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{D 000}	Initial Comments The Adult Care Licensure Section and the Rowan County Department of Social Services conducted a follow-up survey and complaint investigation on 06/04/19 through 06/07/19. The complaint investigations were initiated by the Rowan County Department of Social Services on 05/17/19 and 06/04/19.	{D 000}		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the floor carpeting in 16 resident rooms (#110, #112, #119, #133, #135, #136, #144, #145, #146, #147, #148, #326, #329, #331, #333 and #334) and in the main hallway were cleaned and in good repair. The findings are: Observations during the initial tour of the facility on 06/04/19 from 9:35am to 12:15pm and on 06/05/19 from 9:50 am to 10:50am revealed: -The carpeting in the hallway outside the business office area near the smoking area exit door had a buildup of black grime around the black rubber striping around the bottom of the	D 074		

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door frame.
-There were also particles of white and black trash around the bottom of the door frame.
-The carpeting in most residents' rooms #110, #112, #119, #133, #135, #136, #144, #145, #146, #147, #148, #326, #329, #331, #333 and #334 had numerous stains and unidentifiable black substance matted into the floor.
-There were other stains throughout the carpeting that were red, orange and white along with trash particles and other debris.
-The carpeting in some residents' rooms were severely soiled with an unidentifiable black substance.
-Some carpeting in residents' rooms were the most severely soiled and with an unidentifiable substance where the original color of the carpet (beige) was no longer visible.
-Some soiled areas were measured three feet by two feet wide and circular.
-One resident used a 3x2 incontinent brief to cover the soiled area, but it did not cover the entire soiled area.
-There was also particles of trash and other debris on the floor that was mixed with the resident's oxygen tubing.
-There were massive blackened soiled areas that could not be avoided for the resident to access the bed.
-There were other identified blackened soiled stains throughout residents' rooms.

Interview with six residents on 06/04/16, 06/05/19 and 06/06/19 at various times from 9:00am to 5:00pm revealed:
-The floors were dirty when they moved in the rooms.
-Housekeeping came to the rooms daily but did not always vacuum.
-The carpeting had not been shampooed for at

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least one year.
-The residents complained to housekeeping and management about the soiled carpeting because they did not want to step on the dirty carpet that was blackened and heavily soiled.
-One resident said facility staff told her that it was the corporate office that prevented them from cleaning and/or replacing the carpeting.

Interview with the resident in Room #144 on 06/04/19 at 3:50pm revealed:
-When she moved into the room six months ago the carpeting was already dirty.
-She did not like putting her feet on the dirty soiled spots on the floor.
-One spot was directly in front of her bed and she had to stand on the dirt to get into her bed.
-She had band new house slippers and did not like to wear them at the facility because the carpeting was so badly soiled.
-She had asked housekeeping and the Administrator about getting the carpeting cleaned but was not given a response.

Interview with the resident in Room #147 on 06/04/19 at 1:00pm revealed:
-The stains in the carpet had been on the floor since she moved into the facility 10/16/18.
-The carpet had not been shampooed since she moved into the facility.
-She covered the stains with a three feet by two feet incontinence pad because she was embarrassed for visitors to see the how bad the carpet was stained.
-The stain was wider than the incontinent brief but was all she had to cover up the dirt in the carpet.
-She asked the Administrator and the Director of Resident Care about getting her carpet cleaned.
-Neither of them responded back to her regarding when the carpet would be cleaned.

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D 074	Continued From page 3 Interview with the resident in Room #331 on 06/04/19 at 4:10pm revealed: -The carpeting was dirty and badly stained. -He had told the housekeeping staff the carpet looked "rough." -The housekeepers agreed with him but had done nothing regarding cleaning the carped. -No one had shampooed the carpeting and when asked, staff did not respond when they would shampoo the carpet. Interview with the resident in Room #334 on 06/04/19 at 4:20pm revealed: -The carpeting looked bad. -She did not know what happened to make the carpeting so dirty. -The housekeepers cleaned, but no one shampooed the carpet. -She carpet was so dirty shampooing was not going to help, it needed to be replaced with new carpeting. -She did not tell staff about the carpeting because they came to her everyday and were able to see how badly stained the carpeting was in her room. Interview with a housekeeper on 06/05/19 at 8:30am revealed: -She had worked at the facility for two weeks. -She vacuumed residents' rooms, if it was needed and the trash cans were emptied. -She tried to deep clean at least one resident room per week but did not shampoo the carpet when she deep cleaned the rooms. -The carpeting in the residents' rooms did not get shampooed because the facility did not have a carpet cleaner that would shampoo the carpet.. -Sometimes she used a brush to try and clean the black soiled spots on the carpet, but that did not work.	D 074		

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D 074	Continued From page 4 Interview with a second housekeeper on 06/07/19 at 12:00pm revealed: -The carpet cleaner broke "a while ago," maybe one year ago. -She asked the Administrator about getting another carpet cleaner and she was supposed to try to get one but never got one. -She had worked at the facility for two years and there was always difficulty getting a carpet cleaner. -Sometimes she rented a carpet cleaner using her own money. -Once the Director of Resident Care (DRC) brought her own carpet cleaner from home then later took it back home. -Residents had complained to her about the dirty soiled carpeting their room. -Sometimes the residents spilled things, urinated on the carpet, and put soiled briefs on the carpet. -Even if she cleaned up the stains some stains were difficult to get out of the carpet without a carpet cleaner. -A little more than one month ago the Administrator had a carpeting company come into the facility and shampoo the carpeting in the hallways. -The carpet in the residents' room did not get shampooed and they were still very soiled with dirt. Interview with the Administrator on 06/04/19 at 9:01am revealed: -The facility had hired an outside company to clean the carpet. -The company was contracted two weeks ago. -They were to clean the carpet in the hallway on 06/05/19, and then start cleaning the residents' room by the end of the week. -The carpeting in some residents' rooms had	D 074		

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D 074	Continued From page 5 been replace. -The plan was to replace the carpeting throughout the entire building, but that would take time and money.	D 074		
{D 188}	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care	{D 188}		

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{D 188}	Continued From page 6 residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure aide hours met the minimum requirements resulting in inadequate staff to meet the supervision and personal care needs of the residents for 57 of 66 shifts during sixteen days from 05/13/19 to 06/03/19. The findings are: Review of the facility's 2019 license revealed the facility had a capacity of 120 residents. Review of the facility's resident roster dated 06/04/19 revealed the facility had a current census of 61 residents. Review of the facility's resident roster for May 2019 revealed the facility had a census of 63 residents. Interview with a resident on 06/07/19 at 1:19pm revealed: -She needed assistance with most of her daily	{D 188}		

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{D 188}	Continued From page 7 living activities. -Staff helped her get in and out of her wheelchair. -Staff helped her with her bathing. -She wore incontinence briefs but needed assistance with changes. -She had to wait to get assistance with transferring to and from her chair because there was often not adequate staff. -She sometimes had back pain at night and could not get assistance with getting into bed when she asked for it due to having to wait on someone to come and help her. -Two people normally assisted her in and out of bed, but sometimes there was only one person. -Sometimes she had to wait more than 25 minutes when she rang her call bell and was told she had to wait until a second person was free to help with her. -Staff were nice to her, they were just under-staffed. Interview with a second resident on 06/07/19 at 1:08pm revealed: -She was able to transfer from the bed to her wheelchair independently most of the time. -She needed assistance transferring from her wheelchair to the toilet and from the toilet to her wheelchair because the toilet was low making it difficult to lower herself to the toilet or pull up to the wheelchair. -Sometimes she would have to wait 20 minutes or more for staff to come to assist her from the toilet. -Staff would tell her they were short on staff and could not get to her because of helping other residents. Interview with a third resident on 06/07/19 at 5:05pm revealed: -She needed assistance with some of her daily	{D 188}		

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living activities.
-She needed assistance with bathing and dressing because she only had one good hand.
-Staff applied and removed her support hose.
-Staff were often slow to help her at bathing time because they told her they were short of help.
-The Medication Aide (MA) had to stop administering medications to assist the care aides with getting residents out of bed, off the toilet, or cleaning up soiled clothing.
-She thought the facility was often short on staff and the staff who worked had to pull extra shifts.

Interviews with six residents on 06/07/19 between 12:30pm and 1:16pm revealed:
-A resident did not feel like the facility did not have enough staff to help to take care of residents.
-Sometimes there were only two people in the halls during the day.
-Staff were overworked and the facility was understaffed.
-Sometimes it took 20 minutes for staff to respond to a call bell.
-Sometimes residents did not get their showers like they were supposed to.
-Staff did not check on residents every 2 hours because they did not have time.
-"They have too many people to take care of."

Interviews with 6 staff members on 06/07/19 between 11:37am and 1:43pm revealed:
-Staff had to work without full personal care aide staffing numbers.
-Occasionally staff assigned to do laundry were reassisgned to help with personal care, leaving the residents' laundry and linens undone when scheduled.
-MA staff sometimes had to stop the medication pass to assist with transferring a resident from

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the toilet to a wheelchair or to assist with personal care of a soiled resident. (this made it hard to complete the medication pass within scheduled times).
-One resident required total assistance with daily activities due to muscle weakness, and two staff were required for transfers to prevent back injuries to the staff.
-A second resident required assistance with transferring from her wheelchair to the toilet and back into the wheelchair.
-A third resident had complained regarding the facility being short staffed and unable to attend to residents' needs in a timely manner, especially when she had to wait 20 minutes for staff to get free to assist her to or from the toilet.
-The facility was always short staffed.
-Some days there was one PCA on the first shift and no MA.
-Sometimes the MAs had to stay over from the third shift to cover the first shift.
-The staff helped the residents but it took a long time for staff to get around to helping residents.
-Residents complained about the staff taking so long to assist them with personal care needs.
-Two staff (1 MA and 1 PCA) were not enough to provide adquate care to residents.
-There were around 40 residents assigned to 1 PCA on most shifts.
-Staff did what they could do and showered the residents who needed it the most.

Review of the facility's staff time cards and resident census revealed the facility was short personal care and supervision staff hours as follows:
-On 05/13/19, first shift was short 3.12 staff hours, second shift was short 14.34 staff hours and third shift was short 1.89 staff hours.
-On 05/14/19, first shift was short 2.33 staff

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hours, second shift was short 12.37 staff hours, and third shift was short 1.12 staff hours.
-On 05/15/19, first shift was short 3.22 staff hours, second shift was short 14.49 staff hours, and third shift was short 2.03 staff hours.
-On 05/16/19, first shift was short 1.25 staff hours, second shift was short 7.77 staff hours, and third shift was short 0.53 staff hours.
-On 05/17/19, first shift was short 1.25 staff hours and second shift was short 16.25 staff hours.
-On 05/18/19, first shift was short 14.10 staff hours, second shift was short 14.94 staff hours, and third shift was short 7.5 staff hours.
-On 05/19/19, first shift was short 9.12 staff hours, second shift was short 16.27 staff hours, and third shift was short 7.94 staff hours.
-On 05/20/19, first shift was short 1.67 staff hours, second shift was short 6.83 staff hours, and third shift was short 9.24 staff hours.
-On 05/21/19, second shift was short 6.6 staff hours and third shift was short 8.46 staff hours.
-On 05/22/19, second shift was short 12.56 staff hours and third shift was short 8 staff hours.
-On 05/23/19, second shift was short 8.84 staff hours and third shift was short 2.2 staff hours.
-On 05/24/19, second shift was short 12.76 staff hours and third shift was short 8.25 staff hours.
-On 05/25/19, first shift was short 8.57 staff hours, second shift was short 7.58 staff hours and third shift was short 12.5 staff staff hours.
-On 05/26/19, first shift was short 8 hours, second shift was short 8.27 hours and third shift was short 8 hours.
-On 05/27/19, first shift was short 1.25 staff hours, second shift was short 16 staff hours, and third shift was short 7.02 staff hours.
-On 05/28/19, second shift was short 9.05 staff hours and third shift was short 8 staff hours.
-On 05/29/19, second shift was short 8.5 staff hours and third shift was short 8 staff hours.

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{D 188}	Continued From page 11 -On 05/30/19, second shift was short 3.59 staff hours and third shift was short 1.63 staff hours. -On 05/31/19, first shift was short 2.95 staff working hours and second shift was short 9.5 staff working hours. -On 06/01/19, first shift was short 13.96 staff working hours, second shift was short 5.57 staff working hours, and third shift was short 3.71 staff working hours. -On 06/02/19, first shift was short 16.13 staff working hours, second shift was short 4.94 staff working hours, and third shift was short 4.8 staff working hours. -On 06/03/19, first shift was short 1.25 staff working hours, second shift was short 4.78 staff working hours, and third shift was short 10.91 staff working hours. Interview with Director of Resident Care (DRC) on 06/07/19 at 12:52pm revealed: -The medication aide/supervisor (MA/S) was responsible for creating the work schedule. -Although, she did not create the work schedule for the personal care aides (PCAs) and medication aides (MAs), the plan was to cover the building with staff according to the census. -She worked as the DRC, but some days she was not in the building all day because she had to take residents to appointments. -She also worked in the marketing office preparing the paperwork for new residents to get their monies. -There should be two MAs and two PCAs from 6:00am to 6:00pm and two MAs and two PCAs from 6:00pm to 6:00am. -She could only recall one date, 05/31/19 when a MA was a no call no show on the first shift and the facility was short staffed. -She had a DRC in training and made her be the MA at 6:00am until she was able to get another	{D 188}		

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staff to come in.
-When facility staff called off they usually called the MA/S because she was responsible.
-If the MA/S had a problem covering a shift she was supposed to let her or the Administrator know.

Interview with the medication aide/supervisor (MA/S) on 06/07/19 at 1:41pm revealed:
-She started doing the staff schedule last year to help the DRC out.
-The staff schedule had become her responsibility.
-Almost daily each shift was short staffed, especially on the evening shift after 6:00pm.
-When doing the schedule she tried to put two MAs and two PCAs on the all shifts, but planning for evening shift was a big problem.
-It was difficult to find staff that wanted to work overnight leaving the shift short staffed.
-She sometimes called in a part-time person to work from 11:00pm to 6:00am.
-When she was not able to find staff coverage for any shift she notified the Administrator and the DRC.

Interview with the Administrator on 06/07/16 at 5:45pm revealed:
-She knew some staff had unexpectedly quit or did not show up for work.
-The facility did not have the extra staff for call-offs.
-She knew there were days when the facility was short staffed.
-She knew some dates the facility was short staffed, because there was no one to work when staff called off.
-She did not know each shift was short staffed most days.
-The MA/S or the DRC were to let her know when

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THE MEADOWS OF ROCKWELL RETIREMENT CENTI	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

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{D 188}	Continued From page 13 they were not able to find staff to cover each shift. -The facility was in the process of hiring new staff, but had a hard time finding new staff. -She would make hiring staff a priority. _____ The facility failed to ensure adequate staff for personal care and supervision of the residents resulting in residents waiting long periods of time for staff assistance with personal care needs. The facility's 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 on 06/07/19 in accordance with G. S. 131D-34 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 23, 2019.	{D 188}		
{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 A2 VIOLATION Based on observations, interviews and record	{D 273}		

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{D 273}	Continued From page 14 reviews the facility failed to assure physician referrals and notifications for 3 of 6 sampled residents (Residents #2, #4, and #6) regarding a referral to cardiology for shortness of breath, and referral for bone density test (#2), a referral to a gastroenterologist and labs that were not obtained (#4), and a resident not seen by neurology and not scheduled for a mammogram and gynecology appointment (#6). The findings are: 1. Review of Resident #2's current FL2 dated 05/18/19 revealed: -Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), pulmonary emboli (PE) and chronic atrial fibrillation. -Physician's order for oxygen 1 liter per minute (lpm) continuously (used to treat shortness of breath). Review of Resident #2's record revealed hospital visits for complaint of chest pain and/or shortness of breath on the following dates: -Hospital admission 01/26/19 for chest pain with shortness of breath. -Hospital admission 05/16/19 for chest pain. -Hospital emergency department visit 05/26/19 for shortness of breath. Review of Resident #2's hospital discharge summary dated 05/18/19 revealed: -There was an admission date of 05/16/19 due to chest pain. -There were additional diagnoses of systolic congestive heart failure and chronic bronchitis. -Resident #2 presented to the hospital complaining of chest pain with associated shortness of breath.	{D 273}		

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{D 273}	Continued From page 15 -Resident #2 had a previous admission for complaints of chest pain on 01/26/19. a. Review of Resident #2's staff progress notes for May 2019 revealed documentation on 05/26/19 Resident #2 complained of shortness of breath and requested to be sent to the hospital. (Resident sent out the same day). Interview with Resident #2 on 06/06/19 at 10:56am revealed: -She had experienced shortness of breath daily, usually more than once per day. -When she was short of breath she had to sit in front of a fan to get air. -She informed facility staff when she felt short of breath. -Sometimes she requested to be sent to the hospital. -On 05/26/19 she requested to be sent to the hospital because she was experiencing shortness of breath. -She was not sure if she had not requested to be sent to the hospital facility staff would send her out. Interview with a medication aide (MA) on 06/05/19 at 4:18pm revealed: -Resident #2 had complained of shortness of breath daily. -Resident #2's primary care provider (PCP) should be notified through the 'Smart Page' system when Resident #2 had shortness of breath. -There was no documentation to show the PCP was notified when the resident was experiencing shortness of breath. Interview with the Director of Resident Care (DRC) on 06/05/19 at 4:13pm revealed:	{D 273}		

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-Resident #2 complained of shortness of breath 2-3 times daily after she had walked inside the building.
-The resident was on oxygen 2 lpm continuously.
-When Resident #2 complained of shortness of breath, the personal care aide (PCA) should notify the medication aide (MA).
-The MA should notify the PCP that the resident complained of shortness of breath.
-The MA should document the PCP was notified and why.

Interview with the Director of Resident Care (DRC) on 06/06/19 at 12:54pm revealed if there was no documentation the PCP was notified regarding Resident #2 experiencing shortness of breath, then there was no way to tell the PCP was notified.

Interview with Resident #2's primary care provider (PCP) on 06/07/19 at 9:35am revealed:
-She was notified via Smart Page system of Resident #2's complaint of shortness of breath on 05/16/19.
-There was no other documentation the facility notified her that Resident #2 continually experienced episodes of shortness of breath.
-She was not aware Resident #2 had daily complaint of shortness of breath.
-Should have informed when the resident was experiencing shortness of breath because the resident had a history of cardiac problems and COPD.

b. Review of Resident #2's hospital discharge summary dated 05/18/19 revealed there was a referral to cardiology if the resident continued to experience intermittence shortness of breath.

Review of Resident #2's hospital discharge

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{D 273}	Continued From page 17 summary dated 05/18/19 revealed: -Resident #2 had previous admission for complaints of chest pain on 01/26/19. -Following the discharge on 05/18/19, Resident #2 was to follow-up with cardiology if intermittent shortness of breath continued. Review of Resident #2's staff progress notes for May 2019 revealed: -On 05/26/19 Resident #2 complained of shortness of breath and requested to be sent to the hospital. -No other progress notes were documented for May 2019. Interview with Resident #2 on 06/06/19 at 10:56am revealed: -She had experienced shortness of breath on a daily basis, usually more than once per day. -She was seen by a cardiologist during the hospital admission in May 2019. -She had not seen a cardiologist since she was discharged from the hospital on 05/18/19. -She returned to the hospital emergency department due to shortness of breath on 05/26/19. -She does not have an appointment with a cardiologist. -Staff had not discussed a cardiology referral with her. -She believed she should follow-up with a cardiologist. Interview with a medication aide (MA) on 06/05/19 at 4:18pm revealed: -Resident #2 had complained of shortness of breath daily. -The primary care provider (PCP) should be notified through the 'Smart Page' system when Resident #2 had shortness of breath.	{D 273}		

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{D 273}	Continued From page 18 -The MA did not know if Resident #2 experienced shortness of breath she was to be referred for cardiology follow-up. Interview with another MA on 06/06/19 at 10:10am revealed: -The Director of Resident Care (DRC) was responsible for reviewing and implementing discharge orders from the hospital. -MAs did not have a key to access residents record, which were kept in the DRC's office, when the DRC was not present. Interview with the DRC on 06/05/19 at 4:13pm and 06/06/19 at 12:15pm revealed: -Resident #2 complained of shortness of breath 2-3 times daily after she had walked inside the building after 05/18/19 discharge from the hospital. -When Resident #2 had complained of shortness of breath, the personal care aide should have notified the MA. -The MA should notify the PCP of Resident #2's complaint of shortness of breath. Interview with the DRC on 06/06/19 at 12:54pm revealed: -Resident #2 was re-admitted to the facility on a weekend; on the following Monday, the DRC should have reviewed and assured implementation of the discharge orders. -There was no documentation a referral to cardiology for shortness of breath was made. Interview with Resident #2's PCP on 06/07/19 at 9:35am revealed: -The PCP was aware of the cardiology referral. -Resident #2 needed a cardiologist follow-up if she had been short of breath. -She was notified of Resident #2 complaining of	{D 273}		

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shortness of breath on 05/16/19; she was admitted to the hospital on 05/16/19.
-She was not notified on any other date of Resident #2 having been short of breath after 05/18/19.
-She was presented and signed the hospital discharge plan; and expected the orders to be implemented.
-The PCP stated Resident #2 needed to see a cardiologist when asked what could be the impact to her health.

c. Review of Resident #2's primary care provider (PCP) visit on 04/03/19 revealed an order for a Dexa scan (used to determine bone density).

Review of Resident #2's hospital discharge summary dated 5/18/19 revealed a diagnosis of osteoporosis.

Interview with Resident #2 on 06/05/19 at 2:12pm revealed:
-She had not had a Dexa (bone) scan.
-She had not been scheduled to have a bone scan.
-She did not know a bone scan had been ordered.

Interview with a medication aide (MA) 06/06/19 at 10:10am revealed:
-The MA did not know of Resident #2's order for a Dexa (bone) scan dated 04/03/19.
-The Director of Resident Care (DRC) was responsible for reviewing and implementing orders from the PCP.

Interview with the DRC on 06/06/19 at 12:15pm revealed she did not know about a Dexa scan order for Resident #2.

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{D 273}	Continued From page 20 Interview with Resident #2's PCP on 06/07/19 at 9:35am revealed: -She ordered a Dexa scan for Resident #2 on 04/03/19. -She did not know if the scan had been done. -She had not seen scan results. Interview with Resident #2's Radiology office staff on 06/07/19 revealed no Dexa scan had been scheduled or performed for Resident #2. 2. Review of Resident #4's current FL2 dated 01/09/19 revealed diagnoses included chronic kidney disease stage II, anxiety, coronary artery disease, depression, diabetes mellitus, dyskinesia, hypertension, osteoporosis, and vitamin D deficiency. a. Review of a progress note from a specialist physician dated 01/23/19 revealed: -Resident #4 had been seen on 01/23/19 due to a diagnosis of Achalasia (A rare disorder making it difficult for food and liquid to pass into the stomach.) -Resident #4 regurgitated his food and had reported weight loss. -There were instructions for Resident #4 to return the specialist in 2 months for a follow-up appointment. -The follow-up appointment had been scheduled for 03/27/19 at 11:00am and was printed on the progress note. Review of Resident #4's record revealed no documentation Resident #4 had returned to the specialist for a follow-up appointment on 03/27/19. Interview with Resident #4 on 06/04/19 at 4:10pm and 06/05/16 at 4:16pm revealed:	{D 273}		

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{D 273}	Continued From page 21 -He had been a resident at the facility for around 5 months. -He had been throwing up 3 to 4 times a day usually after he ate. -He had talked to the facility doctor about throwing up after his meals. -He remembered going to see a specialist once since being at the facility, but he had not had any other outside appointments regarding throwing up after his meals. Interview with the Director of Resident Care (DRC) on 06/06/19 at 9:25am revealed: -Her responsibilities included reviewing and following up with physician's orders from the primary care provider (PCP) and other outside physicians. -She was responsible for scheduling medical appointments for residents. -She did not remember seeing the progress note from the specialist physician dated 01/23/19 with the recommendation with the follow-up appointment scheduled for 03/27/19. -She contacted the specialist office on 06/06/19 and was told Resident #4 had a follow-up appointment scheduled for 03/27/19 and he did not attend. -The appointment scheduled for 03/27/19 was not written on her resident appointment calendar. -She did not know why Resident #4 did not attend the follow-up appointment with the specialist on 03/27/19. Interview with the Administrator on 06/05/19 at 6:06pm revealed: -She did not know Resident #4 had a follow-up appointment with the specialist scheduled for 03/27/19. -She did not know why Resident #4 had not attended his scheduled appointment with the	{D 273}		

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specialist.
-She expected staff to make sure resident attended their medical appointments.

Interview with the PCP on 06/05/19 at 2:10 pm revealed:
-She knew Resident #4 continued to regurgitate food.
-She did not know Resident #4 did not attend his scheduled appointment with the specialist on 03/27/19.
-She expected Resident #4 to attend his follow-up appointment with the specialist regarding him regurgitation food.

Interview with a representative from the specialist office on 06/07/19 at 2:19pm revealed:
-Resident #4 had an appointment scheduled for 03/27/19.
-Resident #4 was a no-show to the follow-up appointment scheduled for 03/27/19 and the facility did not call to reschedule the appointment.
-The facility called on 06/07/19 to reschedule the follow-up appointment for 06/13/19.

b. Review of a progress note from a specialist physician dated 01/23/19 revealed:
-Resident #4 had been seen on 01/23/19 due to a diagnosis of Achalasia.
-Resident #4 regurgitated his food.
-A referral was made over a year ago (prior to Resident #4 being admitted to the facility) to see another specialist for a 2nd opinion regarding the diagnosis of Achalasia (A rare disorder making it difficult for food and liquid to pass into the stomach).
-Resident #4 had not been seen by the referred specialist for a 2nd opinion.
-As a result of the visit with the specialist on 01/23/19, the specialist recommended Resident

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{D 273}	Continued From page 23 #4 see the previously referred hospital specialist for manometry (esophageal study) to confirm diagnosis of achalasia. Review of a physician's order dated 01/23/19 revealed an order to schedule an appointment for Resident #4 with the hospital specialist for manometry to confirm diagnosis of achalasia. Review of Resident #4's record revealed no documentation Resident #4 had been seen by the hospital specialist to confirm diagnosis of achalasia. Interview with Resident #4 on 06/04/19 at 4:10pm and 06/05/16 at 4:16pm revealed: -He had been a resident at the facility for around 5 months. -He had been throwing up 3 to 4 times a day usually after he ate. -He had talked to the facility doctor about throwing up after his meals. -He remembered going to see a specialist once since being at the facility, but he did not see the hospital specialist for testing. Interview with the Director of Resident Care (DRC) on 06/06/19 at 9:25am revealed: -Her responsibilities included reviewing and following up with physician's orders from the primary care provider (PCP) and other outside physicians. -She was responsible for scheduling medical appointments for residents. -She did not remember seeing the progress note from the specialist physician dated 01/23/19 with the recommendation for Resident #4 to see a hospital specialist for manometry to confirm the diagnosis of achalasia. -She remembered seeing the order from	{D 273}		

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Resident #4's PCP for him to be seen by the hospital specialist.
-She asked Resident #4's PCP if the resident saw the hospital specialist and remembered being told it was thought that Resident #4 had been seen by the hospital specialist.
-She had not followed up with the hospital specialist's office to ensure resident had been seen.

Interview with the Administrator on 06/05/19 at 6:06pm revealed:
-She did not know Resident #4 had an order dated 01/23/19 to see a hospital specialist and she did not know Resident #4 had not been seen by the hospital specialist as of 06/06/19.
-She did not know why Resident #4 was not scheduled or attended an appointment with the hospital specialist.
-She expected staff to make sure residents attended their medical appointments.

Interview with the PCP on 06/05/19 at 2:10 pm revealed:
-She knew Resident #4 continued to regurgitate food.
-She wrote an order on 01/23/19 for Resident #4 to see the hospital specialist because of him continuing to regurgitate and to confirm his diagnosis of achalasia.
-The facility had not informed her Resident #4 had not been seen by the hospital specialist regarding his diagnosis of achalasia.
-She would think Resident #4 would worsen if he did not follow up with the hospital specialist.
-She expected Resident #4 to be seen by the hospital specialist as ordered.

Interview with a representative from the specialist office on 06/07/19 at 2:19pm revealed Resident

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{D 273}	Continued From page 25 #4 had a follow up appointment scheduled with this clinic scheduled for 06/13/19 and the specialist would assess to see if another referral to the hospital specialist was still needed. Attempted telephone interview with the hospital specialist office on 06/07/19 at 3:57pm was unsuccessful. c. Review of Resident #4's primary care physician's (PCP) encounter report dated 03/27/19 revealed an order for laboratory work including a complete blood count (CBC), a comprehensive metabolic panel (CMP), thyroid stimulating hormone (TSH), fasting lipids, and Vitamin D level. Review of Resident #4's record revealed: -There were laboratory tests results dated 01/16/19 for CBC, CMP, and TSH. -There were no lab test results for a CBC, CMP, or TSH, after labs were ordered on 03/27/19. Interview with Resident #4 on 06/05/16 at 4:16pm revealed he did not know if any lab tests had been ordered and did not remember when he last had blood drawn for lab tests. Interview with the Director of Resident Care (DRC) on 06/07/19 at 12:05pm revealed: -It was her responsibility to schedule for labs to be completed by a contracted laboratory provider. -Phlebotomists had difficulty locating a vein to draw blood from Resident #4 for labs. -She had to reorder labs for Resident #4 twice due to difficulty obtaining a blood sample. -She did not remember the dates when blood draws for labs were requested and she did not know where lab request forms were for Resident #4.	{D 273}		

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THE MEADOWS OF ROCKWELL RETIREMENT CENTI	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(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 273}	Continued From page 26 -She did not document attempts to have blood drawn and labs completed in Resident #4's resident notes. Interview with the Administrator on 06/07/19 at 11:16am revealed: -The DRC was responsible for scheduling labs to be completed for residents. -She did not know about the laboratory tests ordered for Resident #4 on 03/27/19. -Usually when the order for laboratory tests was sent to the lababoratory, the laboratory staff came out within 24 hours to draw labs. -She did not know if there were times when the laboratory staff was unable to draw Resident #4's blood to complete tests. -She expected to be laboratory tests to be completed as ordered by the physician. Interview with the contracted laboratory provider on 06/07/19 at 9:09am revealed: -There was not an order for laboratory tests for Resident #4 dated 03/27/19. -The last labs for a CBC or CMP were completed for Resident #4 on 01/16/19. -There was no documentation of any unsuccessful attempts to draw blood from Resident #4 to obtain labs. Interview with Resident #4's PCP on 06/05/19 at 2:10pm revealed: -She wrote an order for laboratory tests on 03/27/19. -She had not seen the results of the laboratory tests ordered on 03/27/19. -The last laboratory test results that she has seen were from 01/16/19. -The PCP group has a lab which could draw and process results, but the facility liked to use their own contracted lab.	{D 273}		

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{D 273}	Continued From page 27 -The facility scheduled the labs for residents and gave results to her when she visited the facility each week. -She ordered the labs for Resident #4 because he was not able to hold his food down and without the lab results, she was not able to tell what was going on within Resident #4. -She expected for lab tests to be completed as ordered. 3. Review of Resident #6's current FL2 dated 05/04/19 revealed: -Diagnoses included pneumonia, sepsis, encephalopathy, transient ischemic attack, acute kidney injury, hyponatremia, hypertension, and acute respiratory failure. a. Review of Resident #6's record revealed a physician's order dated 04/03/19 to "schedule routine mammogram (history of breast cancer)." Review of Resident #6's record revealed no documentation an appointment was scheduled for a mammogram. Review of the Director of Resident Care (DRC) scheduling book revealed there was no past or current appointment scheduled for a mammogram for Resident #6. Interview with Resident #6 on 06/04/19 4:52 pm revealed: -She previously had breast cancer. -She felt it was important for her to have mammogram to ensure she was still cancer free. -She asked the DRC several times last year (2018) and this year (2019) to schedule her a mammogram appointment. -As of 06/04/19, the DRC had not scheduled her an appointment.	{D 273}		

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{D 273}	Continued From page 28	{D 273}		

-When she asked the DRC why she had not scheduled the appointment and she was told the facility did not have a driver to take her to appointments.
-The facility previously had a van driver, but he left in March 2019.

Interview with Resident #6's primary care provider (PCP) on 06/05/19 at 2:22pm revealed:
-On 04/03/19, Resident #6 made her aware that she had been asking for a mammogram.
-On 04/03/19, she wrote a referral for the resident to have a mammogram.
-As of today's, date Resident #6 had not gotten the mammogram.
-The facility staff were "bad" about scheduling referral appointments and rescheduling appointments.
-The facility's process about scheduling referral appointments had not been followed.
-She did not know what the problem was or why the facility failed to obtain health care services for the residents as requested.
-The facility's failure to make or take residents to referral appointments delayed the residents getting treatment or diagnoses for health care problems.

Interview with the DRC on 06/06/19 at 11:30am revealed:
-She was unable to find an appointment for Resident #6 to have a mammogram.
-She did not know why Resident #6 was not scheduled for a mammogram.
-She suspected the referral for the mammogram had been filed in the resident's record.
-She was the one that filed the paperwork in the resident's record.
-She missed the referral for the mammogram.
-It was her responsibility to review paperwork and

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{D 273}	Continued From page 29	{D 273}		

identify physician's orders like referrals for mammograms.
-She missed some physician's orders for referrals because she did not have the time to go through all the "stacks of papers" to identify orders for referrals.
-The plan was to have a set person that was responsible for scheduling appointments and making arrangements to get residents to the appointments.
-But as of 06/06/19, no one had been hired to perform those duties, therefore she was going it all.

b. Review of Resident #6's record revealed a physician's order dated 04/03/19 to schedule a "GYN" (gynecology) visit.

Review of Resident #6's record revealed no documentation an appointment was scheduled for a GYN visit.

Review of the DRC's scheduling book revealed there was no past or current appointment scheduled for a GYN visit for Resident #6.

Interview with Resident #6 on 06/04/19 4:52 pm revealed:
-She had not seen a GYN doctor in at least two years.
-The facility had not mentioned to her that they had scheduled her an appointment with the GYN doctor.

Interview with Resident #6's PCP on 06/05/19 at 2:22pm revealed:
-On 04/03/19, she referred Resident #6 for a GYN visit.
-It was time for the resident to have a check-up.
-As of 06/05/19 Resident #6 had not been to see

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{D 273}	Continued From page 30	{D 273}		

the GYN doctor.
-The facility's process about scheduling referral appointments had not been followed.

Interview with the DRC on 06/06/19 at 11:30am revealed:
-She was unable to find an appointment made for Resident #6 to see the GYN doctor.
-She did not know why Resident #6 was not scheduled see the GYN doctor.
-She suspected that the referral had been filed in the resident's record and the order for the GYN visit was missed.
-Right now, she was responsible for reviewing the paperwork and scheduling appointments.
-She did miss physician's orders for referrals because she did not have the time to go through all the "stacks of papers" to identify orders for referrals.

c. Review of Resident #6's current FL2 dated 01/09/19 revealed diagnoses included chronic pain.

Interview with Resident #6 on 06/04/19 4:52pm revealed:
-She had painful migraine headaches.
-The primary care provider (PCP) had referred her to a neurologist for the headaches.
-She asked the Director of Resident Care (DRC) several times about her neurology appointment and was told there was no one to take her to appointments.
-Her head hurts all the time and she felt like she could not take much more.

Interview with Resident #6's PCP on 06/05/19 at 2:22pm revealed:
-Over a month ago, maybe March or early April 2019, Resident #6 complained about bad

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{D 273}	Continued From page 31 headaches. -She thought the headaches were migraines and wanted the resident to see a neurologist. -Resident #6 complained the headaches were getting worse. -She ordered pain medication for the headaches, but still wanted the resident to see a neurologist. -She wrote a referral for the facility staff to make an appointment for Resident #6 to see a neurologist. -She felt it was important that Resident #6 was seen by a neurologist to possibly help with the migraine headaches. -As of 06/05/19, the facility staff still had not made the appointment for Resident #6. -The facility's process about scheduling referral appointments had not been followed. Review of Resident #6's record revealed there was no appointment scheduled with a neurologist. Review of the DRC's appointment scheduling book on 06/06/16 revealed: -There was a past appointment for neurology scheduled for 05/29/19. -There was a line drawn through the appointment and the letters "Res" wrote across the resident's name. -There was another appointment date scheduled for 07/02/19. Interview with the DRC on 06/06/19 at 11:43am revealed: -Resident #6 was referred to neurology for migraine headaches. -She made the resident an appointment for 05/29/19. -The appointment had to be rescheduled because there was no staff to take the resident to	{D 273}		

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{D 273}	Continued From page 32 the appointment. -The appointment was now scheduled for 07/02/19. -When the physician made a referral, she was responsible for reviewing the paperwork and scheduling appointments. -Some days she took residents to their appointments, but most times she just rescheduled appointments. Interview with the Administrator on 06/07/19 at 5:50pm revealed: -She did not know the DRC had not made referral appointments for residents. -The DRC was responsible for scheduling appointments for the residents. -The DRC was to ensure all residents had a ride to their appointment. -She knew the facility van was broken in March 2019, but the facility got a new van in April 2019. -The DRC was supposed to find someone to drive the van, seek family members for assistance with taking resident's to appointments or obtain outside transportation. The facility failed to assure referral and follow up for the acute health care needs of 4 of 6 sampled residents including Resident #2 who had four visits to the hospital for difficulty breathing and was referred to cardiology with continued shortness of breath, Resident #4 had a serious esophageal condition and he was regurgitating after meals, and Resident #6 had migraine headaches and a history of breast cancer and a referral for a mammogram was not scheduled. The facility's failure to contact the primary care provider and health care specialist placed the residents at substantial risk of neglect and physical harm and constitutes a Type A2 Violation.	{D 273}		

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{D 273}	Continued From page 33 The facility provided a Plan of Protection on 06/06/19 in accordance with G. S. 131D-34. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 7, 2019.	{D 273}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 1 of 5 sampled residents (Resident #3) with an order for prune juice daily. The findings are: Review of Resident #3's current hospital FL2 dated 05/10/19 revealed diagnoses included hypertension, urinary retention, and constipation.	D 276		

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D 276	Continued From page 34 Review of Resident #3's primary care provider (PCP) orders revealed prune juice daily was ordered on 05/22/19 and clarified on 05/22/19 to administer 8 ounces of prune juice daily. Review of Resident #3's May 2019 electronic medication administration record (eMAR) revealed: -There was no entry for prune juice eight ounces daily listed on the eMAR. -There was no documentation of administration of 8 ounces of prune juice from 05/22/19 to 05/31/19. Review of Resident #3's June 2019 eMAR revealed: -There was no entry for prune juice eight ounces daily listed on the eMAR. -There was no documentation of administration of 8 ounces of prune juice from 06/01/19 to 06/07/19. Interview with Resident #3 during the initial tour on 06/04/19 at 10:20am revealed: -He had been in the hospital recently for constipation. -He was still very uncomfortable because he did not have routine bowel movements. -He had not had a bowel movement in several days. -He had been seen by the resident's PCP related to his constipation, but he was still having difficulty having bowel movements. Interview with Resident #3's PCP on 06/05/19 at 9:15am revealed; -Resident #3 was treated in the hospital for a bowel impaction and released on 05/10/19. -Resident #3 did not currently have another impaction.	D 276		

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D 276	Continued From page 35 Interview with the Dietary Manager on 06/07/19 at 8:15 am revealed: -He did not know Resident #3 had an order for prune juice 8 ounces daily. -If he knew Resident #3 an order for eight ounces of prune juice daily, he would assure the dining room staff served the prune juice. -He did not have any prune juice in the kitchen area that could be administered to Resident #3. -He had not seen prune juice available to be ordered from the food supplier. -The Director of Resident Care (DRC) would be responsible to inform the DM if he needed to serve Resident #3 prune juice daily. Interview with Resident #3 on 06/07/19 at 8:25am revealed: -He knew his PCP ordered prune juice for him because she told him prune juice may help with his constipation. -The DRC told him on 06/06/19 that she would go to the store to buy him prune juice. -He had not received any prune juice as of today, 06/07/19. -He still felt like he needed to have a bowel movement. -He did not recall a bowel movement in about a week. Interview with the DRC on 06/07/19 at 8:50 am revealed: -She had not processed the order for Resident #3's prune juice. -The order was entered in the eMAR system by the DRC on 05/16/19 but needed clarification for the quantity of the dose. -The PCP clarified the dose for 8 ounces of prune juice daily on her next facility visit on 05/22/19. -The DRC had not released the order for	D 276		

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Resident #3's prune juice to appear in the eMAR system for the MAs to administer.
-Resident #3's prune juice would need to be purchased at a local grocery store because she did not think the food vendor stocked prune juice.
-She had not spoken with the DM regarding Resident #3's order for prune juice.
-She did not have a system in place to routinely audit residents' records for implementing new orders in a timely manner.
-She overlooked completing Resident #3's order for 8 ounces of prune juice daily.
-She had not purchased Resident #3's prune juice.
-She would purchase prune juice for Resident #3 and start his order today (6/07/19).

Interview with Resident #3's PCP on 06/07/19 at 9:20am revealed:
-She did not know Resident #3 was not taking prune juice.
-She expected the facility to start orders for residents with 24 to 48 hours after the orders were written.
-Resident #3 had a chronic problem with constipation including the recent hospitalization for constipation.
-She felt Resident #3 would benefit from the addition of prune juice helping to promote bowel movements and relieve his stomach aching and feeling of fullness.
-He could end up with another bowel impaction or blockage.

Interview with a medication aide (MA) on 06/07/19 at 10:15am revealed:
-The MA staff did not enter orders into the facility eMAR system.
-She had never seen prune juice on the medication cart for Resident #3.

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D 276	Continued From page 37 -She did not know Resident #3 had an order for prune juice daily. -If prune juice was on the eMAR, the MAs would be responsible to either go to the kitchen to get prune juice to administer, verify somebody gave the resident prune juice or the resident received prune juice in the dining room. Interview with a second MA on 06/07/19 at 11:10am revealed: -Resident #3 did not have an order for 8 ounces of prune juice daily on the June eMAR. -She did not enter orders into the facility's eMAR computer system. -She did not know Resident #3 had an order for 8 ounces of prune juice daily because it did not show up on the eMAR for administration. -The MA on duty when physician's orders were left by the PCP was responsible to fax the new orders to the pharmacy for entering into the facility eMAR system. -The DRC was responsible to review the orders entered into the eMAR system and release orders to appear for the MAs to administer. Interview with the Administrator on 06/07/19 at 6:35pm revealed: -The DRC was responsible to assure orders were implemented for residents. -The DRC, the contract pharmacy, and a lead MA Supervisor had the ability to enter orders in the eMAR system. -The DRC and lead MA Supervisor were responsible to release orders that had been entered in order for the orders to appear for the MAs to administer.	D 276		
{D 282}	10A NCAC 13F .0904(a)(1) Nutrition and Food Service	{D 282}		

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{D 282}	Continued From page 38 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: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations and interviews, the facility failed to keep food prep table shelving, steam table pans and cutting board, and the dish washing area floor clean and free of contamination. The findings are: Observation of the kitchen on 06/04/19 at 9:40am revealed: -There were three shelves which stored cooking pots, pans, and lid covers which had a sticky brown substance and a crusty white substance on them. -There was one shelve which stored saucers that had a sticky brown substance. -There were five steam pans on the steam table and all were rusted and had a buildup of a brown sticky film in them. -The black gasket inside of the ice machine lid was missing from the entire length of the door; the gaskets on the side of the door were breaking apart and loose. Observation of the kitchen on 06/04/19 at 9:47am and 1:36pm revealed:	{D 282}		

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{D 282}	Continued From page 39 -There was a drain pipe which ran from the dishwasher food trap sink, curved under into the floor where a floor tile that had been cut out, and the pipe ran from the floor into a food/grease trap box which sat on the floor. -There was dirty standing water in the hole where the tile had been cut out for the drain to fit. -The grease/food trap box on the floor under the dishwasher was leaking and water was standing on the floor between the grease/food trap box and the wall and behind the grease/food trap box. -There was a light brown substance floating on top of the standing water and there was a foul odor. -There was a grimy black substance which outlined the grease/food trap where it connected to the floor. Observation of the kitchen on 06/05/19 at 8:41am and 6:38pm revealed: -The steam table had a wooden cutting board which was approximately 6 to 8 feet long. -The cutting board side edge of the serving staff and about 2 inches on the top of the cutting board on the side of the serving staff were covered in a thick coat of a dirt. -The DM took a scrubbing pad and scrubbed the cutting board removing the dirt from the top and side edge of the cutting board. Interviews with the Dietary Manager (DM) on 06/04/19 at 9:41am and 06/05/19 at 6:38pm revealed: -There was tile removed from the floor under the dishwasher so that there would be room for the drain pipe to run under the floor level where the tile was removed. -There was water up under the tile that always filled the hole where the pipe laid under the floor under the dishwasher.	{D 282}		

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{D 282}	Continued From page 40 -There has been standing water in the hole under the dishwasher since he started working in October 2018. -He had not told maintenance staff about the standing water in the hole under the dishwasher. -"The Administrator knows and the Director of Resident Care (DRC) knows." -Water usually came out of the grease/food trap box on the floor when the dietary staff ran dishes through the dishwasher. -He usually let the water drain while the dishes were being washed and then cleaned it up. -The water had been draining into the floor for about a week. -If there was an issue with equipment, he would usually tell the maintenance staff or the Administrator. -He had not told anyone about the water draining from the grease/food trap box onto the floor. -He thoroughly cleaned the ice machine, but he did not know why the gasket around the lid had not been replaced. -The steam pans were cleaned after every shift, but they needed to be replaced. -He had not told anyone the gaskets on the ice maker lid needed to be replaced. -There was a cleaning schedule posted in the kitchen. -The staff were to complete cleaning tasks on certain days. -There was no way to assure tasks were completed because the cleaning schedule did not have dates or lines to sign or initial when a task had been completed. -The kitchen should be cleaned daily. -He did not remember the last time the kitchen was deep cleaned. Interviews with the cook on 06/04/19 at 1:36pm and 06/05/19 at 8:25am revealed:	{D 282}		

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{D 282}	Continued From page 41 -The hole in the floor where the pipe was always held standing water. -"You can put a rag down and soak it up and it will come right back." -Maintenance staff had looked at the pipe and standing water a few months ago, but there was nothing done about it. -The water started leaking from the grease/food trap box around January 2019. -She mopped the leaking water up from around the grease/food trap box several times during her shift. -All the upper management knew about the leaking water. -The maintenance staff had not looked at the leaking water around the grease/food trap box to her knowledge. -She and the DM were responsible for cleaning the kitchen area. -There was not a weekly schedule that they signed off on when cleaning tasks were completed. -There was a generic cleaning chart posted on the wall in the kitchen. -She last cleaned the shelf with the saucers on Monday, 06/03/19, and she did not know how the shelf got dirty again. -The DM cleaned the other shelves yesterday, on 06/04/19. -The dietary staff did not clean the steam pans. -She usually just rinsed the steam pans and put clean water in them when she started her shift. -Sometimes there was water and food particle left in the steam pan when she came in to work. -"We definitely need new steam pans." -She cleaned the cutting board everyday with a rag and sanitizer, but it had never been deep cleaned. -The cutting board was so old, she was not sure the dirt would ever come out.	{D 282}		

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{D 282}	Continued From page 42 Interview with maintenance staff on 06/04/19 at 3:31pm revealed: -He came to the facility twice a week. -He knew the drain pipe that ran into the floor leaked. -"I knew it was there, but I didn't know what to do with it. -It had been leaking since before he started working at the facility in March 2019. -He had not consulted with a Corporate Maintenance staff or contacted a plumber. -Dietary staff had not told him about the water leaking from grease/food trap box. -He knew a grease trap box on the other side of the dish washing area had been cleaned out around April 2019, but he did not know the last time the leaking grease/food trap box had been cleaned. -He did not know about the gasket that was torn and missing in some places on the inside cover of the ice machine. Interview with a second maintenance staff on 06/05/19 at 11:21am revealed: -He was called from another facility on 06/05/19 to assist with the water leaking from the grease/food trap box and the standing water in the floor from the leaking pipe, -The pipe in the floor leaked and it was going to be replaced. -Maintenance staff lifted the top of the grease/food trap and there was a lot of food particles and water trapped inside which was more than likely causing the leaking water on the floor. -The grease/food trap should have been cleaned out about once a month. -The odor came from the build-up of food in the grease/food trap box.	{D 282}		

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{D 282}	Continued From page 43 Observation of the kitchen on 06/05/19 at 12:29pm revealed: -The cracked pipe had been removed from the floor and the missing tile had been filled in to the level of the floor. -There was a new drainage pipe which led to the back of the sink instead of to the floor. -The grease/food trap box under the dishwashing sink area had been removed and the floor under the dishwasher area had been cleaned. Interview with the Administrator on 06/06/19 at 12:04pm revealed: -She knew the gasket on the inside cover of the ice machine needed to be replaced, but she did not know why it had not been replaced. -"Maintenance staff had a hard time getting everything together." -She knew there was standing water surrounding the drainage pipe in the floor in the kitchen under the dishwasher food trap sink. -Maintenance staff could not figure out what to do about the drainage pipe or standing water. -The dietary staff kept putting a bleach in the standing water to sanitize it. -She did not know how long the pipe had been leaking or if a plumber had been called. -She thought a work order had been placed with the company, but no one followed up to see if one had been received. -She should have followed up regarding the work order for the leaking drainage pipe with standing water. -No one had notified her about the water leaking from the grease/food trap box. -The grease food/storage box should have been cleaned every 3 to 6 months. -She contacted the corporate office on 06/05/19, to check about getting a new steam table.	{D 282}		

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{D 282}	Continued From page 44 -The pans on the steam table were in bad shape and could have been replaced. -She did not know why the pans on the steam table had not been replaced. -There was a cleaning schedule, but she did not understand how to read it. -She did not know how the dietary staff kept up with what was cleaned or who clean what in the kitchen. -She expected for the kitchen staff to follow a cleaning schedule and for the kitchen to be kept clean.	{D 282}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to assure 3 of 6 sampled residents (#2, #9, and #10) with therapeutic diet orders for a cardiac diet (#2), a ground meal (#9), and a puree diet (#10) were served as ordered. The findings are: 1. Review of Resident #2's current FL2 dated 01/09/19 revealed: -Diagnoses included chronic obstructive pulmonary disease, coronary artery disease, Chron's disease, hypertension, Parkinson's disease, pulmonary embolism, anxiety and depression.	{D 310}		

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{D 310}	Continued From page 45 -There was a diet order for chopped meats and no added table salt (NATS). Review of a hospital discharge summary orders for Resident #2 dated 05/18/19 revealed an order for a cardiac diet. Review of the therapeutic diet list dated 02/08/19 posted in the kitchen on 06/04/19 revealed: -Resident #2 was listed to be served a NATS diet. Review of the facility's therapeutic diet menus revealed there was no menu for a Cardiac diet; therefore, it could not be determined what Resident #3 should have been served. Review of the NATS lunch menu for 06/05/19 revealed residents were to be served spinach chicken tortellini, yellow squash with onions, beverage of choice, and assorted cookies. Observation of the lunch meal service on 06/05/19 between 11:30am and 12:30pm revealed: -Resident #2 was served spinach chicken tortellini, yellow squash with onions, a cookie, tea, and water. -Resident #2 consumed 75% of the meal. Review of the NATS lunch menu for 06/06/19 revealed residents were to be served baked pork chops, smashed sweet potatoes, fried okra, a baked roll, beverage of choice and cinnamon stewed apples. Observation of the lunch meal service on 06/06/18 at 11:30am to 12:30pm revealed: -Resident #2 was served baked pork chop, mashed potatoes, breaded okra, a roll, orange sherbet, tea, and water.	{D 310}		

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{D 310}	Continued From page 46	{D 310}		

-Resident #2 gave her porkchop to another resident and consumed about 75% of her remaining meal.

Interview with Resident #2 on 06/07/19 at 8:55am revealed:
-She did not think she was on a special diet.
-She had not been told by her primary care provider (PCP) she needed to be on a special diet and did not know about the order from the hospital for a cardiac diet.
-Staff sometimes cut up her meat and sometimes she cut up her meats.

Interview with the Director of Resident Care (DRC) on 06/06/19 at 9:25am revealed:
-She was responsible for maintaining and for updating the therapeutic diet list for the dietary staff when there was a change in a resident's diet or when a new resident was admitted to the facility.
-The facility served regular, NATS, chopped, ground, and pureed diets.
-If a resident received a diet order for a therapeutic diet that was not served at the facility, she would contact the resident's PCP to see which diet the PCP wanted the resident to be served.
-She was responsible for reviewing hospital discharge summaries for new orders.
-She did not know there was an order on Resident #2's hospital discharge summary dated 05/18/19 for a cardiac diet for Resident #2.
-The facility did not serve a cardiac diet and did not have a menu for a cardiac diet.
-"It was an oversight."
-She would contact Resident #2's PCP to see if she could get an updated diet order.
-The Dietary Manager (DM) and dietary staff were responsible for making sure diets were served as

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{D 310}	Continued From page 47 ordered. Interview with the DM on 06/06/19 at 5:59pm revealed: -He had never seen any diets orders and did not know Resident #2 had a diet order dated 05/18/19 for a cardiac diet. -He did not know there was a diet order dated 01/19/19 for a NATS diet with chopped meats. -The facility did not serve a cardiac diet and there was not a menu for a cardiac diet. -He thought Resident #2 was on a regular diet and had been serving her a regular diet. -Residents on NATS diets were served the same as residents on regular diets. -If there was a change in a resident's diet order, the DRC would tell him what the change was or bring him a "paper" with instructions. Interview with the Administrator on 06/06/19 at 12:04pm revealed: -The DRC was responsible for reviewing hospital discharge summaries for changes in diet orders. -The DRC was responsible for making sure the dietary staff knew of any changes in diet orders. -She did not know there was an order for a cardiac diet for Resident #2 on a hospital discharge summary dated 05/18/19. -The facility did not serve a cardiac diet. -The DRC should have contacted Resident #2's PCP to obtain orders for an appropriate diet which the facility serves. Interview with Resident #2's PCP on 06/07/19 at 9:13am revealed: -Resident #2 should be on a regular diet. -There was an order from the hospital for a cardiac diet, but the facility did not offer a cardiac diet. -The facility had not contacted her to get Resident	{D 310}		

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{D 310}	Continued From page 48 #2's diet order updated prior to 06/06/19. -Resident #2 could have her meats chopped per her request. 2. Review of Resident #9's current FL2 dated 01/09/19 revealed: -Diagnoses included dementia, gastroesophageal reflux disease, dysphagia, and B12 deficiency. -There was a physician's order for a pureed diet. Review of Resident #9's diet order dated 01/09/19 revealed: -There was an order for a pureed diet. -Pureed was defined on the diet order as a "modification designed to provide foods of a smooth, soft consistency, like fluffy, whipped potatoes. Pureed foods should hold their shape without liquid separating them. A thickener may need to be used. This diet is usually ordered for residents with difficulty swallowing." Review of the therapeutic diet list dated 02/08/19 posted in the kitchen on 06/04/19 revealed Resident #9 was listed to be served a pureed diet. Review of the facility pureed lunch menu for 06/05/19 revealed Resident #9 was to be served pureed spinach chicken tortellini, pureed yellow squash and onions, beverage of choice, and pureed assorted cookies. Observation of the lunch meal service on 06/05/19 between 11:30am and 12:30pm revealed: -Resident #9 was served a large green scoop of a pureed food, 1 medium yellow scoop of a pureed food, water and tea. -The green and the yellow pureed food appeared runny and was separated by liquid on the plate.	{D 310}		

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{D 310}	Continued From page 49	{D 310}		

-The green and the yellow pureed food appeared to have small chucks of the food mixed in.
-Resident #9 was eating independently with no difficulty.
-Resident #9 consumed 90% of the meal.

Review of the facility pureed dinner menu for 06/05/19 revealed Resident #9 was to be served pureed hamburger pizza, pureed garden green salad, milk, and pears.

Observation of the dinner meal service for 06/05/19 between 5:30pm and 6:30pm revealed:
-Resident #9 was served a large green scoop of a pureed food, a large brown scoop of a pureed substance, a bowl of a brown pureed food on the plate, and a bowl of a tan pureed food served along with the plate, water, and tea.
-The green pureed scoop appeared runny and held liquid within and surrounding the scoop.
-The brown pureed scoop appeared thick and chunky.
-The bowl of the brown pureed food appeared very runny and had tiny chunks of food in it.
-The bowl of the tan pureed food appeared to be runny with liquid bubbles.
-Resident #9 was eating independently had no difficulty.
-Resident #9 consumed 75% of the meal.

Interview with a cook on 06/05/19 at 12:44pm revealed:
-She pureed foods by adding water to the food item.
-She puts thickener in pureed food sometimes, but the facility ran out of thickener on last week and it had not been reordered.
-She thought pureed foods should be soft and soupy like baby food.
-She prepared the lunch meal for Resident #9 on

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06/05/19 by adding each food item and water in a blender and blending each food item separately.
-The green scoop of pureed food was spinach chicken tortellini and the yellow scoop of pureed food was squash with onions.
-No thickener was added to the spinach chicken tortellini or squash with onions to give it a smooth consistency.
-She described the pureed foods prepared for lunch on 06/05/19 as watery and stated there were chunks of food in the pureed foods.
-She was trained how to prepare pureed food by another staff member.

Interview with the Dietary Manager (DM) on 06/05/19 at 6:38pm revealed:
-He prepared the pureed dinner meal for Resident #9 on 06/05/19.
-The green pureed food was spinach, the brown pureed food was crab cake and scallops, the bowl of brown pureed food was salad, and the bowl of the tan pureed food was pureed pears.
-He did not puree pizza because it got too sticky and would turn out like bread and sauce.
-The dietary staff had been out of thickener for about 2 weeks, but he rarely used thickener in his pureed food.
-He did order thickener with his last food order.
-He thought pureed foods should have the consistency of applesauce.
-He was trained how to prepare pureed foods by another staff member.

Interview with the Director of Resident Care (DRC) on 06/06/19 at 9:25am revealed:
-Resident #9 was on a pureed diet.
-Pureed foods should have the consistency of pudding.
-She did not know the pureed foods prepared for the lunch meal on 06/05/19 were runny and

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{D 310}	Continued From page 51 chunky. -She did not know the pureed foods prepared for the dinner meal on 06/05/19 were runny, thick and chunky. -The DM was responsible for providing training in the kitchen to other dietary staff. -The DM and dietary staff were responsible for making sure food was served as ordered by the physician at the correct consistency. Interview with the Administrator on 06/06/19 at 12:04pm revealed: -A pureed diet should be a pudding like consistency. -The Administrator described a picture of the puree spinach chicken tortellini and yellow squash and onions served to Resident #9 at the lunch meal on 06/05/19 as "not pureed consistency." -The Administrator described a picture of the pureed crab cake and scallops, garden green salad, and pears served to Resident #9 at the dinner meal on 06/05/19 as "not pureed consistency." -She expected for Resident #9 to be served a pureed diet as ordered by the physician at the correct consistency. Interview with Resident #9's primary Care physician (PCP) on 06/07/19 at 9:13am revealed: -Resident #9 was on a pureed diet. -The initial diet order for a pureed diet was made prior to Resident #9 becoming her patient. -She expected for Resident #9 to be served a pureed diet as ordered and at the correct consistency. Based on observation and record review, it was determined that Resident #9 was not interviewable.	{D 310}		

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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 310}	Continued From page 52 c. Review of Resident #10's current FL2 dated 01/09/19 revealed: -Diagnoses included Alzheimer's disease, history of falls, fracture of unspecified spine and pelvis. -There was a physician's order for mechanical soft ground meal. Review of the therapeutic diet list dated 02/08/19 posted in the kitchen on 06/04/19 revealed Resident #9 was to be served a ground meal. Review of the facility mechanical soft menu for 06/05/19 revealed Resident #9 was to be served spinach chicken tortellini with ground chicken, mechanical soft yellow squash and onions, beverage of choice, and mechanical soft assorted cookies. Observation of the lunch meal service on 06/05/19 between 11:30am and 12:30pm revealed: -Resident #10 was served a large green scoop of a pureed food (spinach chicken tortellini), 1 medium yellow scoop of a pureed food (squash with onions), water and tea. -The green and the yellow pureed food appeared runny and was separated by liquid on the plate. -The green and the yellow pureed food appeared to have small chucks of the food mixed in. -Resident #10 was fed by staff with and had no difficulty. -Resident #10 consumed about 50% of the meal. Review of the facility mechanical soft dinner menu for 06/05/19 revealed Resident #9 was to be served mechanical soft hamburger pizza, mechanical soft garden green salad, milk, and mechanical soft pears.	{D 310}		

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{D 310}	Continued From page 53 Observation of the dinner meal service for 06/05/19 between 5:30pm and 6:30pm revealed: -Resident #10 was served a large green scoop of a pureed food (spinach), a large brown scoop of a pureed substance (crab cake and scallops), a bowl of a brown pureed food on the plate (salad), a bowl of a tan pureed food served along with the plate (pears), water and tea. -The green pureed scoop appeared runny and held liquid within and surrounding the scoop. -The brown pureed scoop appeared thick and chunky. -The bowl of the brown pureed food appeared very runny and had tiny chunks of food in it. -The bowl of the tan pureed food appeared to be runny with liquid bubbles. -Resident #10 was fed by staff and had no difficulty. -Resident #10 consumed about 50% of the meal. Interview with a cook on 06/05/19 at 12:44pm revealed: -She thought Resident #10 was on a pureed diet. -She had not been told Resident #10 was on a mechanical soft (ground meal) diet. -She did not look at the therapeutic diet list for guidance in preparation of the meal for Resident #10. -She did not know Resident #10 was listed on the therapeutic diet list to be served a ground meal and not a pureed diet. -She prepared a pureed lunch meal for Resident #10 on 06/05/19 by adding each food item and water in a blender and blending each food item separately. -The green scoop of pureed food was spinach chicken tortellini and the yellow scoop of pureed food was squash with onions. -She was trained on preparation of food by another staff member.	{D 310}		

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{D 310}	Continued From page 54 Interview with the Dietary Manager (DM) on 06/05/19 at 6:38pm revealed: -He did not know Resident #10 had diet orders for a mechanical soft (ground meal) diet. -He had always been told by staff who assisted in the dining hall Resident #10 was on a pureed diet. -He had not been told by the DRC or any other staff Resident #10 was on a mechanical soft (ground meal) diet. -He did not look at the therapeutic diet list for guidance in preparation of the meal for Resident #10. -He did not know Resident #10 was listed on the therapeutic diet list to be served a ground meal and not a pureed diet. -He had not seen a diet order for a mechanical soft (ground meal) or pureed diet. -He prepared a pureed dinner meal for Resident #10 on 06/05/19. -The green pureed food was spinach, the brown pureed food was crab cake and scallops, the bowl of brown pureed food was salad, and the bowl of the tan pureed food was pureed pears. -He was trained on preparation of food by another staff member. Interview with the Director of Resident Care (DRC) on 06/06/19 at 9:25am revealed: -She did not think Resident #10 was on a pureed diet, but she was not sure what her current diet orders were. -The facility physician was not her primary care provider (PCP) and she did not think her current PCP at hospice would change her diet order. -She did not know Resident #10 was served a pureed diet for the lunch and dinner meals on 06/05/19. -The DM and dietary staff were responsible for	{D 310}		

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{D 310}	Continued From page 55 making sure food was served as ordered by the physician at the correct consistency. Interview with the Administrator on 06/06/19 at 12:04pm revealed: -She did not know Resident #10 had a diet order for a mechanical soft (ground meal) diet. -She did not know Resident #10 was being served a pureed diet. -She expected the dietary staff to use the therapeutic diet list and therapeutic menus for guidance in serving the correct diet to residents. -She expected for Resident #10 to be served the therapeutic diet ordered by the physician. Interview with the facility's primary care provider on 06/07/19 at 9:13am revealed: -She no longer saw Resident #10 as a patient. -Resident #10 was a hospice patient. -The last diet order she wrote for Resident #10 was on 01/09/19 for a mechanical soft (ground meal) diet. -She wrote the order for a mechanical soft meal on 01/09/19 due to Resident #10 getting weaker and having a nutritional deficiency. -She had not written a diet order for a pureed diet. Interview with a nurse at Resident #10's PCP's office at hospice on 06/06/19 at 9:14am revealed: -She did not see a diet order in Resident #10's chart. -The PCP usually did not change diet orders. -The PCP usually instructed caretakers to provide comfort foods and foods that residents could tolerate. Based on observation, interview, and record review, it was determined that Resident #9 was not interviewable.	{D 310}		

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{D 310}	Continued From page 56 Attempted interview with Resident #10's responsible party on 06/07/19 at 9:04 was unsuccessful.	{D 310}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews, and interview the facility failed to clarify medication orders for 1 of 5 sampled residents (Resident #2) regarding medications ordered on a hospital discharge FL2 resulting in conflicting medication orders between providers for Resident #2's. The findings are:	D 344		

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Review of Resident #2's current hospital discharge FL2 dated 05/18/19 revealed:
-Diagnoses included depression, coronary artery disease (CAD) due to lipid rich plaque, Parkinson's disease and chronic obstructive pulmonary disease (COPD).
-Medications ordered included sertraline 100mg daily (used to treat depression), atorvastatin 80mg daily (used to treat high cholesterol and triglyceride levels), carbidopa-levodopa 10-100mg two times daily (used to treat Parkinson's disease), albuterol sulfate2.5mg/3ml nebulizer solution four times daily (used to treat wheezing and shortness of breath) and ipratropium-albuterol 0.5-2.5mg/3ml nebulizer solution four times daily as needed (used to treat wheezing and shortness of breath).

Review of Resident #2's signed hospital discharge summary dated 05/18/19 revealed orders matched the hospital FL2 dated 05/18/19.

a. Review of Resident #2's current hospital FL2 dated 05/18/19 revealed an order for sertraline 100mg daily.

Review of Resident #2's signed physician's orders dated 03/13/19 revealed an order for sertraline 100mg take one and one-half (1.5) tablets daily.

Review of Resident #2's May 2019 and June 2019 (electronic Medication Administration Record (eMAR) revealed:
-There was an entry for sertraline 100mg give one and one-half tablets (150 mg) daily, scheduled at 9:00am.
-Sertraline 150 mg was documented as administered daily from 05/01/19 to 06/06/19., except on 05/17/19, 05/18/19, 06/01/19 and

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D 344	Continued From page 58 06/02/19. Review of progress notes for May 2019 and June 2019 for Resident #2 revealed: -No documentation of contact with the pharmacy for clarification of Resident #2's sertraline. -No documentation of contact with medical providers for clarification of medication orders for sertraline. Interview with Resident #2's psychiatric provider on 06/07/19 at 1:40pm revealed: -The provider had been made aware Resident #2 had been to the hospital but was not aware she had been admitted. -The hospital had been known to use old orders in discharge documents, so the provider does not review the documents. -The provider was not aware Resident #2 had a new FL2 completed at the hospital or new signed discharge orders. -She expected to be made aware of signed orders when changes had been made to psychiatric medications. -The provider expected her orders to be followed for psychiatric medications. -She expected Resident #2 to have received sertraline 100mg one and one-half tablets (150 mg) daily. -Facility staff did not clarify orders with her following Resident #2's hospital discharge on 05/18/19. Interview with a pharmacy staff member on 06/07/19 at 10:45am revealed: -The most recent signed physician orders on file for Resident #2 were dated 03/13/2019. -The pharmacy did not have a signed FL2 or signed discharge summary on file dated 05/18/19 which included the order for sertraline 100mg	D 344		

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D 344	Continued From page 59 daily. Refer to interview with Director of Resident Care (DRC) on 06/07/2019 at 12:30pm. Refer to interview with the Administrator on 06/05/19 at 6:12pm. b. Review of Resident #2's current hospital FL2 dated 05/18/19 revealed an order for atorvastatin 80mg daily.. Review of Resident #2's signed physician's orders dated 03/13/19 revealed an order for atorvastatin 80mg daily. Review of Resident #2's record revealed the was no documentation for an order for atorvastatin 20mg available for review. Review of Resident #2's May 2019 and June 2019 electronic medication administration record (eMAR) revealed: -There was an entry for atorvastatin 20mg daily, scheduled at 9:00pm. -Atorvastatin 20 mg was documented as administered daily from 05/01/19 to 06/05/19 except on 05/04/19, 05/05/19, 05/06/19, and 05/17/19. Review of progress notes for May 2019 and June 2019 for Resident #2 revealed: -No documentation of contact with the pharmacy regarding atorvastatin. -No documentation of contact with medical providers for clarification of medication orders for atorvastatin. Interview with the primary care provider (PCP) on 06/07/19 at 9:35am revealed:	D 344		

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-In July 2018, she reduced Resident #2's atorvastatin from 80mg to 20mg.
-The PCP was presented and signed the hospital discharge summary dated 05/18/19 and expected the orders to be implemented.
-She did not realize that the hospital orders included atorvastatin 80mg.
-Facility staff did not clarify orders with her following Resident #2's hospital discharge on 05/18/19.

Interview with a pharmacy staff member on 06/07/19 at 10:45am revealed:
-The most recent signed physician orders on file for Resident #2 were dated 03/13/2019.
-The pharmacy did not have a signed FL2 or signed discharge summary on file dated 05/18/19 which included the order for atorvastin 80mg daily.

Refer to interview with Director of Resident Care (DRC) on 06/07/2019 at 12:30pm.

Refer to interview with the Administrator on 06/05/19 at 6:12pm.

c. Review of Resident #2's current hospital FL2 dated 05/18/19 revealed an order for carbidopa-levodopa 10-100mg two times daily.

Review of Resident #2's signed physician's orders dated 03/13/19 revealed an order for carbidopa-levodopa 10-100mg two times daily.

Review of Resident #2's April 2019, May 2019 and June 2019 electronic medication administration records (eMARs) revealed:
-There was an entry for carbidopa-levodopa 10-100mg daily, scheduled at 9:00am.
-Carbidopa-levodopa 10-100mg was documented

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as administered daily from 04/01/19 to 06/06/19 except 05/17/19, 05/18/19 and 06/02/19 - 06/06/19.

Interview with Resident #2 on 06/06/2019 at 6:10pm and 06/07/19 at 1:15pm revealed:
-She was diagnosed with Parkinson's disease prior to coming to live at the facility.
-She did not know the name of the medication she had been prescribed for Parkinson's disease or how often she had received the medication.

Interview with the primary care provider (PCP) on 06/07/19 at 9:35am revealed:
-On 03/13/19 she changed Resident #2's carbidopa-levodopa administration from twice a day to once a day.
-The PCP was presented and signed the hospital discharge summary dated 05/18/19 and expected the orders to be implemented.
-She did not know the hospital orders included carbidopa-levodopa 10-100mg two times daily.
-Facility staff did not clarify orders with her following Resident #2's hospital discharge on 05/18/19.

Interview with a pharmacy staff member on 06/07/19 at 10:45am revealed:
-The most recent signed physician orders on file for Resident #2 were dated 03/13/2019.
-The pharmacy did not have a signed FL2 or signed discharge summary on file dated 05/18/19 which included the order the order for carbidopa-levodopa 10-100mg two times daily.

Refer to interview with Director of Resident Care (DRC) on 06/07/2019 at 12:30pm.

Refer to interview with the Administrator on 06/05/19 at 6:12pm.

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D 344	Continued From page 62 d. Review of Resident #2's current hospital FL2 dated 05/18/19 revealed an order for albuterol sulfate 2.5/3ml solution for nebulizer, 4 times daily for shortness of breath or wheezing. Review of Resident #2's signed physician's orders dated 03/13/19 revealed an order for albuterol sulfate 2.5/3ml solution for nebulizer, every 6 hours as needed for shortness of breath or wheezing. Review of Resident #2's May 2019 and June 2019 electronic medication administration record s (eMARs) revealed: -There was an entry for albuterol sulfate 2.5/3ml solution for nebulizer, every 6 hours as needed for shortness of breath or wheezing. -There was documentation the medication was administered on 05/14/19 for one dose only. Review of progress notes for May 2019 and June 2019 for Resident #2 revealed: -There was no documentation of contact with the pharmacy regarding clarification for administration of albuterol sulfate 2.5/3ml solution for nebulizer . -There was no documentation of contact with medical providers for clarification of medication orders for albuterol sulfate 2.5/3ml solution for nebulizer. Interview with the primary care provider (PCP) on 06/07/19 at 9:35am revealed: -The PCP was presented and signed the hospital discharge summary dated 05/18/19 and expected the orders to be implemented. -She was not aware that the hospital orders included -She expected resident to have been	D 344		

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administered albuterol sulfate2.5mg/3ml nebulizer solution every 6 hours as needed.
-Facility staff did not clarify orders with her following Resident #2's hospital discharge on 05/18/19.

Interview with a pharmacy staff member on 06/07/19 at 10:45am revealed:
-The most recent signed physician orders on file for Resident #2 were dated 03/13/2019.
-The pharmacy did not have a signed FL2 or signed discharge summary on file dated 05/18/19 which included the order for albuterol sulfate2.5mg/3ml nebulizer solution four times daily for shortness of breath or wheezing

Refer to interview with Director of Resident Care (DRC) on 06/07/2019 at 12:30pm.

Refer to interview with the Administrator on 06/05/19 at 6:12pm.

e. Review of Resident #2's current hospital FL2 dated 05/18/19 revealed an order ipratropium-albuterol sulfate 0.5-2.5mg/3ml solution for nebulizer, 4 times daily as need for shortness of breath or wheezing.

Review of Resident #2's signed physician's orders dated 03/13/19 revealed an order for ipratropium-albuterol sulfate 0.5-2.5mg/3ml solution for nebulizer, 4 times a day at 9:00am, 1:00pm, 5:00pm and 9:00pm daily.

Review of Resident #2's May 2019 and June 2019 eMAR revealed:
-There was an entry for ipratropium-albuterol sulfate 0.5-2.5mg/3ml solution for nebulizer four times daily, scheduled at 9:00am, 1:00pm, 5:00pm and 9:00pm.

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-Ipratropium-albuterol sulfate 0.5-2.5mg/3ml solution for nebulizer was documented as administered daily at 9:00am, 1:00pm, 5:00pm and 9:00pm except for 05/01/19 at 1:00pm, 05/08/19 at 5:00pm, 05/17/19 and 05/18/19 at 9:00am and 1:00pm, 05/23/19 at 1:00pm, and 05/26/19 at 5:00pm.

Review of progress notes for May 2019 and June 2019 for Resident #2 revealed:
-No documentation of contact with the pharmacy for clarification of the dosing directions for ipratropium-albuterol sulfate 0.5-2.5mg/3ml solution for nebulizer.
-No documentation of contact with medical providers for clarification of medication orders for ipratropium-albuterol sulfate 0.5-2.5mg/3ml solution for nebulizer.

Interview with the primary care provider (PCP) on 06/07/19 at 9:35am revealed:
-The PCP was presented and signed the hospital discharge summary dated 05/18/19 and expected the orders to be implemented.
-She did not know that the hospital orders included ipratropium-albuterol 0.5-2.5mg/3ml nebulizer solution four times daily as needed.
-She expected the resident to have been administered ipratropium-albuterol 0.5-2.5mg/3ml nebulizer solution four times daily scheduled.
-Facility staff did not clarify orders with her following Resident #2's hospital discharge on 05/18/19.

Refer to interview with a pharmacy staff member on 06/07/19 at 10:45am.

Refer to interview with Director of Resident Care (DRC) on 06/07/2019 at 12:30pm.

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THE MEADOWS OF ROCKWELL RETIREMENT CENTI	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

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D 344	Continued From page 65 Refer to interview with the Administrator on 06/05/19 at 6:12pm. _____ Interview with the DRC on 06/07/19 at 12:30pm revealed: -If a resident returned from the hospital with a signed discharge summary or a signed FL2, the new orders would have superseded previous orders. -All previous orders would have been discontinued and the new orders would have been used, so no clarification would have been needed. -Resident #2 was re-admitted 05/18/19, on a weekend, the MA should have faxed the signed orders to the pharmacy. -On the following Monday the DRC should have reviewed and assured implementation of the hospital discharge orders. -Only the DRC and lead medication aide/Supervisor had access to make changes or approve orders on the eMAR. -New orders must have been approved in the system before the order can be seen and documented by the MAs. -The signed discharge summary dated 06/18/19 was not sent to the pharmacy and the orders were not put in the eMAR system. -Clarification of orders and contacts with the pharmacy should have been documented in the progress notes. Interview with the Administrator on 06/05/19 at 6:12pm revealed the DRC was responsible for accuracy of the eMAR and assuring medications were administered correctly.	D 344		
{D 358}	10A NCAC 13F .1004(a) Medication Administration	{D 358}		

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{D 358}	Continued From page 66 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facility's policies for 2 of 4 residents (#7, and #8) observed during the medication pass including errors with a pain medication (#7), and medications for acid reflux and anxiety (#8); and for 4 of 6 sampled residents (Resident #2, #3, #4, and #6) related to a blood pressure medication and a medication for constipation (#3), a blood thinner, a medication used to treat Parkinson's disease, medication used to lower cholesterol, and aspirin (#2), a potassium supplement medication (#4), and a medication for hypertension, an antidepressant medication, and a medication for angina (#6).	{D 358}		

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{D 358}	Continued From page 67 The findings are: 1. The medication error rate was 10% (percent) as evidenced by the observation of 3 errors of 29 opportunities during the 8:00am medication pass on 06/05/19. a. Review of Resident #7's current FL2 dated 05/28/19 revealed: -Diagnoses included cellulitis of left lower limb, rheumatoid arthritis, and anxiety disorder. -There was an order for tramadol 50 mg 2 times a day. (Tramadol is used to treat mild to moderate pain.) Review of Resident #7's record revealed a physician's order dated 05/28/19 for tramadol 50 mg one tablet every 6 hours as needed for pain, and one tablet 2 times a day for moderate to severe pain. Observation of medication administration for Resident #7 on 06/05/19 at 8:02am revealed: -The morning medication aide (MA) prepared 11 oral medications, that did not include one tramadol 50 mg tablet. -The MA administered the medications to the resident, sitting in his wheelchair at the nurse's desk on the front hall. Review of Resident #7's May 2019 electronic medication administration record (eMAR) revealed: -There was an entry for tramadol 50 mg as needed. -There was no entry for tramadol 50 mg one tablet 2 times a day as ordered on the current FL2 dated 05/28/19 or the physician's order dated 05//28/19.	{D 358}		

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{D 358}	Continued From page 68 Review of Resident #7's June 2019 eMAR revealed: -There was an entry for tramadol 50 mg as needed. -No tramadol 50 mg was documented as administered from 06/01/19 to 06/05/19. -There was no entry for tramadol 50 mg one tablet 2 times a day. Observation of Resident #7's medications on hand for administration on 06/05/19 at 1:20pm revealed: -There were 89 tramadol 50 mg tablets remaining in a bottle of ninety tablets dispensed from an outside pharmacy on 05/28/19. -The directions on the label were take one tablet every 6 hours as needed for pain and one tablet 2 times a day for moderate to severe pain. Review of the facility's medication policy for Move-In Orders revealed: -The facility was responsible to provide the contract pharmacy with a copy of all medication orders daily. -The facility can enter medication orders on the electronic medication administration record as well as the pharmacy. -If a resident uses a third party pharmacy, the facility should fax the medication orders to the contracted pharmacy and indicate "PROFILE ONLY, DO NOT FILL" prior to faxing. Telephone interview with a pharmacist at the contracted pharmacy on 06/05/19 at 11:45am revealed: -The pharmacy did not enter the orders for Resident #7 into the eMAR system or provide his medications. -The facility entered medication orders for Resident #7 and approved the orders.	{D 358}		

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{D 358}	Continued From page 69 -The orders entered by the facility were visible by the pharmacy for information as to the medications a resident was taking. Interview with the medication aide (MA) administering Resident #7's medications during the morning medication pass on 06/05/19 at 1:10pm revealed: -She did not enter orders into the facility's eMAR system. -The contracted pharmacy staff representative, the Director of Resident Care (DRC), and a lead MA/Supervisor had the ability to enter orders into the eMAR system. -The DRC was responsible to check orders entered into the eMAR system and approve the orders so the orders would appear in the eMAR system for the MA staff to administer. -Resident #7's prescription bottle for tramadol 50 mg was stored in the locked control substance box on the medication cart and would not be routinely reviewed by the MAs unless the resident requested an as needed (prn) tramadol. -She did not know Resident #7 should be receiving tramadol 50 mg scheduled 2 times a day as well as on an as needed basis. Interview with Resident #7 on 06/05/19 at 4:10pm revealed: -He received a stronger pain medication at 6:00am, mid-afternoon, and at bedtime. -He had a breakthrough pain medication he could ask for when he was hurting bad. -His pain came from his rheumatoid arthritis. -He hurt most days at the end of the day before he received his bedtime dose of the strong pain reliever for upper back pain. -Taking a scheduled tramadol might help his back pain.	{D 358}		

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{D 358}	Continued From page 70 Interview with the DRC on 06/07/19 at 3:00pm revealed: -She was responsible to assure medications were administered as ordered. -She entered Resident #7's medication in the facility eMAR system on 05/28/19. -Resident #7's family member had gone over medications the resident was taking with the DRC. -The family member had requested Resident #7 not receive scheduled tramadol 50 mg due to sedation. -The DRC entered the tramadol 50 mg for as needed but not for scheduled. -The DRC had not contacted Resident #7's prescriber to authorize the change. Interview with the Administrator on 06/07/19 at 6:15pm revealed the DRC was responsible to assure medications were administered as ordered. b. Review of Resident #8's current FL2 dated 05/08/19 revealed a diagnosis of unspecified dementia with behaviors. A. Review of Resident #8's current physician's orders dated 05/08/19 revealed an order for ranitidine 300mg one tablet every day. (Ranitidine used to treat indigestion and acid reflux). Review of Resident #8's record revealed a physician's encounter form dated 05/08/19 with a subsequent physician's order to stop ranitidine 300 mg and start ranitidine 150 mg. Observation of medication administration for Resident #8 on 06/05/19 at 7:28am revealed: -The morning medication aide (MA) for 100 Hall prepared 2 oral medications, including one	{D 358}		

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ranitidine 300 mg tablet.
-The MA administered the medications to the resident at the nurse's desk on the 100 Hall.

Review of Resident #7's June 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for ranitidine 150 mg one tablet every day at 8:00am.
-Ranitidine 150 mg was documented as administered daily at 8:00am from 06/01/19 to 06/05/19.

Observation of Resident #8's medications on hand for administration on 06/05/19 at 1:00pm revealed:
-There were 86 tablets of ranitidine 300 mg remaining from a bottle of 90 tablets dispensed from a mail order pharmacy on 05/30/19.
-The directions on the label were take one tablet daily.

Review of the facility's medication policy for new or changed medications revealed:
- "When a new order changes a previously prescribed medication, the Wellness Director or licensed nurse should discontinue the previous order in the medication records and enter the new prescription as a new medication order."
-The new order should be sent to the pharmacy for processing including entering or verifying the medication order on the resident's medication profile and sending the medication to the facility if the resident's medication are provided by the pharmacy.

Telephone interview with Resident #8's primary care provider (PCP) on 06/05/19 at 11:00am revealed:
-She ordered to change Resident #8's ranitidine

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{D 358}	Continued From page 72 300 mg to ranitidine 150 mg on 05/08/19 because the resident was doing very well, symptom free, and she wanted to see if the lower dose of 150 mg would manage the reflux symptoms (heartburn, indigestion, or abdominal pain). -She spoke with a medication aide 2 weeks ago, on a visit to the facility, regarding making sure Resident #8 was receiving 150 mg ranitidine. -She was not aware Resident #8 had been receiving Ranitidine 300 mg. Telephone interview with a pharmacist at the contracted pharmacy on 06/05/19 at 11:45am revealed: -The pharmacy entered the order for Resident #8's change from ranitidine 300 mg to ranitidine 150 mg on 05/08/19 into the eMAR system. -The pharmacy documented dispensing 29 of ranitidine 150 mg tablets on 05/18/19. -The pharmacy had not dispensed additional ranitidine tablets for Resident #8. Interview with the lead MA/Supervisor administering Resident #8's medications on 06/05/19 at 6:10pm revealed: -She overlooked Resident #8's ranitidine bottle being 300 mg. -Resident #8's medications were ordered through mail-order by a family member. -She did not pay close enough attention to the strength of the medication in the bottle compared to the order displayed on the eMAR. Interview with the Director of Resident Care (DRC) on 06/07/19 at 8:30am revealed: -She was responsible to assure medications were administered as ordered. -Staff should be administering medications as ordered. -Resident #8's family member ordered	{D 358}		

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medications for the resident through a mail-order pharmacy.
-She did not think the PCP had written a hard copy of the medication order for the facility to provide to the family member.
-She would be responsible for assuring the family member received new orders for sending to the mail-order pharmacy.
-She overlooked obtaining a prescription order for the family member.
-The family member wanted the resident to use the prescription just purchased instead of spending money to get a new order.

Interview with the Administrator on 06/07/19 at 6:15pm revealed the DRC was responsible to assure medications were administered as ordered.

B. Review of Resident #8's current physician's orders dated 05/08/19 revealed an order for alprazolam 0.5 mg one tablet every day. (Alprazolam is used to treat anxiety).

Review of Resident #8's record revealed a physician's encounter form dated 05/30/19 with a subsequent physician's order to stop alprazolam 0.5 mg daily and start alprazolam 0.25 mg daily.

Observation of medication administration for Resident #8 on 06/05/19 at 7:28am revealed:
-The morning medication aide (MA) for 100 Hall prepared 2 oral medications, including one alprazolam 0.5 mg tablet.
-The MA administered the medications to the resident at the nurse's desk on the 100 Hall.

Review of Resident #7's June 2019 electronic medication administration record (eMAR) revealed:

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{D 358}	Continued From page 74 -There was an entry for alprazolam 0.5mg one tablet every day scheduled for administration at 9:00am. -Alprazolam 0.5 mg was documented administered from 06/01/19 to 06/04/19 at 9:00am. -There was an entry for alprazolam 0.25mg one tablet every day scheduled for administration at 8:00am. -Alprazolam 0.25 mg was documented administered from 06/05/19 at 8:00am. Observation of Resident #8's medications on hand for administration on 06/05/19 at 1:00pm revealed: -There were 67 tablets of alprazolam 0.5 mg remaining from a bottle of 90 tablets dispensed from a mail-order pharmacy on 02/03/19. -The directions on the label were take one tablet daily. -There was no alprazolam 0.25 mg tablets available for administration. Review of the facility's medication policy for new or changed medications revealed: - "When a new order changes a previously prescribed medication, the Wellness Director or licensed nurse should discontinue the previous order in the medication records and enter the new prescription as a new medication order." -The new order should be sent to the pharmacy for processing including entering or verifying the medication order on the resident's medication profile and sending the medication to the facility if the resident's medication are provided by the pharmacy. -If a resident uses a third party pharmacy, the facility should fax the medication orders to the pharmacy and indicate "PROFILE ONLY, DO NOT FILL" prior to faxing.	{D 358}		

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{D 358}	Continued From page 75 Telephone interview with a pharmacist at the contracted pharmacy on 06/05/19 at 11:45am revealed: -The pharmacy entered the order for Resident #8's change from alprazolam 0.5 mg daily to alprazolam 0.25 mg into the eMAR system when the pharmacy received the new medication order on 05/30/19. -Resident #8's alprazolam 0.25 mg was marked for "PROFILE ONLY". -The pharmacy had not dispensed alprazolam 0.25 mg for Resident #8. Telephone interview with Resident #8's mental health Physician's Assistant (PA) on 06/05/19 at 5:00pm revealed: -She would have expected the facility to have changed the strength of the medication within 48 hours from 05/30/19. -She did not know Resident #8 was receiving alprazolam 0.5 mg after the dose was changed to alprazolam 0.25 mg. -She had written a hard copy of the prescription order for the facility to provide to the family for the pharmacy to obtain the new strength. -She ordered changed Resident #8's alprazolam 0.5 mg to alprazolam 0.25 mg because the resident was doing very well, symptom free, and she wanted to wean the resident from the class of drugs since long term use in elderly residents was not recommended. Interview with the lead MA/Supervisor administering Resident #8's medications during the medication pass on 06/05/19 at 6:10pm revealed: -She overlooked Resident #8's change to alprazolam 0.25 mg on the eMAR. -She should have broken the 0.5 mg tablet,	{D 358}		

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administered half of a tablet, and wasted the other half of the tablet.
-Staff could use the resident's current medication until the new strength was obtained for the resident.

Interview with the Director of Resident Care (DRC) on 06/07/19 at 8:30am revealed:
-She was responsible to assure medications were administered as ordered.
-Staff should be administering medications as ordered.
-Resident #8's family member ordered medications for the resident through a mail-order pharmacy.
-The hard copy for Resident #8's alprazolam 0.25 mg was in a stack of papers to be filed and had not been given to the Resident's family member.
-She would be responsible for assuring the family member received new orders for sending to the mail-order pharmacy.
-The order for Resident #8's alprazolam change was faxed to the contracted pharmacy on 05/30/19 or 05/31/19 (Thursday or Friday) but did not show up in the eMAR computer until Monday (06/03/19) for her to approve and release for medication aides to see for administration.
-Staff should break the 0.5 mg alprazolam tablet in half along the scored line, administer half a tablet and waste the other half.

Interview with the Administrator on 06/07/19 at 6:15pm revealed the DRC was responsible to assure medications were administered as ordered.

2. Review of Resident #3's current hospital FL2 dated 05/10/19 revealed diagnoses included hypertension, urinary retention, and constipation.

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{D 358}	Continued From page 77 Review of Resident #3's record revealed Resident #3 was hospitalized on 05/06/19 for constipation and discharged on 05/10/19. a. Review of Resident #3's current FL2 dated 05/10/19 revealed there was an order for mineral oil liquid take 45 milliliters (mls) daily. Interview with Resident #3 during the initial tour on 06/04/19 at 10:20 am revealed: -He had been in the hospital recently for constipation. -He was still very uncomfortable because he did not have routine bowel movements. -He had not had a bowel movement in several days. -He had been seen by the facility primary care provider (PCP) related to his constipation, but he was still having difficulty having bowel movements. -He was not currently receiving medication for his constipation. Review of Resident #3's May 2019 electronic medication administration record (eMAR) revealed: -There was an entry for mineral oil 45mls daily and scheduled for administration at 9:00am daily. -Mineral oil 45mls was documented as administered daily from 05/12/19 to 05/25/19. -Mineral oil 45mls was documented as not administered daily from 05/25/19 to 05/31/19 with awaiting delivery documented for reason not administered. Review of Resident #3's June 2019 eMAR revealed: -There was an entry for mineral oil 45mls daily and scheduled for administration at 9:00am daily. -Mineral oil 45mls was documented as not	{D 358}		

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{D 358}	Continued From page 78 administered daily from 06/01/19 to 06/06/19 with awaiting delivery documented for reason not administered. Observation of medications on hand for Resident #3 on 06/06/19 revealed there was no mineral oil on hand for administration. Interview with Resident #3 on 06/07/19 at 8:25 am revealed: -He had not been receiving mineral oil in more than one week. -He did not know why staff had not given him mineral oil. -Staff did not tell him why he was not receiving the mineral oil. -The mineral oil helped him have a bowel movement when he was getting it. Interview with a medication aide (MA) on 06/06/19 at 6:15pm revealed: -Resident #3 did not have mineral oil on the medication cart for administration. -Resident #3 did not have mineral oil in the back-up overstock for administration. -She did not routinely work on the medication cart in the mornings when the mineral oil was scheduled for administration. -She would not have been responsible for re-ordering mineral oil for Resident #3. -The MA administering the last dose of mineral oil would be responsible to make sure there was mineral oil for administration at the next dose. Interview with the same MA on 06/07/19 at 10:00am revealed: -MAs were supposed to audit contents of the medication cart compared to the residents' medication on the eMAR once a month. -Cart audits had not been done in the past 3 to 4	{D 358}		

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{D 358}	Continued From page 79 months due to MA staff shortages. MAs had been working double shifts to cover. -Medications should be re-ordered when the supply remaining was 7 days and no medication was available in the residents' overstock medications. -The pharmacy routinely sent notification to the facility in the drug delivery tote if the residents' medications needed physician's authorization for refilling. -The MAs were responsible to call the pharmacy to find out why a medication was not sent, and notify the Director of Resident Care (DRC) of any problem obtaining medications. -The MAs administer medications as ordered on the eMAR. -She did not know why the resident had no mineral oil available for administration. Interview with the DRC on 06/07/19 at 8:30am revealed: -She was responsible to assure medications were administered as ordered. -She was not aware Resident #3 was out of mineral oil for 10 days. -The MAs should order medications when the on-hand supply got down to 7 days remaining. -MAs were supposed to inform her if they were having trouble getting a resident's medication. -She would call the pharmacy to find out why the mineral oil was not shipped. Interview with a medication aide (MA) on 06/07/19 at 10:15am revealed: -The contracted pharmacy sent a bottle of mineral oil for Resident #3 when the order first appeared on the eMAR. -Resident #3's mineral oil was on the cart for a while then it ran out. -She was not sure how long the resident had	{D 358}		

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{D 358}	Continued From page 80 been out of mineral oil because it was administered in the morning and she routinely worked in the evenings. Telephone interview with a pharmacist at the contracted pharmacy on 06/07/19 at 10:40am revealed: -The pharmacy received an order for mineral oil 45ml daily on 05/10/19 for Resident #3. -The pharmacy dispensed 473 mls of mineral oil for Resident #3 on 05/11/19. -The facility was responsible to reorder Resident #3's mineral oil. -There was no documentation the facility reordered mineral oil for Resident #3 until 06/06/19 when 473 mls were sent again. Interview with a second MA on 06/07/19 at 11:00am revealed: -She ordered Resident #3's mineral oil when the supply got low somewhere around 05/21/19. -She had informed the DRC at least 2 times that Resident #3 was out of mineral oil. -She did not go back to the pharmacy order sheet to see if the medication was sent by the pharmacy. -If the pharmacy needed a new order the DRC would be responsible to contact the PCP for an order. Telephone interview with Resident #3's primary care provider (PCP) on 06/07/19 at 9:20am revealed: -Resident #3 should be receiving medications for constipation as ordered. -Resident #3 had been in the hospital recently with chronic constipation and an impaction. -Resident #3 was at risk of developing another impaction or ruptured bowel from impaction.	{D 358}		

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{D 358}	Continued From page 81 Interview with the Administrator on 06/07/19 at 6:15pm revealed the DRC was responsible to assure medications were administered as ordered. Review of the facility's medication policy for reordering medications revealed: -The facility should review all on-demand (not automatic cycle fill) medications daily and re-order when a 5 day supply of the medication is remaining. -The facility should peel the 2-part medication label and affix to the re-order form or write the medication name and patient name of the medication to be re-ordered on the form. -The facility should fax the re-order form to the pharmacy for delivery the next business day. b. Review of Resident #3's FL2 dated 1/08/19 revealed an order for metoprolol 25 mg once daily. (Metoprolol is used to treat high blood pressure and/or rapid heart beat rate). Review of Resident #3's record revealed there was a subsequent order dated 03/20/19 for metoprolol 50 mg twice a day. Review of Resident #3's current FL2 dated 05/10/19 hospital discharge medications revealed there was an order for metoprolol 50 mg one tablet every morning. Review of Resident #3's signed physician's orders dated 05/15/19 revealed an order for metoprolol 50 mg one tablet twice a day. Review of the facility's medication policy for new or changed medications revealed: - "When a new order changes a previously prescribed medication, the Wellness Director or	{D 358}		

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licensed nurse should discontinue the previous order in the medication records and enter the new prescription as a new medication order."
-The new order should be sent to the pharmacy for processing including entering or verifying the medication order on the resident's medication profile and sending the medication to the facility if the resident's medication are provided by the pharmacy.

Review of Resident #3's May 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for metoprolol 50 mg one tablet twice a day and administration scheduled at 9:00am and 9:00pm.
-Metoprolol 50 mg was documented as administered at 9:00am and 9:00pm from 05/01/19 to 05/06/19 at 9:00am.
-Resident #3 was documented as in the hospital from 05/06/19 to 05/10/19.
-There was an entry for metoprolol 50 mg with "special instructions" take one tablet twice a day and "frequency" once a day listed on the eMAR and scheduled at 8:00am only beginning on 05/11/19.
-Metoprolol 50 mg was documented as administered at 8:00am daily from 05/11/19 to 05/31/19.
-There was no entry for metoprolol 50 mg one tablet twice a day beginning 05/15/19 as ordered on the signed physician's orders dated 05/15/19.

Review of Resident #3's June 2019 eMAR revealed:
-There was no entry for metoprolol 50 mg one tablet twice a day as ordered on the signed physician's orders dated 05/15/19.
-There was an entry for metoprolol 50 mg with "special instructions" take one tablet twice a day

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and "frequency" once a day listed on the eMAR and scheduled at 8:00am only beginning on 06/01/19.
-Metoprolol 50 mg was documented as administered at 8:00am daily from 06/01/19 to 06/05/19.

Interview with the lead medication aide (MA)/Supervisor on 06/05/19 at 6:20pm revealed:
-The lead MA/Supervisor, the Director of Resident Services (DRC), and the contracted pharmacy staff representative entered medication orders into the eMAR system.
-A copy of all orders was supposed to be faxed to the pharmacy and a copy placed in the DRC's office for review.
-The DRC was responsible for assuring medications orders were entered into the eMAR system correctly and was responsible to release medication orders for appearing on the eMAR for the MAs to administer medications.
-Resident #3's order for metoprolol 50 mg was entered into the eMAR computer system by the DRC and scheduled for once daily instead of twice daily.

Telephone interview with Resident #3's primary care provider (PCP) on 06/06/19 at 1:20pm revealed:
-She re-ordered Resident #3's metoprolol 50mg for one tablet twice a day on 05/15/19.
-She wanted Resident #3 on the same dose or metoprolol as before he went to the hospital.
-She did not know Resident #3 had been receiving metoprolol 50 mg daily since 05/15/19.
-She had seen Resident #3 at the facility since the hospitalization and did not think there would be any negative outcome from him receiving metoprolol 50 mg daily instead of twice a day.

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{D 358}	Continued From page 84 Telephone interview with a pharmacist at the contracted pharmacy on 06/06/19 at 2:45pm revealed: -The facility was responsible to send all medication orders to the pharmacy for entering on the residents' medication profile. -The pharmacy received an order for metoprolol 50 mg twice a day dated 03/20/19 and dispensed 36 tablets on 03/20/19, sixty tablets were dispensed on 04/03/19, and sixty tablets were dispensed on 05/03/19. -The pharmacy received the hospital FL2 dated 05/10/19 for metoprolol 50 mg once daily and dispensed 24 tablets on 05/14/19. -The pharmacy did not receive the signed physician's orders dated 05/15/19 for metoprolol 50 mg twice a day. Observation of medication on hand for administration for Resident #3 on 06/07/19 revealed: -There was a bingo card of metoprolol 50 mg labeled one tablet daily dispensed for 24 tablets on 05/14/19 with 2 tablets remaining. -There was one bingo card with 30 tablets remaining of two bingo cards totaling 60 tablets of metoprolol 50 mg labeled one tablet twice a day dispensed on 05/03/19. Interview with the Director of Resident Care (DRC) on 06/06/19 at 2:20pm revealed: -She entered Resident #3's order for metoprolol 50 mg on the May 2019 eMAR from the hospital discharge summary. -She entered the order incorrectly for the "special instructions" listing one tablet twice a day and the "frequency" once a day. -She scheduled the medication for one dose daily at 8:00am. -She overlooked the change back to metoprolol	{D 358}		

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{D 358}	Continued From page 85 50 mg two times a day on the physician's orders dated 05/15/19 and did not change the order in the eMAR computer system. Interview with Resident #3 on 06/07/19 at 8:25 am revealed: -He could not keep up with the strength and name of all his medications. -He depended on the medication aide staff to administer his medications as ordered. -He only knew of medication for his constipation not being administered as ordered. Interview with the Administrator on 06/07/19 at 6:15pm revealed the DRC was responsible to assure medications were administered as ordered. 3. Review of Resident #2's current FL2 dated 05/18/19 revealed diagnoses included pulmonary emboli (PE) and chronic atrial fibrillation. a. Review of Resident #2's current FL2 dated 05/10/19 revealed an order for Xarelto (used to prevent blood clots) 15mg daily. Review of Resident #2's signed hospital discharge summary dated 05/18/19 revealed an order for Xarelto 15mg by every evening. Review of Resident #2's April 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Xarelto 15mg every evening and scheduled at 5:00pm. - Xarelto 15mg was documented as administered correctly from 04/01/19 to 04/30/19 (26 times). - Xarelto 15mg was documented not administered 4 times due to waiting on delivery 04/04/19 and 04/28/19-04/30/19.	{D 358}		

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{D 358}	Continued From page 86 Review of Resident #2's May 2019 eMAR revealed: -There was an entry for Xarelto 15mg every evening and scheduled for 5:00pm. - Xarelto 15mg was documented as administered from 05/01/19 to 05/31/19 on 19 opportunities. - Xarelto 15mg was not documented as administered 10 times due to being 'on order' from 05/01/19-05/07/19, and 05/29/19-05/31/19. Review of a pharmacy delivery sheet dated 05/04/19 revealed: -Thirty doses of Xarelto 15mg was dispensed on 05/03/19. -The time stamp for delivery was 05/04/19 at 9:52pm. -The MA signature was dated 05/06/19. Review of Resident #2's June 2019 MAR revealed: -There was an entry for Xarelto 15mg one tablet daily scheduled at 5:00pm. -Xarelto 15mg was documented as administered on 06/05/19. -Xarelto 15mg was not documented as administered due to waiting on pharmacy to send the medication from 06/01/19 to 06/04/19. Observation of medications on hand for Resident #2 on 06/06/2019 at 10:10am revealed there was no Xarelto 15mg available for administration. Observation of medications on hand for Resident #2 on 06/07/2019 at 11:34am revealed a bubble pack of Xarelto 15mg was dispensed on 06/02/19, the bubble pack was signed for administration by the MA on 06/05/19; 2 doses had been removed from the bubble package.	{D 358}		

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{D 358}	Continued From page 87 There was no pharmacy delivery sheet for the bubble pack dispensed on 06/02/19 available for review. Review of progress notes for April, May and June 2019 for Resident #2 revealed: -No documentation of contact with the pharmacy. -No documentation of contact with the PCP regarding missed medications. Interview with Resident #2 on 06/06/19 at 6:10pm and 06/07/19 at 1:15pm revealed: -She had a history of blood clots in her lungs. -She knew she took medications for thinning blood. -She hoped she received her medications as ordered. Interview with a medication aide (MA) on 06/06/19 at 10:10am revealed: -Xarelto was a cycle filled medication. -Cycle filled medications were auto-filled and re-fills should not have had to be ordered. -The MA was responsible for ordering medications that were not available. -MAs ordered medications by removing the re-order sticker from the medication container and then faxed the refill request to the pharmacy. -If the medication had not arrived by the next day the MA should have called the pharmacy to determine the reason for the delay. -She did not know why Xarelto had not been delivered. Interview with another MA on 06/07/19 at 4:55pm revealed: -She had no explanation why Resident #2 ran out of Xarelto 15mg delivered for 30 doses on 05/04/19, after administration of 19 doses. -There should have been enough Xarelto 15 mg	{D 358}		

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to administer one dose daily through 06/06/19.
-There was documentation for the disposal of 11 Xarelto 15mg tablets.

Interview with the Director of Resident Care (DRC) on 06/06/19 at 12:54pm revealed:
-Cycle filled medications should have been auto-filled monthly.
-If a medication was not on the medication cart, the MA should have looked in the overstock prior to ordering.
-If a medication had been ordered but had not arrived, the MA should have called the pharmacy to determine why the medication had not been delivered.
-Contacts with the pharmacy should have been documented in the resident's progress notes.

Interview with Resident #2's primary care provider (PCP) on 06/07/19 at 9:35am revealed:
-The PCP was presented and signed the hospital discharge summary dated 05/18/19 and expected the orders to be implemented.
-The facility staff sent a Smart Page on 06/04/19 which indicated Resident #2 had missed Xarelto administration.
-The PCP did not know the exact number of Xarelto doses Resident #2 had missed or that Resident #2 was out of the medication.
-Missed doses of Xarelto put Resident #2 at risk of pulmonary emboli (blood clots in the lungs) due to atrial fibrillation.

Interview with a pharmacy staff member on 06/07/19 at 10:45am revealed:
-Xarelto was a cycle filled medication.
-The pharmacy dispensed 30 doses of Xarelto 15mg to the facility for Resident #2 on 05/03/19 and 06/02/19, labeled for administration of 1 tablet every evening, scheduled at 5:00pm.

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{D 358}	Continued From page 89 -Resident #2 should have enough Xarelto 15mg to last until 06/03/19. Interview with the Administrator on 06/05/19 at 6:12pm revealed the DRC was responsible for assuring medications were administered correctly. b. Review of Resident #2's current FL2 dated 05/18/19 revealed: -Diagnoses included Parkinson's disease. -Medication orders included Sinemet (carbidopa-levodopa, used to treat Parkinson's disease) 10-100mg two times daily. Review of Resident #2's signed hospital discharge summary dated 05/18/19 revealed an order for Sinemet 10-100mg two times daily. Review of Resident #2's June 2019 electronic medication administration record (eMAR) revealed: -There was an entry for carbidopa-levodopa 10-100mg once daily and scheduled at 9:00am. -Carbidopa-levodopa 10-100mg was documented as administered on 06/01/19 at 9:00am. -Carbidopa-levodopa 10-100mg was not documented as administered due to 'on delivery' from 06/02/19-06/06/19. Observation of medications on hand for Resident #2 on 6/6/2019 at 10:10am revealed there was no carbidopa-levodopa 10-100mg available for administration. Interview with Resident #2 on 06/06/2019 at 6:10pm and 06/07/19 at 1:15pm revealed: -She was diagnosed with Parkinson's disease prior to coming to the facility. -She did not know the name of the medication	{D 358}		

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{D 358}	Continued From page 90 she had been prescribed for Parkinson's disease. -She had not experienced tremors at this time. Interview with a medication aide (MA) on 06/06/19 at 10:10am revealed: -Only the Director of Resident Care (DRC) and lead MA/supervisor had access to approve or change orders in the eMAR system, which had to be completed before medications appeared for the MAs to administer. -Cycle filled medications were auto-filled and re-fills should not have had to be ordered. -The MA was responsible for ordering medications that were not available. -MAs ordered non-cycle medications by removing the re-order sticker from the medication container and then faxed the refill request to the pharmacy. -If the medication had not arrived by the next day, the MA should have called the pharmacy to determine the reason for the delay. -The MA had called the pharmacy and ordered carbidopa-levodopa; she did not know why it had not been delivered. -Staff should have documented contacts with the pharmacy and PCP in the resident's progress notes. Interview with the DRC on 06/06/19 at 12:54pm and 06/07/19 at 12:30pm revealed: -If a resident returned from the hospital with a signed discharge summary or a signed FL2, the new orders would have superseded previous orders. -All previous orders would have been discontinued and the new orders would have been used, so no clarification would have been needed. -Resident #2 was re-admitted 05/18/19, on a weekend, the MA should have faxed the signed orders to the pharmacy.	{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 91 -On the following Monday the DRC should have reviewed and assured implementation of the discharge orders. -Only the DRC and lead MA/supervisor had access to make changes or approve orders on the eMAR. -New orders must have been approved in the eMAR system before the order appeared and documented by the MAs. -The signed discharge summary dated 06/18/19 was not sent to the pharmacy and the orders were not put in the eMAR system. -Cycle medications should have been auto-filled monthly. -If a medication was not on the medication cart the MA should have looked in the overstock prior to ordering. -If a medication had been ordered, but had not arrived the MA should have called the pharmacy to determine why the medication had not been delivered. -Contacts with the pharmacy should have been documented in the resident's progress notes. Review of Resident #2's record revealed there were no progress notes available for review for June 2019. Interview with Resident #2's primary care provider (PCP) on 06/07/19 at 9:35am revealed: -On 03/13/19 she changed Resident #2's carbidopa-levodopa administration from twice a day to once a day. -The PCP was presented and signed the hospital discharge summary dated 05/18/19 and expected the orders to be implemented. -The PCP was not notified Resident #2 was out of carbidopa-levodopa. -Missed doses of carbidopa-levodopa put Resident #2 at risk of increased Parkinson's	{D 358}		

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{D 358}	Continued From page 92 symptoms like trembling and even falling. Interview with a pharmacy staff member on 06/07/19 at 10:45am revealed: -The pharmacy dispensed 30 doses of carbidopa-levodopa 10-100mg on 04/03/19. -Carbidopa-levodopa 10-100mg was a cycle filled medication. -If a cycle filled medication was not automatically filled it was typically because there were no refills. -The most recent signed physician orders on file for Resident #2 were dated 03/13/2019 for administration two times daily but the pharmacy could not use the order. -They had an order on file for carbidopa-levodopa 10-100mg dated 03/13/19 to discontinue twice daily and start daily administration but there were no refills. -The pharmacy did not have a signed FL2 or signed discharge summary on file dated 05/18/19. -There was no information regarding if the pharmacy notified the facility for no refills available. Interview with the Administrator on 06/05/19 at 6:12pm revealed the DRC was responsible for assuring medications were administered correctly. c. Review of Resident #2's current FL2 dated 05/18/19 revealed: -Diagnoses included coronary artery disease (CAD) due to lipid rich plaque. -There was an order for Lipitor (atorvastatin, used to treat high cholesterol and triglyceride levels) 80mg at bedtime. Review of Resident #2's signed hospital discharge summary dated 05/18/19 revealed an	{D 358}		

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{D 358}	Continued From page 93 order for Lipitor 80mg at bedtime. Review of Resident #2's May 2019 electronic medication administration record (eMAR) revealed: -There were multiple entries for atorvastatin (Lipitor) 20mg daily. -Atorvastatin 20mg was documented as administered at 9:00pm on from 05/01/19 to 05/03/19, 05/07/19 to 05/16/19, and 05/18/19 to 05/31/19. - Atorvastatin 20mg was not documented as administered 05/4/19 -05/06/19, with no reason for the exception documented and 05/17/19 for hospitalization. -There was no entry for atorvastatin 80mg. Review of Resident #2's June 2019 eMAR revealed: -There was an entry for atorvastatin (Lipitor) 20mg daily. -Atorvastatin 20mg was documented as administered from 06/01/19 to 06/05/19. -There was no entry for atorvastatin 80mg. Observation of medications on hand for Resident #2 on 06/06/19 at 10:10am revealed: -There was a supply of atorvastatin 20mg for Resident #2. -The packaging documented 30 tablets were dispensed on 05/03/19 with 11 pills remaining. -There was no supply of atorvastatin 80 mg for Resident #2. Interview of a medication aide (MA) 06/06/19 at 10:10am revealed: -The Director of Resident Care (DRC) was responsible for review and implementation of discharge orders from the hospital. -The MAs did not have a key to access resident	{D 358}		

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{D 358}	Continued From page 94	{D 358}		

records/documents, which were kept in the DRC's office.
-Only the DRC and lead MA/Supervisor had access to approve or change orders in the eMAR system, which must be done in order for MAs to be able to document administration.

Interview with another MA on 06/07/19 at 1:02pm revealed:
-The DRC was responsible for sending new orders from the hospital to the pharmacy.
-If a resident returned from the hospital on the weekend then the MA was responsible for sending orders to the pharmacy.
-The MAs could not add or approve orders to the eMAR and orders could not be carried out until they had been approved.

Interview with the DRC on 06/06/19 at 12:54pm and 06/07/19 at 12:30pm revealed:
-When a resident returned from the hospital with a signed discharge summary or a signed FL2, the new orders superseded previous orders.
-All previous orders were to be discontinued and the new orders would be used, so no clarification would be needed.
-Resident #2 was re-admitted on a weekend, the MA should have faxed signed orders to the pharmacy.
-On the following Monday the DRC should have reviewed and assured implementation of the discharge orders.
-Only the DRC and lead MA/Supervisor had access to make changes or approve orders on the eMAR.
-New orders must have been approved in the eMAR system before the order could be seen and administration documented by the MAs.
-The signed discharge summary dated 05/18/19 was not sent to the pharmacy and the orders

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{D 358}	Continued From page 95 were not put in the eMAR system Interview with Resident #2's primary care provider (PCP) on 06/07/19 at 9:35am revealed: -In July 2018, she reduced Resident #2's atorvastatin from 80mg to 20mg. -The PCP was presented and signed the hospital discharge summary dated 05/18/19 and expected the orders to be implemented. -The last laboratory test results for Resident #2's cholesterol levels was June 2018. Interview with a pharmacy staff member on 06/07/19 at 10:45am revealed: -They had signed physician orders on file dated 03/13/19 which had two entries for atorvastatin; one for 20mg and one for 80mg. -The pharmacy had been filling the atorvastatin 20mg order. -The pharmacy did not have a signed FL2 or signed discharge summary dated 05/18/19 on file ordering atorvastatin 80mg. Interview with the Administrator on 06/05/19 at 6:12pm revealed the DRC was responsible for assuring medications were administered correctly. d. Review of Resident #2's current FL2 dated 05/18/19 revealed: -Diagnoses included pulmonary emboli (PE) and chronic atrial fibrillation. -Medications included aspirin (used as a preventive for heart disease and/or a blood thinner) 81mg daily. Review of Resident #2's signed hospital discharge summary dated 05/18/19 revealed aspirin 81 mg daily was ordered.	{D 358}		

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Review of Resident #2's May 2019 electronic medication administration record (eMAR) revealed there was no entry for aspirin 81mg and no documentation aspirin 81 mg was administered from 05/01/19 to 05/31/19.

Review of Resident #2's June 2019 eMAR revealed there was no entry for aspirin 81mg and no documentation aspirin 81 mg was administered from 06/01/19 to 06/06/19.

Observation of medications on hand for Resident #2 on 6/6/2019 at 10:10am revealed there was no aspirin 81mg available for administration.

Interview with Resident #2 on 06/06/19 at 6:10pm revealed she believed she was on aspirin and hoped staff administered it to her.

Interview with Resident #2's primary care provider (PCP) on 06/07/19 at 9:35am revealed:
-The PCP was presented and signed the hospital discharge plan dated 05/18/19 and expected the orders to be implemented.
-Resident #2 should have been administered aspirin.

Interview with the Administrator on 06/05/19 at 6:12pm revealed the DRC was responsible for assuring medications were administered correctly.

4. Review of Resident #5's current FL2 dated 05/04/19 revealed:
-Diagnoses included pneumonia, sepsis, encephalopathy, transient ischemic attack, acute kidney injury, hyponatremia, hypertension, and acute respiratory failure.

a. Review of the current FL2 dated 05/04/19

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{D 358}	Continued From page 97 revealed a physician's order for carvedilol (used to treat hypertension) 12.5mg two times daily. Review of a physician order report signed by the physician on 05/10/19 revealed an order for carvedilol 12.5mg twice daily. Review of Resident #5's May 2019 electronic medication administration records (eMARs) revealed: -There was an entry on the eMAR for carvedilol 12.5mg twice daily. -Carvedilol was documented as administered daily at 9:00am and 9:00pm from 05/01/19 to 05/04/19, from 05/07/19 to 05/09/19, from 05/10/19 at 9:00pm to 05/26/19. -There was documentation carvedilol was not available in the facility on the following dates: 05/05/19 at 9:00am and 9:00pm, 05/06/19 at 9:00am and 9:00pm, 05/10/19 at 9:00am, 05/27/19 through 05/31/19 at 9:00am and 9:00pm. Review of Resident #5's June 2019 eMAR revealed: -There was an entry on the eMAR for carvedilol 12.5mg twice daily and scheduled at 9:00am and 9:00pm. -There was documentation carvedilol was not available in the facility on the following dates: 06/01/19 through 06/04/19 at 9am and 9pm. Observation of Resident #5's medications on hand on 06/05/19 at 5:10pm revealed there was one bubble pack medication card of carvedilol 12.5mg filled on 06/04/19 for a quantity of 14 tablets with 13 tablets of carvedilol remaining. Review of a fax request from the pharmacy dated 05/30/19 revealed the pharmacy requested the	{D 358}		

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{D 358}	Continued From page 98 facility to send a new order for Resident #5's carvedilol. Interview with a pharmacist at the contracted pharmacy on 06/05/19 at 11:32am revealed: -On 05/04/19, the pharmacy received notification that Resident #5 was a hospice resident. -When a resident was on hospice medications were not automatically refilled. -The facility staff had to call and request a refill. -It was the pharmacy's policy, when a resident was a hospice patient they filled medications once for a fifteen day supply, and then required a new prescription. -The pharmacy filled carvedilol on 05/06/19 to get the resident through 05/10/19, then the fifteen day supply should have been requested. -The pharmacy filled and dispensed six tablets of carvedilol 12.5mg on 05/06/19. -The six tablets would have lasted the resident for three days. -On 05/10/19 the facility staff requested another refill of carvedilol, and thirty tablets were dispensed on 05/10/19. -The medication should have lasted fifteen days. -On 05/10/19, the pharmacy reminded facility staff they would need a new order to refill the medication. -On 05/30/19 the pharmacy faxed a reminder to the facility staff reminding them they needed a new order for carvedilol. -The pharmacy received a verbal order on 06/04/19 from the primary care provider (PCP) for carvedilol. -On 06/04/19, the medication was filled and thirty tablets were dispensed. -Carvedilol was not filled or dispensed from 05/10/19 through 06/04/19, therefore the resident would have been out of the medication for over one week.	{D 358}		

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{D 358}	Continued From page 99 -Suddenly, stopping the medication could cause change in heart rhythm or an increase in blood pressure. -The facility staff did not provide a new prescription for carvedilol and did not request a refill of the medication until 06/04/19. Interview with Resident #5's primary care provider (PCP) at hospice on 06/05/19 at 12:11pm revealed: -Resident #5 was discharged from the hospital on 05/04/19. -When the resident was discharged there was a new FL2 that listed the resident's current medication orders. -The facility staff should have administered the medications according to the orders on the FL2. -On 05/04/19 hospice assessed Resident #5 for intake. -On 05/10/19 she reviewed and signed Resident #5's medication list given by the facility staff titled "physician's order report." -The resident's current list of medications included carvedilol 12.5mg twice daily. -The medication should have been administered twice daily as ordered. -If facility staff did not administer the medication they should have let her know. -Resident #5 had a history of pneumonia, hypertension and other health issues. -The resident should not have gone from 05/27/19 through 06/04/19 without carvedilol. Interview with the Administrator on 06/05/19 at 6:00pm revealed: -She did not know that Resident #5 was out of carvedilol from 05/27/19 through 06/04/19. -The medication aide/supervisor (MA/S) or the Director of Resident Care (DRC) were responsible for contacting the physician when a	{D 358}		

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resident needed a refill on medications.
-No resident should be out of medications.
-The DRC was supposed to check the eMARs daily to make sure nothing was wrong, like medication running out.
-The DRC was responsible for managing the administration of medications and ensuring medication were administered as ordered.

Interview with the medication aide (MA) on 06/05/19 at 5:45pm revealed:
-She knew that Resident #5 had been without her carvedilol for at least one week.
-She knew the pharmacy requested a new order for Resident #5's carvedilol.
-One evening she noticed a request from the pharmacy for a new order for carvedilol on the fax machine.
-The DRC had left for the day, so she made a copy of the pharmacy request, and put one copy underneath the DRC's door.
-It was the facility's policy when a medication card was pulled and the last medication was administered, then the MA on the cart should contact the pharmacy to refill the medication.
-If a new medication order was needed, the DRC was responsible for contacting the PCP to obtain a new order.
-She did not ask or remind the DRC about a new prescription for Resident #5's carvedilol.

Interview with the MA/S on 06/05/19 at 6:25pm revealed:
-On 06/04/19 she noticed that Resident #5 was still out of her carvedilol.
-She called the PCP and informed the pharmacy needed a new order.
-The medication was delivered to the facility late on 06/04/19.
-The medication was administered again on

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{D 358}	Continued From page 101 06/05/19. -She knew the pharmacy had requested a new order for the medication. -One of the MAs on the cart should have contacted the physician to obtain a new order. -She did not contact the PCP because she was working on a different medication cart and then was off work for a few days. -She was surprised on 06/04/19 to see the medication was still not available for administration. -The DRC was responsible for medication orders, but the MAs were also responsible for contacting the physician and requesting new orders. -Resident #5 should not have been without her carvedilol from 05/27/19 through 06/05/19. Interview with the Director of Resident Care (DRC) on 06/06/17 at 10:55am revealed: -She did not recall seeing a fax from the pharmacy requesting a new order for Resident #5's carvedilol. -The MA's or the MA/S were on the medication cart daily and one of them should have called the pharmacy to find out why the medication had not been delivered. -The MAs were able to call the PCP and request new orders. -A resident should not go more than three days without a medication -If there was a problem getting the medication, the facility would also buy a resident's medication to ensure the resident was not without the medication. -If a medication was not automatically refilled then, the MA was supposed to request the refill before the medication was out. -There was an eMAR audit that was supposed to be completed weekly to identify medications that were not available or medication that were	{D 358}		

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{D 358}	Continued From page 102 missed on the eMAR. -She had been very busy and had not done an eMAR audit for almost two weeks. Based on observation, interview and record review it was determined that Resident #5 was not interviewable. b. Review of Resident #5's current FL2 dated 05/04/19 revealed a physician's order for sertraline 25mg at bedtime (antidepressant medication). Review of a physician's order report dated 05/10/19 revealed sertraline was not listed as one of the resident's medications. Review of Resident #5's May 2019 electronic medication administration record (eMAR) revealed: -There was an entry on the eMAR for sertraline 25mg at bedtime. -Sertraline was documented as administered at 9:00pm on 05/05/19 and 05/06/19. -There was documentation on the eMAR the medication was discontinued on 05/07/19. Review of Resident #5's June 2019 eMAR revealed there was no entry on the eMAR for sertraline 25mg. Observation of Resident #5's medications on hand on 06/05/19 at 5:11pm revealed: -Sertraline 25mg was available for administration. -There was a bubble packed medication card labeled as dispensed on 05/03/19 for a quantity of thirty tablets. -No medication had been removed from the bubble packed card.	{D 358}		

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{D 358}	Continued From page 103 Interview with the medication aide (MA) on 06/05/19 at 5:45pm revealed: -According to the eMAR sertraline 25mg was discontinued on 05/07/19. -She could not see the staff that discontinued the medication. -There should be an order in the resident's record to discontinue the medication or the pharmacy should have an order to discontinue the medication. -She could tell the medication had not been administered because the seals on the back of the bubble pack medication card was not broken. Interview with a pharmacist at the contracted pharmacy on 06/05/19 at 11:36am revealed: -On 05/03/19, they filled and dispensed a thirty sertraline 25mg tablets. -The pharmacy did not have any orders that discontinued the medication. -Resident #5 was a hospice patient and the medication would not be refilled unless the facility called and requested a refill. -No one at the facility requested the medication be refilled. -On 06/04/19, the pharmacy received a verbal order from the PCP for sertraline 25mg at bedtime. -The medication was filled, and fifteen tablets were dispensed on 06/04/19. Interview with Resident #5's primary care provider (PCP) at hospice on 06/05/19 at 12:13pm revealed: -Resident #5 had a hospital FL2 dated 05/04/19 that included sertraline 25mg at bedtime. -She saw Resident #5 on 05/10/19, and the facility staff gave her a physician's order report listing the resident's medications. -She did not realize the sertraline was not on the	{D 358}		

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order report.
-She did not want sertraline 25mg at bedtime discontinued.
-The facility should have called her to clarify the medication order instead stopping the medication.
-Facility staff should not stop a medication unless there was an order to stop the medication.
-On 06/04/19 she received a phone call from facility staff stating Resident #5 needed new orders for the pharmacy to fill the resident's medications.
-She called the contracted pharmacy and gave verbal orders for all of Resident #5's current medications including sertraline 25mg.

Interview with the Administrator on 06/05/19 at 6:00pm revealed:
-She did not know Resident #5 was not administered sertraline in May and June 2019.
-No resident should be out of a medication, especially not for a whole month.
-The DRC was supposed to check the eMARs daily to make sure nothing was wrong, like medication running out.
-The DRC was responsible for managing the administration of medications and ensuring medication were administered as ordered.

Interview with the medication aide/supervisor (MA/S) on 06/05/19 at 6:25pm revealed:
-On 06/04/19 she noticed that Resident #5 was still out of one of her medications.
-She called the PCP and informed the PCP the pharmacy needed new orders for Resident #5's medications.
-She did not know that Resident #5 was not administered sertraline.
-She did not see an order in the system showing why the medication was discontinued.
-She did not know why sertraline was

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discontinued in the eMAR system because the medication was on the resident's 05/04/19 current FL2.
-The medication was not on the physician's order report because it was discontinued in the eMAR system.
-She had no idea why the medication was discontinued.

Interview with the Director of Resident Care (DRC) on 06/06/17 at 10:55am revealed:
-She did not know Resident #5 was not administered sertraline 25mg at bedtime.
-The medication was on the current FL2, so she did not know why the medication was stopped.
-There was an eMAR audit that was supposed to be completed weekly to identify medications that were not available or medications that were missed on the eMAR.
-She had been very busy and had not done an eMAR audit for almost two weeks.

Based on observation, interview and record review it was determined that Resident #5 was not interviewable.

c. Review of the current FL2 dated 05/04/19 revealed a physician's order for isosorbide mononitrate (IMDUR) 30mg daily (used to treat angina).

Review of a physician's order report dated 05/10/19 revealed isosorbide mononitrate (IMDUR) 30mg daily was listed as one of the resident's current medications.

Review of Resident #5's May 2019 electronic medication administration records (eMARs) revealed:
-There was an entry on the eMAR for isosorbide

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mononitrate 30mg daily.
-Isosorbide mononitrate was documented as administered daily at 8:00am from 05/01/19 to 05/05/19, 05/07/19 to 05/09/19, 05/11/19 to 05/28/19.
-There was documentation isosorbide mononitrate was not available in the facility on the following dates: 05/06/19, 05/10/19, and 05/29/19 through 05/31/19.
-On 05/29/19 and 05/30/19 the medication aide (MA) documented "awaiting."
-On 05/31/19 the medication aide/Supervisor (MA/S) documented "need new signed physician order."

Review of Resident #5's June 2019 eMAR revealed:
-There was an entry for isosorbide mononitrate 30mg daily and scheduled at 8:00am.
-Isosorbide mononitrate was documented as not available in the facility on the following dates: 06/01/19 through 06/04/19.
-On 06/01/19 the MA documented "signed dr order."
-On 06/02/19 and 06/03/19 the MAs documented "need refills."
-On 06/04/19 the MA documented "awaiting delivery."

Observation of Resident #5's medications on hand on 06/05/19 at 5:10pm revealed there was no isosorbide mononitrate 30mg available for administration.

Review of a fax request from the pharmacy dated 05/30/19 revealed the pharmacy requested the facility to send a new order for Resident #5's isosorbide mononitrate 30mg daily.

Interview with a pharmacist at the contracted

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pharmacy on 06/05/19 at 11:32am revealed:
-On 05/10/19 the pharmacy filled and dispensed fifteen isosorbide mononitrate 30mg tablets.
-The medication should have lasted fifteen days, so by 05/25/19 the facility staff should have requested another refill.
-On 05/30/19 the pharmacy faxed the facility a reminder that a new order was needed to fill isosorbide mononitrate.
-On 06/04/19, the PCP called in a verbal order for isosorbide mononitrate 30mg daily.
-The medication was filled, and fifteen tablets were dispensed on 06/04/19.

Interview with Resident #5's primary care provider (PCP) at hospice on 06/05/19 at 12:11pm revealed:
-On 06/04/19 she received a phone call from a staff at the facility stating the pharmacy needed new orders for Resident #5 medications.
-She called the pharmacy and gave verbal orders for all the resident's medications.
-Resident #5 was a hospice patient and should not be running out of medications.
-If facility staff were unable to administer the medication they should have let her know.

Interview with the Administrator on 06/05/19 at 6:00pm revealed:
-She did not know Resident #5 was out of isosorbide.
-The MA/S or the Director of Resident Care (DRC) were responsible for contacting the physician when a resident needed a refill on medications.
-No resident should be out of medications.
-The DRC was supposed to check the eMARs daily to make sure nothing was wrong, like medication running out.
-The DRC was responsible for managing the

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{D 358}	Continued From page 108 administration of medications and ensuring medication were administered as ordered. Interview with the MA/S on 06/05/19 at 6:25pm revealed: -On 06/04/19 she noticed that Resident #5 was still out of isosorbide mononitrate. -She called the PCP and informed the pharmacy needed a new order -She had noted on 05/31/19 the medication needed a new order. -She expected the MAs to contact the PCP and get a new order. -She did not contact the PCP because she was working on a different medication cart and then was off work for a few days. -She was surprised on 06/04/19 to see the medication was still not available for administration. -The DRC was responsible for medication orders, but the MAs were also responsible for contacting the physician and requesting new orders. Interview with the Director of Resident Care (DRC) on 06/06/17 at 10:55am revealed: -She did not recall seeing a fax from the pharmacy requesting a new order for Resident #5's isosorbide mononitrate. -The MAs or the MA/S were on the medication cart daily and one of them should have called the pharmacy to find out why the medication had not been delivered. -The MAs were able to call the PCP and request new orders. -The DRC was responsible to assure medications were administered as ordered. Based on observation, interview and record review it was determined that Resident #5 was not interviewable.	{D 358}		

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5. Review of Resident #4's current FL2 dated 01/09/19 revealed:
-Diagnoses included chronic kidney disease stage II, anxiety, coronary artery disease, depression, diabetes mellitus, dyskinesia, hypertension, osteoporosis, and vitamin D deficiency.

Review of a physician's order dated 03/27/19 revealed an order for K-Phosphate (K-Phos) 500mg 1 tablet three times a day (used to treat complications of advanced renal disease)

Review of Resident #4's electronic Medication Administration Record (eMAR) for April 2019 revealed:
-There was an entry for K-Phos 500mg 1 tablet three times daily at 9:00am, 3:00pm, and 9:00am.
-K-Phos was not documented as administered 3 times in April 2019.
-K-Phos was not documented as administered on 04/19/19 at 9:00pm and 04/20/19 at 3:00pm due to "on order."
-K-Phos was not documented as administered on 04/20/19 at 3:00pm due to "delivery."

Review of Resident #4's eMAR for May 2019 revealed:
-There was an entry for K-Phos 500mg 1 tablet three times daily at 9:00am, 3:00pm, and 9:00am.
-K-Phos was not documented as administered 16 times in May 2019.
-K-Phos was not documented as administered on 05/03/19 at 9:00pm due to "on delivery."
-K-Phos was not documented as administered on 05/04/19, 05/05/19, and 05/06/19 at 9:00am, 3:00pm, and 9:00pm and on 05/07/19 at 9:00am and 3:00pm due to "no refills,"

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{D 358}	Continued From page 110 -K-Phos was not documented as administered on 05/07/19 at 9:00pm and 05/08/19 at 9:00am due to "awaiting pharmacy." -K-Phos was not documented as administered on 05/08/19 at 3:00m due to "delivery" and on 05/09/19 at 9:00am due to "waiting on delivery." Observation of Resident #5's medications on hand on 06/06/19 at 5:27pm revealed: -K-Phos was in the medication cart and was available for administration. -The pharmacy label indicated there were 90 tablets of K-Phos dispensed on 05/08/19. -There were 15 tablets remaining in the bubble pack. Interview with the Director of Resident Care (DRC) on 06/06/19 at 9:21am revealed: -If a medication was not a cycle filled medication, it should be ordered within 7 days of running out. -If the medication was not in the building after being ordered, she expected the medication aides (MAs) to contact the pharmacy and to let her know. -She was able to print a report of missed medication, but she did not run the report to review daily and did not know the last time she printed and reviewed the report of missed medications. -MAs should be completing cart audits daily to make sure there were no expired medications and to make sure all medications were on the cart. -She did not know about the missed doses of K-Phos. -She did not know why staff documented "on order," "no refills," and "waiting on pharmacy for K-Phosphate for 8 days. -Staff should have let her know so she could see what was going on.	{D 358}		

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{D 358}	Continued From page 111 Interview with the Administrator on 06/06/19 at 12:04pm revealed: -Medication should be reordered within 2 to 3 days of running out. -If a medication was not in the facility, the MA or DRC should have contacted the pharmacy to find out where the medication was. -She did not know K-Phos was not administered 3 times in April 2019 and 16 times in May 2019. -Resident #4's physician should have been contacted regarding the missed doses of medication and for a prescription if it was needed. Interview with a MA on 06/07/19 at 9:57am revealed: -The eMAR audits were supposed to be completed once a week and entailed the eMARs being printed off and compared to the medication on the cart. -She had not completed a eMAR audit in about a month. -Cart audits were completed daily and included checking to see if the correct medications were on the cart. -If a medication was not on the cart, the MA should have looked in the medication room to see if the medication was in overstock. -If a medication was not on the cart and not in overstock, the MA should have contacted the pharmacy to reorder it, documented on the eMAR "on order", and told other MAs the medication was on order. -Medication should be reordered within 7 days of it running out. -If there was an issue with ordering a medication, she would let the DRC know. -MAs notified the physician if a resident missed a medication 3 days in a row. -Resident #4 was out of K-Phos a couple of days	{D 358}		

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{D 358}	Continued From page 112 in April and May 2019. -She documented 3 times in April and May 2019 K-Phos was not administered due to the medication not being in the facility. -She contacted the pharmacy to see why the medication had not been sent, but she did not remember the date. -The pharmacy told her Resident #4 needed an updated order for K-Phos. -She did not remember if she contacted Resident #4's PCP to get an updated order or told the DRC an order was needed. Interview with a pharmacist at Resident #4's pharmacy on 06/07/19 at 10:51am revealed: -There was a current order dated 03/27/19 for K-Phos 500mg 1 tablet 3 times daily. -A month supply was usually sent out to the facility, but the pharmacy sent K-Phos out in 10 day increments to begin with to see if Resident #4 would remain on the medication. -On 03/28/19, 30 tablets were dispensed (10-day supply). -On 04/08/19, 30 tablets were dispensed (10-day supply). -On 04/20/19, 30 tablets were dispensed (10-day supply). -On 05/08/19, 90 tablets were dispensed (30-day supply). -On 06/04/19, 90 tablets were dispensed (30-day supply). -K-Phos was automatically sent out to the facility on 03/28/19, but the facility had to call to have K-Phos refilled on 04/08/19 and 04/20/19. -The pharmacy told the facility a new prescription was needed after the last dispense date of 04/20/19. -The pharmacy received an order for K-Phos 1 tablet 3 times daily on 05/08/19 and K-Phos became a cycle fill medication on this date.	{D 358}		

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{D 358}	Continued From page 113 -There was no documentation regarding medication not being dispensed between 04/30/19 and 05/08/19. Interview with a second MA on 06/07/19 at 4:58pm revealed: -She documented K-Phos was not administered to Resident #4 in April due to "no refills." -K-Phos was not available in the facility to administer on 05/05/19 and 05/07/19 when she documented not administered due to "no refills." -"We needed a new signed physician's order and we can only get the physician's order on Wednesdays when the PCP is here because we don't have a fax number for her." -She could have contacted the PCP by phone or paged her for a medication order, but she did not know why she did not. Interview with Resident #4's primary crae physician (PCP) on 06/07/19 at 9:17am and 2:19pm revealed: -She did not know facility staff documented K-Phos was not administered to Resident #4 nineteen times on 04/19/19 through 04/21/19 and 05/03/19 through 05/09/19 due to "no refills" and "waiting on pharmacy." -She visited the facility on 05/08/19 and was informed an order was needed for K-Phos to be filled by Resident #4's pharmacy. -The facility usually let her know what medications residents needed and she wrote the orders while in the facility. -She wrote an order for K-Phos on 05/08/19. -She had not been notified of the need for new prescription prior to 05/08/19. -She expected the facility to notify her of missed doses of K-Phos and of the need for a new prescription. -Resident #4's food intake was not adequate	{D 358}		

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{D 358}	Continued From page 114 enough to sustain his potassium levels without medication. -A possible outcome could be death if potassium levels were not adequate. -Resident #4's labs were behind and she did not have a current potassium level for him. -Normal potassium levels were between 3.5 and 5.5 and Resident #4's last documented potassium lab result was 4.3 on 12/10/18. The facility failed to assure medications were administered for 2 of 4 residents (#7, and #8) observed during the medication pass including errors with a pain medication (#7) causing the resident undue suffering from pain, and medications for acid reflux and anxiety (#8) ; and for 4 of 6 sampled residents with orders for a blood pressure medication and a medication for constipation for a resident who had been hospitalized for constipation (#3) placing the resident at risk for elevated blood pressure symptoms like headache and stroke and intestinal blockage or rupture; blood thinners, a medication for Parkinson's disease, a medication to reduce cholesterol (#2) placing the resident at risk for a deep vein blood clot or pulmonary embolism, increased tremors or shaking and risk for falls, a renal medication (#4) placing the resident at risk for complications of chronic renal disease, and a medication for hypertension, a medication for panic and stress disorder and a medication for angina (#6) placing the resident at risk for elevated blood pressure and stroke, increased anxiety and stress, and the risk for angina and/or heart attack due to decreased blood supply to the heart (treated by isosorbide). The facility's failure to administer medications as ordered placed the residents at substantial risk for health problems and constitutes a Type A2 Violation.	{D 358}		

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{D 358}	Continued From page 115 The facility provided a Plan of Protection on 06/06/19 in accordance with G. S. 131D-34. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 7, 2019.	{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).	D 367		

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D 367	Continued From page 116 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the medication administration records (MARs) were accurate and complete for 1 of 6 sampled residents (Residents #2), as related to a vitamin supplement and anti-psychotic medication (#2). The findings are: Review of Resident #2's current FL2 dated 05/18/19 revealed diagnoses included pulmonary emboli (PE) and chronic atrial fibrillation. a. Review of Resident #2's current FL2 dated 05/18/19 revealed an order for Vitamin D3 1000u daily (used to treat vitamin D deficiency). Review of Resident #2's signed hospital discharge summary dated 05/18/19 revealed an order for Vitamin D3 1000u daily. Review of Resident #2's April 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D3 1000u daily and scheduled for 9:00am, with start date of 03/08/18, open ended. -There was documentation for administration of Vitamin D3 1000u daily from 04/01/19 -04/30/19. -There was an entry for Vitamin D3 1000u daily and scheduled for 8:00am, with start date of 03/08/19 and end date of 05/07/19. -There was documentation of double administration of Vitamin D3 1000u daily from 04/24/19 to 04/28/19 (5 times). Review of Resident #2's May 2019 eMAR revealed: -There was an entry for Vitamin D3 1000u daily	D 367		

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	HAL080026	A. BUILDING: _____ B. WING _____	R 06/07/2019

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D 367	Continued From page 117	D 367		

and scheduled for 9:00am.
-There was documentation of administration of Vitamin D3 1000u daily from 05/01/19 -05/17/19 and 05/19/19 to 05/31/19.
-There was an entry for Vitamin D3 1000u daily and scheduled for 8:00am, with start date of 03/08/19 and end date of 05/07/19.
-There was documentation of double administration of Vitamin D3 1000u daily from 05/03/19 to 05/07/19 (5 times).

Review of Resident #2's June 2019 MAR (06/01/19-/06/06/19 only) revealed:
-There was an entry for Vitamin D3 1000u daily and scheduled for 9:00am.
-There was documentation of administration of Vitamin D3 1000u daily from 06/01/19 to 06/06/19.
-There was an entry for Vitamin D3 1000u daily and scheduled for 8:00am, with start date of 05/0719.
-There was documentation of double administration of Vitamin D3 1000u daily from 06/04/19 to 06/06/19 (2 times).

Interview of a medication aide (MA) on 06/07/19 at 4:55pm revealed:
-When there had been duplicate orders on the eMAR the MA did not know which one was correct and had to choose one to administer.
-When a duplicate order had appeared on the eMAR, the MA documented 'duplicate order' on the eMar and notified the lead MA/Supervisor with a written note.
-Only the Director of Resident Care (DRC) and lead MA/Supervisor had access to make changes/corrections or approve orders for administration on the eMAR.
-The DRC was responsible for review and accuracy of entries on the eMAR.

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D 367	Continued From page 118 Interview of another MA on 6/7/2018 at 5:10pm revealed: -When there had been duplicate orders on the eMAR the MA did not know which one was correct. -The MA would compare the medication label to the eMAR for clarification of which order to follow. -The MAs were expected to perform weekly medication cart audits and verify medications against the physician orders. -Medication cart audits were documented with the MA signature and date of audit documented on a copy of the resident's physician orders. -When the facility had been short staffed the MAs have not been able to perform weekly audits. -When a duplicate order had appeared on the eMAR, the MA notified the lead MA/supervisor; she could not confirm when the supervisor was notified. -The MA did not know who was responsible for review and accuracy of entries on the eMAR. Interview with the DRC on 06/07/19 at 12:30pm revealed: -Only the DRC and lead MA/Supervisor had access to make changes/corrections or approve orders on the eMAR. -New orders must be approved in the system before the order could be seen and documented by the MAs. Interview with the Administrator on 06/05/19 at 6:12pm revealed the DRC was responsible for accuracy of the MAR and assuring medications were administered correctly. b. Review of Resident #2's current FL2 dated 05/18/19 revealed an order for Zoloft 100mg daily (used to treat depression).	D 367		

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D 367	Continued From page 119 Review of Resident #2's signed hospital discharge summary dated 05/18/19 revealed an order for Zoloft 100mg daily. Review of Resident #2's May 2019 MAR revealed: -There was an entry for sertraline (Zoloft) 100mg take one and one-half tablets daily, scheduled for 9:00am, There was a start date of 01/19/19 and an end date of 05/04/19. -There was documentation of administration of sertraline (Zoloft) 100mg one and one-half tablets daily from 05/01/19 to 05/04/19. -There was an entry for sertraline 100mg take one and one-half tablets daily, scheduled for 1:00am with a start date of 05/04/19 and an end date of 05/07/19. -There was no documentation of administration of sertraline (Zoloft) 100mg one and one-half tablets daily. -There wa an entry for sertraline 100mg take one and one-half tablets daily scheduled for 8:00am and 9:00am with a start date of 05/07/19, and no stop date (open ended). -There was documentation of administration of sertraline (Zoloft) 100mg one and one-half tablets daily on 05/08/19 at 8:00am and at 9:00am from 05/09/19 to 05/31/19. -There was no documentation of administration of sertraline on 05/05/19-05/07/19 and no exceptions documented. Review of Resident #2's June 2019 MAR (06/01/19-/06/06/19 only) revealed: -There was an entry for sertraline 100mg take one and one-half tablets daily, scheduled for 8:00am and 9:00am with a start date of 05/07/19. -There was documentation of administration of sertraline (Zoloft) 100mg one and one-half tablets	D 367		

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D 367	Continued From page 120 daily on 06/03/19-06/06/19 at 9:00am. Interview of a medication aide (MA) on 06/07/19 at 4:55pm revealed: -When there had been duplicate orders on the eMAR the MA did not know which one was correct and had to choose one to administer. -When a duplicate order had appeared on the eMAR, the MA documented 'duplicate order' on the eMar and notified the lead MA/Supervisor with a written note. -Only Director of Resident Care (DRC) and lead MA/Supervisor had access to make changes/corrections or approve orders for administration on the eMAR. -The DRC was responsible for review and accuracy of entries on the eMAR. Interview of another MA on 6/7/2018 at 5:10pm revealed: -When there had been duplicate orders on the eMAR the MA did not know which one was correct. -The MA would compare the medication label to the eMAR for clarification of which order to follow. -The MAs were expected to perform weekly medication cart audits and verify medications against the physician orders. -Medication cart audits were documented with the MA signature and date of audit documented on a copy of the resident's physician orders. -When the facility had been short staffed the MAs have not been able to perform weekly audits. -When a duplicate order had appeared on the eMAR, the MA notified the lead MA/supervisor; she could not confirm when the supervisor was notified. -The MA did not know who was responsible for review and accuracy of entries on the eMAR.	D 367		

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D 367	Continued From page 121 Interview with the DRC on 06/07/19 at 12:30pm revealed: -Only the DRC and lead MA/Supervisor had access to make changes/corrections or approve orders on the eMAR. -New orders must be approved in the system before the order could be seen and documented by the MAs. Interview with the Administrator on 06/05/19 at 6:12pm revealed the DRC was responsible for accuracy of the MAR and assuring medications were administered correctly.	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. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to assure every resident had the right to receive care and services which were adequate, and in compliance with rules and regulations as related to Personal Care and Other staffing, and Medication Administration. 1. Based on interviews and record reviews, the facility failed to assure aide hours met the	{D912}		

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{D912}	Continued From page 122 minimum requirements resulting in inadequate staff to meet the supervision and personal care needs of the residents for 57 of 66 shifts during sixteen days from 05/13/19 to 06/03/19. [Refer to Tag 0188 10A NCAC 13F .0604(e) Personal care and Other Staffing (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 facility's policies for 2 of 4 residents (#7, and #8) observed during the medication pass including errors with a pain medication (#7), and medications for acid reflux and anxiety (#8); and for 4 of 6 sampled residents (Resident #2, #3, #4, and #6) related to a blood pressure medication and a medication for constipation (#3), a blood thinner, a medication used to treat Parkinson's disease, medication used to lower cholesterol, and aspirin (#2), a potassium supplement medication (#4), and a medication for hypertension, an antidepressant medication, and a medication for angina (#6). [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].	{D912}		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were free of neglect and physical abuse in	D914		

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D914	Continued From page 123 compliance with federal and state laws and rules and regulations related to Health Care. The findings are Based on observations, interviews and record reviews the facility failed to assure physician referrals and notifications for 3 of 6 sampled residents (Residents #2, #4, and #6) regarding a referral to cardiology for shortness of breath, and referral for bone density test (#2), a referral to a gastroenterologist and labs that were not obtained (#4), and a resident not seen by neurology and not scheduled for a mammogram and gynecology appointment (#6). [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D914		