STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey on 08/13/19 to 8/14/19.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews, and record review, the facility failed to ensure 1 out of 5 sampled residents (Resident #2) received follow-up and referral for an Magnetic Resonance Imaging (MRI) to rule out a neurological cause of the resident's vision impairment. The findings are: Review of Resident #2's FL2 dated 06/19/19 revealed diagnoses included bacteremia, sepsis due to methicillin resistant staphylococcus, Type II diabetes mellitus with other diabetic kidney complications, cellulitis, and hypoglycemia. Review of Resident #2's Ophthalmology	D 273		

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D 273	Continued From page 1 Assessment/Impression Plan date 06/03/19 revealed: -Resident #2 had an HVF (Humphrey Visual Field Analyzer) (used to check each eye separate for visual field abnormalities) completed. -The HVF did not correlate with the OCT (Optical Coherence Tomography) (used for imaging the retina) or clinical exam. -Based on the clinical exam, the doctor was more suspicious of a neurological cause and recommended an MRI of the brain with and without contrast. -The physician stressed the importance of compliance with medications usage, and follow-ups with the resident and the facility. -The physician explained the risk of irreversible vision loss associated glaucoma. -The record note was sent to the "nursing facility." Review of Resident #2's Ophthalmology physician orders dated 06/03/19 revealed: -There was an order for an MRI of the brain with and without contrast. -The diagnosis code for the procedure was a homonymous (effects the same area in both eyes) bilateral field defect on the right side. -The physician office had scheduled the appointment for 06/10/19 with a 9:30am arrival time. Review of Resident #2's facility appointment reminder notebook calendar revealed: -There was no date on the appointment reminder. -The top of the appointment reminder documented, "has an MRI scheduled for 06/10/19 at 9:30am." -Resident #2 also had a follow-up appointment with the physician for 06/17/19 at 11:10am. Review of Resident #2's Ophthalmology	D 273		

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D 273	Continued From page 2 Assessment/Impression Plan dated 06/17/19 revealed: -This was the second appointment/MRI order -Physician discussed with Resident #2 that his HVF did not correlate with the OCT or the clinical exam. -The doctor was suspicious of a neurological cause. -"Therefore, AGAIN recommended MRI of brain with and without contrast." -The physician documented in all capital letters, "MRI orders sent to nursing facility, however patient has not received MRI. Discussed importance of compliance with MRI." Observation of Resident #2 on 08/14/19 at 9:40am revealed: -Resident #2 was lying in bed with his legs elevated and both eyes closed. -Resident #2 never opened his eyes during the interview. Interview with Resident #2 on 08/14/19 at 9:40am and at 4:54pm revealed: -He was not feeling well. -His eyes had an "irritation feeling," "uncomfortable feeling," and "bothersome feeling". -He felt like something was in his eye all the time. -The vision was worse in the right versus the left eye. -He was light sensitive at times. -He did not know the date of his next scheduled eye appointment or about the MRI appointment. Telephone interview with Resident #2's ophthalmologist's clinical manager on 08/14/19 at 4:18pm revealed: -Resident #2 was followed by the ophthalmologist primarily for angle glaucoma.	D 273		

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-The ophthalmologist ordered the MRI because there was an issue with Resident #2's visual fields and an MRI would show possible causes such as a tumor.
-The doctor was concerned with Resident #2 having a neurological cause for his visual impairment.
-The ophthalmologist received a telephone call from the facility on 08/13/19 regarding the resident missing the appointment for the MRI that was scheduled on 06/10/19 (64-days after the appointment was missed).
-Resident #2 had an appointment with the ophthalmologist scheduled for 07/25/19 that was canceled by the facility.
-The facility rescheduled Resident #2's follow-up appointment for 08/17/19 after the MRI was supposed to be completed on 08/16/19.
-On 06/03/19, Resident #2 was given the diagnosis of Iridocyclitis which was inflammation of the iris and could be very painful.

Telephone interview with the scheduler from the imaging center of the MRI on 08/14/19 3:45pm revealed:
-Resident #2 had an appointment rescheduled previously.
-The system did not show the date of Resident #2's previous appointment.
-The facility staff called on 08/13/19 to schedule the appointment, and the appointment was scheduled for 08/16/19 at 12:30pm.

Interview with a Medication Aide (MA) on 08/14/19 at 3:04pm revealed:
-The facility's receptionist was responsible for setting up appointments with outside doctors or MRIs.
-The facility's receptionist was responsible for maintaining the book for all outside appointments.

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D 273	Continued From page 4 -The facility's receptionist placed a calendar at the front desk so that the Personal Care Aide (PCA) would know who to get ready for appointments. -The MA was unsure if Resident #2 had an appointment for an MRI scheduled. Telephone interview with a second MA on 08/14/19 at 4:15pm revealed: -The receptionist was responsible for scheduling appointments. -A calendar was placed at the front desk to show the appointments for the week. -She was not aware Resident #2 had an appointment for an MRI. Interview with the receptionist on 08/14/19 at 3:17pm revealed: -She was responsible for keeping track of all scheduled appointments. -Typically, she did not schedule appointments for residents. -The RCC or the RCD scheduled the appointments. -She recalled someone calling to say Resident #2 had an appointment, but she did not remember the details or timeframe. -She would reschedule an appointment if there was a conflict with another scheduled appointment. Review of the facility's scheduling notebook on 08/14/19 at 3:25pm revealed: -There was a brown folder in the pocket of the notebook with scheduled appointments. -There was an appointment reminder for Resident #2 with the scheduled MRI for 06/10/19. -There was a follow-up appointment for the ophthalmologist on 06/17/19.	D 273		

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D 273	Continued From page 5 Interview with the RCC on 08/14/19 at 4:05pm revealed: -The RCC or the RCD scheduled the appointments. -She tried to schedule all the appointments with the specialists. -She reviewed the paperwork received form Resident #2's appointments upon returning to the facility. -She would make the appointment and give a copy of the information to the receptionist. -After she reviewed the appointment for Resident #2, she gave the receptionist the copy of the appointment for Resident #2 to have the MRI and the follow-up appointment with the ophthalmologist to enter in the appointment book. -She never looked at the book to see if the appointment was entered for Resident #2. -The facility's receptionist printed out a schedule for all outside resident's appointments monthly or as needed. -Copies of the appointment schedule were given to the RCC, and the RCD and a copy was placed at each nurses station. -Scheduling appointments was not on the New Order Tracking form. Interview with the RCD on 08/14/19 at 4:50pm revealed: -She called and scheduled Resident #2 to have the MRI on 08/16/19 (64-days after the doctor requested). -The information for the follow up appointment and the MRI after she and the RCC reviewed the appointments were given to the receptionist, but not logged in the appointment book for Resident #2. -She was unaware of the MRI appointment in June 2019 until a surveyor asked to see the result of the appointment.	D 273		

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D 273	Continued From page 6 Interview with the Administrator on 08/14/19 at 10:30am and 4:59pm revealed: -She was not aware Resident #2 missed a scheduled appointment for a MRI in June until today (08/14/19). -The information for Resident #2's appointment was given to the receptionist after reviewed by the RCC and RCD, but never logged into the appointment book. -She did not know why the appointment was not logged into the appointment book. -There were no systems in place to ensure residents' appointments were scheduled and confirmed. -The facility was having a problem getting paperwork back from outside medical appointments. -She hired a MA last week who would be responsible for getting residents to and from medical appointments, bringing back the paperwork, scheduling medical follow-ups, and staying with the resident at the appointment. _____ The facility failed to assure follow-up with physician's orders for Resident #2 who was ordered an MRI of the brain to rule out a neurological cause of the resident's vision impairment and to prevent risk for irreversible vision loss. This failure to assure healthcare referral and follow-up on physician's orders 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 08/14/19 for this violation.	D 273		

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D 273	Continued From page 7 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 28, 2019.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 1 of 5 sampled residents (Resident #2) with an order for an eye shield. The findings are: Review of Resident #2's FL2 dated 06/19/19 revealed diagnoses included bacteremia, sepsis due to methicillin resistant staphylococcus, Type II diabetes mellitus with other diabetic kidney complication, cellulitis, and hypoglycemia.	D 276		

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D 276	Continued From page 8 Review of Resident #2's Ophthalmology Assessment/Impression Plan date 06/03/19 revealed: -The chart note was sent to the "nursing facility" stressing the importance of compliance with Resident #2's using the eye shield to prevent further damage to the right eye. -Resident #2 was advised to refrain from rubbing/touching the eye. -Resident #2 was ordered to wear a night shield every night until directed otherwise. -Resident #2 was diagnosed with Iridocyclitis (inflammation of the iris and ciliary body) of the right eye. Review of Resident #2's Ophthalmology Assessment/Impression Plan dated 06/17/19 revealed: -Chart note was sent to the "nursing facility" stressing the importance of compliance with Resident #2's using the eye shield to prevent further damage to the right eye. -Resident #2 was advised to refrain from rubbing/touching the eye. -Resident #2 was told in all capital letters "tape shield on at night until directed otherwise ...4+ warning about importance with compliance". Interview with Resident #2 on 08/14/19 at 9:40am and at 4:54 pm revealed: -He was not feeling well. -He did not wear the eye shield at all. -He kept the eye shield in his nightstand. -He did not wear the eye shield because staff would not assist him in putting the eye shield on by taping the eye shield to his right eye. -He asked the medication aide (MA)'s several times after returning from the visit to assist him in taping the eye shield on at night but was not helped with that.	D 276		

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-His eyes had an "irritation feeling," "uncomfortable feeling," and "bothersome feeling".
-He felt like something was in eye all the time.
-His vision was worst in the right versus the left eye.
-He was light sensitive at times.
-He did not know when his next scheduled eye appointment.

Observation on 08/14/19 at 9:40am revealed there was an eye shield in Resident #2's nightstand drawer.

Review of Resident #2's Medication Administration Record (MAR) for June of 2019 revealed:
-There was an entry dated 06/03/19 for Resident #2 to refrain from rubbing/touching the eye and wear night shield at night until directed otherwise.
-The entry on the MAR was initialed by the RCC to complete at 8:00PM.
-Staff initialed that the eye shield was worn by Resident #2 from 06/04/19 until 06/30/19.

Review of the Resident #2's MARs for July 2019 and August 2019 revealed:
-There was an entry for Resident #2 to wear the eye shield over his right eye at night time.
-There was no documentation of Resident #2 wearing the eye shield at night.

Review of Resident #2's orders revealed there was no order to discontinue wearing the eye shield at night.

Telephone interview with Resident #2's ophthalmologist's clinical manager on 08/14/19 at 4:18pm revealed:
-Resident #2 was followed by the ophthalmologist

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primarily for angle glaucoma.
-On 06/03/19, Resident #2 was given the diagnosis of Iridocyclitis, which caused inflammation of the iris that could be very painful.
-Resident #2 was supposed to be wearing the eye shield at night for protection from rubbing his right eye and causing damage.
-If the eye shield was not worn and Resident #2 rubbed his right eye, the inflammation in the eye would continue to get worse if physician's orders were not followed.

Interview with a MA on 08/14/19 at 3:04pm revealed:
-Resident #2 was normally up and dressed in the morning when she arrived around 6:45am.
-Resident #2's eye shield was kept in the resident's nightstand drawer.
-She had never observed Resident #2 wear the eye shield.
-She did not know if staff assisted the resident with putting the eye shield on at night.

Telephone interview with a second MA on 08/14/19 at 4:15pm revealed:
-She primarily worked second shift.
-She did not assist Resident #2 in putting the eye shield on at night.
-She did not recall Resident #2 asking for help to put the eye shield on at night.
-The eye shield was kept in the resident's nightstand drawer.

Interview with the RCC on 08/14/19 at 4:05pm revealed she was not aware that Resident #2 was not wearing the eye shield at night.

Interview with the RCD on 08/14/19 at 4:50pm revealed:
-She was not aware that resident was not wearing

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D 276	Continued From page 11 an eye shield at night. -She informed by staff that Resident #2 had a lot of refusals with compliance with physician orders, but there was no documentation to reflect any refusals with wearing the eye shield. Interview with the Administrator on 08/14/19 at 4:59pm revealed: -The facility was having a problem getting paperwork back from outside medical appointments. -She was not aware that Resident #2 was supposed to wear an eye shield at night.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION	D 358		

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D 358	Continued From page 12 Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 1 of 5 residents (Residents #1) observed during the medication pass including errors with the dosage of a medication to treat pain, and for 4 of 5 residents sampled (Residents #1, #2, #4, and #5) for record review including errors with a medication used to treat pain and a medication used to decrease elevated lipid levels (Resident #1), a medication used to treat high blood pressure and coronary artery disease, a medication used to thin the blood, a medication used to decrease elevated lipid levels, a medication used to treat allergies, a medication used to treat high blood pressure, a medication used to treat gastro esophageal reflux disease and a medication used to treat an enlarged prostate (Resident #5), a cream used to treat dry skin and eye drops (Resident #2), and a vitamin supplement (Resident #4). The findings are: Observation of the 7:30am medication pass on 08/14/19 revealed: -At 7:55am, the morning medication aide (MA) prepared 10 medications for administration to Resident #1. -The MA removed two acetaminophen 325mg tablets from the resident's blister pack and placed them in a medication cup. -The MA administered the two whole tablets (acetaminophen 650mg) to Resident #4. 1. Review of Resident #1's current FL2 dated 03/11/19 revealed: -Diagnoses included unspecified dementia, cardiomegaly, history of circulatory disorder,	D 358		

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hypertension and osteoarthritis.
-There was a physician's order for tylenol 325mg, administer two tablets twice a day for pain.
-There was a physician's order for tylenol 325mg, administer two tablets every 12 hours as needed for pain (PRN).

a. Review of Resident #1's record revealed:
-There was a physicians order dated 06/24/19 to discontinue all prior tylenol orders.
-There was a physician's order dated 06/24/19 for tylenol 325mg, administer two tablets (650mg) every 4 hours PRN pain.

Review of Resident #1's June 2019 through August 2019 Medication Administration Record (MAR), from 06/24/19 through 08/13/19 revealed:
-There was a handwritten entry for tylenol 325mg, administer two tablets (650mg) twice daily.
-Tylenol 325mg, two tablets (650mg), was documented as administered twice a day at 9:00am and 9:00pm from 06/24/19 through 08/13/19.
-There was a handwritten entry for tylenol 325mg, administer two tablets every 4 hours PRN pain.

Observation of Resident #1's medications on hand on 08/13/19 at 3:08pm revealed:
-There was a blister pack of 30 tablets of tylenol 325mg, administer two tablets twice a day, with a fill date of 08/06/19 and 26 tablets remaining in the blister pack.
-There was a second blister pack of 60 tablets of tylenol 325mg, each casing contained two tablets, and the directions were to administer 2 tablets (650mg) twice a day and 650mg every 4 hours PRN pain, with 28 casings of 2 tablets each remaining in the blister pack. The fill date for the tylenol was 08/01/19.

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D 358	Continued From page 14 Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/13/19 at 3:45pm revealed: -The pharmacy staff was responsible for computer generated entries of medication orders received from the facility staff and signed by a physician. -The facility staff was responsible for entering physician orders generated after the first of the new month, when the MARs were delivered from the pharmacy. -These new orders, handwritten by the staff during the month, would be computer generated entries by the pharmacy staff for the following month. -The pharmacy delivered the MARs to the facility at the end of the current month for the following month. -The pharmacy had delivered the Resident #1's medications on a cycle fill basis since June 2019. -The current order on profile, dated 03/11/19, for Resident #1's tylenol 325mg was two tablets, 650mg, twice a day, and 650mg every 4 hours PRN pain. -There was no order on file for Resident #1's scheduled tylenol, 325mg administer two tablets (650mg) twice a day, to be discontinued on 06/24/19. Interview with a medication aide (MA) on 08/14/19 at 1:38pm revealed: -The medications for the residents had been on a cycle fill for a few months. -Any overstock medications were kept in the bottom drawer of the medication cart. -The Resident Care Coordinator (RCC) and the Memory Care Coordinator (MCC) added handwritten entries of new physician orders prescribed during the month. -MA's could fax new orders to the pharmacy and	D 358		

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fill out the New Order Tracking form.
-If she filled out the New Order Tracking Form, she would submit it to the RCC or MCC to review.
-She did not enter orders onto the MARs.
-She administered medications as entered on the MARS.
-Resident #1's tylenol 325mg was entered on the MARS as two tablets, 650mg, twice a day, and 650mg every 4 hours PRN pain.

Interview with the MCC on 08/13/19 at 4:05pm revealed:
-There was a New Order /Medication Refill Checklist to be completed by whomever received a new order.
-Upon completion, the checklist was placed in the MCC or RCC office for their verification and signature.
-In signing the checklist, the MCC or RCC were verifying all steps of the process were complete.
-There was a New Order form filled out for the tylenol order 325mg, administer two tablets every 4 hours PRN pain.
-She had completed the form and thought the order read to discontinue the previous tylenol PRN order only.
-She had forwarded the New Order Form to the pharmacy with only a change in the tylenol PRN order.
-Resident #1 continued to receive tylenol 325mg, administer 2 tablets twice a day.

Telephone interview with the physician assistant (PA) on 08/14/19 at 4:05pm revealed:
-He prescribed Resident #1's medications.
-He had discontinued all previous tylenol orders on 06/24/19 and wrote an order for tylenol 325mg, administer two tablets every 4 hours as needed for pain.
-He thought Resident #1 did not need tylenol

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325mg scheduled twice a day since staff had not reported observing the resident in pain.
-He left a PRN order on the MAR when Resident #1 may experience pain.
.He did not know the scheduled tylenol 325mg, two tablets twice a day had continued since 06/24/19.
-He expected the facility staff to administer medications as he had ordered for the health of his residents.

Interview with the Administrator on 08/14/19 at 8:15am revealed:
-The MCC and RCC were responsible for medication oversight, physician orders, resident appointments to physicians and any other medical or physical needs of the residents.
-The MCC, RCC or MAs could fill out a New Order Form when new orders were transmitted to the pharmacy.
-She did not know the MCC had misinterpreted a physicians order for Resident #1.
-She did not know Resident #1 received tylenol 625mg from 06/24/29 through 08/14/19 in error.

Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable.

b. Review of Resident #1's physician's orders dated 03/11/19 revealed an order for simvastatin 20 mg, one tablet to be administered every evening.

Review of Resident #1's June 2019 through August 2019 Medication Administration Record (MAR), from 06/01/19 through 08/13/19 revealed:
-There was a computer generated entry for simvastatin 20mg to be administered every evening at 8:00pm, for elevated lipid levels..

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D 358	Continued From page 17 -Simvastatin 20mg was documented as administered every evening at 8:00pm from 06/01/19 through 08/13/19. Observation of Resident #1's medications on hand on 08/13/19 at 3:08pm revealed there was no simvastatin 20mg available for administration. Interview with the MA on 08/13/19 at 3:17pm revealed: -She had ordered the simvastatin 20mg last evening, on 08/12/19, and it would arrive at the facility this evening. -She administered the simvastatin 20mg to Resident #1 when she worked second shift. -She administered the last dose of simvastatin to Resident #1 on 08/12/19. Observation of Resident #1's medications on hand on 08/14/19 at 10:05am revealed: -There was a blister pack of 30 tablets of simvastatin 20mg, with a fill date of 08/08/19, and 29 tablets remaining. -Resident #1 had missed 6 doses of simvastatin. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/13/19 at 3:45pm revealed: -Resident #1's medications were on a cycle fill from the pharmacy. -The last fill date for simvastatin 20mg was a blister pack of 30 tablets filled on 08/08/19. -No other requests for simvastatin had been received from the facility. Telephone interview with the physician assistant (PA) on 08/14/19 at 4:05pm revealed: -He prescribed simvastatin 20mg to Resident #1 for elevated cholesterol, which could lead to health complications.	D 358		

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D 358	Continued From page 18 -He expected the facility staff to administer medications as he had ordered for the health of his residents. Interview with the Memory Care Coordinator (MCC) on 08/14/19 at 8:15am revealed: -Medication cart audits were completed once a week on Wednesday evening by the third shift MAs. -MAs on every shift were responsible to check their medications when administering with the MARs for accuracy. -For residents with medications that were not on cycle fill, the MAs should re-order the medication when there were 8 tablets or less remaining in the blister pack. -A Refill Request Form was completed when a medication refill was needed, and the form was faxed to the pharmacy. -If the medication was not received within 24 hours, the MA should call the pharmacy and follow up. -The MCC, RCC and two MAs reviewed the MARs at the end of the month and compared it to the MARs for the following month to ensure accuracy. Interview with the Resident Care Coordinator (RCC) and Administrator on 08/14/19 at am revealed: -The facility had been on cycle fill since June 2019. -The facility started "fresh" in July with cycle fill medications. the cycle fill medications in July were all administered from the day they were filled. -There were no other medications in the facility. -The pharmacy sent the medications with a 30 day supply. -There should have been 5 tablets of simvastatin	D 358		

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20mg administered since 08/08/19.
-The RCC did not know why only one tablet had been removed from the blister pack dated 08/08/19.
-The MAs did not count the tablets in the blister pack or check the creams and drops for usage, during a cart audit.

2. Review of Resident #5's current FL2 dated 12/22/18 revealed diagnoses included diabetes mellitus, hypertension, neurogenic bladder and prostate cancer.

a. Review of Resident #5's current FL2 dated 12/22/18 revealed there was an order for amlodipine besylate 5mg, used to treat hypertension, administer 1 tablet daily.

Review of Resident #5's July 2019 through August 2019 Medication Administration Record (MAR), from 07/10/19 through 08/14/19 revealed:
-There was a computer generated entry for amlodipine besylate 5mg tablet, once daily to be administered at 8:00am.
-Amlodipine besylate 5mg was documented as administered daily at 8:00am from 07/10/19 through 08/14/19.
-Thirty five doses of amlodipine besylate were documented as administered from 07/10/19 through 08/14/19.

Observation of Resident #5's medications on hand on 08/14/19 at 10:05am revealed:
-There was a blister pack of 30 tablets of amlodipine besylate 5mg with a fill date of 07/10/19 and with 6 tablets remaining.
-There was a second blister pack of 30 tablets of amlodipine besylate 5mg was in the overstock drawer of the medication cart with a fill date of 08/05/19 and 30 tablets remaining.

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D 358	Continued From page 20 Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/14/19 at 10:15am revealed: -Resident #5's medications were on a cycle fill from the pharmacy. -The last fill date for amlodipine besylate 5mg was a blister pack of 30 tablets sent on 08/08/19. -The fill date for amlodipine besylate prior to 08/08/19 was a blister pack of 30 tablets on 07/10/19. Interview with a medication aide (MA) on 08/14/19 at 3:35pm revealed: -The MA's were responsible for making sure each resident had all medications available for administration. -Resident #5's amlodipine besylate 5mg was on the medication cart.. -She did not know why 35 doses of amlodipine had been documented as administered, and only 24 tablets had been administered to Resident #5. Interview with the Resident Care Coordinator (RCC) and Administrator on 08/14/19 at 3:25pm revealed: -They did not know Resident #5's amlodipine besylate 5mg, fill date of 07/10/19 with 30 tablets, had been documented as administered 35 times. -They did not know of any overstock medications since the facility began cycle fill from the pharmacy late June. -They did not know why 35 doses of amlodipine had been documented as administered, and only 24 tablets had been administered to Resident #5. Telephone interview with Resident #5's physician assistant (PA) on 08/14/19 at 4:05pm revealed: -He prescribed amlodipine 5mg for Resident #5 for elevated blood pressure, which could lead to	D 358		

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health complications.
-He expected the facility staff to administer medications as he had ordered for the health of the residents.

b. Review of Resident #5's FL2 dated 12/22/18 revealed there was a physician's order for aspirin 81mg one tablet to be administered daily, used as a blood thinner.

Review of Resident #1's July 2019 through August 2019 Medication Administration Record (MAR), from 07/10/19 through 08/14/19 revealed:
-There was a computer generated entry for aspirin 81mg tablet, daily at 8:00am, from 07/10/19 through 08/14/19,-
-Aspirin 81mg was documented as administered daily at 8:00am from 07/10/19 through 08/14/19.
-Aspirin 81mg was documented as administered to Resident #5 thirty five times.

Observation of Resident #5's medication on hand on 08/14/19 at 10:05am revealed:
-There was a blister pack of 30 tablets of aspirin 81mg, administer daily, with a fill date of 07/10/19 and 6 tablets left in the blister pack.
-There was a blister pack of 30 tablets of aspirin 81mg, administer daily, with a fill date of 08/05/19 and 30 tablets left in the blister pack.
-There were 24 aspirin tablets administered to Resident #5 from 07/10/19 through 08/14/19.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/14/19 at 10:15am revealed:
-Resident #5's medications were on a cycle fill.
-The last fill date for aspirin 81mg daily was a blister pack of 30 tablets filled on 08/05/19.
-Prior to 08/05/19, aspirin 81mg daily, 30 tablets, was filled on 07/10/19.

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D 358	Continued From page 22 Interview with a medication aide (MA) on 08/14/19 at 1:38pm revealed: -The MA's were responsible for making sure each resident had all their medications available for administration. -Most of the residents received their medications on a cycle fill from the pharmacy. -The MAs only have to order medications if the resident has less than 8 pills in their blister pack and they are not on cycle fill. -She was not responsible for completing cart audits. Interview with the RCC and Administrator on 08/14/19 at 3:25pm revealed: -They did not know Resident #5's aspirin 81mg, fill date of 07/10/19 with 30 tablets, had been documented as administered 35 times. -They did not know of any overstock medications since the facility began cycle fill from the pharmacy late June. -They did not know why 35 doses of aspirin had been documented as administered, and only 24 tablets had been administered to Resident #5. Telephone interview with the physician assistant (PA) on 08/14/19 at 4:05pm revealed: -He prescribed aspirin 81mg once daily to keep Resident #5 from getting a blood clot which could lead to health complications. -He expected the facility staff to administer medications as he had ordered for the health of the residents c. Review of Resident #5's FL2 dated 12/22/18 revealed there was a physician's order for atorvastatin calcium 20mg, used to treat high cholesterol, administer one tablet at bedtime.	D 358		

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Review of Resident #5's July 2019 through August 2019 Medication Administration Record (MAR), from 07/10/19 through 08/14/19 revealed:
-There was a computer generated entry for atorvastatin calcium 20mg, once daily in the evening.
-Atorvastatin calcium 20mg was documented as administered daily, at 8:00pm from 07/10/19 through 08/14/19.
-Atorvastatin 20mg was documented as administered to Resident #5 thirty five times.

Observation of Resident #5's medications on hand on 08/14/19 at 10:05am revealed;
-There was a blister pack of 30 tablets of atorvastatin 20mg daily, with a fill date of 07/10/19, and thirteen tablets remaining in the blister pack.
-There was a bubble pack of 30 tablets in the overstock drawer with a fill date of 08/05/19, and thirty tablets remaining in the blister pack.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/14/19 at 10:15am revealed:
-The last fill date for atorvastatin 20mg daily was a blister pack of 30 tablets filled on 08/05/19.
-Prior to 08/05/19, atorvastatin 20mg daily, 30 tablets, was filled on 07/10/19.

Interview with the Resident Care Coordinator (RCC) and the Administrator on 08/14/19 at 3:25pm revealed:
-They did not know Resident #5's atorvastatin 20mg, fill date of 07/10/19 with 30 tablets, had 13 tablets remaining in the blister pack..
-They did not know of any overstock medications since the facility began cycle fill from the pharmacy late June.
-They did not know why 35 doses of atorvastatin

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D 358	Continued From page 24 had been documented as administered, and only 17 tablets had been administered to Resident #5. Telephone interview with the physician assistant (PA) on 08/14/19 at 4:05pm revealed: -He prescribed atorvastatin 20mg daily to Resident #5 for elevated cholesterol levels, which could lead to health complications. -He expected the facility staff to administer medications as he had ordered for the health of the residents c. Review of Resident #5's FL2 revealed there was a physician's order dated 12/22/18 for fluticasone propionate 120 metered sprays 50mcg, two sprays in each nostril every day. Review of Resident #5's June 2019 through August 2019 Medication Administration Record (MAR), from 06/01/19 through 08/14/19 revealed: -There was a computer-generated entry for fluticasone propionate 50mcg, two sprays in each nostril every day. -Fluticasone nasal spray was documented as administered daily at 8:00am from 06/01/19 through 08/14/19. Observation of Resident #5's medications on hand on 08/13/19 at 10:05am revealed: -There was a bottle of fluticasone propionate 50mcg with a computer generated label, 2 sprays into each nostril daily. -The fill date on the fluticasone bottle was 03/04/19. -There were no other bottles of fluticasone spray on the medication cart. -The fluticasone propionate bottle was three fourths full. Telephone interview with a pharmacist from the	D 358		

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D 358	Continued From page 25 facility's contracted pharmacy on 08/14/19 at 10:15am revealed: -The last fill date for fluticasone propionate 50mcg was 03/04/19. -Fluticasone was not a cycle fill medication. -The facility staff were required to call or Fax the pharmacy for a refill of fluticasone. Interview with a medication aide (MA) on 08/14/19 at 1:38pm revealed: -She administered the fluticasone nasal spray to Resident #5 when she worked first shift. -She did not know the fill date on the fluticasone bottle was 03/04/19. -She did not know the bottle was 3/4 full. -She did not know of any other fluticasone nasal spray for Resident #5. -Resident #5 had no documented refusals of fluticasone nasal spray. Interview with the Resident Care Coordinator and Administrator on 08/04/19 at 3:25pm revealed: -They did not know Resident #5's fluticasone nasal spray, fill date of 03/04/19 was three quarters full. -They did not know of any overstock medications since the facility began cycle fill from the pharmacy late June. -They did not know why the fluticasone nasal spray, dated as opened on 04/10/19, was 3/4 full. Telephone interview with the physician assistant (PA) on 08/14/19 at 4:05pm revealed: -He did not prescribe fluticasone propionate 50mcg. -It was prescribed by the previous physician for allergies. -He expected the facility staff to administer medications as ordered for the health of the residents.	D 358		

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D 358	Continued From page 26 d. Review of Resident #5's FL2 dated 12/22/18 revealed there was a physician's order for metoprolol 25mg, used to treat elevated blood pressure, to be administered twice a day . Review of Resident #5's July 2019 through August 2019 Medication Administration Record (MAR), from 07/10/19 through 08/14/19 revealed: -There was a computer generated entry for metoprolol 25mg, to be administered twice daily at 9:00am and 9:00pm. -Metoprolol 25mg was documented as administered twice daily at 9:00am and 9:00pm from 07/10/19 through 08/14/19. -Metoprolol was documented as administered 35 times in the morning and 35 times in the evening from 07/10/19 through 08/14/19. Observation of Resident #5's medications on hand on 08/14/19 at 10:05am revealed: -There was a blister pack of thirty tablets of metoprolol 25mg, administer twice daily, dispensed on 07/10/19 and identified as the morning (am), dose with 5 tablets remaining in the blister pack. -There was a blister pack of thirty tablets of metoprolol 25mg, administer twice daily, dispensed on 07/10/19 and identified as the evening (pm) dose with 19 tablets remaining in the blister pack. -There was a blister pack of thirty tablets of metoprolol 25mg, administer twice daily, dispensed on 08/05/19 with 28 tablets remaining in the blister pack. -There was a blister pack of thirty tablets of metoprolol 25mg, administer twice daily, dispensed on 08/05/19 with 30 tablets remaining in the blister pack. -There were 27 metoprolol tablets administered in	D 358		

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the morning dose from 07/10/19 through 08/14/19.
-There were 19 metoprolol tablets administered in the evening dose from 07/10/19 through 08/14/19.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/14/19 at 10:15am revealed:
-Metoprolol 25mg was a cycle fill medication.
-Sixty tablets of Metoprolol 25mg, in 2 blister packs of 30 each, were dispensed to the facility on 07/10/19.
-Sixty tablets of metoprolol 25mg , in two blister packs of 30 tablets each, were dispensed to the facility on 08/05/19.

Telephone interview with the physician assistant (PA) on 08/14/19 at 4:05pm revealed:
-He prescribed the metoprolol 25mg, twice a day, for elevated blood pressure .
-He expected the facility staff to administer medications as ordered for the health of the residents.

Interview with the Resident Care Coordinator (RCC) and the Administrator on 08/14/19 at 3:25pm revealed:
-They did not know Resident #5's metoprolol 25mg, administer twice daily, had been documented as administered 35 times in the morning and 35 times in the evening.
-They did not know of any overstock medications since the facility began cycle fill from the pharmacy late June.
-They did not know why 35 doses of metoprolol had been documented as administered in the morning, and only 27 tablets administered to Resident #5.
-They did not know why 35 doses of metoprolol

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had been documented as administered in the evening, and only 19 tablets administered to Resident #5.

e. Review of Resident #5's FL2 dated 12/22/18 revealed there was a physician's order for omeprazole 20mg delayed release (DR), used to treat gastro esophageal reflux disease (GERD), administer two tablets daily.

Review of Resident #5's July 2019 through August 2019 Medication Administration Record (MAR), from 07/10/19 through 08/14/19 revealed:
-There was a computer generated entry for omeprazole 20mg Delayed Release (DR), two tablets (40mg) once daily to be administered at 7:30am.
-Omeprazole 20mg DR, two tablets (40mg), was documented as administered daily at 7:30am, from 07/10/19 through 08/14/19.
-Omeprazole was documented as administered to Resident #5 thirty five times from 07/10/19 through 08/14/19.

Observation of Resident #5's medications on hand on 08/14/19 at 10:05am revealed:
-There was a blister pack of 60 tablets of omeprazole 20mg packaged in 2 tablets per casing, with a fill date of 07/10/19.
-There were 18 casings (36 tablets) remaining in the blister pack.
-There was a blister pack of 60 tablets of omeprazole 20mg packaged in 2 tablets per casing, with a fill date of 08/05/19.
-There were 27 casings (54 tablets) remaining in the blister pack.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/14/19 at 10:15am revealed:

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-Omeprazole 20mg DR, 2 tablets daily was a cycle fill medication.
-Sixty tablets of omeprazole DR, packaged in 2 tablets per casing, were dispensed to the facility on 07/10/19.
-Sixty tablets of omeprazole DR, packaged in 2 tablets per casing, were dispensed to the facility on 08/08/19.

Interview with the Resident Care Coordinator (RCC) and the Administrator on 08/14/19 at 3:25pm revealed:
They did not know Resident #5's omeprazole DR 40mg, fill date of 07/10/19, had been documented as administered 35 times.
-They did not know of any overstock medications since the facility began cycle fill from the pharmacy late June.
-They did not know why only 15 doses of omeprazole DR 40mg had been administered to Resident #5.

Telephone interview with the physician assistant (PA) on 08/14/19 at 4:05pm revealed:
-The omeprazole was prescribed for gastro esophageal reflux disease (GERD).
-He expected the facility staff to administer medications as ordered for the health of the residents.

f. Review of Resident #5's FL2 dated 12/22/18 revealed there was a physician's order for terazosin 2mg, used to treat symptoms of an enlarged prostate, administer one tablet at night.

Review of Resident #5's July 2019 through August 2019 Medication Administration Record (MAR), from 07/10/19 through 08/14/19 revealed:
-There was a computer generated entry for terazosin 2mg, administer once daily in the

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evening.
-Terazosin was documented as administered once daily at 8:00pm from 07/10/19 through 08/14/19.

Observation of Resident #5's medications on hand on 08/14/19 at 10:05am revealed:
-There was a blister pack of 30 tablets of terazosin with a dispense date of 07/10/19.
-There were 8 tablets remaining in the blister pack.
-Twenty two tablets of terazosin were administered to Resident #5 from 07/10/19 through 08/14/19.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/14/19 at 10:15am revealed:
-Terazosin 2mg, once daily at bedtime, was a cycle fill medication.
-Thirty tablets of terazosin were dispensed on 07/10/19.
-Thirty tablets of terazosin were dispensed on 08/05/19.

Interview with the Resident Care Coordinator (RCC) and the Administrator on 08/14/19 at 3:25pm revealed:
They did not know Resident #5's terazosin 2mg, fill date of 07/10/19 with 30 tablets, had been documented as administered 35 times.
-They did not know of any overstock medications since the facility began cycle fill from the pharmacy late June.
-They did not know why 35 doses of terazosin had been documented as administered, and only 22 tablets had been administered to Resident #5.

Telephone interview with the physician assistant (PA) on 08/14/19 at 4:05pm revealed:

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-The terazosin was prescribed for the control of the symptoms of prostate cancer.
-He expected the facility staff to administer medications as ordered for the health of the residents.

4. Review of Resident #2's FL dated 06/19/19 revealed diagnoses included bacteremia, sepsis due to methicillin resistant staphylococcus, Type II diabetes mellitus with other diabetic kidney complication, cellulitis, and hypoglycemia.

a. Review of Resident #2's FL dated 06/19/19 revealed a medication order for Amlactin Foot Cream topical to be applied twice a day.

Observation of Resident #2's medications on-hand on 08/14/19 at 9:45am revealed.
-A 3-ounce tube of Amlactin foot care with a fill date of 03/30/19 and an open date of 04/03/19 written in black ink on the tube.
-The tube of Amlactin was almost full tube of cream.

Review of Resident #2's Medication Administration Record (MAR) for June 2019 revealed:
-An entry for Amlactin foot cream, apply topically to both feet every day at 9:00am and 9:00pm.
-Amlactin foot cream was documented as administered at 9:00am and 9:00pm from 06/01/19 through 06/30/19.
-There were no days documented that Resident #2 missed any applications of the Amlactin cream applied to his feet.

Review of Resident #2's MAR for July 2019 revealed:
-An entry for Amlactin foot cream, apply topically

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to both feet every day at 9:00am and 9:00pm.
-Amlactin foot cream was documented as administered at 9:00am and 9:00pm from 07/01/19 through 07/31/19.
-There were no days documented that Resident #2 missed any applications of the Amlactin cream applied to his feet.

Review of Resident #2's MAR for August 2019 revealed:
-An entry for Amlactin foot cream, apply topically to both feet every day at 9:00am and 9:00pm.
-Amlactin foot cream was documented as administered at 9:00am and 9:00pm from 08/01/19 through 08/14/19.
-There were no days documented that Resident #2 missed any applications of the Amlactin cream applied to his feet.

Observation of Resident #2 on 08/14/19 at 9:40am revealed:
-Resident #2 was lying in bed with his legs elevated with both eyes closed.
-He was lying in bed with his legs elevated on a pillow wedge.
-Both legs were dark scaly with pimple like blister all over both legs.
-Both feet were dry and cracked.
Interview with Resident #2 on 08/14/19 at 9:40am and at 4:54 pm revealed he did complain of his legs being dry all of the time and pain in both legs and feet.

Interview with the pharmacist of Resident #2's contracted pharmacy on 08/14/19 at 4:05PM revealed:
-The Amlactin foot cream was dispensed for Resident #2 on 02/25/19 and 03/30/19.
-The cream was not typically used on-going to treat dry skin.

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-It was hard to determine how long one 3 oz tube of the foot cream would last.
-If the cream was used twice per day a 3-ounce tube could last one month or less, but no longer than a month.

Interview with a Medication Aide (MA) on 08/14/19 at 3:04pm revealed:
-She would apply the cream to Resident #2's feet and legs.
-She applied the cream to his legs at the resident's request because he felt his legs felt better.
-Resident could be stubborn at times, but she did not have a problem getting him take his medications.
-Resident #2 did refuse the Amlactin occasionally.

Telephone interview with a MA on 08/14/19 at 4:15pm revealed:
-She primarily worked second shift.
-Resident #2 would refuse the cream being applied to his feet occasionally.
-She did not document any refusals by Resident #2 nor did she notify the doctor of any refusals.

Interview with the Resident Care Coordinator (RCC) on 08/14/19 at 4:05PM revealed:
-She was aware that resident was non-compliance with some orders but not the Amlactin.
-The policy was to document on the MAR if a resident refused a medication or treatment and give the reason for the medication or treatment not administered.

Interview with the Resident Care Director (RCD) on 08/14/19 at 4:50pm revealed:
-She was informed by staff that Resident #2 had a lot of refusals with compliance with physician

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orders but not the Amlactin foot cream.
-The policy was to document on the MAR if a resident refused a medication or treatment and give the reason for the medication or treatment not administered.

Interview with the Administrator on 08/14/19 at 4:59pm revealed:
-She did not know how Resident could be receiving the cream to his feet when the last time the 3-ounce tube of foot cream was dispensed in March of 2019 and it was almost full.
-The policy was to document on the MAR if a resident refused a medication or treatment and give the reason for the medication or treatment not administered.
-The only tube of the Amlactin foot cream was on the cart.

b. Review of an order for Resident #2 dated 06/03/19 revealed: Pred Forte 1% eye drops (a steroid used to treat inflammation of the eye) was ordered one drop in the right eye daily.

Review of a order for Resident #2 dated 06/17/19 Pred Forte 1% eye drops 1 drop to the right eye four times a day for one week, 3 times a day for one week then two times a day for one week and then once a day.

Observation of Resident #2's medications on-hand on 08/14/19 at 9:45am revealed.
-There were three bottles of Pred Forte 1% eye drops with fill dates of 06/05/19; 07/10/19; and 08/05/19.
-There was one bottle of Pred Forte 1% eye drop open that was almost full with a dispense date of 06/05/19.
-There were two bottles of Pred Forte 1% eye drops with dispense dates of 07/10/19 and

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D 358	Continued From page 35 08/05/19 which were unopened. Review of Resident #2's Medication Administration Record (MAR) for June 2019 revealed: -There was an entry for Pred Forte 1% drops administered at 8:00am every day. -The Pred Forte 1% drops were documented as administered daily at 8:00am from 06/05/19 until 06/17/19 with no missed doses. -There was an entry for Pred Forte 1% drops 1 drop to be administered four times a day day. -The Pred Forte 1% drops were documented as administered four times a day at 9:00am, 12:00pm, 4:00pm, and 8:00pm from 06/18/19 until 06/30/19. Review of Resident #2's MAR for July 2019 revealed: -There was an entry for Pred Forte 1% drops administered at four times a day from 07/01/19 to 07/17/19. -The Pred Forte 1% drops were documented as administered four times a day at 9:00am, 12:00pm, 4:00pm, and 8:00pm from 07/01/19 until 07/17/19 with no missed doses. -There was an entry for Pred Forte 1% drops administered at three times a day from 07/18/19 to 07/24/19. -The Pred Forte 1% drops were documented as administered three times day at 8:00am, 2:00pm, and 8:00pm from 07/18/19 until 07/24/19 with no missed doses. -There was an entry for Pred Forte 1% drops administered at twice a day from 07/25/19 to 07/31/19. -The Pred Forte 1% drops were documented as administered twice day at 8:0am, and 8:00pm from 07/25/19 until 07/31/19 with no missed doses.	D 358		

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D 358	Continued From page 36 Review of Resident #2's MAR for August 2019 revealed: -There was an entry for Pred Forte 1% drops administered one time a day from 08/01/19 to 08/14/19. -The Pred Forte 1% drops were documented as administered once a day at 8:00am from 08/01/19 until 08/14/19 with no missed doses. Telephone interview with the pharmacist at Resident #2's contracted pharmacy on 08/14/19 at 11:00am revealed: -The Pred Forte 1% drops were dispensed in 5ml bottle. -There are 20 eyes drops per each milliliter. -A five-milliliter bottle of Pre Forte 1% drops had 100 eye drops per bottle which was a 90 supply if there was 1 drop administered into the right eye. -When the order changed to 1 drop administered into the right eye 4 times a day then the bottle would have been a 25 day supply. -When the order changed to the "tapered dose" of 1 drop into the right eye 4 times a day for 1 week, 1 drop into the right eye 3 times a day for 1 week, 1 drop into the right eye 2 times a day for a week and then 1 drop into the right eye every day from then on would have been a 30 day supply with a reorder to continue the 1 drop a day. -The facility was not on a cycle fill for Pred Forte 1% drops. -The facility requested eye drop refills when needed. -Pred Forte 1% drops were usually used to treat inflammation of the eye. -Pred Forte 1% drops were not administered correctly because you have barely used one bottle out of the 3 dispensed. Review of Resident #2's Ophthalmology	D 358		

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D 358	Continued From page 37 Assessment/Impression Plan date 06/03/19 revealed: -Resident #2 was diagnosed with Iridocyclitis (inflammation of the iris and ciliary body) of the right eye. -The physician stressed the importance of compliance with medications. -The physician explained the risk of irreversible vision loss/blindness associated glaucoma. -The chart note was sent to the "nursing facility" stressing the importance of compliance with Resident #2's medications. Review of Resident #2's Ophthalmology Assessment/Impression Plan dated 06/17/19 revealed: -The physician stressed the importance of compliance with medications. -The physician explained the risk of irreversible vision loss/blindness associated glaucoma. -A chart note was sent to the "nursing facility" stressing the importance of compliance with medications. -The physician highlighted the orders for the facility because the front page of the orders documented " new orders" were "highlighted". -The physician documented on the plan for Resident # 2 that the facility staff did not administer the eye drops every day. Interview with Resident #2 on 08/14/19 at 9:40am and at 4:54 pm revealed: -He said he was not feeling well. -He described his eyes as having an "irritation feeling," "uncomfortable feeling," and "bothersome feeling". -He felt like something was in his eye all the time. -His vision was worse in the right eye versus the left eye. -He was light sensitive at times.	D 358		

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D 358	Continued From page 38 -Staff did not put drops in his eyes daily. Telephone interview with Resident #2's ophthalmologist's clinical manager on 08/14/19 at 4:18pm revealed: -Resident #2 was followed by the ophthalmologist primarily for angle glaucoma and had previous surgeries. -On 06/03/19, Resident #2 was given the diagnosis of Iridocyclitis, which caused inflammation of the iris that could be very painful. -An order was written on 06/17/19 for Pred Forte 1% eye drops, 1 drop in the right eye 4 times a day. -A second order was written on 07/17/19 for the Pred Forte 1% eye drops, 1 drop in the right eye 4 times a day for 1 week; then, 1 drop in the right eye 3 time a day for 1 week; then 1 drop in the right eye 2 times a day for 1 week; 1 drop in the right eye daily after that. -The inflammation in the eye would continue to get worse if the physician's orders were not followed. -The eye drops were steroid drops used to prevent inflammation of the eye. Interview with a Medication Aide (MA) on 08/14/19 at 3:04pm revealed: -She had no problem administering Resident #2's eye drops. -Resident could be stubborn at times and refuse his medications on occasion. Telephone interview with a sedcond MA on 08/14/19 at 4:15pm revealed: -Resident #2 would refuse the eye drops. -She did not document any refusals by Resident #2 nor did she notify the doctor of any refusals. Interview with the RCC on 08/14/19 at 4:05pm	D 358		

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	HAL060130	A. BUILDING: _____ B. WING _____	08/14/2019

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D 358	Continued From page 39	D 358		

revealed:
-She was aware that resident was occasionally non-compliance with some orders.
-She was not aware that Resident #2 had told the physician he was not getting his eye drops.

Interview with the RCD on 08/14/19 at 4:50pm revealed:
-She was informed by staff that Resident #2 had a lot of refusals with compliance with physician orders, but there was no documentation to reflect any refusals with refusals of the eye drops.
-She was was not aware of Resident #2 receiving samples of the eye drops.
-She expected the MA's to give the eye drops as ordered and if the resident refused to document that on the MAR.

Interview with the Administrator on 08/14/19 at 4:59pm revealed:
-She was informed that Resident #2 received sample eye drops from each physician visit.
-She was was not aware of Resident #2 receiving samples of the eye drops.
-She expected the MA's to give the eye drops as ordered and if the resident refused to document that on the MAR.
4. Resident #4's current FL2 dated 07/03/19 revealed:
-Diagnoses included Alzheimer's dementia with behavioral issues, vitamin b-12 deficiency.
-There was a medication order for Vitamin B12 (used to treat vitamin deficiency) 500mcg 1 tablet twice per week.

Review of Resident #4's Resident Register revealed an admission date of 07/03/19.

Review of Resident #4's Medication Administration Record for August 2019 revealed:

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D 358	Continued From page 40 -There was an entry for Vitamin B12 500mcg one tablet every Saturday and Sunday with an administration time of 8:00am. -There was documentation the Vitamin B12 was administered 08/03/19-08/04/19 and 08/10/19-08/11/19. Observation of Resident #4's medications available for administration on 08/13/19 at 3:50pm revealed there was an over-the-counter bottle of Vitamin B12 2500mcg available for administration with the residents' name written on the bottle. Telephone interview with the facility's contracted pharmacy on 08/14/19 at 2:50pm revealed: -The pharmacy received an order for Vitamin B12 500mcg twice per week on 07/03/19. -8 tablets of Vitamin B12 was dispensed on 07/05/19 for a one-month supply. -There were no refills requested for Vitamin B12 500mcg. -Vitamin B12 500mcg was available for a refill and would be dispensed once requested. Interview with a medication aide (MA) on 08/14/19 at 2:40pm revealed: -She worked as a MA every other weekend. -She administered Vitamin B12 2500mcg tablet to Resident #4. -She did not realize the Vitamin B12 on the cart was not the correct dosage. -She did not know how the bottle of Vitamin B12 2500mcg got on the cart. Interview with the Memory Care Coordinator (MCC) on 08/14/19 at 2:45pm revealed: -When Resident #4 was first admitted to the facility, the family brought medications to the facility.	D 358		

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D 358	Continued From page 41 -The family brought the incorrect dose of Vitamin B12 and she notified the family member to pick up the Vitamin B12 2500 mcg. -She removed the Vitamin B12 from the medication cart and but it in the medication room. -She ordered Vitamin B12 from the pharmacy so that the resident could receive the correct dosage. -She placed the bottle in the office for the residents' family member to pick-up. -She did not know why the Vitamin B12 2500mcg was placed back on cart. -She expected the Vitamin B12 500mcg to be reordered from the pharmacy before it ran out. -The MAs on 3rd shift were responsible for completing cart audits to ensure medications were available for administration. -She did not know why none of the MAs recognized the incorrect dosage of Vitamin B12 was not available for administration. Telephone interview with Resident #4's primary care provider (PCP) on 08/14/19 at 4:30pm revealed: -Vitamin B12 500mcg was ordered by the previous PCP and he continued the order. -He had not ordered Vitamin B12 2500mcg for Resident #4. -He expected medications to be administered as ordered. Interview with Resident #4's responsible party on 08/14/19 at 10:52am revealed: -He brought medications to the facility when Resident #4 was first admitted. -He did not know of any issues with Resident #4's medications. -No one informed him that he needed to pick up any medication from the facility.	D 358		

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D 358	Continued From page 42 Interview with the Administrator on 08/14/19 at 4:55pm revealed: -She did not know the incorrect dosage of Vitamin B12 was administered to Resident #4. -She expected MAs to administer the correct dosage of medication. -She expected MAs to reorder medication before it ran out. -She expected cart audit to be completed every Wednesday by the third shift MAs to ensure the correct dosage of medication was on the cart. _____ The failure of the facility to administer medications as ordered related to Pred Forte eyedrops (#2) increasing the risk for inflammation of the eyes which could result in irreversible vision loss and blindness, tylenol with 100 doses administered in error after being discontinued by the provider, not administering simvastatin as ordered which could result in elevated cholesterol and health complications (#1), missed doses of aspirin which could result in increased risk for blood clots and other health complications and metoprolol tartrate as ordered missing 16 doses which could result in elevated blood pressure (#5). 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 08/14/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 28, 2019.	D 358		

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D912	Continued From page 43	D912		
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 assure residents received care and services which are adequate, appropriate and in compliance with relevant state laws and rules related to medication administration and healthcare. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure health care referral and follow up to meet the acute health care needs of Resident #2 related to scheduling an appointment for a medical imaging procedure. [Refer to Tag 0273, 10A NCAC 13F. 0902(b) Health Care (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 1 of 5 residents (Residents #1) observed during the medication pass including errors with the dosage administered of tylenol, a medication to treat pain, and for 4 of 5 residents sampled (Residents #1,	D912		

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D912	Continued From page 44 #2, #4, #5) for record review including errors with administering an as needed dosage of tylenol (650mg every 4 hours) as a scheduled dose twice a day (#1), medications not administered as ordered included simvastatin (used to decrease elevated lipid levels) (#1), amlodipine (used to treat high blood pressure and coronary artery disease), aspirin (used to thin the blood), atorvastatin (used to decrease elevated lipid levels), fluticasone spray (used to treat allergies), metoprolol (used to treat high blood pressure), omeprazole (used to treat gastro esophageal reflux disease) and terazosin (used to treat an enlarged prostate) (#5), a cream used to treat dry skin and eye drops (#2), and related to administering the incorrect dosage of a vitamin (#4). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		