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 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on June 28-29, 2018 and July 2-3, 2018 with an exit conference via telephone on July 6, 2018. The complaint investigation was initiated by the Forsyth County Department of Social Services on 06/21/18.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision for 3 of 5 sampled residents (#1, #2, and #5) who were disoriented and semi-ambulatory resulting in repeated falls with injuries to include a broken elbow (#2), subdural hematoma (#5), and broken wrist (#1). The findings are: 1. Review of Resident #2's current FL-2 dated 05/12/18 revealed: -Diagnoses included atrial fibrillation, bladder cancer, coronary artery disease, right lung cancer, combined systolic and diastolic congestive heart failure, acute kidney injury superimposed on chronic kidney disease,	D 270		

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dementia, depression, hypertension, ischemic cardiomyopathy, status-post triple vessel bypass, and stroke.
-Resident #2 was semi-ambulatory.
-Resident #2 was disoriented in four areas, person, place, time and situation.

Review of Resident #2's Resident Register revealed an admission date of 02/28/18.

Review of Resident #2's current Care Plan dated 06/12/18 revealed:
-Resident #2 needed assistance with personal care needs in the area of bathing and dressing.
-Resident #2 needed an alarm for his wheelchair and the bed.

Review of an Incident/Accident Report for Resident #2 dated 04/18/18 revealed:
-The report was completed by a medication aide (MA).
-Resident #2 had a witnessed fall in his room and had a nose bleed, a knot on his head, and a bruised right shoulder.
-Resident #2 was transported to the emergency department (ED).
-Resident #2 was sent to the ED and returned with no new orders."

Review of Resident #2's ED after visit notes dated 04/18/18 revealed:
-Diagnoses of fall and dehydration and there were no new orders on discharge.
-There was no documentation of interventions.

Review of an Incident/Accident Report for Resident #2 dated 05/25/18 revealed Resident #2 was observed in the hallway with bleeding from the left elbow due to unknown cause.

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Review of Resident #2's Hospice notes revealed:
-There was documentation of admission to Hospice services on 05/22/18.
-Hospice nurse was notified at 11:58 pm on 05/25/18 because Resident #2 fell and had a small skin tear and the Hospice nurse was coming to check on the resident.
-The Hospice nurse came to facility on 05/26/18 and dressed the wound on the left elbow.
-There were orders from the Hospice physician for wound care.
-There was no documentation of interventions after the 05/22/18 fall.

Review of Resident #2's progress notes revealed there was no documentation of interventions after the fall on 05/25/18.

Review of an Incident/Accident Report for Resident #2 dated 06/06/18 revealed Resident #2 had an unwitnessed fall in the living room without any injuries.

Review of Resident #2's record revealed there was no documentation of interventions after the 06/06/18 fall..

Review of an Incident/Accident Report for Resident #2 dated 06/07/18 at 12:45 pm revealed:
- Resident #2 fell in the hallway while ambulating to the bathroom without any injuries.
-There was documentation of vital signs taken by the MA after the fall as follows: blood pressure 114/67, heart rate 88, temperature 98 degrees.

Review of Resident #2's progress notes dated 06/07/18 revealed there was no documentation of interventions after the 06/07/18 fall.

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Review of Resident #2's Hospice notes 06/07/18 revealed comfort and spiritual support was provided.

Review of a second Incident/Accident Report for Resident #2 dated 06/07/18 at 3:05 pm revealed-Resident #2 had an unwitnessed fall, no location indicated, and no injuries were documented.

Review of Resident #2's progress notes revealed there was no documentation of other interventions after the 06/07/18 fall.

Review of Resident #2's Hospice notes dated 06/07/18 revealed:
-The Hospice nurse notes indicated "prn fall visit" and lorazepam and a chair alarm for safety were ordered.
-There were orders from Hospice for lorazepam 0.5 mg every four hours prn for restlessness/agitation, and for a chair alarm for safety.

Review of an Incident/Accident Report for Resident #2 dated 06/08/18 at 7:30 am revealed:
-Resident #2 fell in the dining room off his walker and had a laceration to the right eye brow.
-Resident #2 was sent to the ED.

Review of Resident #2's progress notes dated 06/08/18 revealed there was no documentation of interventions after the 06/08/18 fall.

Review of Resident #2's Hospice notes dated 06/08/18 revealed Resident #2 had a swollen, blue-purple right eye and identified Resident #2 as a fall risk.

Review of a second separate Incident/Accident

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Report for Resident #2 dated 06/08/18 at 7:45 pm revealed Resident #2 was found on the floor, no location indicated, with complaints of right wrist pain.

Review of Resident #2's Hospice notes dated 06/08/18 revealed:
-Resident #2 had "a black eye, garbled speech and was fidgeting, picking, showing signs of terminal restlessness."
-The medication aide (MA) was educated on medication administration related to "Ativan use".
-Ativan was "started" and Hospice wanted to ensure Resident #2 was given a dose every four hours to calm Resident #2.
-The Resident Care Coordinator (RCC) was notified.
-There was no documentation of other interventions after the 06/08/18 fall.

Review of an Incident/Accident Report for Resident #2 dated 06/11/18 revealed Resident #2 slid out of a chair in the lobby, without injury.

Review of Resident #2's Hospice notes dated 06/11/18 revealed:
-The chair alarm was not working even after the batteries were changed.
-The "equipment company was notified."
-There was no documentation of other interventions after the 06/11/18 fall.

Review of an Incident/Accident Report for Resident #2 dated 06/12/18 revealed Resident #2 was lying on the floor in the living room, without injury.

Review of Resident #2's progress notes revealed:
-On 06/13/18 that a chair alarm arrived and Resident #2 was connected to the chair alarm.

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D 270	Continued From page 5 -There was no documentation of other interventions after the 06/12/18 fall. Review of an Incident/Accident Report for Resident #2 dated 06/14/18 revealed: -Resident #2 fell in the lobby. -Resident #2 was sent to the ED. Review of Resident #2's Hospice notes dated 06/14/18 revealed: -There was bruising to the right side of Resident #2's face was decreasing and there was no documentation about the fall. -There was an order from the Hospice physician for Resident #2 to use a wheelchair when not in bed with a gel cushion, and chair mat alarm dated 06/14/18. -There was no documentation of other interventions after the 06/14/18 fall. Review of Resident #2's progress notes revealed there was no documentation of other interventions after the 06/14/18 fall. Review of Resident #2's ED after visit summary dated 06/14/18 revealed a diagnoses of fall and closed fracture of the shaft of the right ulna with splint application. Review of an Incident/Accident Report for Resident #2 dated 06/20/18 revealed Resident #2 was found on the floor in his room, under the bed, without injury and the bed alarm did not make a sound. Review of Resident #2's Hospice notes dated 0/20/18 revealed: -The Hospice nurse would visit Resident #2 that day. -Resident #2 did not have injuries as a result of	D 270		

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the fall and was transitioning based on irregular heartbeat, jerking and tremors.
-There were orders from the Hospice physician for Haldol 1 mg four times a day, Haldol 1 mg every six hours prn for restlessness/behaviors, lorazepam 0.5mg every four hours prn for restlessness and agitation, and morphine concentrate 5 mg/.25 ml every four hours prn for shortness of breath, restlessness, agitation, heart rate over 100, respiration rate over 24 and pain.

Review of Resident #2's progress notes revealed there was no documentation of interventions after the 06/20/18 fall.

Review of an Incident/Accident Report for Resident #2 dated 06/25/18 revealed Resident #2 fell in the dining room onto buttocks, no injuries were documented.

Review of Resident #2's Hospice notes dated 06/26/18 revealed Resident #2 did not have injuries as a result of the fall on 06/25/18.

Review of Resident #2's progress notes revealed there was no documentation of interventions in the progress notes dated 06/25/18.

Observation on 6/28/18 at 11:00 am of room #10 revealed a low profile bed and bed alarm mat lying on the mattress.

Observation on 07/02/08 at 11:30 am of Resident #2 in the dining room revealed a chair alarm was in Resident #2's wheelchair.

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

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D 270	Continued From page 7 Interview with Resident #2's NP on 07/03/18 at 10:07 am revealed: -She was Resident #2's medical provider until he was admitted to Hospice services on 05/22/18. -The facility staff notified her only if Hospice services could not be reached. -She last examined Resident #2 on 04/10/18. -She was notified of one fall on 06/08/18 only. -She did not order any interventions after the 06/08/18 fall, because he was followed up with Hospice services. -She was not notified of the 04/18/18 fall. -She did not have documentation of notification from the facility staff of the 05/25/18 fall. -The facility staff placed the paperwork in her folder when a resident returned from the hospital. -She did not recall reviewing the hospital paperwork for Resident #2 after the 04/18/18 and 05/25/18 falls. Interview with a Hospice representative on 07/02/18 at 3:02 pm revealed: -Resident #2 was admitted to Hospice services on 05/22/18. -Hospice services were responsible for Resident #2's orders for a high low bed, fall mat, chair and bed alarms. -The facility staff reported that Resident #2 disassembled the chair and bed alarms. -The Hospice nurse and Hospice nurse aide (NA) had both reported the alarms were not operating during visits to see Resident #2. -Resident #2 was anxious, agitated at times, not able to interact with others, and picked at objects including the floor and anything within reach. -NA visited the resident on 05/26/18 and notified the Hospice nurse about bruises on Resident #2's buttocks and fingers on the right hand. -The Hospice nurse visited on 05/26/18 and gave the facility a new order for Haldol.	D 270		

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D 270	Continued From page 8 -The Hospice nurse made a second visit to assess Resident #2 on 05/26/18, noted a skin tear on the elbow and provided the facility staff with a wound care order and antibiotic ointment. -Hospice services was notified concerning the 06/06/18 fall and a visit was made to Resident #2 without any new orders provided. -Hospice services was notified concerning the two falls on 06/07/18; Resident #2 was visited, found to have no injuries; given Haldol which was not effective; a safety alarm for the chair was obtained, lorazepam was ordered, during a subsequent visit on the same day the alarm was found disabled, and the facility staff was told to monitor Resident #2 more frequently. -Hospice services was notified about Resident #2's fall and ED visit on 06/08/18. -Resident #2 had three falls in the last three days, a gash on the right eye brow with three sutures, negative x-rays, after the resident was seen by the Hospice nurse on 06/09/18 and the family member was notified. -After the consecutive falls from 06/06/18 to 06/08/18 the Hospice nurse documented Resident #2 had terminal restlessness and was not given medications of Haldol, and lorazepam in order to prevent terminal restlessness. -The Hospice nurse was notified on 06/11/18 because Resident #2 slid out of the chair without injury and the facility was instructed to monitor Resident #2. -Hospice service was notified on 06/12/18 because Resident #2 fell without injury and Resident #2 was visited by the Hospice nurse, Resident #2 was restless, given lorazepam by MA and oxygen was applied during the 06/12/18 visit. -The Hospice nurse spoke with the Administrator about terminal restlessness, administration of prn medications to prevent terminal restlessness for Resident #2, and offered to conduct a class on	D 270		

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terminal restlessness.
-A new order for a wheelchair, gel seat mat and seat alarm for Resident #2 was obtained on 06/14/18.
-The Hospice nurse spoke with the MA on duty on 06/15/18 and the MA was unable to provide an update about administration times for prn medication for Resident #2.
-Hospice responded to an unwitnessed fall on 06/16/18, Resident #2 had a splint on the right arm and lorazepam and Haldol were administered by the MA on duty.
-Resident #2 was seen twice by the Hospice nurse on 06/16/18 because the facility notified Hospice services about a second fall after the scheduled visit.
-Resident #2 had an abrasion on the left posterior arm and a dressing was applied by hospice, lorazepam was administered before the second visit, Haldol and Tylenol were administered by MA after the Hospice nurse arrived.
-The facility staff notified Hospice services on 06/20/18 because Resident #2 was found under his bed without injury and the bed alarm did not sound off prior to the event.
-Another bed alarm was ordered on 06/20/18, both the Hospice nurse and Hospice Nurse Aide visited Resident #2 and tested the new bed alarm.
-The facility notified Hospice services on 06/26/18 about Resident #2's fall on 06/25/18 and documented Resident 2's repeated falls with varying degrees of injury, improving right eye brow bruising, and medications given as ordered.
-Resident #2 was discussed during Hospice interdisciplinary meeting and concerns about the facility staff reluctance to medicate Resident #2 before behaviors like agitation/restlessness were observed.
-The Hospice interdisciplinary discussed giving a

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class about medicating ahead of agitation, in order to decrease falls, but the class had not been scheduled with the facility staff.

Interview with a personal care aide (PCA) on 07/02/18 at 2:45 pm revealed:
-There was a fall risk list and there were currently four residents on the list including Resident #2.
-Resident #2 was one of the residents on the fall risk list.
-When she began working he walked, but after two or three falls Resident #2 received a chair alarm.
-Resident #2 was able to stand but the staff would tell him to remain seated.
-She knew Resident #2 fell many times but did not know the exact number.

Interview with a first shift MA on 07/02/18 at 3:00 pm revealed:
-Resident #2 was "complicated" with regard to falls.
-Resident #2 took his chair and bed alarms apart, and removed the batteries.
-Hospice had replaced the alarm many times.
-When the alarm had batteries and was not tampered with by Resident #2, it worked.
-She did not know of any other interventions put into place for Resident #2 other than the chair and bed alarm.

Attempted telephone interview with Resident #2's family member on 07/03/18 at 8:12 am was unsuccessful.

Interview with the RCC on 07/02/18 at 4:50 pm revealed:
-There were two residents identified as fall risk (including Resident #2).
-The two residents were watched by the assigned

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D 270	Continued From page 11 PCA during each shift. -This was done in response to frequent falls from Resident #2 and other residents. -The facility staff had not received a class from hospice services on terminal restlessness. Interview with the Administrator on 07/03/18 at 4:20 pm revealed: -Resident #2 fell a lot but he was taking his alarms apart. -Hospice services replaced Resident #2's alarm and the alarm batteries on different occasions. -Resident #2 received the interventions ordered by hospice services. Refer to interview with a first shift medication aide (MA) on 07/02/18 at 1:10 pm. Refer to interview with a personal care aide (PCA) on 07/02/18 at 2:55 pm. Refer to interview with another first shift MA on 07/02/18 at 3:05 pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/02/18 at 4:45 pm. Refer to interview with Administrator on 07/03/18 at 4:30 pm. 2. Review of Resident #5's current FL-2 dated 03/02/18 revealed: -Diagnoses included lymphoid leukemia, chronic pain syndrome and acute subdural hematoma. -Resident #5 was constantly disoriented. -Resident #5 needed personal care assistance with bathing, feeding, and dressing. -Resident #5 was continent to bowel and incontinent to bladder at times.	D 270		

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D 270	Continued From page 12 Review of the Resident Register for Resident #5 revealed there was no admission date documented, but was signed by the Power of Attorney on 08/09/17. Review of Resident #5's Hospice notes revealed: -The resident was on Hospice upon admission to the facility. -Hospice noted a change in the attending physician on 08/09/17. -Resident #5 was discharged from Hospice on 02/16/18. -Resident #5 was admitted back to Hospice 03/06/2018. Review of Resident #5's Incident/Accident reports revealed: -Resident #5 had 5 unwitnessed falls and 2 witnessed falls from 01/01/18 through 03/20/18. -Three of the unwitnessed falls were documented as occurred in the resident's room. -One of the unwitnessed falls was documented as occurred in the dining room. -One of the witnessed falls was documented as occurred in the dining room. -One fall was in the lobby with no notation if witnessed or unwitnessed. -Resident #1 had 1 additional fall where the location was not documented. Review of Resident #5's progress notes revealed: -There was a fall documented on 01/16/18 and a fall documented on 01/13/18. Neither fall had an Incident/Accident report documented by the facility staff. -There was no documentation of interventions in the progress notes for increased supervision checks.	D 270		

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Review of Resident #5's Hospice notes revealed:
-Documentation on 01/18/18 for skilled nursing (SN) to cleanse skin tear to right forearm and apply dry dressing one time today.
-There was no documentation of interventions in the Hospice nurse notes for increased supervision checks.

Review of Resident #5's Incident/Accident reports for January 2018 revealed:
-On 01/25/18 at 9:30 am, Resident #5 fell in the dining room while turning around to get walker, and hit right elbow causing skin tear; Hospice to evaluate and encouraged to use walker was documented.
-On 01/26/18 at 7:30 am, Resident #5 lost balance and eased self to the floor; there was no documentation for the location of the incident. Hospice to evaluate, and encourage to use walker was documented for recommendations; no interventions were listed.
-On 01/28/18 at 7:30 am, Resident #5 had an unwitnessed fall in his room (resident found on floor); Hospice assessed; continue to monitor was documented for recommendations.

Review of Resident #5's Hospice note dated 01/28/18 revealed a documented visit by on-call skilled nursing after facility staff called reporting several falls this week; resident seemed confused today. There was no documentation of interventions in the Hospice nurse notes.

Review of Resident #5's progress notes revealedor facility notes for increased supervision or any other interventions after the falls on 01/25/18, 01/26/18,or 01/28/18.

Review of Resident #5's Accident/Incident reports for February 2018 revealed on 02/27/18 at 6:00

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am, Resident #5 had unwitnessed fall in his room, found laying on his side with no head injury and no complaint of pain. Continue to monitor for changes and will notify hospice for another assessment was documented for recommendations.

Review of Resident #5's progress notes revealed:
-On 02/27/18 at 6:00 am, the resident had been up and trying to walk around all night without the wheelchair, a medication ordered as needed for anxiety was administered to calm down.
-On 02/27/18 at 6:50 pm, Resident #5 was found in the lobby, sent to hospital and admitted was documented on the report.
-The resident was "on floor when staff came to the lobby and his head was bleed [sic]. Resident is being sent out to the hospital".

Review of Resident #5's Hospital Discharge Summary dated 03/02/18 revealed:
-The resident presented to the hospital emergency department (ED) on 02/27/18 with repeated falls. "He actually had a fall in the [local hospital] ER this evening. Pt [sic] noted to have acute subdural hemotoma". The resident was noted to be agitated and required sedation.

Review of Resident #5's progress notes revealed:
-On 03/02/18, from 7:00 am to 3:00 pm, the resident returned to the facility around 2:30 pm with large bruise, covering his right eye, underneath his right eye and on top of his forehead. Resident #5 had a bruise on the left side of his face.
-On 03/03/18, from 11:00 pm to 7:00 am and from 3:00 pm to 11:00 pm, the resident received a prn (as needed) medication for anxiety/agitation.
-On 03/04/18 from 7:00 am to 3:00 pm, the

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resident kept getting out of his chair.
-On 03/04/18 from 3:00 pm to 11:00 pm, the entire shift Resident #5 kept getting up out of his chair and pulled his shirt off so the chair alarm would be attached. "Each aide [sic] and medication aide rotated sitting one on one with the resident so he will not get up". He became verbally abusive. (Alarm is on him at all times). Staff assisted resident back in wheelchair and moved up front where he could be continuously monitored.
-On 03/05/18 at 7:00 am, resident in bed at 10:45 pm and slept all night. At 3:00 pm, the resident was agitated this morning and trying to get out of wheelchair. From 11:00 pm to 7:00 am, resident slept all night.

Review of Hospice notes revealed:
-On 03/13/18, Hospice visited on 03/06/18 for an assessment; resident sitting in wheelchair, unable to stand or ambulate without assistance, had multiple falls with one resulting in subdural hematoma. Has bruising to right side of face, with laceration closed with sutures at right eye.
-On 03/14/18 at 11:00 pm, Hospice in to see resident for wound on right eye brow, with small drainage noted.
-Hospice saw the resident daily from 03/14/18 to 03/17/18, on 03/20/18, 03/21/18, 03/23/18, 03/26/18, 03/27/18, 03/28/18, and 03/29/18.

Review of Resident #5's Accident/Incident reports for March 2018 revealed on 03/17/18 at 5:10 pm, Resident #5 had unwitnessed fall in his room, found laying at bedside with no injury; "continue to monitor for changes; hospice" was documented for recommendations.

Review of Resident #5's progress notes revealed:
-On 03/17/18 at 5:10 pm, Hospice was notified

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and came out to do a visit.
-There was documentation for checks each shift on 03/17/18 and 03/18/18 but no documentation for increased supervision.
-On 03/20/18 at 6:15 am, Resident #5 was sitting at the dining table with wheelchair locked, was found onthe floor lying on his right side with the chair alarm button in his pocket; continue to monitor for falls was documented for recommendation. There was no documentation for increased supervision in the resident's notes. Small amount of blood from old scab that was reopened on elbow.

Review of Hospice notes revealed Hospice visited on 03/20/18 at 8:52 pm. Right eye brow healed; left elbow skin tear bandaged.

Telephone interview on 07/03/18 at 10:20 am with Resident #5's primary care Nurse Practitioner (NP) revealed:
-There was documentation the facility notified her office for Resident #5's falls on 12/06/17, 12/29/17, 01/25/18, and 01/26/18.
-She knew Resident #5 was hospitalized from a fall on 02/27/18 and came back to the facility.
-She did not routinely recommend physical therapy or occupational therapy for Hospice residents.
-Resident #5 was very independent until he rapidly declined in health.
-She thought the facility staff "did the best they could" to try to keep the resident from falling, but his dementia made it difficult.
-She did not know who ordered a wheelchair alarm, but was fine with the facility having one for Resident #5.

Interview on 07/03/18 at 11:00 am with a day shift medication aide (MA) revealed:

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D 270	Continued From page 17 -She knew Resident #5 had several falls. -Resident #5 was very independent and would not listen to request for him to stay seated in his wheelchair. -"He was constantly trying to get up and down from his chair." -Staff were supposed to document shift checks on a resident post fall for 3 days. -MAs were responsible to report from shift to shift how a "hot box" (area in medication room office that was used to place a record for a resident who needed increased supervision to help staff identify the resident requiring more supervision). -Resident #5 did have a chair alarm to help alert staff when he was trying to stand up. -She did not know of any increased supervision or any other interventions for Resident #5 other than "keeping a close eye" on him for being a risk to stand up unassisted. Interview with the Administrator on 07/03/18 at 4:20 pm revealed Rsident #5 fell a lot but he was taking his alarms apart. Telephone interview on 07/06/18 at 2:34 pm with the Hospice Quality Assurance Supervisor revealed: -There was documentation that Hospice was notified after the falls on 03/17/18 and 03/20/18. -There was no documentation for recommendations for increased supervision or fall interventions recommended by Hospice. Refer to interview with a first shift medication aide (MA) on 07/02/18 at 1:10 pm. Refer to interview with a personal care aide (PCA) on 07/02/18 at 2:55 pm. Refer to interview with another first shift MA on	D 270		

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D 270	Continued From page 18 07/02/18 at 3:05 pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/02/18 at 4:45 pm. Refer to interview with Administrator on 07/03/18 at 4:30 pm. 3. Review of Resident #1's current FL-2 dated 02/22/18 revealed: -Diagnoses included advanced dementia, osteoarthritis, diabetes mellitus, vitamin D deficiency, neuropathy, anemia, and falls. -Resident #1 was constantly disoriented, ambulatory with a walker, and continent of bowel and bladder. Review of Resident #1's current Care Plan dated 02/12/18 revealed Resident #1 wandered. Observation on 06/29/18 at 11:00 am revealed Resident #1 was in the standard wheelchair and chair alarm was on. Observation on 07/02/18 at 2:30 pm revealed Resident #1 was in the standard wheelchair and chair alarm was on. Review of Resident #1's Incident/Accident reports revealed: -Resident #1 had 10 falls unwitnessed between 04/18/18 through 06/22/18. -Five of the unwitnessed falls were documented as occurring in the resident's room. -Three of the unwitnessed falls were documented as occurring in the hallway. -Resident #1 had 2 additional falls where the location was no documented.	D 270		

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Review of an Incident/Accident report for Resident #1 dated 05/04/18 at 11:30 am revealed:
-Resident #1 had an unwitnessed fall in the hallway lying on her side.
-There was no injury noted.
-The resident's blood pressure was 144/80.
-The resident's heart rate was 79.
-She was transported to the Emergency Department (ED) for evaluation via EMS (Emergency Medical Services).

Review of Resident #1's progress notes dated 05/04/18 revealed Resident #1 had an unwitnessed fall in the hallway.

Review of an Incident/Accident report for Resident #1 dated 05/05/18 at 10:15 am revealed:
-Resident #1 was found in her room sitting on the floor by her chair and complained of side pain.
-The resident's blood pressure was 120/64.
-The resident's heart rate was 86.
-She was transported to the ED for evaluation via EMS.
-Resident #1 was sent to the ED and returned to the facility with no new orders.

Review of Resident #1's progress notes dated 05/14/18 revealed:
-The resident had an unwitnessed fall in her room, EMS was called, and the resident was transferred to the ED.
-A physical therapy consult was sent to a contracted Home Health agency.
-The facility staff documented they continued to encourage the resident to use proper footwear and use her walker for safety.

Review of an Incident/Accident report for

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Resident #1 dated 05/17/18 at 9:55 pm revealed:
-Resident #1 had an unwitnessed fall in her room and complained of hip and arm pain.
-Resident #1 was transported to the emergency department for evaluation via EMS.
-Staff noted at the bottom of the incident report Resident #1 was diagnosed with a fracture of the left wrist and follow up with orthopedic.

Review of Resident #1's progress notes dated 05/18/18 revealed:
-The resident returned to the facility from the hospital post fall.
-The resident was diagnosed with a left wrist fracture.
-The resident was given new medication orders for pain.

Review of an Incident/Accident report for Resident #1 dated 05/25/18 at 1:05 am revealed:
-Resident #1 was found in the resident's room sitting on the floor beside the bed.
-She did not have the fall alarm on at the time of the incident and it was documented Resident #1 continued to remove the fall alarm.
-She had a red spot on the top of her head and when facility staff touched the area she complained of pain.
-She was transported to the ED for evaluation via EMS.
-Staff noted at the bottom of the incident report Resident #1 was diagnosed with a urinary tract infection (UTI).

Review of Resident #1's progress notes dated 05/25/18 revealed:
-The resident was found on the floor by the staff.
-The resident did not have the fall alarm on.
-The note also reflected a fall on first shift.
-Third shift staff noted a red spot on the resident's

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head.
-Resident #1 was sent to the ED for evaluation.

Review of Resident #1's hospital discharge summary dated 05/26/18 revealed a diagnosis of Urinary Tract Infection.

Review of Resident #1's progress notes dated 05/26/18 revealed the resident was sent to the ED due to behavioral changes.

Review of Resident #1's hospital discharge summary dated 05/27/18 revealed a diagnosis of hyperglycemia.

Review of an Incident/Accident report for Resident #1 dated 06/06/18 at 2:30 pm revealed:
-Resident #1 had an unwitnessed fall in the hallway.
-Resident #1 sustained a laceration to her right eye.
-The resident's blood pressure was 158/96.
-The resident's heart rate was 83.
-Resident #1 was transported to the ED for evaluation via EMS.

Review of Resident #1's hospital discharge summary dated 06/06/18 revealed:
-The resident was seen due to a fall.
-The resident was diagnosed with a closed fracture of the distal end of the left radius with delayed healing and laceration of the head.

Review of Resident #1's progress notes dated 06/06/18 revealed the staff was assisting the resident with dressing and she fell.

Review of an Incident/Accident report for Resident #1 dated 06/07/18 at 6:22 am revealed:
-Staff was assisting Resident #1 to get dressed

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and the resident stumbled and fell on her bottom.
-Resident #1 denied pain or discomfort.
-The resident's blood pressure was 118/93.
-The resident's heart rate was 70.
-At the bottom of the incident report the facility staff noted to continue to monitor for changes.

Review of Resident #1's Increased Supervision/Monitoring of Resident Post Fall Form dated 06/07/18 revealed the staff documented 30 min safety checks from 6:00 am until 7:00 pm.

Review of physician's notification form dated 06/11/18 revealed:
-Physical therapy order was requested due to frequent falls.
-The Nurse Practitioner noted "awaiting ortho to clear".

Review of an Incident/Accident report for Resident #1 dated 06/12/18 at 1:30 pm revealed:
-Resident #1 had an unwitnessed fall in the hallway.
-Resident #1 sustained a laceration to her right eye.
-The resident's blood pressure was 142/82.
-The resident's heart rate was 58.
-She was transported to the ED for evaluation via EMS.
-Resident #1 was sent to the ED for evaluation and returned to the facility with no new orders.

Review of Resident #1's hospital discharge summary dated 06/12/18 revealed the resident was evaluated for fall and facial laceration.

Review of Resident #1's progress notes dated 06/12/18 revealed the resident was sent to the ED for evaluation post fall.

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D 270	Continued From page 23 Review of a physician notification form dated 06/12/18 revealed: -The resident had an unwitnessed fall in the hallway. -The resident would not sit in the wheelchair with the chair alarm. -The resident continued to take the chair alarm off and hide it. -The resident was sent to the hospital for evaluation for head injury. -The PCP sent back "noted" and signed. Review of an Incident/Accident report for Resident #1 dated 06/15/18 at 6:58 am revealed: -Resident #1 had an unwitnessed fall in her room. -There were no injuries noted. -The resident's blood pressure was 140/85. -The resident's heart rate was 80. Review of Resident #1's hospital discharge summary dated 06/15/18 revealed: -The resident was sent to the ED for evaluation post fall. -The resident also had suture removal due to fall on 06/12/18. Review of Resident #1's progress notes dated 06/15/18 revealed: -The resident had an unwitnessed fall. -The location of the fall was not documented. -The resident was sent to the ED for evaluation. Review of Resident #1's ED visit note dated 06/19/18 revealed the resident had a follow up appointment due to closed fracture of distal end of the left radius. Review of an Incident/Accident report for Resident #1 dated 06/22/18 at 10:00 am	D 270		

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D 270	Continued From page 24 revealed: -Resident #1 had an unwitnessed fall in her room. -Staff performed range of motion. -Resident #1 denied pain or discomfort. -The resident's blood pressure was 130/80. -The resident's heart rate was 60. -The Primary Care Physician (PCP) was onsite at the time of the fall. Review of physician notification form dated 06/22/18 revealed an order for a fall alarm. Interview with a first shift medication aide (MA) on 07/02/18 at 1:05 pm revealed: -When a resident hit their head they were sent to the ED for evaluation. -Resident #1 was changed to a wheelchair, placed on a bed/chair alarm, and placed on one on one staff to decrease risk for falls. -The staff would perform range of motion, obtain vital signs, notify the PCP and family. -Every resident was monitored every 2 hours. Interview with a second shift MA on 07/02/18 at 2:40 pm revealed: -Any resident with a head injury or complaining of pain would automatically be sent to the hospital for evaluation. -The staff would perform range of motion, obtain vital signs, notify the PCP and family. -Resident #1 was changed to a wheelchair, placed on a bed/chair alarm, and placed on one on one staff to decrease risk for falls. Interview with a second shift personal care aide (PCA) on 07/02/18 at 3:10 pm revealed: -She would report falls to the Supervisor. -The supervisor would obtain vitals. -If the resident hit their head the resident would be sent to the ED for evaluation.	D 270		

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D 270	Continued From page 25 -Resident #1 had an assigned a staff member and chair alarm to decrease risk for falls. -One on one supervision was implemented a few weeks ago. Interview with the Administrator and the Resident Care Coordinator on 07/03/18 at 8:30 am revealed: -Resident #1's family member came into the facility and took all shoes that may have been causing falls. -Resident #1 was using a walker and changed to a wheelchair to decrease falls. -A chair and bed alarm was ordered to help reduce risk for falls. -Resident #1 took several chair alarms apart and the current chair alarm was purchased by the resident's family member. -Resident #1 was placed on one on one observation on 06/17/18, which meant a PCA was assigned to watch Resident #1 for the entire shift. -The chair alarm had a monitor that staff could keep in their pocket. Interview with Resident #1's PCP on 07/02/18 at 10:10 am revealed: -She knew Resident #1 had 9 falls between April-June 2018. -The facility staff did not notify her after each fall. -She found out about the falls when she visited the facility. -She expected to be notified after each fall. -A physical therapy consult was ordered for Resident #1 but she could not recall the order date. -A chair alarm and bed alarm was ordered around two months ago. -She felt the resident's declining mental condition was possibly contributing to the falls; as well as hyperglycemia.	D 270		

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D 270	Continued From page 26 -She knew Resident #1 had a fractured wrist due to a fall. Interview with Resident #1's family member on 07/06/18 at 1:35 pm revealed: -The staff notified the family after incidents or if the resident had to be sent to the ED. -In an attempt to decrease falls, the resident was changed from a walker to a wheelchair and a chair alarm was ordered. -He attempted to visit once a month. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Refer to interview with a first shift medication aide (MA) on 07/02/18 at 1:10 pm. Refer to interview with a personal care aide (PCA) on 07/02/18 at 2:55 pm. Refer to interview with another first shift MA on 07/02/18 at 3:05 pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/02/18 at 4:45 pm. Refer to interview with Administrator on 07/03/18 at 4:30 pm. _____ Interview with a first shift medication aide (MA) on 07/02/18 at 1:10 pm revealed: -When a resident hit their head they were sent to the ED for evaluation. -Staff would stay with the resident while another staff would call 911. -The staff would perform range of motion on the resident, obtain vital signs, notify the PCP and the residents family.	D 270		

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D 270	Continued From page 27 -The staff were also expected to fax the PCP. -The staff were expected to document in the 24 hour log and the residents' records. -The staff would report off the incident to the next shift. -The resident would be placed in the "hot box" when they return from the hospital. -All residents were monitored at least every 2 hours. Interview with a personal care aide (PCA) on 07/02/18 at 2:55 pm revealed: -The PCAs were instructed to notify the medication aides (MAs) when a resident fell. -The PCAs were not allowed to move the resident until told to do so by the MAs. -The PCAs did not document anything on residents, only the MAs documented resident care. -There was a paper to document every fifteen minute checks, but it is no longer used. -The PCAs made every two hours rounds to check residents, and to change incontinence briefs. -There was a fall risk list and there were currently four residents on the list. -There were four aides on duty during the day shift and each aide was assigned to one of the fall risk residents. -The assignment to fall risk residents was started recently, she did not recall the exact date but was it during the month of June 2018. -The aides were to "keep fall risk residents in their eyesight at all times." -If an aide took a break, the aide had to tell another aide on duty so that the fall risk resident was watched. Interview with another first shift MA on 07/02/18 at 3:05 pm revealed:	D 270		

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-Residents who were fall risks were placed on a list.
-Each resident on the fall risk list was assigned to one of the four PCAs on shift.
-The PCAs were assigned residents by the MAs.
-The assignment sheets were kept in the medication room and completed by the MAs at the beginning of the shift.
-The assignment of a PCA to the fall risk residents was started June 2018.

Interview with the Resident Care Coordinator (RCC) on 07/02/18 at 4:45 pm revealed:
-The facility staff did not utilize the every fifteen minute checks or the documentation used for the frequent checks.
-The facility staff utilized a one to one assignment of fall risk residents that started June 2018.
-A PCA was assigned to watch one fall risk resident.
-The facility staff had not received a class from Hospice services regarding how the Hospice residents should be managed when exhibiting anxious behaviors that might lead to falls.

Interview with the Administrator on 07/03/18 at 4:30 pm revealed:
-The facility did have a falls policy.
-For each fall, the facility notified the resident's physician, family member, the MA completed an incident report, the resident was put on the "hot box" list, and the MAs documented on progress notes once each shift for three days following the fall.
-Continue to monitor written at the bottom of the incident reports meant that the staff would continue to watch the resident who fell because they were placed on the "hot box" list.
-The facility staff made rounds every two hours.
-Residents on the "hot box" list were placed on

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D 270	Continued From page 29 one to one watching by a PCA. -Some residents were seen by physical therapy due to falls, other residents received new medical equipment like walkers, and others received fall mats, it just depended on the resident. -The staff were expected to send residents to the hospital for evaluation if they hit their head or had obvious injures. -Staff were expected to check on every resident in the facility at least every two hours. The facility failed to supervise confused, disoriented, and semi-ambulatory residents (#1, #2 and #5) who experienced multiple repeated falls, causing multiple bruises, and a left wrist fracture (#1), a broken elbow (#2), and subdural hematoma (#5); resulting in substantial risk of physical harm to residents and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/03/18 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED August 5, 2018.	D 270		
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	D 358		

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D 358	Continued From page 30 and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to administer medications as prescribed by a licensed prescribing practitioner for 2 of 7 sampled residents observed during the medication pass with errors related to crushing medications that should not be crushed for vitamin B12, metoprolol extended release, isosorbide extended release (#2), and improper dosing for sertraline liquid (#6); and 3 of 6 sampled residents related to furosemide (#2), morphine sulfate 30 mg ER, morphine sulfate oral solution, and lorazepam oral solution (#5), and atenolol (#6). The findings are: 1. The medication pass error rate was 16 % as evidenced by the observation of 4 errors out of 25 opportunities during the 8:00 am medication pass on 06/29/18. a. Review of Resident #2's current FL-2 dated 05/12/18 revealed: -Diagnoses included atrial fibrillation, coronary artery disease, combined systolic and diastolic congestive heart failure, acute kidney injury superimposed on chronic kidney disease, dementia, hypertension, ischemic cardiomyopathy, status-post triple vessel bypass, stroke, anasarca, and vitamin B12 deficiency. -An order for vitamin B12 (used to treat vitamin B12 deficiency) 1000mcg tablet take one tablet daily.	D 358		

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-An order for metoprolol tartrate (used to treat hypertension and congestive heart failure) 25 mg daily.
-An order for isosorbide mononitrate (used to treat coronary artery disease) 30 mg take one tablet daily.

Review of Resident #2's June 2018 electronic medication administration record (eMAR) revealed:
-An entry for isosorbide MN ER 30 mg tablet take one tablet daily, scheduled for 9:00 am and do not crush in capital letters, and documented as administered on 06/29/18 at 9:00 am.
-An entry for metoprolol succinate ER 25 mg take one tablet daily, scheduled for 9:00 am and do not crush in capital letters, and documented as administered on 06/29/18 at 9:00 am.
-An entry for vitamin B-12 TR 1000 mcg tablet take one tablet daily, scheduled for 9:00 am and do not crush in capital letters, and documented as administered on 06/29/18 at 9:00 am.

Review of Resident #2's physicians' order dated 07/01/18 revealed an order to crush all appropriate medications and mix in applesauce or pudding.

Observation of the medication pass on 06/29/18 at 8:28 am revealed:
-The medication aide (MA) prepared the medications for Resident #2 by popping the blister tablets of each medication package.
-The total number of tablets were counted as thirteen including isosorbide, metoprolol, succinate, and vitamin B12 .
-The tablets were in a souffle medication cup and the thirteen tablets were poured into a small clear plastic bag and crushed in the pill crusher.
-All the crushed tablets were, placed in pudding in

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a souffle medication cup.
-The crushed tablets and pudding mixture were administered to Resident #2 at 8:33 am.
-The medications were signed off as administered by the MA immediately after administration on the computer.

Crushing medications with instructions not to crush may cause serious side effects, prevent medications from working properly and slow down recovery from illness.

Observation of Resident #2's medication on hand on 06/29/18 at 12:42 pm revealed:
-The vitamin B12 blister packet medication label indicated do not crush and available for administration.
-The metoprolol succinate ER blister packet medication label indicated do not crush and available for administration.
-The isosorbide mononitrate blister packet medication label indicated do not crush and available for administration.

Interview with the MA who performed the medication pass on 06/29/18 at 12:50 pm revealed:
-Medications were administered by first looking at the order on the screen, and then she compared the order with the medication available for the resident three times.
-The pharmacy indicated on the eMAR when a medication was not allowed to be crushed.
-The pharmacy also placed a label on the medication package to indicate do not crush.
-Resident #2 did have labels for do not crush on the metoprolol and the vitamin B12.
-She did not know the isosorbide was not to be crushed.
-She did not see the do not crush on the

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isosorbide.
-She did not see the words do not crush for each medication on the eMAR.
-She did not crush the metoprolol and vitamin B12.

Interview with the contracted pharmacy on 07/02/18 at 11:50 am revealed:
-The pharmacy began dispensing for the facility on 04/01/18.
-The pharmacy provided a medication administration policy to the facility during onboarding in March 2018.
-The pharmacy provided classes to the facility staff each month on a variety of topics including medication administration, insulin, eMAR.
-The last class was on 06/14/18 or 06/26/18, she was unsure.
-The pharmacy had taught a total of four classes about crushing medications.
-Resident #2's eMAR entries and the medication package were labeled with do not crush.
-To assist the facility staff a list of medications not to be crushed would be given to the facility and placed in the medication room for the MAs to use.

Interview with the Resident Care Coordinator (RCC) on 06/29/18 at 3:30 pm revealed:
-She was responsible for the MAs.
-She expected the MAs to administer medications by taking all the medication due at a specific time out of the medication cart, checking each medication against the eMAR, check the right resident, right dose, right time, measure liquid medications at eye level only, and note labels from pharmacy such as do not crush.
-The MAs were to report to her if there were discrepancies between the eMAR entry and the medication label.
-The MAs were not to crush any medication

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without a physician's order to crush the medications and this was taught in the MA course.
-A list of medications not to be crushed was not available for use by the MAs.
-Resident #2's hospice provider would be notified, and the resident would be observed for twenty-four hours.

Interview with the Administrator on 06/29/18 at 3:25 pm revealed:
-The pharmacy labeled medication with do not crush when appropriate.
-The pharmacy indicated on the eMAR do not crush when appropriate.
-She expected the MAs to read the order and the medication label prior to administration.

b. Review of Resident #6's current FL-2 dated 06/04/18 revealed:
-Diagnosis included anxiety.
-An order for sertraline (used to treat depression) 20 mg/ml seven milliliters daily.

Review of Resident #6's six month physician medication review dated 06/22/18 revealed a diagnosis of depression.

Review of Resident #6's June 2018 electronic medication administration record (eMAR) revealed:
-An entry for sertraline 20 mg/ml oral concentrate give seven milliliters daily for depression, scheduled at 9:00 am.
-An entry for polyethylene glycol mix one capful in eight ounces of fluid daily, scheduled at 9:00 am.

Observation of the medication pass on 06/29/18 at 8:40 am revealed:
-The medication aide (MA) poured five milliliters

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of clear liquid into a thirty milliliters disposable medication cup from a bottle labeled sertraline.
-The disposable medication cup was poured into a four ounce disposable cup that contained polyethylene glycol and water.
-The MA took the four ounce disposable cup, another disposable medication cup with tablets to Resident #6.
-Resident #6 refused the liquid medication in the four ounce disposable cup.

Interview with the MA on 06/29/18 at 12:50 pm revealed:
-Resident #6's order for sertraline liquid indicated five milliliters and she prepared five milliliters of sertraline liquid to administer during the morning medication pass.
-Resident #6 had refused the medication.
-She did not know Resident #6's current order for sertraline liquid indicated administration of seven milliliters.
-The label for sertraline liquid available on the cart indicated five milliliters.
-There was another box that contained a bottle of sertraline liquid with a label that indicated six milliliters available on the medication cart.

Interview with the contracted pharmacy manager on 06/29/18 at 11:02 am revealed there was an order in the computer system dated 05/18/18 for Zoloft 20 mg/ml to give seven milliliters daily.

Interview with the contracted pharmacist on 07/02/18 at 12:00 noon revealed:
-The pharmacy dispensed sertraline liquid with instructions to administer 5 ml first, with an order date of 04/25/18.
-The pharmacy received a new order for sertraline liquid give 6 ml daily and dispensed another bottle, with an order date of 05/05/18.

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D 358	Continued From page 36 -The pharmacy received another new order dated 06/04/18 for sertraline liquid to give seven milliliters daily and the insurance would not pay for another bottle. -The pharmacy did not issue a new label and relabeling a medication was against the pharmacy's policy. -The facility was given small labels that stated "direction change" and the labels were used for instances like this one with the sertraline for Resident #6. -The pharmacy did not tell the facility staff during the medication cart audit two weeks ago about the difference in the sertraline medication label and the eMAR entry for Resident #6's sertraline. -The pharmacy did not want to continue to have to prompt the MAs, the pharmacy expected the MAs to administer the correct dose based on the eMAR. Interview with the (Resident Care Coordinator) RCC on 06/29/18 at 3:30 pm revealed: -She did not know about the difference in Resident #6's sertraline label and Resident #6's eMAR entry for sertraline. -She expected the MAs to read the medication, the dose, the label, and the eMAR before administering medication. -Pharmacy completed a medication cart audit two weeks ago but did not report any discrepancies about Resident #6's medications or medication orders. -She knew about the labels that indicated direction change but was unsure if they were available on the medication carts. Interview with the Administrator on 06/29/18 at 3:25 pm revealed: -A medication cart audit was completed by the former RCC approximately three weeks ago.	D 358		

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-No discrepancies were reported to her for Resident #6.
-The pharmacy completed a medication cart audit and no discrepancies were reported to her for Resident #6.

2. Review of Resident #2's current FL-2 dated 05/12/18 revealed:
-Diagnoses included atrial fibrillation, coronary artery disease, combined systolic and diastolic congestive heart failure, acute kidney injury superimposed on chronic kidney disease, dementia, hypertension, ischemic cardiomyopathy, status-post triple vessel bypass, stroke, anasarca, and vitamin B12 deficiency.
-An order for furosemide (used to treat congestive heart failure) 40 mg take one tablet two times daily.

Review of Resident #2's record revealed an order dated 03/05/18 for furosemide 40 mg tablet take one and a half tablets (60 mg) two times daily.

Review of six month physician's medication review dated 06/26/18 revealed an order for furosemide 40 mg tablet take one tablet two times daily.

Review of Resident #2's May 2018 printed electronic medication administration record (eMAR) revealed:
-There were two entries for furosemide.
-There was an entry for furosemide 40 mg tablet take one tablet two times daily, and scheduled at 9:00 am and 5:00 pm, and documented as administered on 05/14/18 at 5:00 pm.
-Furosemide 40 mg one tablet two times daily was documented as administered from 05/14/18 at 5:00 pm to 05/31/18 at 5:00 pm with the exception of three doses which were documented

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as refused by Resident #2 on 05/16/18, 05/17/18 and 05/20/18 at 9:00 am.
-There was entry furosemide 40 mg tablet take one and a half tablets (60 mg) daily, and scheduled at 9:00 am, and documented as administered from 05/01/18 to 05/31/18.
-Furosemide 40 mg one and half tablets daily was documented as refused by Resident #2 on 05/02/18, 05/04/18, 05/07/18, 05/09/18, 05/10/18, 05/11/18, 05/12/18, 05/16/18, 05/17/18, and 05/20/18

Review of Resident #2's June 2018 eMAR revealed:
-There were two entries for furosemide.
-There was an entry for furosemide 40 mg tablet take one tablet two times daily, and scheduled at 9:00 am and 5:00 pm.
-Furosemide 40 mg was documented as administered from 06/01/18 to 06/29/18 at 9:00 am, with the exception of one dose which was documented as refused by Resident #2 on 06/08/18.
-Furosemide 40 mg was documented as administered from 06/01/18 to 06/28/18 at 5:00 pm.
-There was an entry for furosemide 40 mg tablet take one and a half tablets (60 mg) daily, and scheduled at 9:00 am.
-Furosemide 40 mg one and a half tablets daily was documented as administered from 06/01/18 to 06/05/18.
-There was a small box with yellow highlighted "DC'd" beside the entry for Furosemide 40 mg one and a half tablets on the MAR.

Review of Resident #2's blood pressure readings revealed:
-Resident #2's blood pressure on 05/25/18 was 142/70.

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D 358	Continued From page 39 -Resident #2's blood pressure on 06/06/18 was 153/94. Observation of Resident #2's medication on hand on 06/29/18 at revealed there was a blister package for furosemide 40 mg one tablet twice daily dispensed on 06/05/18 and ten of sixty tablets were available for administration. Interview with the contracted pharmacy on 07/03/18 at 2:05 pm revealed: -The pharmacy did not note any discrepancies because other facilities had residents with two orders of medications. -The pharmacy did dispense both orders for furosemide. -Furosemide 40 mg one and a half tablet order was dispensed to accommodate the stop date of 06/06/18 for this order. -The facility staff needed to communicate to the pharmacy that the 05/12/18 furosemide order was a "readmission" order for the previous furosemide order to discontinue. -The facility staff needed to obtain a written discontinue order for the 03/05/18 furosemide order for it to be stopped when the 05/12/18 order was received. Interview with a first shift medication aide (MA) on 07/03/18 at 12:35 pm revealed: -She did not recall two furosemide orders or entries on the May and June eMAR for Resident #2. -She verified her initials on the printed May 2018 eMAR for 05/17/18, 05/21/18, and 05/31/18 for both entries for furosemide. -She verified her initial on the printed June 2018 eMAR for 06/04/18 for both entries for furosemide. -She did not recall administering furosemide to	D 358		

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Resident #2 from both orders.

Interview with the Nurse Practitioner (NP) on 07/03/18 at 10:32 am revealed:
-She was told by pharmacy on 07/03/18 that Resident #2 had two active orders during May 2018 and June 2018 for furosemide.
-She did not believe Resident #2 had received both doses of furosemide because Resident #2 had not shown signs and symptoms of dehydration.
-Resident #2 had a history of edema and had been hospitalized due to edema because of heart failure in the past.

Interview with the Resident Care Coordinator (RCC) on 07/03/18 at 1:00 pm revealed:
-She did not know Resident #2 had two active orders for furosemide.
-The pharmacy did not notify her of the two active orders for furosemide.
-She expected the MAs to read the eMAR carefully and notify her of any discrepancies.

Interview with the Administrator on 07/03/18 at 1:05 pm revealed:
-She was not told of any discrepancies by pharmacy after their medication cart audit.
-She was not told of any discrepancies by the former RCC after a medication cart audit was completed.
-She was not told of any eMAR problems by the staff or pharmacy.
-She did not know there were two entries for furosemide on Resident #2's eMAR.

3. Review of Resident #6's current FI-2 dated 06/04/18 revealed:
- Diagnoses included vascular dementia, hypertension, history of stroke, and

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cerebrovascular disease.
- An order for atenolol (used to treat hypertension) 25 mg tablet one-half tablet daily.

Review of Resident #6's June 2018 electronic medication administration record (eMAR) revealed:
-An entry for atenolol 25 mg tablet take ½ tablet (12.5 mg) daily, scheduled for 9:00 am.
-There was documentation of administration from 06/01/18 to 06/28/18.
-There was documentation of refusal of the atenolol 25 mg 1/2 tablet on 06/08/18.

Observation of Resident #6's medications on hand on 06/29/18 at 12:37 pm revealed:
-A blister package of whole white tablets labeled atenolol 25 mg tablets take ½ tablet daily 30 tablets dispensed on 06/05/18.
-There were six remaining tablets in the atenolol blister package.

Interview with the first shift medication aide (MA) on 06/29/18 at 8:46 am and 12:50 pm revealed:
-The atenolol was provided in whole tablets.
-A pill splitter was not available for use during the medication pass.
-She notified the Resident Care Coordinator (RCC) that whole atenolol tablets were provided for Resident #6 and half tablets were needed.
-She faxed an "as soon as possible" request to pharmacy for half tablets of atenolol 25 mg on 06/29/18 at 9:37 am.
-She planned to obtain an order from Resident #6's Nurse Practitioner (NP) to administer the atenolol at a different time.
-The pharmacy delivered the half tablets of atenolol on 06/29/18 at 10:30 am.

Interview with the contracted pharmacy manager

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on 06/29/18 at 11:02 am revealed:
-Atenolol 25 mg ½ tablets were dispensed on 05/29/18 and delivered with the cycle fill around the beginning of the month.
-He could not provide an explanation for the whole tablets of atenolol that were on hand for Resident #6
-The pharmacy records indicated a request was made by the facility to send ½ tablets on 06/29/18.

Interview with the contracted pharmacist on 07/02/18 at 11:55 am revealed:
-There was a previous order for atenolol 25 mg give one tablet.
-The facility was sent six tablets to provide the facility with enough doses until the cycle fill date.
-The cycle had already ran and the delivery totes were packed with the orders available at the time of the cycle fill.
-When the atenolol order was changed at the mid-cycle fill from one tablet to ½ tablet, the previous atenolol order amount was already packed inside the delivery totes and was not removed from the pharmacy delivery totes.

Interview with the RCC on 06/29/18 at 3:30 pm revealed:
-The first shift MA notified her about the atenolol order for Resident #6 versus the atenolol on hand for Resident #6 on 06/29/18.
-She did not know the whole tablets of atenolol on hand for Resident #6 were administered by the MAs.
-She expected the MAs to read the eMAR carefully and notify her of any discrepancies.

Interview with the Administrator on 06/29/18 at 3:25 pm revealed:
-A medication cart audit was completed by the

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former RCC approximately three weeks ago.
-No discrepancies were reported to her for Resident #6.
-The pharmacy completed a medication cart audit and no discrepancies were reported to her for Resident #6.

4. Review of Resident #5's current hospital FL-2 dated 03/02/18 revealed:
-Diagnoses included lymphoid leukemia, chronic pain syndrome and acute subdural hematoma.
-There was a physician order for morphine sulfate 30 mg extended release (ER) two time a day. (Morphine sulfate is a narcotic pain reliever used to treat severe pain.)
-There was an order for lorazepam 1 mg tablet one every 3 hours as needed for agitation/anxiety. (Lorazepam is a controlled substance used to treat increased anxiety or agitation.)

a. Review of Resident 5's Hospice physicians' orders dated 03/27/18 revealed an order for morphine sulfate 30 mg ER tablets to be discontinued, and morphine sulfate 5 mg/0.25 ml prefilled syringes give 10 mg (2 syringes) every 4 hours ATC (around the clock) and 5 mg (1 syringe) every hour as needed for pain.

Review of Resident #5's March 2018 medication administration record (MAR) and electronic medication administration record (eMAR) revealed:
-On the MAR, there was an entry for one morphine sulfate 30 mg ER tablet and documented as administered at 8:00 am on 03/27/18 on the MAR.
-On the eMAR, there was an entry for one morphine sulfate 30 mg ER tablet and documented as administered at 8:00 pm on

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D 358	Continued From page 44 03/27/18, one tablet at 8:00 am on 03/28/18, and one tablet at 8:00 pm 03/28/18. -There were a total of 5 tablets documented as administered from 03/27/18 to 03/28/18. Review of Resident #5's pharmacy generated controlled substance count sheet (CSCS) [CSCS sheets are used to track administration of a medication by tracking a decreasing inventory count] for morphine sulfate 30 mg ER tablets revealed: -There were 60 morphine sulfate 30 mg ER tablets dispensed on 02/23/18. -There was one tablet at 8:00 am and 8:00 pm on 03/27/18 and, one tablet at 8:00 am on 03/28/18 signed out as administered. -There were a total of 3 tablets signed out as administered from 03/27/18 to 03/28/18. Review of Resident #5's March 2018 MAR and electronic medication administration record (eMAR) revealed: -There was a handwritten entry for morphine sulfate 5 mg/0.25 ml prefilled syringes give 10 mg (2 syringes) every 4 hours around the clock with 2 doses documented as administered on 03/28/18 (no times documented), and one dose documented as administered on 03/29/18 (no time documented). -There was a handwritten entry for morphine sulfate 5 mg/0.25 ml prefilled syringes give 5 mg (1 syringe) every 1 hour as needed for pain/dyspnea with no doses documented as administered. -There was a printed entry for morphine sulfate 5 mg/0.25 ml prefilled syringes give 10 mg (2 syringes) every 4 hours ATC (around the clock) (scheduled time of administration) and 5 mg (1 syringe) every hour as needed (prn) for pain (prn time of administration) were both on the eMAR as	D 358		

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one entry beginning on 03/29/18 at 9:46 am. There was one dose of 2 syringes (10 mg) documented on 03/29/18 on the eMAR under the prn dosing at 8:29 pm.
-There were a total of 5 doses documented as administered on 03/29/18.

Review of Resident #5's handwritten CSCS for morphine sulfate 5 mg/0.25 ml prefilled syringes revealed:
-There was documentation for a beginning balance of 20 prefilled syringes.
-The first line of the CSCS sheet was blank for who administered the medication and the time the medication was administered, but the balance decreased by one.
-On 03/28 at 9:30 (no am or pm indicated), 1 oral syringe was documented as administered.
-On 03/28 at 1:30 (no am or pm indicated), 1 oral syringe was documented as administered.
-On 03/28 at 8:30 (no am or pm indicated), 1 oral syringe was documented as administered.
-On 03/28 at 9:30 (no am or pm indicated), 1 oral syringe was documented as administered.
-On 03/29 at 2:00 am, 1 oral syringe was documented as administered.
-On 03/29 at 6:00 am, 1 oral syringe was documented as administered.
-On 03/29 at 10:30 am, 1 oral syringe was documented as administered.
-On 03/29 at 8:29 (no am or pm indicated), 2 oral syringes (10 mg) were documented as administered.
-There were a total of 9 doses (10 syringes) documented as administered from 03/28/18 to 03/29/18.
-There were 10 morphine sulfate 5 mg/0.25 ml prefilled syringes remaining on 03/29/18.

Based on review of Resident #5's March 2018

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MAR and eMAR compared to the CSCS for morphine sulfate 5 mg/0.25 ml prefilled syringes and the physician's orders, Resident #5 should have received scheduled doses of 10 mg (2 syringes) morphine sulfate 5 mg/0.25 ml prefilled syringes at 8:00 pm on 03/28/18, 2 syringes at 12:00 am on 03/29/18, 2 syringes at 4:00 am on 03/29/18, 2 syringes at 8:00 am on 03/29/18, 2 syringes at 12:00 pm on 03/29/18, 2 syringes at 4:00 pm on 03/29/18, and 2 syringes at 8:00 pm on 03/29/18 for a total of 14 syringes.

Review of the Hospice notes for Resident #5 revealed:
-The resident was in declining health.
-Resident #5 had been on Hospice previously and was placed on Hospice again beginning 03/02/18.
-Resident #5 was seen by Hospice at least once daily beginning 03/13/18 and continuing until 03/29/18.
-Resident #5 passed away late in the night (11:38 pm) on 03/29/18.
-On 03/29/18 at 2:48 am, the facility was contacted via phone by the Hospice nurse on behalf of a family member regarding Resident #5 not receiving morphine sulfate 5 mg/0.25 ml prefilled syringes as ordered. There was documentation the medication aide (MA) on duty was questioned by the Hospice nurse regarding the administration of morphine sulfate and the MA stated she did not have an order to administer the morphine sulfate syringes that she could locate.
-There was documentation by the Hospice nurse for the MA "to administer med".

Review of Resident #5's record revealed a controlled substance count sheet (CSCS) documented as "assisted with the disposal of the medications" signed by the Hospice nurse on 03/30/18 at 3:20 am listing 10 morphine sulfate 5

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mg/0.25 ml prefilled syringes disposed of by the nurse and a MA.

Telephone interview on 07/06/18 at 9:15 am with the Hospice Quality Assurance Supervisor revealed 20 morphine sulfate 5 mg/0.25 ml prefilled syringes had been delivered to the facility on 03/27/18 at 11:30 pm by an on-call Hospice nurse.

Interview on 07/02/18 at 11:55 am with the Pharmacist for the contract pharmacy revealed:
-The facility staff started using electronic MARs on 03/27/18.
-The staff could document on the eMAR and/or the MAR during the transition to the eMAR system.
-The pharmacy entered the orders for the transition to the eMAR.
-The Resident Care Coordinator (RCC) was able to enter orders into the eMAR system at the facility.
-The RCC had entered the Hospice order for morphine sulfate 5 mg/0.25 ml prefilled syringes give 10 mg (2 syringes) every 4 hours ATC (around the clock) (scheduled time of administration) and 5 mg (1 syringe) every hour as needed (prn) for pain (prn time of administration) were both on the eMAR as one entry for the scheduled time of administration. The order should have been entered as 2 separate entries.

Interview on 07/02/18 at 12:25 pm with the Administrator revealed:
-The RCC was responsible to audit the residents' MARs and eMARs for medication administration, including auditing the CSCS documentation compared to the MARs and eMARs to assure medications were administered as ordered.

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-The RCC working now had only been at the facility since June 2018.
-The former RCC would have been responsible for the audits.
-The former RCC was not available for interview because the number given was not working.

Interview on 07/03/18 at 11:00 am with a MA revealed:
-She administered Resident #5 a morphine sulfate 30 mg ER tablet on 03/28/18 at 8:00 am because she did not see the order from 03/27/18 at 11:30 pm. (The order was date stamped 03/28/18 at 7:40 am).
-She did not document the morphine sulfate ER 30 mg on the MAR but she did document on the CSCS.
-She gave 5 mg (1 syringe) every hour as needed for pain/dyspnea at 9:30 am after the Hospice order was received, and one 5 mg (1 syringe) every hours as needed for pain for pain/dyspnea at 1:30 pm on 03/28/18. She documented both doses on the CSCS but only one dose on the handwritten entry on the MAR.
-She did not administer 2 syringes (for 10 mg dose) when she worked on 03/29/18 because she did not think the eMAR was correct; she did not clarify the order.

Attempted telephone interview on 07/03/18 at 12:40 pm with the MA working on 03/28/18 was unsuccessful.

Interview on 07/03/18 at 3:30 pm with a Hospice nurse revealed:
-The original Hospice nurse assigned to Resident #5 was no longer working at Hospice.
-She was working the night Resident #5 was taken off regular medications and switched to liquid morphine and lorazepam.

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-The Hospice nurse transcribed the orders to the resident's MARs at the facility on 03/27/18.
-An order was sent to the facility the same night (03/27/18) at 11:35 pm.
-The facility received a second faxed order on 03/28/18 at 7:28 am because the facility staff said they could not locate the original Hospice order.

Interview on 07/03/18 at 3:50 pm with the RCC revealed:
-She was hired at the facility in June 2018.
-Resident #5 was not at the facility when she was hired.
-She had been working with the MAs regarding administering medications as ordered since she came to the facility.

Telephone interview on 07/06/18 at 11:02 am with a family member revealed:
-She stayed most of the last 3 days the resident was at the facility (03/27/18 to 03/29/18).
-She had spoken with the MAs regarding administering Resident #5's morphine sulfate 5 mg/0.25 ml prefilled syringes as ordered.
-She knew Resident #5 did not receive morphine sulfate 5 mg/0.25 ml prefilled syringes give 10 mg (2 syringes) every 4 hours around the clock beginning 03/27/18 at 11:00 pm.

b. Review of Resident 5's Hospice physicians' orders dated 03/27/18 revealed an order for lorazepam tablets to be discontinued, and lorazepam 0.5/ 0.25 ml prefilled syringe give 1 mg orally or sublingually (under the tongue) every 3 hours as needed for agitation, anxiety, or restlessness.

Review of Resident #5's March 2018 MAR and eMAR revealed:
-There was a handwritten entry for lorazepam

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0.5/ 0.25 ml prefilled syringe 1 mg orally or sublingually every 3 hours as needed for agitation, anxiety, or restlessness on the MAR.
-There were no doses of lorazepam 0.5/ 0.25 ml prefilled syringe documented as administered on the MAR.
-There was a printed entry for lorazepam 0.5/ 0.25 ml prefilled syringe 1 mg orally or sublingually every 3 hours as needed for agitation, anxiety, or restlessness on the eMAR beginning 03/29/18 at 9:58 am. The medication was scheduled for as needed (prn) administration.
-There were no doses of lorazepam 0.5/ 0.25 ml prefilled syringe documented as administered on the eMAR.

Telephone interview on 07/06/18 at 9:15 am with the Hospice Quality Assurance Supervisor revealed 20 lorazepam 0.5/ 0.25 ml prefilled syringes had been delivered to the facility on 03/27/18 around midnight by an on-call Hospice nurse.

Review of Resident #5's record revealed there was not a controlled substance count sheet (CSCS) for lorazepam 0.5/ 0.25 ml prefilled syringes.

Review of Resident #5's CSCS revealed "assisted with the disposal of the medications" signed by the Hospice nurse on 03/30/18 at 3:20 am listing 18 lorazepam 0.5/ 0.25 ml prefilled syringes disposed by the nurse and a MA.

Based on review of Resident #5's MAR and eMAR, (with no CSCS for lorazepam 0.5/ 0.25 ml prefilled syringe and the physician's orders, it could not be determined if Resident #5's lorazepam 0.5/ 0.25 ml prefilled syringes were

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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 51 administered as needed within the ordered parameters. Interview on 07/02/18 at 12:25 pm with the Administrator revealed: -The RCC was responsible to audit the residents' MARs and eMARs for medication administration, including auditing the CSCS documentation compared to the MARs and eMARs to assure medications were administered as ordered. -The RCC working now had only been at the facility since June 2018. -The former RCC would have been responsible for the audits. -The former RCC was not available for interview because the phone number provided did not work. Attempted telephone interview on 07/03/18 at 12:40 pm with the MA working on 03/28/18 was unsuccessful. Interview on 07/03/18 at 3:30 pm with a Hospice nurse revealed: -The original Hospice nurse assigned to Resident #5 was no longer working at Hospice. -She was working the night Resident #5 was taken off regular medications and switched to liquid morphine and lorazepam. -The Hospice nurse transcribed the orders to the resident's MARs at the facility on 03/27/18. -An order was sent to the facility the same night (03/27/18) at 11:35 pm. -The facility received a second faxed order on 03/28/18 at 7:28 am because the facility staff said they could not locate the original Hospice order. Interview on 07/03/18 at 3:50 pm with the RCC revealed: -She was hired at the facility in June 2018.	D 358		

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D 358	Continued From page 52 -Resident #5 was not at the facility when she was hired. -She had been working with the MAs regarding administering medications as ordered since she came to the facility. Telephone interview on 07/06/18 at 11:02 am with a family member revealed: -She stayed most of the last 3 days the resident was at the facility (03/27/18 to 03/29/18). -She had spoken with the MAs regarding administering Resident #5's medications as ordered. -She did not believe Resident #5 was receiving his medications as ordered. Interview on 07/03/18 at 4:45 pm with the Administrator revealed: -She did not know where there CSCS for lorazepam 0.5/ 0.25 ml prefilled syringes could be located. -She depended on the RCC to oversee the MAs and assure medications were administered as ordered. _____ The facility failed to ensure medications were administered as ordered related to a resident observed during the medication pass with errors related to crushing medications that should not be crushed; including vitamin B12, metoprolol extended release, isosorbide extended release (#2) improper dosing for sertraline liquid (#6) which affects the absorption of the medication and could lead to overdoses of medications, sub-therapeutic concentration of medication and failed therapy; and not receiving medications as ordered related to furosemide (#2), morphine sulfate 30 mg ER, morphine sulfate oral solution, and lorazepam oral solution (#5), and atenolol (#6). This noncompliance placed the residents at	D 358		

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D 358	Continued From page 53 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 06/28/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 05, 2018.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by:	D 367		

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D 367	Continued From page 54 Based on observation, record reviews, and interviews, the facility failed to assure the medication administration record (MAR) and electronic medication administration records (eMARs) were accurate for 1 of 5 sampled residents (#5)) regarding morphine sulfate oral solution and lorazepam oral solution. The findings are: Review of Resident #5's current hospital FL-2 dated 03/02/18 revealed: -Diagnoses included lymphoid leukemia, chronic pain syndrome and acute subdurial hematoma. -There was a physician order for morphine sulfate 30 mg extended release (ER) two times a day. (Morphine sulfate is a narcotic pain reliever used to treat severe pain.) -There was an order for lorazepam 1 mg tablet one every 3 hours as needed for agitation/anxiety. (Lorazepam is a controlled substance used to treat increased anxiety or agitation.) 1. Review of Resident 5's Hospice physicians' orders dated 03/27/18 revealed an order for morphine sulfate 30 mg ER tablets to be discontinued, and morphine sulfate 5 mg/0.25 ml prefilled syringes give 10 mg (2 syringes) every 4 hours ATC (around the clock) and 5 mg (1 syringe) every hour as needed for pain. Review of Resident #5's March 2018 medication administration record (MAR) and electronic medication administration record (eMAR) revealed: -On the MAR, there was an entry for one morphine sulfate 30 mg ER tablet and documented as administered at 8:00 am on 03/27/18 on the MAR.	D 367		

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 367	Continued From page 55 -On the eMAR, there was an entry for one morphine sulfate 30 mg ER tablet and documented as administered at 8:00 pm on 03/27/18, one tablet at 8:00 am on 03/28/18, and one tablet at 8:00 pm 03/28/18. Review of Resident #5's pharmacy generated controlled substance count sheet (CSCS) [CSCS sheets are used to track administration of a medication by tracking a decreasing inventory count] for morphine sulfate 30 mg ER tablets revealed: -There were 60 morphine sulfate 30 mg ER tablets dispensed on 02/23/18. -There was one tablet at 8:00 am and 8:00 pm on 03/27/18 and, one tablet at 8:00 am on 03/28/18 signed out as administered. Review of Resident #5's March 2018 medication administration record (MAR) and electronic medication administration record (eMAR) revealed: -There was a handwritten entry for morphine sulfate 5 mg/0.25 ml prefilled syringes give 10 mg (2 syringes) every 4 hours around the clock with 2 doses (4 syringes) documented as administered on 03/28/18, and one dose (2 syringes) documented as administered on 03/29/18. -There was a handwritten entry for morphine sulfate 5 mg/0.25 ml prefilled syringes give 5 mg (1 syringe) every 1 hour as needed for pain/dyspnea with no doses documented as administered. -There was a printed entry for morphine sulfate 5 mg/0.25 ml prefilled syringes give 10 mg (2 syringes) every 4 hours ATC (around the clock) (scheduled time of administration) and 5 mg (1 syringe) every hour as needed (prn) for pain (prn time of administration) and both were listed as one entry for the time of administration on the	D 367		

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D 367	Continued From page 56 eMAR beginning on 03/29/18 at 9:46 am. There was one dose of 2 syringes documented as administered on 03/29/18 on the eMAR under the prn dosing at 8:29 pm. Review of Resident #5's handwritten CSCS for morphine sulfate 5 mg/0.25 ml prefilled syringes compared to the March 2018 eMAR and MAR revealed: -There was documentation for a beginning balance of 20 prefilled syringes on the CSCS. -The first line of the CSCS sheet was blank for who administered the medication and the time the medication was administered, but the balance decreased by one. -On 03/28 at 9:30 (no am or pm indicated), 1 oral syringe was signed out as administered, with no matching documentation on the MAR or eMAR. -On 03/28 at 1:30 (no am or pm indicated), 1 oral syringe was signed out as administered, with no matching documentation on the MAR or eMAR. -On 03/28 at 8:30 (no am or pm indicated), 1 oral syringe was signed out as administered, with no matching documentation on the MAR or eMAR. -On 03/28 at 9:30 (no am or pm indicated), 1 oral syringe was signed out as administered, with no matching documentation on the MAR or eMAR. -On 03/29 at 2:00 am, 1 oral syringe was signed out as administered, with no matching documentation on the MAR or eMAR. -On 03/29 at 6:00 am, 1 oral syringe was signed out as administered, with no matching documentation on the MAR or eMAR. -On 03/29 at 10:30 am, 1 oral syringe was signed out as administered, with no matching documentation on the MAR or eMAR. -On 03/29 at 8:29 (no am or pm indicated), 2 oral syringes were signed out as administered (This matched the dose documented on the eMAR).	D 367		

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D 367	Continued From page 57 Based on review of Resident #5's MAR and eMAR compared to the CSCS for morphine sulfate 5 mg/0.25 ml prefilled syringes and the physician's orders, Resident #5 should have received scheduled doses of 10 mg (2 syringes) morphine sulfate 5 mg/0.25 ml prefilled syringes at 8:00 pm on 03/28/18, 2 syringes at 12:00 am on 03/29/18, 2 syringes at 4:00 am on 03/29/18, 2 syringes at 8:00 am on 03/29/18, 2 syringes at 12:00 pm on 03/29/18, 2 syringes at 4:00 pm on 03/29/18, and 2 syringes at 8:00 pm on 03/29/18 for a total of 14 syringes. Review of Resident #5's CSCS revealed "assisted with the disposal of the medications" signed by the Hospice nurse on 03/30/18 at 3:20 am listing 10 morphine sulfate 5 mg/0.25 ml prefilled syringes disposed by the nurse and a MA. Telephone interview on 07/06/18 at 9:15 am with the Hospice Quality Assurance Supervisor revealed 20 morphine sulfate 5 mg/0.25 ml prefilled syringes had been delivered to the facility on 03/27/18 at 11:30 pm by an on-call Hospice nurse. Interview on 07/02/18 at 11:55 am with the Pharmacist for the contract pharmacy revealed: -The facility started on electronic MAR on 03/27/18. -The facility staff could document on the eMAR and/or the MAR during the transition to the eMAR system. -The pharmacy entered the orders for the transition to the eMAR. -The Resident Care Coordinator (RCC) was able to enter orders into the eMAR system at the facility. -The RCC had entered the Hospice order for	D 367		

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D 367	Continued From page 58 morphine sulfate 5 mg/0.25 ml prefilled syringes give 10 mg (2 syringes) every 4 hour ATC (around the clock) (scheduled administration time) and 5 mg (1 syringe) every hour as needed (prn) for pain (prn administration time) were both listed for the scheduled time of administration on the eMAR. The order should have been entered as 2 seperate entries. Interview on 07/02/18 at 12:25 pm with the Administrator revealed: -The RCC was reponsible to audit the residents' MARs and eMARs for medication administration, including auditing the CSCS documentation compared to the MARs and eMARs to assure medications were documented accurately for administration -The RCC working now had only been at the facility since June 2018. -The former RCC would have been responsible for the audits. -The former RCC was not available for interview. Interview on 07/03/18 at 11:00 am with a MA revealed: -She administered Resident #5 a morphine sulfate 30 mg ER tablet on 03/28/18 at 8:00 am. -She did not document the morphine sulfate ER 30 mg on the MAR but she did document on the CSCS. -She gave 5 mg (1 syringe) every hours as needed for pain as needed (prn) for pain/dyspnea at 9:30 am after the hospice order was received, and one 5 mg (1 syringe) every hours as needed for pain for pain/dyspnea at 1:30 pm on 03/28/18. She documented both doses on the CSCS but only one dose on the handwritten entry on the MAR. -She did not administer 2 syinges (for 10 mg dose) when she worked on 03/29/18.	D 367		

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D 367	Continued From page 59 Attempted telephone interview on 07/03/18 at 12:40 pm with the MA working on 03/28/18 was unsuccessful. Interview on 07/03/18 at 3:30 pm with a Hospice nurse revealed: -The original Hospice nurse assigned to Resident #5 was no longer working at Hospice. -She was working the night Resident #5 was taken off regular medications and switched to liquid morphine and lorazepam. -The Hospice nurse transcribed the orders to the resident's MARs at the facility on 03/27/18. -An order was sent to the facility the same night (03/27/18) at 11:35 pm. -The facility received a second faxed order on 03/28/18 at 7:28 am because the facility staff said they could not locate the original Hospice order. 2. Review of Resident 5's Hospice physicians' orders dated 03/27/18 revealed an order for lorazepam tablets to be discontinued, and lorazepam 0.5/ 0.25 ml prefilled syringe give 1 mg orally or sublingually (under the tongue) every 3 hours as needed for agitation, anxiety, or restlessness. Review of Resident #5's March 2018 medication administration record (MAR) and electronic medication administration record (eMAR)revealed: -There was a handwritten entry for lorazepam 0.5/ 0.25 ml prefilled syringe-1 mg orally or sublingually every 3 hours as needed for agitation, anxiety, or restlessness on the MAR. -There were no doses of lorazepam 0.5/ 0.25 ml prefilled syringe documented as administered on the MAR. -There was a printed entry for lorazepam 0.5/	D 367		

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0.25 ml prefilled syringe-1 mg orally or sublingually every 3 hours as needed for agitation, anxiety, or restlessness on the eMAR beginning 03/29/18 at 9:58 am. The medication was scheduled for as needed (prn) administration.
-There were no doses of lorazepam 0.5/ 0.25 ml prefilled syringe documented as administered on the eMAR.

Telephone interview on 07/06/18 at 9:15 am with the Hospice Quality Assurance Supervisor revealed 20 lorazepam 0.5/ 0.25 ml prefilled syringe had been delivered to the facility on 03/27/18 around midnight by an on-call Hospice nurse.

Review of Resident #5's CSCS revealed there was not a CSCS for lorazepam 0.5/ 0.25 ml prefilled syringes.

Review of Resident #5's CSCS revealed "assisted with the disposal of the medications" signed by the Hospice nurse on 03/30/18 at 3:20 am listing 18 lorazepam 0.5/ 0.25 ml prefilled syringes disposed by the nurse and a MA.

Based on review of Resident #5's MAR and eMAR, (with no CSCS for lorazepam 0.5/ 0.25 ml prefilled syringe) and the physician's orders, it could not be determined if Resident #5's lorazepam 0.5/ 0.25 ml prefilled syringes were administered as needed within the ordered parameters.

Interview on 07/02/18 at 12:25 pm with the Administrator revealed:
-The RCC was reponsible to audit the residents' MARs and eMARs for medication administration, including auditing the CSCS documentation

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D 367	Continued From page 61	D 367		

compared to the MARs and eMARs to assure medications were administered as ordered.
-The RCC working now had only been at the facility since June 2018.
-The former RCC would have been responsible for the audits.
-The former RCC was not available for interview (No working phone number was available.
-The facility switched to eMARs on 03/27/18 and ther had been a lot of confusssion among the medication aide staff.

Attempted telephone interview on 07/03/18 at 12:40 pm with the MA working on 03/28/18 was unsuccessful.

Interview on 07/03/18 at 3:30 pm with a Hospice nurse revealed:
-The original Hospice nurse assigned to Resident #5 was no longer working at Hospice.
-She was working the night Resident #5 was taken off regular medications and switched to liquid morphine and lorazepam.
-The Hospice nurse transcribed the orders to the resident's MARs at the facility on 03/27/18.
-An order was sent to the facility the same night (03/27/18) at 11:35 pm.
-The facility received a second faxed order on 03/28/18 at 7:28 am because the facility staff said they could not locate the original Hospice order.

Interview on 07/03/18 at 3:50 pm with the Resident Care Coordinator (RCC) revealed she had been working with the MAs regarding documenting medications and assuring eMARs were accurate.

Interview on 07/03/18 at 4:45 pm with the Administrator revealed:
-She did not know where the CSCS for

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D 367	Continued From page 62 lorazepam 0.5/ 0.25 ml prefilled syringes could be located. -She depended on the RCC to oversee the MAs and assure medication administration was documented correctly.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure records of the receipt and administration of controlled substances were maintained, accurate and reconciled for 1 of 4 residents sampled (#5) who was prescribed controlled substances including morphine sulfate oral solution and lorazepam oral solution. The findings are: Review of Resident #5's current hospital FL-2 dated 03/02/18 revealed: -Diagnoses included lymphoid leukemia, chronic pain syndrome and acute subdural hematoma. -There was a physician's order for morphine sulfate 30 mg extended release (ER) two times a day. (Morphine sulfate is a narcotic pain reliever used to treat severe pain.) -There was a physician's order for lorazepam 1 mg tablet one every 3 hours as needed for	D 392		

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agitation/anxiety. (Lorazepam is a controlled substance used to treat increased anxiety or agitation.)

1. Review of Resident 5's Hospice physicians' orders dated 03/27/18 revealed an order for morphine sulfate 30 mg ER tablets to be discontinued, and morphine sulfate 5 mg/0.25 ml prefilled syringes give 10 mg (2 syringes) every 4 hours ATC (around the clock) and 5 mg (1 syringe) every hour as needed for pain.

Review of Resident #5's March 2018 medication administration record (MAR) and electronic medication administration record (eMAR) revealed:
-On the MAR, there was an entry for one morphine sulfate 30 mg ER tablet was documented as administered at 8:00 am on 03/27/18.
-On the eMAR, there was an entry for one morphine sulfate 30 mg ER tablet was documented as administered at 8:00 pm on 03/27/18, one tablet at 8:00 am on 03/28/18, and one tablet at 8:00 pm on 03/28/18.
-There were a total of 5 tablets documented as administered from 03/27/18 to 03/28/18.

Review of Resident #5's pharmacy generated controlled substance count sheet (CSCS) for morphine sulfate 30 mg ER tablets revealed:
-There were 60 morphine sulfate 30 mg ER tablets dispensed on 02/23/18.
-On 03/27/18, there was one tablet signed out as administered at 8:00 am, and one tablet signed out as administered at 8:00 pm.
-On 03/28/18, there was one tablet signed out as administered at 8:00 am, but not one tablet signed out as administered at 8:00 pm.
-There were a total of 3 tablets signed out as

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D 392	Continued From page 64 administered from 03/27/18 to 03/28/18. Review of Resident #5's March 2018 MAR and eMAR revealed: -There was a handwritten entry for morphine sulfate 5 mg/0.25 ml prefilled syringes give 10 mg (2 syringes) every 4 hours around the clock on the MAR. -There were 2 doses (10 mg= 2 syringes for total of 4 syringes) documented as administered on the MAR for 03/28/18, and one dose (10 mg= 2 syringes) documented as administered on 03/29/18. -There was a handwritten entry for morphine sulfate 5 mg/0.25 ml prefilled syringes give 5 mg (1 syringe) every 1 hour as needed for pain/dyspnea with no doses documented as administered. -There was a printed entry for morphine sulfate 5 mg/0.25 ml prefilled syringes give 10 mg (2 syringes) every 4 hours ATC (around the clock) (scheduled time of administration) and 5 mg (1 syringe) every hours as needed (prn) for pain (prn time of administration) were both listed as on entry for the time of administration on the eMAR beginning 03/29/18 at 9:46 am. There was one dose of 2 syringes (10 mg) documented on 03/29/18 on the eMAR under the prn dosing at 8:29 pm. -There were a total of 6 doses documented as administered on 03/29/18. Review of Resident #5's handwritten CSCS for morphine sulfate 5 mg/0.25 ml prefilled syringes revealed: -There was documentation for a beginning balance of 20 prefilled syringes. -The first line of the CSCS sheet was blank for who administered the medication and the time the medication was administered, but the balance	D 392		

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decreased by one.
-On 03/28 at 9:30 (no am or pm indicated), 1 oral syringe was signed out as administered.
-On 03/28 at 1:30 (no am or pm indicated), 1 oral syringe was signed out as administered.
-On 03/28 at 8:30 (no am or pm indicated), 1 oral syringe was signed out as administered.
-On 03/28 at 9:30 (no am or pm indicated), 1 oral syringe was signed out as administered.
-On 03/29 at 2:00 am, 1 oral syringe was signed out as administered.
-On 03/29 at 6:00 am, 1 oral syringe was signed out as administered.
-On 03/29 at 10:30 am, 1 oral syringe was signed out as administered.
-On 03/29 at 8:29 (no am or pm indicated), 2 oral syringes was signed out as administered.
-There were a total of 10 doses signed out as administered from 03/28/18 to 03/29/18.
-There were 10 morphine sulfate 5 mg/0.25 ml prefilled syringes remaining on 03/29/18.

Review of Resident #5's March 2018 MAR and eMAR compared to the CSCS for morphine sulfate 5 mg/0.25 ml prefilled syringes and the physician's orders:
-Resident #5 should have received scheduled doses of 10 mg (2 syringes) morphine sulfate 5 mg/0.25 ml prefilled syringes at 8:00 pm on 03/28/18, 2 syringes at 12:00 am on 03/29/18, 2 syringes at 4:00 am on 03/29/18, 2 syringes at 8:00 am on 03/29/18, 2 syringes at 12:00 pm on 03/29/18, 2 syringes at 4:00 pm on 03/29/18, and 2 syringes at 8:00 pm on 03/29/18 for a total of 14 syringes.
-Resident #5 received 10 doses of morphine sulfate 5 mg/0.25 ml prefilled syringes per the CSCS log.
-Resident #5 had 8 syringes (4 doses of 2 syringes each dose) documented on the MAR

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and eMAR.
-There were 2 morphine sulfate 5 mg/0.25 ml prefilled syringes not documented on the MAR and eMAR.

Review of Resident #5's CSCS revealed "assisted with the disposal of the medications" signed by the Hospice nurse on 03/30/18 at 3:20 am listing 10 morphine sulfate 5 mg/0.25 ml prefilled syringes disposed by the nurse and a MA.

Telephone interview on 07/06/18 at 9:15 am with the Hospice Quality Assurance Supervisor revealed 20 morphine sulfate 5 mg/0.25 ml prefilled syringes had been delivered to the facility on 03/27/18 at 11:30 pm by an on-call Hospice nurse.

Interview on 07/02/18 at 11:55 am with the Pharmacist for the contract pharmacy revealed:
-The facility staff started on electronic MAR on 03/27/18.
-The facility staff could document on the eMAR and/or the MAR during the transition to the eMAR system.
-The pharmacy entered the orders for the transition to the eMAR.
-The Resident Care Coordinator (RCC) was able to enter orders into the eMAR system at the facility.
-The RCC had entered the Hospice order for morphine sulfate 5 mg/0.25 ml prefilled syringes give 10 mg (2 syringes) (scheduled administration time) every 4 hours ATC (around the clock) and 5 mg (1 syringe) every hour as needed (prn) for pain (prn administration time) were both listed as one entry for the time of administration on the eMAR. The order should have been entered as 2 separate entries.

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D 392	Continued From page 67 Interview on 07/02/18 at 12:25 pm with the Administrator revealed: -The RCC was responsible to audit the residents' MARs and eMARs for medication administration, including auditing the CSCS documentation compared to the MARs and eMARs to assure medications were administered as ordered. -The RCC working now had only been at the facility since June 2018. -The former RCC would have been responsible for the audits. -The former RCC was not available for interview. Interview on 07/03/18 at 11:00 am with a MA revealed: -She administered Resident #5 a morphine sulfate 30 mg ER tablet on 03/28/18 at 8:00 am because she did not see the order from 03/27/18 at 11:30 pm. (The order was date stamped 03/28/18 at 7:40 am). -She did not document the morphine sulfate ER 30 mg on the MAR but she did document on the CSCS. She concentrated on assuring the medication was correct on the CSCS but overlooked documenting on the MAR or eMAR. -She gave 5 mg (1 syringe) every hours as needed for pain as needed (prn) for pain/dyspnea at 9:30 am after the Hospice order was received, and one 5 mg (1 syringe) every hour as needed for pain for pain/dyspnea at 1:30 pm on 03/28/18. She documented both doses on the CSCS but only one dose on the handwritten entry on the MAR. -She did not administer 2 syringes (for 10 mg dose) when she worked on 03/29/18 because she did not think the eMAR was correct. Attempted telephone interview on 07/03/18 at 12:40 pm with the MA working on 03/28/18 was	D 392		

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D 392	Continued From page 68 unsuccessful. Interview on 07/03/18 at 3:30 pm with a Hospice nurse revealed: -The original Hospice nurse assigned to Resident #5 was no longer working at Hospice. -She was working the night Resident #5 was taken off regular medications and switched to liquid morphine and lorazepam. -The Hospice nurse transcribed the orders to the resident's MARs at the facility on 03/27/18. -An order was sent to the facility the same night (03/27/18) at 11:35 pm. -The facility received a second faxed order on 03/28/18 at 7:28 am because the facility staff said they could not locate the original Hospice order. Interview on 07/03/18 at 3:50 pm with the RCC revealed: -She was hired at the facility in June 2018. -Resident #5 was not at the facility when she was hired. -She had been working with the MAs regarding administering medications as ordered since she came to the facility. b. Review of Resident 5's Hospice physicians' orders dated 03/27/18 revealed an order for lorazepam tablets to be discontinued, and lorazepam 0.5/ 0.25 ml prefilled syringe- give 1 mg orally or sublingually (under the tongue) every 3 hours as needed for agitation, anxiety, or restlessness. Review of Resident #5's March 2018 MAR and eMAR revealed: -There was a handwritten entry for lorazepam 0.5/ 0.25 ml prefilled syringe 1 mg orally or sublingually every 3 hours as needed for	D 392		

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agitation, anxiety, or restlessness on the MAR.
-There were no doses of lorazepam 0.5/ 0.25 ml prefilled syringe documented as administered on the MAR.
-There was a printed entry for lorazepam 0.5/ 0.25 ml prefilled syringe 1 mg orally or sublingually every 3 hours as needed for agitation, anxiety, or restlessness on the eMAR beginning 03/29/18 at 9:58 am. The medication was scheduled for as needed (prn) administration.
-There were no doses of lorazepam 0.5/ 0.25 ml prefilled syringe documented as administered on the eMAR.

Telephone interview on 07/06/18 at 9:15 am with the Hospice Quality Assurance Supervisor revealed 20 lorazepam 0.5/ 0.25 ml prefilled syringes had been delivered to the facility on 03/27/18 around midnight by an on-call Hospice nurse.

Review of Resident #5's record revealed there was not a controlled substance count sheet (CSCS) for lorazepam 0.5/ 0.25 ml prefilled syringes.

Review of Resident #5's CSCS revealed "assisted with the disposal of the medications" signed by the Hospice nurse on 03/30/18 at 3:20 am listing 18 lorazepam 0.5/ 0.25 ml prefilled syringes disposed by the nurse and a MA.

Based on review of Resident #5's MAR and eMAR, (with no CSCS for lorazepam 0.5/ 0.25 ml prefilled syringes) and the physician's orders, it could not be determined if Resident #5's lorazepam 0.5/ 0.25 ml prefilled syringes were administered correctly.

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D 392	Continued From page 70 Interview on 07/02/18 at 12:25 pm with the Administrator revealed: -The RCC was responsible to audit the residents' MARs and eMARs for medication administration, including auditing the CSCS documentation compared to the MARs and eMARs to assure medications were administered as ordered. -The RCC working now had only been at the facility since June 2018. -The former RCC would have been responsible for the audits. -The former RCC was not available for interview (The former RCC did not return the phone call). Attempted telephone interview on 07/03/18 at 12:40 pm with the MA working on 03/28/18 was unsuccessful. Interview on 07/03/18 at 3:30 pm with a Hospice nurse revealed: -The original Hospice nurse assigned to Resident #5 was no longer working at Hospice. -She was working the night Resident #5 was taken off regular medications and switched to liquid morphine and lorazepam. -The Hospice nurse transcribed the orders to the resident's MARs at the facility on 03/27/18. -An order was sent to the facility the same night (03/27/18) at 11:35 pm. -The facility received a second faxed order on 03/28/18 at 7:28 am because the facility staff said they could not locate the original Hospice order. -The facility was responsible for generating a CSCS sheet for tracking the lorazepam syringes. Interview on 07/03/18 at 3:50 pm with the RCC revealed: -She was hired at the facility in June 2018. -Resident #5 was not at the facility when she was hired.	D 392		

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D 392	Continued From page 71 -She had been working with the MAs regarding administering medications as ordered since she came to the facility. Interview on 07/03/18 at 4:45 pm with the Administrator revealed: -She did not know where the CSCS for lorazepam 0.5/ 0.25 ml prefilled syringes could be located. -She depended on the RCC to oversee the MAs and assure medications were administered as ordered.	D 392		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure residents received care and services necessary to maintain the residents health, safety, and welfare as related to personal care and supervision and medication administration. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to administer medications as prescribed by a licensed prescribing practitioner for 2 of 7 sampled	D912		

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D912	Continued From page 72 residents observed during the medication pass with errors related to crushing medications that should not be crushed for vitamin B12, metoprolol extended release, isosorbide extended release (#2), and improper dosing for sertraline liquid (#6); and 3 of 6 sampled residents related to furosemide (#2), morphine sulfate 30 mg ER, morphine sulfate oral solution, and lorazepam oral solution (#5), and atenolol (#6). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).] 2. Based on observations, record reviews, and interviews, the facility failed to provide supervision for 3 of 5 sampled residents (#1, #2, and #5) who were disoriented and semi-ambulatory resulting in repeated falls with injuries to include a broken elbow (#2), subdural hematoma (#5), and broken wrist (#1). [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).]	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following:	D935		

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D935	Continued From page 73 a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure all medication aides had completed the medication aide qualifications to administer medications including 1 of 3 sampled medication aides (Staff B) who had not completed the written medication administration exam prior to administering medication from January 2018 to March 2018.	D935		

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D935	Continued From page 74 The findings are: Review of Staff B, personal care aide's personnel file revealed: -Staff B was hired on 07/11/17. -There was documentation Staff B completed the 5 hour medication training on 10/13/17, and the 10 hour medication training on 10/16/17. -There was documentation Staff B was competency validated with a Medication Clinical Skills Checklist on 10/26/17. -There was documentation Staff B had taken and passed the written medication administration exam on 04/17/18. Review of a resident's medication administration records (MARs) for January 2018, February 2018, and March 2018 revealed: -There was documentation Staff B administered 8:00 am medications for January 2018 on 01/01, 01/09, 01/12, 01/20, 01/21, and 01/29. -There was documentation Staff B administered 8:00 am medications for February 2018 on 02/01, 02/05, 02/10, 02/17, and 02/24. -There was documentation Staff B administered 8:00 am medications for March 2018 on 03/09, 03/13-03/18, 03/20, 03/22-03/25, 03/26, 03/28-03/29, and 03/31/18. -Medications administered included morphine sulfate (a narcotic for pain), gabapentin (for neuropathy), allopurinol (for gout prevention), Interview on 07/03/18 at 10:20 am with Staff B revealed: -She had administered medication routinely on the day shift (7:00 am to 3:00 pm). -She had worked on the medication cart since her Medication Clinical Skills Checklist on 10/26/17. -She did not take the written medication	D935		

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D935	Continued From page 75 administration exam until 04/17/18 because the exam was rescheduled at least one time due to snow and bad weather. -She did not know she should not pass medications after 60 days from hire as a medication aide (MA). -The former Resident Care Coordinator (RCC) had not instructed her to stop administering medications until she had taken and passed the written medication administration examination. Interview on 07/03/18 at 4:00 pm with the Administrator revealed: -The Administrator and the Resident Care Coordination (RCC) were responsible for making sure all staff training and requirements were completed. -The former RCC had been primarily in charge of assuring MAs met all the requirements for passing medications. -She knew MAs were not allowed to administer medications after 60 days from hire as a MA until all requirements had been met. -She knew Staff B had problems getting scheduled for the written medication administration exam at least one time due to bad weather. -Staff B passed the written medication administration exam on 04/17/18. -She did not realize Staff B had passed medications from 01/01/18 to 04/17/18 without all her qualifications.	D935		