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D 000	Initial Comments The Adult Care Licensure and the Stokes County Department of Social Services conducted an annual survey on 05/15/18-05/18/18 with an exit conference via-telephone on 05/22/18.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the environmental storage room, containing hazardous materials, was locked and not accessible to residents. The findings are: Observation of the environmental storage room in the Special Care Unit on 05/16/18 at 8:15 am revealed: -The exterior environmental storage room was unlocked and left ajar. -The exterior door had an access code lock. -There was an interior room that was unlocked and contained odor neutralizers, disinfectant cleaners, disinfectant wipes, air fresheners, a bottle of adhesive remover, a bathroom drain cleaner, insecticides, a bottle of rust remover,	D 056		

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stainless steel cleaner, sanitizer/virucide cleaner, and a multi-purpose sanitizer.
-There was also an unlocked cabinet containing a disinfectant cleaner, an air freshener, and a multi-surface cleaner.

Observation of the hallway near the environmental storage room in the Special Care Unit on 05/16/18 from 8:15 am-8:20 am revealed:
-There were several residents seen in the hallway near the environmental storage room.
-No resident attempted to enter the environmental storage room.

Interview with the housekeeper on 05/16/18 at 8:20 am revealed:
-She did not know the environmental storage room was unlocked/open.
-The environmental storage room should have been closed and locked.
-She thought she closed and the door behind her when she last left.
-She did not check to make sure it was locked.

Interview with the Administrator on 05/16/18 at 8:30 am revealed:
-She did not know the environmental storage room was unlocked/open.
-She expected the staff to close the door and then turn the handle and push against the door to make sure the door locked before walking away from the room.
-All staff had the access code for the environmental storage room but only maintenance, housekeeping, and the Administrator had a key to the locked interior chemical room and locked cabinet within the environmental storage room.
-Maintenance checked the batteries in the door key pads every week to make sure the door

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D 056	Continued From page 2 remained locked. Interview with the maintenance supervisor on 05/16/18 at 8:40 am revealed: -He expected all staff to pull the door closed and check to make sure the door was locked before walking away. -He would make sure all staff were retrained on the importance of making sure the door was closed and locked before walking away from the door. -He checked the batteries in the door key pads every week to make sure the door remained locked. -No log was provided of when the batteries were checked.	D 056		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the floors, walls, handrails, baseboards, ceiling air vents in resident rooms #2, #6, #9, #11, #14, #15, #17, #18, and #22 , window resident room #1, doors, door frames, door thresholds, windows and common bathrooms were kept clean and in good repair.	D 074		

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D 074	Continued From page 3 Review of the facility's health inspection dated 03/21/18 revealed a score of 87. Observation of the resident's community bathroom on the left-hand side of the north hall on 05/15/18 at 8:49am revealed the porcelain soap dish was broken leaving a rough jagged edge. Observation of resident rooms #2, #6, #9, #11, #14, #15, #17, #18, and #22 on 05/15/18 between 9:17am-10:12am revealed air vents that were loose, hanging from the ceiling. Observation of resident rooms #16 and #19 on 05/15/18 between 9:17am-10:12am revealed the trim on upper inside edge of the door had been broken revealing the wood. Observation of the hallways and common area rooms on 05/15/18 between 9:00am-10:30am revealed: -The white wooden baseboard throughout the facility had paint chipped off in multiple places revealing the original wood; there were black scrapes and dust buildup on all the baseboards. -The doors in the hallways to resident rooms, bathrooms, offices and storage closets had black marks on the lower 12 inches of the door and chipped paint around the door frame. -The edges of the floors at the baseboard throughout the facility had a buildup of a black granular substance. -The white wooden handrail throughout the facility had black marks. -The wallpaper in the hallways had dust and dirt buildup; it was open at the seams and doors in multiple areas. -There were 3 of 3 exit doors on the north hall had a ½ inch gap between the door and threshold	D 074		

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D 074	Continued From page 4 that exposed the outside. Observation of resident room #1 on 05/15/18 at 9:42am during the initial tour of the facility revealed: -The window by bed A was cracked in 2 places; the first crack was approximately 22 inches in length, and the second crack was approximately 6 inches in length. -The 22-inch crack had a piece of tape covering approximately 14 inches of the crack. -The 6 inch crack had old tape residue, there was no tape covering the crack. Interview with the resident in room #1 on 05/15/18 at 9:42am revealed she did not know what happened to the window; it had been like that since she moved in 8 years ago. Observation of the resident common bathroom on the right-hand side of the south hall on 05/15/18 at 10:56am revealed: -The resident common bathroom had one shower stall, a sink and a toilet. -There was black mildew on the grout between the tiles on two of the walls. -There was black mildew on the grout between the tiles on floor of the shower; there were rust stains on the floor of the shower. -The wall behind the toilet had a 10 by 10 inch area that had been patched, but had not been sanded and painted. Interview with the housekeeper on 05/16/18 at 11:29am revealed: -She had been employed at the facility for about 6 weeks. -Her job was to clean resident rooms and common area bathrooms. -She did not clean the floors in the hallways and	D 074		

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common areas unless there was a spill that she would get up.
-Another housekeeper mopped and waxed the floors in the hallway and common areas 2 times per week.
-If she saw something that needed to be repaired she would tell the Administrator unless she saw the Maintenance Director, then she would tell him.
-She had mentioned to the Maintenance Director the baseboards needed to be painted (she did not recall the date).
-She cleaned the showers in the resident common bathroom daily using a chemical cleaner.
-The black mildew on the grout did not come off; she had not told anyone the grout would not come clean.
-She had noticed the wall behind the commode in the resident common bathroom needed to be sanded and painted; the wall had been like that since she had started working.
-She had mentioned to the housekeeper who did the floors that there was black build up in the corners of the bathroom (she did not recall the date).
-She had not noticed the gap between the doors and the threshold of the exit doors.

Interview with the Administrator on 05/16/18 at 11:39am revealed:
-The housekeeper was responsible for the floors in resident rooms and in the common area bathrooms.
-She had talked to the housekeeper about the black buildup in the corners on Monday, 05/14/18.
-She was not aware of the mildew in the resident bathroom shower on the south hall; she had been made aware of the mildew when the health department was in for their inspection in March

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2018, but thought it had been cleaned.
-"We should have been looking at those areas"
-If it was not coming clean when the housekeeper cleaned it, she needed to notify the Maintenance Director.
-She had talked to the Maintenance Director about 2 weeks ago concerning the handrails, baseboards and doors needing to be painted; the facility was going to contract this work out due to the large amount of painting involved.
-She knew the wallpaper needed to be repaired, but was not aware that some areas were dirty and needed to be cleaned.
-They had not decided, but she thought they were going to remove the wallpaper and paint.
-The Maintenance Director worked in the facility "typically 5 days per week."
-He had been working 2 days, but there was so much to do, he was coming daily.
-When things needed to be repaired, the staff would tell her and she would tell the Maintenance Director.
-She made rounds daily through the facility.
-She had noticed the ceiling vents falling a couple of weeks ago (did not recall the date) and had mentioned to the Maintenance Director.
-She knew the ceiling vents needed to be pushed back in.

Interview with the Maintenance Director on 05/16/18 at 12:34pm revealed:
-He had been doing maintenance at the facility for approximately 8 months.
-He was at the facility at least two days per week.
-He had cleaned the mildew out of the grout in the shower "about a month ago."
-Housekeeping was supposed to clean the shower daily, but he would have to clean it again.
-The rust stains on the floor of the shower would not come off.

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-He had not noticed the gap between the door and threshold on three exit doors.
-He would purchase a door sweep to put on the door to cover the gap.
-He knew the air vents were hanging from the ceiling.
-He had tried to push them back in but the clips were broken that would hold them in place; he needed to order clips.
-He had worked on the air vents about two weeks ago.
-He knew the wall behind the resident common bathroom commode needed to be sanded and painted; it had been like that since he had started working at the facility.
-He did not know the window in resident room #1 was broken; he would have it repaired.
-He did not know the porcelain soap dish was broken; he would have it replaced.
-He had talked to the Administrator about painting the baseboards, handrails and doors.
-He made round when he was in the facility to see what needed to be repaired; the PCAs, housekeeper and Administrator also reported to him what needed to be repaired.

Interview with a PCA on 05/16/18 at 2:40pm revealed:
-If she noticed anything that needed to be repaired she would tell the housekeeper or the Maintenance Director.
-She had not noticed any of the ceilings vents had come loose from the ceiling.
-She had not noticed a gap at the bottom of the exit doors.

Second interview with the Administrator on 05/17/18 at 9:46am revealed she had not noticed there was a gap between the door and threshold on three of the exterior doors that exposed the

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D 074	Continued From page 8 outdoors. Interview with the second housekeeper on 05/18/18 at 8:12am revealed: -He worked 2 days a week at the facility. -He was responsible for mopping and buffing the floors in the halls and common areas. -He was not responsible for bathrooms or resident rooms. -He had mopped and buffed the floors on Monday, 05/17/18. -He did not have time to get around the edges every time. -He thought the black build up around the edges was settled dust.	D 074		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure testing for tuberculosis (TB) to 1 of 5 sampled staff (Staff E) was completed upon employment. Review of Staff E, Dietary Manager's personnel record on 05/18/2018 revealed:	D 131		

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D 131	Continued From page 9 -Staff E was hired on 04/06/2018 as a Dietary Manager -There was results from a TB skin test administered by a previous employer in October 2017 and read as negative. -There was no documentation of a second TB skin test since Staff E's hire date. Interview with Dining Services Coordinator on 05/18/2018 at 9:25am revealed: -He obtained results from the TB test from a previous employer completed in October 2017. -He was unsure why a blood test was done to obtain TB testing results, but it was done for employment at a local hospital. -He had not had a TB skin test completed since he had been employed with the facility. Interview with the Administrator on 05/18/2018 at 9:30am revealed: -She was responsible for ensuring all staff have TB skin tests upon employment. -She knew the Dining Services Coordinator did not have a TB skin test as of 05/18/2018. -The Nurse Practitioner was scheduled to come to the facility next week to complete several TB skin tests for staff. -The procedure was to get the TB skin tests completed for each staff as soon as possible. The company was responsible for the cost of the TB skin tests. The facility was still working on a system with possible dates and available times with the Nurse Practitioner to complete the TB skin tests in a timely manner.	D 131		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

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D 273	Continued From page 10 (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 A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to notify the physician for 3 of 5 sampled residents (Resident #2, #4 and #6) with orders to contact the physician if fingerstick blood sugar (FSBS) was over 400 (#4), Thrombo-Embolic Deterrent (TED) hose not applied as ordered (#2), and a resident threatening suicide who had no antipsychotic medication available for administration resulting in behavioral changes (#6). The findings are: 1. Review of Resident #6's current FL-2 dated 01/25/18 revealed: -Diagnoses included major vascular neurocognitive disorder probable, with behavioral disturbances, non-adherence to medical treatment, major depressive disorder, (recurrent severe), homicidal ideations, peripheral edema, congestive heart failure, chronic renal impairment, and history of cerebrovascular disease. -There was an order for Haloperidol 1mg (0.5ml) three times daily (Haloperidol is an antipsychotic medication used to treat mental illness). Review of Resident #6's Resident Register revealed an admission date of 01/25/18.	D 273		

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Review of a hospital discharge note (prior to admission to the facility) dated 01/25/18 for Resident #6 revealed:
-Resident #6 was admitted for psychiatric evaluation on 01/18/18 for evaluation of exacerbation of major vascular neurocognitive disorder, probable, with behavioral disturbance.
-At the time of psychiatric admission there was documentation that acute suicide or self-harm risk was medium; there was documentation that acute homicide or violence risk was high.

Review of Resident #6's Care Plan dated 02/13/18 revealed:
-Resident #6 was receiving medication for mental illness/behavior.
-Resident #6 was currently receiving mental health services through the facility's on-site provider.

Revew of Resident #6's physician notes revealed:
- Resident #6 was seen on 02/13/18 by the facility Primary Care Provider (PCP) for an initial visit for behavior agitation.
-There was no docuumentation that Resident #6 was seen by a PCP from admission on 01/25/18 through 02/12/18.

Review of Resident #6's Mental Health Nurse Practitioner (NP) care note, dated 02/22/18 revealed Resident #6 was seen for an initial psychiatric encounter on 02/22/18.

Review of progress notes for Resident #6 dated 02/11/18 at 5:45pm revealed:
-Documentation that "Resident #6 admitted to trying to kill himself around dinner time when aide witnessed a pipe under sink was busted and water covered the floor. Resident stated the only way for him to get out was if he committed

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suicide."
-There was no documentation the PCP had been notified of Resident #5's threat of suicide or change in behavior.

Review of progress notes for Resident #6 dated 02/11/18 at 10:30pm revealed:
-Documentation that "Resident was slightly agitated during the shift, stated he was going to commit suicide. Resident was redirected with eating dinner and eating a snack. There were no further threats of suicide."
-There was no documentation the PCP had been notified of Resident #5's threat of suicide or change in behavior.

Review of consulting pharmacy note dated 02/08/18 recommended changing Haldol 1mg (0.5ml) to 1mg tablet three times a day.

Review of Resident #6's PCP note dated 02/13/18 revealed an order to stop Haldol oral concentrate and begin Haldol 1mg pill three times a day.

Review of January 2018 Medication Administration Record (MAR) for Resident #6 revealed:
-There was an entry for Haldol 1mg (0.5ml) to be administered three times a day at, 8:00am, 2:00pm and 8:00pm.
-There were 5 missed doses of Haldol 1mg (0.5ml) at 2:00pm.
-There was no documentation that Haldol was administered at 2:00pm on 01/26/18-01/30/18.

Review of February 2018 MAR for Resident #6 revealed:
-There was an entry for Haldol 0.5ml was to be administered three times a day, 8:00am, 2:00pm

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D 273	Continued From page 13 and 8:00pm. -Haldol 0.5ml was not documented as administered 22 out of 36 opportunities from 02/03/18-02/12/18. -There was no documentation that Haldol 0.5ml was administered at 8:00am from 02/07/18-02/12/18. -There was no documentation that Haldol 0.5ml was administered at 2:00pm on 02/04/18, 02/06/18-02/12/18. -There was no documentation that Haldol 0.5ml was administered at 8:00pm on 02/03/18, 02/06/18-02/12/18. -There was documentation that Haldol 0.5ml was discontinued on 02/13/18. -There was a handwritten order on 02/13/18 for Haldol 1mg administer three times per day. -Haldol 1mg was not documented as administered 4 out of 45 opportunities from 02/13/18-02/28/18. Interview with a medication aide (MA) on 05/18/18 at 3:20pm revealed: -She had documented on the Medication Administration Record (MAR) that Resident #6 was out of his Haldol 0.5ml. -She had called the pharmacy when Resident #6 was out and "they sent some, not the full amount" (She did not recall the dates). -She did not notify the NP that Resident #6 was out of his Haldol 0.5ml. -She was not working when Resident #6 had threatened to commit suicide, but she had been told about it. -Another MA had told her to "keep an eye on him." -She checked on Resident #6 during her shifts every 30 minutes instead of every 2 hours; she did this for "about a week." -She did not contact the PCP because the MA on	D 273		

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1st shift had told her she notified the PCP.

Telephone interview with another MA on 05/21/18 at 11:11am revealed:
-She did not recall Resident #6 running out of his Haldol 0.5ml .
-She recalled Resident #6's Haldol was liquid.
-She did not recall notifying the PCP of Resident #6 running out of Haldol 0.5ml.

Interview with the Resident Care Coordinator (RCC) on 05/18/18 at 3:26pm revealed:
-She was not employed at the facility when Resident #6 had run out of his Haldol 1mg (0.5ml).
-If a resident was out of a medication, she expected the MA to call the pharmacy.
-If there was a problem getting a prescription refilled, she expected the MA to notify the PCP.
-She was not employed at the facility when Resident #6 had threatened to commit suicide.
-She would expect the staff to notify the PCP if a resident threatened suicide.

Telephone interview with a Pharmacist at the facility's pharmacy provider in February 2018 on 05/18/18 at 4:19pm revealed:
-He had received notification from the Administrator on 02/11/18 at 6:18pm that Resident #6 was out of his Haldol 0.5ml.
-He had offered to send some Haldol 1mg (0.5ml) to the facility for Resident #6; however the Administrator told him she did not need it as she planned to send Resident #6 to the hospital.
-Resident #6 should not have been out of Haldol 1mg (0.5ml) had it been administered as ordered.
-They had filled Resident #6's Haldol 1mg (0.5ml) prescription on 01/25/18 for a 30-day supply.
-They did not have any documentation that they had been notified Resident #6 was out of his

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Haldol 0.5ml prior to 02/11/18.
-He suggested changing the Haldol 1mg (0.5ml)liquid to a tablet because if Resident #6 was out of Haldol that soon, it was possible they had been giving him 1ml instead of 0.5ml.

Interview with the Administrator on 05/18/18 at 3:38pm revealed:
-She was not aware that Resident #6 had threatened suicide.
-Had someone told her Resident #6 had threatened suicide, they would have sent him to the hospital.
-The normal procedure would be to send a resident to the hospital who had threatened suicide.
-She did not know why she had not been told that Resident #6 had threatened suicide.
-She was not aware that Resident #6 had run out of his Haldol 0.5ml.
-The normal procedure when a resident run out of medication was to reorder it.
-If there was a problem re-ordering a medication she expected to be notified; "Staff should have brought that to our attention."

Interview with Resident #6 on 05/18/18 at 3:43pm revealed:
-He did not like being at the facility; "I would do anything to get out of here."
-He had wanted to leave since "they put me here."
-He did not recall pulling the pipe off the sink 02/11/18.
-He did not recall threatening to commit suicide.
-He did not like to take medication.

Telephone interview with the responsible party for Resident #6 on 05/21/18 at 10:50am revealed:
-She had not visited Resident #6 since he had

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moved to the facility.
-She had not been called in February 2018 regarding Resident #6 having any changes in his behavior that would warrant the need to be sent to the hospital.
-She had not received notification that Resident #6 had run out of his medication.

Attempted interview with Resident #4's PCP on 05/18/18 at 11:38 am was unsuccessful.

Telephone interview with Resident #6's Mental Health Nurse Practitioner (NP) on 05/18/18 at 2:48pm revealed:
-She had not seen Resident #6 as a mental health patient prior to his outburst on 02/11/18.
-She had been told that Resident #6 had busted a pipe; she did not find out until later, 1-2 months later, that Resident #6 had threatened suicide when he had broken the pipe.
-She felt his actions and comments were more of a behavioral outburst than a suicide attempt.
-When she talked to him about it he denied having suicidal thoughts.
-When he moved in he had a lot of adjustment problems which resulted in behavior problems.
-She was not aware that Resident #6 went without his Haldol 1mg (0.5ml).
-Resident #6 going without his antipsychotic medication could have exacerbated his behavior.
-"It would be assumed that Resident #6 being without his antipsychotic medication would have caused his behavioral outburst on 02/11/18."
-When a resident had a change in behavior the first thing she looked at was to see if any medications had been changed.
-There was always a Mental Health provider available 24/7; there were no notes that a Mental Health provider had been notified of the outburst on 02/11/18.

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D 273	Continued From page 17 -Had the facility called when the incident occurred on 02/11/18, they would have caught the Haldol 1mg (0.5ml) error as they always compared what the resident was taking and what they should be taking. -There was a note in Resident #6's electronic chart the PCP was to evaluate new patient, Resident #6 on 02/13/18 for behavior agitation. -She had not talked to the PCP about the incident on 02/11/18. -She would have been concerned why Resident #6 ran out of his Haldol 1mg (0.5ml) medication at the dose that was prescribed. -She would have been concerned about him being overly sedated and could have even been in a chemically sedated coma. -She felt the timing of Resident #6 running out of medication and his behavioral outburst on 02/11/18 "would be about the time the medication would have been out of his system." -It did not surprise her that Resident #6 had behavior problems when he was out of his medication. 2. Review of Resident #4's hospital discharge summary dated 05/06/18 revealed: -Diagnoses included Alzheimer's with behavioral disturbance and type II diabetes with hyperglycemia with long-term use of insulin. -There was no order for fingerstick blood sugar (FSBS) monitoring. -There was an order for Humalog 75/25 100 units/ml (a rapid-acting insulin used to lower elevated blood sugar levels) inject 10 units into the skin 15 minutes before meals. -There was an order for Levemir 100 units/ml (a long-acting insulin used to lower elevated blood sugar levels) inject 20 units into the skin at bedtime.	D 273		

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Further review of Resident #4's hospital discharge summary dated 05/06/18 revealed:
-The admitting diagnosis on 05/05/18 was hyperglycemia.
-The resident had presented to the hospital with blood sugars greater than 600.
-Resident #4 was discharged back to the facility on 05/07/18.

Review of a previous physician's order dated 12/19/17 revealed an order to give orange juice and snack for blood sugar <70 and repeat FSBS in 15 minutes, may repeat x 2 to obtain FSBS >70, and call physician with blood sugar >400.

Review of a previous physician's order dated 03/13/18 revealed an order for FSBS twice daily.

Review of a previous physician's order dated 04/03/18 revealed an order for FSBS every morning.

Review of Resident #4's March 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for FSBS before meals and at bedtime and scheduled for 7:15 am, 12:15 pm, 5:00 pm, and 9:00 pm. This order was discontinued on 03/15/18.
-There was an entry for FSBS twice daily scheduled for 5:00 pm and 9:00 pm.
-Resident #4's FSBS ranged from 68 to 541.
-Resident #4's FSBS was documented as 400 or greater 5 times with examples as follows:
-On 03/03/18, FSBS was documented as 431 at 9:00 pm and there was no documentation Resident #4's primary care physician was notified.
-On 03/07/18, FSBS was documented as 541 at 5:00 pm and there was no documentation

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Resident #4's primary care physician was notified.
-On 03/23/18, FSBS was documented as 512 at 5:00 pm and there was no documentation Resident #4's primary care physician was notified.

Review of Resident #4's April 2018 eMAR revealed:
-There was an entry for FSBS before meals and at bedtime and scheduled for 7:30 am, 11:30 am, 4:30 pm, and 9:00 pm.
-Resident #4's FSBS ranged from 73 to "600+".
-Resident #4's FSBS was documented as 400 or greater 54 of 118 opportunities with examples as follows:
-On 04/06/18, FSBS was documented as 488 at 4:30 pm and 588 at 9:00 pm. There was no documentation Resident #4's primary care physician was notified.
-On 04/17/18, FSBS was documented as 454 at 7:30 am, 600 at 11:30 am, "600+" at 4:30 pm, and 600 at 9:00 pm. There was no documentation Resident #4's primary care physician was notified.
-On 04/19/18, FSBS was documented as 462 at 7:30 am, 490 at 11:30 am, 545 at 4:30 pm, and 591 at 9:00 pm. There was no documentation Resident #4's primary care physician was notified.
-On 04/26/18, FSBS was documented as 600 at 11:30 am, "600+" at 4:30 pm, and 600 at 9:00 pm. There was no documentation Resident #4's primary care physician was notified.

Review of Resident #4's May 2018 eMAR revealed:
-There was an entry for FSBS before meals and at bedtime and scheduled for 7:30 am, 11:30 am, 4:30 pm, and 9:00 pm.

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D 273	Continued From page 20 -Resident #4's FSBS ranged from 79-"600+". -Resident #4's FSBS was documented as 400 or greater 12 of 51 opportunities with examples as follows: -On 05/02/18, FSBS was documented as 487 at 11:30 am, "600+" at 4:30 pm, and 600 at 9:00 pm. There was no documentation Resident #4's primary care physician was notified. -On 05/04/18, FSBS was documented as 600 at 4:30 pm and 512 at 9:00 pm. There was no documentation Resident #4's primary care physician was notified. -On 05/05/18, FSBS was documented as 600 at 11:30 am. There was no documentation Resident #4's primary care physician was notified (Resident #4 was sent to the hospital on 05/05/18 with elevated blood sugars). Review of Resident #4's progress notes revealed there was no documentation where staff contacted the physician for FSBS of 400 or greater. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Interview with the Resident Care coordinator (RCC) on 05/18/18 at 12:00 and 12:24 pm revealed: -Staff in charge (supervisor/medication aide (s/MA)/RCC) was responsible for notifying the physician if the FSBS was greater than the ordered parameters. -She thought the physician's order was to notify the physician when Resident #4's FSBS was 350 or greater. -Currently no one performed eMAR audits. -She did not know Resident #4's FSBS had been running high so often.	D 273		

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-The staff should have documented any physician communication in the eMAR system or resident notes.
-She had not notified the physician of blood sugars greater than 400.
-She did not know the staff were not notifying the physician as ordered and not documenting in the eMAR system or resident notes when the physician was notified.

Interview with the Administrator on 05/18/18 at 2:55 pm revealed:
-In the past, the RCC was performing eMAR audits but no one had been completing eMAR audits recently since the new RCC started.
-Resident #4's physician should have been contacted if her FSBS was over the ordered parameters.
-She was not sure of the FSBS parameter orders for Resident #4.
-She expected the Supervisor, MAs and RCC to notify the physician as ordered and document in the eMAR system/resident notes.
-She was not sure how often the FSBS was to be monitored.
-She did not know Resident #4's FSBS was running high frequently.

Interview with a second shift MA on 05/18/18 at 5:33 pm revealed:
-She had been employed at the facility since November 2017.
-She thought the physician's order was to be notified if the FSBS was 600 or greater.
-Resident #4's FSBS was greater than 600 frequently.
-She contacted the physician when the FSBS was greater than 600, but she never received a call back from the physician.
-She documented in the eMAR system when the

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provider was notified but did not document when the provider did not return call.
-She thought she had documented each time the provider was called either in the eMAR system or the resident notes.
-Resident notes could not be located with documentation of the facility notifying the physician of blood sugar readings greater than 400.
-She did not know where the resident notes were at.
-Resident #4's blood sugar was monitored four times a day.
-She had notified the RCC and Administrator regarding her concerns with Resident #4's elevated FSBS since Resident #4's Humalog was discontinued.
-She could not recall when the Humalog was discontinued and a signed discontinue order could not be located.

Interview with Resident #4's guardian on 05/21/18 at 10:45 am revealed:
-She visited Resident #4 at least once a quarter but attempted to visit once a month.
-She kept track of the residents blood sugar and knew of the resident's elevated FSBS.
-She had mentioned her concerns to the RCC and Administrator. (She was unable to provide dates when she spoke with staff).
-The facility staff made her aware of Resident #4's admission to the hospital from 05/05/18-05/07/18, which was related to hyperglycemia.
-Resident #4's FSBS had not been elevated into the 400-600s until the last 2-3 months.
-She had talked with the medication aides, RCC, and Administrator several times regarding the blood sugars.
-The Administrator would direct all

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D 273	Continued From page 23 questions/concerns to the RCC. Attempted interview with Resident #4's physician on 05/18/18 at 11:38 am was unsuccessful. 3. Review of Resident #2's current FL2 dated 05/10/2018 revealed diagnoses included congestive heart failure, acute kidney injury superimposed on chronic kidney disease, and dementia. Review of a previous physician's order revealed a physician's order for TED hose dated 03/13/2018. Review of a hospital discharge summary on 05/02/2018 revealed: -An admission diagnosis of leg swelling (Edema). -There was a physician's order for TED hose. Review of Resident #2's March 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for TED hose to be applied in the morning and removed in the evening daily. -There was no documentation on the eMAR of the TED hose were applied from 03/14/2018 through 03/26/2018 with no documentation on the back of the eMAR for the reason why TED hose were not applied. -There was documentation TED hose had been applied from 3/27/18 to 3/31/18. -There were 12 days where there was no documentation TED hose had been applied for Resident #2. Review of the April and May 2018 eMAR revealed TED hose were applied daily as ordered. Review of Resident #2's record revealed there	D 273		

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was no documentation in the nurses notes why the TED hose were not being applied for 12 days in March 2018.

Observation on 05/16/2018 at 12:45pm revealed:
-Resident #2 was in his room and had his TED hose on both legs.
-There was mild edema noted in both lower le
Interview with a personal care aide (PCA) on 05/17/2018 at 10:00am revealed:
-The staff on 3rd or 1st shift normally placed the TED hose on Resident #2 and 2nd shift took them off.
-She was unsure if there had been a time when Resident #2 had gone without the TED hose.
-The medication aides (MAs) documented on the eMAR when the TED hose were applied, but PCAs physically placed them on.
-She knew documentation should be done daily when TED hose were placed on Resident #2 and if TED hose were not placed on Resident #2.

Interview with a MA on 05/17/2018 at 11:50am revealed:
-The MAs applied the TED hose and removed the TED hose for Resident #2.
-She had only recalled him being without his TED hose when he was admitted into the hospital.
-She had recalled Resident #2 taking them off himself because they were too tight due to the swelling in his legs.

Interview with the previous pharmacy on 05/17/2018 at 1:15pm revealed:
-The pharmacy had received the order for the TED hose on 03/13/18.
-The pharmacy had contacted theResident Care Coordinator (RCC) immediately for measurements of Resident #2 legs.
-The pharmacy had not received a returned

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phone call back with the requested measurements from the RCC.

Interview with a representative at the contracted pharmacy on 05/17/2018 at 2:32pm revealed:
-The pharmacy had received the TED hose order on 03/13/18 through the "white run system" and it came through faint.
-She knew the order was a clarification order from the doctor.
-She had not sent any TED hose without measurements being given to the pharmacy.
-The pharmacy had documentation the first order for TED hose was dispensed through the courier to the facility on 04/11/2018.
-The pharmacy's "white run system" was the system in place to begin services for a facility; all current eMARs were printed and placed in the system with a profile for each resident.
-No medications could be dispensed to the facility until the "white run" was completed.
-The pharmacist spoke with the RCC the week of 03/25/18 regarding Resident #2 needing a pair of TED hose as soon as possible.

Interview with a MA on 05/18/2018 at 5:40pm revealed:
-Resident #2's "feet have been really swollen".
-TED hose were taken off by 2nd shift staff.
-The 3rd shift staff were responsible for washing the TED hose.
-She recalled the resident losing one TED hose and notified the RCC it was lost.
-Resident #2 went a week without his TED hose on, sometime in March 2018.

Interview with the RCC on 05/16/2018 at 3:24pm revealed:
-She was responsible for sending orders to the pharmacy.

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D 273	Continued From page 26 -She had trouble getting the TED hose for Resident #2 because of the transition to using another pharmacy. -She knew the previous pharmacy did not send the TED hose and she had tried to obtain them from a medical supply company. -She had made a call to the current pharmacy to obtain the TED hose and a delivery was made the next day by the pharmacist on 4/11/18. -She could not remember the date or time when the call was made to the current pharmacy. -She had recalled 03/27/18 was the first day the TED hose were placed on the resident and documented. -Resident #2 did not have his TED hose and it should have been documented on the eMAR. -The doctor was not notified when Resident #2 did not have his TED hose in the facility. Interview with the Administrator on 05/17/2018 at 11:55am revealed: -The MAs were responsible for putting the TED hose on and taking them off. -She knew documentation should always be completed for each task even if they were not applied. -She was not sure why Resident #2 would not have had the TED hose since he had the order for them. -She recalled an issue at one point with the previous pharmacy and the resident lost a pair, but did not recall the date. -She did not know there was no documentation showing where he would have refused to have the TED hose placed or why he went without the TED hose for 12 days. Based on observation, record review and staff iterviews, it was determined Resident #2 was not interviewable.	D 273		

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D 273	Continued From page 27 The facility failed to notify the primary care physician (PCP) of a resident whose blood sugar was greater than 400, 5 times in March 2018, 54 times in April 2018 and 12 times in May 2018 for Resident #4; and a resident, who had been recently discharged from an inpatient psychiatric hospitalization, had threatened suicide and had run out of his antipsychotic medication which contributed to his change in behavior (#6). The facility's failure placed the residents at substantial risk for serious physical harm and serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G. S. 131D-34 on 05/21/18 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED June 21, 2018.	D 273		
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: (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, record reviews and	D 287		

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D 287	Continued From page 28 interviews, the facility failed to assure all residents received a place setting of a non-disposable bowl, knife, spoon and fork. Review of the lunch menu for 05/15/18 revealed beef chili with beans, cornbread and sliced pears was to be served. Observation of the lunch meal service on 05/15/18 at 12:45pm revealed: -There were 33 residents served chili beans in disposable bowls, 3 large pieces of pear and 1 piece of cornbread. -Every place setting had a spoon and napkin. -There were no forks or knives at any place settings. Review of the dinner menu for 05/15/18 revealed tuna salad, potato salad, lettuce and tomato, dinner roll, and fruit salad was to be served. Observation of the dinner meal service on 05/15/18 at 4:43pm revealed: -Every place setting had a fork and a napkin. -There were no spoons or knives provided for the residents. Review of the breakfast menu for 05/16/18 revealed choice of cold or hot cereal, sausage links and toast was to be served. Observation of the breakfast meal service on 05/16/18 at 8:16am revealed: -There were 31 residents served cereal in disposable bowls. -Every place setting had a spoon and napkin. -There were no forks or knives at any place settings. -There were 2 residents observed trying to pick up their sausage using a spoon.	D 287		

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D 287	Continued From page 29 -There was 1 resident who picked up their sausage with their hands and ate it. Review of the lunch menu for 05/16/18 revealed herb lemon chicken, southern style green beans, yellow squash and bread was to be served. Observation of the lunch meal service on 05/16/18 at 12:11pm revealed: -Residents were served chicken cut into bite size pieces. -Each place setting had a napkin, spoon and fork; there were no knives at the lunch meal. Observation of the lunch meal service on 05/16/2018 at 12:50pm revealed: -A resident was served peas and a chicken breast on a non-disposable plate. The chicken was not cut up and the only utensil provided to the resident was a fork. The resident had difficulty picking up the peas with the fork. -Staff cut the chicken up for the resident. Interview with a personal care aide (PCA) on 05/16/18 at 2:40pm revealed: -She had not seen any place settings that included a knife, only a fork and spoon. -She did not know why the residents did not have a knife, "maybe it isn't safe." -She did not know any resident who should not have a knife. -She had not noticed residents using disposable bowls. Interview with a dietary aide on 05/16/18 at 2:45pm revealed: -She had been working at the facility for a "couple of months". -Her role was to set up place settings, which included forks, spoons and napkins.	D 287		

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-She had not given residents knives; no one told her to use knives or not to, she "just didn't."
-She had not used disposable bowls, she always used glass bowls.
-She did not know why anyone had used disposable bowls, because there were enough glass bowls for everyone.

Interview with the Dietary Manager on 05/16/18 at 2:50pm revealed:
-The dietary aide was responsible for setting the tables.
-The residents should have proper silverware for what they were eating.
-They should have knives, forks, spoons and napkins.
-He was not sure who could and could not have knives.
-He was not aware they were not giving residents knives with their meals.
-They have hard plastic bowls to use for resident meals.
-They were only supposed to use non-disposable dishes in case of an emergency.
-The Administrator had talked with him about it today, 05/16/18, when she saw disposable bowls being used for cereal.
-He knew they were not supposed to use disposable bowls, but had "just forgot."

Observation of bowls on hand on 05/16/18 at 2:56 pm revealed 45 hard plastic bowls.

Observation of knives on hand on 05/16/18 at 2:56 pm revealed 21 knives.

Interview with the Dietary manager on 05/16/18 at 3:00pm revealed he thought they had enough knives, but would put an order in to purchase more.

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D 287	Continued From page 31 Interview with the Resident Care Coordinator on 05/16/18 at 3:11pm revealed: -The PCAs assisted with meals as needed. -She was not aware that knives were not being provided. -There were no residents who could not have knives. Interview with a resident on 05/16/2018 at 9:00am revealed: -Several meals were served every day in the disposable bowls and only one utensil was given with each meal to eat. -The resident had never seen non-disposable bowls served at meals. -The resident was rarely getting napkins during the meals. -The resident would like to the have the option to cut her own meats up since she was physically able to do so. -The resident would like to have the option to receive a non-disposable bowl, napkin, fork, spoon and knife for every meal. -The resident received a recent meal that consisted of soup and the only utensil available to the resident was a fork. Interview with a second resident on 05/16/2018 at 9:15am revealed: -The resident received food served in a disposable bowl very often and normally got oatmeal and cereal served in it. -The resident received some type of soup served in a disposable bowl every Friday. -She had not received a fork, spoon, and a knife at one time at meals. -She had been receiving a spoon and a fork or only getting a spoon or only getting a fork at	D 287		

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meals.
-She only received a knives if she asked for one.

Interview with a third resident on 05/16/2018 at 9:25am revealed:
-The resident received food served in disposable bowls more often lately than, at least once a day.
-The resident had usually not received a knife at all, usually only got a fork or a spoon.
-The resident had been receiving a disposable fork rather than a non-disposable fork and would prefer non-disposable utensils to use for meals.

Interview with a fourth resident on 05/16/2018 at 9:35am revealed:
-The meals were served with disposable bowls two to three times a week.
-The resident received a fork and a spoon as the normal utensils served, not a knife unless "you ask for it".

Interview with the Administrator on 05/16/18 at 3:18pm revealed:
-A complete place setting should be used at each meal; a complete place setting consisted of a table mat, fork, spoon, knife and napkin.
-She did not know residents were not given a knife with each meal.
-There was probably only one resident who should not have a knife due to stabbing staff with a fork.
-She normally made rounds in the dining room daily for at least one meal.
-She knew that disposable dishes were not to be used and had noticed the disposable bowls being used this morning at breakfast (05/16/18).
-She had not noticed it being used before today, 05/16/18.
-She was not aware disposable bowls had been used on 05/15/18 for the lunch meal service.

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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 A2 VIOLATION Based on interviews and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 6 of 8 sampled residents including a behavior medication and an antipsychotic medication that had been discontinued (Resident #2); a sleep supplement that had been discontinued (Resident #5) and a sleep supplement increased (Resident #6); high blood pressure medication, cholesterol medication, 2 dementia medications, a rapid-acting insulin and a long-acting insulin, an antipsychotic medication, an antidepressant, and vitamin supplement (Resident #4); a topical steroid cream (Resident #7), and a moisturizing cream (Resident #8). The findings are: 1. Review of Resident #2's current FL2 dated 05/10/2018 revealed: -Diagnoses included congestive heart failure, acute kidney injury superimposed on chronic	D 358		

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D 358	Continued From page 34 kidney disease, and dementia with behavioral disturbances. -A physician's order for depakote 125 mg (used to treat behavior disturbances) 2 tablets every 12 hours, and risperdal 0.5 mg (used to treat mood disorders) 1 tablet at bedtime. . Review of Resident #2's hospital discharge summary dated 05/12/2018 revealed an order to depakote 125 mg and risperdal 0.5 mg. Review of Resident #2's May 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for depakote 125 mg 2 tablets every 12 hours scheduled for administration at 9:00 am and 9:00 pm. -Depakote was documented as administered from 5/12/18 to 5/14/18 at 9:00 am and 9:00 pm daily. -There was an entry for risperdol 0.5 mg 1 tablet at bedtime scheduled for administration at 9:00 pm daily. -Risperdol was documented as administered at 9:00 pm from 5/12/18 to 5/14/18. Interview with a medication aide (MA) on 05/17/2018 at 10:55am revealed: -The process was to send prescriptions to the pharmacy and then file the prescription into the resident's record. -She was responsible for ensuring any necessary documents be sent to the pharmacy immediately following any resident being admitted back to the facility on her shift. -She did not know of the changes made to Resident #2's medication. Interview with the Resident Care Coordinator on 05/17/2018 at 11:00am revealed:	D 358		

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-The clinical staff were responsible for reporting all changes to the pharmacy via fax.
-The supervisor that admitted Resident #2 back into the facility was responsible for ensuring the necessary documents were sent to the pharmacy for changes.
-She was responsible for updating the FL-2 following an admission from the hospital.
-She had not had time to send the discharge summary with updated orders to the pharmacy.

Interview with the Psychiatrist on 05/17/2018 at 11:30am revealed:
-She last visited the facility on 05/03/2018.
-She had not had a chance to see Resident #2.
-She did not know of the notes from the discharge summary regarding the changes that should have taken place to the medication list concerning depakote and risperdol being discontinued.
-The procedure was for the facility staff to call the on-call physician to report any changes requested by the hospital.

Based on observations, record reviews and staff interviews, it was determined Resident #2 was not interviewable.

Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am.

Refer to interview with the Administrator on 05/17/18 at 9:46am.

Refer to interview with a first shift Medication Aide (MA) on 05/17/18 at 1:35 pm.

Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm.

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Refer to interview with a second first shift MA on 05/18/18 at 8:34 am.

Refer to interview with the Administrator on 05/18/18 at 2:55 pm.

2. Review of Resident #4's hospital discharge summary dated 05/06/18 revealed diagnoses included type II diabetes mellitus with hyperglycemia without long-term current use of insulin, chronic kidney disease, Alzheimer's dementia with behavioral disturbance, essential hypertension, mixed hyperlipidemia, and osteoporosis.

a. Further review of Resident #4's hospital discharge summary dated 05/06/18 revealed an order for amlodipine besylate (used to treat high blood pressure) 5 mg take two tablets once daily.

Review of a previous physician's order dated 03/20/18 revealed an order for amlodipine besylate 5 mg take two tablets once daily.

Review of a previous physician's order dated 03/13/18 revealed an order for amlodipine besylate 5 mg tablet once daily.

Review of Resident #4's March 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for amlodipine besylate 5 mg tablet once daily scheduled at 9:00 am and was documented as administered from 03/16/18 through 03/29/18.
-There was an entry for amlodipine besylate 5 mg take two tablets once daily scheduled at 9:00 am and was documented as administered from 03/01/18 through 03/15/18.
-Amlodipine besylate 5 mg was not documented

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as administered 03/30/18 and 03/31/18.
-The eMAR reflected the amlodipine besylate 5 mg was discontinued on 03/29/18.

Review of Resident #4's April 2018 eMAR revealed:
-There was an entry for amlodipine besylate 5 mg tablet once daily scheduled at 9:00 am and was documented as administered from 04/03/18 through 04/30/18.
-Amlodipine besylate 5 mg was not documented as administered on 04/01/18 and 04/02/18.

Review of Resident #4's May 2018 eMAR revealed:
-There was an entry for amlodipine besylate 5 mg tablet once daily scheduled at 9:00 am and documented as administered from 05/01/18 through 05/05/18.
-The eMAR did not reflect a dose change from the FL2 dated 05/06/18 to amlodipine besylate 5 mg take two tablets once daily.
-Amlodipine besylate 5 mg was not documented as administered on 05/06/18, 05/07/18, and 05/13/18. (hospital stay 05/05/18-05/07/18)
-There was an entry for amlodipine besylate 5 mg tablet once daily scheduled at 9:00 am and documented as administered from 05/08/18 through 05/12/18 and 05/14/18 through 05/16/18.

Observation on 5/18/18 at 4:30 pm of Resident #4's medications on hand revealed amlodipine besylate 5 mg twice daily was available for administration.

Interview with first shift medication aide on 05/17/18 at 1:35 pm revealed:
-She did not know about the medication changes on the hospital discharge summary dated 05/06/18.

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-She did not know Resident #4 was ordered amlodipine besylate 5 mg take two tablets once daily.

Interview with the facility's contracted pharmacy (after April 2018) on 05/18/18 at 4:15 pm revealed:
-The facility did not receive the hospital discharge summary dated 05/06/18.
-The pharmacy currently had an order for Resident #4 to recieve amlodipine 5 mg twice daily.
-Amlodipine was last filled on 05/04/18 for a quantity of 60 tablets.

Based on observations, record review and interviews, it was determined Resident #4 was not interviewable.

Attempted interview with Resident #4's primary care physician on 05/18/18 at 11:38 am 05/21/18 at 11:50 am and 05/22/18 at 12:00 pm was unsuccessful.

Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am.

Refer to interview with the Administrator on 05/17/18 at 9:46am.

Refer to interview with a first shift Medication Aide (MA) on 05/17/18 at 1:35 pm.

Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm.

Refer to interview with a second first shift MA on 05/18/18 at 8:34 am.

Refer to interview with the Administrator on

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D 358	Continued From page 39 05/18/18 at 2:55 pm. b. Review of Resident #4's hospital discharge summary dated 05/06/18 revealed an order for atorvastatin (used to treat high cholesterol) 10 mg at bedtime. Review of a previous physician's order dated 03/20/18 revealed an order for atorvastatin 10 mg tablet at bedtime. Review of a previous physician's order dated 03/13/18 revealed an order for atorvastatin 10 mg (1/2 tablet) tablet at bedtime. Review of Resident #4's March 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for atorvastatin 10 mg tablet at bedtime scheduled at 9:00 pm and was documented as administered from 03/01/18 through 03/14/18. -There was an entry for atorvastatin 10 mg tablet, take 1/2 tablet at bedtime scheduled at 9:00 pm and was documented as administered from 03/15/18 through 03/28/18. -The eMAR did not reflect a dose change from the physician's order dated 03/20/18 for atorvastatin 10 mg at bedtime. -Atorvastatin 10 mg (1/2 tablet) at bedtime was not documented as administered from 03/29/18 through 03/31/18. Review of Resident #4's April 2018 eMAR revealed: -There was an entry for atorvastatin 10 mg tablet, take 1/2 tablet at bedtime scheduled at 9:00 pm and was documented as administered on 04/03/18, 04/05/18 through 04/26/18, and 04/28/18 through 04/30/18.	D 358		

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D 358	Continued From page 40 -Atorvastatin 10 mg (1/2 tablet) was not documented as administered on 04/01/18 and 04/02/18. -Atorvastatin was documented as held per doctor orders on 04/04/18. -The eMAR was blank on 04/27/18 and did not reflect an explanation for why the medication was not given. Review of Resident #4's May 2018 eMAR revealed: -There was an entry for atorvastatin 10 mg tablet, take 1/2 tablet at bedtime scheduled at 9:00 pm and was documented as administered from 05/01/18 through 05/04/18 and 05/07/18 through 05/15/18. -The eMAR did not reflect a dose change from the FL2 dated 05/06/18 for atorvastatin 10 mg at bedtime. -The eMAR reflected atorvastatin 10 mg (1/2 tablet) at bedtime was held on 05/05/18 and 05/06/18 because the Resident #4 was out of the facility. Observation on 5/18/18 at 4:35 pm of Resident #4's medications on hand revealed atorvastatin 10 mg 1/2 tablet daily was available for administration. Interview with first shift medication aide on 05/17/18 at 1:35 pm revealed: -She did not know Resident #4's atorvastatin order changed to 10 mg at bedtime on 03/20/18. -She did not know about the medication changes on the hospital discharge summary dated 05/06/18. Interview with the facility's contracted pharmacy (after April 2018) on 05/18/18 at 4:15 pm revealed:	D 358		

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D 358	Continued From page 41 -The facility did not receive the hospital discharge summary dated 05/06/18. -The pharmacy currently had an order for Resident #4 to receive atorvastatin 10 mg take 1/2 tablet daily. -Atorvastatin was last filled on 05/04/18 and 15 tablets were dispensed. Based on observations, record review and interviews, it was determined Resident #4 was not interviewable. Attempted interview with Resident #4's primary care physician on 05/18/18 at 11:38 am 05/21/18 at 11:50 am and 05/22/18 at 12:00 pm was unsuccessful. Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am. Refer to interview with the Administrator on 05/17/18 at 9:46am. Refer to interview with a first shift Medication Aide (MA) on 05/17/18 at 1:35 pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm. Refer to interview with a second first shift MA on 05/18/18 at 8:34 am. Refer to interview with the Administrator on 05/18/18 at 2:55 pm. c. Review of Resident #4's hospital discharge summary dated 05/06/18 revealed an order for donepezil hcl (used to treat dementia) 5 mg at bedtime.	D 358		

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Review of Resident #4's May 2018 eMAR revealed:
-There was no entry for donepezil on the eMAR.

Observation on 5/18/18 at 4:40 pm of Resident #4's medications on hand revealed donepezil hcl 5 mg was not available for administration

Interview with first shift medication aide on 05/17/18 at 1:35 pm revealed:
-She did not know about the medication changes on the hospital discharge summary dated 05/06/18.
-She did not know Resident #4 was ordered donepezil hcl 5 mg at bedtime.

Interview with the facility's contracted pharmacy (after April 2018) on 05/18/18 at 4:15 pm revealed:
-The facility did not receive the hospital discharge summary dated 05/06/18.
-The pharmacy had no current order for donepezil for Resident #4.

Based on observations, record review and interviews, it was determined Resident #4 was not interviewable.

Attempted interview with Resident #4's primary care physician on 05/18/18 at 11:38 am 05/21/18 at 11:50 am and 05/22/18 at 12:00 pm was unsuccessful.

Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am.

Refer to interview with the Administrator on 05/17/18 at 9:46am.

Refer to interview with a first shift Medication Aide

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(MA) on 05/17/18 at 1:35 pm.

Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm.

Refer to interview with a second first shift MA on 05/18/18 at 8:34 am.

Refer to interview with the Administrator on 05/18/18 at 2:55 pm.

d. Review of Resident #4's hospital discharge summary dated 05/06/18 revealed an order for Humalog 75/25 (a rapid-acting insulin used to lower elevated blood sugar levels) 100 units/ml inject 10 units 15 minutes before meals.

Further review of Resident #4's hospital discharge summary dated 05/06/18 revealed:
-The admitting diagnosis on 05/05/18 was hyperglycemia.
-The resident had presented to the hospital with blood sugars greater than 600.
-Resident #4 was discharged back to the facility on 05/07/18.

Review of a physician's order dated 03/20/18 revealed an order for Humalog 75/25 100 units/ml inject 10 units subcutaneously three times a day 15 minutes before meals.

Review of Resident #4's March 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Humalog 75/25 inject 10 units subcutaneously three times a day 15 minutes before meals scheduled to be administered at 7:30 am, 12:30 pm, and 5:30 pm.
-The eMAR reflected Humalog inject 10 units was documented as administered at 7:30 am and

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12:30 pm from 03/01/18 through 03/18/18 and discontinued on 03/19/18.
-The eMAR reflected Humalog inject 10 units subcutaneously was documented as administered at 5:30 pm from 03/01/18 through 03/26/18.
-Humalog inject 10 units subcutaneously three times a day 15 minutes before meals was at 5:30 pm was discontinued on 03/26/18.

Review of Resident #4's April and May 2018 eMAR revealed there was no entry for Humalog on the eMAR.

Observation on 5/18/18 at 4:45 pm of Resident #4's medications on hand revealed Humalog 75/25 was not available for administration.

Interview with first shift medication aide on 05/17/18 at 1:35 pm revealed:
-She did not know about the medication changes on the hospital discharge summary dated 05/06/18.
-She did not know Resident #4 was ordered Humalog 75/25 inject 10 units 15 minutes before meals.

Interview with the facility's contracted pharmacy (after April 2018) on 05/18/18 at 4:15 pm revealed:
-The facility did not receive the hospital discharge summary dated 05/06/18.
-Humalog 75/25 was on the original orders sent 03/19/18, but when the pharmacist reviewed the active medications with the facility staff, the Humalog 75/25 was removed from the medication profile on 03/23/18. The Humalog was never dispensed.

Interview with Resident #4's guardian on 05/21/18

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D 358	Continued From page 45 at 10:42 am revealed: -She visited at least every quarter but attempted to visit once a month. -She did not know why the Humalog was discontinued. -Since the Humalog was discontinued Resident #4's FSBS had been higher than normal, running into the 600s frequently. -She had expressed her concern to the Resident Care Coordinator (RCC) and Administrator and no changes had been made and FSBS continued to run high. Based on observations, record review and interviews, it was determined Resident #4 was not interviewable. Attempted interview with Resident #4's primary care physician on 05/18/18 at 11:38 am 05/21/18 at 11:50 am and 05/22/18 at 12:00 pm was unsuccessful. Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am. Refer to interview with the Administrator on 05/17/18 at 9:46am. Refer to interview with a first shift Medication Aide (MA) on 05/17/18 at 1:35 pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm. Refer to interview with a second first shift MA on 05/18/18 at 8:34 am. Refer to interview with the Administrator on 05/18/18 at 2:55 pm.	D 358		

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e. Review of Resident #4's hospital discharge summary dated 05/06/18 revealed an order for Levemir 100 units/ml (a long-acting insulin used to lower elevated blood sugar levels) inject 20 units at bedtime.

Further review of Resident #4's hospital discharge summary dated 05/06/18 revealed:
-The admitting diagnosis on 05/05/18 was hyperglycemia.
-The resident had presented to the hospital with blood sugars greater than 600.
-Resident #4 was discharged back to the facility on 05/07/18.

Review of a subsequent physician's order dated 04/24/18 revealed an order for Levemir 100 units/ml, inject 20 units subcutaneously every morning and 40 units subcutaneously at bedtime.

Review of a subsequent physician's order dated 04/19/18 revealed an order for Levemir 100 units/ml, inject 40 units subcutaneously at bedtime.

Review of subsequent physician's order dated 04/14/18 revealed:
-An order for Levemir 100 units/ml inject 15 units subcutaneously now.
-Tomorrow increase Levemir to 15 units subcutaneously every morning with breakfast and inject 30 units subcutaneously at bedtime.

Review of previous physician's order dated 04/03/18 revealed an order for Levemir 100 units/ml inject 30 units subcutaneously at bedtime.

Review of previous physician's order dated 03/20/18 revealed an order for Levemir 100

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D 358	Continued From page 47 units/ml, inject 20 units at bedtime. Review of Resident #4's March 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Levemir inject 20 units subcutaneously at bedtime scheduled at 9:00 pm and was documented as administered from 03/01/18 through 03/10/18, 03/12/18 through 03/16/18, 03/18/18, and 03/21/18 through 03/31/18. -The eMAR did not reflect documentation of administration for Levemir on 03/11/18, 03/17/18, 03/19/18, and 03/20/18. Review of Resident #4's April 2018 eMAR revealed: -There was an entry for Levemir inject 20 units subcutaneously at bedtime scheduled to be administered at 9:00 pm and documented as administered from 04/01/18 to 04/02/18. -There was an entry for Levemir inject 30 units subcutaneously at bedtime scheduled to be administered at 9:00 pm and documented as administered from 04/03/18 through 04/22/18. -There was an entry for Levemir inject 15 units subcutaneously every morning scheduled to be administered at 9:00 am and documented as administered from 04/15/18 through 04/25/18. -There was an entry for Levemir inject 40 units subcutaneously at bedtime scheduled to be administered at 9:00 pm and documented as administered from 04/23/18 through 04/30/18. -There was an entry for Levemir inject 20 units subcutaneously every morning scheduled to be administered at 9:00 am and documented as administered from 04/26/18 through 04/30/18. Review of Resident #4's May 2018 eMAR revealed:	D 358		

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D 358	Continued From page 48 -There was an entry for Levemir inject 20 units subcutaneously every morning scheduled to be administered at 9:00 am and documented as administered from 05/01/18 through 05/05/18, 05/08/18 through 05/12/18, and 05/14/18 through 05/16/18. -There was no documentation of administration for Levemir inject 20 units at 9:00 am on 05/13/18. -There was an entry for Levemir inject 40 units subcutaneously at bedtime scheduled to be administered at 9:00 pm and documented as administered from 05/01/18 through 05/04/18 and 05/07/18 through 05/15/18. -The eMAR did not reflect a dose change from the FL2 dated 05/06/18 for Levemir inject 20 units at bedtime. Observation on 5/18/18 at 4:40 pm of Resident #4's medications on hand revealed 1 Levimir pen was available for administration. Interview with first shift medication aide on 05/17/18 at 1:35 pm revealed she did not know about the medication changes on the hospital discharge summary dated 05/06/18. Interview with the facility's contracted pharmacy (after April 2018) on 05/18/18 at 4:15 pm revealed: -The facility did not receive the hospital discharge summary dated 05/06/18. -Levemir 100 units/ml was last filled on 04/25/18 for a quantity of 5 pens dispensed. Based on observations, record review and interviews, it was determined Resident #4 was not interviewable. Attempted interview with Resident #4's primary	D 358		

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care physician on 05/18/18 at 11:38 am 05/21/18 at 11:50 am and 05/22/18 at 12:00 pm was unsuccessful.

Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am.

Refer to interview with the Administrator on 05/17/18 at 9:46am.

Refer to interview with a first shift Medication Aide (MA) on 05/17/18 at 1:35 pm.

Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm.

Refer to interview with a second first shift MA on 05/18/18 at 8:34 am.

Refer to interview with the Administrator on 05/18/18 at 2:55 pm.

f. Review of Resident #4's hospital discharge summary dated 05/06/18 revealed Namenda XR 24 hr (used to treat dementia) 28 mg capsule once daily.

Review of a subsequent physician's order dated 04/19/18 revealed an order for Namenda 10 mg capsule twice daily.

Review of a subsequent physician's order dated 03/20/18 revealed an order for Namenda XR 28 mg capsule once daily.

Review of Resident #4's March 2018 Electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Namenda XR 28 mg capsule daily scheduled to be administered at

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D 358	Continued From page 50 9:00 am and documented as administered from 03/01/18 through 03/03/18, 03/05/18 through 03/11/18, 03/13/18 through 03/20/18, and 03/22/18 through 03/31/18. -There was no documentation of administration of Namenda XR 28 mg on 03/04/18, 03/12/18 and 03/21/18. Review of Resident #4's April 2018 eMAR revealed: -There was an entry for Namenda HCL ER 28 mg capsule daily scheduled to be administered at 9:00 am and documented as administered from 04/01/18 through 04/08/18 and 04/10/18 through 04/20/18. -There was no documentation of administration for Namanda HCL ER 28 mg on 04/09/18 with documentation on the eMAR memantine was withheld per physician orders. - The eMAR did not reflect the dose change from the new order dated 04/19/18 to Namenda 10 mg capsule twice daily. The order change was initiated on 04/23/18. -There was an entry for Namenda HCL 10 mg capsule twice daily at 9:00 am and 5:00 pm and documented as administered from 04/23/18 (5:00 pm dose) through 04/30/18. -There was no documentation of administration for Namenda HCL 10 mg capsule twice daily on 04/21/18 and 04/23/18 (9:00 am dose). There was no documentation on the back of the eMAR for an explanation as to why the medication was not given. Review of Resident #4's May 2018 eMAR revealed: -There was an entry for Namenda HCL 10 mg tablet twice daily at 9:00 am and 5:00 pm and documented as administered from 05/01/18 through 05/05/18 9:00 (am dose), 05/07/18 (5:00	D 358		

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pm dose) through 05/12/18, and 05/13/18 (5:00 pm dose) through 05/16/18.
-The eMAR did not reflect the dose change from the FL2 dated 05/06/18 to Namenda XR 24 hr 28 mg capsule once daily.
-There was no documentation of administration for Namenda HCL 10 mg capsule twice daily on 05/05/18 (5:00 pm dose) through 05/07/18 (9:00 am dose) and 05/13/18.
-There was no documentation of administration for Namenda HCL 10 mg capsule twice daily from 05/05/18 through 05/07/18 with documentation on the back of the eMAR the resident was out of the facility.
-There was no documentation on the back of the eMAR for the reason the Namenda HCL 10 mg tablet was not given on 05/13/18.

Observation on 5/18/18 at 4:40 pm of Resident #4's medications on hand revealed Namenda HCL 10 mg was available for administration.

Interview with first shift medication aide on 05/17/18 at 1:35 pm revealed:
-She did not know about the medication changes on the hospital discharge summary dated 05/06/18.
-She did not know Resident #4's order was changed to Namenda XR 24 hr 28 mg capsule once daily.

Interview with the facility's contracted pharmacy (after April 2018) on 05/18/18 at 4:15 pm revealed:
-The facility did not receive the hospital discharge summary dated 05/06/18.
-The pharmacy had a current order for Resident #4 for Namenda 10 mg twice daily and was last filled on 05/04/18 for a quantity of 60 tablets.

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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 358	Continued From page 52 Based on observations, record review and interviews, it was determined Resident #4 was not interviewable. Attempted interview with Resident #4's primary care physician on 05/18/18 at 11:38 am 05/21/18 at 11:50 am and 05/22/18 at 12:00 pm was unsuccessful. Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am. Refer to interview with the Administrator on 05/17/18 at 9:46am. Refer to interview with a first shift Medication Aide (MA) on 05/17/18 at 1:35 pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm. Refer to interview with a second first shift MA on 05/18/18 at 8:34 am. Refer to interview with the Administrator on 05/18/18 at 2:55 pm. g. Review of Resident #4's hospital discharge summary dated 05/06/18 revealed an order for risperidone (used to treat behavior problems) 0.5 mg tablet at bedtime. Review of subsequent physician's order dated 03/20/18 revealed no order for risperidone. Review of Resident #4's March 2018 electronic Medication Administration Record (eMAR) revealed the eMAR did not reflect an entry for risperidone.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 53 Review of Resident #4's April 2018 eMAR revealed: -There was an entry for risperidone 1mg/ml solution, give 0.5 ml (0.5 mg) twice daily at 9:00 am and 5:00 pm and documented as administered from 04/20/18 (5:00 pm dose), 04/21/18 (5:00 pm dose), 04/22/18, and 04/23/18 (5:00 pm dose), 04/24/18 through 04/30/18. -There was no documentation of administration for risperidone 1mg/ml solution, give 0.5 ml (0.5 mg) on 04/21/18 (9:00 am dose) and 04/23/18 (9:00 am dose) with documentation on the back of the eMAR on the back of risperdone was withheld per physician orders. Review of Resident #4's May 2018 eMAR revealed: -There was an entry for risperidone 1mg/ml solution, give 0.5 ml (0.5 mg) twice daily at 9:00 am and 5:00 pm and documented as administered from 05/01/18 through 05/05/18 (9:00 am dose), 05/07/18 (5:00 pm dose) through 05/12/18, and 05/13/18 (5:00 pm dose) through 05/16/18. -The eMAR did not reflect the dose change from the FL2 dated 05/06/18 to risperidone 0.5 mg tablet at bedtime. -There was no documentation of administration for risperidone 1mg/ml solution give 0.5 ml (0.5 mg) on 05/05/18 (5:00 pm dose) through 05/07/18 (9:00 am dose) and 05/13/18 (9:00 pm dose with no reason not given documented). -There was documentation on the back of the eMAR risperdone was not given on 05/05/18 through 05/07/18 due to the resident was out of the facility. Observation on 5/18/18 at 4:45 pm of Resident #4's medications on hand revealed risperidone 1mg/ml solution give 0.5 ml (0.5 mg) twice daily	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 54 was available for administration. Interview with first shift medication aide on 05/17/18 at 1:35 pm revealed: -She did not know about the medication changes on the hospital discharge summary dated 05/06/18. -She did not know Resident #4 was receiving another resident's order for risperidone. Interview with the RCC on 05/17/18 at 3:04 pm revealed: -She did not know about the order changes on the hospital discharge summary dated 05/06/18. -She did not know Resident #4 was receiving another resident's order for risperidone. Interview with the Administrator on 05/18/18 at 2:50 pm revealed: -She did not know about the the medications changes/errors with Resident #4. -She did not know Resident #4 was receiving another resident's order for risperidone. Interview with the facility's contracted pharmacy (after April 2018) on 05/18/18 at 4:15 pm revealed: -The pharmacy did not receive the hospital discharge summary dated 05/06/18 for Resident #4. -The pharmacy did not have Resident #4 on risperidone. The pharmacy received a "split fax" and the resident was started on the risperidone 1mg/ml solution, give 0.5 ml (0.5 mg) twice daily by error. The fax received from the facility staff came through with another resident's order for risperidone, but had Resident #4's name on it. The pharmacy planned to correct the error immediately.	D 358		

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D 358	Continued From page 55 Interview with mental health provider on 05/18/18 at 3:20 pm revealed: -She discontinued the risperidone 0.5 mg daily at bedtime on 01/20/18. -She had not written a new order for risperidone. -She looked into the system and the primary care provider had not written a new order to restart the risperidone. -When Resident #4 was on risperidone, she was always on the tablet form and never on the liquid form of risperidone. -She did not know Resident #4 was hospitalized in May 2018. -She expected the staff to notify her when the resident was hospitalized. -Resident #4 was in the hospital and the facility staff did not provide a current list of medications. When the resident was discharged, the incorrect medications/dosages were ordered. -She would expect the staff to clarify the medications after discharge from the hospital. Based on observations, record review and interviews, it was determined Resident #4 was not interviewable. Attempted interview with Resident #4's primary care physician on 05/18/18 at 11:38 am 05/21/18 at 11:50 am and 05/22/18 at 12:00 pm was unsuccessful. Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am. Refer to interview with the Administrator on 05/17/18 at 9:46am. Refer to interview with a first shift Medication Aide (MA) on 05/17/18 at 1:35 pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 56 Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm. Refer to interview with a second first shift MA on 05/18/18 at 8:34 am. Refer to interview with the Administrator on 05/18/18 at 2:55 pm. h. Review of Resident #4's hospital discharge summary dated 05/06/18 revealed an order for sertraline (used to treat depression) 25 mg tablet daily. Review of a subsequent physician's order dated 03/20/18 revealed an order for sertraline 25 mg tablet daily. Review of Resident #4's March 2018 Electronic Medication Administration Record (eMAR) revealed: -There was an entry for sertraline tablet 25 mg daily scheduled to be administered at 9:00 am and documented as administered from 03/01/18 through 03/20/18 and 03/22/18 through 03/31/18. -There was no documentation of administration for sertraline 25 mg on 03/21/18 with no documentation on the back of the eMAR for why sertraline was not administered. Review of Resident #4's April 2018 eMAR revealed: -There was an entry for sertraline tablet 25 mg daily at 9:00 am and documented as administered from 04/01/18 through 04/08/18 and 04/10/18 through 04/20/18. -There was no documentation of administration for sertraline 25 mg on 04/09/18 with documentation on the back of the eMAR sertraline was withheld per physician order.	D 358		

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D 358	Continued From page 57 -There was an entry for sertraline HCL 100 mg tablet take once tablet daily. (Continue on tablet until liquid comes in) scheduled to be administered at 9:00 am. -There was documentation of administration of sertraline HCL 100 mg at 9:00 am on 04/22/18. -There was no documentation of administration of sertraline HCL 100 on 04/21/18 and 04/23/18 with documentation on the back of the eMAR sertraline was withheld per physician order. -There was an entry for sertraline 20 mg/ml oral concentration give 5 ml (100 mg) once daily at 9:00 am and documented as administered on 04/22/18 and 04/24/18 through 04/30/18 -There was no documentation of administration of sertraline 20 mg/ml oral concentration on 04/21/18 and 04/23/18 with documentation on the back of the eMAR sertraline was withheld per physician order. Review of Resident #4's May 2018 eMAR revealed: -There was an entry for sertraline 20 mg/ml oral concentration, give 5 ml (100 mg) once daily scheduled to be administered at 9:00 am. -The eMAR reflected sertraline 20 mg/ml oral concentration, give 5 ml (100 mg) once daily documented as administered at 9:00 am on 05/01/18 through 05/05/18, 05/08/18 through 05/12/18, and 05/14/18 through 05/16/18. -The eMAR did not reflect a dose change from the FL2 dated 05/06/18 for sertraline 25 mg tablet daily. - The eMAR did not reflect documentation of administration for sertraline 20 mg/ml oral concentration, give 5 ml (100 mg) once daily scheduled to be administered at 9:00 am on 05/06/18, 05/07/18, and 05/13/18. - The eMAR did not reflect documentation of administration for the sertraline 20 mg/ml oral	D 358		

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concentration, give 5 ml (100 mg) once daily from 05/05/18 through 05/07/18 due to the resident was out of the facility.
-The eMAR did not reflect documentation for the reason the sertraline 20 mg/ml oral concentration, give 5 ml (100 mg) once daily was not administered on 05/13/18.

Observation on 5/18/18 at 4:50 pm of Resident #4's medications on hand revealed sertraline 20 mg/ml oral concentration was available for administration.

Interview with first shift medication aide on 05/17/18 at 1:35 pm revealed:
-She did not know about the medication changes on the hospital discharge summary dated 05/06/18.
-She did not know Resident #4 was receiving another resident's order for sertraline.

Interview with the RCC on 05/17/18 at 3:04 pm revealed:
-She did not know about the order changes on the hospital discharge summary dated 05/06/18.
-She did not know Resident #4 was receiving another resident's order for sertraline.

Interview with the Administrator on 05/18/18 at 2:45 pm revealed:
-She did not know about the the medications changes/errors with Resident #4.
-She did not know Resident #4 was receiving another resident's order for sertraline.

Interview with the mental health provider on on 05/18/18 at 3:20 pm revealed:
-Resident #4 should be receiving sertraline 25 mg at bedtime.
-She had not changed the sertraline order.

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-She did not know Resident #4 was hospitalized in May 2018.
-She expected the staff to notify her that the resident was hospitalized.
-Resident #4 was recently discharged from the hospital and the facility did not provide a current list of medications.
-When the resident was discharged the incorrect medications/dosages were ordered.
-She would expect the staff to clarify the medications after discharge from the hospital.
-The current sertraline order was another resident's in the facility also.

Interview with the facility's contracted pharmacy (after April 2018) on 05/18/18 at 4:15 pm revealed:
-The facility did not receive the hopsital discharge summary dated 05/06/18.
-The pharmacy currently had an order for Resident #4 to receive sertraline 20 mg/ml oral concentration, give 5 ml (100 mg) once daily. (The sertraline was initially filled in a 100 mg tablet form until the liquid was available).
-This was also part of the "split fax" and an order for another resident in the facility, but came through from the facility with Resident #4's name on it.
-Sertraline 20 mg/ml was last filled 04/23/18 for 120 ml. Resident #4 should have received 25 mg tablets daily and was last filled 04/02/18 for a quantity of 30 tablets. The pharmacy planned to correct the error immediately.

Based on observations, record review and interviews, it was determined Resident #4 was not interviewable.

Attempted interview with Resident #4's primary care physician on 05/18/18 at 11:38 am 05/21/18

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D 358	Continued From page 60 at 11:50 am and 05/22/18 at 12:00 pm was unsuccessful. Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am. Refer to interview with the Administrator on 05/17/18 at 9:46am. Refer to interview with a first shift Medication Aide (MA) on 05/17/18 at 1:35 pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm. Refer to interview with a second first shift MA on 05/18/18 at 8:34 am. Refer to interview with the Administrator on 05/18/18 at 2:55 pm. i. Review of Resident #4's hospital discharge summary dated 05/06/18 revealed an order for vitamin D3 (a vitamin supplement) 400 unit tablet once daily. Review of a previous physician's order dated 03/20/18 revealed an order for vitamin D3 400 unit tablet once daily. Review of a previous physician's order dated 03/16/18 revealed an order to discontinue calcium plus D 500/400 daily and start calcium plus D 500/200 daily. Review of previous physician's order dated 03/15/18 revealed and order to discontinue vitamin D3 400 units daily and start calcium plus D 500/400 daily.	D 358		

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D 358	Continued From page 61 Review of Resident #4's March 2018 Electronic Medication Administration Record (eMAR) revealed: -There was an entry for vitamin D3 400 unit tablet once daily at 9:00 am and documented as administered on 03/01/18 through 03/15/18. -There was an entry for calcium with vitamin D 500/400 unit take one tablet daily at 9:00 am and documented as administered from 03/17/18 through 03/20/18 and 03/22/18 through 03/31/18. -The eMAR did not reflect an order change for the order dated 03/20/18 for vitamin D3 400 unit tablet once daily. -There was no documentation of administration of calcium with vitamin D 500/400 unit on 03/16/18 and 03/21/18 with no documentation on the back of the eMAR why the calcium with vitamin D 500/400 unit was not administered on 03/16/18 and 03/21/18. Review of Resident #4's April 2018 eMAR revealed: -There was an entry for calcium with vitamin D 500/400 unit take one tablet daily at 9:00 am and documented as administered on 04/01/18 through 04/08/18 and 04/10/18 through 04/30/18. -There was no documentation of administration of calcium with vitamin D 500/400 unit on 04/09/18 with documentation on the back of the eMAR calcium with vitamin D 500/400 unit was withheld per physician order. Review of Resident #4's May 2018 eMAR revealed: -There was an entry for calcium with vitamin D 500/400 unit take one tablet daily at 9:00 am and documented as administered at 9:00 am on 05/01/18 through 05/05/18, 05/08/18 through 05/12/18, and 05/14/18 through 05/16/18. -There was no documentation of administration of	D 358		

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calcium with vitamin D 500/400 unit on 05/06/18, 05/07/18, and 05/13/18. with documentation on the back of the eMAR the medication was withheld per physician order.
-The eMAR did not reflect an order change for the FL2 dated 05/06/18 for vitamin D3 400 unit tablet once daily.
-There was documentation the calcium with vitamin D 500/400 unit take one tablet daily was not administered on 05/06/18 and 05/07/18 due to the resident was out of the facility.
-There was no documentation for the reason the calcium with vitamin D 500/400 unit was not administered on 05/13/18.

Observation on 5/18/18 at 4:55 pm of Resident #4's medications on hand revealed calcium with vitamin D 500/400 one tablet daily was available for administration.

Interview with first shift medication aide on 05/17/18 at 1:40 pm revealed the calcium with vitamin D 500/400 had possibly been missed due to miscommunication between the pharmacy and the facility.

Interview with the RCC on 05/17/18 at 3:00 pm revealed:
-She did not know about the order changes on the hospital discharge summary dated 05/06/18.
-She did not know why the order was not faxed to the pharmacy.

Interview with the Administrator on 05/18/18 at 2:52 pm revealed she did not know about the the medications changes/errors with Resident #4.

Interview with the facility's contracted pharmacy (after April 2018) on 05/18/18 at 4:15 pm revealed:

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D 358	Continued From page 63 -The facility did not receive the hospital discharge summary dated 05/06/18. -The pharmacy currently had an order for Resident #4 to receive calcium with vitamin D 500/400 one tablet daily. -The pharmacy did not have an order for calcium with D 500/200 or vitamin D3 400 units daily. Calcium with vitamin D 500/400 was last filled 05/04/18 for 30 tablets. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Attempted interview with Resident #4's primary care physician on 05/18/18 at 11:38 am 05/21/18 at 11:50 am and 05/22/18 at 12:00 pm was unsuccessful. Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am. Refer to interview with the Administrator on 05/17/18 at 9:46am. Refer to interview with a first shift Medication Aide (MA) on 05/17/18 at 1:35 pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm. Refer to interview with a second first shift MA on 05/18/18 at 8:34 am. Refer to interview with the Administrator on 05/18/18 at 2:55 pm. 3. Review of Resident #7's FL2 dated 07/31/17 revealed diagnoses included aortic valve regurgitation, aortic valve stenosis, allergic	D 358		

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D 358	Continued From page 64 rhinitis, insomnia, anxiety, dementia, and depression. Review of a subsequent physician's order dated 03/27/18 revealed an order for hydrocortisone 0.1% cream (used to treat inflammation of the skin) apply to areas on the back twice daily. Review of Resident 7's March 2018 Electronic Medication Administration Record (eMAR) revealed there was no entry for hydrocortisone 0.1% cream, apply to areas on the back twice daily. Review of Resident #7's April 2018 eMAR revealed there was no entry for hydrocortisone 0.1% cream, apply to areas on the back twice daily. Review of Resident #7's May 2018 eMAR revealed there was no entry for hydrocortisone 0.1% cream, apply to areas on the back twice daily. Interview with the facility's contracted pharmacy (prior to April 2018) on 05/17/18 at 12:30 pm revealed: -The pharmacy filled one (28 gm) tube of hydrocortisone 0.1% cream on 03/29/18. -The pharmacy did not have a discontinue order for hydrocortisone 0.1% cream. Interview with a first shift medication aide on 05/17/18 at 1:45 pm revealed: -She did not know about the hydrocortisone order for Resident #7. -She did not remember administering hydrocortisone to Resident #7. -The medication had possibly been missed due to miscommunication between the pharmacy and	D 358		

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MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 65 the facility. Interview with Resident #7's nurse practitioner on 05/17/18 at 4:15 pm revealed: -She did not recall the hydrocortisone order. -She did not know Resident #7 was not receiving the hydrocortisone as ordered. -Not receiving the medication could have caused increased/continued itching. Interview with the RCC on 05/17/18 at 3:03 pm revealed: -She did not know about the hydrocortisone order for Resident #7. -She did not know why the order was not listed on the eMAR. Interview with a second first shift MA on 05/18/18 at 8:30 am revealed: -She did not know about the hydrocortisone order for Resident #7. -She did not know why the order was not listed on the eMAR. -She had never administered hydrocortisone to Resident #7 and the medication was not available on the medication cart. Interview with the Administrator on 05/18/18 at 2:53 pm revealed: -She did not know about the hydrocortisone order. -She did not know hydrocortisone was not being administered as ordered. Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am. Refer to interview with the Administrator on 05/17/18 at 9:46am.	D 358		

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Refer to interview with a first shift Medication Aide (MA) on 05/17/18 at 1:35 pm.

Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm.

Refer to interview with a second first shift MA on 05/18/18 at 8:34 am.

Refer to interview with the Administrator on 05/18/18 at 2:55 pm.

4. Review of Resident #8's FL2 dated 12/12/17 revealed diagnoses included hypertension, dementia, hypothyroid, neuropathy, muscle weakness, depression, insomnia, pacemaker, cardiovascular accident, coronary artery stenosis, peripheral vascular disease, and heel ulcer.

Review of a subsequent physician's order dated 04/24/18 revealed an order for mild moisturizing cream (used to treat dry skin) to feet daily but not between toes.

Review of Resident #8's April 2018 electronic Medication Administration Record (eMAR) revealed there was no entry for mild moisturizing cream to feet daily

Review of Resident #8's May 2018 eMAR revealed there was no entry for mild moisturizing cream to feet daily

Interview with the facility's contracted pharmacy (after April 2018) on 05/17/18 at 9:30 am revealed the pharmacy did not have an order for mild moisturizing cream to feet daily on Resident #8's medication profile.

Interview with a first shift medication aide on

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D 358	Continued From page 67 05/17/18 at 1:30 pm revealed: -She did not know about the moisturizing cream order for Resident #8. -She did not recall administering moisturizing cream to Resident #8. -She administered what was due on the eMAR for her shift. Interview with the RCC on 05/17/18 at 3:00 pm revealed: -She did not know about the moisturizing cream order for Resident #8. -She did not know why the order was not listed on the eMAR. Interview with Resident #8's specialist provider on 05/17/18 at 6:23 pm revealed: -He did not know the staff were not administering moisturizing cream as ordered. -He expected staff to send the order to the pharmacy, medication would be filled, and staff would administer the medication as ordered. -He expected the facility staff to call with questions/concerns. -He visited Resident #8 every 3 months for podiatry needs. -He would not expect Resident #8's skin to be increasingly dry but the cream was ordered to treat the dry skin. Interview with a second first shift MA on 05/18/18 at 8:32 am revealed: -She did not know about the moisturizing cream order for Resident #8. -She did not know why the order was not listed on the eMAR. -She had never administered moisturizing cream to Resident #8 and the medication was not available on the medication cart.	D 358		

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D 358	Continued From page 68 Interview with the Administrator on 05/18/18 at 2:58 pm revealed: -She did not know about the moisturizing cream order. -She did not know the moisturizing cream was not being administered as ordered. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable. Attempted interview with primary care provider on 05/18/18 at 11:38 am was unsuccessful. Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am. Refer to interview with the Administrator on 05/17/18 at 9:46am. Refer to interview with a first shift Medication Aide (MA) on 05/17/18 at 1:35 pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm. Refer to interview with a second first shift MA on 05/18/18 at 8:34 am. Refer to interview with the Administrator on 05/18/18 at 2:55 pm. 5. Review of Resident #5's FL-2 dated 05/23/17 revealed: -Diagnoses included dementia with behavioral disturbances, hypertension, major depression, insomnia, recurrent urinary tract infections, vitamin D deficiency, chronic kidney disease III and diabetes II.	D 358		

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D 358	Continued From page 69 -There was an order for melatonin 3mg at bedtime (melatonin is a sleep aid supplement). Review of the mental health Nurse Practitioner (NP) visit note dated 04/05/18 revealed: -There was an order to discontinue melatonin 3mg at bedtime. -There was an order to start melatonin 1mg at bedtime. Review of the mental health NP visit noted dated 04/19/18 revealed an order to discontinue melatonin 1mg. Review of the April 2018 MAR revealed: -The entry for melatonin 3mg was discontinued on 04/05/18. -An entry for melatonin 1mg to be administered at bedtime. -There was documentation of administraton of melatonin 1mg at 9:00 pm from 04/06/18 to 04/30/18. Review of the May 2018 MAR revealed melatonin 1mg was documented as administered at 9:00 pm from 05/01/18-05/16/18. Telephone interview with a pharmacist at the facility pharmacy on 05/17/18 at 9:20 am revealed. -Resident #5 had a current order for melatonin 1mg. -They had not received an order to discontinue melatonin 1mg for Resident #5. Interview with the mental health Nurse practitioner (NP) on 05/17/18 at 9:34 am revealed: -She had discontinued melatonin for Resident #5 because she no longer needed this medication.	D 358		

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D 358	Continued From page 70 -She wanted melatonin 1mg to be discontinued and would re-write the order to discontinue today, 05/17/18. Interview with the Resident Care Coordinator (RCC) on 05/17/18 at 9:38 am revealed: -She was not sure how they missed the melatonin 1mg being discontinued for Resident #5. -The mental health NP faxed patient encounters to the facility. -Staff were responsible for giving the fax to her, the RCC. -If a medication was discontinued she could enter it into the system immediately, and then she would fax the new orders to the pharmacy. Interview with the Administrator on 05/17/18 at 9:46am revealed she did not know melatonin 1mg had been discontinued for Resident #5. Observation of medication on hand on 05/17/18 at 11:11am revealed: -There was a punch card for melatonin 1mg dated as filled on 04/06/18 for 30 tablets. -There were 3 tablets remaining in the packet, 27 of 30 tablets had been administered. Interview with a second shift MA on 05/18/18 at 5:40pm revealed she was not aware of the order to discontinue melatonin 1mg for Resident #5. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am. Refer to interview with the Administrator on 05/17/18 at 9:46am.	D 358		

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D 358	Continued From page 71 Refer to interview with a first shift Medication Aide (MA) on 05/17/18 at 1:35 pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm. Refer to interview with a second first shift MA on 05/18/18 at 8:34 am. Refer to interview with the Administrator on 05/18/18 at 2:55 pm. Refer to interview with a second shift MA on 05/18/18 at 5:40pm. 6. Review of Resident #6's FL-2 dated 01/25/18 revealed diagnoses included major vascular neurocognitive disorder probable, with behavioral disturbances, non-adherence to medical treatment, major depressive disorder, (recurrent severe), homicidal ideations, peripheral edema, congestive heart failure, chronic renal impairment, history of cerebrovascular disease. Review of Resident #6's Mental Health Nurse Practitioner (NP) care note dated 02/22/18 revealed: -Resident #6 was seen for an initial psychiatric encounter on 02/22/18. -There was an order to start melatonin (a sleep aid supplement) 1mg at bedtime for insomnia. Review of Resident #6's Mental Health NP care note, dated 03/08/18 revealed an order to discontinue melatonin 1mg and start melatonin 3mg at bedtime for insomnia. Interview with the Resident Care Coordinator (RCC) on 05/17/18 at 9:38am revealed:	D 358		

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-The mental health NP faxed patient encounters to the facility.
-Staff were responsible for giving the fax to her, the RCC.
-If a medication was discontinued she could enter it into the system immediately, and then she would fax the new orders to the pharmacy.

Telephone interview with Resident #6's Mental Health NP on 05/18/18 at 3:59pm revealed:
-She had increased Resident #6's melatonin after he complained he was experiencing insomnia.
-During her visit on 04/19/18 Resident #6 expressed he still was not sleeping.
-She had noted on her visit on 04/19/18, while reviewing the MAR, the melatonin 1mg was still being administered.
-She had to repeat the order to discontinue melatonin 1mg and begin melatonin 3mg.
-She reviewed the May 2018 MAR on her visit on 05/17/18 that the melatonin 3mg was being documented as administered.

Observation of medication on hand on 05/18/18 @ 6:56pm revealed:
-There was a punch card for Melatonin 3mg that was filled on 05/06/18 for 30 tablets.
-There were 24/ of 30 tablets remaining in the packet, 6 tablets had been administered.

Interview with the RCC on 05/18/18 at 3:26pm revealed she did not know why the melatonin 1mg was not increased to melatonin 3mg for Resident #6; she did not see the faxed note from the Mental Health NP.

Interview with the Administrator on 05/18/18 at 3:38pm revealed she did not know the physicians order for Resident #6's melatonin 1mg had been increased to melatonin 3mg had not been

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D 358	Continued From page 73 implemented. Observation of medication on hand on 05/18/18 at 6:54pm revealed a punch card for melatonin 3mg that had been filled on 05/06/18 for 30 tablets. Refer to telephone interview with a pharmacist at the contracted pharmacy on 05/17/18 at 9:20am. Refer to interview with the Administrator on 05/17/18 at 9:46am. Refer to interview with a first shift Medication Aide (MA) on 05/17/18 at 1:35 pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/17/18 at 3:04 pm. Refer to interview with a second first shift MA on 05/18/18 at 8:34 am. Reref to interview with the Administrator on 05/18/18 at 2:55 pm. Refer to interview with a second shift MA on 05/18/18 at 5:40pm _____ Telephone interview with a pharmacist at the facility pharmacy on 05/17/18 at 9:20am revealed. -They received orders from the facility via fax. -The system they used immediately changed the MAR. -There were staff at the facility who could do a temporary order in the MAR to change it until the pharmacy could enter it into the system. Interview with the Administrator on 05/17/18 at 9:46am revealed: -They had a lot of issues with the pharmacy fax	D 358		

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machine.
-The normal procedure was once a fax comes in, it was faxed to the pharmacy and then "we need to make sure we follow up."
-The RCC and some medication aides (MAs) could make changes in the medication system.
-She expected staff to follow up.
-They had used a tracking system in the past but had stopped using it when they started using the new pharmacy.
-She thought with the new pharmacy system they did not need the tracking system.

Interview with a first shift MA on 05/17/18 at 1:35 pm revealed:
-She administered what was due on the eMAR for her shift.
-She thought eMAR audits were performed but was not sure who completed them.
-The MAs and the RCC could send and receive orders.
The supervisors and RCC could enter, change, and discontinue orders in the eMAR system.

Interview with the RCC on 05/17/18 at 3:04 pm revealed:
-She had not completed eMAR audits.
-She was planning to start eMAR audits the following week.
-The MAs and RCC are responsible for receiving orders, faxing orders, and making sure orders are added to the eMAR.

Interview with a second first shift MA on 05/18/18 at 8:34 am revealed:
-The MAs and the RCC could receive and fax orders.
-The supervisors and the RCC could enter, change, and discontinue orders in the eMAR system.

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D 358	Continued From page 75 -There was no one assigned to perform eMAR audits to her knowledge. Interview with the Administrator on 05/18/18 at 2:55 pm revealed: -She expected staff to fax new, changed and discontinued orders to the pharmacy and make changes as needed. -The MAs and RCC were responsible for sending and receiving orders. -The RCC was not performing eMAR audits to her knowledge. -The supervisors, RCC and the Administrator were capable of making changes to orders in the eMAR system. Interview with a second shift MA on 05/18/18 at 5:40pm revealed: -When a new order comes in they faxed it to the pharmacy; then filed the order in the resident charts. -The new order was put into the eMAR by pharmacy. -She filed the confirmation from the pharmacy in the resident's record. _____ The facility failed to ensure medications were administered as order resulting in depakote and risperdal continued to be administered when depakote and risperdal had been discontinued for a resident (#3); continued to administer melatonin when it was discontinued (#5) and failed to administer melatonin with an order for an increased dosage for a resident (#6) who had expressed concerns of not sleeping; failed to administer amlodipine besylate, atorvastatin, donepezil, humalog (with blood sugar ranges of 600), levemir, Namenda, risperdol, sertraline, and vitamin D3 as ordered for a resident (#4); failed to administer hydrocorticone cream for a resident	D 358		

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D 358	Continued From page 76 (#7) and eucerin cream for a resident (#8), which was placed the residents at substantial risk of physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/18/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED June 21, 2018.	D 358		
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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that the residents were free of neglect as related to health care and medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to notify the physician for 3 of 5 sampled residents (Resident #2, #4 and #6) with orders to contact the physician if fingerstick blood sugar (FSBS) was over 400 (#4), Thrombo-Embolic Deterrent (TED) hose not applied as ordered (#2), and a resident threatening suicide who had no antipsychotic medication available for administration resulting in behavioral changes (#6). [Refer to Tag 0273	D914		

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D914	Continued From page 77 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 2. Based on interviews and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 6 of 8 sampled residents including a behavior medication and an antipsychotic medication that had been discontinued (Resident #2); a sleep supplement that had been discontinued (Resident #5) and a sleep supplement increased (Resident #6); high blood pressure medication, cholesterol medication, 2 dementia medications, a rapid-acting insulin and a long-acting insulin, an antipsychotic medication, an antidepressant, and vitamin supplement (Resident #4); a topical steroid cream (Resident #7), and a moisturizing cream (Resident #8). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].	D914		