STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A NEW OUTLOOK OF TAYLORSVILLE	360 WOOD ROAD TAYLORSVILLE, NC 28681

(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 000}	Initial Comments The Adult Care Licensure Section and the Alexander County Department of Social Services conducted a follow-up survey on October 23-24, 2018.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to notify the physician for 1 of 4 residents sampled, related to Resident #2 who was refusing an antipsychotic medication and being aggressive toward other residents. The findings are: Review of Resident #2's current FL2 dated 02/19/18 revealed: -The diagnoses included schizophrenia, history of head trauma and a history of polysubstance abuse. -The medication order Haloperidol Decanoate 200 mg IM 1ml every 30 days. Review of Resident #2's electronic Medication Administration Records (eMAR) for August 2018 revealed documentation Resident #2 had	{D 273}	10A NCAC 13F .0902 Health Care Facility will evaluate and send all requests for healthcare referrals to appropriate parties. Facility will also continue to follow up on such requests and referrals. To prevent further occurrence, Medication Aide will monitor daily, RCC will monitor weekly, Administrator will monitor quarterly and as needed.	10/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teresa Matos	Administrator	12/3/18

Reviewed and acknowledged 12/06/18
Karen M. Polce, RN

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{D 273}	Continued From page 1 received his Haloperidol Decanoate injection on 08/02/18 with no documented administration time. Review of Resident #2's eMAR for September 2018, revealed documentation that Resident #2 had received his Haloperidol Decanoate injection on 09/02/18 with no documented administration time. Review of Resident #2's eMAR for October 2018 revealed: -Resident #2 had not received his Haloperidol Decanoate injection with documentation it was "withheld per doctor orders." -There was documentation the Haloperidol Decanoate injection was discontinued on 10/05/18. -There was an additional entry on the MAR for the Haloperidol Decanoate injection to be restarted on 10/22/18. -There was documentation on 10/23/18 the Haloperidol Decanoate injection was "withheld per doctor orders." Interview with a medication aide (MA) on 10/23/18 at 1:00pm revealed: -She should have reported the Haldol injection not being administered as ordered to the Assistant Administrator so the prescribing physician could be notified. -She should have reported to her supervisor there was an entry for Haldol Decanoate injection monthly on the eMAR and the medication was not being administered. Interview with a second MA on 10/23/2018 at 2:48pm revealed: -The home health agency that had been responsible for administering the Haloperidol injection to Resident #2.	{D 273}		

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{D 273}	Continued From page 2 -The home health agency discharged the resident in March (03/04/18) for refusing the injections on multiple occasions. Interview with a MA on 10/23/2018 at 2:48pm revealed: -Resident #2 got in an altercation with another resident over the weekend. -Resident #2 had hit the other resident 3 times. -Resident #2 could be loud at times, but he was not always aggressive when he was loud. -Resident #2 had been refusing to see the house doctor. Interview with a MA on 10/23/18 at 1:00pm revealed: Attempted telephone interview with the facility home health agency on 10/24/18 at 9:45am was unsuccessful. Interview with a second MA on 10/23/18 at 1:00pm revealed: -She did not know she documented her initials on 09/02/18 on the eMAR indicating Resident #2 had received his Haloperidol Decanoate injection. -He had always refused his Haloperidol Decanoate injections. Review of Resident #2's progress notes revealed: -Between 08/06/18 and 10/21/18 Resident #2 had 4 incidents of loud, disruptive, and aggressive behaviors. -There were three incidents of loud and disruptive behaviors on 08/06/18, 08/19/18 and the third incident was not dated. -There was one incident of resident to resident aggressive behaviors on 10/21/18. -There was no documentation the three incidents of loud and disruptive behaviors had been reported to the Primary Care Provider (PCP). -The incident of the resident to resident aggressive behavior on 10/21/18 had been	{D 273}		

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{D 273}	Continued From page 3	{D 273}		

reported to the PCP on 10/22/18.
-There was no documentation of Resident #2's Haldol Decanoate refusals reported to the PCP.

Interview with a representative from the facility Pharmacy on 10/24/18 at 9:40am revealed:
-The Haloperidol Decanoate injection had been filled for Resident #2 last on 02/19/2018.
-On 02/20/2018 the pharmacy received a new FL2 for Resident #2 with the Haloperidol Decanoate injection documented under medications..
-The facility had not ordered the Haloperidol Decanoate for Resident #2 since February 2018.
-The Haloperidol Decanoate injections were only sent to the facility when requested.
-The Haloperidol Decanoate injections were not on auto refill.

Interview with Resident #2's mental health Nurse Practitioner on 10/24/18 at 3:43pm revealed:
-She last saw Resident #2 on 10/22/18 at the facility and he "appeared more agitated and manic".
-Resident #2 informed her that he got into an altercation with another resident, and said "he was going to kill him".
-She thought Resident #2 had been administered the Haldol every month because it was listed on the MAR.
-She saw a discontinue order in Resident #2's record for the Haldol dated 10/01/18 written by the primary care provider (PCP).
-She wrote a new order on 10/22/18 for Haldol, because she felt Resident #2 needed the medication.
-She did not know Resident #2 had not received his Haldol injection since February 2018.
-She did not know Resident #2 was discharged from the home health agency on 03/04/18 due to

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{D 273}	Continued From page 4	{D 273}		

refusal of Haldol injections.
-She would have wanted to be notified of missed injections of Haldol for Resident #2.
-She did not receive notification of refusals and did not see any documentation in Resident #2's record.
-It was the responsibility of the facility to ensure Resident #2 received his Haldol injections.
-If she was notified of the missed Haldol injections, she would have prescribed Resident #2 Haldol tablets scheduled daily.
-Resident #2 was "mentally unstable", the Haldol injections would help control his behaviors.
-Failure to give Resident #2 his Haldol injections would cause him to be more agitated, sick, and "he could end up in the hospital".
-She assessed Resident #2 six times from May 2018-October 2018; each visit she requested the Haldol injections to continue.
-The facility notified the provider about the fight Resident #2 was in over the weekend (10/21/18).

Interview with the Administrator on 10/24/2018 at 2:00pm revealed:
-She did not know Resident #2 was not getting the injection.
-She thought that Resident #2 had been on the shot from the start of the year.

Interview with a resident on 10/23/18 at 11:00am revealed:
-He had been in the facility for 2 weeks.
-He had told staff that he had been threatened by Resident #2, but did not remember who he had told.
-He tried to stay away from Resident #2.

Interview with the Housekeeper on 10/23/2018 at 11:30am revealed:
-Resident #2 had threatened other staff members

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{D 273}	Continued From page 5 and residents before. -When he heard Resident #2 threaten residents or staff he would tell the medication aide, but could not give specific times or incidents. The facility failed to assure physician notification for 1 of 4 sampled residents who was refusing their antipsychotic medications resulted in Resident #2 presenting with manic, aggressive behaviors, fighting and spitting on another resident. The facility's failure was detrimental to the residents in the facility and placed them at risk for physical harm which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/24/18 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 7, 2018.	{D 273}		
{D 282}	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to assure the food preparation table and can opener, stove, flat top griddle and ventilation hood were free from potential food contamination.	{D 282}	10A NCAC 13F .0904(a)(1) Nutrition and Food Service Rule met as evidenced by, all areas in the kitchen have been cleaned and maintained. Items have been replaced as necessary. To prevent further occurrence, Dietary cooks will clean daily, RCC will monitor weekly and as needed. Administrator will monitor monthly and as needed.	11/14/18

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{D 282}	Continued From page 6 The findings are: Observations of the food preparation table with can opener attached on 10/23/18 at 10:00am revealed: -The surface of the food preparation table that secured a can opener was tacky to the touch. -The can opener had a heavy buildup of a black substance around the base and the blade had a thick buildup of a black substance. -Observations of the gas range stove top, flat top griddle and ventilation hood over the stove on 10/23/18 at 10:05am revealed: -A heavy buildup of black burnt grease on the stove eyes which flaked away upon touch. -The flat top griddle had a heavy buildup of caked burnt food in the corners of the griddle. -The filters in the ventilation hood over the stove had been burned and the metal filaments were hanging out over the stove eyes. Interview with the dietary staff on 10/23/18 at 10:30am revealed: -It was the responsibility of whoever was working in the kitchen to make sure it was clean before they left for the day. -The can opener did not work and was not used. -There was a hand held can opener that was used to open all cans in the kitchen. -When he started in the kitchen he was told by the Administrator not to use the stationary can opener, but to use the hand held one. -He had not had a chance to get the kitchen cleaned since he had served breakfast. Interview with the Resident Care Coordinator on 10/23/18 at 10:45am revealed: -The company that serviced the kitchen stove and	{D 282}		

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{D 282}	Continued From page 7 ventilation hood was trying to find filters for the range hood. -She had been told by the company since the range hood was so old the filters were not readily available. -The buildup on the stove eyes was very hard to clean. -It was the responsibility of whoever was working in the kitchen to make sure the kitchen was clean. -The can opener is no longer used, "we have a hand held can opener we use on all cans." Interview on 10/24/18 at 11:00am with a second dietary worker revealed: -Everyone who works in the kitchen is responsible for keeping the kitchen clean. -He had used the hand held can opener since he had worked at the facility. -The stationary can opener did not work. Attempted telephone interview on 10/24/18 at 9:00am and 1:45pm with the company that serviced the kitchen stove and ventilation system was unsuccessful.	{D 282}		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358	10A NCAC 13F .1004(a) Medication Administration Rule met as evidenced by, Administrator will do an impromptu inservice on medication administration. Facility will ensure that all medications, orders and treatments are in the residents records and all orders or outsode provider discharges are sent to prescribing MD. To prevent further occurrence, Med aides will follow up daily, RCC will monitor weekly and Administrator will monitor quarterly and as needed.	11/14/18

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D 358	Continued From page 8 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to assure medications were administered as ordered for 1 of 4 sampled residents (Resident #2) related to a monthly injection of Haloperidol Decanoate, used for long term treatment of mental/mood disorders, for a period of 8 months. The findings are: Review of Resident #2's current FL2 dated 11/18/17 revealed: -Diagnoses included schizophrenia, hypertension, diabetes, and a history of polysubstance abuse. -There was an order for Haloperidol Decanoate 50mg/ml, 200mg intramuscular (IM) injection every 30 days. Review of Resident #2's record revealed: -Home health services were opened on 01/04/18 for administration of the monthly injection of Haloperidol Decanoate IM. -Resident #2 was discharged from home health services on 03/04/18 due to refusing services. -There was no documentation the Haloperidol injection would be administered by another party. -There was no documentation the Haloperidol Decanoate was discontinued by the mental health provider.	D 358		

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Review of Resident #2's March 2018 electronic medication administration record (eMAR) revealed there was an entry for Haloperidol Decanoate IM and it was documented by the medication aid (MA) as refused.

Review of Resident #2's April 2018 and May 2018 eMAR revealed there was no entry for Haloperidol Decanoate IM.

Review of Resident #2's June 2018 eMAR revealed:
-There was an entry for Haloperidol Decanoate IM.
-It was documented the injection was held per physician's order.

Review of Resident #2's July 2018 eMAR revealed an entry for Haloperidol Decanoate IM and documented as administered on 07/02/18.

Review of Resident #2's physician orders dated 08/27/18 revealed an order to administer Haloperidol Decanoate 100mg/ml, inject 200mg once every 30 days

Review of Resident #2's August 2018 eMAR revealed an entry for Haloperidol Decanoate IM and documented as administered on 08/02/18.

Review of Resident #2's September 2018 eMAR revealed an entry for Haloperidol Decanoate IM and documented as administered on 09/02/18.

Review of a primary care physician's order dated 10/04/18 revealed Haloperidol Decanoate 100mg/mL, inject 2 vials once monthly was discontinued.

Review of Resident #2's progress notes from the

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D 358	Continued From page 10 facility's mental health provider revealed: -On 03/26/18 there were no medication changes recommended. -On 05/22/18 there were no medication changes or gradual dose reductions of existing medications recommended. -On 06/25/18 there were no medication changes or gradual dose reductions of existing medications recommended. -On 07/29/18 the recommendation after reviewing the medical record was to continue all medications related to current diagnoses. "A dose reduction of any of these medications would potentially lead to an exacerbation of the resident's underlying psychiatric disorder and impair function." Interview with a MA on 10/23/18 at 1:00pm revealed: -Resident #2 had been refusing the Haloperidol injection for several months. -"He does not get that medication any longer." -The home health nurse who administered the injections had discharged Resident #2 from their services due to his non compliance. -She did not know why there was an entry on the eMAR for the Haloperidol injection every month for the past 7 months. -She did not know why she documented that he had been administered the medication or refused the medication in September and October 2018. -She should have reported the Haldol injection not being administered as ordered to the Assistant Administrator so the prescribing physician could be notified. -She had not contacted the pharmacy to send the Haloperidol Decanoate since she thought the injection had been discontinued. Interview with a second MA on 10/23/18 at	D 358		

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D 358	Continued From page 11 2:48pm revealed: -She had not requested the Haloperidol Decanoate be sent from the pharmacy because the resident kept refusing it. -She thought the medication had been discontinued when the home health agency discharged the resident for non compliance with the medication on 03/04/18. -She knew an order had to be discontinued by the prescribing physician. -She had not seen an order to discontinue the Haloperidol, but she did not see all the orders received by the facility. -She should have reported to the prescribing physician and her supervisor the medication was entered on the electronic Medication Administration Record (eMAR) but not being administered. Telephone interview with a representative from the facility pharmacy on 10/24/18 at 9:40am revealed: -The order for Haloperidol Decanoate IM was received from the facility on 12/07/17 on an FL2 from a hospital discharge. -The vial was not sent to the facility routinely. For insurance purposes the vial was sent 1 week before the next 30 day period. -The facility called the pharmacist 1 week before the next scheduled administration and the vial would be sent in the tote. -The facility had not requested the Haloperidol Decanoate since 02/19/18. -The pharmacy never received a discontinue order for the medication, which is the reason it was entered each month on the eMAR. -The Haloperidol was entered on the eMAR for the months of April and May for Resident #2 as viewed by the pharmacist. -She would enter the date for administration of	D 358		

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the injection. If the nurse did not administer the injection on that day, she adjusted the date on the eMAR.
-The MAs or the Administrator would document the administration of the injection on the eMAR.
-Orders were not removed from the eMAR by a pharmacist unless there was a discontinue order.

Review of the pharmacy manifest revealed the last delivery of Haloperidol Decanoate was February 02/19/18.

Attempted phone interview with the home health agency was unsuccessful.

Interview with the Assistant Administrator on 10/24/18 at 11:25am revealed:
-She did not know Resident #2 was not receiving his Haloperidol Decanoate injection monthly.
-The MAs would call the pharmacy and let them know when they needed the vial of medication for his next injection.
-She reviewed the eMAR weekly. The MAs were documenting the medication was administered or refused, so she thought it was being administered.
-She knew the home health agency had discharged Resident #2 for non-compliance, but thought the mental health provider had made other arrangements for the injection to be administered.
-She expected the mental health provider to arrange for a nurse to administer the Haldol injection to Resident #2.

Telephone interview with Resident #2's mental health provider on 10/24/18 at 3:43pm revealed:
-Her last visit with Resident #2 was on 10/22/18 at the facility, and he "appeared more agitated and manic".

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A NEW OUTLOOK OF TAYLORSVILLE	360 WOOD ROAD TAYLORSVILLE, NC 28681

(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 13 -Resident #2 informed her that he had an altercation with another resident, and said "he was going to kill him". -She thought Resident #2 was being administered the Haloperidol Decanoate every month because it was listed on the eMAR. -She did not know Resident #2 had not received his Haloperidol injection since February 2018. -She did not know Resident #2 was discharged from the home health agency on 03/04/18 due to the refusal of Haldol injections. -She would have wanted to be notified of missed injections of Haloperidol for Resident #2. -She did not receive notification of refusals and did not see any documentation in Resident #2's record. -It was the responsibility of the facility to ensure Resident #2 received his Haloperidol injections. -If she was notified of the missed Haloperidol injections, she would have prescribed Resident #2 Haldol tablets, scheduled daily. -Resident #2 was "mentally unstable". The Haloperidol injections assisted in controlling his behaviors. -Failure to give Resident #2 his Haloperidol injections would cause him to be more agitated, sick, and "he could end up in the hospital". -She assessed Resident #2 six times from May 2018-October 2018 and after each visit she requested the Haloperidol injections to be continued. -She wrote a new order on 10/22/18 for Haloperidol injections monthly because she felt Resident #2 needed to continue with the medication. Interview with the Administrator on 10/24/18 at 4:00pm revealed: -She thought Resident #2 had been receiving Haloperidol Decanoate injections since the	D 358		

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D 358	Continued From page 14 hospital discharge in December 2017. -The Assistant Administrator was to review the eMAR weekly and she reviewed the eMAR monthly for medications not signed for, medications not administered, as needed medications and orders entered incorrectly. -She reviewed the eMAR monthly and thought the medication was being administered since the MAs were documenting the Haloperidol as administered or refused. -She knew the home health agency had discharged Resident #2 due to his refusal of care. -She thought the mental health provider had designated another nurse to administer the injections. -It was her expectation the mental health provider would arrange for the implementation of her orders for the Haldol injection. -The MAs thought the discharge from the home health services meant the medication was discontinued. -The process for orders on the eMAR that are questionable was to contact the supervisor, the pharmacy and the prescribing physician to clarify the orders. -The MAs should have reported to the prescribing physician and their supervisor the medication was entered on the electronic Medication Administration Record (eMAR) but not being administered. Based on observations, interview and record review, it was determined Resident #2 was not interviewable. The failure of the facility to administer medications as ordered to 1 of 4 sampled residents (Resident #2), who had a history of psychiatric disorders, related to not administering	D 358		

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D 358	Continued From page 15 the monthly injection of Haloperidol Decanoate 200mg IM for 8 months, placed the resident at risk to be more agitated, manic and aggressive, and was detrimental to the health, safety, and welfare of the resident, which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/14/18 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED December 7, 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	D 367	10A NCAC 13F .1004(j) Medication Administration Rule met as evidenced by, Administrator will do an impromptu inservice on medication administration. Facility will ensure that all medications, orders and treatments are in the residents records and all orders or outsode provider discharges are sent to prescribing MD. To prevent further occurrence, Med aides will follow up daily, RCC will monitor weekly and Administrator will monitor quarterly and as needed.	11/24/18

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D 367	Continued From page 16 documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure electronic Medication Administration Records (eMARs) were accurate for 1 of 4 sampled residents (Resident #2) related to inaccurate documentation of Haloperidol Decanoate injections. The findings are: Review of Resident #2's current FL2 dated 02/19/18 revealed: -Diagnoses included chronic schizophrenia, hypertension, diabetes, history of previous head trauma. -There was an order for Haloperidol Decanoate 200mg intramuscular(IM) every 30 days. Review of Resident #2's record revealed: -Home health services were opened on 01/04/18 for administration of the monthly injection of Haloperidol Decanoate. -There was a home health discharge summary completed on 03/04/18. -Resident #2 was discharged from home health services on due to repeated refusal of service. -There was no documentation the Haloperidol Decanoate injection would be administered by another party. -There was no documentation the Haloperidol Decanoate was discontinued by the mental health provider. Review of Resident #2's March 2018 eMAR revealed:	D 367		

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D 367	Continued From page 17 -There was an entry for Haloperidol Decanoate 100mg/mL, inject 2 vials IM once monthly. -The Haloperidol Decanoate was documented as refused. Review of Resident #2's April 2018 eMAR revealed there was no entry for Haloperidol Decanoate. Review of Resident's #2 May 2018 eMAR revealed there was no entry for Haloperidol Decanoate. Review of Resident #2's June eMAR revealed: -There was an entry for Haloperidol Decanoate 100mg/mL, inject 2 vials IM once monthly. -The Haloperidol Decanoate was documented as withheld per physicians orders. Review of Resident #2's July 2018 eMAR revealed: -There was an entry for Haloperidol Decanoate 100mg/mL, inject 2 vials IM once monthly. -The Haloperidol Decanoate was documented as administered 07/02/18. Review of Resident #2's August 2018 eMAR revealed: -There was an entry for Haloperidol Decanoate 100mg/mL, inject 2 vials IM once monthly. -The Haloperidol Decanoate was documented as administered on 08/02/18. Review of Resident #2's September 2018 eMAR revealed: -There was an entry for Haloperidol Decanoate 100mg/mL, inject 2 vials IM once monthly. -The Haloperidol Decanoate was documented as administered on 09/02/18.	D 367	10A NCAC 13F .1004(j) Medication Administration Rule met as evidenced by, Administrator will do an impromptu inservice on medication administration. Facility will ensure that all medications, orders and treatments are in the residents records and all orders or outsode provider discharges are sent to prescribing MD. To prevent further occurrence, Med aides will follow up daily, RCC will monitor weekly and Administrator will monitor quarterly and as needed.	11/24/18

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D 367	Continued From page 18 Review of a subsequent physician's order dated 10/04/18 revealed Haloperidol Decanoate 100mg/mL, inject 2 vials once monthly was discontinued. Review of a subsequent physician's order dated 10/22/18 revealed Haloperidol Decanoate 100mg/mL, inject 100mg once monthly. Review of Resident #2's October 2018 eMAR revealed: -There was an entry for Haloperidol Decanoate 100mg/mL, inject 2 vials IM once monthly. -The Haloperidol Decanoate was documented as withheld per physician orders on 10/02/18. - Haloperidol Decanoate 100mg/mL, inject 2 vials IM once monthly was discontinued on 10/05/18. -There was an entry for Haloperidol Decanoate 100mg/mL, inject 1mL once monthly. -The Haloperidol Decanoate 100mg/mL, inject 1mL once monthly was documented as withheld per physicians orders on 10/23/18. Attempted interview with the contracted home health agency on 10/24/18 at 10:34am was unsuccessful. Telephone interview with a representative from the facility pharmacy on 10/23/18 at 3:15pm revealed: -The order for Haloperidol Decanoate IM was received from the facility on 12/07/17 on an FL2 from a hospital discharge. -The Haloperidol Decanoate vial was not sent routinely. -The facility has not requested the Haloperidol Decanoate since February 2018. -The Haloperidol Decanoate was last filled on 02/19/18. -They never received a discontinue order for the	D 367		

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D 367	Continued From page 19	D 367		

medication therefore it continued to be on the eMAR each month.
-Medication orders were not removed from the eMAR at the pharmacy unless there was a discontinue order.

Interview with a medication aide (MA) on 10/23/18 at 1:00pm revealed:
-Resident #2 had been refusing the Haloperidol injection for several months.
-"He does not get that medication any longer."
-She did not know why there was an entry on the eMAR for the Haloperidol injection every month for the past 7 months.
-She did not know why she documented that he had been administered the medication or refused the medication in September and October 2018.
-She should have notified the Assistant Administrator about the Haloperidol Decanoate showing up on the eMAR.

Interview with a second MA on 10/24/18 at 1:33pm revealed:
-She thought the Haloperidol Decanoate was showing up incorrectly on the eMAR.
-She thought the Haloperidol Decanoate was discontinued by the home health agency.
-She documented the Haloperidol Decanoate as administered in error in August 2018.
-She had not notified the Assistant Administrator about the Haloperidol Decanoate showing up on the eMAR.
-She reviewed the eMAR when the physician came into the facility to ensure the orders matched.

Interview with the Assistant Administrator on 10/24/18 at 3:11pm revealed:
-She did not know Resident #2 was not receiving his Haloperidol Decanoate injection monthly.

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D 367	Continued From page 20 -There was currently no process for her to review the eMAR. -MAs were supposed to review the eMAR monthly when the physician came to the facility. -No one mentioned any issues with the Haloperidol Decanoate being administered. -She would expect the MAs to notify if they are unclear about how to document on the eMAR. Interview with the Administrator on 10/24/18 at 4:50pm revealed: -She thought Resident #2 was receiving Haloperidol Decanoate injections monthly as ordered. -She did not know the Haldol Decanoate was documented on the MAR incorrectly. -The eMARs were checked by MAs, the Assistant Administrator, and by her to ensure medications listed matched the FL2. -She had not noticed the documentation of the administration of the Haloperidol Decanoate. -The eMARs were reviewed for accuracy and holes, there was no process to review the exceptions listed on the eMAR. Based interview, observation and record review, Resident #2 was not interviewable.	D 367		
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.	D912	Refer to corrected Tags: Tag 273 10A NCAC 13F .0908(b) Health Care and Tag 358 10A NCAC 13F .1004(a) Medication Administration	

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D912	Continued From page 21 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations in the area of Health Care and Medication Administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide appropriate referral and follow-up for 1 of 4 residents sampled, by failing to notify the physician that the resident was refusing an antipsychotic medication and being aggressive toward other residents (Resident #2). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation.)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 1 of 4 sampled residents (Resident #2) related to a monthly injection of Haloperidol Decanoate, used for long term treatment of mental/mood disorders, for eight months. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation.)].	D912		