but she realized she should have contacted the provider herself. Interview with the Administrator on 08/22/24 at 3:53pm revealed: -She was not aware of Resident #2 missing doses of medications. -She did not know if Resident #2's provider was contacted regarding the missed doses or if there had been a discussion with the provider about adjustment to the administration schedule on dialysis days. -The provider should have been notified of missed medication because they would not want to make medication dose changes if phosphorus increased due to the medication doses being	D 358			

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D 358	Continued From page 37 missed. -The Director of Clinical Services was responsible for contacting the providers for the notification. Attempted telephone interview with Resident #2's primary care provider (PCP) on 08/22/24 at 9:28am was unsuccessful. Attempted telephone interview with Resident #2's dialysis team on 08/22/24 at 10:48am was unsuccessful. 3. Review of Resident #3's current FL-2 dated 12/21/23 revealed diagnoses included type II diabetes, chronic kidney disease, cerebrovascular disease, atrial premature depolarization, and rheumatic mitral valve disease. Review of Resident #3's physician's order dated 05/24/24 revealed: -There was an order to check blood glucose every morning. -There was an order to check blood glucose as needed. -There was an order for Humulin N injection U-100 KWP Inject 20 units subcutaneously every morning with breakfast at 8am. (Humulin N is used to control blood sugar levels in people with diabetes.) -There was an order for Humulin N injection U-100 KWP Inject 15 units subcutaneously every night at bedtime at 8pm. Review of Resident #3's physician visit note dated 08/17/23 revealed an order to continue checking FSBS levels three times daily before meals. Review of Resident #3's August 2024 medication administration record (MAR) revealed:	D 358			

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D 358	Continued From page 38 -There was an order for Humulin N injection U-100KWP Inject 15 units subcutaneously every night at bedtime at 8:00pm. -There was an order for Humulin N injection U-100KWP Inject 20 units subcutaneously every morning with breakfast at 8:00am. -Humulin N injection was not administered to Resident #3 on 08/01/24 at 8:00pm because the facility was waiting on the medication to arrive from the facility's contracted pharmacy. -Resident #3's blood glucose level was 118 on 08/02/24 at 6:08am. - Humulin N injection was not administered to Resident #3 on 08/16/24 at 8:00pm because the facility was waiting on the medication to arrive from the facility's contracted pharmacy. -Resident #3's blood glucose level was 116 on 08/17/24 at 6:36am. Telephone interview with the Quality Assurance Specialist at the facility's contracted pharmacy on 08/22/24 at 11:13am revealed: -There was an order dated 05/10/24 for Humulin N injection KWP to be administered 20 units before breakfast and 20 units at bedtime. -Humulin N injection was prescribed for diabetes. -Two pens of Humulin N were dispensed on 08/01/24 and delivered to the facility on 08/02/24 at 10:57pm. -One Humulin N pen was dispensed on 08/16/24 and delivered to the facility on 08/17/24 at 10:10pm. -A 2nd pen of Humulin N was called in to a local pharmacy at the request of the facility on 08/16/24. -A medication was called in to the local pharmacy when the facility did not have any of the medication on hand and needed the medication before the medication would have been delivered from the contracted pharmacy.	D 358			

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D 358	Continued From page 39 -The facility had to request refills on insulin because insulin could not be cycle filled. -Each Humulin pen contained 300 units of the medication. -Two Humulin pens should have lasted approximately 15 days, including the priming of the pen. -On 08/01/24 and 08/16/24, the Humulin refill requests were sent to the pharmacy after the cut off time for same day delivery. -The same day delivery cut off time was 2:00pm Monday through Thursday and Saturday; and 5:00pm on Friday. -She was unsure of the impact of missing the bedtime doses of Humulin on 08/01/24 and 08/16/24. Interview with Resident #3 revealed: -She was administered insulin morning and night. -She was not allowed to administer her own medication. -Facility staff ordered and administered her medication. Interview with Resident #3's primary care physician's (PCP) office staff on 08/22/24 at 12:15pm revealed: -Resident #3 was prescribed Humulin N for diabetes. -Facility staff administered Resident #3's medication. -Humulin N started to work 2 to 4 hours after injection and peaked after 4 hours. -Failure to administer Humulin N would not harm Resident #3 if she was having low blood sugar levels. -Failure to administer Humulin N could cause hyperglycemia, blindness, neuropathy and coma if Resident #3 was having high blood sugar levels.	D 358			

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D 358	Continued From page 40 Interview with Resident Care Coordinator (RCC) on 08/22/24 at 2:54pm revealed: -She also worked at the medication aide (MA). -The MAs administered Resident #3's Humulin N. -She administered Resident #3's morning Humulin N. -Insulin refills had to be requested. -Insulin refills were ordered when the last pen was opened. -The facility's contracted pharmacy only sent 1 pen at a time and that was why Resident #3 ran out of the Humulin N. -The 3rd shift MA received all medication and put it on the cart. -The medication was already on the cart when she administered it. -She did not have to go in the refrigerator to get any medications, so she did not see if there were other Humulin pens available. -The RCC was responsible for cart audits. -Cart audits were done monthly. -She had been the RCC for 1 month so her first cart audit was yesterday, 08/21/24. -During a cart audit, the RCC looked for out of date medications, discontinued medications and made sure insulin pens were there. -The RCC also checked the refrigerator during the cart audit. -She was not aware Resident #3 was not administered her bedtime Humulin N on 08/01/24 and 08/16/24. -She did not know why Resident #3's Humulin N was not ordered prior to 08/01/24 and 08/16/24. Interview with the Director of Clinical Services (DCS) on 08/22/24 at 11:54am revealed: -The MA was responsible for ordering insulin. -Anyone working on the medication cart could order insulin including the MA, RCC and DCS.	D 358			

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D 358	Continued From page 41 -Insulin was ordered after 1 pen had been used. -Resident #3's Humulin N was ordered when there was 1 pen left. -The facility had been having problems getting Resident #3's Humulin N. -The facility's contracted pharmacy had been sending 1 to 2 pens. -Each Humulin N pen contained 100 units of the medication. -She contacted the facility's contracted pharmacy to request that they send a box of Humulin pens instead of just 2 pens. -She reviewed the electronic medication administration record (EMAR) which showed if a medication was not given. -She had the ability to review the report to see if a medication had been ordered. -She was not aware Resident #3 was not administered her bedtime Humulin N on 08/01/24 and 08/16/24. -The missed doses on 08/01/24 and 08/16/24 meant the MA did not reorder the medication in time. -She did not know why the Humulin N was not ordered in advance. -The Humulin N should have been reordered when the MA opened the last pen. Interview with the Administrator on 08/22/24 at 3:53pm revealed: -The MA was responsible for ordering all medication including insulin. -Insulin was to be ordered when the last pen was opened. -She was not aware Resident #3 was not administered her bedtime Humulin N on 08/01/24 and 08/16/24. -She did not know why the Humulin N was not ordered earlier. -The MA should have ordered the Humulin N	D 358			

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D 358	Continued From page 42 before it ran out. -Failure to administer Humulin N to Resident #3 could have caused inappropriate adjusting of insulin dosing due to the blood sugar reading. Attempted interview with Resident #3's responsible person (RP) on 08/22/24 at 8:52am was unsuccessful.	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 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, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate	D 367	DCS/RCC or designee to perform 100% Medication Aide Inservice/Re-education on New Order Tracking Form process.	9/23/24

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAVION OF NEW BERN

**1336 SOUTH GLENBURNIE ROAD
NEW BERN, NC 28562**

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D 367	Continued From page 43 for 1 of 5 sampled residents (#1) including inaccurate documentation of a medication used to treat elevated cholesterol and triglycerides. The findings are: Review of Resident #1's current FL-2 dated 06/05/24 revealed: -Diagnoses included chronic kidney disease, diabetes mellitus, benign essential hypertension, diabetic peripheral neuropathy and impaired cognition. -There was an order for fenofibrate (fenofibrate is used to lower high triglyceride and cholesterol levels) 145mg, take a half tablet every day. Review of Resident #1's signed physicians order sheet dated 07/11/24 revealed an order for fenofibrate 145mg, take a half tablet every day. Review of Resident #1's hospital discharge summary dated 08/17/24 revealed under the discharge medications heading, fenofibrate 145mg, take one tablet daily was listed. Observation of the 8:00am medication pass on 08/21/24 revealed: -The medication aide (MA) prepared Resident #1's morning medications for administration which included a half tablet of fenofibrate 145mg. -The MA administered Resident #1's morning oral medications which included the half tablet of fenofibrate 145mg tablet at 9:12am. Review of Resident #1's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for fenofibrate 145mg, take one tablet daily scheduled at 8:00am. -Fenofibrate 145mg, one tablet was documented	D 367		

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STATE FORM

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If continuation sheet 44 of 54

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D 367	Continued From page 44 as administered at 8:00am on 08/20/24 and 08/21/24. Observation of Resident #1's medication on hand on 08/21/24 at 2:18pm revealed: -There was a medication bottle labeled with the resident's name for fenofibrate 145mg, take one half tablet daily, dispensed from the Veterans Affairs (VA) pharmacy on 06/05/24 for a quantity of 45 tablets. -There were seven whole tablets and one-half tablet of fenofibrate remaining in the medication bottle. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 08/22/24 at 10:23am revealed: -A hospital medication discharge list was received for Resident #1 on 08/16/24 included an order for fenofibrate 145mg, take one tablet daily. -The new fenofibrate order from 08/16/24 for Resident #1 was "profiled" and not dispensed to the facility. Attempted telephone interview with the VA pharmacy on 08/22/24 at 11:07am was unsuccessful. Interview with the MA on 08/21/24 at 2:07pm revealed: -Resident #1 used the VA pharmacy for most of his medications. -He brought a lot of outside medication with him when he was admitted to the facility in June 2024. -The MAs compared the residents' medication label to the eMAR entry. -She did not realize Resident #1's fenofibrate order had changed from one half tablet daily to one tablet daily. -She had never administered a whole fenofibrate	D 367			

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D 367	Continued From page 45 tablet to Resident #1. -She was nervous during the morning medication pass and must not have read the fenofibrate entry thoroughly. -When a resident had new medication orders, the MAs, Resident Care Coordinator (RCC) or the Director of Clinical Services (DCS) faxed the new orders to the pharmacy. -The pharmacy entered the new order into the eMAR system and when the new medication arrived at the facility, the MA compared the medication to the eMAR entry. -She did not realize she had documented on the eMAR that she administered a whole tablet of fenofibrate to Resident #1 instead of a half tablet. Interview with the RCC on 08/21/24 at 2:12pm: -Resident #1 had been admitted the hospital recently but was not aware his fenofibrate order had changed. -The MAs compared the medication labels to the order on the eMAR. -A whole tablet of Fenofibrate should not have been documented as administered to Resident #1 if only a half tablet was given, Interview with the Director of Clinical Services (DCS) on 08/21/24 at 2:57pm revealed: -She, the RCC or the MAs were responsible for faxing new medication orders to the pharmacy. -The pharmacy entered the new medication orders into the eMAR system. -Once the new medication was received from the pharmacy, it was compared to the eMAR. -She reviewed the hospital discharge paperwork for the residents to look for new medication orders, referrals or new diagnosis. -She faxed Resident #1's 08/16/24 hospital discharge medication list to the facility's contracted pharmacy provider.	D 367			

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D 367	Continued From page 46 -Resident #1's new fenofibrate order was profiled by the pharmacy but not dispensed since he received his medications from the VA. -A new fenofibrate prescription had not been recieved from either the contracted pharmacy or the VA pharmacy for the new fenofibrate dosage for Resident #1. -Resident #1's 08/16/24 hospital discharge medication list should have been faxed to his primary care provider for review and a prescription, but she was unable to tell if it had been sent to his PCP. -The MAs were always to compare the medication label to the eMAR when medications were administered to the residents. -The MAs were to always document accurately on the eMAR. Interview with the Administrator on 08/21/24 at 3:27pm revealed: -The MAs were expected to administer medications to the residents following the seven rights of medication administration, the right person, the right medication, the right dose, the right time, the right route, the right reason and the right documentation. -The MAs were to always compare the medication label to the eMAR. -The MAs were expected to document on the eMAR accurately.	D 367			
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent	D 371			

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D 371	Continued From page 47 cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered in accordance with infection control measures by 1 of 1 medication aides (MA), observed during the 8:00am medication pass on 08/21/24, who did not sanitize or wash her hands between the preparation and administration of multiple oral medications to residents, and did not wash her hands or don gloves prior to administering eye drops, to provide a safe and sanitary environment for residents and to prevent the transmission of disease and infection The findings are: Review of the facility's hand hygiene policy dated 03/12/20 and revised 03/01/22 revealed: -Hand washing is performed as follows, before starting to work, when hands are visibly soiled or contaminated with blood or other body fluids, before and after each resident contact, after contact with an object (i.e. doorknobs, faucets) or source where there is a concentration of microorganisms such as mucous membranes, non-intact skin, body fluids or wounds, before and after administering eye drops or ointments, before applying and after removal of gloves. -Use of alcohol-based cleaners, use for routine decontamination of hands in clinical area. -Recommend use of alcohol-based cleaners can be alternated with hand washing with soap and water of visibly non-contaminated hands.	D 371	CZC DCS or designee to in service all Med Aides regarding infection control policies and and procedures prior to Medication Aides next scheduled shift. ED/DCS/RCC or designee will perform 15-minute med pass observations/audits 2x/week for 4 weeks, then ongoing monthly RDCS or designee will perform 100% Medication Aide In-Service/Re-Education on DHSR 3 HR Infection Control, handwashing, and proper medication administration. Team will be trained on Infection control policies/procedures upon hire and yearly thereafter	df 9/4/24 9/29/24 9/18/24 9/20/24	

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D 371	Continued From page 48 Review of the facility's undated Medication/Treatment Administration Policy revealed: -Appropriate infection control practices will be followed during the administration process. -Washing hands or using hand sanitizer in-between residents. -Individual receptacles will be used; such as drinking cups, pill cups and souffle cups. -Wearing gloves with the administration of injectables, eye or ear drops, sprays, patches, inhalers, suppositories, etc. or whenever the possibility of having contact with bodily fluid is present. -Infection control practices for washing hands in-between each resident during the administration will be followed. -Washing hands with every third resident medication administration, using hand sanitizer (if hands are not visibly dirty) in-between. Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 08/21/24 from 8:22am through 9:13am revealed: -There was a bottle of hand sanitizer on the medication cart. -The MA unlocked the medication cart. -The MA did not sanitize or wash her hands prior to preparing medications for a resident. -The MA prepared and administered oral medications to a resident at 8:26am. -The MA returned to the medication cart and used her hands to enter documentation into the computer system and unlocked the medication cart and did not sanitize or wash her hands. -The MA prepared and administered oral medications to a second resident at 8:32am. -The MA returned to the medication cart and used her hands to enter documentation into the	D 371			

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D 371	Continued From page 49 computer system and unlocked the medication cart and did not sanitize or wash her hands. -The MA prepared medications for a third resident by popping the medications directly on to the top of the medication cart then used her bare fingers to place the tablets in a small plastic sheath and placed in the pill crusher and crushed the tablets by pumping the pill crusher lever. -At 8:40am, the MA emptied the crushed medications from the small plastic sheath in a small amount of pudding and entered the third resident's room. -The MA administered the crushed medications mixed with pudding to the third resident using a spoon at 8:42am. -The MA returned to the medication cart, used her hands to enter documentation into the computer system and did not sanitize her hands. -The MA left the medication cart to go assist a staff with another resident. -The MA returned to the medication cart wearing gloves. -At 8:50am, the MA removed the gloves, unlocked the medication cart and did use hand sanitizer on her hands. -The MA prepared oral medications for a fourth resident and entered her room with the oral medications and a bottle of eye drops. -The MA did not wash her hands or don gloves, and administered eye drops to both of the resident's eyes at 8:58am. -The MA gave the resident a tissue and stroked the resident's hair then administered her oral medications at 9:01am. -The MA returned to the medication cart, did not sanitize or wash her hands, unlocked the medication cart and returned the eye drops to the medication cart, and used her hands to enter documentation into the computer system. -At 9:03am, the MA prepared medications for a	D 371			

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D 371	Continued From page 50 fifth resident, the fifth resident had medication bottles, she shook some tablets into the medication bottle lid and retrieved one tablet with her bare fingers and placed it into the medication cup, she did the same with a second bottle of medication, she prepared the remainder of the medications from the bottles into the medication cup, then popped a medication from a bubble package into her bare palm and placed it in the medication cup. -The MA entered the fifth resident's room with the medication cup, a bottle of eye drops and a nasal spray. -The MA gave the fifth resident the nasal spray and he administered 2 sprays in each nostril, capped the bottle and handed it back to her at 9:10am. -At 9:11am, the MA did not wash her hands or don gloves, and administered eye drops to both of the resident's eyes, she then handed the fifth resident a cup of water and administered his morning oral medications, she did not wash her hands. -At 9:13am, she returned to the medication cart, unlocked the medication cart and returned to nasal spray and eye drops, she then used her hands to enter documentation into the computer system and did not wash or sanitize her hands. Interview with the MA on 08/21/24 at 2:37pm revealed: -She usually used hand sanitizer or washed her hands before and after she administered medications to each resident. -She used gloves for insulin injections, finger stick blood sugars and perineal care. -She did not usually wear gloves to administer eye drops because one resident had complained about the gloves when she administered eye drops.	D 371		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/22/2024
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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 371	Continued From page 51 -She did not realize she had not sanitized or washed her hands between administration of the residents' medications. -She knew she was not to touch the residents' medications and medications were always to be placed in a medication cup. -She was nervous during the medication pass and forgot to sanitize her hands and use gloves. Interview with the Resident Care Coordinator (RCC) on 08/22/24 at 9:41am revealed: -MAs should use hand sanitizer after administering medication to each resident. -The MAs were to wash their hands after every 3rd resident during the medication pass or if hands were visibly soiled. -Gloves should always be used for the application of topical medications, administration of eye drops, ear drops, insulin injections and fingerstick blood sugars. -MAs should never place tablets or capsules in their bare hands or on top of the medication cart. -She had just started in the RCC role a little over a month ago. -She was not sure how the MAs were trained as far as hand hygiene and infection control. -The MAs were expected to use good hand hygiene and gloves to prevent the spread of germs and contamination. Interview with the Director of Clinical Services (DCS) on 08/21/24 at 2:57pm revealed: -The MAs should always use hand sanitizer between each resident if they were not close to a sink to wash their hands. -Gloves should always be used for fingerstick blood sugars, insulin injections, application of any type of topical medication, cream, powder or lotion, eye drops, ear drops, and nasal sprays. -The MAs were to wash their hands before and	D 371			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/22/2024
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D 371	Continued From page 53 accordance with G.S. 131D-34 on August 30, 2024, for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 06, 2024	D 371			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/22/2024
NAME OF PROVIDER OR SUPPLIER NAVION OF NEW BERN		STREET ADDRESS, CITY, STATE, ZIP CODE 1336 SOUTH GLENBURNIE ROAD NEW BERN, NC 28562			
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D 371	Continued From page 52 after using gloves. -Medications should always be popped into a clean medication cup and never into a bare hand or onto a surface. Interview with the Administrator on 08/21/24 at 3:52pm revealed: -MAs should wash their hands prior to starting the medication pass. -MAs should perform hand hygiene, using hand sanitizer between each resident when preparing and administering medications. -Gloves were used to administer eye drops, ear drops, topical creams and ointments, insulin injections, and fingerstick blood sugars. -Hand hygiene was reviewed during employee orientation, training and periodic in-services. -Infection control in-services were held during employee orientation, MA training and annually. -MAs were expected to use good hand hygiene and gloves during the medication pass. -Not performing hand hygiene could spread infection or contaminate resident medications. The facility failed to ensure medications were administered in accordance with infection control measures by 1 of 1 MAs, observed during the 8:00am medication pass on 08/21/24, who did not sanitize or wash her hands between the preparation and administration of multiple oral medications to residents, popped medications into her hand and on to the medication cart surface and did not don gloves to administer eye drops to two residents. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in	D 371			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/22/2024
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D 371	Continued From page 53 accordance with G.S. 131D-34 on August 30, 2024, for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 06, 2024	D 371			