Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Brookdale Asheville Overlook
Address: 308 OVERLOOK ROAD ASHEVILLE, NC 28803
County: Buncombe
License Number: HAL011036

II. Date(s) of Visit(s): 03/11/2024, 04/02/2024
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 04/29/2024

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of the Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent**: *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 13F.1004(a) MEDICATION ADMINISTRATION Rule/Statutory Reference: 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. Level of Non-Compliance: A1 Violation Findings: Based on interviews and record reviews, the facility failed to administer medications as ordered for 3 of 6 sampled residents (#1, #2, and #6), related to not being administered two blood pressure medications(#1), being administered the incorrect dosage of an ulcerative colitis medication (#2), and not receiving insulin for a full day (#6). The findings are: Review of Resident #1's current FL2 dated 08/24/23 revealed: - Diagnoses included type 2 diabetes, hyperlipidemia, and hypertension. - An order for a clonidine patch 0.3mg to be applied weekly on Tuesday (clonodine is a medication used to treat high blood pressure). - An order for labetalol 100mg with orders to take 1 tablet twice	☒ POC Accepted SDY *DSS Initials*	

daily (a medication that treats high blood pressure).

a. Review of Resident #1's Medication Administration Record (MAR) dated 03/01/24-03/11/24 revealed:
- There was an entry for clonidine 0.3mg transdermal patch to be applied weekly on Tuesday.
- The clonidine 0.3mg patch was documented as applied on Tuesday, 03/05/24, at 10:00am.

Review of hospital records for Resident #1 revealed:
- On 03/08/24, the resident presented in the Emergency Department (ED) for a hypertensive emergency complicated by acute kidney injury (an acute elevation in blood pressure associated with signs of major organ damage).
- The hypertensive emergency was due to the resident's clonidine patch not being administered.
- Only a patch cover was present on the resident at the time of arrival and not the actual medicated patch.
- The absence of the patch led the resident to experience clonidine withdrawal symptoms and the hypertensive emergency.
- It was documented the resident had been experiencing vomiting and substernal chest pain at her facility prior to coming to the ED.
- She was actively vomiting upon arrival to the ED and her blood pressure was 242/118.
- She was admitted to the Intensive Care Unit (ICU).
- She was at imminent risk of organ failure and/or had a life threatening illness.
- Admission diagnoses included hypertension encephalopathy (a brain dysfunction caused by extremely high blood pressure), acute kidney injury on chronic kidney disease suspected due to hypertensive emergency with end organ damage (an acute elevation in blood pressure associated with severe impairment of major organs) vs. ATN (acute tubular necrosis [disorder involving damage to kidney cells that can lead to acute kidney failure] due to decrease in blood pressure from 256/123 to 97/53 within 5 hours of presentation.

Interview with Resident #1 on 04/02/24 at 5:00pm revealed:
- On 03/05/24, when the medication aid (MA) was supposed to apply her clonidine patch, the MA only applied the cover.
- She knew this because the staff at the hospital told her she was only wearing a patch cover and not a clonidine patch.
- She remembered having difficulty breathing a few days after her patch was supposed to have been applied.
- She became very sick and very confused.
- She could not remember most of what happened right before and during her hospitalization.
- She believed this medication error almost killed her.

Interview with a MA on 03/21/24 at 3:50pm revealed:
- She had failed to apply the clonidine patch as prescribed to Resident #1.
- She now realized she had only applied the protective patch cover and not the medicated patch.

- She felt she had received adequate training on medication administration, as well as training specific to applying medicated patches.
- She had a lot of other responsibilities and had to rush through administering medications.
- She had to administer medications very quickly and did not feel the pace required was safe because some residents had complex medications.
- She felt the medication error with the clonidine patch was made because she was rushing to get all the medications administered.

Interviews with the Health and Wellness Director (HWD) on 03/11/24 at 2:45pm, 04/02/24 at 3:00pm, and 04/05/24 at 10:00am revealed:
- There was a medication error with Resident #1's clonidine patch.
- On 03/05/24, the MA on duty had only applied the patch cover to the resident and had forgotten to apply the medicated patch.
- The box for the clonidine patch was clearly marked that a patch needs to be applied as well as a cover.
- The facility was initially unaware of the error but sent the resident to the ED when her blood pressure was unusually high.
- The hospital noticed the error.
- The resident had been admitted to the ICU.

Interviews with Resident #1's Primary Care Provider (PCP) on 03/25/24 at 1:25pm and 04/05/24 at 4:20pm revealed:
- The clonidine patch helped to control Resident #1's blood pressure, which tended to run very high.
- The patch not being applied caused Resident #1 to go into a hypertensive crisis.
- Risks of a hypertensive crisis included stroke and myocardial infarction (a heart attack).

Refer to interview with a MA on 3/21/24 at 3:50pm.

Refer to interview with a second MA on 03/22/24 at 4:00pm.

Refer to with a third MA on 04/02/24 at 2:25pm.

Refer to interview with a fourth MA on 04/02/24 at 2:45pm

Refer to interviews with the HWD on 03/11/24 at 2:45pm, 04/02/24 at 3:00pm, and 04/05/24 at 10:00am

Refer to interviews with the Administrator on 03/11/24 at 2:45pm and 04/02/24 at 3:30pm.

b. Review of MAR for Resident #1 dated 02/01/24-02/29/24 revealed:
- An entry for labetalol 100mg with orders to take 1 tablet twice a day, hold for systolic blood pressure below 130 or pulse below 70.
- On 02/15/24 at 9:00am, the resident's blood pressure was documented as 167/80 and her pulse was 70.
- Labetalol was documented as not administered due to "Other/ See

Nurse Notes."
- On 02/23/24 at 9:00pm, the resident's blood pressure was documented as 170/78 and her pulse was 72.
- Labetalol was documented as not administered due to "vital sign outside of parameter."

Review of MAR for Resident #1 dated 03/01/24-03/11/24 revealed:
- An entry for labetalol 100mg with orders to take 1 tablet twice a day, hold for systolic blood pressure below 130 or pulse below 70.
- On 03/02/24 at 9:00am, the resident's blood pressure was documented as 174/95 and her pulse was 81.
- Labetalol was documented as not administered due to "Hold/See Nurse Notes."
- On 03/05/24 at 9:00am, labetalol was documented as not administered due to "vital signs outside of parameter."
- No vital signs were documented for this date/time.
- On 03/06/24 at 9:00am, the resident's blood pressure was documented 205/95 and her pulse was 73.
- Labetalol was documented as not administered due to "vital signs being outside of parameter."
- On 03/06/24 at 9:00pm, the resident's blood pressure was documented as 200/112 and her pulse was 71.
- Labetalol was documented as not administered due to "vital signs being outside of parameter."
- On 03/07/24 at 9:00pm, the resident's blood pressure was documented as 222/115 and her pulse was 102.

Review of nursing progress notes for Resident #1 revealed:
- On 02/15/24, the following note was documented for the 9:00am dose of labetalol: "vitals documented."
- On 03/02/24, the following note was documented for the 9:00am dose of labetalol: "hold heart rate 81."

Interview with a MA on 03/21/24 at 3:50pm revealed:
- She knew that Resident #1's labetalol should be held for certain blood pressure and pulse readings.
- She did not know why there were errors in administering according to parameters, but she suspected it was due to herself and other MAs administering medication very quickly and not being careful.

Interviews with a second MA on 03/22/24 at 4:00pm revealed:
- She felt she understood the blood pressure and pulse parameters of when to hold Resident #1's labetalol.
- She did not know why she had administered it incorrectly at times.

Interviews with the HWD on 03/11/24 at 2:45pm, 04/02/24 at 3:00pm, and 04/05/24 at 10:00am revealed:
- She was not aware of the medication errors with Resident #1's labetalol.
- She had trained the MAs on administering medications with parameters and was not sure why there had been so many errors.

Interviews with Resident #1's PCP on 03/25/24 at 1:25pm and 04/05/24 at 4:20pm revealed:

- The facility did not notify her of the medication errors with Resident #1's labetalol.
- Labetalol was a short-acting blood pressure medication.
- The labetalol not being administered correctly in the days leading up to her hospitalization, especially combined with missing her clonidine patch, contributed to Resident #1's hypertensive crisis.

Refer to interview with a MA on 3/21/24 at 3:50pm.

Refer to interview with a second MA on 03/22/24 at 4:00pm.

Refer to with a third MA on 04/02/24 at 2:25pm.

Refer to interview with a fourth MA on 04/02/24 at 2:45pm

Refer to interviews with the HWD on 03/11/24 at 2:45pm, 04/02/24 at 3:00pm, and 04/05/24 at 10:00am

Refer to interviews with the Administrator on 03/11/24 at 2:45pm and 04/02/24 at 3:30pm.

2. Review of Resident #2's current FL2 dated 02/02/24 revealed:
- Diagnoses included Parkinson's disease (a disorder of the nervous system that affects movement).
- The resident was semi-ambulatory and intermittently disoriented.
- An order for mesalamine 400mg, take 4 tablets twice daily (mesalamine is a medication used to treat ulcerative colitis).

Review of the Resident #2's MAR dated 02/09/24-02/29/24 revealed:
- An entry for mesalamine oral capsule delayed release 400mg capsule, take 2 tablets twice daily.
- Two mesalamine 400mg tablets were documented as administered twice daily from 02/09/24-02/29/24, except for 02/15/24 at 8:00am, 02/17/24 at 9:00pm, and 02/18/24 at 8:00am when the resident was out of the facility.

Review of the Resident #2's MAR dated 03/01/24-03/10/24 revealed:
- An entry for mesalamine oral capsule delayed release 400mg capsule, take 2 tablets twice daily.
- Two mesalamine 400mg tablets were documented as administered twice daily from 03/01/24-03/10/24.

Interviews with the HWD on 03/11/24 at 2:45pm, 04/02/24 at 3:00pm, and 04/05/24 at 10:00am revealed:
- She had not been aware that Resident #2 was not getting the correct dosage of mesalamine.
- The Resident Care Coordinator (RCC) had incorrectly transcribed the order for Resident #2's mesalamine.

Interview with a medical assistant at Resident #2's PCP's office on 04/05/24 at 9:50am revealed:
- The resident should be taking 1600mg of mesalamine twice daily.

- Since the tablets are 400mg tablets, he should be taking four tablets, not two tablets.
- The resident had been diagnosed with ulcerative colitis and this medication helped prevent flareups.
- Flareups could include bloody diarrhea.
- There could be an increased risk of bleeding since the resident was also prescribed blood thinners.

Refer to interview with a MA on 3/21/24 at 3:50pm.

Refer to interview with a second MA on 03/22/24 at 4:00pm.

Refer to interview with a third MA on 04/02/24 at 2:25pm.

Refer to interview with a fourth MA on 04/02/24 at 2:45pm

Refer to interviews with the HWD on 03/11/24 at 2:45pm, 04/02/24 at 3:00pm, and 04/05/24 at 10:00am

Refer to interviews with the Administrator on 03/11/24 at 2:45pm and 04/02/24 at 3:30pm.

3. Review of Resident #6's current FL2 dated 10/03/23 revealed diagnoses included type 2 diabetes.

Review of a physician order for Resident #6 dated 02/27/24 revealed an order for insulin lispro, 10 units with meals (insulin lispro is a short-acting insulin used to treat diabetes).

Review of Resident #6's MAR for March of 2024 revealed:
- An entry for Humalog Kwikpen (insulin lispro) 100 units/ml, administer 10 units three times daily for "unsupervised self-administration."
- There was no documentation insulin lispro was administered due to "unsupervised self-administration."

Interview with Resident #6 on 04/01/24 at 10:10am revealed:
- He took insulin 3 times a day and had an order for self administration.
- At the beginning of March, he was out of insulin for a full day and missed three doses.
- He believed it was the first Saturday in March (03/02/24).
- He depended on the facility staff to order refills and make sure he had his medication.
- He had been telling the MAs for a few days that he was running low on insulin.
- On the evening of 03/01/24, he told an MA he was taking his last dose.
- On the morning of 03/02/24, he was out of insulin and did not have any for the rest of the day.
- On either the night of 03/02/24 or the morning of 03/03/24, a MA found his insulin in the medication refrigerator.
- The MA had told him the insulin had been there the whole time.
- He knew it had been there the whole time because the insulin label

had the date filled as 02/27/24.

Interviews with the HWD on 03/11/24 at 2:45pm, 04/02/24 at 3:00pm, and 04/05/24 at 10:00am revealed:
- Resident #6's insulin had been in the medication refrigerator, it was filled on 02/27/24.
- The MA who did the cycle change on 02/27/24 forgot to deliver the insulin to the resident, which is why he missed his insulin for a day.

Interview with Resident #6's PCP on 04/05/24 at 4:20pm revealed risks of missing a full day of insulin included hyperglycemia (elevated blood sugar).

Interview with a MA on 03/21/24 at 3:50pm revealed:
- She had to administer medications very quickly due to time constraints and did not feel the pace required was safe because some residents have complex medications.
- She had addressed her concerns with the Administrator multiple times that she needed to be allowed to focus on administering medications instead of helping with other tasks, but the Administrator was not responsive to her concerns.

Interview with a second MA on 03/22/24 at 4:00pm revealed:
- It was true that MAs had a lot of other responsibilities and sometimes had to pause the medication pass to do other things.
- Responsibilities included staying in the dining room during meals and helping clean up the dining room after meals.
- MAs had to stop administering medications to be in the dining room or attend staff meetings.
- Sometimes MAs had to stop administering medications to help get residents up, dressed, and toileted before breakfast.

Interview with a third MA on 04/02/24 at 2:25pm revealed:
- MAs had to "rush" to get medications administered on time due to other mandatory responsibilities.
- Mandatory responsibilities included staying in the dining room for the duration of all meals and cleaning up afterwards.
- If the facility was short staffed, MAs also had to do the work of Personal Care Aids (PCAs) and get residents up and dressed.
- To get all the medications administered, MA's had to move very quickly and did not always have time to doublecheck the orders on the screen.
- Sometimes residents noticed they were being given the wrong medication or wrong dosages and would stop staff from administering it.
- She had informed the Administrator on several occasions that MAs needed time to focus on medication administration, but was told no changes would be made.

Interview with a fourth MA on 04/02/24 at 2:45pm revealed:
- It was a facility requirement that MAs stay in the dining room during all meals, even if they are not finished with their medication

pass.
- MAs were also required to attend a staff meeting every day at 9:30am.
- Morning medications were a "heavy" medication pass and these mandatory interruptions made passing medications very difficult.
- MAs have spoken to administration to try to get this changed so they can focus on safely administering medication, but nothing has been done.

Interviews with the Health and Wellness Director (HWD) on 03/11/24 at 2:45pm, 04/02/24 at 3:00pm, and 04/05/24 at 10:00am revealed:
- She was responsible for auditing MARs.
- The last audit was done at the end of February of 2024.
- It was true that MAs had to assist in the dining room during all meals and attend a mandatory 9:30am staff meeting

Interviews with the Administrator on 03/11/24 at 2:45pm and 04/02/24 at 3:30pm revealed:
- She was aware of the error with Resident #1's clonidine patch but had not been aware of the other medication errors.
- She and the HWD were responsible for ensuring medication audits were completed.
- The facility had completed a medication audit at the end of February of 2024.
- MAs did have to stay in the dining room during all meals.
- MAs had expressed their concerns to her.
- She and the HWD had worked with medical providers to space out medication administration times so the MA's extra duties did not interfere with safe and timely medication administration.
- She would look at medication administration times again with the HWD.

The facility failed to ensure medications were administered as ordered to Resident #1 by not applying her clonidine patch or administering her labetalol medication used to control her high blood pressure, resulting in a severe increase in her blood pressure which led to a hypertensive crisis and required treatment in the ICU. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/02/24 for this violation.

DATE OF CORRECTION FOR THE A1 VIOLATION SHALL NOT EXCEED 06/01/2024

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation* • *Findings of non-compliance*	III (b). Facility plans to correct/prevent: *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	III (c). Date plan to be completed
Rule/Statute Number: 13F.0902(b) HEALTH CARE Rule/Statutory Reference: The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. Level of Non-Compliance: B Violation Findings: Based on interviews and record reviews, the facility failed to assure health care needs were followed up on for 3 of 6 sampled residents (#1, #2, and #6), related to not notifying the Primary Care Physician (PCP) of elevated blood pressure (#1), and not notifying the PCP of medication errors(1#, #2, and #6). The findings are: 1. Review of Resident #1's current FL2 dated 08/24/23 revealed: - Diagnoses included type 2 diabetes, hyperlipidemia, and hypertension. - An order for labetalol 100mg with orders to take 1 tablet twice daily (a medication that treats high blood pressure). Review of the Medication Administration Record (MAR) for Resident #1 dated 02/01/24-02/29/24 revealed: - An entry for labetalol 100mg with orders to take 1 tablet twice a day, hold for systolic blood pressure below 130 or pulse below 70. - On 02/15/24 at 9:00am, the resident's blood pressure was documented as 167/80 and her pulse was 70. - Labetalol was documented as not administered due to "Other/ See Nurse Notes." - On 02/23/24 at 9:00pm, the resident's blood pressure was documented as 170/78 and her pulse was 72. - Labetalol was documented as not administered due to "vital sign outside of parameter." Review of MAR for Resident #1 dated 03/01/24-03/11/24 revealed: - An entry for labetalol 100mg with orders to take 1 tablet twice a day, hold for systolic blood pressure below 130 or pulse below 70. - On 03/02/24 at 9:00am, the resident's blood pressure was documented as 174/95 and her pulse was 81. - Labetalol was documented as not administered due to "Hold/See Nurse Notes." - On 03/05/24 at 9:00am, labetalol was documented as not administered due to "vital signs outside of parameter." - No vital signs were documented for this date/time. - On 03/06/24 at 9:00am, the resident's blood pressure was documented 205/95 and her pulse was 73. - Labetalol was documented as not administered due to "vital signs	☒ POC Accepted SDY *DSS Initials*	

being outside of parameter."
- On 03/06/24 at 9:00pm, the resident's blood pressure was documented as 200/112 and her pulse was 71.
- Labetalol was documented as not administered due to "vital signs being outside of parameter."
- On 03/07/24 at 9:00pm, the resident's blood pressure was documented as 222/115 and her pulse was 102.
- No documentation that the PCP was notified of elevated vital signs.

Review of nursing progress notes for Resident #1 revealed:
- On 02/15/24, the following note was documented for the 9:00am dose of labetalol: "vitals documented."
- On 03/02/24, the following note was documented for the 9:00am dose of labetalol: "hold heart rate 81."
- On 03/08/24 at 11:00am, a MA documented the resident was in the hospital.
- No documentation the PCP was notified of elevated vital signs or medication errors.

Review of hospital records for Resident #1 revealed that, on 03/08/24, the resident presented in the Emergency Department (ED) for a hypertensive emergency complicated by acute kidney injury (an acute elevation in blood pressure associated with signs of major organ damage).

Interview with Resident #1 on 04/02/24 at 5:00pm revealed:
- She became very sick and very confused in the days leading up to her hospitalization.
- She could not remember most of what happened right before and during her hospitalization.

Interviews with Resident #1's Primary Care Provider (PCP) on 03/25/24 at 1:25pm and 04/05/24 at 4:20pm revealed:
- Labetalol was a short acting blood pressure medication that Resident #1 took along with a longer-acting blood pressure medication.
- The facility did not notify her of the medication errors with Resident #1's labetalol.
- The facility did not notify her of Resident #1's elevated blood pressure in the days prior to her hospitalization.
- If she had been notified, she could have attempted to intervene and mitigate the hypertensive crisis.

2. Review of Resident #2's current FL2 dated 02/02/24 revealed:
- Diagnoses included Parkinson's disease (a disorder of the nervous system that affects movement).
- The resident was semi-ambulatory and intermittently disoriented.
- An order for mesalamine 400mg, take 4 tablets twice daily (mesalamine is a medication used to treat ulcerative colitis).

Review of the Resident #2's MAR dated 02/09/24-02/29/24 revealed:
- An entry for mesalamine oral capsule delayed release 400mg capsule, take 2 tablets twice daily.

- Two mesalamine 400mg tablets were documented as administered twice daily from 02/09/24-02/29/24, except for 02/15/24 at 8:00am, 02/17/24 at 9:00pm, and 02/18/24 at 8:00am when the resident was out of the facility.

Review of the Resident #2's MAR dated 03/01/24-03/10/24 revealed:
- An entry for mesalamine oral capsule delayed release 400mg capsule, take 2 tablets twice daily.
- Two mesalamine 400mg tablets were documented as administered twice daily from 03/01/24-03/10/24.

Interview with a medical assistant at Resident #2's PCP's office on 04/05/24 at 9:50am revealed:
- The resident should be taking 1600mg of mesalamine twice daily.
- Since the tablets are 400mg tablets, he should be taking four tablets, not two tablets.
- The facility had not notified the PCP of the medication errors.

3. Review of Resident #6's current FL2 dated 10/03/23 revealed diagnoses included type 2 diabetes.

Review of a physician order for Resident #6 dated 02/27/24 revealed an order for insulin lispro, 10 units with meals (insulin lispro is a short-acting insulin used to treat diabetes).

Review of Resident #6's MAR for March of 2024 revealed:
- An entry for Humalog Kwikpen (insulin lispro) 100 units/ml, administer 10 units three times daily for "unsupervised self-administration."
- There was no documentation insulin lispro was administered due to "unsupervised self-administration."

Interview with Resident #6 on 04/01/24 at 10:10am revealed:
- He took insulin 3 times a day and had an order for self administration.
- At the beginning of March, he was out of insulin for a full day and missed three doses.
- He believed it was the first Saturday in March (03/02/24).
- He depended on the facility staff to order refills and make sure he had his medication.
- He had been telling the MAs for a few days that he was running low on insulin.
- On the evening of 03/01/24, he told an MA he was taking his last dose.
- On the morning of 03/02/24, he was out of insulin and did not have any for the rest of the day.

Interview with Resident #6's PCP on 04/05/24 at 4:20pm revealed:
- No one at the facility had notified her that Resident #6 missed his insulin for a full day.
- Risks of missing a full day of insulin included hyperglycemia (elevated blood sugar).

Interviews with the Health and Wellness Director (HWD) on 03/11/24 at 2:45pm, 04/02/24 at 3:00pm, and 04/05/24 at 10:00am revealed:
- Resident #1's provider had not written an order to be notified of elevated blood pressures for the resident.
- Resident #1's blood pressure tended to run very high and the MAs measuring her vitals would not have thought those readings were out of the ordinary.
- She had not notified the PCP's of the medication errors for Residents #1, #2, or #6 because she had not been aware of the medication errors at the time.

Interviews with the Administrator on 03/11/24 at 2:45pm and 04/02/24 at 3:30pm revealed she had not been aware of the other medication errors.

The facility failed to assure health care needs were followed up on for 3 of 6 sampled residents (#1, #2, and #6), related to not notifying the Primary Care Physician (PCP) of elevated blood pressure (#1), and not notifying the PCP of medication errors(1#, #2, and #6). This failure was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/30/24 for this violation.

DATE OF CORRECTION FOR THE B VIOLATION SHALL NOT EXCEED 06/16/2024

IV. Delivered Via: Email	**Certified Mail #:**	Date: 05/02/2024
DSS Signature: Susannah D. Yost		Return to DSS By: 05/23/2024

V. CAR Received by:	Administrator/Designee (print name): Roberta Lloyd	
	Signature:	Date:
	Title: Administrator	

VI. Plan of Correction Submitted by:	Administrator (print name): Roberta Lloyd	
	Signature:	Date: 05/07/2024

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☒ ***POC Accepted***	By: Susannah D. Yost	Date: 05/07/2024
Comments:		

VIII. Agency's Follow-Up	By: KRISTY J. WILSON	Date: 06/13/2024
	Facility in Compliance: ☒ Yes ☐ No	Date Sent to ACLS:
Comments:		

** For follow-up to CAR, attach Monitoring Report showing facility in compliance.*