STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030008	A. BUILDING: _____ B. WING _____	05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF MOCKSVILLE	150 KEN DWIGGINS DRIVE MOCKSVILLE, NC 27028

(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 Davie County Department of Social Services conducted an annual survey on 05/07/19 - 05/08/19.	D 000	Response to the cited defiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.	
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 5 residents sampled (#5) was tested for tuberculosis (TB) disease upon admission. The findings are: Review of Resident #5's current FL-2 dated 08/19/18 revealed diagnoses included coronary artery disease, arthritis, depression, dyslipidemia, chronic kidney disease, gastroesophageal reflux disease, dementia, hypertension, myocardial infarction, diabetes, hypothyroidism, cerebrovascular accident, and orthostatic hypotension. Review of Resident #5's Resident Register	D 234	10A NCAC 13F .0703 Executive Director (ED) and Resident Care Coordinator (RCC) will complete immediate audit of all resident charts to identify TB needs. Registered Nurse (RN) will administer all TB needs identified by June 7th, 2019. ED will review all TB records prior to admission. RCC will maintain record of TB administration in resident record. ED and RCC will complete random weekly resident chart audits to maintain compliance. POC Date 6/6/2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 6/7/19

reviewed and accepted 06/20/19

Jo Scarlett

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D 234	Continued From page 1 revealed: -The date of admission was 01/31/14. -She was admitted from another facility. Review of Resident #5's record revealed there was no documentation of a TB skin test. Interview with the Administrator on 05/08/19 at 11:44am revealed: -The Administrator, and sometimes the Marketing Director were responsible for ensuring TB skin tests was completed for residents. -The first TB skin test was usually completed for residents prior to moving into the facility. -If a resident was being admitted from another facility where 2 TB skin tests had already been completed, the 2 TB tests and results would be accepted. -She did not know prior to today (05/08/19) Resident #5's TB skin tests was not in her record. -The resident records had been thinned and she could not find Resident #5's TB skin tests in any of the documents that had been thinned from the record. -Resident #5 was admitted from a skilled nursing facility so she should have had a documented 2 TB skin tests. -She contacted the previous facility to obtain a copy of Resident #5's TB skin tests and was told records prior to 2015 were stored at an off-site storage. Interview with Resident Care Coordinator (RCC) on 05/08/19 at 4:27pm revealed: -The Administrator was responsible for ensuring a TB skin test was completed for residents upon admission. -Either the RCC or the Administrator was responsible to ensure a TB skin test was completed within a few weeks of admission to the	D 234		

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D 234	Continued From page 2 facility. -Some TB skin tests were placed in thinned records when the facility's ownership changed. -She did not know if Resident #5's TB skin tests were completed. Interview with Resident #5 on 05/08/19 at 4:25pm revealed: -She did not know if she had a TB skin test completed when she was admitted to the facility. -She did not remember if she was admitted to the facility from home or from another facility. Interview with Resident #5's family member on 05/08/19 at 5:12pm revealed: -Resident #5 was admitted to the facility from a nursing rehabilitation facility. -He did not remember if TB skin tests was completed for Resident #5 when she was admitted to the facility. -Resident #5 had never tested positive for TB.	D 234		
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 Order Processing System (Bucket System) initiated on 5/8/19. RCC will monitor and follow up with Bucket System daily to ensure orders processed accurately to include documentation of medication administration. ED and RCC with conduct random observations of MARS weekly to ensure proper order processing and documentation of medication administration. RCC to print adminstration compliance report daily. RN to complete Medication Administration Training June 7th. POC Date 6/6/19.	

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D 358	Continued From page 3	D 358		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #2) including errors with medications used to treat anxiety.

The finding are:

Review of Resident #2's current FL-2 dated 04/29/19 revealed:
-Diagnoses included coronary artery disease, arthritis, depression, dyslipidemia, chronic kidney disease, gastroesophageal reflux disease, dementia, hypertension, myocardial infarction, diabetes, hypothyroidism, cerebrovascular accident, and orthostatic hypotension.
-There was a physician's order for quetiapine 25mg 1 tablet at bedtime (used to treat anxiety).

Review of a previous physician's order dated 04/25/19 revealed quetiapine 25mg 1/2 tablet at bedtime for three nights and if tolerated increase to 1 tablet at bedtime.

Review of Resident #2's record revealed there was a fax transaction report dated 04/30/19 sent from the Resident Care Coordinator (RCC) to the facility contracted pharmacy requesting quetiapine 25mg (whole tablet) as Resident #2 tolerated 1/2 tablet for three days.

Review of Resident #2's April 2019 electronic Medication Administration Record (eMAR) revealed:

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D 358	Continued From page 4 -There was an entry for quetiapine 25mg take 1/2 tablet (12.5 mg) at bedtime for three days. -Quetiapine 25mg (1/2 tablet) was documented as administered at 8:00pm from 04/27/19 through 04/29/19. -There was an entry for quetiapine 25mg If tolerated take 1 tablet at bedtime. -Quetiapine 25mg (1 tablet) was documented as administered at 8:00pm on 04/30/19. Review of Resident #2's May 2019 eMAR revealed: -There was an entry for quetiapine 25mg 1 tablet at bedtime. -Quetiapine 25mg was administered at 8:00pm from 05/01/19 through 05/06/19. Observation of Resident #2's medication on hand on 05/08/19 at 10:43am revealed: -Quetiapine 25mg 1/2 tablets were available for administration. -There were fifteen 1/2 tablets of quetiapine 25mg dispensed on 04/26/19 with four 1/2 tablets remaining. -There was an order on the bubble pack to take 1/2 tablet at bedtime for three days and if tolerated take 1 tablet at bedtime. Interview with Resident #2 on 05/08/19 at 3:41pm revealed: -She was on a medication for anxiety, but she did not know the name of the medication. -She took the medication for anxiety at night and thought it was a 1/2 tablet. -She remembered taking the 1/2 tablet for anxiety last night on 05/07/19. Interview with the RCC on 05/08/19 at 10:52am and 4:27pm revealed: -She was responsible for reviewing new	D 358		

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D 358	Continued From page 5 medication orders when they came into the facility from outside providers or the facility contracted provider. -Once orders were reviewed she or a medication aide (MA) sent the new order to the pharmacy to be transcribed onto the eMAR. -She knew the physician's order for quetiapine 25mg for Resident #2 was 1/2 tablet at bedtime for three days and then 1 tablet at bedtime if 1/2 tablet was tolerated. -She contacted the pharmacy by fax on 04/30/19 to get the quetiapine 25mg (whole) tablets delivered to the facility. -She received a faxed notice from the pharmacy on 04/30/19 which indicated the claim for quetiapine 25mg tablets for Resident #2 was denied by the insurer and was not due to be refilled until 05/01/19. -She did not contact the pharmacy on 05/01/19 to see why quetiapine had not been delivered because she had gotten tied up with physician's orders from three new admissions. -She did not realize prior to today (05/08/19) the MAs were administering 1/2 tablet of quetiapine and documenting 1 tablet was administered to Resident #2. -Staff had not told her the quetiapine on hand did not match the order for quetiapine on the eMAR for Resident #2. -MAs were responsible for completing cart audits which included looking for medication that needed to be reordered, expiration dates, and making sure the label matched the eMAR. Interview with a MA on 05/08/19 at 3:45 on revealed: -Her primary job responsibilities included administering medication to residents. -When she administered medication to residents, she pulled the eMARs for that resident, she	D 358		

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D 358	Continued From page 6 looked at the medication label and compared it to the eMAR three times before punching the medication from the bubble pack to a medication cup, she hit the prep button on the eMAR system which indicated medication was in the medication cup and ready to be administered, she watched the resident take the medication, then she pressed the complete button on the eMAR system and no more steps were needed for that particular medication. -Resident #2 had a physician's order for quetiapine 25mg 1/2 tablet at bedtime for three days and if tolerated 1 tablet daily. -Resident #2 was currently taking quetiapine 25mg 1 tablet at bedtime. -She administered quetiapine 25mg 1/2 tablet to Resident #2 on 04/27/19 and 1 tablet on 04/29/19, 04/30/19. -She did not know prior to today (05/08/19) quetiapine 25mg 1/2 tablets had been on the medication cart and administered to Resident #2 from 04/27/19 to 05/07/19. -She thought the quetiapine 25mg on the medication cart was a whole tablet and did not know quetiapine 25mg 1 tablet at bedtime had not been delivered to the facility by the pharmacy. -She always checked the medication labels and did not know how she missed identifying the medication error. -Had she realized the quetiapine on the medication cart did not match the order for quetiapine on the eMAR, she would have informed the RCC and contacted the pharmacy to get the correct dosage. Observation of Resident #2's medication available in the facility on 05/08/19 at 4:05pm revealed quetiapine 25 mg 1 tablet at bedtime had been dispensed by the pharmacy on 05/08/19.	D 358		

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D 358	Continued From page 7 Interview with a second MA on 05/08/19 at 3:56pm revealed: -Her job responsibility included administering medication to residents. -When she administered medication, she looked at the resident, checked the medication bubble pack three times, popped the medication from the bubble pack into a medication cup, administered the medication to the resident, and then documented on the eMAR the medication was given. -The RCC was responsible for reviewing new medication orders and sending them to the pharmacy to be entered on the eMAR. -Each MA was responsible for completing a cart audit weekly for a specified number of residents directed by the RCC. -When she completed a cart audit she looked to make sure the resident was not running low on medication and if so she would call the pharmacy to see where the medication was and reordered the medication if necessary; She made sure the medication was labeled with the correct name, dosage and route by comparing the bubble pack to the eMAR. -She would let the RCC know if there was a problem or if medication labels did not match the eMAR. -Resident #2 had a current order for quetiapine 25mg 1 tablet at bedtime and the previous order was 1/2 tablet at bedtime for three days. -She administered quetiapine 25mg 1/2 tablet to Resident #2 on 04/27/19 and quetiapine 25mg 1 whole tablet to Resident #2 on 05/02/19 and 05/06/19. -She did not know only 1/2 tablets were in the bubble pack sent to the facility by the pharmacy on 04/26/19. -She did not know quetiapine 25mg 1 (whole)	D 358		

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D 358	Continued From page 8 tablets were dispensed by the pharmacy on 05/08/19. -She had not checked the quetiapine medication label against the eMAR on 05/02/19 and 05/06/19 for correct dosage because she was trying to complete the medication administration for residents. Interview with a representative with the contracted pharmacy on 05/08/19 at 4:09 pm revealed: -The original order was written on 04/25/19 for quetiapine 25mg give 1/2 tablet every night at bedtime for three nights, if the resident tolerated the medication then increase to 25mg 1 tablet every night at bedtime. -The original order was keyed in the computer by a pharmacy representative on 04/26/19. -Quetiapine would have been a cycle fill (sent monthly with reorder sheet) and dispensed on 05/02/19 if the order had not been duplicated and canceled. -Quetiapine 25mg was dispensed in 1/2 tablets for a total of fifteen 1/2 tablets to the facility on 04/26/19. -The order was not keyed in very well and should have been entered into the computer as 2 orders, the first one should have been quetiapine 25mg give 1/2 tablet every night at bedtime for 3 nights with a note to increase if tolerated and the second order should have been Quetiapine 25mg 1 tablet every night at bedtime. -Quetiapine 25mg 1 tablet daily was dispensed on 05/08/19 with a quantity of eight. Interview with the Administrator on 05/08/19 at 4:53 pm revealed: -The RCC was responsible for reviewing new medication orders and sending them to the pharmacy.	D 358		

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D 358	Continued From page 9 -The pharmacy added the orders to the eMAR and the RCC had to approve the orders before they became a permanent entry on the eMAR. -The MA completed weekly cart audits which consisted of printing the eMAR and comparing the order on the eMAR to the medication in the cart and pulling discontinued medication off the cart. -If MAs found any discrepancies during cart audits, they should have notified the RCC and the RCC should have contacted the physician. -MAs were supposed to check the eMAR and the medication label three times before they administered the medication to residents. -She did not know quetiapine 25mg 1/2 tablet at bedtime was administered from 04/30/19 to 05/07/19 when quetiapine 25mg 1 tablet at bedtime should have been administered. -She expected medication to be administered as ordered by the physician. Attempted telephone interview with Resident #2's mental health provider on 05/08/19 at 3:32 pm was unsuccessful.	D 358		