STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092142	A. BUILDING _____ B. WING _____	R 04/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE ASSISTED LIVING COMMUNIT	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 Wake County Department of Social Services conducted an annual survey and follow-up survey on April 2, 2019 through April 3, 2019.	D 000	Administrator immediately verified that one staff person was on the premises at all times who had completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations.	04/03/2019
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure at least one staff was on the premises at all times that had completed a course on cardiopulmonary resuscitation (CPR) and choking management within the last 24 months on third shift for 8 of 11 shifts sampled in February 2019, March 2019 and April 2019. The findings are:	D 167	Previously scheduled American Red Cross training was held on April 16, 2019 for staff that did not attend previous training in March 2019. Business office manager or designee will maintain expiration dates of staff that are CPR certified. List will be updated monthly and provided to the Health and Wellness Director or designee. The Health and Wellness director or designee will identify all staff that are CPR certified on the schedule to verify that at least one person per shift meets the CPR requirement. Administrator or designee will review the schedule daily to verify that at least one staff member per shift meets the CPR requirement.	05/17/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marguerite H Harvey, Adm. | TITLE | (X6) DATE: 05132019

Reviewed and accepted 05/13/19.
Kathy Gray

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D 167	Continued From page 1 Review of staffing assignments and time punch detail reports revealed: -The facility had 3 shifts: first shift was 7:00am - 3:00pm, second shift was 3:00pm - 11:00pm, and third shift was 11:00pm - 7:00am. -There were no staff on third shift who had training on cardiopulmonary resuscitation (CPR) for 8 of 11 days including 02/25/19, 02/27/19, 02/28/19, 03/25/19, 03/26/19, 03/29/19, 03/30/19 and 04/01/19. Interview with a Medication Aide (MA) on 04/03/19 at 7:12pm revealed: -He had been doing the schedule for a long time and it was then assigned to another staff to do. -He recently started back helping with the schedule; he did the schedule for March 2019 and April 2019. -He did not know each shift was required to have at least one person with current CPR training on duty. -He did not know who had current CPR training to be able to use that information for scheduling. Interview with the Health and Wellness Director (HWD) on 04/03/19 at 4:40pm and 6.30pm revealed: -One of the MAs had been scheduling staff. -He thought third shift may not have CPR coverage, but he was not sure. -The Business Office Manager (BOM) was responsible for auditing personnel records. -The BOM would notify the HWD of staff whose CPR was expiring. -The pharmacy provided CPR classes quarterly. -He expected all MAs and personal care aides (PCAs)to have CPR training. Interview with the Administrator on 04/03/19 at 7:00pm revealed:	D 167		

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D 167	Continued From page 2 -She did not know third shift did not have staff with current CPR training on duty. -She would not intentionally leave the facility without CPR coverage. -She expected the BOM to keep up with staff whose CPR had expired. -She already had a CPR class scheduled for 04/16/19. -She would have the facility covered with CPR for all shifts from today (04/03/19) forward. Attempted telephone interview with the BOM on 04/03/19 at 6:38pm was unsuccessful. 1. Review of Staff B, medication aide's (MA), personnel record revealed: -Staff B was hired on 05/22/17. -There was no documentation Staff B had training on cardiopulmonary resuscitation (CPR). Review of the staffing schedule dated 04/01/19 revealed: -Staff B worked third shift (11pm -7am) on 04/01/19. -There was no staff scheduled to work with Staff B who had current CPR training. Attempted telephone interview with Staff B on 04/03/19 at 6:20pm was unsuccessful. Interview with the Administrator on 04/03/19 at 5:07pm revealed she did not know Staff B did not have current CPR training. 2. Review of Staff D, medication aide's (MA), personnel record revealed: -Staff D was hired on 04/24/12. -Staff D's cardiopulmonary resuscitation (CPR) expired on 07/2018. -There was no documentation Staff D had current	D 167		

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D 167	Continued From page 3 CPR training. Review of the staffing schedule dated 02/27/19, 03/29/19 and 04/01/19 revealed: -Staff D worked third shift (11pm -7am) on 02/27/19, 03/29/19 and 04/01/19. -There was no staff scheduled to work with Staff D who had current CPR training. Attempted telephone interview with Staff D on 04/03/19 at 6:34pm was unsuccessful. Interview with the Administrator on 04/03/19 at 5:07pm revealed: -She did not know Staff D did not have current CPR training. -She had looked at Staff D's information on the facility's CPR tracking log incorrectly; she thought Staff D had obtained CPR training in 2018, not that it expired in 2018. 3. Review of Staff E, personal care aide's (PCA), personnel record revealed: -Staff E was hired on 12/13/14. -There was no documentation Staff E had current CPR training. Review of the staffing schedule dated 03/26/19 revealed: -Staff E worked third shift (11pm -7am) on 03/26/19. -There was no staff scheduled to work with Staff E who had current CPR training. Attempted telephone interview with Staff E on 04/03/19 at 6:17pm was unsuccessful. Interview with the Administrator on 04/03/19 at 5:07pm revealed she did not know Staff E did not have current CPR training.	D 167		

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D 167	Continued From page 4 4. Review of Staff F, personal care aide's (PCA), personnel record revealed: -Staff F was hired on 06/29/11. -Staff F's cardiopulmonary resuscitation (CPR) expired on 09/2011. -There was no documentation Staff F had current CPR training. Review of the staffing schedule dated 02/25/19, 03/25/19, 03/29/19 and 03/30/19 revealed: -Staff F worked third shift (11pm -7am) on 02/25/19, 03/25/19, 03/29/19 and 03/30/19. -There was no staff scheduled to work with Staff F who had current CPR training. Telephone interview with Staff F on 04/03/19 at 8:16pm revealed: -She was CPR certified for pediatrics; she did not have adult CPR. -She was scheduled to take adult CPR on 04/16/19. Interview with the Administrator on 04/03/19 at 5:07pm revealed she did not know Staff G did not have current Adult CPR training. 5. Review of Staff G, medication aide's (MA) personnel record revealed: -Staff G was hired on 06/26/18. -There was no documentation Staff G had training on cardiopulmonary resuscitation (CPR). Review of the staffing schedule dated 02/25/19, 02/27/19, 03/25/19, 03/26/19 and 03/30/19 revealed: -Staff G worked third shift (11pm -7am) on 02/25/19, 02/27/19, 03/25/19, 03/26/19 and 03/30/19. -There was no staff scheduled to work with Staff	D 167		

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D 167	Continued From page 5 G who had current CPR training. Telephone interview with Staff G on 04/03/19 at 6:12pm revealed: -Her CPR expired in June 2018. -Someone had told her it had expired (she did not recall who or when she had been told). Interview with the Administrator on 04/03/19 at 5:07pm revealed she did not know Staff G did not have current CPR training. 6. Review of Staff H, personal care aide's (PCA), personnel record revealed: -Staff H was hired on 01/15/19. -There was no documentation Staff G had training on cardiopulmonary resuscitation (CPR). Review of the staffing schedule dated 02/25/19, 02/27/19, 02/28/19, 03/25/19, 03/26/19, 03/29/19, 03/30/19 and 04/01/19 revealed: -Staff H worked third shift (11pm -7am) on 02/25/19, 02/27/19, 02/28/19, 03/25/19, 03/26/19, 03/29/19, 03/30/19 and 04/01/19. -There was no staff scheduled to work with Staff H who had current CPR training. Attempted telephone interview with Staff H on 04/03/19 at 6:15pm was unsuccessful. Interview with the Administrator on 04/03/19 at 5:07pm revealed she did not know Staff H did not have current CPR training. The facility failed to assure there was staff on duty who had training on CPR and choking management in the last 24 months on third shift for 8 of 11 days sampled, resulting in there being no staff available to perform current lifesaving measures in the event of an emergency. The	D 167		

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D 167	Continued From page 6 failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/03/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 18, 2019.	D 167		
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, record reviews, and interviews, the facility failed to assure the kitchen and food storage areas were clean and free of contamination including the floors in the kitchen and dry storage room, reach in-refrigerator and freezer doors, food storage containers in the dry storage room. The findings are: Observation of the floor under and around the ice machine, juice machine and food prep sink on 04/03/19 at 8:15 am revealed black bits of debris and dust, a one-inch piece of a broken dish, a small plastic scoop and a buildup of a brown and black film.	D 282	Daily kitchen cleaning checklist amended to include daily sweeping and mopping of kitchen and dry storage area and cleaning exterior of refrigerator and freezer doors and handles. Dining Services manager or designee will verify daily checklists tasks are completed on a daily basis. Deep cleaning schedule created to include regular cleaning schedule of hard-to reach areas including under the juice machine, ice machine, freezer, refrigerator and stove. It also includes cleaning the baseboards in the kitchen and dry storage routine cleaning of the large food containers and cleaning the gaskets on the refrigerator and freezer doors. Dining services manager or designee will assign deep cleaning assignments according to the deep cleaning schedule and will verify the completion of assigned tasks weekly. Administrator and Dining services manage or designee r will perform sanitation audits of the kitchen bi-monthly for 3 months and monthly thereafter. All dining services staff will be in serviced on new daily cleaning task list and deep cleaning task list by Dining Services Director and Executive Director on 5/17/19	05/17/2019

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D 282	Continued From page 7 Observations of the reach-in refrigerator and reach-in freezer on 04/03/19 at 8:20 am revealed: -There was a yellow, sticky build-up on and around the door handles of the reach-in freezer and reach-in refrigerators, inside the freezer and refrigerator where the door gasket made contact with the freezer and refrigerator, there was a thick black buildup. Observation of the dry storage pantry on 04/03/19 at 8:25 am revealed: -There was a build-up of debris and dust around the baseboards and legs of the shelving in the dry storage room. -There were three large food storage containers that had an opened bag of flour, brown sugar and powdered sugar and an opened bag of granulated sugar. -There was a build-up of a sticky film and brown substance on the lids, inside and outside of the three large food storage containers; the opened bag of flour had a metal scoop laying in the flour. Review of a bulletin board in the kitchen on 04/03/19 at 8:30 am revealed: -There was a daily cleaning schedule hanging on the door to the dry storage room in the kitchen and it was dated for the week of 03/31/19. - There was a listing down the left side of cleaning assignments; there were staff initials beside the assignments; the list was current. -The daily cleaning schedule included "wiping down the refrigerator and freezer doors"; daily sweeping and mopping of the kitchen floors were not included on the schedule. -There were no other cleaning schedules or assignments visible in the kitchen area. -Interview on 04/03/19 at 9:00 am with the kitchen	D 282		

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D 282	Continued From page 8 manager (KM) revealed: -There was a daily cleaning schedule that all kitchen staff were responsible for completing on the day they worked. -Mopping and sweeping the floors were not on the cleaning schedule but the kitchen staff were expected to complete the mopping and sweeping at the end of the day; the kitchen staff were supposed to wipe down the doors to the refrigerators and freezers every day. -She assigned deep cleaning as she saw equipment needed to be cleaned; she did not have a weekly or monthly cleaning schedule to deep clean equipment. -She had deep cleaned the kitchen and dry storage room herself in December 2018; she used a deck brush and a pressure washer to clean the baseboard and floors under and around any equipment. -The kitchen staff could do better sweeping and mopping of the floors at night. -The large food storage containers needed to be deep cleaned or replaced; the food storage containers were deep cleaned about once a week; she did not know when they were last cleaned, and she did not document the deep cleaning. Interview with the Administrator on 04/03/19 at 7:00 pm revealed: -She walked through the kitchen at least once a week and made observations. -The KM conducted monthly kitchen sanitation audits and submitted them to her; the last kitchen audit was dated March 2019. -There should have been daily, weekly and monthly cleaning schedules posted for the kitchen staff to follow and sign off on once completed. -Sweeping and mopping of the kitchen should be	D 282		

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D 282	Continued From page 9 completed twice a day; food bins should be cleaned once a week and the doors to the freezer and refrigerator handles should have been wiped off daily	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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facilities policies for two of three residents (#6, and #7) observed during the medication pass including errors with a medication for constipation (#7), and a topical antifungal cream (#6), and for 1 of 5 sampled residents (#1) related to a blood thinner not being	D 358	Med Staff will receive in services including Coumadin re-training, medication refresher course, and training regarding medication errors. These in services will be presented by a Registered Nurse on 5/17/19. Guidelines for new physician orders implemented including 3 check system to ensure accurate order transcription. Chart Audits completed of resident charts by pharmacy consultant, Health and Wellness Director, RN consultant and Administrator. Guideline for Ordering and Receipt of Medication implemented.by 5/17/2019 Health and Wellness Director or designee will audit 10 percent of resident charts monthly for omissions or discrepancies to verify that physicians' orders are being followed. Daily topical medication times will be evaluated to determine a more suitable time of day or shift per recommendation of community pharmacy consultant and allow staff sufficient time to apply medication. Physicians for residents #1, #5, and #7 contacted to clarify physician orders. Resident #7 order to keep Colace in apartment was discontinued by physician. Staff will administer per physician order. Coumadin flow sheet implemented and in use-daily. Coumadin orders will be listed on a separate MAR and counted by Med Tech each shift to verify given per physician orders. Any discrepancies will be reported immediately to the Health and Wellness director and Administrator. Coumadin Audit form will be implemented and assessed monthly and with each INR by Health and Wellness Director, RN or designee.	5/17/19 5/17/2019

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D 358	Continued From page 10 administered, and changing the dosage for a diuretic. The findings are: 1. The medication error rate was 7% as evidenced by the observation of 2 errors out of 27 opportunities during the 8:00 am medication pass on 04/03/19. a. Review of Resident #6's current FL2 dated 02/06/19 revealed diagnoses included Type 2 Diabetes Mellitus, and primary malignant neoplasms of prostate. Review of Resident #6's dermatologist's physician order dated 03/29/19 revealed an order for ciclopirox 0.77% cream (an anti-fungal cream) apply to toes on Monday, Wednesday, and Friday one time a day for 60 days. Observation of medication administration for Resident #6 on 04/03/19 (Wednesday) from 7:51 am to 8:20 am revealed the MA did not apply ciclopirox 0.77% cream to the residents' toes. Review of Resident #6's April 2019 medication administration record (MAR) revealed: -There was an entry for ciclopirox 0.77% cream apply to toes on Monday, Wednesday, and Friday one time a day scheduled for administration at 8:00 am. -Ciclopirox 0.77% cream was blank for administration on 04/03/19 at 8:00 am when reviewed at 10:00 am on 04/03/19. Interview with the first shift MA on 04/03/19 at 11:42 am revealed: -He had administered Resident #6's medication during the 8.00 am medication pass on 04/03/19.	D 358		

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D 358	Continued From page 11 -Resident #6 received several medications including oral medications and topical creams, as ordered to his stomach, back, and legs. -He did not document administration of the ciclopirox cream 0.77% at 8:00 am when he documented administration of Resident #6's other medications. -He did not administer ciclopirox cream 0.77% to Resident #6's feet at 8:00 am as scheduled on the resident's eMAR. -He had not administered the ciclopirox cream 0.77% to Resident #6's feet as of 11:12 am, but would administer the cream now. -He must have overlooked removing the cream from the medication cart when he applied the resident's other cream. Interview with Resident #6 on 04/03/19 at 3:46 pm revealed: -The foot cream (ciclopirox) had not been administered prior to the receiving his morning oral medications and topical creams around 8:00 am. -He was not administered the cream between his toes until later in the morning when the MA came back to his room. -He was not certain what time it was when the MA applied the anti-fungal cream to his toes. Interview with the Health and Wellness Director (HWD) on 04/03/19 at 6:50 pm revealed: -MAs were supposed to administer medications according to the orders on the eMARs. -He was informed by the morning MA that Resident #6's ciclopirox cream 0.77% was not administered during the 8:00 am medication pass by the MA around lunch time. Interview with the Administrator on 04/03/19 at 7:00 pm revealed:	D 358		

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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 12 -She was not aware Resident #6's ciclopirox cream 0.77% was omitted during the morning medication pass. -The MAs should be looking at the MAR and administering medications as ordered and at scheduled times. b. Review of Resident #7's current FL2 dated 07/06/18 revealed: -Diagnoses included osteoarthritis, rheumatoid arthritis, hypertension, and spinal stenosis. -There was an order for Colace 100 mg (used to treat constipation) one capsule daily as needed for constipation. May self administer. Review of Resident #7's physician's order dated 02/15/19 revealed an order for for starting Colace 100 mg one capsule daily for 90 days. Observation of medication administration for Resident #7 on 04/03/19 at 8:40 am revealed the MA did not administer Colace 100 mg. Review of Resident #7's April 2019 medication administration record (MAR) revealed: -There was an entry for Colace 100 mg one daily as needed for constipation, may self administer listed on the MAR. -There was no entry for Colace 100 mg on daily listed for scheduled administration. Later interview with the second morning MA on 04/03/19 at 1:29 pm revealed: -She did not administer Resident #7 Colace 100 mg during the morning medication pass. -Colace 100 mg did not show on the MAR as a medication for scheduled morning administration. -Resident #7 had an order for Colace 100 mg daily as needed for constipation. -Resident #7 routinely asked for prune juice every	D 358		

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D 358	Continued From page 13 morning to help with her constipation. Interview with Resident #7 on 04/03/19 at 1:40 pm revealed: -She did not know she had colace scheduled every day for constipation. -She had as needed medication she mixed with water for her constipation. -She did not like prunes but drank prune juice occasionally for constipation. Interview with the Health and Wellness Director (HWD) on 04/03/19 at 2:14 pm revealed: -He did not know Resident #7 was not receiving Colace 100 mg daily. -Resident #7 previously had an order for Colace 100 mg if needed daily. -The MA on duty was responsible to transcribe the order on the resident's MAR when the order was received and order the medication from the pharmacy. -The MA transcribed the new order to the resident's MAR. -The MA faxed the order to the contracted pharmacy, and placed the order in a medication order box. -The night shift lead MA was responsible to double check the medication order entry on the MAR for accuracy and completeness. -When the medication arrived, the medication was placed on the medication cart and administered as ordered. -The lead MA must have overlooked the order when she read the discharge information. -The HWD worked with the lead MA on duty when an order was received. -The HWD had not done record audits for medications ordered compared to medications administered since he came to the facility eight weeks ago.	D 358		

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D 358	Continued From page 14 Interview with the Administrator on 04/03/19 at 7:00 pm revealed: -She did not know Resident #7 had not been receiving a scheduled medication (Colace) as ordered. -The HWD would be responsible to assure medications were administered as ordered. 2. Review of Resident #1's current FL-2 dated 02/07/19 revealed diagnoses included atrial fibrillation, back pain, hip pain, osteoarthritis, hypertension, hypercholesterolemia, chronic venous embolism and thrombosis of the leg, trigeminal neuralgia, and hypothyroidism. a. Review of Resident #1's current FL-2 dated 02/07/19 revealed there was an order for Coumadin (a blood thinner) 5 mg half a tablet on Monday, Wednesday and Friday; whole tablet on all other days. Review of Resident #1's February 2019 medication administration record (MAR) revealed: -There was an entry for Coumadin 5 mg one time a day with administration scheduled at 6:00 pm on Tuesday, Thursday, Saturday and Sunday. -There was a second entry for Coumadin 2.5 mg one time a day with administration scheduled at 6:00 pm on Monday, Wednesday and Friday. -Coumadin 5 mg was not documented as administered on 02/01/19 through 02/03/19 and on 02/10/19; there was no documentation on the MAR for those dates. -Based on Resident #1's MAR review for February 2019 it could not be determined if the dosage of Coumadin had been administered for four days; 02/01/19, 02/02/19, 02/03/19 and 02/10/19.	D 358		

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D 358	Continued From page 15 Review of Resident #1's March 2019 MAR revealed: -Coumadin 5 mg was documented as administered 23 out of 23 days and Coumadin 2.5 mg was documented as administered four out of four days. -Coumadin was held by the physician for four days in March 2019. Review of Resident #1's lab reports dated 02/06/19 and 02/14/19 revealed: -There was documentation Resident #1's international normalized ratio (INR) (used to monitor how well the blood thinning medication is working to prevent blood clots) on 02/06/19 was 1.00 (normal range is 1.0 to 1.5). -The next INR was obtained on 02/13/19 and the result was 1.39. Telephone interview with a representative at Resident #1's physician's office on 04/03/19 at 4:55 pm revealed: -There was documentation for an order on 02/07/19 that Resident #1 was ordered Coumadin 5 mg Tuesday, Thursday, Friday, Saturday and Sunday, and Coumadin 2.5 mg on Monday and Wednesday only. -The physician's office had not been notified Resident #1 had any missed dosages of Coumadin; the physician's office expected to be notified by the facility staff of any missed doses of Coumadin. b. Review of Resident #1's current FL-2 dated 02/07/19 revealed there was an order for spironolactone (a diuretic used to treat elevated blood pressure) 50 mg daily. Review of Resident #1's physicians orders dated	D 358		

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D 358	Continued From page 16 03/14/19 revealed an order to reduce spironolactone from 50 mg daily to 25 mg daily. Review of Resident #1's March 2019 medication administration record (MAR) revealed there was documentation spironolactone 50 mg tablet was administered at 8:00 am from 03/15/19 to 03/31/19; there was no change in dosage noted on the MAR. Review of the April 2019 MAR revealed: -There was an entry for spironolactone 25 mg tablet every day, scheduled to be administered at 8:00 am. -There was documentation of administration of spironolactone 25 mg tablet every day at 8:00 am from 04/01/19 through 04/03/19. Observation of medication on hand for Resident #1 on 04/03/19 at 10:30 am revealed: -There were two medication cards for spironolactone on the cart; they were wrapped together with a rubber band. -The first card was spironolactone 50 mg one tablet every day; it had a dispense date of 03/05/19 for 30 tablets and nine tablets remained in the card. -The second card was spironolactone 25 mg one tablet every day; it had a dispense date of 03/15/19 for 30 tablets and all 30 tablets remained in the card. Interview with the medication aide (MA) on 04/03/19 at 10:50 am revealed: -He compared each medication card to the MAR before administering medication; he knew Resident #1's spironolactone had changed from 50 mg to 25 mg but he did not remember when the change had been made. -He thought he had administered Resident #1 the	D 358		

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D 358	Continued From page 17 last spironolactone 25 mg table out of a card that morning and had destroyed the empty card. -He had not administered spironolactone 50 mg out of the card with the nine remaining tablets since it had been discontinued. -He should have sent the spironolactone 50 mg back to the pharmacy when there was a medication change; the spironolactone 50 mg should not have been on the cart. Interview with the Health and Wellness Director (HWD) on 04/03/19 at 2:14 pm revealed: -The HWD worked with the lead MA on duty when an order was received. -The MA transcribed the new order to the resident's MAR. -The MA faxed the order to the contracted pharmacy, and placed the order in the medication order box. -The night shift lead MA was responsible for double checking the medication order entry on the MAR for accuracy and completeness. -When the medication arrived from the contracted pharmacy, the medication was placed on the medication cart and administered as ordered. -The HWD had not done record audits for medications ordered compared to medications administered since he came to the facility eight weeks ago. Telephone interview with a representative from the facility's contracted pharmacy on 004/03/19 at 12:20 pm revealed: -The pharmacy had received an order change for Resident #1's spironolactone on 03/15/19; the change was to decrease the spironolactone from 50 mg to 25 mg one time every day. -The pharmacy last dispensed 30 tablets of spironolactone 50 mg on 03/05/19; the card was not returned to the pharmacy after the	D 358		

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D 358	Continued From page 18 spironolactone 50 mg was discontinued. -The pharmacy dispensed 30 tablets of spironolactone 25 mg on 03/15/19 to the facility for Resident #1. -The MAR for March 2019 should have been changed by the facility staff to reflect the discontinuation of spironolactone 50 mg; the facility staff should have returned the unused medication to the pharmacy once it was discontinued. Telephone interview with a representative from Resident #1's physician's office on 04/03/19 at 1:25 pm revealed: -Resident #1's spironolactone was decreased on 03/14/19 from 50 mg to 25 mg; Resident #1's blood pressure was too low. -The physician's office expected the facility to follow all medication orders; failure to change Resident #1's spironolactone from 50 mg to 25 mg could have contributed to a fall. Interview with the Administrator on 04/03/19 at 7:00 pm revealed: -The facility staff were in the process of conducting MAR audits; about half of the MAR audits were complete. -She wanted the MAs to conduct weekly cart audits to review what medications were on the carts and compare the MAR to the actual medication; she had not had a chance to begin cart audits. -Any changes made in medication orders should be sent to the pharmacy, and "D/C" for discontinued should be written on the MAR; the new orders should be written on the MAR and the unused medication should be returned to the pharmacy. -The MAs and the HWD were responsible for taking care of the changes on the MAR and	D 358		

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D 358	Continued From page 19 returning medication to the pharmacy. -She was not familiar with Resident #1's medications and was not aware Resident #1 had been administered the wrong dosage of spironolactone. The failure of the facility to administer medications as ordered for one resident with atrial fibrillation and hypertension not receiving a blood thinner, and the correct dosage of diuretic which placed the resident at risk for a blood clot and electrolyte imbalance. This failure was detrimental to the health, safety, and welfare of the residents, and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/03/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 18, 2019.	D 358		
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, interviews, and record	D912	Mandatory Resident Rights Training for all staff presented by Ombudsman 04/30/2019.	04/30/2019

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D912	Continued From page 20 reviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and regulations as related to cardio-pulmonary resuscitation and medication administration. The findings are: 1. Based on record reviews and interviews, the facility failed to assure at least one staff was on the premises at all times that had completed a course on cardiopulmonary resuscitation (CPR) and choking management within the last 24 months on third shift for 8 of 11 shifts sampled in February 2019, March 2019 and April 2019. [Refer to Tag 167, 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facilities policies for two of three residents (#6, and #7) observed during the medication pass including errors with a medication for constipation (#7), and a topical antifungal cream (#6); and for 1 of 5 sampled residents (#1) related to a blood thinner not being administered, and changing the dosage for a diuretic. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration(Type B Violation)].	D912		