Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(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 Gaston County Department of Social Services conducted a follow-up survey and complaint investigation on 09/04/19 through 09/06/19.	{D 000}		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure heat/air conditioning (AC) units were maintained in an operating condition for 2 of 43 resident rooms (Room #B18 and #B22). The findings are: Observations during the initial tour of the facility on 09/04/19 from 9:15am to 11:00am revealed the heat/AC unit in room #B18 and #B22 were not functioning properly and missing knobs. 1. Observation of resident room #B18 on 09/04/19 at 10:10am revealed: -The heat/AC unit was an individual unit mounted in the window. -The unit was not on as there was no breeze or air flow coming from the unit. -There was no knob to control the temperature or the air flow. -There was no way for the resident residing in the room to determine the temperature setting of the unit or to adjust the temperature setting to their comfort level.	D 105	Facility ordred 12 new a/c Units (were on order before visit on 9/4/19) Have replaced. all older A/C Units have been replaced w/ new Units.	9/11/19

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Burley Wooten — Manager — 10/9/19

STATE FORM 6899 7T6N12 If continuation sheet 1 of 91

Karen Polce

Received and Acknowledged 11/05/19

Division of Health Service Regulation

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D 105	Continued From page 1 -One resident in the room had a personal fan next to his bed. -The other resident closest to the window did not have a fan available for use. Interview on 09/04/19 at 10:45am with the resident in room #B18 revealed: -The resident by the door was lying on his bed with a small personal fan next to the bed. -The fan was on the high setting. -The resident reported the AC unit had not been in operating condition for "about a year". -He had reported the malfunction to the Manager and to other staff. -"Nothing had been done about it." -He brought the personal fan in usage from his home when he was admitted to the facility. -His room was always hot. Refer to interview with the housekeeping supervisor on 09/06/19 at 9:56am. Refer to interview with manager on 09/06/19 at 1:14pm. Refer to interview with the Administrator on 09/06/19 at 12:40pm. 2. Observation of resident room #B22 on 09/06/19 at 9:33am revealed: -The heat/AC unit was an individual unit mounted in the window -The unit was no sound or airflow coming from the unit. -There was no knob to control the temperature air flow. -There was no way for the resident residing in the room to determine the temperature setting of the unit or to adjust the temperature setting to their comfort level.	D 105	Will have Housekeeping Supervisor. DO Monthly log of Checking all A/C Units working properly. Retrained staff to offer resident a fan if they feel they need more air than what Unit is putting Out. Staff retrained on writing in Repair Log any issues w/ A/C Units or any repairs/problems.	9/11/19

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D 105	Continued From page 2 Interview with a resident residing in room #B22 on 09/06/19 at 11:35am revealed: -The air in his room had been "out for a while." -The unit had been blowing but it was not cold air. -He told staff several times, however nothing was done, he could not remember who he told. -There were never any knobs on the unit to adjust the temperature setting. -There was no way for him to adjust the air in his room. -He opened the window at times to get a breeze. Refer to interview with the housekeeping supervisor on 09/06/19 at 9:56am. Refer to interview with manager on 09/06/19 at 1:14pm. Refer to interview with the Administrator on 09/06/19 at 12:40pm. Interview with the Housekeeping Supervisor on 09/06/19 at 9:56am revealed: -She was responsible for ensuring heat/AC units were functioning properly in the building. -Rooms #B18 and #B22 were older units and needed to be replaced. -The facility recently ran out of replacement units and were currently on order. -She had not provided another fan for the resident in room #B22. -She did not realize room #B22's air was not functioning properly. -She recently turned the switch on the wall in room #B22 and thought it was blowing air. -She did not know until 09/05/19 that the knobs on the air unit were missing in rooms #B18 and #B22.	D 105	Housekeeping to check repair log each AM	

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D 105	Continued From page 3 Interview with the Manager on 09/06/19 at 1:14pm revealed: -She did not know the knobs were missing from the heat/AC unit in rooms #B18 and #B22. -The units in both rooms were going to be replaced, they were waiting on the air units to be delivered. -She did not know the air units were not functioning properly. - None of the residents in rooms #B18 or #B22 complained about air not functioning properly. -Staff were to record all appliances in need of repair in the workbook to be fixed. -If she would have known she would have provided the other resident in B22 with a fan to keep him cool. Interview with the Administrator on 09/06/19 at 12:40pm revealed: -He expected functioning air unit to be available for the residents. -He expected the Manager to order have replacement units available. -"We should have ordered early enough before they were no longer working".	D 105		
{D 269}	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.	{D 269}		

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{D 269}	Continued From page 4 This Rule is not met as evidenced by: Based on interview, observations, and record reviews the facility failed to provide personal care assistance based on the assessed care plan for 1 of 2 sampled resident (Resident #6) who required assistance with bathing and toileting. The findings are: Review of Resident #6's current FL2 dated 03/11/19 revealed: -Diagnoses included dementia, congestive heart failure, history of throat cancer, disability, and compression of fracture spine. -The resident was documented to be semi-ambulatory, no device was noted. -Bathing and dressing were noted under personal care assistance. -The resident was documented as incontinent with bladder and incontinent at times with bowel. Review of Resident #6's Care Plan signed by the physician on 03/11/19 revealed: -The resident needed limited assistance with toileting, bathing, dressing, grooming and personal hygiene. -The resident was semi-ambulatory with the assistance of a wheelchair. Observation of Resident #6 and his room on 09/04/19 from 09:15am-11:00am revealed: -There was a strong urine and musty odor coming from inside of Resident #6's room. -Resident #6 was lying in bed on the window side of the room asleep.	{D 269}	Any Residents that are more difficult to shower will be assigned to Monday- friday. While management is in building to assist if needed. When resident will not change Clothes and pull ups. Staff will immediatley inform SIC and management. If Staff and management	

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{D 269}	Continued From page 5 -There was a strong urine odor from the bed and surrounding area. -There was a soiled brief in the wastebasket next to the bed. -There were soiled clothing draped across the wheelchair next to his bed with a body odor. Interview with a personal care aide (PCA) on 09/05/19 at 4:30pm revealed: -The residents were on a shower schedule and received showers twice per week. -PCAs were responsible for completing showers and documenting in the binder located at the nurse station. -Resident #6 required extensive assistance with bathing, dressing and incontinent care. -Resident #6 was not able to stand long enough to complete his showers or incontinent care independently. -Resident #6 refused to be changed or cleaned. -Staff could not force residents to accept personal care assistance. - He had mentioned to the Resident Care Coordinator (RCC) once before. -The resident often used profanity and argued about taking a shower and receiving incontinent care. -The PCA would ask the resident to shower, however he was never successful. -The RCC would be responsible for contacting family and the physician to determine the next steps for the resident. Observation of Resident #6's room on 09/06/19 at 9:33am revealed: -Resident #6 was lying in bed sleeping. -The room smelled of urine and a strong musty odor. -The resident had soiled his clothes. -There were no incontinent briefs available in the	{D 269}	Still unable to have resident to cooperate then family to be notified to help get resident to take shower or change clothes/ pullups. Staff to document in chart regarding refusing and if notified family. RCC and manager to have meeting w/ resident or family to inform about importance of hygiene and bathing	

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{D 269}	Continued From page 6 room for the resident. Interview with the medication aide (MA) on 09/06/19 at 9:30am revealed: -PCAs were responsible for providing residents with a shower and incontinent care. -Resident #6 was unable to complete incontinent care or shower independently. -She smelled body odor on the resident frequently. -Resident #6 would often "put up a fuss" about receiving incontinent care and with bathing. -Resident #6's bed constantly had to be changed throughout the day because he refused to wear incontinent briefs. -Resident #6 would sit outside during the day and refused incontinence care. -The PCAs would offer incontinent care but could not force the resident to receive incontinent care. -She had notified the RCC and the Manager and at times they were able to get the resident to take a shower. -She was not sure about the Resident #6 showers because there were scheduled to be completed on second shift. Interview with Resident #6's responsible party on 09/06/19 at 9:05am revealed: -Resident #6 had dementia and refused to shower at times. -He had been notified by the facility once in the past year about the resident refusing showers. -He did not know if the resident required incontinent supplies. -He would come to the facility and assist with a shower if needed. Interview with the housekeeper on 09/06/19 at 11:59am revealed: -She was previously served as a first shift PCA	{D 269}	Staff to take out of room all soiled or dirty clothes. If resident fusses about clothes being taken out to clean then try to get clothes when resident is out of room. Clean laundry and put back in closet etc.	10/18/19

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{D 269}	Continued From page 7 who assisted Resident #6. -Resident #6 often did not like to receive showers as often as he should. -Resident #6 was scheduled to receive showers on second shift. -Once she provided a shower to Resident #6 on first shift because he was "filthy". -Resident #6 would often give the PCAs a hard time and "put up a fuss" with getting showers, however she was able to convince the resident to get a shower. -The resident complained about not getting his clothes back from laundry as a reason for not wanting to change his clothes. -Resident #6's clothes were too soiled at times that she was unable to save the clothes, she would have to throw them away. -The resident refused to wear incontinent briefs which often damaged his pants. -She remembered telling the RCC and the Manager and they were aware of the issue. Interview with the Activities Director on 09/06/19 at 11:38am revealed: -She worked first shift in a variety of roles including a MA, supervisor, PCA, Activities Director and as a office assistant at the facility. -Resident #6 was unable to complete his showers independently and required assistance of a PCA. -Resident #6 would often curse out staff, however was never physically combative. -A month ago, she and the housekeeper assisted the resident with showering and dressing because he had an odor. Interview with the Resident Care Coordinator (RCC) 09/06/19 at 12:30pm revealed: -Residents were allowed to refuse showers at least twice per month for various reasons. -She would call the families of the residents who	{D 269}		

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{D 269}	Continued From page 8 were difficult to shower so they might assist with encouraging the resident to shower. -She had not had any residents fight showers or incontinent care in a while. -Resident #6 received his showers on second shift and no staff had complained to her about to being able to get him showered. -She would expect staff to let her know if there were issues with getting the resident showered. -She had not seen him look really clean "recently". -She thought second shift PCAs had given Resident #6 his showers regularly. -Resident #6 was incontinent and should wear incontinent briefs, however he refused. -She did remember trying to get Resident #6 to wear incontinent briefs, "he just refuses". -She had not reached out to Resident #6's responsible party, "we can't make him take a shower". -Staff were signing the bath logs that Resident #6 received showers, therefore she thought they were being done. -She smelled Resident #6's room, however thought the odor was coming from the roommate. -She had not ordered any incontinent briefs for Resident #6, "no one has brought it to my attention". Interview with the Manager on 06/06/19 at 1:14pm revealed: -PCAs were responsible for getting residents bathed and completing incontinent care. -If residents were difficult and refusing personal care, she would expect them to notify her and the RCC. -She did not think anyone had told her that Resident #6 refused incontinent care and showers. -She would try to assist or move the resident's	{D 269}		

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{D 269}	Continued From page 9 showers to a different shift. -She knew Resident #6 had been provided incontinence care and had brought clothes for the resident to change into in the past. -PCAs should have been taking Resident #6 to the bathroom every hour if he was refusing to wear incontinent briefs. -She did not know Resident #6 was incontinent, the RCC was responsible for completing the Care Plan. Interview with the Administrator on 09/06/19 at 12:40pm revealed PCAs and other assigned staff should be providing personal care according to the needs of the resident, "no excuses". Attempted telephone interview with the primary care provider (PCP) on 09/05/19 at 12:45pm was unsuccessful.	{D 269}		
{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: Based on observations, interviews, and record reviews, the facility failed to provide adequate	{D 270}		

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{D 270}	Continued From page 10 supervision during meal services to prevent a resident with an order for a puree diet (Resident #7) from eating regular texture foods. The findings are: Review of Resident #7's current FL-2 dated 01/17/19 revealed diagnoses included dementia/Alzheimer's. Review of Resident #7's physician's orders dated 07/18/19 revealed an order for a puree diet. Observation of the lunch meal service on 09/04/19 from 12:05pm to 12:55pm revealed: -There were 65 residents seated in the dining room. -One staff served drinks in the dining room. -One staff placed plated food onto meal trays in the kitchen. -Two staff retrieved meal trays from the kitchen and served them to the residents in the adjacent dining room. -Resident #7 was seated at a long dining table with eleven other residents. -Resident #7 was served pureed pork loin, pureed green beans, pureed potatoes and a pureed cookie on her meal tray. -Resident #7 ate 100% of her food. -Resident #7 took a cookie from another resident's regular diet meal tray seated next to her. -Resident #7 ate 50% of the regular cookie without difficulty. -After prompting, a staff person removed the cookie from Resident #7's hand. Interview with the Activity Director (AD) on 09/04/19 at 12:50pm revealed: -She assisted in the dining room at times during	{D 270}	All residents on puree diets will be moved to feeding table so staff assigned can manage them. Residents on thickened liquids will be moved to feeding table also. Staff assigned at each meal	10/1/19

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{D 270}	Continued From page 11 the lunch meal service. -Resident #7 was ordered a puree diet. -She did not notice when Resident #7 took the cookie from the regular diet meal tray. -After prompting, she had removed the cookie from Resident #7's hand. -She did not know Resident #7 took food from other meal trays. Observation of the breakfast meal service on 09/05/19 from 7:30am to 8:16am revealed: -There were 63 residents seated in the dining room. -One staff served drinks in the dining room. -One staff placed plated food onto meal trays in the kitchen. -Two staff retrieved meal trays from the kitchen and served them to the residents in the adjacent dining room. -Resident #7 was seated at a long dining table with eleven other residents. -Resident #7 was served pureed eggs, pureed bananas and grits on her meal tray. -Resident #7 ate 100% of her food. -Resident #7 took a bowl of cereal with milk from a resident's regular diet meal tray seated next to her. -Resident #7 ate several bites of the cereal with milk without difficulty. -After prompting, a staff person removed the cereal with milk from Resident #7's place setting. Interview with a personal care aide (PCA) on 09/05/19 at 8:12am revealed: -Resident #7 was ordered a puree diet. -She was talking with another resident and did not see Resident #7 take the cereal with milk from the regular diet meal tray. -After prompting, she removed the cereal with milk from Resident #7's place setting.	{D 270}	to sit at feeding table to monitor and assist. Housekeeper SIC monitoring dining room @ breakfast and lunch. Supply SIC to monitor Dining room. assist with making sure no residents are taking off others trays.	

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{D 270}	Continued From page 12 -"She (Resident #7) does this all the time (takes food from her neighbor's regular diet meal tray)." -Staff had been instructed after the lunch meal service on 09/04/19 to seat Resident #7 at the feeding assistance table in the future so she could be more closely supervised, and she did not know why she was seated at her regular table. -Prior to 09/04/19, she had not been told to supervise Resident #7 at meal times. Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable. Interview with the Dietary Manager (DM) on 09/05/19 at 10:00am revealed: -Resident #7 had been on a puree diet for 4-5 months. -She prepared a puree meal tray for Resident #7 at every meal. -Resident #7 would routinely take food from her neighbor's regular diet meal tray, "pretty much daily." -The PCAs were responsible for meal service and supervising the residents during meals. -She had spoken to the PCAs on several occasions about supervising Resident #7 more closely because she was on a puree diet and was at risk for choking if she continued to eat regular textured foods from her neighbor's tray. -She reported to the RCC Resident #7 was taking foods from regular diet trays. Interview with a second PCA on 09/05/19 at 8:03am revealed: -Resident #7 was ordered a puree diet. -She did not know Resident #7 took food from regular diet trays. -She had never been told to provide closer	{D 270}	RCC (DOPC) and manager to check in on Dining room daily when they are in building. If neither are at facility. Activity Director will check on Dining Room. manager talked with residents regarding sharing food and guns. Told they could always get seconds 9/15/19	

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WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(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 270}	Continued From page 13 supervision to Resident #7 during meal service. Interview with the Resident Care Coordinator (RCC) on 09/06/19 at 9:40am revealed: -She provided oversight to the PCAs. -During each meal service, one PCA was responsible for placing plated food onto the meal trays in the kitchen, two PCAs were responsible for retrieving the meal trays from the kitchen and serving the trays to the residents in the dining room, and another PCA was responsible for serving drinks in the dining room and providing room assistance when call lights came on. -A supervisor was in the dining room to sit at the feeding assistance table if there was a resident at the table that required feeding assistance. -There was no staff person assigned to remain in the dining room at all times to provide supervision to the residents. -She knew Resident #7 routinely took food from regular meal trays. -She had asked the PCAs to "try to watch out for Resident #7 taking food from other meal trays." Interview with the Manager on 09/06/19 at 10:15am revealed: -She expected the four PCAs assigned to the meal service to provide enough supervision to prevent residents from taking other residents' food. -She did not know Resident #7 took food from other meal trays. Telephone interview with Resident #7's primary care provider (PCP) on 09/05/19 at 1:55pm revealed: -She was unsure why Resident #7 was on a puree diet. -She did not know of any episodes of choking or aspiration for Resident #7.	{D 270}	Will also have Sharing food and Seconds brought up at Residents Council meeting in October. Minutes on 10/25/19 10/25/19	

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{D 276}	Continued From page 15 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 physicians' orders were implemented for 1 of 6 sampled residents (Resident #8) related to preparation instructions for a scheduled renal ultrasound. The findings are: Review of Resident #8's current FL-2 dated 08/26/19 revealed: -Diagnoses included chronic kidney disease and vascular dementia. -There was documentation Resident #8 was intermittently disoriented. Review of Resident #8's "Renal Ultrasound Instruction" sheet posted on the Dietary Manager's (DM) office wall on 09/04/19 at 10:15am revealed: -Resident #8 was scheduled for a renal ultrasound on 09/04/19 at 1:00pm with an arrival time of 12:45pm. -Resident #8 was to have no food six hours prior to the appointment. -Resident #8 was to drink only clear liquids during the six hours prior to the appointment. Observation of the lunch meal service on	{D 276}	RCC to put note on Residents door day before appt that they are NPO. also will place reminder Note beside residents bed. NPO note placed @ front desk and for Dietary.	10/9/19

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{D 270}	Continued From page 14 -Resident #7 was being followed by a palliative care provider. -She had no specific expectations for the facility in providing supervision to their residents during meal time. -"The facility just needs to follow their own protocol (for providing supervision)." Telephone interview with Resident #7's palliative care provider on 09/06/19 at 12:05pm revealed: -Resident #7 had been under the services of palliative care for several years. -She did not order a puree diet for Resident #7 and thought she was on a regular diet. -Resident #7 may have returned from a hospital visit with an order for the puree diet. -Due to Resident #7's progressive decline in health, she would prefer she be on a regular "comfort food." -She expected the facility to have enough staff in the dining room to provide close supervision to the residents while eating. Interview with the Administrator on 09/06/19 at 12:37pm revealed: -He relied on the RCC and Manager to oversee the operations of the facility. -He agreed residents should be supervised closely enough to prevent sharing of food.	{D 270}		
{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	{D 276}		

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{D 276}	Continued From page 16 09/04/19 from 12:05pm to 12:55pm revealed: -Resident #8 was served water, tea, pork loin, potatoes, green beans and a slice of bread. -Resident #8 drank all her water and ate all her potatoes and green beans, drank 25 percent of her tea, ate 50 percent of her bread and none of her pork loin. Interview with the DM on 09/04/19 at 12:55pm revealed: -She thought Resident #8 was scheduled for a renal ultrasound today and was not supposed to eat lunch. -She did not know why Resident #8 had been served lunch. -The Resident Care Coordinator (RCC) was responsible for communicating to the servers when a resident could not eat lunch. Interview with the RCC on 09/04/19 at 1:00pm revealed: -She allowed dietary staff to serve Resident #8 lunch because Resident #8's appointment for a renal ultrasound on 09/04/19 was cancelled. -The facility had cancelled Resident #8's appointment because she had reported to staff, she had eaten a snack cake and drank an orange drink in her room earlier that morning. Interview with Resident #8 on 09/05/19 at 9:33am revealed: -She did not know she had an appointment for a renal ultrasound until the transportation driver came to take her around 12:00pm on 09/04/19. -The transportation driver asked her if she had eaten or drank anything and she reported to her she had eaten a snack cake and drank an orange colored drink from the snacks she kept in her room. -The transportation driver then told her the	{D 276}	Reminder note sent out on Quickmar to staff SIC and mid aide re NPO Transport to notify resident, SIC, mid aides and Dietary the AM of appt. RCC to notify manager when residents are NPO so she can follow up to make sure aware being followed	10/9/19

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{D 276}	Continued From page 17 appointment would have to be rescheduled. -No one had told her prior to 09/04/19 she had an appointment for a renal ultrasound or that she could have only clear liquids in the six hours before the appointment. -She assumed a renal ultrasound had been scheduled for her because she "only had one kidney and had been having problems with it; lots of UTIs (urinary tract infections)." Interview with the transportation driver on 09/05/19 at 12:12pm revealed: -Resident #8 was scheduled for a renal ultrasound on 09/04/19. -When she went to Resident #8's room to take her to her appointment, she asked her if she had eaten or drank anything. -Resident #8 reported to her she had eaten a snack cake and drank an orange drink from the snacks she kept in her room. -The RCC was responsible for communicating to the residents any preparation instructions for scheduled appointments, and she thought the RCC had communicated to Resident #8 the day prior to her appointment. -Resident #8 "got confused and was forgetful at times." Interview with the RCC on 09/06/19 at 9:40am revealed: -Resident #8 had an appointment for a renal ultrasound scheduled for 09/04/19 at 12:45pm. -The appointment had to be rescheduled for 09/30/19 because Resident #8 did not know she was not supposed to eat solid food 6 hours prior to the appointment. -She did not know why Resident #8 was scheduled for the renal ultrasound. -When the facility received an order for preparation instructions for scheduled	{D 276}		

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{D 276}	Continued From page 18 appointments, it was her responsibility to communicate the information to all staff and to the resident. -She made a copy of the instruction sheet and posted it in the kitchen for the DM and posted it at the front desk for the personal care aides (PCAs) and medication aides (MAs) the day prior to the appointment. -She had verbally informed Resident #8 on 09/03/19 she had an upcoming appointment on 09/04/19 for a renal ultrasound and informed her she could have nothing to eat or drink other than clear liquids after she woke up on the morning of 09/04/19. -For residents who had cognitive impairment and could not remember not too eat, she would typically have the staff bring them near the front desk so they could be reminded frequently and supervised more closely. -She did not think to instruct staff to bring Resident #8 to the front desk on the morning of her appointment because she was so used to Resident #8 being able to remember details prior to her stay at the SNF. Interview with the Manager on 09/06/19 at 10:15am revealed: -When the facility received preparation instructions for scheduled appointments, it was the RCC's responsibility to communicate those instructions to the dietary staff, PCAs and MAs. -She expected either the RCC or the MA to remind the resident of these instructions on both the day before and the day of the appointment. Telephone interview with the medical assistant from Resident #8's Urology office on 09/05/19 at 10:51am revealed: -The Urologist ordered on 07/18/19 for Resident #8 to have a renal ultrasound performed in six	{D 276}		

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{D 276}	Continued From page 19 weeks (09/04/19). -Resident #8's ultrasound was ordered due to Resident #8 having a single kidney and recent sepsis (an infection in the bloodstream) with swelling of the kidney due to a build-up of urine and removal of a urethral stent (a thin tube inserted into the ureter to treat the urine build up and swelling). -The Urology office scheduled Resident #8's renal ultrasound appointment for 09/04/19 and it was cancelled by facility staff because Resident #8 had eaten the morning of the appointment. -Resident #8's appointment was rescheduled for 09/30/19. Attempted telephone interview with Resident #8's Urologist on 09/06/19 at 10:51am was unsuccessful. Interview with the Administrator on 09/06/19 at 12:37pm revealed he expected the Manager and the RCC to communicate preparation instructions to residents to ensure they were able to attend their scheduled appointments.	{D 276}		
{D 283}	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure all food and	{D 283}		

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{D 283}	Continued From page 20 beverage being procured, stored, prepared or served by the facility was protected from contamination related to expired canned foods, built up grease on walls and appliances, flaking paint on walls, an unclean ice machine and staff not changing their gloves during meal service. The findings are: 1. Review of the county Food Establishment Inspection Report dated 08/19/19 revealed: -The facility's kitchen was inspected on 08/19/19 and received a score of 97. -They received 1.5 demerits due to "observed inside of ice machine and meat slicer needed more detailed cleaning and sanitizing in hard to reach areas." -"Observed places on walls that need paint and or repair such as behind the ice machine. Maintain all physical facilities in good repair." Observation of the main kitchen area on 09/04/19 at 10:11am revealed: -There was a black substance around the inside rim of the ice machine door and both a pink and black substance on the inside of the ice machine. -There was grease built up on the sides of the fryer, oven, and along the walls behind these appliances. -There was an area on the wall behind the ice machine that needed painting and repair. Observation of the dry food storage area in the kitchen on 09/04/19 at 10:06am revealed there were three cans of diced peaches with an expiration date of 08/07/18. Interview with the Dietary Manager (DM) on 09/05/19 at 10:00am revealed: -She was both a cook and the DM.	{D 283}	Ice machine emptied and sanitized. Pm Repair man needs to come out and do sanitizing and cleaning every 6 months. Staff to wipe inside and out of machine weekly	9/30/19

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{D 283}	Continued From page 21 -She had a written cleaning schedule for the kitchen staff to follow. -She or another cook was responsible for cleaning each of the items on the cleaning schedule twice weekly. -The ice machine and oven were two of the items listed on the cleaning schedule. -It was her responsibility to check all items listed on the cleaning schedule to ensure they were cleaned. -She thought both the ice machine and oven had last been cleaned on 09/02/19, but she had not checked to make sure they were clean. -She was responsible for checking the dry storage room once weekly to ensure there were no expired foods and no dented cans. -She had last checked the dry storage room on 09/02/19 but did not see the can of dented peaches or the three cans of expired peaches. -She was not sure why the wall behind the ice machine had not been repaired. Interview with the Manager on 09/06/19 at 10:15am revealed: -She provided oversight to the DM. -The DM was responsible for checking the dry food storage room weekly for expired foods and signing off on a written log. -She had checked the written log to ensure the DM was completing it "for the first little bit" after she had created the log, but she had not done so recently. -She observed the kitchen for cleanliness every two weeks and would point out areas that needed to be cleaned. -She expected there to not be any expired foods in the kitchen and expected the kitchen to be maintained clean in order to prevent food contamination. -The wall behind the ice machine had not yet	{D 283}	Assigned 2nd Shift Kitchen Crew. DM to check behind to make sure cleaning weekly and cleaned every 6 months by Repair man. Wall behind Ice machine repaired and Corrected 2nd shift kitchen staff assigned to clean oven	9/20/19

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{D 283}	Continued From page 22 been repaired and painted because the painter she hired was not able to come to the facility on their agreed upon date, but he was scheduled to come back in the next few days to repair it. Interview with the Administrator on 09/06/19 at 12:37pm revealed: -He checked the kitchen daily for cleanliness and would discuss areas of concern with the DM. -He expected the kitchen to be clean and there not to be expired foods. 2. Observation of the dining room staff during the lunch meal service on 09/04/19 from 12:05pm to 12:55pm revealed: -There were four staff assisting with the lunch meal service. -One staff served drinks in the dining room. -One staff placed plated food onto meal trays in the kitchen. -Two staff retrieved meal trays from the kitchen and served them to the residents in the adjacent dining room. -All four staff wore disposable gloves. -One staff stood in the dining room and ate green beans with a fork while wearing disposable gloves. -A resident asked the staff person for a refill of coffee. -The staff person placed her bowl of green beans on a table, walked to the kitchen and retrieved the coffee pot, and then lifted the resident's coffee mug and filled it with coffee. -The staff person did not change her gloves after eating and prior to serving the resident coffee. Observation of the dining room staff during the breakfast meal service on 09/05/19 from 7:30am to 8:16am revealed: -There were four staff assisting with the breakfast	{D 283}	weekly. DM to Check and log when completed and by which Staff. 10/9/19 Manager to do weekly walk through of kitchen Check for cleanliness 10/9/19 Extra PT admin Staff (AM shift) to check Storage room weekly and log any issues and report to manager 10/9/19	

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{D 283}	Continued From page 23 meal service. -One staff served drinks in the dining room. -One staff placed plated food onto meal trays in the kitchen. -Two staff retrieved meal trays from the kitchen and served them to the residents in the adjacent dining room. -All four staff wore disposable gloves. -One staff pushed a resident's walker out into the common area wearing disposable gloves. -The staff person returned to the dining room and continued serving the residents coffee without changing her gloves. -A second staff rubbed a resident's forehead with her fingers while wearing disposable gloves. -The staff person then went to another resident, without changing her gloves, and lifted that resident's coffee mug to ask if she was going to finish her coffee. -The resident affirmed she was going to finish her coffee and picked up the coffee mug to continue drinking. Interview with the dining room staff at various times during the lunch meal service on 09/04/19 and the breakfast meal service on 09/05/19 revealed: -Dining staff always wore gloves during meal services. -All three staff knew they were to change their gloves after eating, touching residents, or their belongings and prior to serving food or drinks. -The staff had received training on when to change their gloves as recent as two months ago. -One staff reported because she had to go in and out of the dining room often to remove residents' wheelchairs and walkers, she forgot to change her gloves every time prior to serving. -A second staff reported she forgot to change her gloves because she was tending to the resident's	{D 283}	One person assigned to remove walks and wheelchairs that person Doesn't serve trays. This person Call lights and remove walks and wheelchairs assist residents out that need to leave Dining room. 10/9/19 Monitored by SIC and Housekeeper during meals 10/9/19	

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{D 283}	Continued From page 24 request and wanted to provide timely service. -A third staff "just forgot" to change her gloves prior to serving. Interview with the Manager on 09/06/19 at 10:15am revealed: -Her expectation of dining room staff was they would change their gloves each time they ate, touched a resident or their belongings and prior to serving food or drinks. -The staff had training on when to remove gloves in July 2019. -The facility had recently purchased glove dispensers and installed them in the kitchen to make changing gloves more convenient. -There was no reason why staff should not be changing their gloves when they were supposed to. -She observed meal services once weekly to ensure staff were changing their gloves, but she did not stay for the entire service. Interview with the Administrator on 09/06/19 at 12:37pm revealed: -It was difficult to get staff to change their gloves as often as they should. -It was the facility Manager's responsibility to ensure the staff changed their gloves according to the training they had received.	{D 283}		
{D 338}	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by:	{D 338}		

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{D 338}	Continued From page 25 Based on interviews the facility failed to assure the residents were treated with respect and dignity on second and third shifts when speaking to and providing care for the residents. Confidential interview with a resident on 09/04/19 at 4:00pm revealed: -Evening shift staff were often rude. -The evening shift medication aide (MA) would enter the resident's room and "thrust" the medication cup in the resident's face without addressing the resident in any way. -There were "a couple of" evening shift personal care aides (PCA) that refused to give this resident a shower in the past, and they had other PCAs assist. -When the resident approached an evening shift staff person for assistance, the resident was told "you have to ring your call bell if you want assistance." -The resident overheard an evening shift PCA call the resident a rude name to another PCA. -The resident had asked an evening shift PCA to assist with changing the resident's brief and she rudely said "I'm busy," and then she "walked to the front desk and just sat down not doing anything" so another PCA had to assist. -The resident reported most of the incidents of evening shift staff being rude to the Resident Care Coordinator (RCC), but the staff would then "verbally assault" the resident for reporting them to the RCC. Confidential interview with a resident on 09/04/19 at 10:05am revealed: -A second shift medication aide (MA) was very short when speaking to residents. -When the resident requested medication, the MA would not tell the resident when she would administer the medication requested. -This second shift MA was rude and very snappy	{D 338}	RCC scheduled to work / alter schedule to work on 2nd shift to monitor staff and help residents feel management is in the building later. Manager to do drop in visits to check on shifts that are not used to her being at facility at that time.	10/6/19

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{D 338}	Continued From page 26 when answering the resident's questions. -The second shift staff generally were rude and disrespectful interacting with residents. Confidential interview with a resident on 09/04/19 at 10:07 am revealed: -The resident needed assistance during the night (3rd shift) ambulating to the bathroom. -There was a staff person on third shift who was very nasty when this resident requested assistance to the bathroom at night. -She was very gruff and always acted as if the resident was bothering her. -The second shift staff sometimes were somewhat rough when assisting the resident to bed. Confidential interview with a resident on 09/04/19 at 10:31am revealed: -The resident stated the MA on 2nd shift was "hateful" when speaking to residents and administering medications. -The resident stated the 2nd shift MA told the resident one evening, "you will get your medication when I give them to you." Interview with an evening shift MA on 09/05/19 at 4:23pm revealed: -She thought there had been issues in the past with evening shift staff refusing to assist certain residents and being rude to them, but she thought those staff no longer worked at the facility. -When she was made aware of staff refusing to assist residents or being rude to residents, she reported it to the supervisors. Interview with an evening shift PCA on 09/05/19 at 4:35pm revealed: -Some of the evening shift PCAs would refuse to assist certain residents because those residents needed more assistance than others or because	{D 338}	Watch Cameras periodically/randomly to check what is going on in building after management leaves and weekends. Staff retrained recently on resident rights. went over issues and respect to residents in staff meeting on 10/9/19. If management observes any behavior from staff they will be replaced/reprimanded	

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{D 338}	Continued From page 27 the residents were "hateful" to the staff. -She had never refused to assist residents with their ADLs (activities of daily living). -If other staff refused to assist residents, she usually assisted them even if they were not on her assigned hall. -The staff who refused to assist residents no longer worked at the facility as of approximately two weeks ago. Interview with the RCC on 09/06/19 at 1:03pm revealed: -Residents had reported to her staff were "being hateful, especially second shift staff." -When residents complained about staff, she and the Administrator would speak to the staff person, but would not reveal which resident had complained. -She and the Administrator were working to hire a new supervisor for the evening shift who would be a "stronger leader" than the current supervisor. -She hoped hiring a new supervisor would improve the way residents were being treated on the evening shift.	{D 338}	At Resident Council meeting inform residents come to office staff with any staff issues. Changed SIC on 2nd shift on 10/7/19. to see if helps with staff issues etc.	
{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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{D 358}	Continued From page 28 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facilities policies for two of three residents (#9 and #10) observed during the medication pass including errors with a medication for eye pressures and pain (#9), and a medication for constipation and pain (#10); and for 3 of 3 sampled residents related to a medication for pain, a medication for depression, a medication for difficulty with breathing and a medication for sleep (#2), a medication for depression and neuropathy (#17), a medication used for pain (#12). The findings are: The medication error rate was 15% as evidenced by the observation of 4 errors out of 27 opportunities during the 6:45am medication pass on 09/05/19. 1. Review of Resident #10's current FL2 dated 07/15/19 revealed: -Diagnoses included spinal stenosis, lumbar radiculopathy, and memory impairment. -There was an order for Colace (a medication used to treat constipation) 100mg every day.	{D 358}	Facility and Pharmacy Installing scanners to Quickmar On 10/17/19 and Staff receiving training. When med Scanned will Popup if too early w/ red alert and won't allow. Will cut down on med errors.	10/17/19

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{D 358}	Continued From page 29 -There was an order for Tylenol (a medication used to treat pain) 500mg two times a day. Observation of the 6:45am medication pass on 09/05/19 revealed: -At 7:10am, the morning medication aide (MA) prepared 9 medications for administration to Resident #10. -The Tylenol and Colace were not included. Review of Resident #10's September 2019 electronic Medication Record (eMAR) revealed: -There was an entry for Colace 100mg two times a day documented as administered 09/01/19 - 09/04/19 at 8:00am-8:00pm every day and 09/05/19 at 8:00am. -There was an entry for Tylenol 500mg two times a day documented as administered 09/01/19 - 09/04/19 at 8:00am-8:00pm, every day and 09/05/19 at 8:00am. Observation of Resident #10's medications on hand revealed the Tylenol and Colace were available for administration. Based on the review of the September 2019 eMAR and the medication pass, the MA failed to administer the Colace 100mg and the Tylenol 500mg at 8:00am as ordered but documented both as administered. Telephone interview with Resident #10's physician on 09/05/19 at 1:32pm revealed: -She was not aware Resident #10 missed the 09/05/19 8:00am doses of Colace and Tylenol. -The Colace was ordered to keep Resident #10 from getting constipated and if she continued to not receive the Colace as ordered she could become constipated. -The Tylenol was ordered for pain and if she	{D 358}	Computer to be updated to Count Narcotics. Facility has new updated Count Sheets from pharmacy that facility is using. Control sheets from pharmacy attached to all narcotics.	10/21/19 9/30/19 10/21/19

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{D 358}	Continued From page 30 continued to not receive the Tylenol as ordered then her pain could increase. Interview with the MA on 09/06/19 at 9:45am revealed: -She was to identify the resident, match the order in the eMAR with the medication, pop out the medication out of the blister pack in to the medication cup, click the prepare, administer to the resident and the click administer. -She administered everything she was supposed to in the morning medication pass. -She did not know how she missed the Colace and Tylenol that were supposed to be administered. Interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am revealed: -The MAs were to identify the resident, match the blister pack with the order, pop the medication, click as prepared, administer to the resident and document the medications administered. -The MAs were responsible for administering the medications as ordered. Interview with the Manager on 09/06/18 at 11:55am revealed: --The MAs were responsible for administering the medications as ordered. -The MAs were to identify the resident, match the blister pack with the order, pop the medication, click as prepared, administer to the resident and document the medications administered. Interview with the Administrator on 09/06/19 at 12:30pm revealed: -The Operations Manager was responsible for all policies and procedures and the day to day operation of the facility. -The Operations Manager was responsible for	{D 358}	facility has a zero tolerance policy for pre pouring of medication effective 10/1/19. Staff Caught Prepouring meds will be terminated. RCC, manager, and 2 other assigned staff have a cart each to do monthly audits of each med On each resident. Keeping	10/1/19

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{D 358}	Continued From page 31 setting up the training for the MAs. -He expected the staff to follow the policies and procedures. 2. Review of Resident #9's current FL2 dated 06/10/19 revealed: -Diagnoses included Parkinson's Disease, hypertension, denigenerative joint disease, atrial flutter and anxiety. -An order for alphagan 0.2% eye drops (a medication used to decrease eye pressure) one drop two times a day. -An order for Diclofenac Sodium 1% Gel (a medication used to treat pain) apply 2gm to left shoulder and lower back two times a day. Observation of the 6:45am medication pass on 09/05/19 revealed: -At 7:45am, the morning medication aide (MA) prepared 10 medications for administration to Resident #9. -The alphagan and Diclofenac were not included. Review of Resident #9's September 2019 eMAR revealed: -There was an entry for alphagan 0.2% eye drops 1 drop each eye two times a day documented as administered 09/01/19 - 09/04/19 at 8:00am and 8:00pm, and 09/05/19 at 8:00am every day. -There was an entry for Diclofenac Sodium 1% Gel apply 2gm to the left shoulder and lower back two times a day documented as administered 09/01/19 - 09/04/19 at 8:00am and 8:00pm, and 09/05/19 at 8:00am was not documented as administered. Observations of Resident #9's medications on hand revealed the alphagan and the Diclofenac Sodium were available for administration.	{D 358}	log of Amount of meds and rechecking each month to ensure residents are receiving all medications. Log kept of amt started and total have next month. Any issues to be brought to manager and Rec to figure out any discrepancies in amounts. 9/15/19	

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{D 358}	Continued From page 32 Based on the review of the September 2019 eMAR's and the medication pass, the MA failed to administer alphagan 0.2% eye drops and the Diclofenac Sodium 1% Gel at 8:00am as ordered. Telephone interview with Resident #9's physician on 09/05/19 at 1:32pm revealed: -She was not aware Resident #9 missed the 09/05/19 8:00am doses of alphagan and Diclofenac. -The alphagan was ordered to keep Resident #9 eye pressures down and if she continued to not receive the alphagan as ordered her eye pressures could increase. -The Diclofenac was ordered for pain and if she continued to not receive the Diclofenac as ordered then her pain could increase. Interview with the MA on 09/06/19 at 9:45am revealed: -She was to identify the resident, match the order in the eMAR with the medication, pop out the medication out of the blister pack in to the medication cup, click the prepare, administer to the resident and the click administer. -She administered everything she was supposed to in the morning medication pass. -She did not know how she missed the alphagan 0.2% eye drops and the Diclofenac Sodium that were supposed to be administered. Interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am revealed: -The MAs were to identify the resident, match the blister pack with the order, pop the medication, click as prepared, administer to the resident and document the medications administered. -The MAs were responsible for administering the medications as ordered.	{D 358}	When carts are being counted monthly also checking meds in computer to ensure all meds are in facility. All medaides and SIC were retrained with 5 hour medTech training class given by our LTPS RN.	10/1/19

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{D 358}	Continued From page 33 Interview with the Manager on 09/06/18 at 11:55am revealed: -The MAs were responsible for administering the medications as ordered. -The MAs were to identify the resident, match the blister pack with the order, pop the medication, click as prepared, administer to the resident and document the medications administered. Interview with the Administrator on 09/06/19 at 12:30pm revealed: -The Operations Manager was responsible for all policies and procedures and the day to day operation of the facility. -The Operations Manager was responsible for setting up the training for the MAs. -He expected the staff to follow the policies and procedures. 3. Review of Resident #17's current FL2 dated 03/12/19 revealed diagnoses included neuropathy, schizophrenia, lupus and asthma. a. Review of Resident #17's current signed physician orders dated 08/16/19 revealed: -There was an order for alprazolam (used to treat depression) 1mg two times a day. -There was an order for Lyrica (used to treat neuropathy) 50mg two times a day. Review of Resident #17's May 2019 electronic Medication Administration Record (eMAR) revealed the alprazolam 1mg 2 times a day was documented as administered for 14 out of 14 doses (05/25/19 - 05/31/19 at 8:00am and 8:00pm every day). Review of Resident #17's June 2019 eMAR revealed the alprazolam 1mg 2 times a day was documented as administered for 60 out of 60	{D 358}		

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{D 358}	Continued From page 34 doses (06/01/19 - 06/30/19 at 8:00am and 8:00pm every day). Review of Resident #17's July 2019 eMAR revealed the alprazolam 1mg 2 times a day was documented as administered for 62 out of 62 doses (07/01/19 - 07/31/19 at 8:00am and 8:00pm every day). Review of Resident #17's August 2019 eMAR revealed the alprazolam 1mg 2 times a day was documented as administered for 62 out of 62 doses (08/01/19 - 08/31/19 at 8:00am and 8:00pm every day). Review of Resident #17's September 2019 eMAR revealed the alprazolam 1mg 2 times a day was documented as administered for 9 out of 9 doses (09/01/19 - 09/4/19 at 8:00am and 8:00pm, and 09/05/19 at 8:00am every day). Observation of Resident #17 medications on hand 09/05/19 at 10:00am revealed: -There was a blister pack of alprazolam 1mg to be administered two times a day, dated 06/26/19 with 2 of 30 doses left to be administered. -There were 2 blister packs of alprazolam 1mg to be administered two times a day, dated 07/23/19 with 60 of 60 doses left to be administered. -There were 2 blister packs of alprazolam 1mg to be administered two times a day, dated 08/26/19 with 60 of 60 doses left to be administered. Telephone interview on 09/05/19 at 10:25am with a representative from the facility's contracted pharmacy revealed: -On 05/24/19 60 tablets alprazolam 1mg were dispensed to the facility. -The 60 tablets dispensed on 05/24/19 were to start on 05/25/19 and would have run out on	{D 358}		

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{D 358}	Continued From page 35 06/23/19. -On 06/12/19, 60 tablets of alprazolam 1mg were dispensed to the facility. -The 60 tablets dispensed on 06/12/19 were to start on 06/13/19 and would have run out on 07/12/19. -On 06/26/19, 60 tablets of alprazolam 1mg were dispensed to the facility. -The 60 tablets dispensed on 06/26/19 were to start on 06/27/19. -On 07/23/19, 60 tablets of alprazolam 1mg dispensed to the facility. -The 60 tablets dispensed on 07/23/19 were to start on 07/24/19. -On 08/26/19, 60 tablets of alprazolam 1mg were dispensed to the facility. -The 60 tablets dispensed on 08/26/19 were to start on 08/27/19. -The alprazolam 1mg was reordered by the facility when needed. Based on the review of the May, June, July, August and September 2019 eMARs, the interview with the facility's contracted pharmacy, and the medications on hand revealed: -The staff documented the administration of 207 doses of the alprazolam 1mg tablets from 05/25/19 - 09/05/19. -Out of the 300 doses of alprazolam dispensed there should only be 93 doses left. -The facility had 122 alprazolam 1mg doses left to administer. Telephone interview with Resident #17's physician on 09/05/19 at 1:32pm revealed: -She was not aware Resident #17 missed the 09/05/19 8:00am doses of alprazolam. -The alprazolam was ordered to treat Resident #17's depression and if she continued to not receive the alprazolam as ordered her depression	{D 358}		

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{D 358}	Continued From page 36 could increase. Interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am revealed: -The MAs were to identify the resident, match the blister pack with the order, pop the medication, click as prepared, administer to the resident and document the medications administered. -The MAs were responsible for administering the medications as ordered. -The MAs were responsible for weekly medication cart audits. -She was responsible for monthly medication cart and eMAR audits. -The audits would uncover medication issues, i.e.. missing medications, refusals, order errors ect. -The last medication cart audit was preformed in July 2019 and she did not perform the August 2019 audit yet because she was catching up. -She was not aware of orders not being followed as prescribed. -There were no counts of medications to cross check with the blister packs to see if medications were administered as ordered except with controlled substances. -She was responsible for eMAR audits monthly to check behind the MAs. -The last eMAR audit was in July 2019 and had not caught up yet for the August 2019 audit. -The eMAR audits would have uncovered medications not administered as ordered by the holes, or medications not administered. -The audits would have uncovered missing medications but the controlled substance sheets would have uncovered extra or missing Lyrica, alprazolam and Hydrocodone-Acetaminophen. Refer to interview with the medication aide on 09/05/19 at 9:45am.	{D 358}		

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{D 358}	Continued From page 37 Refer to interview with a second MA on 09/05/19 at 3:30pm. Refer to interview with the Activities Director (AD) on 09/05/19 at 3:30pm. Refer to interview with the Manager on 09/06/18 at 11:55am. Refer to interview with the Administrator on 09/06/19 at 12:30pm. b. Review of Resident #17's May 2019 electronic Medication Administration Record (eMAR) revealed the Lyrica 50mg 2 times a day was documented as administered for 16 out of 16 doses (05/24/19 - 05/31/19 at 8:00am and 8:00pm every day). Review of Resident #17's June 2019 eMAR revealed the Lyrica 50mg 2 times a day was documented as administered for 60 out of 60 doses (06/01/19 - 06/30/19 at 8:00am and 8:00pm every day). Review of Resident #17's July 2019 eMAR revealed the Lyrica 50mg 2 times a day was documented as administered for 62 out of 62 doses (07/01/19 - 07/31/19 at 8:00am and 8:00pm every day). Review of Resident #17's August 2019 eMAR revealed the Lyrica 50mg 2 times a day was documented as administered for 62 out of 62 doses (08/01/19 - 08/31/19 at 8:00am and 8:00pm every day). Review of Resident #17's September 2019 eMAR revealed:	{D 358}		

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{D 358}	Continued From page 38 -The Lyrica 50mg 2 times a day was documented as administered for 7 out of 9 doses (09/01/19 - 09/03/19 at 8:00am and 8:00pm, and 09/05/19 at 8:00am every day). -The Lyrica 50mg two times a day was documented as unable to take on 09/04/19 at 8:00am and 8:00pm. Observation of Resident #17 medications on hand 09/05/19 at 10:00am revealed: -There was a blister pack of Lyrica 50mg to be administered two times a day, dated 08/30/19 with 1 of 30 doses left to be administered. -There was a blister pack of Lyrica 50mg to be administered two times a day, dated 09/04/19 with 53 of 53 doses left to be administered. Telephone interview on 09/05/19 at 10:25am with a representative from the facility's contracted pharmacy revealed: -On 05/22/19 30 tablets of Lyrica 50mg were dispensed to the facility. -The 30 tablets dispensed on 05/22/19 were to start on 05/23/19 and would have run out on 07/07/19. -On 06/06/19, 30 tablets of Lyrica 50mg were dispensed to the facility. -The 30 tablets dispensed on 06/06/19 were to start on 06/07/19 and would have run out on 06/22/19. -On 06/18/19, 30 tablets of Lyrica 50mg were dispensed to the facility. -The 30 tablets dispensed on 06/18/19 were to start on 06/19/19. -On 07/03/19, 58 tablets of Lyrica 50mg were dispensed to the facility. -The 58 tablets dispensed on 07/03/19 were to start on 07/04/19. -On 07/31/19, 58 tablets of Lyrica 50mg dispensed to the facility.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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{D 358}	Continued From page 39 -The 58 tablets dispensed on 07/31/19 were to start on 08/01/19. -On 09/04/19, 60 tablets of Lyrica 50mg dispensed to the facility. -The 60 tablets dispensed on 09/04/19 were to start on 09/05/19. -The Lyrica 50mg was reordered by the facility when needed. Based on the review of the May, June, July, August and September 2019 eMARs, the interview with the facility's contracted pharmacy, and the medications on hand revealed: -The staff documented the administration of 207 doses of the Lyrica 50mg tablets from 05/24/19 - 09/05/19. -Out of the 266 doses dispensed they should only have 59 doses left. -The facility had 54 of the Lyrica 50mg doses left to administer. Telephone interview with Resident #17's physician on 09/05/19 at 1:32pm revealed: -She was not aware Resident #17 missed the 09/05/19 8:00am doses of Lyrica. -The Lyrica was ordered for neuropathy and if she continued to not receive the Lyrica as ordered then her neuropathy could increase. Interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am revealed: -The MAs were to identify the resident, match the blister pack with the order, pop the medication, click as prepared, administer to the resident and document the medications administered. -The MAs were responsible for administering the medications as ordered. -The MAs were responsible for weekly medication cart audits. -She was responsible for monthly medication cart	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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{D 358}	Continued From page 40 and eMAR audits. -The audits would uncover medication issues, i.e.. missing medications, refusals, order errors ect. -The last medication cart audit was performed in July 2019 and she did not perform the August 2019 audit yet because she was catching up. -She was not aware of orders not being followed as prescribed. -There were no counts of medications to cross check with the blister packs to see if medications were administered as ordered except with controlled substances. -She was responsible for eMAR audits monthly to check behind the MAs. -The last eMAR audit was in July 2019 and had not caught up yet for the August 2019 audit. -The eMAR audits would have uncovered medications not administered as ordered by the holes, or medications not administered. -The audits would have uncovered missing medications but the controlled substance sheets would have uncovered extra or missing Lyrica, alprazolam and Hydrocodone-Acetaminophen. Refer to interview with the medication aide on 09/05/19 at 9:45am. Refer to interview with a second MA on 09/05/19 at 3:30pm. Refer to interview with the Activities Director (AD) on 09/05/19 at 3:30pm. Refer to interview with the Manager on 09/06/18 at 11:55am. Refer to interview with the Administrator on 09/06/19 at 12:30pm.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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{D 358}	Continued From page 41 4. Review of Resident #12's current FL2 dated 04/03/19 revealed diagnoses included depression, cerebral vascular accident, hypertension, back pain, coronary artery disease, insomnia and rhinitis. Review of Resident #12's physician's orders revealed: -A prescription dated 07/29/19 for Hydrocodone-Acetaminophen 5/325mg every day with a quantity of 7 tablets. -A prescription dated 08/07/19 for Hydrocodone-Acetaminophen 5/325mg every day with a quantity of 7 tablets. -A prescription dated 08/14/19 for Hydrocodone-Acetaminophen 5/325mg every day with a quantity of 30 tablets. Review of Resident #12's July 2019 eMAR revealed the Hydrocodone-Acetaminophen 5/325mg day was documented as administered for 2 out of 2 doses (07/30/19 - 07/31/19 at 8:00am every day). Review of Resident #12's August 2019 eMAR revealed: -The Hydrocodone-Acetaminophen 5/325mg day was not documented as administered 08/01/19 - 08/07/19. -The Hydrocodone-Acetaminophen 5/325mg day was documented as administered for 24 out of 31 doses (08/08/19 - 08/31/19 at 8:00am and every day). Review of Resident #12's September 2019 eMAR revealed the Hydrocodone-Acetaminophen 5/325mg day was documented as administered for 5 out of 5 doses (09/01/19 - 09/05/19 at 8:00am every day).	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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{D 358}	Continued From page 42 Observation of Resident #12's medications on hand 09/05/19 at 10:00am revealed there was a blister pack of Hydrocodone-Acetaminophen 5/325mg day, dated 08/14/19 with 10 of 30 doses left to be administered. Telephone interview on 09/05/19 at 10:25am with a representative from the facility's contracted pharmacy revealed: -On 07/29/19, a prescription for Hydrocodone-Acetaminophen 5/325mg and 7 tablets were dispensed to the facility. -The 7 tablets dispensed on 07/29/19 were to start on 07/30/19 and would have run out on 08/04/19. -On 08/07/19, a prescription for 7 tablets of Hydrocodone-Acetaminophen 5/325mg were dispensed to the facility. -The 7 tablets dispensed on 08/07/19 were to start on 08/08/19 and would have run out on 08/14/19. -On 08/14/19, a prescription for 30 tablets of Hydrocodone-Acetaminophen 5/325mg were dispensed to the facility. -The 30 tablets dispensed on 08/14/19 were to start on 08/15/19 and would have run out on 09/13/19. -The Hydrocodone-Acetaminophen was reordered by the facility when needed. Based on the review of Resident 12's July, August and September 2019 eMARs, the interview with the facility's contracted pharmacy, and the medications on hand revealed: -The staff documented the administration 31 doses of the Hydrocodone-Acetaminophen 5/325mg tablets from 07/30/19 - 09/05/19. -The facility should only have 15 doses left. -The facility had 10 Hydrocodone-Acetaminophen 5/325mg doses left.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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{D 358}	Continued From page 43 Telephone interview with Resident #12's physician on 09/05/19 at 1:32pm revealed: -She was not aware Resident #1 missed doses of Hydrocodone-Acetaminophen. -The Hydrocodone-Acetaminophen was ordered to treat Resident #12's pain and if she continued to not receive the Hydrocodone-Acetaminophen as ordered her pain could increase. Interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am revealed: -The MAs were to identify the resident, match the blister pack with the order, pop the medication, click as prepared, administer to the resident and document the medications administered. -The MAs were responsible for administering the medications as ordered. -The MAs were responsible for weekly medication cart audits. -She was responsible for monthly medication cart and eMAR audits. -The audits would uncover medication issues, i.e.. missing medications, refusals, order errors ect. -The last medication cart audit was performed in July 2019 and she did not perform the August 2019 audit yet because she was catching up. -She was not aware of orders not being followed as prescribed. -There were no counts of medications to cross check with the blister packs to see if medications were administered as ordered except with controlled substances. -She was responsible for eMAR audits monthly to check behind the MAs. -The last eMAR audit was in July 2019 and had not caught up yet for the August 2019 audit. -The eMAR audits would have uncovered medications not administered as ordered by the	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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{D 358}	Continued From page 44 holes, or medications not administered. -The audits would have uncovered missing medications but the controlled substance sheets would have uncovered extra or missing Lyrica, alprazolam and Hydrocodone-Acetaminophen. Refer to interview with the medication aide on 09/05/19 at 9:45am. Refer to interview with a second MA on 09/05/19 at 3:30pm. Refer to interview with the Activities Director (AD) on 09/05/19 at 3:30pm. Refer to interview with the Manager on 09/06/18 at 11:55am. Refer to interview with the Administrator on 09/06/19 at 12:30pm. --- 5. Review of Resident #2's current FL2 dated 04/03/19 revealed diagnoses included rheumatoid arthritis (RA), chronic obstructive pulmonary disease (COPD), hypertension, and insomnia. a. Review of Resident #2's FL2 dated 04/03/19 revealed there was a physician's order for MS Contin 30mg every 8 hours, prescribed for the treatment of chronic pain. Review of Resident #2's June 2019 electronic Medication Administration Record (eMAR), from 06/01/19 through 06/30/19 revealed: -There was a computer generated entry for MS Contin 30mg three times daily, scheduled to be administered at 12:00am, 8:00am and 4:00pm. -There was documentation MS Contin 30mg was	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

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WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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{D 358}	Continued From page 45 administered three times a day from 06/01/19 through 06/22/19, and 06/25/19 through 06/30/19. -There was documentation MS Contin 30mg was not administered from 06/22/19 through 06/24/19. -The documented reason entered on the eMAR by the MAs was "resident physically unable to take the medication." Interview with Resident #2 on 09/04/19 at 10:05am revealed: -Resident #2 experienced chronic pain in his back and legs due to his RA. -He was prescribed MS Contin three times a day for the pain. -He had been administered MS Contin for "about a year or so." -He usually received his medications as scheduled, but earlier in the summer there were several days MS Contin was not available for administration. -The primary care physician (PCP) left a prescription for the MS Contin with the staff each month to send to the pharmacy for the medication. -It was on a Friday (in June) and he was told by the MA the MS Contin had "run out" and the prescription that was left by the PCP was not able to be located. -"I went from Friday to Tuesday without the MS Contin and I went through withdrawal." -He described the withdrawal symptoms he experienced as "being nauseous, weak and had the chills all weekend". Interview with the medication aide (MA) on 09/05/19 at 11:20am revealed: -She worked first shift as a MA supervisor. -She remembered a time in the early summer when Resident #2's MS Contin was not available for administration.	{D 358}		

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	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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{D 358}	Continued From page 46 -It was her weekend off and the MA on duty contacted her and asked why Resident #2's MS Contin was not available for administration. -The pharmacy representative reported they had not received a recent prescription for Resident #2's MS Contin from the prescribing physician. -She did not remember the time frame Resident #2's MS Contin was not available for administration. -She did not know if Resident #2 experienced withdrawal symptoms since she did not work that weekend. -There was no documentation in the progress notes Resident #2 was feeling ill that weekend. Telephone interview with the PCP on 09/05/19 at 1:32pm revealed: -She hand delivered narcotic prescriptions to the RCD when she completed her acute and follow up visits with the residents. -If the RCD was not in the building, she would hand deliver the narcotic prescription to the MA supervising the shift. -She always had the MAs sign for receipt of the prescription in a book the PCP kept with her. -She did not have her computer in front of her and did not remember if Resident #2 missed several doses of MS Contin in June. -She did not remember if Resident #2's MS Contin prescription was unable to be located and sent to the pharmacy. -She did not remember if she wrote a replacement prescription for MS Contin in June for Resident #2. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/06/19 at 9:20am revealed: -The primary physician must write a new prescription each month for residents who are	{D 358}		

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	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 47 prescribed this type of narcotic medication. -Resident #2's MS Contin 30mg, to be administered three times a day, required a new prescription every 30 days. -When the pharmacy received the new prescription for MS Contin, the tablets were sent in a blister pack the same evening in the tote. -There were 90 tablets of MS Contin for Resident #2 delivered to the facility on 05/15/19 and 90 tablets of MS Contin were delivered on 06/24/19. -The thirty tablets sent on 05/15/19 would have been completed on 06/16/19. -If Resident #2 did not receive his scheduled dosage of MS Contin, he would have experienced withdrawal symptoms within 24 to 48 hours. -Withdrawal symptoms would have manifested as nausea, headache and muscle aches. Interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am revealed: -When the PCP wrote a narcotic prescription, she hand delivered the prescription to the RCD. -The facility procedure, when receiving a narcotic prescription, was to copy the original prescription, place the copy in the resident's record, and place the original narcotic prescription in the pharmacy tote box in the medication room. -If the RCD was not in the building, the PCP would hand deliver the prescription to the MA supervisor on that shift. -The PCP required the MA receiving the prescription to sign as verification the MA had received the narcotic prescription. -The MA was to follow the facility process when receiving a narcotic prescription. -The MA who received Resident #2's MS Contin prescription from the physician, the week of June 17th, left the original prescription on the RCD's desk and it was never found. The MA did not follow the facility procedure.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 48 -The pharmacy did not receive Resident #2's MS Contin prescription, the week of June 17th) and the medication was not sent. -The PCP determined the prescription had not been filled at any other pharmacy and wrote another prescription on 06/24/19. -The MAs documented on the eMAR "resident physically unable to take the medication" when a medication was not available for administration. Interview with the Manager on 09/06/19 at 10:55am revealed: -The PCP hand delivered narcotic prescriptions to the RCD to be processed and sent to the pharmacy. -There was a time in June the RCD was not in the building and the MA supervisor signed for the prescription and did not follow the facility policy for the processing of narcotic prescriptions. -An investigation determined the prescription was not filled in any other pharmacy and the PCP wrote a new prescription for Resident #2's MS Contin. -She knew Resident #2's MS Contin was not available for administration for a "few" doses due to the prescription not located in the RCD office -It was not reported to her that Resident #2 had withdrawal symptoms over the weekend. Interview with the Administrator on 09/06/19 at 12:37pm revealed narcotic prescriptions should only be handled by the Manager or the RCD. b. Review of Resident #2's FL2 dated 04/03/19 revealed there was a physician's order for cymbalta 30mg capsule, take with a 60mg capsule to equal 90mg at bedtime, prescribed for the treatment of depression. Review of Resident #2's August 2019 and	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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{D 358}	Continued From page 49 September 2019 electronic Medication Administration Records (eMARs), from 08/12/19 through 09/05/19 revealed: -There was a computer generated entry for cymbalta 30mg, one capsule every evening, scheduled to be administered at 8:00pm. -There was a computer generated entry for cymbalta 60mg, one capsule every evening, scheduled to be administered at 8:00pm. -There was documentation cymbalta 30mg was administered every evening from 08/12/19 through 09/05/19. -There was documentation cymbalta 60mg was administered every evening from 08/12/19 through 09/05/19. -There was documentation cymbalta 30mg was administered 24 of 24 possible opportunities 08/12/19 through 09/05/19. -There was documentation cymbalta 60mg was administered 24 of 24 possible opportunities 08/12/19 through 09/05/19. Observation of Resident #2's medications on hand on 09/05/19 at 11:15am revealed: -There was a 30 tablet blister pack of cymbalta 30mg with a fill date of 08/12/19, to be completed on 09/11/19, with 16 remaining tablets. -There was a 30 tablet blister pack of cymbalta 30mg with a fill date of 09/04/19, with 30 remaining tablets. -There was a 30 tablet blister pack of cymbalta 60mg with a fill date of 08/12/19, to be completed on 09/11/19, with 29 remaining tablets. -There was a 30 tablet blister pack of cymbalta 60mg with a fill date of 09/04/19, with 30 remaining tablets. -There was no other cymbalta 30mg or 60mg on hand, available for administration. Telephone interview with a pharmacist from the	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 50 facility's contracted pharmacy on 09/06/19 at 9:20am revealed: -Resident #2's medications were on a cycle fill. -Resident #2 had an active order for cymbalta 30mg one capsule every evening. -Resident #2 had an active order for cymbalta 60mg one capsule every evening. -There was a 30 tablet blister pack of cymbalta 30mg for Resident #2 sent to the facility on 08/12/19. -There was a 30 tablet blister pack of cymbalta 60mg for Resident #2 sent to the facility on 08/12/19. -There was a 30 tablet blister pack of cymbalta 30mg for Resident #2 sent to the facility on 09/04/19. -There was a 30 tablet blister pack of cymbalta 60mg for Resident #2 sent to the facility on 09/04/19. -If cymbalta was stopped abruptly, the resident could experience withdrawal symptoms manifested as increased depression and anxiety. Interview with a second MA on 09/05/19 at 3:30pm revealed: -The MAs were responsible for weekly medication cart audits to match the medication on hand to the eMAR order entry, order medications that needed to be refilled and to remove medications that had been discontinued or expired. -The Resident Care Director (RCD) was responsible for monthly medication cart audits. Interview with the RCD and the Manager on 09/06/19 at 10:20am revealed: -The MAs were responsible for weekly medication cart audits. -The RCD was responsible for monthly medication cart and eMAR audits. -The audits should uncover medication issues,	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 51 such as missing medications, refusals, errors with order entries and discontinued medications. -She did not know medications were not being administered as prescribed. -There were no count of medications to cross check with the blister packs to determine if medications were administered as ordered, with the exception of controlled substances. Interview with the Administrator on 09/06/19 at 12:37pm revealed: -He did not know some medications were not administered as ordered. -Medications should be administered as prescribed by the physician. Attempted return phone call from the physician on 09/05/19 was unsuccessful. c. Review of Resident #2's FL2 dated 04/03/19 revealed there was a physician's order for Atrovent HFA, 2 puffs every 6 hours, prescribed for the treatment of COPD. Review of Resident #2's July 2019 through September 2019 electronic Medication Administration Records (eMARs), from 07/01/19 through 09/04/19 revealed: -There was a computer generated entry for Atrovent HFA, inhale 2 puffs every 6 hours, scheduled to be administered daily at 2:00am, 8:00am, 2:00pm and 8:00pm. -There was documentation Atrovent inhaler was administered 46 of 52 possible opportunities from 07/18/19 through 7/31/19. -There was documentation Atrovent inhaler was administered 120 of 124 opportunities from 08/01/19 through 08/31/19. -There was documentation Atrovent inhaler was administered 16 of 16 possible opportunities from	{D 358}		

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	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

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{D 358}	Continued From page 52 09/01/19 through 09/04/19. Observation of Resident #2's medications on hand on 09/05/19 at 11:15am revealed: -There was an Atrovent inhaler, in a cardboard box, with a handwritten open date of "07/18." -The counter window identifying the remaining doses in the inhaler showed "zero" medication left in the device. -There was a second unopened Atrovent inhaler in the medication cart for Resident #2 dated 08/31/19. Interview with the MA on 09/05/19 at 11:25am revealed: -She had administered the last dose of the Atrovent inhaler to Resident #2 this morning at 8:00am. -She administered the 8:00am and 2:00pm Atrovent inhaler to Resident #2 when she administered medications on this cart. -She did not know why the Atrovent inhaler, open date of 07/18, had not been completed before today. -"I can not say for sure, but it seems he (Resident #2) may not have been administered the Atrovent inhaler every 6 hours (as prescribed)." Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/06/19 at 9:20am revealed: -Resident #2 had an active order for Atrovent HFA, 2 puffs every 6 hours. -Atrovent HFA had been filled on 07/17/19 and 08/31/19. -Based on the prescribed dosage, the Atrovent inhaler dispensed 07/17/19, would have been completed in 25 days (08/12/19). -A resident who was not receiving the prescribed dosage of Atrovent HFA may experience	{D 358}		

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{D 358}	Continued From page 53 wheezing or shortness of breath. Interview with the Resident Care Director (RCD) and Manager on 09/06/19 at 10:20am revealed: -She was not aware orders were not followed as prescribed. -She did not know Resident #2's Atrovent inhaler was being documented as administered when there was none left in the inhaler and the additional inhaler had not been opened. -The Atrovent inhaler was opened on 07/18/19, and at the prescribed administration, contained medication for 25 days. -There were no count of medications to cross check with the blister packs to determine if medications were administered as ordered, with the exception of controlled substances. d. Review of Resident #2's FL2 dated 04/03/19 revealed there was a physician's order for Melatonin 5mg, prescribed at bedtime for sleep. Review of Resident #2's August 2019 and September 2019 electronic Medication Administration Records (eMARs), from 08/12/19 through 09/05/19 revealed: -There was an entry for Melatonin 5mg daily, scheduled to be administered every evening at 8:00pm. -There was documentation Melatonin 5mg was administered 19 of 19 possible opportunities from 08/12/19 through 08/30/19. -There was documentation Melatonin 5mg was administered 5 of 5 possible opportunities from 09/01/19 through 09/05/19. -There were 24 documented administrations of Melatonin 5mg to Resident #2 from 08/12/19 through 09/05/19. Observation of Resident #2's medications on	{D 358}		

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{D 358}	Continued From page 54 hand on 09/05/19 at 11:15am revealed: -There was a blister pack of Melatonin 5mg with a fill date of 08/12/19, 30 tablets were dispensed and there were 19 remaining tablets. -There were no other blister packs of Melatonin 5mg on the medication cart or in the medication room. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/06/19 at 9:20am revealed: -Resident #2 had an active order for Melatonin 5mg, one tablet every evening at bedtime. -Resident #2's Melatonin 5mg blister pack of 30 tablets had been last filled on 08/12/19. Interview with the Resident Care Director (RCD) and Manager on 09/06/19 at 10:20am revealed: -She was not aware orders were not followed as prescribed. -She did not know Resident #2's Melatonin had not been administered as ordered. Interview with the MA on 09/05/19 at 9:45am revealed she was to identify the resident, match the order in the eMAR with the medication, pop out the medication out of the blister pack in to the medication cup, click the prepare, administer to the resident and the click administer Interview with a second MA on 09/05/19 at 3:30pm revealed: -She was trained by the nurse to administer medications. -She would identify the resident, match the eMAR with the blister pack, pop out the medication into the medicine cup, click prepare in the eMAR, administer the medication and then document the medications as administered. -The MAs were responsible for weekly medication	{D 358}		

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{D 358}	Continued From page 55 cart checks to match the medication blister packs to the eMAR for order accuracy, missing medications and out of date medications. -The last medication cart audit was preformed last week (09/26/19) and should have picked up any missing medications. -The RCD was responsible for monthly medication cart audits and would have caught the extra doses of mediations and missing doses. -She was not sure when the RCD preformed the last medication cart audit was preformed. -The only medication counts were done with the controlled substances to check to see if those medications were administered as ordered. Interview with the Activities Director (AD) on 09/05/19 at 3:30pm revealed: -She was also trained to administer medications. -She would identify the resident, match the eMAR with the blister pack, pop out the medication into the medicine cup, click prepare in the eMAR, administer the medication and then document the medications as administered. -The RCD was responsible for monthly eMAR audits. -The MAs were responsible for weekly medication cart checks to match the medication to the eMAR, missing medications and out of date medications. -The RCD was responsible for monthly medication cart audits. Interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am revealed: -The MAs were to identify the resident, match the blister pack with the order, pop the medication, click as prepared, administer to the resident and document the medications administered. -The MAs were responsible for administering the medications as ordered.	{D 358}		

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{D 358}	Continued From page 56 -The MAs were responsible for weekly medication cart audits. -She was responsible for monthly medication cart and eMAR audits. -The audits would uncover medication issues, i.e.. missing medications, refusals, order errors ect. -The last medication cart audit was preformed in July 2019 and did not perform the August 2019 audit yet because she was catching up. -She was not aware of orders not being followed as prescribed. -There were no counts of medications to cross check with the blister packs to see if medications were administered as ordered except with controlled substances. -She was responsible for eMAR audits monthly to check behind the MAs. -The last eMAR audit was in July 2019 and had not caught up yet for the August 2019 audit. -The eMAR audits would have uncovered medications not administered as ordered by the holes, or medications not administered. Interview with the Manager on 09/06/18 at 11:55am revealed: –The MAs were responsible for administering the medications as ordered. -The MAs were to identify the resident, match the blister pack with the order, pop the medication, click as prepared, administer to the resident and document the medications administered. -The MAs were responsible for weekly medication cart audits. -The RCD was responsible for monthly medication cart and eMAR audits. -The audits would uncover medication issues, i.e.. missing medications, refusals, order errors etc. -There were no counts of medications to cross	{D 358}		

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{D 358}	Continued From page 57 check with the blister packs to see if medications were administered as ordered except with controlled substances. -She was not aware of orders not being followed as prescribed. -She expected the staff to perform the audits to make sure the medication were administered as prescribed. Interview with the Administrator on 09/06/19 at 12:30pm revealed: -The Operations Manager was responsible for all policies and procedures and the day to day operation of the facility. -The Operations Manager was responsible for setting up the training for the MAs. -He expected the staff to follow the policies and procedures. The failure of the facility to administer medications as ordered related to a narcotic pain medication for a chronic condition not administered for several days causing withdrawal symptoms and a medication for COPD to ease difficulty with breathing (Resident #2), and a medication used to treat chronic back pain (Resident #12) . 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 September 5, 2019 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 21, 2019.	{D 358}		

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D 363	Continued From page 58	D 363		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by:	D 363	Facility has a no prepour policy all staff signed and trained regarding medication Prepouring	10/1/19

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D 363	Continued From page 59 Based on observations, interviews, and record reviews, the facility failed to assure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 8 of 8 residents (#11, #12, #13, #14, #15, #16, #17, #18, and #19) during the 6:45am medication pass on 09/05/19. The findings are: Observation of the medication aide (MA) outside the medication room on 09/05/19 at 6:45am revealed: -The MA had prepared morning medications for administration to residents down the 100 hall. -The MA prepulled 8 different resident's medications Residents #11 - #19 in plastic medication cups and placed the medication cups on top of the medication cart; the cups had the residents first names on the cups, and the cups were not labeled with the names of the medications, covered or sealed. -She took the medication cart with the medication cups to the upper end of the 100 hall where 8 residents were in their rooms, and placed the correct medication cup in front of each resident (after calling their name) and then gave each resident their medications (after calling their name). -The residents immediately lifted up the medication cups and took their medications. -The MA watched the residents take their medications before walking away. -The MA documented the medication administration on Resident #11 - #19 in the electronic Medication Administration Record (eMARs) prior to coming down the hall. -The MA left all medication cups on top of the medication cart as she passed out the medications.	D 363		

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D 363	Continued From page 60 1. Review of Resident #11's current FL2 dated 05/06/19 revealed diagnoses included dementia and anxiety. Review of Resident #11's current signed physician orders dated 07/15/19 revealed: -There was an order for hydroxyzine HCL (used to treat allergies) 10mg two times a day. -There was an order for vitamin D3(used to treat low vitamin D) 1000 units daily. Observation of the medication cup's contents on 09/05/19 at 6:45am revealed: -There was a hydroxyzine HCL 10mg tablet. -There was a vitamin D3 1000 units tablet. Based on observations, interviews, and record reviews it was determined Resident #11 was not interviewable. Refer to interview with the medication aide (MA) on 09/05/19 at 9:45am. Refer to interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am. Refer to interview with the Manager on 09/06/18 at 11:55am. Refer to interview with the Administrator on 09/06/19 at 12:30pm. 2. Review of Resident #12's current FL2 dated 04/03/19 revealed diagnoses included depression, cerebral vascular accident, hypertension, back pain, coronary artery disease, insomnia and rhinitis. Review of Resident #12's current signed	D 363		

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D 363	Continued From page 61 physician orders dated 07/15/19 revealed: -There was an order for aspirin (used to treat heart disease) 81mg every morning. -There was an order for docusate sodium (used to keep bowel movements regular) 100mg two times a day. -There was an order for Duloxetine HCL DR (used to improve mood, sleep and anxiety levels) 60mg a day. -There was an order for hydrocodone-acetaminophen (used to treat pain) 5/325mg every morning. -There was an order for propylthiouracil (used to treat hyperthyroidism) 50mg two times a day. -There was an order for ranitidine (used to prevent ulcers in the stomach) 75mg two times a day. Observation of the medication cup's contents on 09/05/19 at 6:45am revealed: -There was an aspirin 81mg tablet. -There was a docusate sodium 100mg gel capsule. -There was a duloxetine HCL DR 60mg capsule. -There was a hydrocodone-acetaminophen 5/325mg tablet. -There was a propylthiouracil 50mg tablet. -There was a ranitidine 75mg tablet. -There was a hydrocodone-acetaminophen 5/325mg tablet. Interview with Resident #12 on 09/05/19 at 8:00am revealed: -She routinely received her morning medication every day and night. -The MA brought her medications to her room every morning. -She could identify some of her medications by the color but not all of them.	D 363		

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D 363	Continued From page 62 Refer to interview with the medication aide on 09/05/19 at 9:45am. Refer to interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am. Refer to interview with the Manager on 09/06/18 at 11:55am. Refer to interview with the Administrator on 09/06/19 at 12:30pm. 3. Review of Resident #13's current FL2 dated 05/06/19 revealed diagnoses included Alzheimer's, bipolar disorder, vitamin D defiency, hypertension, poly neuropathy. Review of Resident #13's current signed physician orders dated 07/15/19 revealed: -There was an order for amlodipine besylate (used to treat high blood pressure) 5mg a morning. -There was an order for ferrous sulfate (used to keep bowel movements regular) 325mg a day. -There was an order for levothyroxine (used to increase thyroid levels) 50mcg every day. -There was an order for Preservision (a vitamin for the eye) with lutein 1 tablet 2 times a day. -There was an order for ranitidine (used to prevent ulcers in the stomach) 75mg two times a day. -There was an order for senexon-s (used in bowel regulation) 1 tablet two times a day. Observation of the medication cup's contents on 09/05/19 at 6:45am revealed: -There was an amlodipine besylate 5mg tablet. -There was a ferrous sulfate 325mg gel capsule. -There was a levothyroxine 50mcg tablet. -There was a Preservision with lutein 1 gel	D 363		

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D 363	Continued From page 63 capsule. -There was a ranitidine 75mg tablet. -There was a senexon-s 1 tablet. Interview with Resident #13 on 09/05/19 at 8:03am revealed: -She received medications every day. -The MA brought her medications to her room every morning. -She could not identify or verbalize the medications she took on a daily basis. Refer to interview with the medication aide on 09/05/19 at 9:45am. Refer to interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am. Refer to interview with the Manager on 09/06/18 at 11:55am. Refer to interview with the Administrator on 09/06/19 at 12:30pm. 4. Review of Resident #14's current FL2 dated 05/06/19 revealed diagnoses included diabetes, hypothyroidism and recent hip fractures with surgery. Review of Resident #14's current signed physician orders dated 07/15/19 revealed: -There was an order for loratadine (used to treat allergies) 10mg a day. -There was an order for donepezil (used to treat dementia) 10mg a day. -There was an order for escitalopram (used to treat depression and anxiety) 10mg a day. -There was an order for levothyroxine (used to treat low thyroid) 100mcg a day. -There was an order for ranitidine (used to	D 363		

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D 363	Continued From page 64 prevent ulcers in the stomach) 150mg two times a day. -There was an order for myrbetriq (used to treat bladder urgency) 25mg a day. Observation of the medication cup's contents on 09/05/19 at 6:45am revealed: -There was a loratadine 10mg tablet. -There was a donepezil 10mg tablet. -There was an escitalopram 10mg tablet. -There was a levothyroxine 100mcg tablet. -There was a ranitidine 150mg tablet. -There was a myrbetriq 25mg tablet. Interview with Resident #14 on 09/05/19 at 8:06am revealed she received medications every day, mostly in the morning. Refer to interview with the medication aide on 09/05/19 at 9:45am. Refer to interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am. Refer to interview with the Operations Manager on 09/06/18 at 11:55am. Refer to interview with the Administrator on 09/06/19 at 12:30pm. 5. Review of Resident #15's current FL2 dated 05/06/19 revealed diagnoses included type 2 diabetes, hyperlipidemia, allergic rhinitis, knee pain, hypertension, vitamin D deficiency, constipation, schizophrenia, hypokalemia and fractured patella. Review of Resident #15's current signed physician orders dated 07/15/19 revealed: -There was an order for aripiprazole (used to treat	D 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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D 363	Continued From page 65	D 363		

schizophrenia and bipolar disorders) 5mg a day.
-There was an order for benazepril HCL (used to treat high blood pressure) 40mg a day.
-There was an order for escitalopram (used to treat depression and anxiety) 20mg a day.
-There was an order for fenofibrate (used to treat hyperlipidemia) 145mg a day.
-There was an order for hydralazine (used to treat high blood pressure) 50mg three times a day.
-There was an order for hydrochlorothiazide (used to treat high blood pressure) 25mg a day.
-There was an order for Januvia (used to treat high blood sugar) 100mg every day.
-There was an order for metformin HCL (used to treat high blood sugar) 500mg a day.
-There was an order for sodium chloride (used to treat high blood pressure) 1gm a day.
-There was an order for vitamin D3 (used to treat vitamin D deficiencies) 4000 units a day.

Observation of the medication cup's contents on 09/05/19 at 6:45am revealed:
-There was a aripiprazole 5mg tablet.
-There was a benazepril HCL 40mg tablet.
-There was an escitalopram 20mg tablet.
-There was a fenofibrate 145mg tablet.
-There was a hydralazine 50mg tablet.
-There was a hydrochlorothiazide 25mg tablet.
-There was a Januvia 100mg tablet.
-There was a metformin 500mg tablet.
-There was a sodium chloride 1gm tablet.
-There was a vitamin D3 2000 units (2) tablets.

Interview with Resident #15 on 09/05/19 at 8:10am revealed:
-She received medications every day.
-The MA brought her medications to her room every morning.

Refer to interview with the medication aide on

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	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

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WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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D 363	Continued From page 66 09/05/19 at 9:45am. Refer to interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am. Refer to interview with the Manager on 09/06/18 at 11:55am. Refer to interview with the Administrator on 09/06/19 at 12:30pm. 6. Review of Resident #16's current FL2 dated 05/06/19 revealed diagnoses included pulmonary hypertension, pulmonary embolism, impaired cognition and memory and disorientation. Review of Resident #16's current signed physician orders dated 07/15/19 revealed: -There was an order for calcium 600-vitamin D3 400 (used as supplements for bone health) 600/400mg a day. -There was an order for escitalopram (used to treat depression and anxiety) 10mg a day. -There was an order for furosemide (used to treat high blood pressure) 40mg a day. -There was an order for potassium CL ER (used to treat low potassium) 20mEq a day. -There was an order for Xarelto (used to prevent blood clots from forming) 20mg a day. Observation of the medication cup's contents on 09/05/19 at 6:45am revealed: -There was a calcium 600-vitamin D3 400 600/400mg tablet. -There was an escitalopram 10mg tablet. -There was a furosemide 40mg tablet. -There was a potassium CL ER 20mEq tablet. -There was a Xarelto 20mg tablet. Interview with Resident #16 on 09/05/19 at	D 363		

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	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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D 363	Continued From page 67 8:13am revealed: -She took medication every day but could not verbalize what medications she took. -The MA brought her medications to her room every morning. Refer to interview with the medication aide on 09/05/19 at 9:45am. Refer to interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am. Refer to interview with the Operations Manager on 09/06/18 at 11:55am. Refer to interview with the Administrator on 09/06/19 at 12:30pm. 7. Review of Resident #17's current FL2 dated 03/12/19 revealed diagnoses included neuropathy, schizophrenia, lupus and asthma. Review of Resident #17's current signed physician orders dated 08/16/19 revealed: -There was an order for alprazolam (used to treat depression) 1mg two times a day. -There was an order for cranberry (used to treat frequent urinary tract infections) 400mg a day. -There was an order for docusate sodium (used to prevent constipation) 100mg a day. -There was an order for Lyrica (used to treat neuropathy) 50mg two times a day. -There was an order for meloxicam (a non-steroidal anti-inflammatory used to treat pain) 15mg a day. -There was an order for metformin (used to treat high blood sugar) 500mg two times a day. -There was an order for Mucinex ER (used as an expectorant) 600mg two times a day. -There was an order for omeprazole (used to	D 363		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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D 363	Continued From page 68	D 363		

treat acid reflux) 40mg two times a day.
-There was an order for ropinirole (used to prevent leg cramps) 0.25mg three times a day.

Observation of the medication cup's contents on 09/05/19 at 6:45am revealed:
-There was an alprazolam 1mg tablet.
-There was a cranberry 400mg tablet.
-There was a docusate sodium 100mg tablet.
-There was a Lyrica 50mg tablet.
-There was a meloxicam 15mg tablet.
-There was a metformin 500mg tablet.
-There was a Mucinex ER 600mg tablet.
-There was an omeprazole 40mg tablet.
-There was a ropinirole 0.25mg tablet.

Interview with Resident #17 on 09/05/19 at revealed:
-She took medications every day and could identify most of her medications.
-The MA brought her medications to her room every morning.

Refer to interview with the medication aide on 09/05/19 at 9:45am.

Refer to interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am.

Refer to interview with the Operations Manager on 09/06/18 at 11:55am.

Refer to interview with the Administrator on 09/06/19 at 12:30pm.

8. Review of Resident #18's current FL2 dated 05/06/19 revealed diagnoses included alcohol-induced cognitive dysfunction and depression.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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D 363	Continued From page 69 Review of Resident #18's current signed physician orders dated 07/15/19 revealed: -There was an order for loratadine (used to treat allergies) 10mg a day. -There was an order for escitalopram (used to treat anxiety and depression) 5mg a day. -There was an order for folic acid (used to help the body make new cells) 1mg a day. -There was an order for vitamin B-12 (used to help the body make new cells) 1000mcg a day. Observation of the medication cup's contents on 09/05/19 at 6:45am revealed: -There was a loratadine 10mg tablet. -There was an escitalopram 5mg tablet. -There was a folic acid 1mg tablet. -There was a vitamin B-12 1000mcg tablet. Interview with Resident #18 on 09/05/19 at 8:30am revealed: -She took very little medications but could not tell what they were. -The MA brought her medications to her room every morning. Refer to interview with the medication aide on 09/05/19 at 9:45am. Refer to interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am. Refer to interview with the Operations Manager on 09/06/18 at 11:55am. Refer to interview with the Administrator on 09/06/19 at 12:30pm. Interview with the medication aide on 09/05/19 at 9:45am revealed: -She "pre-pours" 8 residents' medications every	D 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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D 363	Continued From page 70 morning that she worked. -She had to because the computer would not work at end of the hall. -She labeled 8 medication cups with the resident's name on it, put the correct medication in the cup for that resident, and placed the filled medication cups on top of the medication cart and documented the medications as administered in the electronic Medication Administration Record (eMAR). -She then took the medication cart to the end of the hall and dispensed each medication cup to the resident that each cup belonged to. -She administered "every medication that she documented in the eMAR". -She thought she was to only write the resident's name on the cups and that was all. -She considered pre-pouring of medications as per the facility's policy. Interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am revealed: -The MAs were to identify the resident, match the bubble pack with the order, pop the medication, administer to the resident and document the medications administered. -There was no policy to pre-pour medications. -The MAs were to give the medications to each resident completely before going to the next resident. -She expected the MAs to take the cart to where the internet worked and dispense to one resident at a time and if staff needed to prepare the medications at a different location then they should do so one resident at a time. -She did not know a MA was pre-pouring medications. Interview with the Manager on 09/06/18 at 11:55am revealed:	D 363		

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D 363	Continued From page 71 -The policy was not to pre-pour medications. -She did not know a MA was pre-pouring medications. -The MA received training to administer medications to one resident at a time. Interview with the Administrator on 09/06/19 at 12:30pm revealed: -The Operations Manager was responsible for all policies and procedures and the day to day operation of the facility. -The Operations Manager was responsible for setting up the training for the MAs. -He expected the staff to follow the policies and procedures.	D 363		
{D 378}	10a NCAC 13F .1006 (b) Medication Storage 10a NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration and not accessible to residents in the facility during a medication pass for 2 of 8	{D 378}	facility how has a no pre pour Policy which all medAides have signed. Management to come in and watch med passes randomly	10/1/19

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{D 378}	Continued From page 72 residents (#12 and #17). The findings are: Observation of the medication aide (MA) outside the medication room on 09/05/19 at 6:45am revealed: -The MA had prepared morning medications for administration to 8 residents down the 100 hall. -The MA prepared 7 oral medications for Resident #12, and 9 oral medications for Resident #17, in a plastic medication cups and placed the medication cup aside on top of the medication cart; the cups had the residents first names on them, and the cups were not labeled, covered or sealed. -She took the medication cart with the medication cups on top to the upper end of the 100 hall where 8 residents were in their rooms. -She went into each residents room and left the remaining cups unattended on top of the cart. -The MA left the medication cups on top of the medication cart unattended as she passed out the medications from 6:45am-7:10am. 1. Review of Resident #12's current FL2 dated 04/03/19 revealed diagnoses included depression, cerebral vascular accident, hypertension, back pain, coronary artery disease, insomnia and rhinitis.. Review of Resident #12's current signed physician orders dated 07/15/19 revealed: -There was an order for aspirin (used to treat heart disease) 81mg every morning. -There was an order for docusate sodium (used to keep bowel movements regular) 100mg two times a day. -There was an order for Duloxetine HCL DR (used to improve mood, sleep and anxiety levels)	{D 378}	At least twice monthly on different Meds. will document which Med Pass and which Staff monitored. Scanners being placed on Carts to help w/ Med Pass and keep errors down. Carts being counted monthly and logs kept for amounts and	10/19/19

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WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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{D 378}	Continued From page 73 60mg a day. -There was an order for hydrocodone-acetaminophen (used to treat pain) 5/325mg every morning. -There was an order for propylthiouracil (used to treat hyperthyroidism) 50mg two times a day. -There was an order for ranitidine (used to prevent ulcers in the stomach) 75mg two times a day. Observation of the medication cup's contents on 09/05/19 at 6:45am revealed: -There was an aspirin 81mg tablet. -There was a docusate sodium 100mg gel capsule. -There was a Duloxetine HCL DR 60mg capsule. -There was a hydrocodone-acetaminophen 5/325mg tablet. -There was a propylthiouracil 50mg tablet. -There was a ranitidine 75mg tablet. -There was a Hydrocodone-Acetaminophen 5/325mg tablet. Observation of the medication aide (MA) outside the medication room on 09/05/19 at 6:45am revealed the MA left the medication cups on top of the medication cart unattended as she passed out the medications from 6:45am-7:10am. 2. Review of Resident #17's current FL2 dated 03/12/19 revealed diagnoses included neuropathy, schizophrenia, lupus and asthma. Review of Resident #17's current signed physician orders dated 08/16/19 revealed: -There was an order for alprazolam (used to treat depression) 1mg two times a day. -There was an order for cranberry (used to treat frequent urinary tract infections) 400mg a day. -There was an order for docusate sodium (used	{D 378}	Checked against previous month amounts. third shift SIC/ medaides still checking carts/ Dates on meds and sending out any D/C'd meds	10/19/19

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	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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{D 378}	Continued From page 74 to prevent constipation) 100mg a day. -There was an order for Lyrica (used to treat neuropathy) 50mg two times a day. -There was an order for meloxicam (a non-steroidal anti-inflammatory used to treat pain) 15mg a day. -There was an order for metformin (used to treat high blood sugar) 500mg two times a day. -There was an order for Mucinex ER (used as an expectorant) 600mg two times a day. -There was an order for omeprazole (used to treat acid reflux) 40mg two times a day. -There was an order for ropinirole (used to prevent leg cramps) 0.25mg three times a day. Observation of the medication cup's contents on 09/05/19 at 6:45am revealed: -There was an alprazolam 1mg tablet. -There was a cranberry 400mg tablet. -There was a docusate sodium 100mg tablet. -There was a Lyrica 50mg tablet. -There was a meloxicam 15mg tablet. -There was a metformin 500mg tablet. -There was a Mucinex ER 600mg tablet. -There was an omeprazole 40mg tablet. -There was a ropinirole 0.25mg tablet. Observation of the medication aide (MA) outside the medication room on 09/05/19 at 6:45am revealed the MA left the medication cups on top of the medication cart unattended as she passed out the medications from 6:45am-7:10am. Interview with a medication aide (MA) on 09/05/19 at 9:45am revealed: -She left the medications on the top of the medication cart in order to pass them quickly. -She always put the name of the resident on the medication cup. -She did not know if pre-pulling medications the	{D 378}		

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	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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{D 378}	Continued From page 75 residents' medication cups must be labled with the names of the medications, closed or sealed and maintained in a secure manner. Interview with the Activities Director (AD) on 09/05/19 at 3:30pm revealed: -She was also trained to administer medications. -All medications were to be secured at all times until actually administering to a resident. Interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am revealed all controlled substances were to be kept secured at all times until administering them to a resident. Interview with the Manager on 09/06/18 at 11:55am revealed: -All medications were to be kept secured until administration especially controlled substances. -The MAs were not to place medications on top of the medication cart and left unattended. -MAs were responsible for giving each resident their medications before moving to the next resident. -MAs were trained to pass medications to one resident at a time and secure all medications at all times. -The policy was to secure the medications at all times. Interview with the Administrator on 09/06/19 at 12:30pm revealed: -The Operations Manager was responsible for all policies and procedures and the day to day operation of the facility. -He expected the staff to follow the policies and procedures. The facility failed to assure medications were	{D 378}		

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{D 378}	Continued From page 76 maintained under locked security or under direct supervision of staff in charge of medication administration and left Resident #12's and #17's medications on the medication cart unattended. The facility's failure to assure that medications were stored under secure conditions placed the residents at substantial risk for harm which constitutes a Type B Violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on September 6, 2019. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 28, 2019.	{D 378}		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure records of the administration of controlled substances were maintained, accurate and reconciled for 2 of 5 residents sampled (Residents #12 and #17) who were prescribed controlled substances. The findings are:	D 392	SeePage 30 per Beverly W.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

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D 392	Continued From page 77 1. Review of Resident #17's current FL2 dated 03/12/19 revealed diagnoses included neuropathy, schizophrenia, lupus and asthma. Review of Resident #17's current signed physician orders dated 08/16/19 revealed: -There was an order for alprazolam (used to treat depression) 1mg two times a day. -There was an order for Lyrica (used to treat neuropathy) 50mg two times a day. a. Telephone interview on 09/05/19 at 10:25am with a representative from the facility's contracted pharmacy revealed: -On 05/24/19, an order for alprazolam 1mg two times a day and 60 tablets were dispensed to the facility. -On 06/12/19, 60 tablets of alprazolam 1mg were dispensed to the facility. -On 06/26/19, 60 tablets of alprazolam 1mg were dispensed to the facility. -On 07/23/19, 60 tablets of alprazolam 1mg were dispensed to the facility. -On 08/26/19, 60 tablets of alprazolam 1mg were dispensed to the facility. -The pharmacy did not send a control substance count sheet (CSCS) with the medications when dispensed. Review of Resident #17's May 2019 electronic Medication Administration Record (eMAR) revealed the alprazolam 1mg 2 times a day was documented as administered for 14 out of 14 doses (05/25/19 - 05/31/19 at 8:00am and 8:00pm every day). Review of Resident #17's June 2019 eMAR revealed the alprazolam 1mg 2 times a day was documented as administered for 60 out of 60	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 09/06/2019

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D 392	Continued From page 78 doses (06/01/19 - 06/30/19 at 8:00am and 8:00pm every day). Review of Resident #17's July 2019 eMAR revealed the alprazolam 1mg 2 times a day was documented as administered for 62 out of 62 doses (07/01/19 - 07/31/19 at 8:00am and 8:00pm every day). Review of Resident #17's August 2019 eMAR revealed the alprazolam 1mg 2 times a day was documented as administered for 62 out of 62 doses (08/01/19 - 08/31/19 at 8:00am and 8:00pm every day). Review of Resident #17's September 2019 eMAR revealed the alprazolam 1mg 2 times a day was documented as administered for 9 out of 9 doses (09/01/19 - 09/4/19 at 8:00am and 8:00pm, and 09/05/19 at 8:00am every day). Review of Resident #17's May 2019 Controlled Substance Count Sheet (CSCS) for alprazolam 1mg two times a day revealed: -The alprazolam 1mg tablets dispensed on 05/24/19 were documented on the CSCS as 90 tablets instead of the 60 that were dispensed for routine administration two times a day from 05/25/19 to 05/31/19. -There were 77 alprazolam 1mg tablets were administered out of the 90. -The total alprazolam 1mg tablets dispensed should have been 14 tablets with 46 remaining. -There were 76 tablets documented left on 05/31/19. Review of Resident #17's June 2019 CSCS for alprazolam 1mg two times a day. -The beginning count on 06/01/19 was 76 instead of 77.	D 392		

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D 392	Continued From page 79 -The alprazolam 1mg tablets were documented for routine administration two times a day from 06/01/19 to 06/11/19 for a total of 55 tablets left to dispense. -The entries for 06/07/19 to 06/21/19 were not documented. -The alprazolam 1mg tablets were documented on the CSCS for routine administration two times a day from 06/22/19 to 06/26/19 for a total of 25 tablets left. -On 06/27/19 there was documentation of 90 new alprazolam 1mg tablets were received from the pharmacy with a new total of 115 tablets left. -The alprazolam 1mg tablets were documented on the CSCS for routine administration two times a day from 06/27/19 to 06/30/19 for a total of 107 tablets left. Review of Resident #17's July 2019 CSCS for alprazolam 1mg two times a day. -The CSCS beginning count on 07/01/19 was 106. -The alprazolam 1mg tablets were documented on the CSCS for routine administration two times a day from 07/01/19 to 07/13/19 for a total of 82 tablets left. -On 07//13/19, there were 60 alprazolam 1mg tablets left with a new total of 142 tablets left to be dispensed. -The alprazolam 1mg tablets were documented on the CSCS for routine administration two times a day from 07/13/19 to 07/14/19 for a total of 139 tablets left. -On 07/14/19 the CSCS documented 30 of the alprazolam 1mg tablets were removed and placed on the alprazolam 1mg tablets as needed sheet and 109 was left to be administered. -The alprazolam 1mg tablets were documented on the CSCS for routine administration two times a day from 07/14/19 to 07/23/19 for a total of 90	D 392		

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D 392	Continued From page 80 tablets left. -On 07/24/19, there were 60 alprazolam 1mg tablets were received with a new total of 150 tablets left to dispense. -The alprazolam 1mg tablets were documented on the CSCS for routine administration two times a day from 07/24/19 to 07/27/19 for a total of 142 tablets left. -On 07/27/19, at 10:00pm a new count was preformed and documented there was one missing tablet. The Administrator was notified making the new count 141 left. -The alprazolam 1mg tablets were documented on the CSCS for routine administration two times a day from 07/28/19 to 0731/19 for a total of 133 tablets left. Review of Resident #17's August 2019 CSCS for alprazolam 1mg two times a day. -The beginning count on 08/01/19 was 133 left. -The alprazolam 1mg tablets were documented on the CSCS for routine administration two times a day from 08/01/19 to 08/26/19 for a total of 82 tablets left. -There were no CSCS documented after 08/26/19. Based on the review of the May, June, July, August and September 2019 eMARs, the CSCS, and the medications on hand revealed: -The staff documented the administration of 208 doses of the alprazolam 1mg tablets from 05/25/19 - 09/05/19. -The facility should only have 92 doses left to administer. -The facility had 121 alprazolam 1mg doses left to administer and documented 103 doses as of 08/27/19 left to administer on the CSCS. b. Telephone interview on 09/05/19 at 10:25am	D 392		

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D 392	Continued From page 81 with a representative from the facility's contracted pharmacy revealed: -On 05/22/19, an order for Lyrica 50mg two times a day and 30 tablets were dispensed to the facility. -On 06/06/19, 30 tablets of Lyrica 50mg two times day were dispensed to the facility. -On 06/18/19, 30 tablets of Lyrica 50mg two times day were dispensed to the facility. -On 07/03/19, 58 tablets of Lyrica 50mg two times day were dispensed to the facility. -On 07/31/19, 58 tablets of Lyrica 50mg two times day were dispensed to the facility. -On 09/04/19, 60 tablets of Lyrica 50mg two times day were dispensed to the facility. -The pharmacy did not send a control substance count sheet (CSCS) with the medications when dispensed. Review of Resident #17's May 2019 electronic Medication Administration Record (eMAR) revealed the Lyrica 50mg 2 times a day was documented as administered for 18 out of 18 doses (05/23/19 - 05/31/19 at 8:00am and 8:00pm every day). Review of Resident #17's June 2019 eMAR revealed the Lyrica 50mg 2 times a day was documented as administered for 60 out of 60 doses (06/01/19 - 06/30/19 at 8:00am and 8:00pm every day). Review of Resident #17's July 2019 eMAR revealed the Lyrica 50mg 2 times a day was documented as administered for 62 out of 62 doses (07/01/19 - 07/31/19 at 8:00am and 8:00pm every day). Review of Resident #17's August 2019 eMAR revealed the Lyrica 50mg 2 times a day was	D 392		

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D 392	Continued From page 82 documented as administered for 62 out of 62 doses (08/01/19 - 08/31/19 at 8:00am and 8:00pm every day). Review of Resident #17's September 2019 eMAR revealed: -The Lyrica 50mg two times a day was documented as administered for 7 out of 9 doses (09/01/19 - 09/03/19 at 8:00am and 8:00pm, and 09/05/19 at 8:00am every day). -The Lyrica 50mg two times a day was documented as unable to take on 09/04/19 at 8:00am and 8:00pm. Review of Resident #17's May 2019 CSCS for Lyrica 50mg two times a day revealed the CSCS for 05/24/19 to 05/31/19 were not documented. Review of Resident #17's June 2019 CSCS for Lyrica 50mg two times a day revealed: -The CSCS for 06/01/19 to 06/21/19 were missing. -On 06/22/19, it was documented 28 Lyrica 50mg tablets left to dispense. -The Lyrica 50mg tablets were documented on the CSCS for routine administration two times a day from 06/22/19 to 06/30/19 for a total of 11 tablets left. Review of Resident #17's July 2019 CSCS for Lyrica 50mg two times a day revealed: -The beginning count on 07/01/19 was 11 tablets left to dispense. -The Lyrica 50mg tablets were documented on the CSCS for routine administration two times a day from 07/01/19 to 07/03/19 for a total of 5 tablets left. -On 07/03/19, there was documented 58 Lyrica 50mg tablets left with a new total of 63 tablets left.	D 392		

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D 392	Continued From page 83 -The Lyrica 50mg tablets were documented on the CSCS for routine administration two times a day from 07/03/19 to 07/31/19 for a total of 7 tablets left. Review of Resident #17's August 2019 CSCS for Lyrica 50mg two times a day revealed: -The CSCS beginning count on 08/01/19 was left to dispense. -On 08/01/19 there was documented 58 Lyrica 50mg tablets left with a new total of 65 tablets left. -The Lyrica 50mg tablets were documented on the CSCS for routine administration two times a day from 08/01/19 to 08/27/19 for a total of 12 tablets left. -There were no CSCS documented after 08/27/19. Based on the review of the May, June, July, August and September 2019 eMARs, the CSCS, and the medications on hand revealed: -The staff documented the administration of 207 doses of the Lyrica 50mg tablets from 05/24/19 - 09/05/19. -The facility should only have 59 doses left to administer. -The facility had 54 tablets of the Lyrica 50mg doses left to administer. -The CSCS documented 12 tablets as of 08/27/19 to be administered. Refer to interview with the medication aide on 09/05/19 at 9:45am. Refer to interview with a second MA on 09/05/19 at 3:30pm. Refer to interview with the Activities Director (AD) on 09/05/19 at 3:30pm.	D 392		

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D 392	Continued From page 84 Refer to interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am. Refer to interview with the Manager on 09/06/18 at 11:55am. Refer to interview with the Administrator on 09/06/19 at 12:30pm. 2. Review of Resident #12's current FL2 dated 04/03/19 revealed diagnoses included depression, cerebral vascular accident, hypertension, back pain, coronary artery disease, insomnia and rhinitis. Review of Resident #12's physician's orders revealed: -A prescription written on 07/29/19 for Hydrocodone-Acetaminophen 5/325mg every day with a quantity of 7 tablets. -A prescription written on 08/07/19 for Hydrocodone-Acetaminophen 5/325mg every day with a quantity of 7 tablets. -A prescription written on 08/14/19 for Hydrocodone-Acetaminophen 5/325mg every day with a quantity of 30 tablets. Telephone interview on 09/05/19 at 10:25am with a representative from the facility's contracted pharmacy revealed: -On 07/29/19, an order for Hydrocodone-Acetaminophen 5/325mg day and 7 tablets were dispensed to the facility. -On 08/07/19, 7 tablets of Hydrocodone-Acetaminophen 5/325mg day were dispensed to the facility. -On 08/14/19, 30 tablets of Hydrocodone-Acetaminophen 5/325mg day were dispensed to the facility.	D 392		

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D 392	Continued From page 85 -The pharmacy did not send a control substance count sheet (CSCS) with the medications when dispensed. Review of Resident #12's July 2019 eMAR revealed the Hydrocodone-Acetaminophen 5/325mg every day was documented as administered for 2 out of 2 doses (07/30/19 - 07/31/19 at 8:00am every day). Review of Resident #12's August 2019 eMAR revealed -The Hydrocodone-Acetaminophen 5/325mg every day was documented as administered for 24 out of 31 doses. -The Hydrocodone-Acetaminophen 5/325mg every day was documented as not administered 08/08/19 - 08/31/19 at 8:00am and every day. Review of Resident #12's September 2019 eMAR revealed the Hydrocodone-Acetaminophen 5/325mg every day was documented as administered for 5 out of 5 doses (09/01/19 - 09/05/19 at 8:00am every day). Review of Resident #12's July 2019 CSCS for Hydrocodone-Acetaminophen 5/325mg every day revealed the CSCS entries for 07/30/19 to 07/31/19 were missing. Review of Resident #17's August 2019 CSCS for Hydrocodone-Acetaminophen 5/325mg every day revealed: -The CSCS entries for 08/01/19 to 08/07/19 were not documented. -The CSCS beginning count on 08/08/19 was 7 left. -The Hydrocodone-Acetaminophen 5/325mg tablets were documented on the CSCS for routine administration every day from 08/01/19 to	D 392		

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D 392	Continued From page 86 08/26/19 for a total of 82 tablets left. -There were no CSCS entries documented after 08/26/19. Based on the review of Resident 12's July, August and September 2019 eMARs, the CSCS, and the medications on hand revealed: -The staff documented the administration 31 doses of the Hydrocodone-Acetaminophen 5/325mg tablets from 07/30/19 - 09/05/19. -The facility should have 15 doses left to administer. -The facility had 10 of Hydrocodone-Acetaminophen 5/325mg doses left to administer. -The CSCS documented as of 08/31/19 there were 15 tablets left. Refer to interview with the medication aide on 09/05/19 at 9:45am. Refer to interview with a second MA on 09/05/19 at 3:30pm. Refer to interview with the Activities Director (AD) on 09/05/19 at 3:30pm. Refer to interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am. Refer to interview with the Manager on 09/06/18 at 11:55am. Refer to interview with the Administrator on 09/06/19 at 12:30pm. --- Interview with the medication aide on 09/05/19 at 9:45am revealed: -She was to sign out the CSCS sheet for each	D 392		

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D 392	Continued From page 87 controlled substance she administered to the residents. -The MAs were responsible for filling out the CSCS when a new controlled substance because the pharmacy did not supply them. -At the beginning of each shift the off going MA and the on coming MA counted all controlled substances and made sure they matched the CSCSs. -The last count she did was today (09/05/19) and she did not think there were any problems with the counts. Interview with a second MA on 09/05/19 at 3:30pm revealed: -She was to sign out the CSCS sheet for each controlled substance she administered to the residents. -The pharmacy did not supply the CSCS and the MAs were responsible for filling out a CSCS with all new controlled substances. -There was a count preformed at the beginning of each shift with the off going MA and the on coming MA. -If there was an discrepancy in the count she would report them to the RCD and the Manager. -She did not have any problems with the counts. Interview with the Activities Director (AD) on 09/05/19 at 3:30pm revealed: -She was also trained to administer medications. -When she administered controlled substances she would document in the CSCS and on the eMAR. -When she received a new controlled substance from the pharmacy, she would fill out a new CSCS and document the count at that time of the medications received. -There was a controlled substance count at the beginning of every shift.	D 392		

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D 392	Continued From page 88 -She did not have any problems with the counts but if there were the issues were to be reported to the RCD and the Manager. Interview with the Resident Care Director (RCD) on 09/06/19 at 10:20am revealed: -The MA were responsible for signing out the medication for each controlled substance they removed for the residents. -The MAs were responsible for starting a new CSCS when a new controlled substance. -A count of controlled substances were completed at the beginning of each shift the off going MA and the on coming MA. -The MAs were responsible for informing her of any of the issues with the controlled substances. -The MAs were responsible for placing the monthly CSCS in her office for her to file. -She did not have time to place them in a binder yet so she had to search through piles to find the CSCS for certain resident requested. -Some CSCS were missing and could not be located that day. -She reviewed the CSCS monthly and did not see any issues with the CSCS. Interview with the Manager on 09/06/18 at 11:55am revealed: -She expected the MA to sign out the CSCS sheet for each controlled substance they administered. -The pharmacy did not send CSCS so the MA filled out a new sheet with each controlled substance delivered. -There were controlled substance counts preformed at the beginning of each shift. -The MAs were responsible for informing her and the RCD of any of the issues with the controlled substances. -The MAs were responsible for placing the	D 392		

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D 392	Continued From page 89 monthly CSCS in the RCD's office for the RCD to review and file. -She did not know there were inconsistencies related to the number of narcotics on hand compared to the CSCS documentation. Interview with the Administrator on 09/06/19 at 12:30pm revealed: -The Operations Manager was responsible for all policies and procedures and the day to day operation of the facility. -He expected the staff to follow the policies and procedures.	D 392		
{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 federal and state laws and rules related to administering medications as ordered by a physician and medications are stored and maintained in a safe manner, not accessible to residents in the facility.	{D912}		

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WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(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
{D912}	Continued From page 90 The findings Are: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facilities policies for two of three residents (#9, and #10) observed during the medication pass including errors with a medication for eye pressures and pain (#9), and a medication for constipation and pain (#10); and for 1 of 3 sampled residents (#2) related to a medication for pain, a medication for depression, a medication for difficulty with breathing and a medication for sleep not administered as prescribed. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. Based on observations and interviews, the facility failed to assure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration and not accessible to residents in the facility. [Refer to Tag 358, 10A NCAC 13F .1006(b) Medication Storage (Type B Violation)].	{D912}		