STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086001	A. BUILDING: _____ B. WING _____	R 08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CARE	139 APEX LANE MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 08/06/19 through 08/08/19.	{D 000}		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure 2 of 4 exit doors accessible for residents' use had an alarm that activated for the safety of 2 of 2 sampled residents (Resident #2 and #5) who exhibited exit seeking behaviors, had wandering behaviors, and eloped from the facility without staff's knowledge. Observations of the facility on 08/06/19 between 7:30am and 1:30pm revealed: -At 7:30am, there was no door alarm sounding at the front door of the main entrance upon entering the facility.	D 067		

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D 067	Continued From page 1	D 067		

-At 1:25pm, there was no door alarm sounding at the back door smoking entrance when exiting the facility.
-The door alarms were activated at the entrance doors at the end of A Hall and at the end of B Hall.

1. Review of Resident #2's current FL-2 dated 07/01/19 revealed:
-Diagnoses included cognitive impairment.
-There was documentation Resident #2 was intermittently disoriented.
-Resident #2 was semi-ambulatory.

Review of Resident #2's progress notes dated 05/05/19 revealed:
-Resident #2 was last seen at 1:00am.
-Staff looked all over the facility, but staff could not find Resident #2 so law enforcement was called out to the facility.
-Staff looked for Resident #2 for three hours and found him in another resident's room.

Review of Resident #2's progress notes dated 05/14/19 revealed:
-Staff did rounds at 11:15pm and saw Resident #2 was not in bed.
-Staff searched the entire facility and outside the facility and Resident #2 was nowhere to be found.
-Staff called 911 between 11:45pm and 12:00am and law enforcement came to the facility, took Resident #2's information and left the facility.
-Staff went outside to look for Resident #2 again and heard Resident #2 yelling "help me."
-Resident #2 was found by a trailer on the back, right side of the facility around 1:45am.
-Resident #2 was brought back into the facility.

Review of Resident #2's Incident/Accident Reports revealed:

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D 067	Continued From page 2 -There was an Incident Report dated 05/05/19 regarding a fall in Resident #2's bathroom and Resident was placed on 15 minute checks. -There was no Incident Report dated 05/05/19 regarding Resident #2 being lost in the facility. -There was no Incident Report dated 05/14/19 regarding Resident #2 eloping from the facility. Interview with Resident #2 on 08/06/19 at 1:09pm revealed: -He went outside one night to get his cat and was on the ground by the trailer, but he did not remember when or how long he was outside. -He did not remember if the door alarm sounded when he left the facility to go get his cat. Interview with the Resident Care Coordinator on 08/06/19 at 4:15pm revealed she did not know Resident #2 had eloped from the facility without staff's knowledge and was found outside at 1:45am. Interview with the Administrator on 08/06/19 at 5:34pm revealed she did not know Resident #2 had eloped from the facility on 05/14/19 without staff's knowledge and was found outside at 1:45am. Interview with a Medication Aide (MA) on 08/07/19 at 7:20pm revealed: -She worked third shift the night of 05/14/19 when Resident #2 eloped from the facility. -She started her shift at 11:00pm on 05/14/19 and entered through the back door which was unlocked and unalarmed when she entered. -The alarm on the back door was not usually activated when she came in to work. -She was not sure which door Resident #2 exited through.	D 067		

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D 067	Continued From page 3 Refer to interview with 3 residents on 08/06/19 between 1:26pm and 1:39pm. Refer to interview with the Resident Care Coordinator on 08/06/19 at 4:15pm. Refer to interview with the Administrator on 08/06/19 at 5:34pm and 6:45pm. 2. Review of Resident #5's current FL2 dated 07/24/19 revealed: -Diagnoses included schizoaffective disorder and mania. -There was documentation Resident #5 was ambulatory. -There was no information regarding Resident #5's orientation or behavior. Review of Resident #5's Resident Register dated 09/08/17 revealed Resident #5 had wandering behaviors. Review of Resident #5's progress notes dated 08/02/19 revealed: -Resident #5 went walking up the road. -Police were called and brought Resident #5 back to the facility. -Mobile crisis was called out to the facility for Resident #5. -Resident was put on 15 min checks for the next 24 hours. Review of Resident #5's progress notes dated 08/03/19 revealed at 12:05am mobile crisis was sending resident out of the facility. Review of Resident #5's Incident/Accident Reports revealed there was no report documenting an elopement that occurred on 08/02/19.	D 067		

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D 067	Continued From page 4 Interview with Resident #5 on 08/06/19 at 1:40pm revealed: -She had left out of the facility at night, sometimes after midnight, to smoke. -She left the facility recently and walked down the street. -She did not remember what time it was, but remembered it was dark when she left the facility. -She walked up the street to meet a family member. -The alarm was not on the front door. -She had walked away from the facility before. Interview with the Resident Care Coordinator on 08/06/19 at 4:15pm revealed: -She knew about Resident #5 eloping from the facility on 08/02/19. -She did not know whether or not the front and back doors were alarmed when Resident #5 eloped. -Resident #5 had left the facility about 3 times previously that she was aware of and was found at a neighbor's house. Interview with the Administrator on 08/06719 at 5:34pm revealed: -She knew about Resident #5 eloping from the facility on 08/02/19, but she did not know whether or not the front and back doors were alarmed when Resident #5 eloped. -Resident #5 was an identified wanderer. Observation of the facility parking lot on 08/06/19 between 8:46pm and 8:55pm revealed: -Resident #5 was standing at the edge of the parking lot near a wooded area. -About 10 feet into the wooded area the land dropped off into a steep hill. -Resident #5 took 2 to 3 steps into the wooded	D 067		

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area, but then backed back up to the parking lot.
-The Administrator walked up to Resident #5 and started talking to her appearing to try to coax her back in the facility.

Interview with a Medication Aide (MA) on 08/07/19 at 4:51pm revealed:
-She was working 2nd shift in the facility on 08/02/19 when Resident #5 eloped.
-The alarm was not activated prior to realizing Resident #5 had eloped.
-She did not know what time Resident #5 left the facility.
-She thought Resident #5 had been gone more than 30 minutes, but not quite an hour.
-It was dark outside when she realized Resident #5 was gone.
-She looked for Resident #5 in the facility and went out to the road to look for her but did not see her so she called the cops.

Attempted interview with the local police on 08/07/19 at 2:20pm was unsuccessful.

Refer to interview with 3 residents on 08/06/19 between 1:26pm and 1:39pm.

Refer to interview with the Resident Care Coordinator on 08/06/19 at 4:15pm.

Refer to interview with the Administrator on 08/06/19 at 5:34pm and 6:45pm.

Interview with 3 residents on 08/06/19 between 1:26pm and 1:39pm revealed:
-One resident usually exited the back door entrance to smoke and two residents usually exited the front entrance door to smoke.
-The back door was usually locked about 12:00am, but residents could still go out of the

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back door entrance to smoke.
-There was no alarm on the back door when he went out to smoke day or night.
-When residents went out the front door to smoke at any time of the night, the alarm did not go off.
-Residents went out to smoke without staff knowing they were going out.
-The two side doors were the only doors that had alarms activated.

Interview with the Resident Care Coordinator on 08/06/19 at 4:15pm revealed:
-There were no known wanderers in the building.
-The alarms on the side entrances were always activated, but the alarms on the front and back doors were set at 10:00pm.
-If there was a known wanderer in the building, the resident would wear a wander guard which would set off an alarm if the resident left out of the front or back entrance doors.
-No one in the facility wore a wander guard.

Interview with the Administrator on 08/06/19 at 5:34pm and 6:45pm revealed:
-The doors on the A Hall and the B Hall were always alarmed.
-The front and back entrance doors were alarmed between 9:00pm and 10:00pm and disarmed at 6:30pm.
-The doors had to be locked before the alarm was set.
-Staff had to physically turn the alarms on and off at the alarm panel in the main hallway.
-She came to the facility after midnight about 2 weeks ago and entered through the back door.
-The back door was unlocked and unarmed.
-There were 2 residents sitting by the back door smoking when she arrived, but she did not know whether or not the back door was locked after the residents finished smoking.

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D 067	Continued From page 7 The facility failed to assure all exit doors were alarmed when there was at least one resident identified with wandering behavior and a resident with exit seeking behavior which resulted in two residents (#2 and #5) eloped from the facility without staff's knowledge. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G. S. 131D-34 on 08/06/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 09/22/19.	D 067		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision for 2 of 5 sampled residents (#2 and #5) who exhibited exit-seeking behaviors and eloped from	D 270		

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the facility without staff's knowledge.

The findings are:

1. Review of Resident #5's current FL2 dated 07/24/19 revealed:
-Diagnoses included schizoaffective disorder and mania.
-Resident #5 was ambulatory.
-There was no information regarding Resident #5's orientation or behavior.

Review of Resident #5's Resident Register dated 09/08/17 revealed Resident #5 had wandering behaviors.

Review of Resident #5's care plan dated 11/09/18 revealed:
-There was documentation Resident #5 required supervision with bathing and grooming.
-There was documentation Resident #5 was independent with all other activities of daily living.

Review of Resident #5's progress notes dated 08/02/19 revealed:
-Resident #5 went walking up the road.
-Police were called and brought Resident #5 back to the facility.
-Mobile crisis was called out to the facility for Resident #5.
-Resident was put on 15 min checks for the next 24 hours.

Review of Resident#5's progress notes dated 08/03/19 revealed there was documentation at 12:05am mobile crisis was sending resident out of the facility.

Review of Resident #5's Incident/Accident Reports revealed there was no report

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documenting an elopement that occurred on 08/02/19.

Review of the facilty's Resident Supervision Policy revealed:
-Staff were to perform a head count on all residents every two hours to account for all residents.
-Staff were to perform 30 minute supervision checks on all new admissions for the first 24 hours.
-Staff were to perform 15 or 30 minute supervision checks for any potential flight risks.
-Any resident who verbalized elopement: "I am going home," "I am going to call a cab," "I'm leaving, " was to be immediately placed on a 15 minute supervision check for the next 24 hours.

Interview with Resident #5 on 08/06/19 at 1:40pm revealed:
-She left the facility last week.
-It was dark outside, but she did not remember what time it was.
-She walked down the street and passed tractors.
-There was a lot of traffic "whizzing by."
-A policeman gave her a ride back to the facility.

Interview with the Resident Care Coordinator (RCC)/Medication Aide (MA) on 08/06/19 at 4:15pm revealed:
-She knew about Resident #5 eloping from the facility on 08/02/19.
-Resident #5 had left the facility about 3 times previously that she knew of and had found Resident #5 at a neighbor's house before.

Interview with the Administrator on 08/06719 at 5:34pm revealed:
-She knew about Resident #5 eloping from the facility on 08/02/19.

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D 270	Continued From page 10 -Resident #5 was an identified wanderer. Review of the facility Supervision Checklists revealed: -There was a Supervision Checklist dated 08/02/19 for 15 minute checks for Resident #5. -Staff initialed checking on Resident #5 on 08/02/19 at 9:45pm, 10:00pm. 10:15pm, 10:30pm, and 10:45. -There were no other Supervision Checklists for Resident #5 available for review. Observation of the facility parking lot on 08/06/19 between 8:46pm and 8:55pm revealed: -Resident #5 was standing at the edge of the parking lot near a wooded area. -About 10 feet into the wooded area the land dropped off into a steep hill. -Resident #5 took 2 to 3 steps into the wooded area, but then backed up to the parking lot. -The Administrator walked up to Resident #5 and started talking to her to try to coax her back in the facility. Interview with the Administrator on 08/07/19 at 5:13pm revealed: -She went to get Resident #5 to bring her back to the facility after she saw Resident #5 attempting to go into the woods on the evening of 08/06/19. -She tried to put a wander guard on Resident #5, but she refused to have it placed on her. -Resident #5 told her she would rather run out in the road and kill herself rather than go back into the facility. -Mobile crisis was contacted for Resident #5 and she was transported to the hospital last night, 08/06/07. Interview with a Medication Aide (MA) on 08/07/19 at 4:51pm revealed:	D 270		

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-She was working 2nd shift in the facility on 08/02/19 when Resident #5 eloped.
-She did not know what time Resident #5 left the facility.
-She thought Resident #5 had been gone more than 30 minutes, but not quite an hour.
-It was dark outside when she realized Resident #5 was gone.
-She looked for Resident #5 in the facility and went out to the road to look for her but did not see her so she called the local police.

Interview with Resident #5's mental health provider on 08/07/19 at 9:23am revealed:
-She knew Resident #5 had eloped from the facility on 08/02/19.
-She had concerns, but she knew Resident #5's mental health status was difficult to manage.
-She told the RCC the facility needed to start taking measures to let someone know her level of care exceeds her current level of care.
-Resident #5's mental health status was well for a while, but it took a drastic turn recently.
-Resident #5 was cycling rapidly with persistent psychosis and needed to go to a psychiatric facility.
-If a resident eloped, she expected for the facility to notify her, contact authorities per facility policy and send the resident to the emergency department to get checked out.

Interview with Resident #5's Primary Care Physician (PCP) on 08/07/19 at 2:54pm revealed:
-He could not recall being informed about Resident #5 eloping from the facility on 08/02/19.
-Another provider from his office could have been on call on the day Resident #5 eloped, but he did not recall knowing of the incident.
-If a resident eloped, he expected the facility to contact his office and document in the resident's

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record.
-After an elopement, he would expect the facility to implement more frequent checks for at least the next 24 hours.

Refer to interview with the RCC/MA on 08/06/19 at 4:15pm.

Refer to interview with the Administrator on 08/06/19 at 5:34pm.

2. Review of Resident #2's current FL-2 dated 07/01/19 revealed:
-Diagnoses included cognitive impairment.
-There was documentation Resident #2 was intermittently disoriented.
-There was documentation Resident #2 was semi-ambulatory.

Review of Resident #2's care plan dated 02/18/19 revealed:
-Resident #2 required supervision with transferring, limited assistance with dressing, grooming, and ambulation, and extensive assistance with bathing.
-Resident #2 was independent with eating and toileting.

Review of Resident #2's progress notes dated 05/05/19 revealed:
-Resident #2 was last seen at 1:00am.
-Staff looked all over the facility, but staff could not find Resident #2 so law enforcement was called out to the facility.
-Staff looked for Resident #2 for three hours and found him in another resident's room.

Review of Resident #2's progress notes dated 05/14/19 revealed:
-Staff did rounds at 11:15pm and saw Resident

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#2 was not in bed.
-Staff searched the entire facility and outside the facility and Resident #2 was nowhere to be found.
-Staff called 911 between 11:45pm and 12:00am and law enforcement came to the facility, took Resident #2's information and left the facility.
-Staff went outside to look for Resident #2 again and heard Resident #2 yelling "help me."
-Resident #2 was found by a trailer on the back, right side of the facility around 1:45am.
-Resident #2 was brought into the facility.

Review of Resident #2's Incident/Accident Reports revealed:
-There was an Incident Report dated 05/05/19 regarding a fall in Resident #2's bathroom and Resident was placed on 15 minute checks.
-There was no Incident Report dated 05/05/19 regarding Resident #2 being lost in the in the facility.
-There was no Incident Report dated 05/14/19 regarding Resident #2 eloping from the facility.

Review of the facilty's Resident Supervision Policy revealed:
-Staff were to perform a head count on all residents every two hours to account for all residents.
-Staff were to perform 30 minute supervision checks on all new admissions for the first 24 hours.
-Staff were to perform 15 or 30 minute supervision checks for any potential flight risks.
-Any resident who verbalized elopement: "I am going home," "I am going to call a cab," "I'm leaving, " was to be immediately placed on a 15 minute supervision check for the next 24 hours.

Interview with Resident #2 on 08/06/19 at 1:09pm revealed he went outside one night to get his cat

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and was on the ground by the trailer, but he did not remember when or how long he was outside.

Interview with the Resident Care Coordinator (RCC)/ Medication Aide (MA) on 08/06/19 at 4:15pm revealed She did not know Resident #2 had eloped from the facility without staff's knowledge and was found outside at 1:45am.

Interview with the Administrator on 08/06/19 at 5:34pm revealed:
-She did not know Resident #2 had eloped from the facility on 05/14/19 without staff's knowledge and was found outside at 1:45am.
-She did not know about Resident #2 being lost in the facility on 05/09/19.
-She would have expected staff to contact her if a resident eloped and she would have contacted the county department of social services.

Review of the Supervision Checklists revealed:
-There was a Supervision Checklist dated 05/05/19 for 15 minute checks for Resident #2.
-Staff initialed checking on Resident #2 on 05/05/19 every 15 minutes from 1:00pm until 11:00pm.
-There was no other documentation Resident #2 received 15 minute checks from 11:15pm on 05/05/19 until 1:00pm on 05/06/19 for a complete 24 hours.
-There was no Supervision Checklist for 15 minute checks for Resident #2 on 05/14/19 after his elopement from the facility.

Interview with a Medication Aide (MA) on 08/07/19 at 7:20pm revealed:
-She worked third shift on the night of 05/14/19 when Resident #2 eloped from the facility.
-She started her shift at 11:00pm on 05/14/19 and entered through the back door when she entered

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D 270	Continued From page 15 the facility Interview with Resident #2's mental health provider on 08/07/19 at 9:23am revealed: -She knew Resident #2 had eloped from the facility on 05/15/19. -If a resident eloped, she expected for the facility to notify her, contact authorities per facility policy and send the resident to the emergency department to get checked out. Interview with Resident #2's Primary Care Physician (PCP) on 08/07/19 at 2:54pm revealed: -He could not recall being informed about Resident #2 eloping from the facility on 05/14/19. -Another provider from his office could have been on call on the day Resident #2 eloped, but he did not recall knowing of the incident. -If a resident eloped, he expected the facility to contact his office and document in the resident's chart. -After an elopement, he would expect the facility to implement more frequent checks for at least the next 24 hours. Refer to interview with the RCC/MA on 08/06/19 at 4:15pm. Refer to interview with the Administrator on 08/06/19 at 5:34pm. _____ Interview with the RCC/MA on 08/06/19 at 4:15pm revealed: -No one in the facility wore a wander guard. -If a resident eloped from the facility, the protocol would be to notify the Administrator right away and follow the instructions given by the Administrator. -Staff could also contact her regarding an elopement.	D 270		

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D 270	Continued From page 16 -A resident would be placed on 15 minute checks and the psychiatric provider would be contacted. Interview with the Administrator on 08/06/19 at 5:34pm revealed: -If staff noticed a resident was missing, they should check the building, around the building and contact law enforcement. -Fifteen minute checks were implemented and mobile crisis was called. The facility failed to provide supervision for 2 of 5 sampled (#2 and #5) who eloped from the facility without staff's knowledge. The facility's failure to provide supervision was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G. S. 131D-34 on 08/06/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 09/22/19.	D 270		
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.	D 273		

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D 273	Continued From page 17 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to notify the primary care provider for 2 of 6 sampled residents regarding refusals of medication (#5) and bed bug bites (#6). The findings are: 1. Review of Resident #5's current FL2 dated 07/24/19 revealed: -Diagnoses included schizoaffective disorder, diabetes, hypertension, obesity, hyperlipidemia, hypothyroidism, mania, asthma, allergic rhinitis, degenerative disk disorder, and gastroesophageal reflux disease a. Further review of Resident #5's current FL2 dated 07/24/19 revealed an order for Abilify (an antipsychotic medication) main injection 400 mg inject 400 mg once a month. Review of Resident #5's May 2019 Medication Administration Record (MAR) revealed: -The original date of the physician's order for Abilify main injection 400 mg inject 400 mg once a month was listed as 03/15/19. -There was an entry for Abilify main injection 400 mg inject 400 mg once a month. -The acronym HHN (home health nurse) was printed on the MAR under the hour column. -Abilify was documented as administered by the Resident #5's mental health nurse practitioner on 05/18/19 at 10:40am. Review of Resident #5's June 2019 MAR revealed: -The original date of the physician's order for	D 273		

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Abilify main injection 400 mg inject 400 mg once a month was listed as 03/15/19.
-There was an entry for Abilify main injection 400 mg inject 400 mg once a month.
-The acronym HHN (home health nurse) was printed on the MAR under the hour column.
-There was no documentation Abilify was administered in June 2019.

Review of Resident #5's July 2019 MAR revealed:
-The original date of the physician's order for Abilify main injection 400 mg inject 400 mg once a month was listed as 03/15/19.
-There was an entry for Abilify main injection 400 mg inject 400 mg once a month.
-The acronym HHN (home health nurse) was printed on the MAR under the hour column.
-There was no documentation Abilify was administered in July 2019.

Review of Resident #5's August 2019 MAR revealed:
-The original date of the physician's order for Abilify main injection 400 mg inject 400 mg once a month was listed as 03/15/19.
-There was an entry for Abilify main injection 400 mg inject 400 mg once a month.
-The acronym HHN (home health nurse) was printed on the MAR under the hour column.
-There was no documentation Abilify was administered on 08/02/19.

Review of Resident #5's progress note dated 08/02/19 revealed:
-Resident #5 was seen by the HHN and refused the Abilify injection after multiple attempts to administer.
-Resident #5 was discharged from services due to no skill needs for the nurse to give injections and resident was discharged from home health

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D 273	Continued From page 19 care. Observation of the medication on hand for Resident #5 on 08/07/19 at 7:50am revealed 1 Abilify main injection 400 mg inject 400 mg once a month was dispensed to the facility on 07/29/19 and was available for administration. Attempted interview with Resident #5 on 08/07/19 was unsuccessful. Interview with the facility's contracted home health provider on 08/07/19 at 9:04am revealed: -Resident #5 was opened for home health services on 06/15/19. -Resident #5 received Abilify injections from the home HHN on 06/05/19 and 07/02/19. -On 08/02/19, the HHN went to the facility to administer the Abilify injection and to recertify Resident #5 for services. -Resident #5 refused the Abilify injection on 08/02/19 and the HHN was not able to recertify Resident #5 for services, so home health services were discontinued effective 08/02/19. -The facility could have Resident #5's home health services restarted for the Abilify injection. -The facility had not contacted the home health service to have Resident #5's services reinstated. Interview with Resident #5's mental health provider on 08/07/19 at 11:19am revealed: -The facility had not notified her home health services discharged Resident #5 from services. -She received notification from home health services yesterday that Resident #5 had been discharged from services. -She expected for the facility to contact her regarding Resident #5 being discharged from home health services.	D 273		

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Interview with the Resident Care Coordinator (RCC) / Medication Aide (MA) on 08/07/19 at 3:39pm revealed:
-She was responsible for following up with care providers regarding orders.
-She had not contacted Resident #5's mental health provider to inform her that Resident #5 was discharged from home health services due to refusing her Abilify injection on 08/02/19.
-She was going to see if the Primary Care Provider (PCP) could give Resident #5 her Abilify injection since he was allowed to give the injection.
-The PCP would be in the facility on Monday, 08/12/19.
-She did not know why she had not contacted Resident #5's mental health provider.

Interview with the Administrator on 08/07/19 at 5:13pm revealed:
-She did not know Resident #5's mental health provider was not notified by the facility that Resident #5 was discharged from home health services due to refusing her Abilify injection on 08/02/19.
-She expected staff to contact the physician each time a medication was refused.

b. Review of Resident #5's current FL2 dated 07/24/19 revealed an order for Lexapro (escitalopram) (used to treat anxiety) 20 mg daily.

Review of Resident #5's July 2019 Medication Administration Record (MAR) revealed:
-The original date of the physician's order for escitalopram 20mg 1 tablet daily was listed as 03/08/19.
-There was an entry for escitalopram 20 mg 1 tablet daily at 6:00am.
-Escitalopram was not documented as

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administered at 6:00am on 07/09/19, 07/10/19, 07/30/19, and 07/31/19.
-There was documentation Resident #5 refused all medications on 07/09/19 and 6:00am medications on 07/30/19.
-There was no documentation why medications were not administered on 07/10/19 and 07/31/19.

Review of Resident #5's August 2019 MAR revealed:
-The original date of the physician's order for escitalopram 20mg 1 tablet daily was listed as 03/08/19.
-There was an entry for escitalopram 20 mg 1 tablet daily at 6:00am.
-Escitalopram was not documented as administered on 08/03/19 through 08/07/19.
-There was no documentation of administration of escitalopram on 08/01/19.

Observation of the medication on hand for Resident #5 on 08/07/19 at 7:50am revealed escitalopram 20 mg 1 tablet daily was available for administration.

Attempted interview with Resident #5 on 08/07/19 was unsuccessful.

Interview with Resident #5's mental health provider on 08/07/19 at 11:19am revealed:
-She visited Resident #5 once a month and prescribed psychotropic medication for her.
-Resident #5 has had multiple psychiatric hospitalizations.
-She thought the facility had let her know Resident #5 had been refusing her medication, but she did not know Resident #5 had been refusing medication on consecutive days since 07/24/19.
-She had concerns, but she knew Resident #5's

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mental health state was difficult.
-Resident #5's mental health state was well for a while, but it took a drastic turn recently.
-Resident #5 was cycling rapidly with persistent psychosis and needed to go to a psychiatric facility.
-Without psychotropic medications, Resident #5 could become symptomatic with agitation, paranoia, delusion, and psychosis.

Interview with the Resident Care Coordinator (RCC/ Medication Aide (MA) on 08/07/19 at 3:28pm revealed:
-Resident #5 had been refusing her medication on consecutive days for almost 2 weeks.
-She had not contacted the Resident #5's PCP to inform him Resident #5 had been refusing consecutive doses of medication since 07/24/19.
-She told the PCP Resident #5 was still refusing medication when he was in the facility on Tuesday, 08/06/19.
-The facility protocol was to contact the physician when a resident refused medication 3 days in a row.
-She did not know why Resident #5's mental health provider had not been contacted after Resident #5 refused her medications 3 days in a row.

Interview with the Administrator on 08/07/19 at 5:13pm revealed she knew Resident #5 refused her medication at times, but she did not know she had refused consecutive doses of medication since 07/24/19.

Refer to interview with the Administrator on 08/07/19 at 5:13pm.

c. Review of Resident #5's current FL2 dated 07/24/19 revealed an order for Zyprexa

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D 273	Continued From page 23 (olanzapine) (used to treat symptoms psychosis and mood disorders) 20 mg ½ tablet (10 mg) twice a day. Review of Resident #5's July 2019 Medication Administration Record (MAR) revealed: -The date of the original physician's order for olanzapine 20mg 1/2 tablet (10 mg) twice a day was listed as 03/08/19. -There was an entry for olanzapine 20 mg ½ tablet (10 mg) twice a day at 6:00am and 7:00pm with an original order date of 03/08/19. -Olanzapine was not documented as administered at 6:00am on 07/09/19, 07/10/19, 07/30/19, and 07/31/19 and at 7:00pm on 07/19/19 and from 07/24/19 through 07/31/19. -There was documentation Resident #5 refused all morning medication on 07/09/19, all evening medication on 07/19/19, all evening medication on 07/22/19, all evening medication on 07/27/19, all morning and evening medication on 07/28/19, all evening medication on 07/29/19, and morning medication on 07/30/19. Review of Resident #5's August 2019 MAR revealed: -The date of the original physician's order for olanzapine 20mg 1/2 tablet (10 mg) twice a day was listed as 03/08/19. -There was an entry for olanzapine 20 mg ½ tablet (10 mg) twice a day at 6:00am and 7:00pm. -Olanzapine was not documented as administered at 6:00am from 08/03/19 through 08/07/19. -Olanzapine was not documented as administered at 7:00pm from 08/01/19 through 08/04/19 and 08/06/19. -There was no documentation of administration of olanzapine at 6:00am on 08/01/19 and at 7:00pm 08/05/19.	D 273		

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D 273	Continued From page 24 Observation of the medication on hand for Resident #5 on 08/07/19 at 7:50am revealed olanzapine 20 mg ½ tablet (10 mg) twice a day was available for administration. Attempted interview with Resident #5 on 08/07/19 was unsuccessful. Interview with Resident #5's mental health provider on 08/07/19 at 11:19am revealed: -She visited Resident #5 once a month and prescribed psychotropic medication for her. -Resident #5 has had multiple psychiatric hospitalizations. -She thought the facility had let her know Resident #5 had been refusing her medication, but she did not know Resident #5 had been refusing medication on consecutive days since 07/24/19. -She had concerns, but she knew Resident #5's mental health state was difficult. -Resident #5's mental health state was well for a while, but it took a drastic turn recently. -Resident #5 was cycling rapidly with persistent psychosis and needed to go to a psychiatric facility. -Without psychotropic medications, Resident #5 could become symptomatic with agitation, paranoia, delusion, and psychosis. Interview with the Resident Care Coordinator (RCC/ Medication Aide (MA) on 08/07/19 at 3:28pm revealed: -Resident #5 had been refusing her medication on consecutive days for almost 2 weeks. -She had not contacted the Resident #5's PCP to inform him Resident #5 had been refusing consecutive doses of medication since 07/24/19. -She told the PCP Resident #5 was still refusing	D 273		

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medication when he was in the facility on Tuesday, 08/06/19.
-The facility protocol was to contact the physician when a resident refused medication 3 days in a row.
-She did not know why Resident #5's or mental health provider had not been contacted after Resident #5 refused her medications 3 days in a row.

Interview with the Administrator on 08/07/19 at 5:13pm revealed she knew Resident #5 refused her medication at times, but she did not know she had refused consecutive doses of medication since 07/24/19.

Refer to interview with the Administrator on 08/07/19 at 5:13pm.

d. Review of Resident #5's current FL2 dated 07/24/19 revealed an order for Prolixin (fluphenazine) (used to treat chronic psychosis) 2.5 mg twice daily.

Review of Resident #5's July 2019 Medication Administration Record (MAR) revealed:
-The original date of the physician's order date for fluphenazine 2.5 mg 1 tablet twice a day was listed as 04/29/19.
-There was an entry for fluphenazine 2.5 mg 1 tablet twice a day at 6:00am and 7:00pm.
-Fluphenazine was documented as not administered at 6:00am on 07/09/19, 07/10/19, 07/30/19, and 07/31/19 and at 7:00pm on 07/19/19 and from 07/24/19 through 07/31/19.
-There was documentation Resident #5 refused all morning medication on 07/09/19, all evening medication on 07/19/19, all evening medication on 07/22/19, all evening medication on 07/27/19, all morning and evening medication on 07/28/19,

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all evening medication on 07/29/19, and morning medication on 07/30/19.

Review of Resident #5's August 2019 MAR revealed:
-The original date of the physician's order for fluphenazine 2.5 mg 1 tablet twice a day was listed as 04/29/19.
-There was an entry for fluphenazine 2.5 mg 1 tablet twice a day at 6:00am and 7:00pm.
-Fluphenazine was documented as not administered at 6:00am from 08/05/19 through 08/07/19.
-Fluphenazine was documented as not administered at 7:00pm from 08/01/19 through 08/04/19 and 08/06/19.
-There was no documentation of administration of Fluphenazine at 6:00am on 08/01/19, 08/03/19, and 08/04/19 and at 7:00pm on 08/05/19.

Observation of the medication on hand for Resident #5 on 08/07/19 at 7:50am revealed fluphenazine 2.5 mg 1 tablet twice a day was available for administration.

Attempted interview with Resident #5 on 08/07/19 was unsuccessful.

Interview with Resident #5's mental health provider on 08/07/19 at 11:19am revealed:
-She visited Resident #5 once a month and prescribed psychotropic medication for her.
-Resident #5 has had multiple psychiatric hospitalizations.
-She thought the facility had let her know Resident #5 had been refusing her medication, but she did not know Resident #5 had been refusing medication on consecutive days since 07/24/19.
-She had concerns, but she knew Resident #5's

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mental health state was difficult.
-Resident #5's mental health state was well for a while, but it took a drastic turn recently.
-Resident #5 was cycling rapidly with persistent psychosis and needed to go to a psychiatric facility.
-Without psychotropic medications, Resident #5 could become symptomatic with agitation, paranoia, delusion, and psychosis.

Interview with the Resident Care Coordinator (RCC/ Medication Aide (MA) on 08/07/19 at 3:28pm revealed:
-Resident #5 had been refusing her medication on consecutive days for almost 2 weeks.
-She had not contacted the Resident #5's PCP to inform him Resident #5 had been refusing consecutive doses of medication since 07/24/19.
-She told the PCP Resident #5 was still refusing medication when he was in the facility on Tuesday, 08/06/19.
-The facility protocol was to contact the physician when a resident refused medication 3 days in a row.
-She did not know why Resident #5's mental health provider had not been contacted after Resident #5 refused her medications 3 days in a row.

Interview with the Administrator on 08/07/19 at 5:13pm revealed she knew Resident #5 refused her medication at times, but she did not know she had refused consecutive doses of medication since 07/24/19.

Refer to interview with the Administrator on 08/07/19 at 5:13pm.

e. Review of Resident #5's current FL2 dated 07/24/19 revealed an order for Depakote

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D 273	Continued From page 28 (divalproex) (used to treat psychiatric conditions) 500 mg twice a day. Review of Resident #5's July 2019 Medication Administration Record (MAR) revealed: -The original date of the physician's order for divalproex 500 mg 1 tablet twice a day was listed as 03/08/19. -There was an entry for divalproex 500 mg 1 tablet twice a day at 6:00am and 7:00pm. -Divalproex was not documented as administered at 6:00am on 07/09/19, 07/10/19, 07/30/19, and 07/31/19 and at 7:00pm on 07/19/19 and from 07/24/19 through 07/31/19. -There was documentation Resident #5 refused all morning medication on 07/09/19, all evening medication on 07/19/19, all evening medication on 07/22/19, all evening medication on 07/27/19, all morning and evening medication on 07/28/19, all evening medication on 07/29/19, and morning medication on 07/30/19. Review of Resident #5's August 2019 MAR revealed: -The original date of the physician's order for divalproex 500 mg 1 tablet twice a day was listed as 03/08/19. -There was an entry for divalproex 500 mg 1 tablet twice a day at 6:00am and 7:00pm. -Divalproex was not documented as administered at 6:00am from 08/02/19 through 08/07/19. -Divalproex was not documented as administered at 7:00pm from 08/01/19 thorough 08/04/19 and 08/06/19. -There was no documentation of administration of divalproex at 6:00am on 08/01/19 and at 6:00am and 7:00pm on 08/05/19. Observation of the medication on hand for Resident #5 on 08/07/19 at 7:50am revealed	D 273		

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divalproex 500 mg 1 tablet twice a day was available for administration.

Attempted interview with Resident #5 on 08/07/19 was unsuccessful.

Interview with Resident #5's mental health provider on 08/07/19 at 11:19am revealed:
-She visited Resident #5 once a month and prescribed psychotropic medication for her.
-Resident #5 has had multiple psychiatric hospitalizations.
-She thought the facility had let her know Resident #5 had been refusing her medication, but she did not know Resident #5 had been refusing medication on consecutive days since 07/24/19.
-She had concerns, but she knew Resident #5's mental health state was difficult.
-Resident #5's mental health state was well for a while, but it took a drastic turn recently.
-Resident #5 was cycling rapidly with persistent psychosis and needed to go to a psychiatric facility.
-Without psychotropic medications, Resident #5 could become symptomatic with agitation, paranoia, delusion, and psychosis.

Interview with the Resident Care Coordinator (RCC/ Medication Aide (MA) on 08/07/19 at 3:28pm revealed:
-Resident #5 had been refusing her medication on consecutive days for almost 2 weeks.
-She had not contacted the Resident #5's PCP to inform him Resident #5 had been refusing consecutive doses of medication since 07/24/19.
-She told the PCP Resident #5 was still refusing medication when he was in the facility on Tuesday, 08/06/19.
-The facility protocol was to contact the physician

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when a resident refused medication 3 days in a row.
-She did not know why Resident #5's or mental health provider had not been contacted after Resident #5 refused her medications 3 days in a row.

Interview with the Administrator on 08/07/19 at 5:13pm revealed she knew Resident #5 refused her medication at times, but she did not know she had refused consecutive doses of medication since 07/24/19.

Refer to interview with the Administrator on 08/07/19 at 5:13pm.

f. Review of Resident #5's current FL2 dated 07/24/19 revealed an order for Cogentin (benztropine) (used to treat sever reactions to medication used to treat nervous, mental, and emotional disorders) 0.5 mg 1 tablet twice a day.

Review of Resident #5's July 2019 Medication Administration Record (MAR) revealed:
-The original date of the physician's order for benztropine 0.5 mg 1 tablet twice a day was listed as 04/29/19.
-There was an entry for benztropine 0.5 mg 1 tablet twice a day at 6:00am and 7:00pm.
-Benztropine was not documented as administered at 6:00am on 07/09/19, 07/10/19, 07/30/19, and 07/31/19 and at 7:00pm on 07/19/19 and from 07/24/19 through 07/31/19.
-There was documentation Resident #5 refused all morning medication on 07/09/19, all evening medication on 07/19/19, all evening medication on 07/22/19, all evening medication on 07/27/19, all morning and evening medication on 07/28/19, all evening medication on 07/29/19, and morning medication on 07/30/19.

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D 273	Continued From page 31 Review of Resident #5's August 2019 MAR revealed: -The original date of the physician's order for benztropine 0.5 mg 1 tablet twice a day was listed as 04/29/19. -There was an entry for benztropine 0.5 mg 1 tablet twice a day at 6:00am and 7:00pm. -Benztropine was not documented as administered at 6:00am from 08/03/19 through 08/07/19. -Benztropine was not documented as administered at 7:00pm from 08/01/19 thorough 08/04/19 and 08/06/19. -There was no documentation of administration of benztropine at 6:00am on 08/01/19 and at 7:00pm on 08/05/19. Observation of the medication on hand for Resident #5 on 08/07/19 at 7:50am revealed benztropine 0.5 mg 1 tablet twice a day was available for administration. Attempted interview with Resident #5 on 08/07/19 was unsuccessful. Interview with Resident #5's mental health provider on 08/07/19 at 11:19am revealed: -She visited Resident #5 once a month and prescribed psychotropic medication for her. -Resident #5 has had multiple psychiatric hospitalizations. -She thought the facility had let her know Resident #5 had been refusing her medication, but she did not know Resident #5 had been refusing medication on consecutive days since 07/24/19. -She had concerns, but she knew Resident #5's mental health state was difficult. -Resident #5's mental health state was well for a	D 273		

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while, but it took a drastic turn recently.
-Resident #5 was cycling rapidly with persistent psychosis and needed to go to a psychiatric facility.
-Without psychotropic medications, Resident #5 could become symptomatic with agitation, paranoia, delusion, and psychosis.

Interview with the Resident Care Coordinator (RCC/ Medication Aide (MA) on 08/07/19 at 3:28pm revealed:
-Resident #5 had been refusing her medication on consecutive days for almost 2 weeks.
-She had not contacted the Resident #5's PCP to inform him Resident #5 had been refusing consecutive doses of medication since 07/24/19.
-She told the PCP Resident #5 was still refusing medication when he was in the facility on Tuesday, 08/06/19.
-The facility protocol was to contact the physician when a resident refused medication 3 days in a row.
-She did not know why Resident #5's PCP or mental health provider had not been contacted after Resident #5 refused her medications 3 days in a row.

Interview with the Administrator on 08/07/19 at 5:13pm revealed she knew Resident #5 refused her medication at times, but she did not know she had refused consecutive doses of medication since 07/24/19.

Refer to interview with the Administrator on 08/07/19 at 5:13pm.

g. Review of Resident #5's current FL2 dated 07/24/19 revealed an order for Synthroid (levothyroxine) (used to treat hypothyroidism) 100 mcg daily.

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D 273	Continued From page 33 Review of Resident #5's July 2019 Medication Administration Record (MAR) revealed: -The original date of the physician's order for levothyroxine 100 mcg 1 tablet daily was listed as 03/08/19. -There was an entry for levothyroxine 100 mcg 1 tablet daily at 6:00am. -Levothyroxine 100 mcg was not documented as administered at 6:00am on 07/09/19, 07/10/19, 07/30/19, and 07/31/19 and at 7:00pm from 07/24/19 through 07/31/19. -There was documentation Resident #5 refused all morning medication on 07/09/19, all evening medication on 07/19/19, all evening medication on 07/22/19, all evening medication on 07/27/19, all morning and evening medication on 07/28/19, all evening medication on 07/29/19, and morning medication on 07/30/19. Review of Resident #5's August 2019 MAR revealed: -The original date of the physician's order for levothyroxine 100 mcg 1 tablet daily was listed as 03/08/19. -There was an entry for levothyroxine 100mcg 1 tablet daily at 6:00am. -Levothyroxine 100 mg was not documented as administered at 6:00am from 08/03/19 through 08/07/19. -There was no documentation of administration of levothyroxine on 08/01/19. Observation of the medication on hand for Resident #5 on 08/07/19 at 7:50am revealed levothyroxine 100 mcg 1 tablet daily was available for administration. Attempted interview with Resident #5 on 08/07/19 was unsuccessful.	D 273		

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D 273	Continued From page 34 Interview with the Primary Care Provider (PCP) on 08/08/19 at 10:34am revealed: -He was aware Resident #5 had been refusing medication, but he did not know she had been refusing consecutive doses of medication. -Missed doses of levothyroxine could lead to a decrease in thyroid levels. Interview with the Resident Care Coordinator (RCC/ Medication Aide (MA) on 08/07/19 at 3:28pm revealed: -Resident #5 had been refusing her medication on consecutive days for almost 2 weeks. -She had not contacted the Resident #5's PCP to inform him Resident #5 had been refusing consecutive doses of medication since 07/24/19. -She told the PCP Resident #5 was still refusing medication when he was in the facility on Tuesday, 08/06/19. -The facility protocol was to contact the physician when a resident refused medication 3 days in a row. -She did not know why Resident #5's PCP had not been contacted after Resident #5 refused her medications 3 days in a row. Interview with the Administrator on 08/07/19 at 5:13pm revealed she knew Resident #5 refused her medication at times, but she did not know she had refused consecutive doses of medication since 07/24/19. Refer to interview with Resident #5's PCP on 08/08/19 at 10:34am. Refer to interview with the Administrator on 08/07/19 at 5:13pm. h. Review of Resident #5's current FL2 dated	D 273		

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D 273	Continued From page 35 07/24/19 revealed an order for Lasix (furosemide) (a medication used to treat fluid retention and hypertension) 20 mg on Monday, Wednesday and Friday. Review of Resident #5's July 2019 Medication Administration Record (MAR) revealed: -The original date of the physician's order for furosemide 20 mg 1 tablet 3 times per week on Monday, Wednesday, and Friday was listed as 03/08/19. -There was an entry for furosemide 20 mg 1 tablet 3 times per week on Monday, Wednesday and Friday at 6:00am. -Furosemide was not documented as administered at 6:00am on 07/10/19. -There was no documentation of administration of furosemide at 6:00am on 07/03/19, 07/19/19, 07/22/19, 07/28/19, and 07/31/19. -There was documentation Resident #5 refused all morning medication on 07/09/19, all evening medication on 07/19/19, all evening medication on 07/22/19, all evening medication on 07/27/19, all morning and evening medication on 07/28/19, all evening medication on 07/29/19, and morning medication on 07/30/19. Review of Resident #5's August 2019 MAR revealed: -The original date of the physician's order for furosemide 20 mg 1 tablet 3 times per week on Monday, Wednesday, and Friday was listed as 03/08/19. -There was an entry for furosemide 20 mg 1 tablet three times per week on Monday, Wednesday and Friday at 6:00am. -Furosemide was documented as not administered at 6:00am on 08/05/19 and 08/07/19.	D 273		

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D 273	Continued From page 36 Observation of the medication on hand for Resident #5 on 08/07/19 at 7:50am revealed furosemide 20 mg 1 tablet three times per week on Monday, Wednesday and Friday was available for administration. Attempted interview with Resident #5 on 08/07/19 was unsuccessful. Interview with the Primary Care Provider (PCP) on 08/08/19 at 10:34am revealed: -He was aware Resident #5 had been refusing medication, but he did not know she had been refusing consecutive doses of medication. -Missed doses of furosemide could lead to increased fluid retention and edema. Interview with the Resident Care Coordinator (RCC/ Medication Aide (MA) on 08/07/19 at 3:28pm revealed: -Resident #5 had been refusing her medication on consecutive days for almost 2 weeks. -She had not contacted the Resident #5's PCP to inform him Resident #5 had been refusing consecutive doses of medication since 07/24/19. -She told the PCP Resident #5 was still refusing medication when he was in the facility on Tuesday, 08/06/19. -The facility protocol was to contact the physician when a resident refused medication 3 days in a row. -She did not know why Resident #5's PCP had not been contacted after Resident #5 refused her medications 3 days in a row Interview with the Administrator on 08/07/19 at 5:13pm revealed she knew Resident #5 refused her medication at times, but she did not know she had refused consecutive doses of medication since 07/24/19.	D 273		

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D 273	Continued From page 37 Refer to interview with Resident #5's PCP on 08/08/19 at 10:34am. Refer to interview with the Administrator on 08/07/19 at 5:13pm. h. Review of Resident #5's current FL2 dated 07/24/19 revealed an order for metformin 500 mg twice a day before meals. Review of Resident #5's July 2019 Medication Administration Record (MAR) revealed: -The original date of the physician's order for metformin 500 mg 1 tablet twice a day was listed as 03/08/19. -There was an entry for metformin 500 mg 1 tablet twice a day before meals at 7:30am and 4:30pm. -Metformin was not documented as administered at 7:30am on 07/09/19, 07/10/19, 07/30/19, and 07/31/19 and at 7:00pm on 07/19/19 and from 07/24/19 through 07/31/19. -There was documentation Resident #5 refused all morning medication on 07/09/19, all evening medication on 07/19/19, all evening medication on 07/22/19, all evening medication on 07/27/19, all morning and evening medication on 07/28/19, all evening medication on 07/29/19, and morning medication on 07/30/19. Review of Resident #5's August 2019 MAR revealed: -The original date of the physician's order for metformin 500 mg 1 tablet twice a day was listed as 03/08/19. -There was an entry for Metformin 500 mg 1 tablet twice a day at 7:30am and 4:30pm. -Metformin was not documented as administered at 7:30am from 08/03/19 through 08/07/19.	D 273		

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-Metformin was not documented as administered at 4:30pm on 08/01/19, 08/03/19, 08/04/19 and 08/06/19.
-There was no documentation of administration of metformin at 7:30am on 08/01/19 and at 4:30pm on 08/02/19 and 08/05/19.

Observation of the medication on hand for Resident #5 on 08/07/19 at 7:50am revealed metformin 500 mg 1 tablet twice a day before meals was available for administration.

Attempted interview with Resident #5 on 08/07/19 was unsuccessful.

Interview with the Primary Care Provider (PCP) on 08/08/19 at 10:34am revealed:
-He was aware Resident #5 had been refusing medication, but he did not know she had been refusing consecutive doses of medication.
-Missed doses of metformin could cause increased blood sugar levels.

Interview with the Resident Care Coordinator (RCC/ Medication Aide (MA) on 08/07/19 at 3:28pm revealed:
-Resident #5 had been refusing her medication on consecutive days for almost 2 weeks.
-She had not contacted the Resident #5's PCP to inform him Resident #5 had been refusing consecutive doses of medication since 07/24/19.
-She told the PCP Resident #5 was still refusing medication when he was in the facility on Tuesday, 08/06/19.
-The facility protocol was to contact the physician when a resident refused medication 3 days in a row.
-She did not know why Resident #5's PCP had not been contacted after Resident #5 refused her medications 3 days in a row

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CENTRAL CARE	139 APEX LANE MOUNT AIRY, NC 27030

(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 39 Interview with the Administrator on 08/07/19 at 5:13pm revealed she knew Resident #5 refused her medication at times, but she did not know she had refused consecutive doses of medication since 07/24/19. Refer to interview with Resident #5's PCP on 08/08/19 at 10:34am. Refer to interview with the Administrator on 08/07/19 at 5:13pm. i. Review of Resident #5's current FL2 dated 07/24/19 revealed an order for fenofibrate (used to treat high levels of cholesterol) 160 mg daily. Review of Resident #5's July 2019 Medication Administration Record (MAR) revealed: -The original date of the physician's order for fenofibrate 160 mg 1 tablet daily was listed as 04/29/19. -There was an entry for fenofibrate 160 mg 1 tablet daily at 6:00am. -Fenofibrate was not documented as administered at 6:00am on 07/09/19, 07/10/19, 07/30/19. -There was documentation Resident #5 refused all morning medication on 07/09/19, all evening medication on 07/19/19, all evening medication on 07/27/19, all morning and evening medication on 07/28/19, all evening medication on 07/29/19, and morning medication on 07/30/19. Review of Resident #5's August 2019 MAR revealed: -The original date of the physician's order for fenofibrate 160 mg 1 tablet daily was listed as 04/29/19. -There was an entry for fenofibrate 160 mg 1	D 273		

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tablet daily at 6:00am.
-Fenofibrate was not documented as administered at 6:00am from 08/03/19 through 08/07/19.
-There was no documentation of administration of fenofibrate at 6:00am on 08/01/19.

Observation of the medication on hand for Resident #5 on 08/07/19 at 7:50am revealed fenofibrate 160 mg 1 tablet daily was available for administration.

Attempted interview with Resident #5 on 08/07/19 was unsuccessful.

Interview with the Primary Care Provider (PCP) on 08/07/19 at 10:34am revealed:
-He was aware Resident #5 had been refusing medication, but he did not know she had been refusing consecutive doses of medication.
-Missed doses of fenofibrate could cause an increase in cholesterol levels.

Interview with the Resident Care Coordinator (RCC/ Medication Aide (MA) on 08/07/19 at 3:28pm revealed:
-Resident #5 had been refusing her medication on consecutive days for almost 2 weeks.
-She had not contacted the Resident #5's PCP to inform him Resident #5 had been refusing consecutive doses of medication since 07/24/19.
-She told the PCP Resident #5 was still refusing medication when he was in the facility on Tuesday, 08/06/19.
-The facility protocol was to contact the physician when a resident refused medication 3 days in a row.
-She did not know why Resident #5's PCP had not been contacted after Resident #5 refused her medications 3 days in a row

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D 273	Continued From page 41 Interview with the Administrator on 08/07/19 at 5:13pm revealed she knew Resident #5 refused her medication at times, but she did not know she had refused consecutive doses of medication since 07/24/19. Refer to interview with Resident #5's PCP on 08/07/19 at 2:54pm and 08/08/19 at 10:34am. Refer to interview with the Administrator on 08/07/19 at 5:13pm. j. Review of Resident #5's current FL2 dated 07/24/19 revealed an order for Pepcid (famotidine) (used to treat gastrointestinal reflux disease) 400 mg daily. Review of Resident #5's July 2019 Medication Administration Record (MAR) revealed: -The original date of the physician's order for famotidine 400mg 1 tablet daily was listed as 03/08/19. -There was an entry for famotidine 400 mg 1 tablet daily at 6:00am. -Famotidine was not documented as administered at 6:00am on 07/09/19, 07/10/19, 07/30/19, and 07/31/19. -There was documentation Resident #5 refused all morning medication on 07/09/19, all evening medication on 07/19/19, all evening medication on 07/27/19, all morning and evening medication on 07/28/19, all evening medication on 07/29/19, and morning medication on 07/30/19. Review of Resident #5's August 2019 MAR revealed: -The original date of the physician's order for famotidine 400mg 1 tablet daily was listed as 03/08/19.	D 273		

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D 273	Continued From page 42 -There was an entry for famotidine 400 mg 1 tablet daily at 6:00am. -Famotidine was not documented as administered at 6:00am from 08/03/19 through 08/07/19. -There was no documentation of administration of benztropine on 08/01/19. Attempted interview with Resident #5 on 08/07/19 was unsuccessful. Interview with Resident #5's Primary Care Provider (PCP) on 08/07/19 at 2:54pm and on 08/08/19 at 10:34am revealed: -He was aware Resident #5 had been refusing medication, but he did not know she had been refusing consecutive doses of medication. -Missed doses of Pepcid could cause an increase in symptoms of gastrointestinal reflux disease. Interview with the Resident Care Coordinator (RCC/ Medication Aide (MA) on 08/07/19 at 3:28pm revealed: -Resident #5 had been refusing her medication on consecutive days for almost 2 weeks. -She had not contacted the Resident #5's PCP to inform him Resident #5 had been refusing consecutive doses of medication since 07/24/19. -She told the PCP Resident #5 was still refusing medication when he was in the facility on Tuesday, 08/06/19. -The facility protocol was to contact the physician when a resident refused medication 3 days in a row. -She did not know why Resident #5's PCP had not been contacted after Resident #5 refused her medications 3 days in a row Interview with the Administrator on 08/07/19 at 5:13pm revealed she knew Resident #5 refused	D 273		

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her medication at times, but she did not know she had refused consecutive doses of medication since 07/24/19.

Refer to interview with Resident #5's PCP on 08/07/19 at 2:54pm and 08/08/19 at 10:34am.

Refer to interview with the Administrator on 08/07/19 at 5:13pm.

2. Review of Resident #6's current FL2 dated 08/02/19 revealed diagnoses included subdermal hemorrhage, diabetes mellitus II, hypertension, dementia, polycythemia, history of falling, and unspecified epilepsy.

Review of a pest control service receipts revealed Resident #6's room was heat treated on 06/04/19 for bed bugs and chemical treated on 07/13/19 for bed bugs.

Review of Resident #6's Initial Wound Evaluation and Management Summary dated 07/02/19 revealed:
-The chief complaint was a wound on Resident #6's left, dorsal foot.
-Resident #6 also had a diffuse rash consistent with scabies.
-Resident #6 was placed on permethrin 5% cream for treatment of scabies.

Review of Resident #6's hospital Patient Visit Information revealed:
-Resident #6 was seen in the emergency department on 07/06/19 for dementia with behavioral disturbance, neurotic excoriations, and traumatic brain injury.
-A prescription was written for permethrin 5% cream.
-There was no indication Resident #6 was seen

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D 273	Continued From page 44 for bed bug bites. Review of Resident #6's progress notes revealed there was no documentation of bed bug bites or contact with Resident #6's Primary Care Provider (PCP) regarding bed bug bites. Observation of Resident #6 and his room on 08/06/19 at 1:26pm revealed: -Resident #6 had multiple red spots and multiple scabs on his right and left arms from the forearms to the wrists. -There were a few scabs on both of Resident #6's ankles and feet. -No bed bugs were observed. Interview with Resident #6 on 08/06/19 at 1:28pm. -He had bed bugs in his room, but the bugs were gone now. -His arms, ankles, and feet were bitten by bed bugs, but they were not biting him anymore. -Staff was putting cream on his arms for a while, but not anymore. -He was scratching his arms a lot causing them to bleed, but was not scratching as much now. Interview with Resident #6's wound physician on 08/07/19 at 2:09pm revealed: -He was seeing Resident #6 for a wound on his foot. -Resident had a rash on his arms, legs, abdomen, and belly which looked like scabies. -He never performed any tests or ordered any lab work, but he gave a soft diagnosis of scabies due to the appearance of the rash. -He saw Resident #6 on 08/06/19 and the rash appeared to have cleared except for scabs. -He did not know for sure, but it was possible Resident #6 could have been bitten by bed bugs.	D 273		

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-He knew Resident #6 had been seen at the hospital and facility staff had told him the hospital said the "rash" looked like bed bug bites.

Interview with Resident #6's PCP on 08/07/19 at 2:54pm revealed:
-He was not informed by the facility Resident #5 had bed bug bites.
-He had not treated Resident #6 or any other resident in the facility for bed bug bites.
-He expected the facility to inform him of the bed bug bites so he could treat.

Interview with the Resident Care Coordinator (RCC)/Medication Aide (MA) on 08/07/19 at 3:28pm revealed:
-Resident #6 had been bitten by bed bugs.
-The MAs had been using hydrocortisone cream on Resident #6's arms, but she had not contacted the PCP to inform him Resident #6 had been bitten by bed bugs.
-Documentation of contacts with Resident #6's PCP was in the progress notes in his record.
-Resident #6 was sent out to the hospital emergency department on 07/06/19 because he was getting aggressive towards staff.
-She spoke to an emergency department staff who asked her if the facility had bed bugs.
-The emergency department staff told her Resident #6 looked like he had bed bug bites.
-The facility started using permethrin on Resident #6 after he came back from the hospital.

Interview with the Administrator on 08/07/19 at 5:13pm revealed:
-Bed bugs were first noticed in Resident #6's room in March 2019.
-Staff was alerted to look for bed bugs because Resident #6 had bites on his arms.
-Resident #6's bedding, clothes, and duffle bag

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were washed and dried and his room was heat treated.
-Resident #6 was seen by his PCP after bedbugs were found in March 2019, but she did not remember when.
-The PCP had ordered cream for the bites, but Resident #6 would refuse the cream sometimes.
-The marks from the bed bug bites were healing.
-Staff found more bed bugs in Resident #6's room in June 2019.
-Resident #6 did not have a whole lot of new bites, but he did have some bed bug bites.
-She did not know if staff followed up with Resident #6's doctor after being bitten by bed bugs in June 2019.
-She expected staff to follow up with Resident #6's PCP after being bitten by bed bugs.

Interview with Resident #5's Primary Care Provider (PCP) on 08/07/19 at 2:54pm and 10:34am revealed he expected the facility to contact him after a resident has refused medication for 3 days in a row and when he made rounds at the facility.

Interview with the Administrator on 08/07/19 at 5:13pm revealed:
-She did not know the doctor had not been contacted regarding the consecutive refusals of medication.
-Once a medication was refused, she expected MAs to attempt to administer a few minutes later.
-She expected for the RCC/MA and MAs to contact the physician after each time a medication was refused.

The facility failed to follow up with Resident #5's mental health and primary care providers regarding resident refusing multiple medications for at least 8 consecutive days, which could have

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D 273	Continued From page 47 resulted in an increase Resident #5's mental health symptoms and exacerbation of physical health diagnoses; follow up with the primary care provider regarding bed bug bites which resulted in untreated bed bug bites and an increase in scratching and bleeding of bites. 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 in accordance with G.S. 131D-34 on 08/07/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 23, 2019.	D 273		
{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.	{D 344}		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure clarification of physician's orders for 1 of 5 sampled residents (Resident #5) regarding an order to administer a diuretic and hypertension medication according to daily and weekly increase in weight.

The findings are:

Review of Resident #5's current FL2 dated 07/24/19 revealed:
-Diagnoses included diabetes, hypertension, obesity, hyperlipidemia, and hypothyroidism.
-There was an order for furosemide (Lasix) (used to treat fluid retention) 20 mg on Monday, Wednesday, and Friday.

Review of Resident #5's hospital discharge revealed:
-There was an order dated 01/14/19 for furosemide 20 mg 1 tablet three times a week; Increase to daily for weight gain of 2 pounds in 24 hours or 5 pounds in 1 week.
-There was no order for daily weights.

Review of Resident #5's June 2019 Medication Administration Record (MAR) revealed:
-There was an entry for furosemide 20 mg 1 tablet 3 times a week on Monday, Wednesday, and Friday.
-There was an entry for Furosemide 20 mg 1 tablet daily on Sunday, Tuesday, Thursday, Saturday as needed for weight gain of 2 pounds in 24 hours or 5 pounds in 1 week.
-There was no documentation furosemide 20 mg was administered due to weight gain.

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{D 344}	Continued From page 49 -There was no entry for daily weights. Review of Resident #5's July 2019 Medication Administration Record (MAR) revealed: -There was an entry for furosemide 20mg 1 tablet 3 times a week on Monday, Wednesday, and Friday. -There was an entry for furosemide 20mg 1 tablet daily on Sunday, Tuesday, Thursday, Saturday as needed for weight gain of 2 pounds in 24 hours or 5 pounds in 1 week. -There was no documentation furosemide 20 mg was administered due to weight gain. -There was no entry for daily weights. Review of Resident #5's August 2019 Medication Administration Record (MAR) revealed: -There was an entry for furosemide 20 mg 1 tablet 3 times a week on Monday, Wednesday, and Friday. -There was an entry for furosemide 20 mg 1 tablet daily on Sunday, Tuesday, Thursday, Saturday as needed for weight gain of 2 pounds in 24 hours or 5 pounds in 1 week. -There was no documentation furosemide 20 mg was administered due to weight gain. -There was no entry for daily weights. Review of Resident #5's Vital Sign Flow Sheet for 2019 revealed there were no weights recorded for June, July, or August 2019. Interview with Resident #5 on 08/06/19 at 1:40pm revealed: -Staff did not weigh her daily and she did not remember the last time she was weighed. -She did not know she was supposed to be weighed daily. Interview with the Resident Care Coordinator	{D 344}		

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{D 344}	Continued From page 50 (RCC) / Medication Aide (MA) on 08/06/19 at 4:15pm and on 08/07/19 at 3:39pm revealed: -The RCC and the MAs were responsible for reviewing orders and implementing them. -If there were issues with orders, the RCC was responsible for contacting the physician for clarification. Interview with the pharmacy on 08/07/19 at 10:50am revealed: -There was an order dated 11/22/17 to check vitals and weight once a month. -There was no order to check daily weights. A second interview with the RCC/MA on 08/07/19 at 3:39pm revealed: -She had noticed the order on the MAR for furosemide 20 mg 1 tablet daily on Sunday, Tuesday, Thursday, Saturday as needed for weight gain of 2 pounds in 24 hours or 5 pounds in 1 week. -She was not sure how to use the furosemide as needed for weight gain of 2 pounds in 24 hours or 5 pounds in 1 week because there was no order to check Resident #5's weight daily. -She meant to say something to Resident #5's Primary Care Provider (PCP) regarding an order for weights, but she had not. -She was not sure if Resident #5 had appeared to gain weight. -Resident #5's weights had not been checked daily. -There was a scale available to weigh residents. Interview with the Administrator on 08/07/19 at 5:13pm revealed: -She did not know about the order for furosemide 20 mg 1 tablet three times a week; Increase to daily for weight gain of 2 pounds in 24 hours or 5 pounds in 1 week.	{D 344}		

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{D 344}	Continued From page 51 -She did not know there was no physician's order for daily weights. -If an order was incomplete, she expected the RCC or the MA to contact the physician to get clarification. -If there was an order for daily weights it would have been documented on the MAR. Interview with Resident #5's PCP on 08/07/19 at 2:54pm revealed: -Resident #5 needed to be weighed daily in order to implement the order for furosemide 20 mg 1 tablet three times a week; Increase to daily for weight gain of 2 pounds in 24 hours or 5 pounds in 1 week. -The facility had not contacted him to clarify the order for 1 tablet three times a week; Increase to daily for weight gain of 2 pounds in 24 hours or 5 pounds in 1 week and did not let him know there was not a physician's order to check Resident #5's weight daily. -He would write an order for Resident #5's weight to be checked daily.	{D 344}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	{D 358}		

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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, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facility's policies for 3 of 5 sampled residents (#7, #8, and #9) observed during the medication pass including errors with an antipsychotic (#7), a medication for hypomagnesaemia (#8), an antihypertensive (#9), and 1 of 5 sampled residents (Resident #5) for record review with missed doses of an anti-anxiety medication (#5).

The findings are:

1. The medication error rate was 10% as evidenced by the observation of 3 errors of 30 opportunities during the 1:00 pm medication pass on 08/06/19.

a. Review of Resident #7's current FL2 dated 09/05/18 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD) and major depressive disorder.
-There was an order for quetiapine 50 mg 3 times a day (used to treat psychosis).

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{D 358}	Continued From page 53 Observation of medication administration to Resident #7 on 08/06/19 at 1:20pm revealed: -The Resident Care Coordinator (RCC) prepared 2 oral medications, one used to treat pain and the second one to treat anxiety. -The RCC said, "quetiapine was not available for 1 pm dosing". The blister pack was empty. -The RCC administered 2 medications then went back to the cart and signed the medication administration record for 3 medications but circled quetiapine and documented "not available" on the back of the MAR. -There was no quetiapine available on the medication cart. -The RCC did not call the pharmacy to get a replacement dose and she did not call the physician. Review of Resident #7's August 2019 medication administration record (MAR) revealed: -There was an entry for quetiapine 50 mg 3 times a day scheduled for 6:00am, 1:00pm, and 7:30pm. -Quetiapine was documented as administered at 6:00am on 08/06/19. -Quetiapine was documented as not available at 1:00pm on 08/06/19. Interview with Resident #7 on 08/06/19 at 1:22pm revealed: -She usually received all her medications. -The RCC would let her know if her medications were not available. -She could not recall the last time she did not have medications available. Interview with the Resident Care Coordinator (RCC)/Medication Aide (MA) administering Resident #7's medications during the afternoon	{D 358}		

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{D 358}	Continued From page 54 medication pass on 08/06/19 at 2:07pm revealed: -She recalled not administering Resident #7's quetiapine at 1:00pm because it was unavailable. -Resident #7's quetiapine was on a cycle fill. -She did not call the pharmacy to get a replacement tablet sent and she did not notify the physician of the missing dose because medications for the next month had came in (was physically in the building) and would be placed on the medication cart at 7:00 pm. Interview with the Administrator on 08/06/19 at 7:11pm revealed she was not aware Resident #7 did not receive quetiapine as scheduled at 1:00pm. Interview with the primary care physician on 08/08/19 at 2:25pm revealed: -Resident #7 was taking Quetiapine for treatment of a schizoaffective disorder. -He did not know Resident #7 had missed a dose of quetiapine and the facility had not contacted him to let him know. -Missing a dose of Quetiapine could decrease the effectiveness of the anti-psychotic medication leading to increased behaviors. Refer to interview with the RCC on 08/06/19 at 2:07pm. Refer to interview with the Administrator on 08/06/19 at 7:11pm. Refer to interview with the contracted pharmacy on 08/07/19 at 10:07am. Refer to the interview with the primary care physician on 08/08/19 at 2:25pm. b. Review of Resident #8's current FL2 dated	{D 358}		

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{D 358}	Continued From page 55 08/10/18 revealed: -Diagnoses included 3rd degree heart block with a pacemaker, dementia, hyponatremia, and gastroesophageal reflux disorder. -There was an order for magnesium oxide (a supplement used to treat low magnesium) 400 mg 3 times a day. Observation of medication administration to Resident #8 on 08/06/19 at 1:17pm revealed: -The Resident Care Coordinator (RCC) said, "magnesium oxide was not available for 1 pm dosing". The blister pack was empty. -The RCC circled magnesium oxide and documented "not available" on the back of the MAR. -There was no magnesium oxide available on the medication cart. -The RCC did not call the pharmacy to get a replacement dose and she did not call the physician. Review of Resident #8's August 2019 medication administration record (MAR) revealed: -There was an entry for magnesium oxide 400 mg 3 times a day scheduled for 6:00am, 1:00pm, and 7:30pm. -Magnesium oxide was documented as administered at 6:00am on 08/06/19. -Magnesium oxide was documented as not available at 1:00pm on 08/06/19. Based on observations, interviews, and record reviews it was determined Resident # 8 was not interviewable. Interview with the RCC/MA administering Resident #8's medications during the afternoon medication pass on 08/06/19 at 2:07pm revealed: -She recalled not administering Resident #8's	{D 358}		

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magnesium oxide at 1:00pm because it was unavailable.
-Resident #8's magnesium oxide was on a cycle fill.
-She did not call the pharmacy to get a replacement tablet sent and she did not notify the physician of the missing dose because medications for the next month had came in (was physically in the building) and would be placed on the medication cart at 7:00 pm.

Interview with the Administrator on 08/06/19 at 7:11pm revealed she did not know Resident #8 did not receive magnesium oxide as scheduled at 1:00pm.

Interview with the primary care physician on 08/08/19 at 2:25pm revealed:
-Resident #8 was taking magnesium oxide for low magnesium levels.
-He did not know Resident #8 had missed a dose of magnesium oxide and the facility had not contacted him to let him know.
-Missing a dose of magnesium oxide could increase symptoms of low magnesium, including causing severe muscle cramping.

Refer to interview with the RCC on 08/06/19 at 2:07pm.

Refer to interview with the Administrator on 08/06/19 at 7:11pm.

Refer to interview with the contracted pharmacy on 08/07/19 at 10:07am.

Refer to the interview with the primary care physician on 08/08/19 at 2:25pm.

c. Review of Resident #9's current FL2 dated

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{D 358}	Continued From page 57	{D 358}		

04/23/19 revealed:
-Diagnoses included chronic kidney disease stage 3, coronary artery disease, and Vitamin B12 deficiency.
-There was an order for Hydralazine (medication used to treat high blood pressure) 25 mg 3 times a day.

Observation of medication administration to Resident #9 on 08/06/19 at 1:12pm revealed:
-The Resident Care Coordinator (RCC) said, "Hydralazine was not available for 1:00pm dosing". The blister pack was empty.
-The RCC circled Hydralazine and documented "not available" on the back of the MAR.
-There was no Hydralazine available on the medication cart.
-The RCC did not call the pharmacy to get a replacement dose and she did not call the physician.

Review of Resident #8's August 2019 medication administration record (MAR) revealed:
-There was an entry for Hydralazine 25 mg 3 times a day scheduled for 6:00am, 1:00pm, and 7:30pm.
-Hydralazine was documented as administered at 6:00am on 08/06/19.
-Hydralazine was documented as not available at 1:00pm on 08/06/19.

Interview with the RCC/MA administering Resident #9's medications during the afternoon medication pass on 08/06/19 at 2:07pm revealed:
-She recalled not administering Resident #9's Hydralazine at 1:00pm because it was unavailable.
-Resident #9's Hydralazine was on a cycle fill.
-She did not call the pharmacy to get a replacement tablet sent and she did not notify the

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{D 358}	Continued From page 58 physician of the missing dose because medications for the next month had came in (was physically in the building) and would be placed on the medication cart at 7:00 pm. Interview with the Administrator on 08/06/19 at 7:11pm revealed she did not know Resident #9 did not receive Hydralazine as scheduled at 1:00pm. Interview with the primary care physician on 08/08/19 at 2:25pm revealed: -Resident #9 was taking Hydralazine for treatment of hypertension. -He did not know Resident #9 had missed a dose of Hydralazine and the facility had not contacted him to let him know. -Missing a dose of Hydralazine could cause an increase in the resident's blood pressure. Refer to interview with the RCC/MA on 08/06/19 at 2:07pm. Refer to interview with the Administrator on 08/06/19 at 7:11pm. Refer to interview with the contracted pharmacy on 08/07/19 at 10:07am. Refer to the interview with the primary care physician on 08/08/19 at 2:25pm. _____ Interview with the Resident Care Coordinator (RCC) on 08/06/19 at 2:07 pm revealed: -She did not call for replacement medication because it was cycle fill time and the monthly medications would be placed on the medication carts at 7:00 pm (the medications were already in the building). -If the medications were pulled before they were	{D 358}		

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switched out, the following month would be short on medications.
-If it were not cycle fill time, she would had called the pharmacy to get medications in the building.

Interview with the Administrator on 08/06/19 at 7:11 pm revealed:
-When medications were not on the cart, the medication aide (MA) or the RCC was supposed to notify the pharmacy so they could adjust the amount sent.
-The MA's or the RCC was supposed to notify the physician when a dose of medication was not available to administer.
-She expected medications to be administered as ordered by the physician.

Telephone interview with the contracted pharmacy on 08/07/19 at 10:07 am revealed:
-All residents should have enough medication to last the entire month until the next cycle fill.
-The facility was supposed to inform the pharmacy when they were out of medications for any resident.
-The pharmacy would adjust the number of medications sent so that the residents would receive medications as ordered by the physician.

Telephone interview with the primary care physician on 08/08/19 at 2:25 pm revealed he was somewhat concerned that the facility did not have medications for 1:00 pm medication pass so that the resident's received medications as ordered.

3. Review of Resident #5's current FL2 dated 07/24/19 revealed:
-Diagnoses included schizoaffective disorder and mania.
-There was a physician's order for clonazepam (a

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{D 358}	Continued From page 60 medication used to treat anxiety and panic attacks) 0.5 mg twice daily. Review of a previous physician's order dated 07/08/19 revealed an order for clonazepam 0.5 mg twice daily. Review of Resident #5's July 2019 Medication Administration Record (MAR) revealed: -There was an entry for clonazepam 0.5 mg twice daily scheduled at 6:00am and 7:00pm. -Clonazepam was not documented as administered for 12 of 62 opportunities on 07/09/19 at 6:00am due to "refused all medication," 07/10/19 at 7:00pm (nodocumentation why clonazepam was not administered), 07/19/19 at 7:00pm due to "refused all medication," 07/24/19 at 7:00pm (no documentation why clonazepam was not administered), 07/25/19 at 7:00pm due to "refused all medication," 07/26/19 at 7:00pm (no documentation why conazepam was not administered), 07/27/19 at 7:00pm due to "refused all medication," 07/28/19 at 7:00pm due to "refused all medication," 07/29/19 at 7:00pm due to "refused medicaions," 07/30/19 at 6:00am due to "refused all medication," 07/30/19 at 7:00pm (no documentation why clonazepam was not administered), 07/31/19 at 6:00am and 7:00pm due to "out of facilty." Review of Resident #5's August 2019 MAR revealed: -There was an entry for clonazepam 0.5 mg twice daily scheduled at 6:00am and 7:00pm. -Clonazepam was not documented as administered 11 of 13 opportunities on 08/01/19 and 08/02/19 at 7:00pm, 08/03/19 through 08/06/19 at 6:00am and 7:00pm, and 08/07/19 at 6:00pm.	{D 358}		

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{D 358}	Continued From page 61 -There was no documentation clonazepam was administered on 08/01/19 at 6:00am. -There was documentation clonazepam was administered on 08/02/19 at 6:00am. Observation of Resident #5's medication on hand on 08/07/19 at 7:50am revealed: -There was a bubble pack of clonazepam 0.5 mg 1 tablet twice a day (labeled 6:00am) dispensed on 07/09/19 for 30 tablets with 7 tablets remaining. -There was a bubble pack of clonazepam 0.5 mg 1 tablet twice a day (labeled 7:00pm) dispensed on 05/10/19 for 30 tablets with 7 tablets remaining. Review of Resident #5's Controlled Substance Count Sheet (CSCS) revealed: -There was a CSCS for clonazepam 0.5 mg 1 tablet twice a day labeled 6:00am. -The beginning quantity of clonazepam 0.5 mg labeled 6:00am was 30 tablets and the first dispense date was 07/06/19. -One tablet of clonazepam was signed out on 07/06/19 through 07/29/19 at 6:00am leaving an ending quantity of 7 tablets. -There was no documentation why clonazepam was not signed out at 6:00am on 07/30/19 through 08/07/19 -There was a CSCS for clonazepam 0.5 mg 1 tablet twice a day labeled 7:00pm. The beginning quantity of clonazepam 05.mg labeled 7:00pm was 30 tablets and the first sign out date was 07/03/19. -One tablet of clonazepam was signed out on 07/03/19 at 6:00pm, 2 tablets were documented as sent home with Resident #5's family member on 07/04/19 at 9:00am, 1 tablet was signed out from 07/06/19 through 07/15/19 at 6:00pm, 1 tablet was signed out form 07/17/19 through	{D 358}		

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{D 358}	Continued From page 62 07/22/19 at 6:00pm, and on 07/27/19 through 07/27/19 at 6:00pm. -There was no documentation why clonazepam was not signed out at 6:00pm on 07/16/19, and 07/28/19 through 08/06/19. Interview with the Resident Care Coordinator (RCC)/Medication Aide (MA) on 08/07/19 at 7:55am revealed: -Resident #5 had been refusing her medication, including clonazepam, for a few weeks. -There was no documentation on the CSCS after 07/29/19 for the 6:00am and after 07/27/19 for the 7:00pm dose due to the resident refused her medication. -She did not punch clonazepam from the bubble pack to the medication cup to administer to Resident #5 because Resident #5 would tell the RCC/MA not to give her medication because she would not take it. Telephone interview with a representative from the contracted pharmacy on 08/07/19 at 10:50:am revealed: -The original order for clonazepam 0.5 mg twice a day was dated 01/04/19. -Sixty tablets of clonazepam 0.5 mg were dispensed to the facility on 05/03/19, 06/03/19, 07/08/19, and 07/31/19. Interview with Resident #5's mental health provider on 08/07/19 at 11:19 am revealed: -She visited Resident #5 once a month. -Resident #5 has had multiple psychiatric hospitalizations. -She thought the facility had let her know Resident #5 had been refusing her medication, but she did not know Resident #5 had been refusing medication including clonazepam for at least 9 consecutive days.	{D 358}		

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{D 358}	Continued From page 63 -She did not know the facility had not signed out clonazepam on the CSCS to administer to Resident #5 since 07/27/19 (evening dose) and 07/29/19 (morning dose). -She had concerns, but she knew Resident #5's mental health condition was difficult. -Resident #5's mental health state was well for a while, but it took a drastic turn recently. -Resident #5 was cycling rapidly with persistent psychosis and needed to go to a psychiatric facility. -Without psychotropic medications, Resident #5 could become symptomatic with agitation, paranoia, delusion, and psychosis. Interview with the Administrator on 08/07/19 at 5:13pm revealed: -She did not know the CSCS for clonazepam showed the 6:00am dose had not been documented as administered since 07/29/19 and the 7:00pm dose had not been documented as administered since 07/27/19. -She expected staff to attempt to administer medication to residents by punching the medication from the bubble pack and offering to the resident. -The CSCS for Resident #5 should show medication was offered daily to Resident #5 even if she refused to take it. Interview with the Resident Care Coordinator (RCC) on 08/06/19 at 2:07pm revealed: -She did not call for replacement medication because it was cycle fill time and the monthly medications would be placed on the medication carts at 7:00pm (the medications were already in the building). -If the medications were pulled before they were switched out, the following month would be short on medications.	{D 358}		

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{D 358}	Continued From page 64 -If it was not cycle fill time, she would had called the pharmacy to get medications in the building. Interview with the Administrator on 08/06/19 at 7:11pm revealed: -When medications were not on the cart, the medication aide (MA) or the RCC was supposed to notify the pharmacy so they could adjust the amount sent. -The MA's or the RCC was supposed to notify the physician when a dose of medication was not available to administer. -She expected medications to be administered as ordered by the physician. Interview with the contracted pharmacy on 08/07/19 at 10:07am revealed: -All residents should have enough medication to last the entire month until the next cycle fill. -The facility was supposed to inform the pharmacy when they were out of medications for any resident. -The pharmacy would adjust the number of medications sent so that the residents would receive medications as ordered by the physician. Interview with the primary care physician on 08/08/19 at 2:25pm revealed he was somewhat concerned that the facility did not have medications for 1:00 pm medication pass so that the residents received medications as ordered.	{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:	{D 367}		

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{D 367}	Continued From page 65 (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration Records (MARs) for 1 of 5 sampled residents related to a proton pump inhibitor medication (Resident #2). Review of Resident #2's hospital discharge FL2 dated 07/01/19 revealed: -Diagnoses included dehydration, active renal failure, chronic late effect of cerebral venous thrombosis, diabetes mellitus type II, epilepsy, bi-polar disorder, cognitive impairment, coronary artery disease, diarrhea, and benign	{D 367}		

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	HAL086001	A. BUILDING: _____ B. WING _____	R 08/08/2019

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{D 367}	Continued From page 66	{D 367}		

hypertension.
-There was no order for pantoprazole 40 mg.

Review of Resident #2's previous hospital discharge FL2 and hospital discharge instructions dated 06/09/19 revealed an order for pantoprazole (used to treat gastroesophageal reflux disease) 40 mg daily.

Review of Resident #2's June 2019 Medication Administration Record (MAR) revealed:
-There was no entry for pantoprazole 40mg.

Review of Resident #2's July 2019 MAR revealed:
-There was an entry for pantoprazole 40mg 1 tablet daily at 6:00am.
-Pantoprazole was documented as administered at 6:00am form 07/01/19 through 07/31/19.

Observations of medication on hand for Resident #2 on 08/07/19 at 7:43am revealed pantoprazole 40mg 1 tablet daily was available for administration.

Interview with a representative from the contracted pharmacy on 08/07/19 at 10:50am revealed:
-There was an active order for pantoprazole 40 mg 1 tablet daily received by the pharmacy on 06/10/19.
-There were 29 tablets of pantoprazole 40 mg 1 tablet daily dispensed to the facility on 06/10/19.
-There were 30 tablets of pantoprazole 40 mg 1 tablet daily dispensed to the facility on 07/03/19.
-There were 30 tablets of pantoprazole 40 mg 1 tablet daily dispensed to the facility on 07/30/19.

Interview with the Resident Care Coordinator (RCC)/Medication Aide (MA) on 07/06/19 at 4:15pm revealed:

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{D 367}	Continued From page 67 -The RCC and MAs were responsible for reviewing new orders. -After a new order was received, the MA or RCC should add or discontinue the new order on the MAR. -Residents were sent the hospital with a copy of the MAR. -When a resident returned from the hospital with a new FL2, the RCC or MA will send the FL2 to the pharmacy. -The pharmacy would then add any new medications and send them to facility. -If there was a question regarding medication, the RCC or MA would contact the facility medical care provider for clarification. -MAR audits were completed monthly by the RCC and the Administrator. -The Administrator was still teaching her how to complete a MAR audit. -She thought pantoprazole 40 mg was in the facility on 06/10/19 and staff forgot to transcribe it onto the June MAR. -Administration of pantoprazole would not be documented anywhere else besides on the MAR. Interview with the Administrator on 08/06/19 at 4:54pm revealed: -The RCC and MAs were responsible for reviewing hospital orders and FL2's. -New FL2 and orders should be compared to the MAR and changes should be made on the MAR. -The RCC and the Administrator were responsible for completing MAR and chart audits. -When auditing the MAR, they looked for orders left off, empty spots, and administration of as needed medication and the effectiveness. -She did not know pantoprazole was not on the June 2019 MAR and was not documented as administered. -When a medication came from the pharmacy,	{D 367}		

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{D 367}	Continued From page 68 the RCC or MA should have checked to see if the medication was on the MAR. -She thought pantoprazole was administered, but was just not transcribed onto the MAR.	{D 367}		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure medications were administered in accordance with infection control measures to prevent the development and transmission of disease or infection for 1 of 5 sampled residents (Resident #1) with documentation of administration of outdated and expired insulins. The findings are: Review of Resident #1's current FL2 dated 08/6/19 revealed: -Diagnoses included Diabetes Mellitus Type II, major depression, insomnia, and history of right below the knee amputation. -There was an order for Levemir Insulin (long acting insulin used to treat high blood sugar) 25 units subcutaneous every night at bedtime. -There was an order for Novolog Insulin (short acting insulin used to treat high blood sugar)	D 371		

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before meals and at bedtime give 8 units if FSBS check was greater than 300. Repeat FSBS check in 1 hour and repeat if still greater than 300 and notify the physician.
There was an order for finger stick blood sugar (FSBS) checks before meals and at bedtime.

Review of Resident #1's signed physician orders dated 03/04/19 revealed:
-There was an order for Levemir Insulin 40 units subcutaneous every night at bedtime.
-There was an order for Novolog Insulin three times a day before meals with the following sliding scale: 150-200 = 6 units, 201-250 = 7 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 14 units, greater than 400 = 14 units and recheck fingerstick blood sugar (FSBS) in 2 hours if still greater than 400 give 10 units and call physician.

Review of hospital discharge orders dated 05/17/19 revealed:
-There was an order for Levemir Insulin 25 units subcutaneous every night.
-There was an order for Novolog Insulin three times a day before meals with the following sliding scale: 150-200 = 6 units, 201-250 = 7 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 14 units, greater than 400 = 14 units and recheck fingerstick blood sugar (FSBS) in 2 hours if still greater than 400 give 12 units.

Review of a signed physician order dated 06/10/19 revealed:
-There was an order to change the Novolog Insulin sliding scale to before meals and at bedtime if greater than 300 give 8 units of Novolog Insulin and recheck the FSBS in 2 hours if still greater than 300 repeat 10 units of Novolog insulin then recheck in 1 hour and if FSBS was

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D 371	Continued From page 70 greater than 300 notify the physician. Observation of medication on hand on 08/06/19 at 12:15pm revealed: -Resident #1 had 2 vials of Levemir insulin that had been opened. -The first vial of Levemir insulin that the Resident Care Coordinator (RCC) removed from the refrigerator had a label that read "Discard after 42 days expiration date: 7/23". The date was handwritten. -There was no opened date on the vial or the box. -The box that contained the first vial of Levemir Insulin was dated as dispensed on 06/17/19. -The first bottle of Levemir Insulin was half full. -A second bottle of Levemir insulin was removed from the refrigerator by the RCC and it also contained a label that read "Discard after 42 days expiration date: _____". The expiration date had been left blank. -There was no opened date on the vial or the box. -The box that contained the second vial of Levemir Insulin was dated as dispensed on 07/22/19. -The second bottle of Levemir Insulin had approximately 1/3 of the insulin remaining. -The vial of Novolog was removed from the refrigerator by the RCC and it had a label that read "Date opened 7/7/19 Discard after 28 days" (08/04/19 was the 28th day). The date was hand written. -The box that contained the vial of Novolog Insulin was dated as dispensed on 06/25/19. Review of Resident #1's July 2019 medication administration record (MAR) revealed: -There was an entry for Levemir Insulin 25 units every night at bedtime scheduled for 7:00pm. -Levemir Insulin was documented as administered from 07/01/19 through 07/31/19.	D 371		

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-There was an entry for Novolog Insulin before meals and at bedtime give 8 units if FSBS check was greater than 300. Repeat FSBS check in 2 hours and repeat if still greater than 300 give 10 units then recheck in 1 hour if still greater than 300 notify the physician scheduled for 6:30am, 11:30am, 4:30pm, and 8:30pm.
-Novolog Insulin was not documented as administered from 07/01/19 through 07/31/19.

Review of Resident #1's August 2019 MAR revealed:
-There was an entry for Levemir Insulin 25 units every night at bedtime scheduled for 7:00pm.
-Levemir Insulin was documented as administered from 08/01/19 through 08/04/19.
-There was an entry for Novolog Insulin before meals and at bedtime give 8 units if FSBS check was greater than 300. Repeat FSBS check in 2 hours and repeat if still greater than 300 give 10 units then recheck in 1 hour if still greater than 300 notify the physician scheduled for 6:30am, 11:30am, 4:30pm, and 8:30pm.
-Novolog Insulin was documented as administered on 08/05/19 at 8:30pm.

Interview with Resident #7 on 08/06/19 at 1:22pm revealed:
-He was on two types of insulin.
-He received one insulin every night and the other with meals if his blood sugar was greater than 300.

Interview with the Resident Care Coordinator on 8/06/19 at 12:35am revealed:
-The RCC did not know the first vial of Levemir insulin expired on 07/23/19.
-She did not know the second vial of Levemir Insulin had been opened but not dated.
-They started refrigerating insulin about 2-3

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weeks ago because a pharmacy representative told them they could use them up to 90 days after opening the vials if refrigerated.
-Prior to being told about keeping insulin in the refrigerator, they kept insulin on the medication carts. Levemir was good for 42 days after opening a vial and Novolog was good up to 28 days after opening the vial.
-Medication cart audits were performed monthly. This audit included checking expiration dates.
-The last medication cart audit was performed on 07/14/19.
-All medication aides, including herself, were responsible for ensuring the open insulin vials had not expired.

Telephone interview with a representative from the contracted pharmacy on 08/08/19 at 2:00pm revealed:
-Levemir Insulin was good up to 42 days after opening a vial. Any use after that 42 days increased the risks of bacterial infection.
-Novolog Insulin was good up to 28 days after opening the vial. Any use after that 28 days increased the risks of bacterial infection.
-Insulin retained its effectiveness until the manufactured date of expiration.
-"When insulin was opened and a syringe was inserted into the vial, you risk introducing bacteria into the insulin and causing a bacterial infection for the diabetic resident."
-A contracted representative had misinformed the facility of how long insulins were good after opening.

Interview with the Administrator on 08/07/19 at 2:30pm revealed:
-She did not know the medication aides (MAs) or the Resident Care Coordinator (RCC) had been using expired insulin.

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D 371	Continued From page 73 -Levemir insulin was good for up to 42 days after opening the vial and Novolog was good up to 28 days after opening the vial. -The MAs and the RCC were supposed to check for expiration dates prior to giving a medication. -She expected all medications to be given as ordered with medication that was not outdated. Telephone interview with the primary care physician on 08/08/19 at 2:25pm revealed: -Levemir insulin was good for 42 days after opening and Novolog insulin was good for 28 days after opening. -When insulins were out dated they lost their effectiveness and would not lower blood sugar as effectively causing the resident to have higher than normal blood sugars. -If insulins were being administered past their expiration date, he would expect the facility to provide some extra training to ensure it did not happen again.	D 371		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents	{D912}		

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{D912}	Continued From page 74 received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to physical environment, personal care and supervision, and health care. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to assure 2 of 4 exit doors accessible for residents' use had an alarm that activated for the safety of 2 of 2 sampled residents (Resident #2 and #5) who exhibited exit seeking behaviors, had wandering behaviors, and eloped from the facility without staff's knowledge. [Refer to Tag 0067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to provide supervision for 2 of 5 sampled residents (#2 and #5) who exhibited exit-seeking behaviors and eloped from the facility without staff's knowledge. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)] 3. Based on observations, interviews and record reviews, the facility failed to notify the primary care provider for 2 of 6 sampled residents regarding refusals of medication (#5) and bed bug bites (#6). [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	{D912}		