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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on June 28-30, 2017 with a telephone exit on July 5, 2017.	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: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up for 3 of 5 sampled residents (Resident #2, #3 and #5), with a referral for psychiatry and psychotherapy services and a physician's order for a gastrointestinal (GI) consult (Resident #2), a physician's order for a GI consult (Resident #3), and a referral for Physical Therapy (Resident #5). The findings are: A. Review of Resident #2's current FL2 dated 4/22/17 revealed: -Diagnoses of severe major depression and irritable bowel syndrome (IBS). -Medications included Seroquel 50mg daily (to treat depression) and trazodone 50mg twice daily (to treat major depression). Review of Resident #2's Resident Register revealed: -An admission date of 4/7/17.	D 273		

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D 273	Continued From page 1 -She had a Power of Attorney (POA). Review of Resident #2's care plan dated 4/12/17 revealed: -No documentation for mental health or social history. -Gastrointestinal was documented as normal. -She was oriented and had an adequate memory. 1. Interview with Resident #2 on 6/28/17 at 10:30am revealed: -She had been having issues with her nerves. -She saw a psychiatrist regularly when she lived at home. -She had lived in the facility for 3 months. -She had tried to commit suicide while at the facility and was sent to the hospital. -She had overdosed "a bunch of times" on aspirin when she lived at home. -She had asked a family member to bring her a bottle of Tylenol PM (used to treat insomnia and pain) on 6/11/17. -She took 26 Tylenol PM on 6/11/17 that her family member had given her. -She had suicidal thoughts several times in the past week, and had told the staff about suicidal ideation a few times, but they "just talked to me". -There were other times she did not tell the staff about her suicidal thoughts. -She had not seen a mental health provider since her admission to the facility. -She had only seen Primary Care Provider (PCP) in the facility once since she was admitted to the facility. -She was doing better when she saw the psychiatrist while she lived at home. Review of Resident #2's admission packet documents revealed her medical history included anxiety and depression.	D 273		

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Record review of the PCP's initial visit note dated 4/22/17 for Resident #2 revealed:
-The chief complaint was documented as "MD initial history and physical".
-Impression documented as severe major depression disorder and psychosis.
-"Denies any depression but does have a history of anxiety".
-"The patient's level of care is stable but guarded".

Review of the Mental Health provider's Request for Healthcare Services form for Resident #2 revealed:
-Service requested was documented as psychiatry and psychotherapy.
-The form was signed by Resident #2's POA and completed by the Administrator on 4/5/17.
-Printed at the bottom of the form was "Completed forms can be faxed to" and listed the provider's fax number.

Review of an incident report dated 6/11/17 at 10:15pm for Resident #2 revealed:
-Type of incident was documented as overdose.
-Resident #2 took 28 Tylenol PM (acetaminophen 500mg and diphenhydramine 25mg) tablets and was "trying to kill herself".
-Resident #2 was transported by emergency medical services (EMS) to the hospital.
-The PCP was notified on 6/11/17 at 10:15pm.
-The Mental Health provider "was notified to see if resident is approved" for services for Resident #2.

Review of staff nurses notes for Resident #2 revealed:
-On 6/11/17 at 10:20pm "(Resident #2) stated that her (family member) brought her 2 bottles of

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Tylenol 500mg PM of 24 count and she stated she took 26 pills including the two Tylenol 500mg PRN with night meds. EMS was called and POA was called and he stated this is not the first time this has happened to her".
-On 6/11/17 "resident (named family member) brought resident Tylenol PM. Resident stated to med tech that she had taken 28 Tylenol PM. Police was called EMS and resident was transported to the hospital to be eval. POA was notified and made aware of the action of (named family member) and was told she could not bring over the counter items to facility".

Review of Resident #2's hospital records dated 6/12/17 revealed:
-She arrived to the emergency department on 6/11/17 at 10:34pm.
-Presenting complaint was documented as overdose.
-Acetaminophen level of 152 ug/ml on 6/11/17 at 11:36pm.
-The therapeutic range for acetaminophen was documented as 10 - 30 ug/ml.
-A physician order dated 6/12/17 for Ativan 1mg every 8 hours as needed for anxiety.
-She was discharged from the emergency department on 6/12/17.

Interview with a staff member on 6/29/17 revealed:
-A family member had brought a bottle of Tylenol PM to Resident #2 on 6/11/17.
-Resident #2 overdosed on Tylenol PM and was sent to the hospital, but was not admitted.
-The staff member had notified the Mental Health provider's Psychotherapist on 6/28/17 about Resident #2's need for mental health service.
-The staff had notified the same Psychotherapist in the past, but was told they were unsure if visits

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for Resident #2 would be covered due to insurance issues, and the staff member did not follow-up to see if services could be provided.
-The Psychotherapist met with Resident #2 on 6/28/17 "just to talk with her".

Interview with the Administrator on 6/30/17 at 12:49pm and 3:19pm revealed:
-She was unaware that Resident #2's family member brought a bottle of Tylenol PM to the resident prior to the incident on 6/11/17.
-She was unaware of Resident #2's history of mental illness upon admission to the facility.
-Resident #2 had not had any behaviors prior to 6/11/17.
-When asked if the Mental Health provider was faxed a referral for Resident #2 in April, she stated "now let me check".
-She was unable to find documentation of a faxed referral.
-When asked what interventions the facility put in place after the 6/11/17 incident she replied "that was her (Resident #2's) first attempt to harm herself, and display this behavior."
-She had notified the PCP of behaviors and overdose on 6/11/17 and he started resident on lorazepam on 6/24/17.
-There were no other interventions implemented for Resident #2 after she overdosed on 6/11/17.
-Resident #2 "did see the MD immediately following the incident on 6/11".

Review of a PCP visit note dated 6/24/17 for Resident #2 revealed:
-Chief complaint documented as "MD visit".
-Primary diagnosis documented as generalized anxiety disorder.
-Anxiety level was controlled after administration of lorazepam.

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Interview with the Resident Care Coordinator (RCC) on 6/29/17 at 12:35pm revealed:
-Resident #2 had talked to the RCC, Resident Care Director (RCD) and the Administrator later in the day on 6/28/17 about being anxious.
-The RCC had received an order for lorazepam 0.5mg twice daily, and keep the "as needed" dose.
-The facility had also faxed a referral to the Mental Health provider on 6/28/17.

Further record review for Resident #2 revealed:
-A physician's order dated 6/28/17 for lorazepam 0.5mg twice daily.
-There were no visits with the PCP between 4/22/17 and 6/24/17.

Observation and interview with Resident #2 on 6/29/17 at 12:40pm revealed:
-Resident #2 approached the surveyor and stated she wanted to go to the 7th floor (behavioral health unit) due to anxiety and sadness.
-She was observed to be tearful and anxious.
-The surveyor immediately notified the Medication Aide (MA) and she stated she would send Resident #2 to the hospital for evaluation.

On 6/29/17 at 12:45pm the surveyor notified the RCD of how Resident #2 was feeling, and notified her that she had requested an as needed dose of her Ativan.

Further review of staff nurses notes for Resident #2 revealed:
-On 6/28/17 "resident has complained of being depressed. Primary MD notified. (named Mental Health provider) paper referral was sent over. Resident was placed on 30 min checks. Telephone order given by (named PCP) to increase lorazepam. Will follow up with

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psychiatric help".
-On 6/29/17 at 1:15pm "resident stated to a guest and staff that she wanted to harm or kill herself due to being very depressed. She has had a attempt several weeks ago".
-On 6/29/17 "resident was sent out to ER to be eval due to having suicidal thoughts".

Review of an incident report dated 6/29/17 at 1:15pm for Resident #2 revealed:
-Type of incident documented was "communicating suicide".
-"Resident told guess (guest) and staff that she was very depressed and wanted to harm or kill herself. She stated she needed help."
-Resident #2 was transported by EMS to the hospital.
-The PCP was notified on 6/29/17 at 1:20pm.

Interview with the RCC and MA on 6/29/17 at 2:01pm revealed:
-Resident #2 was sent to the hospital for evaluation and they had notified the Power of Attorney (POA).
-Resident #2 was transported by EMS to the hospital.

Interview with the Administrator on 6/29/17 at 2:35pm revealed:
-The Mental Health provider's Request for Health Care Services form was to notify Mental Health that a consultation for services was needed for Resident #2.
-The Mental Health provider usually had a "quick turn-around time, which was less than 30 days", to evaluate the resident.

Interview with the Mental Health provider's scheduler on 6/30/17 at 11:26am revealed:
-Resident #2 was not in their system.

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-He would have the Intake Coordinator call the surveyor.

Interview with the Mental Health provider's Intake Coordinator on 6/30/17 at 11:39am revealed:
-The Mental Health provider's Request for Health Care Services form was their referral form.
-It was to be faxed to her when it was completed by the facility.
-Resident #2 had never been referred to the Mental Health provider since her admission to the facility, and was not in their system.
-The facility had never "reached out" to the Intake Coordinator regarding Resident #2.
-Normally, the RCD or the Administrator notified her of new referrals.
-She had not received a referral for Resident #2 from the facility in the past week.

Interview with Resident #2's POA on 6/30/17 at 11:59am revealed:
-He visited Resident #2 one time per week and would call her daily.
-Resident #2 had a history of suicidal thoughts in the past and wanted to harm herself.
-The facility was made aware of Resident #2's psychiatric history on the admission paperwork that the POA had completed.
-Resident #2's family member did bring the Tylenol PM to the facility on 6/11/17.
-He stated "(Resident #2) had just asked for them, (family member) was not thinking."
-He was notified of the incidents that occurred on 6/11/17 and 6/29/17.
-He was unaware if Resident #2 had any psychotherapy visits since admission to the facility.
-He was never notified of insurance issues related to Mental Health services.

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Interview with two MAs on 6/30/17 at 2:11pm revealed:
-They did not know where the 30 minute checks (frequent rounds made on residents) documentation was kept.
-It was the responsibility of the Personal Care Aides (PCAs) to document 30 minute checks.

Interview with the RCC on 6/30/17 at 2:30pm revealed:
-Resident #2 was seen by the PCP until she obtained health insurance to cover Mental Health services.

Requested documentation from the RCC of 30 minute checks performed on Resident #2 after the 6/11/17 incident and for 6/28/17 and 6/29/17. The requested information was not received by exit.

Interview with the Administrator on 6/30/17 at 2:33pm revealed the Mental Health provider's Request for Health Care Services form was "filled out initially and only sent to provider if needed".

Review of facility's policy and guidelines for Resident Increased Agitation revealed:
-Increased agitation, aggression or physically abusive behaviors will be addressed with increased observation.
-Possible interventions included room change, medication review, observation, pain management, and environmental stimulation adjustment.
-The level of observation is determined by the RCD and will be a minimum of 72 hours.
-Levels of observation include 1:1 observation, documented 15 minute checks, documented 30 minute checks, and documented 1 hour checks.
-At the end of each designated time period, if

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there are no additional incidents, the staff will progress to the next level of observation as directed by Resident Care Management.
-At the conclusion of the 72 hours, if there are no incidents of agitated, aggressive, or physically abusive behaviors, the resident will be moved back to routine 2 hour checks with the permission of the Resident Care Manager.

Attempted telephone interview with Resident #2's PCP on 6/30/17 was unsuccessful.

Refer to interview with the Administrator on 6/30/17 at 12:49pm.

2. Review of Resident #2's PCP's visit note dated 4/22/17 revealed:
-Gastrointestinal was documented "negative for nausea, diarrhea, vomiting or constipation".
-Abdomen was documented "fine, non-tender and non-distended. Good bowel sounds, no rebound or guarding, no masses felt".
-Impression was documented irritable bowel syndrome (IBS) with diarrhea component.

Review of Resident #2's LHPS (Licensed Health Professional Support) form dated 4/25/17 revealed:
-An umbilical hernia was present and caused occasional pain.
-The Physician had been contacted and a request had been made for a GI referral.
-Resident #2 reported frequent diarrhea.

Review of Resident #2's physician's orders revealed a gastrointestinal (GI) referral dated 4/29/17

Review of Resident #2's admission packet documents revealed her medical history included

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digestive issues.

Review of Resident #2's electronic Medication Administration Record (eMAR) for June 2017 revealed she had as needed medications which included antacid liquid (for heartburn), milk of magnesia (for constipation), pink bismuth suspension (for upset stomach, diarrhea and nausea), and promethazine (used to treat nausea and vomiting).

Interview with a staff member on 6/29/17 revealed there was no GI appointment made for Resident #2.

Interview with the RCD on 6/29/17 at 3:35pm revealed the facility was unable to make the GI appointment due to Resident #2 had no insurance.

Interview with the RCD and RCC on 6/29/17 at 4:30pm revealed:
-A GI appointment had been scheduled on 6/29/17 for Resident #2 for 7/20/17.
-Resident #2 did not have health insurance.
-Corporate and the office manager were working to obtain health insurance for Resident #2.

Interview with transportation staff on 6/30/17 at 11:33am revealed there was no GI appointment documented in her book for Resident #2.

Interview with Resident #2's POA on 6/30/17 at 11:59am revealed:
-He was not aware that a GI referral had been ordered.
-He was not notified about health insurance issues.

Interview with the Administrator on 6/30/17 at

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12:49pm revealed:
-She was unaware of a GI referral appointment being made prior to 6/28/17 for Resident #2.
-She was unaware if Resident #2's PCP was notified of the delay in services.
-Resident #2 did not currently have health insurance.
-The Office Manager was working with corporate to obtain health insurance for Resident #2.

Second interview with the Administrator on 6/30/17 at 3:19pm revealed:
-The GI referral was not sent due to no health insurance for Resident #2.
-The Office Manager knew there was no coverage, so the referral was never sent for Resident #2.

Attempted telephone interview with Resident #2's PCP on 6/30/17 was unsuccessful upon exit.

Refer to interview with the Administrator on 6/30/17 at 12:49pm.

B. Resident #3's current FL2 dated 4/22/17 revealed:
-Diagnoses included cognitive impairment, diabetes mellitus type 2, hypertension, shortness of breath, and benign prostatic hypertrophy.
-Medications included omeprazole 40mg daily (used to treat gastroesophageal reflux disease).

Review of Resident #3's Resident Register revealed:
-An admission date of 4/7/17.
-He had a Power of Attorney (POA).

Interview with Resident #3 revealed he had chronic neck pain and prostate issues.

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Review of Resident #3's Primary Care Physician (PCP) visit note dated 4/22/17 revealed his abdomen was documented as "soft, non-tender and non-distended. Good bowel sounds. No rebound or guarding. No masses felt".

Review of Resident #3's LHPS form dated 4/25/17 revealed:
-"Skin assessment revealed an umbilical hernia presenting with redness and draining at times".
-She contacted the PCP to request a "GI consult referral and treatment".
-The umbilical hernia "causes him trouble".

Review of Resident #3's physician's orders revealed a gastrointestinal (GI) referral dated 4/25/17.

Interview with a staff member on 6/29/17 revealed no GI appointment had been made for Resident #3.

Interview with the RCD on 6/29/17 at 3:35pm revealed no GI appointment had been made for Resident #3 prior to 6/29/17.

Interview with the RCD and RCC on 6/29/17 at 4:30pm revealed a GI appointment had been scheduled on 6/29/17 for Resident #3 for 7/20/17.

Interview with transportation staff on 6/30/17 at 11:33am revealed there was no GI appointment documented in her book for Resident #3.

Interview with Resident #3's POA on 6/30/17 at 11:59am revealed:
-He was not aware that a GI referral had been ordered.
-He was not notified about health insurance issues.

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AURORA OF STATESVILLE	1902 ORA DRIVE STATESVILLE, NC 28625

(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
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Interview with the LHPS RN on 6/30/17 at 12:35pm revealed Resident #3 was on antibiotics for the wound on his abdomen, and now it was healed.

Interview with the Administrator on 6/30/17 at 12:49pm revealed:
-She was unaware of a GI referral appointment being made prior to 6/28/17.
-She was unaware if Resident #3's PCP was notified of the delay in services.

Attempted telephone interview with Resident #3's PCP on 6/30/17 was unsuccessful upon exit.

Refer to interview with the Administrator on 6/30/17 at 12:49pm.

C. Review of Resident #5's current FL2 dated 4/24/17 revealed:
-Diagnoses included urinary tract infection (UTI), bilateral pneumonia, and chronic obstructive pulmonary disease (COPD).
-A physician's order for physical therapy (PT) to evaluate and treat.

Review of Facility Medical Order Processing Procedure in the Facility Policy notebook revealed:
-All new orders that came into the facility were to go into the New Order Box including FL2's, telephone orders, fax orders, prescriptions and orders written on anything else (hospital discharge summaries, etc.).
-Each Supervisor for their shift was responsible for checking the New Order Box frequently throughout the shift and processed those orders.
-Once the order has been processed, it was then placed in the 24-48 Hour Verification Box.

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D 273	Continued From page 14 -The Supervisor in Charge would document that there was a new order in the Documentation Notebook. -The Resident Care Director (RCD), on a daily basis each morning, would check, pulled the orders out of the 24-48 hour Verification Box and checked to be sure that they were processed correctly. -The RCD dated and initialed the order to show that it had been verified and the signed order would be put back in the resident's record. If the order is not signed by the physician, the RCD takes responsibility for getting the order signed and into the record. Interview with the Resident Care Coordinator (RCC) on 6/29/17 at 4:43pm revealed: -RCC was not aware of an order for PT on Resident #5's FL2 dated 4/24/17. -There was no documentation of a referral to home health for PT for Resident #5. Interview with the RCD on 6/30/17 at 9:41am revealed: -She was not aware of an order for PT on Resident #5's FL2 dated 4/24/17. -She did not know if there had been a referral made since 4/24/17 for PT for Resident #5. -She could not provide documentation that Resident #5 was referred to or received PT as ordered on the FL2. Telephone interview with a Home Health representative on 6/30/17 at 11:12am revealed: -Home Health never received a referral from the facility for PT for Resident #5 in 2017. -Resident #5 had received PT services in 2015. -The facility faxed orders and FL2's to Home Health for referrals to evaluate residents.	D 273		

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D 273	Continued From page 15 Interview with the Administrator on 6/30/17 at 12:48pm revealed: -Resident #5 participated in PT from December 2015 until May 2016. -She was not aware of an order for PT on Resident #2's FL2 dated 4/24/17. -She was not able to produce any documentation that a referral was made for PT as ordered on FL2. -"When an order is received from a doctor, the Resident Care Director makes sure that it goes to where it needs to go, for example: Home Health, Hospice." Interview with the Administrator on 6/30/17 at 12:49pm revealed: -When the facility received new orders, they were placed in the 24 hour box. -The RCD would send new orders to the appropriate agency and would notify the transportation staff to schedule appointments. _____ The failure of the facility to assure Resident #2, who had a history of a medication overdose on 6/11/17, while at the facility, was referred to mental health services and also who had a history of diarrhea, was referred to a gastrointestinal (GI) specialist. This failure resulted in the resident being admitted to the hospital on 6/28/17 for suicidal ideation and not being scheduled for a GI appointment. The facility, further failed to obtain a GI consultation for Resident #3, who had an umbilical hernia with abdominal pain, and failed to obtain a physical therapy consult after a physician's order for a PT consult for Resident #5. The facility's failures to notify the physician for referral and follow up had substantial risk that death or serious physical harm and neglect and constitutes a Type A2 Violation.	D 273		

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D 273	Continued From page 16 The Plan of Protection provided by the facility on 6/30/17 revealed: -The facility will immediately review resident records for any health care and referral issues and follow up / schedule as needed. -The Administrator will assure regular care team meetings with department heads, medication aides, and personal care aides to gather critical information requiring referral and follow up. -The Administrator will work with the facility nurse to assure a system is implemented to make sure all referral and follow up issues are addressed. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 4, 2017.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure that food stored in the refrigerator was protected from contamination. The findings are: Observation on 06/29/17 at 2:50pm revealed: -A large box of fresh eggs were stored on the top shelf above a bowl of covered lettuce in the refrigerator.	D 283		

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D 283	Continued From page 17 -The lettuce was covered in plastic wrap. -The Dietary Manager moved the bowl of lettuce to another section of the refrigerator after the observation. Interview on 6/29/17 at 2:50pm with the Dietary Manager revealed: -The box of eggs was too big to put on the bottom shelf so he placed the box on the top shelf. -He was aware that the eggs were supposed to be on the bottom shelf. Observation on 6/30/17 at 10:28am revealed: -The fresh eggs were still stored on the top shelf of the refrigerator. -Under the fresh eggs was a ham sandwich in a plastic bag. Interview on 6/30/17 at 10:28am with the Dietary Manager revealed: -He knew the eggs were supposed to be stored on the bottom shelf in the refrigerator. -When the eggs came in, he stored the eggs on the top shelf because he did not have space on the bottom shelf. -Another dietary worker placed the lettuce under the eggs. -He would move the eggs to the bottom shelf today. -He received training in food service and storage from a Culinary Arts School and through the ServSafe program.	D 283		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes:	D 287		

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D 287	Continued From page 18 (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide a place setting which included a knife, fork, and spoon for 50 residents who resided in the facility. The findings are: Observation of the dietary aide on 6/28/17 between 11:00am and 11:45am revealed she was putting the place settings on the assisted living dining room tables. Observation on 6/28/17 between 12:00pm and 12:40pm of the lunch meal service in the Assisted Living dining room revealed: -The residents had been served lasagna, steamed broccoli, salad with ranch dressing, rolls and a brownie for dessert. -None of the residents had a knife with their place settings. -The residents received a fork and spoon. -None of the residents were having any trouble cutting any of the food with the fork. Observation on 6/28/17 at 12:05pm of the lunch meal service in the Special Care Unit (SCU) dining room revealed: -Table napkins had been folded around flatware which included only a fork and spoon. -Staff were placing the napkin with the fork and	D 287		

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D 287	Continued From page 19	D 287		

spoon on the tables for residents.
-No residents received a knife.

Interviews with 6 residents in the Assisted Living dining room on 6/28/17 revealed:
-They did not get knives with their meals.
-They had seen staff helping some residents cut up their food.
-They did not know if they could get a knife if they asked for one.
-They had never had any problem cutting up their food.
-They had never been told they could not have a knife, but they had never asked for one.

Observation on 6/29/17 between 7:45am and 8:30am of the breakfast meal service in the Assisted Living dining room revealed:
-The residents had been served oatmeal, scrambled eggs, livermush, pancakes, and bananas.
-None of the residents had a knife with their place settings.
-The residents received a fork and spoon.
-None of the residents were having any trouble cutting any of the food with the fork.

Interviews with three Personal Care Aides (PCAs) in the Assisted Living unit on 6/29/17 revealed:
-They did not know why the residents did not have knives in their place settings.
-They did not know if a resident could ask for a knife or not.
-"Normally residents don't get knives because the food is tender enough to cut with a fork".
-They had never seen any of the residents having trouble cutting up their food.
-They had never had a resident ask for a knife.
-They would help residents with cutting food if needed.

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D 287	Continued From page 20 Interview with the Resident Care Coordinator (RCC) on 6/29/17 at 12:20pm revealed: -The residents could have a knife if they asked for one. -The residents who had trouble eating meat were on texture modified diets. -She had never been made aware of any resident having trouble eating their food. -She did not know why the residents did not have knives with their place setting. Observation on 6/29/17 at 2:50pm in the kitchen revealed: -A plastic container of flatware which included only a fork and spoon wrapped in napkins was in the storage area. -There was a cutlery rack filled with knives on a counter in the kitchen. Interview with the Dietary Manager on 6/29/17 at 2:50pm revealed: -Knives were included in the flatware service provided to residents. -They had rolled flatware with forks and spoons, but they were not going to use those for residents. Observation on 6/29/17 at 5:15pm in the Assisted Living dining room revealed: -A dietary aide was rolling a cart into the dining hall. -On the cart were paper napkins and a tray of knives, forks, and spoons. Interview with the Administrator on 6/30/17 at 11:50am revealed: -She did not know why the residents did not have knives at their place settings. -There were no residents on the Assisted Living	D 287		

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D 287	Continued From page 21 Unit of the facility who could not have a knife with their meal. -The residents who had difficulty eating their meals were on texture modified diets. -The staff assisted the residents in the special care unit with cutting up their food if needed. Observation on 6/30/17 at 12:00pm of the lunch meal service revealed all residents on the Assisted Living Unit had a knife as a part of their place setting.	D 287		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the therapeutic diet of Low Concentrated Sweets was served as ordered by the physician for 3 of 3 residents sampled (Resident #6, #7, and #8). The findings are: Review of the facility's therapeutic menus for Low Concentrated Sweets (LCS) revealed: -A column for daily food items to be served to residents on the diet. -An explanation at the bottom of each day's menu for LCS - "all beverages, gelatin, syrup, jelly and sweeteners except milk should be sugar free."	D 310		

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D 310	Continued From page 22 -Six ounces juice was to be served at breakfast. Observation of the breakfast meal in the Special Care Unit (SCU) on 6/29/17 from 8:00 to 8:45am revealed all the residents who received juice were served approximately 4 to 6 ounces of cranberry juice. Review of the label on the cranberry juice in the dietary storage area revealed: -The juice was labeled cranberry juice cocktail (a juice cocktail is a juice with added sugars and caloric sweeteners)and contained 12 percent juice. -The juice contained 26 mg of added sugar. -The juice was sweetened with a caloric sweetener. Review of the labels for the orange and apple juice available in the dietary storage area revealed they did not contain caloric sweetener and were 100 percent juice. Interview with the dietary aide in the SCU on 6/29/17 at 8:30am revealed: -The residents were always served either cranberry juice, apple juice, or orange juice daily for breakfast. -She could not say which days cranberry juice was served but they rotated serving the three different juices. Interview with the dietary manager on 6/29/17 at 2:50pm revealed: -He was not aware the cranberry juice was not sugar free. -He was not aware the cranberry juice was only 12 percent juice. -The facility did not purchase any other type of cranberry juice.	D 310		

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-The food service supplier dietitian had not informed him the cranberry juice was not appropriate for residents on a LCS diet.
-He received training in food service at a Culinary Arts School and from a ServSafe program.

A. Review of Resident #7's current FL2 dated 1/22/17 revealed:
-Diagnoses included dementia and high cholesterol.
-A physician's order to check finger stick blood sugars (FSBS) 4 times per day.
-A physician's order for a LCS puree diet.

Review of physician orders for Resident #7 dated 5/6/17 revealed:
-A physician's order to check FSBS twice daily.
-A physician's order Novolog for sliding scale insulin twice daily (a medication to lower blood sugar).
-A physician's order for Levemir 12 units in the morning and 16 units at bedtime (a long acting insulin used to lower blood sugar).

Observation of the breakfast meal in the SCU on 6/29/17 from 8:00 to 8:45am revealed Resident #7 was served approximately 5 ounces of cranberry juice.

Review of Resident #7's June 2017 electronic Medication Administration Records revealed:
-Entries for FSBS at 6:30am and 8:00pm.
-FSBS at 6:30am ranged from 116 to 508.
-FSBS at 8:00pm ranged from 99 to 594.

Based on review of Resident #7's record and attempted interview with Resident #7, it was determined the resident was not interviewable.

B. Review of Resident #8's current FL2 dated

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D 310	Continued From page 24 6/17/17 revealed: -Diagnoses included diabetes and dementia. -A physician's order for a LCS diet. -A physician's order to check finger stick blood sugars (FSBS) twice daily. -A physician's order for Lantus insulin 20 units at bed time (a medication to lower blood sugar). -A physician's order for Glipizide 10 mg daily (a medication to lower blood sugar). Observation of the breakfast meal in the SCU on 6/29/17 from 8:00 to 8:45am revealed Resident #8 was served approximately 5 ounces of cranberry juice. Review of Resident #8's June 2017 electronic Medication Administration Records revealed: -Entries for FSBS at 6:30am and 8:00pm. -FSBS at 6:30am ranged from 48 to 213. -FSBS at 8:00pm ranged from 64 to 341. Based on review of Resident #8's record and attempted interview with Resident #8, it was determined the resident was not interviewable. C. Review of Resident #6's current FL2 dated 1/22/17 revealed: -Diagnoses included diabetes and dementia. -A physician's order for a LCS diet. -A physician's order to check finger stick blood sugars (FSBS) twice daily. -A physician's order for Levemir 2 units at bedtime (a long acting insulin used to lower blood sugar). Observation of the breakfast meal in the SCU on 6/29/17 from 8:00 to 8:45am revealed Resident #6 was served approximately 5 ounces of cranberry juice.	D 310		

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D 310	Continued From page 25 Review of Resident #6's June 2017 electronic Medication Administration Records revealed: -Entries for FSBS at 8:00am and 8:00pm. -FSBS at 8:00am ranged from 101 to 327. -FSBS at 8:00pm ranged from 119 to 549. Based on review of Resident #6's record and attempted interview with Resident #6, it was determined the resident was not interviewable.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications (albuterol sulfate, ipratropium-albuterol, Symbicort inhaler, clonidine and Cymbalta), were administered as ordered by a licensed prescribing practitioner for 4 of 5 sampled residents (#1, #3, #4 and #5). The findings are: A. Review of Resident #5's current FL2 dated	D 358		

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4/24/17 revealed diagnoses included bilateral pneumonia and chronic obstructive pulmonary disease (COPD).

1. Review of Resident #5's signed FL2 dated 4/24/17 referred to the hospital discharge Medication Administration Record (MAR) for a list of medications. The MAR included albuterol sulfate 2.5 mg/3 ml solution - inhale 1 vial 4 times a day. (a medication used to open airways and facilitate airflow through the lungs).

Review of Resident #5's April 2017 electronic Medication Administration Record (eMAR) revealed:
-Documentation Resident #5 was out of the facility in the hospital from 4/24/17 through 4/25/17.
-Albuterol sulfate was documented as administered at 4:00pm and 8:00pm on 4/25/17 and at 8:00am, 12:00pm, 4:00pm, and at 8:00pm from 4/26/17 through 4/27/17.
-Documentation that Resident #5 was out of the facility at the hospital emergency room during the 8:00am, 12:00pm and 4:00pm med pass on 4/28/17, but documented as administered at 8:00pm on 4/28/17.
-Albuterol sulfate was documented as administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 4/29/17 through 4/30/17.

Review of Resident #5's May 2017 eMAR revealed:
-An entry for albuterol sulfate 2.5 mg/3 ml - inhale 1 vial 4 times a day and documented as administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 5/1/17 through 5/31/17 with exceptions.
-Exceptions were documented on eMAR Resident #5 was out of the facility on 5/18/17 and

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AURORA OF STATESVILLE	1902 ORA DRIVE STATESVILLE, NC 28625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 27 5/19/17 at 4:00pm, 5/27/17 at the 4:00pm dose, and on 5/31/17 at the 12:00pm dose. Review of Resident #5's June 2017 eMAR revealed: -An entry for 2.5 mg/3 ml - inhale 1 vial 4 times a day and documented as administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 6/1/17 through 6/19/17 with exceptions. -Exceptions were documented on eMAR Resident #5 was out of the facility on 6/14/17 at the 12:00pm dose and the 4:00pm dose. -Albuterol sulfate was documented as administered at 8:00am, 12:00pm, 4:00pm, and 9:30pm from 6/15/17 through 6/28/17 with exceptions. -Exceptions were documented that Resident #5 was at the hospital on 6/22/17 at the 8:00am dose and the 12:00pm dose and there was no documented reason for a missed dose on 6/25/17 at 9:30pm. Interview with Resident #5 on 6/29/17 at 11:50am revealed: -She had pneumonia 6 times since October 2016. -She had not used her nebulizer this week. -She had not used her nebulizer in about a year. -She had not been short of breath. -Her nebulizer was kept packed away on a shelf in her room. Observation of medications on hand for Resident #5 on 6/29/17 at 11:57am revealed: -One box of albuterol sulfate 2.5 mg/3 ml dispensed on 5/8/17 with a total of 57 vials was remaining. -One box of albuterol sulfate 2.5 mg/3 ml dispensed on 5/8/17 with a total of 30 vials was remaining.	D 358		

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D 358	Continued From page 28 Interview with a Medication Aide (MA) on 6/29/17 at 11:57am revealed: -She usually worked 1st shift, but sometimes had to stay over and work extra shifts. -She administered albuterol sulfate 2.5 mg/3 ml via nebulizer during her shift. -Resident had never ran out of albuterol sulfate 2.5 mg/3 ml. -Albuterol sulfate 2.5 mg/3 ml was a "cycle" medication and was automatically refilled by the pharmacy every two weeks. Interview with the Resident Care Coordinator (RCC) on 6/29/17 at 2:38pm revealed: -"Cycle" medications were automatically refilled by the pharmacy. -"Cycle" refills provided enough medication to last for two weeks. Interview with a family member of Resident #5 on 6/29/17 at 3:57pm revealed: -Resident #5 had been taking medication daily for her COPD including nebulizer treatments. -Resident #5 had pneumonia one time this year, 2017, and six times between last year, 2016 and this year. Interview with a pharmacy technician from the contracted pharmacy on 6/29/17 at 11:22am revealed: -The pharmacy dispensed 180 vials of albuterol sulfate 2.5 mg/3 ml on 5/8/17. -Albuterol sulfate 2.5 mg/3 ml should have lasted 45 days from the date it was dispensed (should have been used by 6/22/17). Observation of Resident #5's room on 6/29/17 at 4:20pm revealed: -The resident was out of her room at an activity. -The MA and RCC searched the room for	D 358		

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Resident #5's nebulizer.
-The MA and RCC were unable to locate Resident #5's nebulizer.
-The MA went to ask Resident #5 where her nebulizer was and after she returned to the room, she (MA) located it on a bottom shelf at the foot of Resident #5's bed.
-The nebulizer was packed neatly in a box secured with a rubber band around it.
-The nebulizer had very little wear.
-The MA looked around the room for the nebulizer tubing, and found the tubing in a clear, plastic bag on the same shelf where nebulizer was stored.
-The nebulizer tubing had dried dark particles on the inside of the tubing.
-There was no moisture build-up observed in the nebulizer.

Interview with a first shift Medication Aide (MA) on 6/29/17 at 4:20pm revealed.
-She did not know where Resident #5's nebulizer was.
-She was responsible for administering nebulizer treatments during her shift.
-Nebulizer tubing was changed weekly.
-A supply of nebulizer tubing was kept in the medication room.
-New tubing could be reordered and it would be in the facility by this evening.

Interview with a second shift Medication Aide (MA) on 6/30/17 at 3:30pm revealed:
-The MA had administered nebulizer treatments during his shift.
-Only one vial was administered twice during his shift.
-The nebulizer was kept plugged in by Resident #5's bed.
-Resident #5 never ran out of Albuterol.
-Resident #5 never refused nebulizer treatments

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during his shift.

Interview with a Nursing Assistant (NA) at Resident #5's physician's office on 6/30/17 at 11:36am revealed:
-Albuterol sulfate 2.5 mg/3 ml was on Resident #5's record and was to be administered 4 times a day via nebulizer.
-Medications were expected to be administered as ordered by the physician.
-The physician was unavailable and no other staff was available to answer specific questions.

Refer to interview with the Administrator on 6/30/17 at 2:30pm.

Refer to the medication administration policy and new order review policy.

2. Review of Resident #5's current FL2 dated 4/24/17 referred to hospital discharge Medication Administration Record (MAR) for a list of medications. The hospital discharge MAR revealed physician orders for ipratropium-albuterol 0.5-3(2.5) mg/3ml - inhale 1 vial 2 times a day (a medication used to open airways and facilitate airflow through the lungs).

Review of Resident #5's April 2017 electronic Medication Administration Record (eMAR) revealed:
-Documentation Resident #5 was out of the facility in the hospital from 4/24/17 through 4/25/17.
-Ipratropium-albuterol was documented as administered at 8:00pm and 8:00pm on 4/25/17 and at 8:00am and at 8:00pm from 4/26/17 through 4/27/17.
-Documentation Resident #5 was out of the facility at the hospital emergency room during the

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8:00am med pass on 4/28/17, but was documented as administered at 8:00pm on 4/28/17.
-Ipratropium-albuterol was documented as administered at 8:00am and 8:00pm from 4/29/17 through 4/30/17.

Review of Resident #5's May 2017 eMAR revealed an entry for ipratropium-albuterol 0.5-3(2.5) mg/3ml - inhale 1 vial 2 times a day and documented as administered at 8:00am and 8:00pm from 5/1/17 through 5/31/17 as ordered.

Review of Resident #5's June 2017 eMAR revealed:
-An entry for ipratropium-albuterol 0.5-3(2.5) mg/3ml - inhale 1 vial 2 times a day and documented as administered at 8:00am and 8:00pm from 6/1/17 through 6/19/17.
-Ipratropium-albuterol was documented as administered at 8:00am and 9:30pm from 6/20/17 through 6/28/17 with exceptions.
-Exceptions were documented that Resident #5 was at the hospital on 6/22/17 at 8:00am and there was no documented reason for a missed dose on 6/25/17 at 9:30pm.

Review of the Resident Medical Order Processing Procedure in the Facility Policy notebook revealed:
-All new orders that came into the facility were to go into the New Order Box including FL2's, telephone orders, fax orders, prescriptions and orders written on anything else (hospital discharge summaries, etc.).
-Each Supervisor for their shift was responsible for checking the New Order Box frequently throughout the shift and processed those orders.
-Once the order has been processed, it was then placed in the 24-48 Hour Verification Box.

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-The Supervisor in Charge documented that there was a new order in the Documentation Notebook.
-The Resident Care Director (RCD), on a daily basis each morning, pulled the orders out of the 24-48 hour Verification Box and checked to be sure that they were processed correctly.
-The RCD dated and initialed the order to show that it had been verified and the signed order would be put back in the resident's record. If the order was not signed by the physician, the RCD took responsibility for getting the order signed and into the record.

Observation of medication on hand 6/29/17 at 11:57am revealed that there was no ipratropium-albuterol 0.5-3(2.5) mg/3ml available for administration.

Interview with a MA on 6/29/17 at 11:57am revealed:
-There was no ipratropium-albuterol 0.5-3(2.5) mg/3ml for administration to Resident #5.
-The MA last administered ipratropium-albuterol 0.5-3(2.5) mg/3ml two days ago.
-The MA reordered ipratropium-albuterol 0.5-3(2.5) mg/3ml two days ago.
-There was no documentation the ipratropium-albuterol 0.5-3(2.5) mg/3ml had been ordered two days ago.
-Albuterol was a "cycle-filled" medication and she did not understand why it was not automatically reordered.
-She was responsible for reordering medication if she saw that a medications was out.
-Medications were reordered by faxing the pharmacy.
-She called the pharmacy in addition to faxing to ensure the request for reorder was received.
-Fax receipts were put into the 24 hour box which management was responsible for checking daily.

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D 358	Continued From page 33 -There was no documentation of a fax sent to the pharmacy to refill medication for resident dated within the last two days. -When ordered, meds arrived the same day if in stock and may take up to two days for delivery if not in stock at pharmacy. -"Cycle-filled" medications were automatically refilled. -As needed medications had to be ordered. -Ipratropium-albuterol 0.5-3(2.5) mg/3ml was a cycled medication and should have been sent to the facility by the pharmacy automatically. Interview with a contracted pharmacist in the facility on 6/30/17 at 10:25am revealed: -Ipratropium-albuterol 0.5-3(2.5) mg/3ml was not a "cycle-filled" medication and needed to have a request to be refilled. -Medications such as inhalers, inhalation solutions, and eye drops were not "cycle" medications and needed to be reordered. Interview with the RCC on 6/29/17 at 2:38pm revealed no medication reorders for Resident #5 were made this week. Interview with a pharmacy technician from the contracted pharmacy on 6/29/17 at 11:22am revealed: -The pharmacy received a new prescription for ipratropium-albuterol 0.5-3(2.5) mg/3ml in Resident #5's profile on 1/30/17. -The facility never requested to have ipratropium-albuterol 0.5-3(2.5) mg/3ml filled. -The pharmacy never filled the prescriptions for ipratropium-albuterol 0.5-3(2.5) mg/3ml because it was never requested to be filled by the facility. Second interview with a pharmacy technician on 6/30/17 at 12:21pm revealed:	D 358		

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D 358	Continued From page 34 -The facility requested, on 6/29/17, to have ipratropium-albuterol 0.5-3(2.5) mg/3ml filled. -"This is the first and only time that this medication has been filled." -A package of 90 vials was sent out to the facility on 6/29/17. Interview with Resident #5 on 6/29/17 at 11:50am revealed: -She had pneumonia 6 times since October 2016. -She had not used her nebulizer this week. -She had not used her nebulizer in about a year. -She had not been short of breath. -Her nebulizer was kept packed away on a shelf in her room. Interview with the Administrator on 6/30/17 at 12:48pm revealed: -She had been employed at the facility for 2 years. -There were a few residents in the facility who were on nebulizer treatments. -Nebulizers were kept in the residents' rooms. -She was not aware that ipratropium-albuterol 0.5-3(2.5) mg/3ml was not available for Resident #5 in the facility. -The Care Coordinators were responsible for doing cart audits ensuring that orders matched the eMARs and medications were on hand for administration. Observation of Resident #5's room on 6/29/17 at 4:20pm revealed: -The resident was out of her room at an activity. -The MA and RCC searched the room for Resident #5's nebulizer. -The MA and RCC were unable to locate Resident #5's nebulizer. -The MA went to ask Resident #5 where her nebulizer was, and after she returned to the	D 358		

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room, she (MA) located it on a bottom shelf at the foot of Resident #5's bed.
-The nebulizer was packed neatly in a box secured with a rubber band around it.
-The nebulizer appeared to have very little wear.
-The MA looked around the room for the nebulizer tubing, and found the tubing in a clear, plastic bag on the same shelf where nebulizer was stored.
-The nebulizer tubing had dried dark particles on the inside of the tubing.
-There was no moisture build-up observed in the nebulizer.

Interview with a MA on 6/29/17 at 4:20pm revealed.
-She did not know where Resident #5's nebulizer was.
-She was responsible for administering nebulizer treatments during her shift.
-Nebulizer tubing was changed weekly.
-A supply of nebulizer tubing was kept in the medication room.
-New tubing could be reordered and it would be in the facility by this evening.

Interview with a second shift MA on 6/30/17 at 3:30pm revealed:
-The MA had administered nebulizer treatments during his shift.
-Only one vial was administered twice during his shift.
-The nebulizer was kept plugged in by Resident #5's bed.
-Resident #5 never ran out of Albuterol.
-Resident #5 never refused nebulizer treatments during his shift.

Interview with a Nursing Assistant (NA) at Resident #5's physician's office on 6/30/17 at 11:36am revealed:

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-Ipratropium-albuterol 0.5-3(2.5) mg/3ml was on Resident #5's record and was to be administered 2 times a day via nebulizer.
-Medications were expected to be administered as ordered by the physician.
-The physician was unavailable and no other staff was available to answer specific questions.

Refer to interview with the Administrator on 6/30/17 at 2:30pm.

Refer to the medication administration policy and new order review policy.

3. Review of Resident #5's current FL2 dated 4/24/17 referred to hospital discharge Medication Administration Record (MAR) for a list of medications. Hospital discharge MAR revealed a physician's order for Symbicort 160-4.5 mcg Inhaler - Inhale 2 puffs 2 times a day (a medication used to treat chronic obstructive pulmonary disease).

Review of Resident #5's April 2017 electronic Medication Administration Record (eMAR) revealed:
-Documentation that Resident #5 was out of the facility in the hospital from 4/24/17 through 4/25/17.
-Symbicort 160-4.5 mcg was documented as administered at 8:00pm on 4/25/17 and at 8:00am and at 8:00pm from 4/26/17 through 4/27/17.
-Documentation Resident #5 was out of the facility at the hospital emergency room during the 8:00am med pass on 4/28/17 but was documented as administered at 8:00pm on 4/28/17.
-Symbicort 160-4.5 mcg Inhaler - Inhale 2 puffs 2 times a day was documented as administered at

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D 358	Continued From page 37 8:00am and 8:00pm from 4/29/17 through 4/30/17. Review of Resident #5's May 2017 eMAR revealed an entry for Symbicort 160-4.5 mcg Inhaler - Inhale 2 puffs 2 times a day and documented as administered at 8:00am and 8:00pm from 5/1/17 through 5/31/17 as ordered. Review of Resident #5's June 2017 eMAR revealed: -An entry for Symbicort 160-4.5 mcg Inhaler - Inhale 2 puffs 2 times a day and documented as administered at 8:00am and 8:00pm from 6/1/17 through 6/19/17. -Symbicort 160-4.5 mcg was documented as administered at 8:00am and 9:30pm from 6/20/17 through 6/28/17 with exceptions. -Exceptions were documented that Resident #5 was at the hospital on 6/22/17 at 8:00am and there was no documented reason for a missed dose on 6/25/17 at 9:30pm. Review of the facility Medical Order Processing Procedure in the Facility Policy notebook revealed: -All new orders that came into the facility were to go into the New Order Box including FL2s, telephone orders, fax orders, prescriptions and orders written on anything else (hospital discharge summaries, etc.). -Each Supervisor for their shift was responsible for checking the New Order Box frequently throughout the shift and processed those orders. -Once the order has been processed, it was then placed in the 24-48 Hour Verification Box. -The Supervisor in Charge would document that there was a new order in the Documentation Notebook. -The Resident Care Director (RCD), on a daily	D 358		

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basis each morning, pulled the orders out of the 24-48 hour Verification Box and checked to be sure that they were processed correctly.
-The RCD dated and initialed the order to show that it has been verified and the signed order would be put back in the resident's record. If the order was not signed by the physician, the RCD took responsibility for getting the order signed and into the record.

Observation of medications on hand 6/29/17 at 11:57am revealed there was no Symbicort 160-4.5 mcg Inhaler available for administration.

Interview with a MA on 6/29/17 at 11:57am revealed:
-There was no Symbicort 160-4.5 mcg Inhaler available for administration to Resident #5.
-The MA last administered Symbicort 160-4.5 mcg Inhaler two days ago.
-The MA reordered Symbicort 160-4.5 mcg Inhaler two days ago.
-Symbicort was a "cycle" medication and she did not understand why it was not automatically reordered.
-She was responsible for reordering medication if she saw that a medication was out.
-Medications were reordered by faxing the pharmacy.
-She called the pharmacy in addition to faxing to ensure that request for reorder was received.
-Faxed receipts were put into the 24 hour box which management was responsible for checking daily.
-When ordered, meds arrived the same day if in stock and may take up to two days for delivery if not in stock at pharmacy.
-There was no documentation of a fax sent to the pharmacy to refill medication for resident dated within the last two days.

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AURORA OF STATESVILLE	1902 ORA DRIVE STATESVILLE, NC 28625

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-"Cycle-filled" medications were automatically refilled.
-As needed medications had to be ordered.
-Symbicort 160-4.5 mcg Inhaler was a cycled medication and should have been sent to the facility by the pharmacy automatically.

Interview with Resident #5 on 6/29/17 at 11:50am revealed:
-She had Pneumonia 6 times since October 2016.
-She had not used her inhaler this week.
-"I don't use it. They never give it to me."
-She had not been short of breath.

Interview with a contracted pharmacist in the facility on 6/30/17 at 10:25am revealed:
-He reviewed medications, but did not check to see what medications were on hand.
-Symbicort 160-4.5 mcg Inhaler was not a "cycle" medication and needed to have a request to be refilled.
-Medications such as inhalers, inhalation solutions, and eye drops were not "cycle" medications and needed to be reordered.

Interview with the Resident Care Coordinator (RCC) on 6/29/17 at 2:38pm revealed no medication reorders for Resident #5 were made this week.

Interview with a pharmacy technician at the contracted pharmacy on 6/29/17 at 11:22am revealed:
-Symbicort 160-4.5 mcg Inhaler was last filled on 3/20/17.
-The inhaler had 120 inhalations and should have lasted one month if used as ordered.
-The facility would have to make a request to refill.

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D 358	Continued From page 40 Second interview with a pharmacy technician at the contracted pharmacy on 6/30/17 at 12:21pm revealed that the facility requested on 6/29/17 to have Symbicort 160-4.5 mcg Inhaler refilled. Interview with the Administrator on 6/30/17 at 12:48pm revealed: -She had been employed at the facility for 2 years. -She was not aware Symbicort 160-4.5 mcg Inhaler was not available for Resident #5 in the facility. -The Care Coordinators were responsible for doing cart audits ensuring that orders matched the eMAR and medications were on hand for administration. Refer to interview with the Administrator on 6/30/17 at 2:30pm. Refer to the medication administration policy and new order review policy. B. Review of Resident #1's current FL-2 dated 2/7/17 revealed diagnoses included bipolar disorder, malignant neoplasm of breast, and depressive disorder. Review of an order written by the Mental Health Nurse Practitioner for Resident #1 dated 2/3/17 revealed: -Cymbalta 30mg (a medication used for depression) daily if approved by the primary care provider. -The reason for starting the Cymbalta was increased depression. -The Resident Care Coordinator (RCC) had received a telephone order from the primary care provider for approval to start the Cymbalta on	D 358		

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D 358	Continued From page 41 3/16/17. Review of Resident #1's April, May, and June 2017, electronic medication administration records (eMAR) revealed no documentation of Cymbalta present on the MARs. Interview on 6/29/17 at 10:15am with a representative from the contracted pharmacy revealed: -The pharmacy had never received an order for Cymbalta 30mg daily. -The facility had sent the physician's order for Cymbalta to the pharmacy on 6/30/17. Interview with Resident #1's Mental Health Nurse Practitioner on 6/29/17 at 2:45 pm revealed: -She came to the facility once per month and seen the Resident #1 every time she came. -She had noticed on several occasions that the Cymbalta had not been started. -She did not have any "real concerns" about the medication not being started. -She had not let anyone at the facility know about the medication not being on the eMAR. -The resident had been doing "much better" and seemed to improve on each visit. -The facility had not notified her prior to 6/29/17 about not starting the Cymbalta. Interview with Resident #1 on 6/30/17 at 9:40 am revealed: -She had not known that her physician was going to add the medication Cymbalta. -She had previously had some increased depression, but she "feels better now". -She had been less depressed over the past several months. Interview on 6/30/17 at 1:45 pm with the RCC	D 358		

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revealed:
-She had received a telephone order on 3/16/17 from the primary care physician for approval to start the Cymbalta 30mg every day.
-She did fax the order to the pharmacy.
-She did not follow up with the pharmacy to assure they had received the medication order.

Interview on 6/30/17 at 2:45 pm with the Administrator revealed:
-She thought that since the FL2 was dated 2/7/17 and the Cymbalta order was dated 2/7/17 that the FL2 superseded the Cymbalta order.
-She did not know why the Cymbalta order dated 2/7/17 and approved by the primary physician on 3/16/17 was not sent to the pharmacy.

Refer to interview with the Administrator on 6/30/17 at 2:30pm.

Refer to the Medication Administration and New Order Review Policies.

C. Resident #3's current FL2 dated 4/22/17 revealed:
-Diagnoses included cognitive impairment, diabetes mellitus type 2, hypertension, shortness of breath, and benign prostatic hypertrophy.
-Medications included metoprolol ER 50mg daily (used to treat high blood pressure) and ramipril 10mg twice daily (used to treat high blood pressure).

Review of Resident #3's physician's order dated 4/22/17 revealed an order for clonidine 0.2mg now, and every 8 hours as needed if systolic blood pressure (SBP) more than 160 or diastolic blood pressure (DBP) more than 95.

Review of Resident #3's Resident Register

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revealed:
-An admission date of 4/7/17.
-He had a Power of Attorney (POA).

Interview with Resident #3 revealed:
-He had chronic neck pain and prostate issues.
-He did not report any problems with his blood pressure.

Review of Resident #3's May 2017 electronic Medication Administration Record (eMAR) revealed:
-An entry for Clonidine 0.2mg tablet every 8 hours as needed if SBP more than 160 or DBP more than 95.
-Clonidine 0.2mg was not administered from 4/23/17 to 4/31/17.
-An entry to check blood pressure every 8 hours and if SBP more than 160 or DBP more than 95 give clonidine.
-Clonidine 0.2mg was not documented as administered on 4/23/17 at 4:00 pm when his blood pressure reading was 165/70.

Review of Resident #3's June 2017 electronic eMAR revealed:
-An entry for Clonidine 0.2mg tablet every 8 hours as needed if SBP more than 160 or DBP more than 95.
-Clonidine 0.2mg was documented as administered on 6/9/17 at 9:43am and 6/19/17 at 8:28am.
-An entry to check blood pressure every 8 hours and if SBP more than 160 or DBP more than 95 give clonidine.
-Clonidine 0.2mg was not documented as administered 32 times out of 34 opportunities.
-Blood pressure readings were 180/110 on 6/4/17 at 4:00pm, 181/101 on 6/5/17 at 12am, 198/100 on 6/9/17 at 8am, 184/76 on 6/10/17 at 8am,

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180/68 on 6/13/17 at 4pm, 179/82 on 6/14/17 at 12am, 180/112 on 6/18/17 at 4pm, 195/100 on 6/24/17 at 12am, and 189/78 on 6/26/17 at 8am.

Interview with the Medication Aide (MA) on 6/29/17 at 3:24pm revealed:
-She administered the medication to Resident #3 every time, but she "got in a hurry and didn't chart it".
-She had worked in the facility for 15 years.

Telephone interview with a pharmacist on 6/29/17 at 4:15pm revealed:
-The pharmacy dispensed clonidine 0.2mg 16 tablets on 4/14/17 and again on 5/16/17.
-Only one cassette with 16 tablets was dispensed at a time because it was an "as needed" medication.
-No refills had been requested for the clonidine.

Observation of Resident #3's medications on hand on 6/29/17 at 4:20pm revealed:
-A cassette with 11 tablets of clonidine 0.2mg remaining.
-The cassette was dispensed on 5/16/17.

Interview with Resident #3's POA on 6/29/17 at 11:59am revealed:
-He visited Resident #3 at the facility every week, and talked to him on the phone daily.
-He was unaware Resident #3 had missed 32 doses of clonidine 0.2mg.

Attempted telephone interview with Resident #3's primary care physician on 6/30/17 was unsuccessful.

Attempted second interview with Resident #3 was unsuccessful.

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D 358	Continued From page 45 Refer to interview with the Administrator on 6/30/17 at 2:30pm. Refer to the Medication Administration and New Order Review Policies. D. Review of Resident #4's FL2 dated 5/17/17 revealed: -Diagnoses included dementia and chronic rhinitis. -A physician order for Systane (a lubricating eye drop) .3-4 percent 1 drop in each eye twice daily. -A physician order for fluticasone propionate (a steroidal nasal spray) 50 mcg 2 sprays in each nostril once daily. Observation of Resident #4's medications on hand on 6/28/17 at 4:15 pm revealed: -No Systane eye drops available for administration. -No fluticasone propionate nasal spray 50 mcg available for administration. Interview with the Medication Aide (MA) in the Special Care Unit (SCU) 6/28/17 at 4:15 pm revealed: -She usually worked on the Assisted Living Care Unit, but occasionally was called to work in the SCU. -She could not find Resident #4's Systane eye drops or the fluticasone propionate nasal spray. -She did not know if the Systane eye drops or the fluticasone propionate nasal spray had been ordered. Second observation of Resident #4's medications on hand on 6/29/17 at 11:10am revealed no Systane eye drops or fluticasone propionate nasal spray available for administration.	D 358		

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D 358	Continued From page 46 Review on 6/29/17 of Resident #4's June 2017 electronic Medication Administration Record (eMAR) revealed: -An entry for and documentation by a MA of the administration of Systane .3-4 percent Lubricant drops on 6/28/17 at 8:00pm. -Documentation by a different MA of the administration of Systane .3-4 percent Lubricant eye drops on 6/29/17 at 8:00am and an entry for and documentation of fluticasone propionate nasal spray 50 mcg on 6/29/17 at 8:00am. Interview on 6/29/17 at 11:10am with the MA who documented the administration of Systane .3-4 percent to Resident #4 and the administration of fluticasone propionate on 6/29/17 at 8:00am revealed: -She could not find Resident #4's Systane eye drops or the fluticasone propionate nasal spray in the medication cart. -She did not administer the Systane eye drops or the fluticasone propionate nasal spray at 8:00 am today, but did document the administrations in error. -She was distracted because "There was so much going on in the back." -The Systane eye drops and the fluticasone propionate nasal spray had been ordered. -She did not know when the Systane eye drops and the fluticasone propionate nasal spray ran out but if MAs continued to document the administration when none was available, no one would know they did not have any and it would not be ordered. Interview on 6/29/17 at 3:15pm with the MA who documented the administration of Systane .3-4 percent eye drops to Resident #4 on 6/28/17 at 8:00pm revealed she did not administer the Systane eye drops but did document the	D 358		

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D 358	Continued From page 47 administration in error. Telephone interview with the contracted pharmacist on 6/29/17 at 9:07 am revealed: -The Systane .3-4 percent lubricant eye drop was an "active" order, had not been discontinued, and none had been requested since they dispensed a 30 day supply on 5/10/17. -The fluticasone propionate 50 mcg was an "active" order, had not been discontinued, and none had been requested since they dispensed a 30 day supply on 5/10/17. -The Systane eye drops and the fluticasone propionate were not automatically dispensed but staff had to request them when they were needed. Telephone interview with Resident #4's primary care physician on 6/29/17 at 11:31am revealed: -The Systane eye drops were ordered to counter dry eyes caused by other medications and was not significant if not administered. -If the fluticasone propionate nasal spray was not administered it was not significant and it was difficult for a resident with dementia to actually be administered the spray. Based on review of Resident #4's record and attempted interview with Resident #4, it was determined the resident was not interviewable. Attempted telephone interview with Resident #4's responsible person on 6/29/17 at 9:45am was not successful. Refer to interview with the Administrator on 6/30/17 at 2:30 pm. Refer to the medication administration policy and new order review policies.	D 358		

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D 358	Continued From page 48 Interview on 6/30/17 at 2:30 pm with the Administrator revealed: -The Resident Care Director (RCD) or the RCC was responsible to assure the orders from the physicians were on the MARs. -The RCC and RCD should make regular checks to assure all orders are sent to the pharmacy and put on the MARs. -She will work with the Facility Nurse to assure all medication orders are followed through with to assure the medications are ordered and available to be administered. Review of the facility's policy and procedures for administration of medications revealed "All Medication Administration staff will be reviewed periodically to ensure adherence to adherence to correct medication administration practices. Medication audits will be reviewed by the corporate compliance officer or designee and random audits performed as deemed necessary". Review of the facility's policy and procedures for daily new order review revealed "On a daily basis, the RCD will pull all new orders from previous day or days when weekends are included. Utilizing the daily review of new orders, the RCD will document the orders to ensure accuracy and availability. Should the RCD be unavailable, he/she will designate someone to perform this review on a daily basis, and then recheck the review upon return". The failure of the facility to administer medications as ordered (albuterol, Symbicort and ipratropium-albuterol) to Resident #5, who had chronic obstructive pulmonary disease and was recently hospitalized for pneumonia, placed this	D 358		

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D 358	Continued From page 49 resident at risk for recurrent hospitalizations related to respiratory disease and failure. Additionally, failure of the facility to administer clonidine to Resident #3 who had hypertensive disease resulted in continued elevated blood pressure measurements, which if left unchecked, could result in heart attack and/or stroke. This failure of the facility to administer medications as ordered was detrimental to the health of these residents and constitutes a Type B Violation. The Plan of Protection provided by the facility on 6/29/17 revealed: -The facility administration will immediately review the residents medications to assure all medications are available for administration. -The facility administration will immediately review resident records and Medication Records to assure all orders are current and accurate. -The facility will immediately review and utilize the medication ordering system to assure all medications are ordered in a timely manner to assure the residents do not miss any doses of medications. -The facility nurse will develop a 24 hour medication order check / verification system to assure all medication orders are followed as ordered by the licensed practitioner. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 19, 2017.	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	D 367		

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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 assure the electronic medication administration record (eMAR) was accurate and complete for 2 of 5 sampled residents (Resident #4 and #5).

A. Review of Resident #4's FL2 dated 5/17/17 revealed diagnoses included dementia and chronic rhinitis.

1. Review of a physician order for Resident #4 dated 6/8/17 revealed Cefdinir 300 mg every 12 hours (an antibiotic) with no information related to reason for treatment and no number of tablets to be dispensed.

Review of June 2017 electronic Medication Administration Record (eMAR) revealed:
-Computer generated entry for Cefdinir 300 mg

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every 12 hours with no discontinue (DC) documented on the eMAR but did have "need stop date" after the directions and a stop date of 6/9/18.
-Documentation of administration at 8:00 am on 6/10 through 6/15, on 6/19 through 6/21, and 6/25 through 6/27.
-Documentation of administration at 8:00 pm on 6/10 through 6/16, on 6/18 through 6/20, and on 6/22.
-Documentation of administration at 7:00 pm on 6/23 through 6/26 and on 6/28.
-The facility staff documented the administration of Cefdinir for a total of 27 doses.

Telephone interview with the contracting pharmacist on 6/29/17 at 9:07 am revealed:
-The pharmacy dispensed 14 doses of Cefdinir for a 7 day supply.
-If an antibiotic order did not have a stop date, they usually dispensed a 7 day supply.

Interview with a Medication Aide (MA) on 6/29/17 at 11:10 am revealed she did not know why 27 doses of Cefdinir was documented when only 14 doses were dispensed.

Interview with the Resident Care Director (RCD) on 6/29/17 at 10:45 am revealed:
-She did not know why the MAs documented the antibiotic for 27 doses when only 14 doses were dispensed.
-She understood it was not a medication administration error but a documentation error.

Refer to review of the facility's policy and procedures for administration of medications.

Refer to review of the facility's policy and procedures for daily new order review.

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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 367	Continued From page 52 2. Review of Resident #4's FL2 dated 5/17/17 revealed a physician order for Systane (a lubricating eye drop) .3-4 percent 1 drop in each eye twice daily. Observation of Resident #4's medications on hand on 6/28/17 at 4:15 pm revealed no Systane eye drops available for administration. Review on 6/29/17 of Resident #4's May and June 2017 electronic Medication Administration Record (eMAR) revealed: -An entry for Systane .3-4 percent Lubricant drops with times of administration for 8:00am and 8:00pm. -Documentation of administration of Systane eye drops began on 5/11/17 at 8:00am and continued through 6/298/17 at 8:00am. -One MA documented the administration of Systane .3-4 percent Lubricant eye drops on 6/28/17 at 8:00pm and another MA documented the administration of Systane eye drops on 6/29/17 at 8:00am. A second observation of Resident #4's medications on hand on 6/29/17 at 11:10 am revealed no Systane eye drops available for administration. Interview on 6/29/17 at 11:10 am with the MA who documented the administration of Systane .3-4 percent to Resident #4 revealed: -She could not find Resident #4's Systane eye drops in the medication cart. -She did not administer the Systane eye drops at 8:00 am today, but did document the administration in error. -She was distracted because "There was so much going on in the back."	D 367		

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-The Systane eye drops had been ordered.
-She did not know when the Systane eye drops ran out but if MAs continued to document the administration when none was available, no one would know they did not have any and it would not be ordered.

Interview on 6/29/17 at 3:15pm with the MA who documented the administration of Systane .3-4 percent eye drops to Resident #4 on 6/28/17 at 8:00 pm revealed she did not administer the Systane eye drops but did document the administration in error.

Telephone interview with the contracted pharmacist on 6/29/17 at 9:07 am revealed:
-The Systane .3-4 percent lubricant eye drop was an "active" order, had not been discontinued, and none had been requested since they dispensed a 30 day supply on 5/10/17.
-The Systane eye drops were not automatically dispensed but staff had to request them.

Refer to review of the facility's policy and procedures for administration of medications.

Refer to review of the facility's policy and procedures for daily new order review.

3. Review of Resident #4's FL2 dated 5/17/17 revealed a physician order for fluticasone propionate (a steroidal nasal spray) 50 mcg 2 sprays in each nostril once daily.

Observation of Resident #4's medications on hand on 6/28/17 at 4:15 pm revealed no fluticasone propionate nasal spray available for administration.

Review on 6/29/17 of Resident #4's May and

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D 367	Continued From page 54 June 2017 electronic Medication Administration Record (eMAR) revealed: -An entry for fluticasone propionate 50 mcg 2 sprays in each nostril once daily with time of administration at 8:00am. -Documentation of administration of fluticasone nasal spray which began on 5/11/17 at 8:00am and continued through 6/29/17 at 8:00am. A second observation of Resident #4's medications on hand on 6/29/17 at 11:10 am revealed no fluticasone propionate nasal spray available for administration. Interview on 6/29/17 at 11:10 am with the MA who documented the administration of Resident #4's fluticasone propionate on 6/29/17 at 8:00 am revealed: -She could not find Resident #4's fluticasone propionate nasal spray in the medication cart. -She did not administer the fluticasone propionate nasal spray at 8:00 am today, but did document the administration in error. -She was distracted because "There was so much going on in the back." -The fluticasone propionate nasal spray had been ordered. -She did not know when the fluticasone propionate nasal spray ran out but if MAs continued to document the administration when none was available, no one would know they did not have any and it would not be ordered. Telephone interview with the contracted pharmacist on 6/29/17 at 9:07 am revealed: -The fluticasone propionate 50 mcg was an "active" order, had not been discontinued, and none had been requested since they dispensed a 30 day supply on 5/10/17. -The fluticasone propionate nasal spray was not	D 367		

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automatically dispensed but staff had to request it.

Based on review of Resident #4's record and attempted interview with Resident #4, it was determined the resident was not interviewable.

Refer to interview with the Administrator on 6/30/17 at 2:30 pm.

Refer to review of the facility's policy and procedures for administration of medications.

Refer to review of the facility's policy and procedures for daily new order review.

B. Review of Resident #5's current FL2 dated 4/24/17 referred to hospital discharge Medication Administration Record (MAR) for a list of medications. The hospital discharge MAR revealed physician's orders for ipratropium-albuterol 0.5-3(2.5) mg/3ml - inhale 1 vial 2 times a day (a medication used to open airways and facilitate airflow through the lungs).

1. Review of Resident #5's April 2017 electronic Medication Administration Record (eMAR) revealed:
-Documentation Resident #5 was out of the facility in the hospital from 4/24/17 through 4/25/17.
-ipratropium-albuterol was documented as administered at 8:00pm and 8:00pm on 4/25/17 and at 8:00am and at 8:00pm from 4/26/17 through 4/27/17.
-Documentation Resident #5 was out of the facility at the hospital emergency room during the 8:00 am med pass on 4/28/17, but was documented as administered at 8:00pm on 4/28/17.

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-ipratropium-albuterol was documented as administered at 8:00am and 8:00pm from 4/29/17 through 4/30/17.

Review of Resident #5's May 2017 eMAR revealed an entry for ipratropium-albuterol 0.5-3(2.5) mg/3ml - inhale 1 vial 2 times a day and documented as administered at 8:00am and 8:00pm from 5/1/17 through 5/31/17 as ordered.

Review of Resident #5's June 2017 eMAR revealed:
-An entry for ipratropium-albuterol 0.5-3(2.5) mg/3ml - inhale 1 vial 2 times a day and documented as administered at 8:00am and 8:00pm from 6/1/17 through 6/19/17.
-ipratropium-albuterol was documented as administered at 8:00am and 9:30pm from 6/20/17 through 6/28/17 with exceptions.
-Exceptions were documented that Resident #5 was at the hospital on 6/22/17 at 8:00am and there was no documented reason for a missed dose on 6/25/17 at 9:30pm.

Review of the Resident Medical Order Processing Procedure in the Facility Policy notebook revealed:
-All new orders that came into the facility were to go into the New Order Box including FL2's, telephone orders, fax orders, prescriptions and orders written on anything else (hospital discharge summaries, etc.).
-Each Supervisor for their shift was responsible for checking the New Order Box frequently throughout the shift and processed those orders.
-Once the order has been processed, it was then placed in the 24-48 Hour Verification Box.
-The Supervisor in Charge documented that there was a new order in the Documentation Notebook.
-The Resident Care Director (RCD), on a daily

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basis each morning, pulled the orders out of the 24-48 hour Verification Box and checked to be sure that they were processed correctly.
-The RCD dated and initialed the order to show that it had been verified and the signed order would be put back in the resident's record. If the order was not signed by the physician, the RCD took responsibility for getting the order signed and into the record.

Observation of medication on hand 6/29/17 at 11:57am revealed that there was no ipratropium-albuterol 0.5-3(2.5) mg/3ml available for administration.

Interview with a Medication Aide (MA) on 6/29/17 at 11:57am revealed:
-There was no ipratropium-albuterol 0.5-3(2.5) mg/3ml for administration to Resident #5.
-The MA last administered ipratropium-albuterol 0.5-3(2.5) mg/3ml two days ago.
-The MA reordered ipratropium-albuterol 0.5-3(2.5) mg/3ml two days ago.
-There was no documentation the ipratropium-albuterol 0.5-3(2.5) mg/3ml had been ordered two days ago.
-Albuterol was a "cycle-filled" medication and she did not understand why it was not automatically reordered.
-She was responsible for reordering medication if she saw that a medications was out.
-Medications were reordered by faxing the pharmacy.
-She called the pharmacy in addition to faxing to ensure the request for reorder was received.
-There was no documentation of a fax sent to the pharmacy to refill medication for resident dated within the last two days.

Interview with the Resident Care Coordinator

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D 367	Continued From page 58 (RCC) on 6/29/17 at 2:38pm revealed no medication reorders for Resident #5 were made this week. Interview with a pharmacy technician from the contracted pharmacy on 6/29/17 at 11:22am revealed: -The pharmacy received a new prescription for ipratropium-albuterol 0.5-3(2.5) mg/3ml in Resident #5's profile on 1/30/17. -The facility never requested to have ipratropium-albuterol 0.5-3(2.5) mg/3ml filled. -The pharmacy never filled the prescriptions for ipratropium-albuterol 0.5-3(2.5) mg/3ml because it was never requested to be filled by the facility. Second interview with a pharmacy technician on 6/30/17 at 12:21pm revealed: -The facility requested, on 6/29/17, to have ipratropium-albuterol 0.5-3(2.5) mg/3ml filled. -"This is the first and only time that this medication has been filled." -A package of 90 vials was sent out to the facility on 6/29/17. Interview with Resident #5 on 6/29/17 at 11:50am revealed: -She had pneumonia 6 times since October 2016. -She had not used her nebulizer this week. -She had not used her nebulizer in about a year. -She had not been short of breath. -Her nebulizer was kept packed away on a shelf in her room. Interview with the Administrator on 6/30/17 at 12:48pm revealed the Care Coordinators were responsible for doing cart audits ensuring that orders matched the eMARs and medications were on hand for administration.	D 367		

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Interview with a Nursing Assistant (NA) at Resident #5's physician's office on 6/30/17 at 11:36am revealed:
-ipratropium-albuterol 0.5-3(2.5) mg/3ml was on Resident #5's record and was to be administered 2 times a day via nebulizer.
-Medications were expected to be administered as ordered by the physician.
-The physician was unavailable and no other staff was available to answer specific questions.

Refer to interview with the Administrator on 6/30/17 at 2:30pm.

Refer to review of the facility's policy and procedures for administration of medications.

Refer to review of the facility's policy and procedures for daily new order review.

2. Review of Resident #5's current FL2 dated 4/24/17 referred to hospital discharge Medication Administration Record (MAR) for a list of medications. Hospital discharge MAR revealed a physician's order for Symbicort 160-4.5 mcg Inhaler - Inhale 2 puffs 2 times a day (a medication used to treat chronic obstructive pulmonary disease).

Review of Resident #5's April 2017 eMAR revealed:
-Documentation that Resident #5 was out of the facility in the hospital from 4/24/17 through 4/25/17.
-Symbicort 160-4.5 mcg was documented as administered at 8:00pm on 4/25/17 and at 8:00am and at 8:00pm from 4/26/17 through 4/27/17.
-Documentation Resident #5 was out of the facility at the hospital emergency room during the

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D 367	Continued From page 60 8:00 am med pass on 4/28/17 but was documented as administered at 8:00pm on 4/28/17. -Symbicort 160-4.5 mcg Inhaler - Inhale 2 puffs 2 times a day was documented as administered at 8:00am and 8:00pm from 4/29/17 through 4/30/17. Review of Resident #5's May 2017 eMAR revealed an entry for Symbicort 160-4.5 mcg Inhaler - Inhale 2 puffs 2 times a day and documented as administered at 8:00am and 8:00pm from 5/1/17 through 5/31/17 as ordered. Review of Resident #5's June 2017 eMAR revealed: -An entry for Symbicort 160-4.5 mcg Inhaler - Inhale 2 puffs 2 times a day and documented as administered at 8:00am and 8:00pm from 6/1/17 through 6/19/17. -Symbicort 160-4.5 mcg was documented as administered at 8:00am and 9:30pm from 6/20/17 through 6/28/17 with exceptions. -Exceptions were documented that Resident #5 was at the hospital on 6/22/17 at 8:00am and there was no documented reason for a missed dose on 6/25/17 at 9:30 pm. Observation of medications on hand for resident #5 on 6/29/17 at 11:57am revealed there was no Symbicort 160-4.5 mcg Inhaler available for administration. Interview with a MA on 6/29/17 at 11:57am revealed: -There was no Symbicort 160-4.5 mcg Inhaler available for administration to Resident #5. -The MA last administered Symbicort 160-4.5 mcg Inhaler two days ago. -The MA reordered Symbicort 160-4.5 mcg	D 367		

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Inhaler two days ago.
-There was no documentation that the Symbicort 160-4.5 mcg Inhaler had been ordered two days ago.

Interview with Resident #5 on 6/29/17 at 11:50am revealed:
-She had Pneumonia 6 times since October 2016.
-She had not used her inhaler this week.
-"I don't use it. They never give it to me."
-She had not been short of breath.

Interview with a contracted pharmacist in the facility on 6/30/17 at 10:25am revealed:
-He reviewed medications, but did not check to see what medications were on hand.
-Symbicort 160-4.5 mcg Inhaler was not a "cycle" medication and needed to have a request to be refilled.
-Medications such as inhalers, inhalation solutions, and eye drops were not "cycle" medications and needed to be reordered.

Interview with a pharmacy technician at the contracted pharmacy on 6/29/17 at 11:22am revealed:
-Symbicort 160-4.5 mcg Inhaler was last filled on 3/20/17.
-The inhaler had 120 inhalations and should have lasted one month if used as ordered.
-The facility would have to make a request to refill.

Second interview with a pharmacy technician at the contracted pharmacy on 6/30/17 at 12:21pm revealed that the facility requested on 6/29/17 to have Symbicort 160-4.5 mcg Inhaler refilled.

Refer to interview with the Administrator on

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D 367	Continued From page 62 6/30/17 at 2:30pm. Refer to review of the facility's policy and procedures for administration of medications. Refer to review of the facility's policy and procedures for daily new order review. _____ Interview on 6/30/17 at 2:30pm with the Administrator revealed: -She did not know why the MAs were documenting administering medications when they were not administered or available. -She would get with the RCD and the RCC to make sure the MAs did not document medications that were not administered. -She would make sure all the MAs were trained on medication documentation. Review of the facility's policy and procedures for administration of medications revealed "All Medication Administration staff will be reviewed periodically to ensure adherence to adherence to correct medication administration practices. Medication audits will be reviewed by the corporate compliance officer or designee and random audits performed as deemed necessary". Review of the facility's policy and procedures for daily new order review revealed "On a daily basis, the RCD will pull all new orders from previous day or days when weekends are included. Utilizing the daily review of new orders, the RCD will document the orders to ensure accuracy and availability. Should the RCD be unavailable, he/she will designate someone to perform this review on a daily basis, and then recheck the review upon return".	D 367		

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D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow up on the quarterly pharmaceutical medication review recommendations for 1 of 5 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 2/7/17 revealed diagnoses included bipolar disorder, malignant neoplasm of breast, and depressive disorder. Review of a Physician's order written by the Mental Health Nurse Practitioner for Resident #1 dated 2/3/17 revealed: -Cymbalta 30mg (a medication used for depression) daily if approved by the primary care provider. -The reason for starting the Cymbalta was increased depression. -The Resident Care Coordinator (RCC) had received a telephone order from the primary care provider for approval to start the Cymbalta on 3/16/17. Review of Resident #1's current medication review dated 5/1/17 revealed: -"(+) Cymbalta 30mg'. Add Cymbalta."	D 406		

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D 406	Continued From page 64 -There was a "Yes" in the recommendation column. Review of Resident #1's April, May, and June 2017, electronic medication administration records (eMAR) revealed no documentation of Cymbalta present on the MARs. Interview on 6/29/17 at 10:15am with a representative from the contracted facility pharmacy revealed: -The pharmacy had never received an order for Cymbalta 30mg daily. -The facility had sent the physicians order for Cymbalta to the pharmacy on 6/30/17. Interview with Resident #1's Mental Health Nurse Practitioner on 6/29/17 at 2:45pm revealed: -She came to the facility once per month and seen the Resident #1 every time she came. -She had noticed on several occasions that the Cymbalta had not been started. -She did not have any "real concerns" about the medication not being started. -She had not let anyone at the facility know about the medication not being on the MAR. -The resident had been doing "much better" and seemed to improve on each visit. -The facility had not notified her prior to 6/29/17 about the Cymbalta. Interview with Resident #1 on 6/30/17 at 9:40am revealed: -She had not known that her physician was going to add the medication Cymbalta. -She had been less depressed over the past several months. -"I still have some chronic pain, but have accepted that it will always be there."	D 406		

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	HAL049028	A. BUILDING: _____ B. WING _____	R 07/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA OF STATESVILLE	1902 ORA DRIVE STATESVILLE, NC 28625

(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 406	Continued From page 65 Interview with the contracted pharmacy consultant on 6/30/17 at 10:30am revealed: -He reviewed the resident's record for new orders and the eMAR's for accuracy. -Once he completed the onsite review he sent the facility the recommendation worksheet with "recommendation pages to be sent to the physician." -He had noticed that the order for Cymbalta was not on the MAR. Interview on 6/30/17 at 1:45pm with the RCC revealed: -She had received a telephone order on 3/16/17 from the primary care physician for approval to start Cymbalta 30mg every day. -She did fax the order to the pharmacy. -She did not follow up with the pharmacy to assure the medication had been started. -She was with the Mental Health Provider when she came to the facility and she did not let her know the Cymbalta was going to be started. Interview on 6/30/17 at 2:30pm with the Administrator revealed: -The Resident Care Directors (RCD) or the RCC was responsible to assure the orders from the physician were on the MARs. -She thought that since the FL2 was dated 2/7/17 and the Cymbalta order was dated 2/7/17 that the FL2 superseded the Cymbalta order. -She did not know why the Cymbalta order dated 2/7/17 and approved by the primary physician on 3/16/17 was not sent to the pharmacy.	D 406		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights:	D911		

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D911	Continued From page 66 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to assure all residents were treated with respect, consideration, dignity, and full recognition of his or her individuality. The findings are: Based on observations and interviews, the facility failed to provide a place setting which included a knife, fork, and spoon for 50 residents who resided in the facility. [Refer to Tag 0287, 10A NCAC 13F .0904(b)(2) Nutrition and Food Service].	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to implementation of orders and referral and follow-up.	D912		

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D912	Continued From page 67 The findings are: A. Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up for 3 of 5 sampled residents (Resident #2, #3 and #5), with a referral for psychiatry and psychotherapy services and a physician's order for a gastrointestinal (GI) consult (Resident #2), a physician's order for a GI consult (Resident #3), and a referral for Physical Therapy (Resident #5). [Refer to Tag 273, 10A NCAC 13F .0901(b) Health Care (Type A2 Violation)]. B. Based on observations, interviews, and record reviews, the facility failed to assure medications (albuterol sulfate, ipratropium-albuterol , Symbicort inhaler, clonidine and Cymbalta), were administered as ordered by a licensed prescribing practitioner for 4 of 5 sampled residents (#1, #3, #4 and #5). [Refer to Tag 0358, 10A NCAC 13F .1004 (a) Medication Administration (Type B Violation)]. C. Based on observations, interviews, and record reviews, the administrator failed to assure the total operation of the facility met and maintained rules related to healthcare referral and follow-up, medication administration, nutritional services, and pharmaceutical care. [Refer to Tag 980, GS 131D-25 Implementation (Type A2 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

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D914	Continued From page 68 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 3 of 5 sampled residents (Resident #2, #3 and #5), were free of neglect related to referral and follow-up. Thr findings are: Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up for 3 of 5 sampled residents (Resident #2, #3 and #5), with a referral for psychiatry and psychotherapy services and a physician's order for a gastrointestinal (GI) consult (Resident #2), a physician's order for a GI consult (Resident #3), and a referral for Physical Therapy (Resident #5). [Refer to Tag 273, 10A NCAC 13F .0901(b) Health Care (Type A2 Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the administrator failed to assure the total operation of the facility met and maintained rules related to healthcare referral and follow-up, medication administration, nutritional services,	D980		

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D980	Continued From page 69 and pharmaceutical care. The findings are: Interview with the Administrator on 6/30/17 at 2:15pm revealed: -She had been the Administrator at the facility for around two years. -One of the owners is an administrator and is always available for consultation if needed. -She is responsible for the total operation of the facility. -She gives the department heads the autonomy to run their respective departments. -She plans on having more frequent meetings with her staff to assure all rules and regulations are followed. -The Resident Care Coordinators (RCC) are responsible for making sure all orders are followed. -She answers to the owners of the facility. Non-compliance identified during the survey included: A. Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up for 3 of 5 sampled residents (Resident #2, #3 and #5), with a referral for psychiatry and psychotherapy services and a physician's order for a gastrointestinal (GI) consult (Resident #2), a physician's order for a GI consult (Resident #3), and a referral for Physical Therapy (Resident #5). [Refer to Tag 273, 10A NCAC 13F .0901(b) Health Care (Type A2 Violation)]. B. Based on observations and interviews, the facility failed to assure that food stored in the refrigerator was protected from contamination. [Refer to Tag 0283, 10A NCAC 13F .0904 (a) (2)	D980		

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D980	Continued From page 70 Nutrition and Food Service]. C. Based on observations and interviews, the facility failed to provide a place setting which included a knife, fork, and spoon for 50 residents who resided in the facility. [Refer to Tag 0287, 10A NCAC 13F .0904 (b) (2) Nutrition and Food Service]. D. Based on observations, interviews, and record reviews, the facility failed to assure the therapeutic diet of Low Concentrated Sweets was served as ordered by the physician for 3 of 3 residents sampled (Resident #6, #7, and #8). [Refer to Tag 0310, 10A NCAC 13F .0904 (e) (4) Nutrition and Food Service]. E. Based on observations, interviews, and record reviews, the facility failed to assure medications (albuterol sulfate, ipratropium-albuterol , Symbicort inhaler, clonidine and Cymbalta), were administered as ordered by a licensed prescribing practitioner for 4 of 5 sampled residents (#1, #3, #4 and #5). [Refer to Tag 0358, 10A NCAC 13F .1004 (a) Medication Administration (Type B Violation)]. F. Based on observations, interviews, and record reviews, the facility failed to assure the electronic medication administration record (eMAR) was accurate and complete for 2 of 5 sampled residents (Resident #4 and #5). [Refer to Tag 0367, 10A NCAC 13F .1004 (j) Medication Administration]. G. Based on record review and interview, the facility failed to follow up on the quarterly pharmaceutical medication review recommendations for 1 of 5 sampled residents (#1). [Refer to Tag 0406, 10A NCAC 13F .1009	D980		

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D980	Continued From page 71 (b) Pharmaceutical Care]. _____ Failure of management to provide oversight and monitor the facility for all licensure rule areas resulted in failure to assure health care referral and follow-up for 3 of 5 sampled residents in accordance with the resident's assessed needs and current symptoms. The failure to provide oversight in the area of medication administration for 4 of 5 sampled residents to assure physicians orders were followed in accordance to the assessed needs of the residents caused substantial risk for physical harm and neglect. The failure of management to provide oversight in these areas constitutes a Type A2 Violation. _____ The Plan of Protection provided by the facility on 6/29/17 revealed: -The Administrator will immediately meet with all department heads to assure compliance to the rules and regulations. -The Administrator will assure all staff are trained on the rules and regulations. -The Administrator will with the assistance of the Facility Nurse make frequent checks to assure all rules and regulations are being followed. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 4, 2017.	D980		