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	HAL059035	A. BUILDING: _____ B. WING _____	R 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION ASSISTED LIVING	5235 NC 226 SOUTH MARION, NC 28752

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{D 000}	Initial Comments The Adult Licensure Section and McDowell County Department of Social Services conducted a follow-up survey on May 20, 2025 through May 21, 2025.	{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 record reviews, interviews, and observations, the facility failed to ensure physician notification for 2 of 6 sampled residents (#1 and #4) related to two vomiting episodes (#1) and for fingerstick blood sugars (FSBS) greater than 400 (#4). The findings are: 1. Review of Resident #1's current FL2 dated 01/30/25 revealed diagnoses included dementia, traumatic brain injury, acquired absence of digestive tract (the loss of portions of the digestive system), history of peptic ulcer disease, and acute gastrointestinal bleed. Observation of Resident #1 on 05/20/25 at 8:45am revealed: -Resident #1 was lying flat in a geri chair while the personal care aide (PCA) was assisting Resident #1 with feeding. -The PCA gave Resident #1 a bite of the pureed meal when Resident #1 began coughing a lot.	{D 273}		

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{D 273}	Continued From page 1 Interview with the PCA on 05/20/25 at 8:45am revealed Resident #1 vomited a large amount of "black" liquid before breakfast and vomited again with the first bite of the breakfast meal. Observation of Resident #1 on 05/20/25 at 12:00pm revealed: -Resident #1 was lying flat in a geri chair while the PCA was assisting Resident #1 with feeding. -The PCA gave Resident #1 a bite of the pureed meal when Resident #1 began coughing a lot. Interview with the PCA on 05/20/25 at 12:00pm revealed Resident #1 vomited a black substance again so she was going to give Resident #1 soup because Resident #1 could not eat the pureed food without vomiting and coughing. Review of the facility's text messaging service with Resident #1's Primary Care Provider (PCP) revealed: -On 05/07/25 at 5:15pm, a medication aide (MA) documented Resident #1 was eating supper and "just suddenly threw up" a "black" substance. -On 05/07/25 at 5:37pm, a reply from Resident #1's PCP office documented a request for vital signs, if Resident #1 was nauseated, what was Resident #1 eating, report of pain, any diarrhea, any symptoms reported now and did Resident #1 resume eating, any pain or cough? -On 05/07/25 at 5:37pm, the MA replied Resident #1 was not complaining she was nauseated, did not resume eating and Resident #1 was eating pureed sloppy joe's and applesauce, no pain and no cough. -On 05/07/25 at 5:37pm, a reply from Resident #1's PCP office documented a STAT complete blood count (CBC, a blood test used to analyze the size and quantity of different blood cells), a chest xray and to monitor and report any acute	{D 273}		

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{D 273}	Continued From page 2 changes or concerns. Telephone interview with Resident #1's PCP on 05/20/25 at 12:57pm revealed: -On 05/07/25, Resident #1 had a previous episode of vomiting a small amount of dark liquid. -On 05/07/25 she ordered a blood test to check Resident #1's hemoglobin to make sure Resident #1 was not showing signs of anemia due to the dark vomit and the results were within normal limits. -She instructed the staff to notify her if it happened again because she would order a gastrointestinal consult due to the dark vomit. -Resident #1 was also at risk for aspiration due to her previous history. Interview with a MA on 05/20/25 at 1:10pm revealed: -On 05/20/25 before breakfast, Resident #1 vomited a large amount of a dark colored liquid that had phlegm in it. -She helped the PCA clean Resident #1 up and change her clothes. -On 05/20/25 around 6:00am she administered Resident #1's morning medications with vanilla pudding. -She did not know what the dark colored liquid was, and she did not notify the PCP about the vomiting episode. -She was trained in MA class and instructed by the Resident Care Coordinator (RCC), Business Office Manager (BOM) and the Administrator to use the facility's text messaging service to notify the PCP immediately after the episode to receive new orders. -She did not notify the PCP because she forgot. Interview with RCC on 05/20/25 at 1:23pm revealed:	{D 273}		

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{D 273}	Continued From page 3 -Today, on 05/20/25, she did not know Resident #1 vomited a dark liquid earlier before breakfast. -A few weeks ago, Resident #1 vomited dark liquid and the PCP thought it might be due to anemia, but the blood work came back ok. -The PCP instructed the staff to notify her if it happened again. -The MAs were responsible to notify the PCP using the facility's texting service. -She did not know the PCP was not notified after the vomiting episode happened. Interview with the BOM on 05/20/25 at 1:23pm revealed: -On 05/20/25, the MA was responsible to notify the PCP after Resident #1 vomited a dark liquid using the facility's texting service. -She did not know the PCP was not notified. Interview with the Administrator on 05/21/25 at 10:50am revealed: -The MAs were responsible to notify the PCP using the facility's texting service when Resident #1 vomited a dark liquid before breakfast this morning (05/20/25). -He was made aware that the MA did not notify the PCP until 05/20/25 at 2:00pm. 2. Review of Resident #4's FL2 dated 06/21/24 revealed: -Diagnoses included diabetes mellitus type 2, chronic obstructive pulmonary disease, hypertension, bipolar affective disorder with mania and psychosis, heart failure, hypothyroidism, hyperglycemia, dyslipidemia, neuropathy, and arthritis. -There was an order for lantus solostar (used to control blood sugar) 100 units/ml inject 36 units subcutaneously every morning. -There was an order for lantus solostar 100	{D 273}		

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{D 273}	Continued From page 4 units/ml inject 20 units subcutaneously every evening. -There was an order for fingerstick blood sugar (FSBS) twice a day. -There was an order for FSBS parameters: if FSBS equal or less than 60 recheck opposite hand, if FSBS was still equal or less than 60 give snack and recheck FSBS in one hour or at mealtime, eat and recheck in one hour. If not alert or unable to drink safely call 911. If FSBS is less than or equal to 60 and able to drink, give 4 oz juice with two tablespoons sugar and recheck in 15 minutes, if FSBS was still less than or equal to 60 call the Primary Care Provider (PCP). If she becomes unresponsive call 911. If on insulin/sliding scale and refuses FSBS three times, fax results for instructions. Review of Resident #4's primary care physician (PCP) order dated 02/24/25 revealed: -There was an order to discontinue previous FSBS monitoring parameter. -There was an order for blood glucose monitoring parameters: if FSBS less than 60, give 4oz of orange juice and small snack, recheck FSBS in 30 min if still less than 60, notify PCP immediately; if FSBS greater than 350, notify PCP. Review Resident #4's May 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for lantus solostar 100 units/ml inject 38 units subcutaneously every morning. -There was an entry for lantus solostar 100 units/ml inject 30 units subcutaneously every evening. -There was an entry for lispro kwikpen 100 units/ml inject 8 units subcutaneously with meals	{D 273}		

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{D 273}	Continued From page 5 with breakfast lunch and dinner, hold if FSBS is less than 200. -There was an entry to check FSBS twice a day at 6:30am and 7:00pm if FSBS less than 60 give 4oz of orange juice and small snack recheck FSBS in 30 min if still less than 60 notify PCP; if FSBS greater than 350 notify PCP. -On 05/04/25 at 7:00am, the FSBS was 406, and there was no documentation the PCP was notified. -On 05/04/25 at 7:00pm, the FSBS was 386, and there was no documentation the PCP was notified. -On 05/06/25 at 7:00pm, the FSBS was 374, and there was no documentation the PCP was notified. -On 05/07/25 at 7:00am, the FSBS was 372, and there was no documentation the PCP was notified. -On 05/07/25 at 7:00pm, the FSBS was 395, and there was no documentation the PCP was notified. -On 05/08/25 at 7:00am, the FSBS was 360, and there was no documentation the PCP was notified. -On 05/08/25 at 7:00pm, the FSBS was 382, and there was no documentation the PCP was notified. -On 05/09/25 at 7:00pm, the FSBS was 371, and there was no documentation the PCP was notified. -On 05/10/25 at 7:00pm, the FSBS was 396, and there was no documentation the PCP was notified. -On 05/13/25 at 7:00pm, the FSBS was 362, and there was no documentation the PCP was notified. -On 05/17/25 at 7:00pm, the FSBS was 359, and there was no documentation the PCP was notified.	{D 273}		

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{D 273}	Continued From page 6 Interview with Resident #4 on 05/21/25 at 9:42am revealed: -Her FSBS stayed "high". -The staff checked her blood sugars four times a day. -The staff had her drink water anytime her blood sugars were high. Interview with a medication aide (MA) on 05/21/25 at 9:06am revealed: -Resident #4's FSBS would run high and the PCP was working to manage them. -The PCP changed all residents FSBS parameters to notify if over 400 but left Resident #4's parameters at 350. -She would send an electronic message to the PCP on the facility's electronic text message service when Resident #4's FSBS were high. Interview with the MA Supervisor on 05/21/25 at 9:17am revealed: -The MA's are expected to follow orders as written. -The MA's should message the PCP through the facility's electronic text message service. -She would make a note in the eMAR chart notes when the PCP was notified of Resident #4's high sugars and any other changes. Interview with the Business Office Manager (BOM) on 05/20/25 at 4:41pm revealed: -The PCP had changed FSBS parameters for all facility residents to notify the PCP when over 400. -On 05/19/25, she discovered during eMAR audits that Resident #4's blood sugar parameters were still written to notify the PCP when the FSBS were over 350. -She found there were multiple times Resident #4's FSBS were over 350 and there was no	{D 273}		

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{D 273}	Continued From page 7	{D 273}		

message sent to the PCP in facility's text messaging service.
-On 05/20/25, there was a mandatory staff meeting to review Resident #4's FSBS orders.

Interview with Resident #4's primary care physician (PCP) on 05/21/25 at 11:30am revealed:
-Resident #4's FSBS parameters order to notify when over 350 was written by the previous PCP.
-Resident #4's FSBS parameters should have been changed to notify when over 400 when she became the PCP.
-If she was notified that Resident #4's FSBS was high she would instruct staff to give water and recheck FSBS in one hour.
-If Resident #4's FSBS was high and she wasn't notified, the resident would become symptomatic which would include lethargy, sweating, and change in mental status.
-She expects facility staff to notify if Resident #4 became symptomatic.
-The expectation is that facility staff follow any blood sugar parameters regardless if they are written to notify if FSBS was over 350 or 400.

Interview with the Administrator on 05/21/25 at 10:52am revealed:
-The expectation was that staff read the physicians' orders thoroughly and follow them entirely.
-Staff notified provider immediately if there was a new problem for any resident for new orders.
-The expectation was that staff use the facility's text message service to notify the PCP of updates on residents and also notify administrative staff.
-Staff would document in the shift report notebook or in the eMAR chart notes.
-The previous provider had changed the FSBS

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{D 273}	Continued From page 8 parameters for residents to notify when over 400, but Resident #4's order was to notify the PCP when FSBS over 350.	{D 273}		