STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT CENTE	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on October 2-4, 2019 and October 7, 2019 with an exit conference via telephone on October 7, 2019.	{D 000}	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physician orders were implemented for 1 of 5 sampled residents (#3) with orders for continuous oxygen. The findings are: Review of Resident #3's current FL-2 dated 06/10/19 revealed: -Diagnoses included chronic obstructive pulmonary disease exacerbation, hypertension, sleep apnea, chronic lower extremity edema, and type II diabetes mellitus.	{D 276}	All med tech are to be trained on proper implementation of written procedures, treatments or orders from physicians and other licensed health professionals by LHPS Nurse by 10/31/19. All care staff to be trained on oxygen procedures including the storage, availability of and order implementation for all oxygen supplies by Executive Director by 11/21/19. The Community's policy and procedures on oxygen storage to be monitored weekly by the Director of Resident Care to ensure proper storage and availability of oxygen tanks. Furthermore, when the community receives an order or change of order for oxygen, the Director of Resident Care will review the physician order and ensure it is implemented.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gillian Dreyer | TITLE: Director | (X6) DATE: 11/7/19

Reviewed and accepted 11/12/19 Kathy Gray

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{D 276}	Continued From page 1 -There was an order for continuous oxygen at 4 liters (L). Review of Resident #3's electronic Medication Administration Record (eMAR) for July, August, and September 2019 revealed there was no entry for documentation of the administration of oxygen. Observation of Resident #3 at various times from 10/02/19 through 10/03/19 revealed: -Resident #3 did not have oxygen in place when she was in the hallways and dining hall. -Resident #3 did not appear to have difficulty breathing. Observation of Resident #3's room on 10/03/19 at 10:18am revealed: -There was an oxygen concentrator in the room with tubing attached. -There was not a portable oxygen tank available for Resident #3 for when she left the room. Interview with Resident #3 on 10/03/19 at 10:19am revealed: -She had been on continuous oxygen for a couple of years. -She was ordered continuous oxygen at 4L. -She needed oxygen because she had difficulty breathing and she had a diagnosis of chronic obstructive pulmonary disease. -She did not wear oxygen when she was outside of her room, because she did not have a portable oxygen tank. -She had a portable oxygen tank at her other facility, but she was told by staff when she got to the current facility the oxygen concentrator was all she had. -She went outside to smoke several times a day and knew she could not wear oxygen when she	{D 276}		

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{D 276}	Continued From page 2	{D 276}		

smoked.
-She did not have portable oxygen when she went to the dining hall.
-She became short of breath sometimes when she ambulated outside of her room, but she did not tell staff.
-She would like to have a portable oxygen tank in her room to take with her when she ambulated outside of her room.
-She ambulated using a walker and the larger tanks were too heavy to drag, but she could take a smaller tank on her walker.

Interview with a medication aide (MA) on 10/04/19 at 9:03am revealed:
-Resident #3 had physician's orders for continuous oxygen.
-Resident #3 should have her oxygen in place all the time except for when she went outside to smoke.
-Resident #3 usually had portable oxygen when she was in the dining hall.
-Portable oxygen was kept in an oxygen storage room and not in residents' rooms.
-Staff had to get oxygen for Resident #3 out of the oxygen storage room when Resident #3 left her room.

Interview with the Director of Resident Care (DRC) on 10/04/19 at 9:30am revealed:
-Resident #3 had physician's orders for 4 L of continuous oxygen.
-Resident #3 had portable oxygen in the oxygen storage room.
-Staff took the portable oxygen to Resident #3 if they saw she was in distress or if she asked for it while outside of her room.
-She had taken portable oxygen to Resident #3 in the dining hall since she had been in the facility.
-Resident #3 ambulated independently

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{D 276}	Continued From page 3 throughout the facility and she was supposed to push the call bell to let staff know when she planned to leave her room. Observation of the oxygen storage room on 10/04/19 at 10:27am revealed: -The oxygen was stored in a locked room. -There were multiple tanks of oxygen in the storage room. -There were 4 large and 5 small oxygen tanks which had a sheet of paper attached with Resident #3's name. Interview with the Administrator on 10/04/19 at 10:33am revealed: -Resident #3 was on continuous oxygen, but she had been noncompliant with her oxygen use. -She noticed Resident #3 did not have her oxygen in place on yesterday and asked her why she did not have it on. Resident #3 replied that she did not need it. -Resident #3's portable oxygen was not kept in her room because she did not think portable oxygen could be kept in a resident's room. -Staff was supposed to get oxygen for Resident #3 when she left her room. Interview with another MA on 10/04/19 at 12:43pm revealed: -Resident #3 was on continuous oxygen, but she refused to take the oxygen out of her room. -She did not know if portable oxygen was always in her room but "it should be." -She had seen Resident #3 outside of her room without her oxygen and she was having trouble breathing, but she did not remember when. -Resident #3 asked for oxygen when she needed oxygen outside of her room. Interview with a hospice nurse on 10/04/19 at	{D 276}		

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{D 276}	Continued From page 4 4:53pm revealed: -She visited Resident #3 twice a week. -Resident #3's oxygen saturation ranged from 88% to 94% with her oxygen on. -She usually visited Resident #3 in her room and Resident #3 had her oxygen on during the visits. -She had documented labored breathing once during her visits with Resident #3. Interview with Resident #3's PCP on 10/04/19 at 11:23am revealed: -Resident #3 was on continuous oxygen due to having a diagnosis of chronic obstructive pulmonary disorder. -He had spoken to Resident #3 about wearing her oxygen all the time, but he did not know Resident #3 did not have portable oxygen in her room to take with her when she left her room. -He expected for Resident #3 to wear oxygen continuously except for when she smoked. -He expected for facility staff to have portable oxygen available in Resident #3's room for her to take with her and use outside of her room. A second interview with Resident #3's PCP on 10/04/19 at 4:40pm revealed: -Not using oxygen continuously as ordered could cause increased shortness of breath. -Resident #3 was very alert and oriented and would know when her oxygen levels were low. -The facility did not check Resident #3's oxygen saturation and he did not know if the MAs were able to give accurate information regarding Resident #3's respiratory status. -He made a referral to hospice services for Resident #3 so that her respiratory status could be monitored carefully.	{D 276}		

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{D 310}	Continued From page 5	{D 310}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to assure therapeutic diets were served as ordered for 2 of 6 sampled residents (#6 and #7) with physician's orders for a regular no added table salt (NATS) diet with chopped meats (#6) and a mechanical soft (MS) (entire meal) diet (#7). The findings are: 1. Review of Resident #6's current FL2 dated 08/13/19 revealed: -Diagnoses included hyperlipidemia. -There was an order for a regular diet with chopped meats. Review of a diet order for Resident #6 dated 09/10/19 revealed an order for a no added table salt (NATS) diet with chopped meats. Review of the therapeutic diet list dated 08/30/19 posted in the kitchen revealed Resident #6 was listed to be served a NATS diet with chopped meats. Review of the NATS diet menu for the lunch meal service on 10/02/19 revealed residents were to be served chicken alfredo pasta, broccoli, garlic bread, grapes, and beverage of choice.	{D 310}	Dietary staff to be trained on therapeutic diets and the implementation of licensed dietician's menu. A diet tracking system has been implemented to verify that each resident is getting the correct diet by creating a card system placed on the back of each residents' chair that gives an up to date symbol for the order. Any diet of concern or in need of clarification will be report to resident's physician, with any changes made documented and shared with Dietary Manager and updated on diet list. Dietary Manager or Administrator to observe five (5) meal times weekly verifying that the meal is cooked to Dietician's orders, each resident is receiving the correct meal, and the diet orders are current and valid.	

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{D 310}	Continued From page 6 Observation of the lunch meal service on 10/02/19 between 11:30am and 12:30pm revealed: -Staff were serving lunch plates to residents which consisted of either chicken alfredo pasta or corndogs. -Resident #6 was served 2 corndogs on a stick (not chopped), broccoli, and grapes, water and tea. -Resident #6 consumed 100% of the meal with no difficulty and requested another corndog. -Resident #6 was served a 3rd corndog on a stick (not chopped) and ate it without difficulty. Review of the NATS diet menu for the dinner meal service on 10/02/19 revealed residents were to be served baked flounder fillet, baked beans, sautéed yellow squash, milk, and coconut cake. Observation of the dinner meal service on 10/02/09 between 5:30pm and 6:30pm revealed: -Resident #6 was served baked flounder fillet (not chopped), baked beans, green beans, sautéed yellow squash, coconut cake, water, and Kool-Aid. -Resident #6 consumed 100% of the meal with no difficulty. Interview with a dietary aide on 10/02/19 at 12:12pm revealed: -She thought Resident #6 was on a regular diet. -She served Resident #6 a corndog on a stick today. -She did not know Resident #6 was supposed to be served chopped meats. Interview with the dietary manager (DM) on 10/02/19 at 5:45pm revealed: -He prepared the lunch meal plate for Resident	{D 310}		

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{D 310}	Continued From page 7 #6. -He knew Resident #6 has an order for chopped meats. -He had chopped up corndogs on the serving line for all residents who had orders for chopped meats. -The therapeutic diet list was posted on the wall as a guide to staff who assisted with serving and posted on the serving line for the cooking staff. -The staff who served must have served Resident #6 the wrong plate. -He did not prepare the dinner meal and did not know Resident #6 was served a fillet of flounder that was not chopped. -He was responsible for ensuring residents were served diets as ordered by their physicians. Interview with the assistant Administrator on 10/02/19 at 6:01pm revealed: -He was responsible for monitoring the dining hall and the cleanliness of the kitchen. He also made sure the diet orders were correct and in the kitchen for dietary staff. -He did not know Resident #6 was not being served according to his diet order of chopped meats. -The dietary staff was responsible for ensuring diets were served as ordered. -He expected for diets to be served as ordered by the physician. Interview with Resident #6 on 10/03/19 at 8:50am revealed: -He used to be served chopped meats, but not anymore. -He sometimes had trouble swallowing when he ate meat. -He was able to cut the meat up himself when he needed to. -He ate three corndogs on a stick for lunch on	{D 310}		

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{D 310}	Continued From page 8 10/2/19 and did not have any trouble swallowing. -His physician told him he needed to eat his meats cut up, eat slower, and count his bites. Interview with the Director of Resident Care (DRC) on 10/03/19 at 8:58pm revealed: -The DM was responsible for making sure meals were served as ordered. -She did not know Resident #6 was served corndogs and baked flounder that were not chopped until the assistant Administrator told her on 10/02/19. Interview with a personal care aide (PCA) on 10/03/19 at 9:15am revealed: -She assisted by serving plates in the dining hall during meal times on her shift. -There was a list on the wall in the kitchen which told staff which diet each resident was on. -The cooks usually told staff which plate was to be served to each resident. Interview with a cook on 10/03/19 at 9:42am revealed: -She prepared the dinner meal plate for Resident #6 on 10/02/19. -She thought Resident #6 was supposed to be served a regular diet, but she found out after the dinner meal Resident #6 was supposed to be served chopped meats. -The name listed on the therapeutic diet list for Resident #6 was not what staff called him and that was why she did not know he was to be served chopped meats. -She had not seen nor asked for a diet order for the name staff called Resident #6. Interview with the Administrator on 10/04/19 at 9:52am revealed: -She knew Resident #6 has a physician's order	{D 310}		

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{D 310}	Continued From page 9	{D 310}		

for chopped meats, but she did not know chopped meats were not being served as ordered.
-Resident #6 sometimes refused to eat chopped meats, but she did not know if it was documented anywhere.
-The DM and the cooks who prepared the food were responsible for making sure residents were served according to their diet orders.
-The dietary aides and PCAs served meals in the dining halls during their shifts.
-The therapeutic diet list was posted in the kitchen for guidance in serving meals.
-She expected for diets to be served as ordered by the physician.

Interview with Resident #6's Primary Care Provider (PCP) on 10/04/19 at 11:23am revealed:
-Resident #6 was ordered a chopped diet.
-He thought staff had informed him about Resident #6 being served a corndog on last week, but he did not know Resident #6 was served 3 whole corndogs instead of chopped corndogs on 10/02/19.
-He expected for staff to serve Resident #3 chopped meats as ordered.

2. Review of Resident #7's current FL2 dated 08/19/19 revealed:
-Diagnoses included chronic obstructive pulmonary disease, hypertension, respiratory distress syndrome, memory loss, and hyperparathyroidism.
-There was an order for a mechanical soft (MS) (entire meal) diet.

Review of a diet order for Resident #7 dated 08/19/19 revealed an order for MS (entire meal) diet.

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{D 310}	Continued From page 10 Review of the therapeutic diet list dated 08/30/19 posted in the kitchen revealed Resident #7 was listed to be served a Regular MS diet. Review of the MS diet menu for the lunch meal service on 10/02/19 revealed residents were to be served chicken alfredo pasta with ground chicken, MS broccoli, garlic bread soaked, mashed fruit and beverage of choice. Observation of the lunch meal service on 10/02/19 between 11:30am and 12:30pm revealed: -Staff were serving lunch plates to residents which consisted of either chicken alfredo pasta or corndogs. -Resident #7 was served ground chicken alfredo, MS broccoli, 1 stick of garlic bread (should have been soaked), grapes (should have been mashed), water and tea. -Resident #7 did not eat the grapes, but she consumed about 50% of the meal without difficulty. Review of the MS diet menu for the dinner meal service on 10/02/19 revealed residents were to be served ground baked flounder fillet, baked beans, MS sautéed yellow squash, coconut cake without the coconut, and milk. Observation of the dinner meal service on 10/02/09 between 5:30pm and 6:30pm revealed: -Resident #7 was served whole baked flounder fillet (should have been ground), baked beans, green beans, MS sautéed yellow squash, coconut cake with coconut (should have been served without coconut), tea, and water. -Resident #7 consumed about 50% of the meal with no difficulty.	{D 310}		

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{D 310}	Continued From page 11 Interview with the dietary manager (DM) on 10/02/19 at 5:45pm revealed: -He prepared the lunch meal plate for Resident #7. -He knew Resident #7 had orders for a MS diet and he prepared a MS meal to be served to Resident #7 10/02/09. -He told staff to give the MS plate to Resident #7. -He did not know Resident #7 had grapes on her plate. -He mashed grapes for residents on a MS diet and thought he had put the mashed grapes on Resident #7's plate. -He did not prepare the dinner meal and did not know Resident #7 was served a fillet of flounder that was not ground according to the MS diet menu. -He was responsible for ensuring residents were served diets as ordered by their physicians. Interview with the assistant Administrator on 10/02/19 at 6:01pm revealed: -He was responsible for monitoring the dining hall and the cleanliness of the kitchen. He also made sure the diet orders were correct and in the kitchen for dietary staff. -He did not know Resident #7 was not being served according to her diet order of chopped meats. -The dietary staff was responsible for ensuring diets were served as ordered. -He expected for diets to be served as ordered by the physician. Interview with the Director of Resident Care (DRC) on 10/03/19 at 8:58pm revealed: -The DM was responsible for making sure meals were served as ordered. -She did not know Resident #7 was served grapes, a whole flounder fillet, and coconut.	{D 310}		

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{D 310}	Continued From page 12 Interview with a personal care aide (PCA) on 10/03/19 at 9:15am revealed: -She assisted by serving plates in the dining hall during meal times on her shift. -There was a list on the wall in the kitchen which told staff which diet each resident was on. -The cooks usually told staff which plate was to be served to each resident. Interview with a cook on 10/03/19 at 9:42am revealed: -She prepared the dinner meal plate for Resident #7 on 10/02/19, but she was not sure whether Resident #7 was on a MS diet or chopped meats. -The DM helped her during the dinner meal on 10/02/19 by writing down all residents who were on MS diets or chopped meats and those residents were served first. -She thought she served Resident #7 chopped fish for the dinner meal on 10/02/19. -She looked at the therapeutic diet list, but she did not look at the therapeutic diet menus each time she prepared a meal. -"I look at the menus sometimes, but not every time." Interview with the Administrator on 10/04/19 at 9:52am revealed: -She did not know Resident #7 was not being served the diet as ordered by her physician. -The DM and the cooks who prepared the food were responsible for making sure residents were served according to their diet orders. -The dietary aides and PCAs served meals in the dining halls during their shifts. -The therapeutic diet list was posted in the kitchen for guidance in serving meals. -She expected for diets to be served as ordered by the physician.	{D 310}		

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{D 310}	Continued From page 13 Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. Attempted interview with Resident #7's Primary Care Physician (PCP) on 10/03/19 at 9:29am was unsuccessful.	{D 310}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance continues. TYPE B VIOLATION	{D 358}	Med Techs and SICs to be trained on 6 rights of Medication Administration, FL2 verification of medications/treatments by LHPS nurse by 11/21/19. All orders to be reviewed by Director of Resident Care and Resident Care Manager upon returning from hospital and upon admission to ensure all medications and treatments are maintained in resident records and accuracy prior to being recorded. All discharge summaries will be reviewed and initialed by Director of Resident Care prior to being faxed to pharmacy and upon receipt of the medication to ensure medications are correct and available on MAR. This process to be monitored weekly as well as during routine weekly medication cart audits reviewed by Director of Resident Care and Executive Director.	

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{D 358}	Continued From page 14 Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 5 of 5 residents sampled for record review (#1, #2, #3, #4, #5) including errors with a medication used to treat chronic obstructive pulmonary disease (#3), with a reflux medication and a steroid medication (#4), a diabetic medication and an anti-inflammtory medication (#5), a diabetic medication and a pain medication (#1), and an antidepressant medication (#2). The findings are: 1. Review of Resident #3's current FL-2 dated 06/10/19 revealed diagnoses included chronic obstructive pulmonary disease exacerbation, hypertension, sleep apnea, chronic lower extremity edema, and type II diabetes mellitus. Review of Resident #3's physician's orders revealed there was an order dated 08/07/19 revealed an order for incruse (a medication used to treat chronic obstructive pulmonary disease (COPD)) once daily. Review of a hospital discharge summary dated 08/26/19 for Resident #3 revealed Resident #3 was hospitalized from 08/21/19 through 08/226/19 due to COPD exacerbation and chronic respiratory failure due to hypoxia (the absence of enough oxygen in the tissues to sustain bodily functions and hypercapnia (the buildup of carbon dioxide in the bloodstream). Review of a hospital discharge summary dated 09/11/19 for Resident #3 revealed: -Resident #3 was hospitalized from 09/07/19	{D 358}		

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{D 358}	Continued From page 15	{D 358}		

through 09/11/19 due to COPD exacerbation and acute on chronic respiratory failure due to hypoxia and hypercapnia.
-Oxygen saturations were at 50%.
-Resident #3 had 4 recent hospitalizations due to COPD exacerbation.
-Resident #3 self-reported smoking 1 pack of cigarettes a day.
-Palliative care was introduced to Resident #3 and hospice versus palliative care was discussed.

Review of Resident #3's record revealed Resident #3 was hospitalized in April 2019 and July of 2019 for COPD exacerbation.

Review of Resident #3's electronic Medication Administration Record (eMAR) for August and September 2019 revealed there was no entry for incruse.

Interview with Resident #3 on 10/03/19 at 12:11pm revealed:
-She was only on 1 inhaler, Symbicort.
-She did not know she was supposed to be administered incruse.
-She was not administered incruse by staff.

Observation of Resident #3's medication on hand on 10/03/19 at 5:22pm revealed incruse was not on the medication cart.

Interview with a second shift medication aide (MA) on 10/03/19 at 5:27pm revealed:
-Incruse was not on the eMAR and not on the medication cart for Resident #3.
-The Director of Resident Care (DRC) was responsible for reviewing new orders when they came into the facility and sending the new orders to the pharmacy.
-The pharmacy would then add the medication to

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{D 358}	Continued From page 16 the eMAR and deliver the medication. Interview with a first shift MA on 10/04/19 at 9:03am revealed: -The DRC was responsible for reviewing new physician's orders when came in from resident medical appointments. -The DRC faxed the new orders to the pharmacy, or the DRC would have an MA to fax the new order to the pharmacy. -She did not know who was responsible for record audits or how often record audits were completed. -She did not know if Resident #3 has an order for incruse. -She had not seen incruse on the cart for Resident #3 and had not administered incruse to Resident #3. Interview with the DRC on 10/04/19 at 9:30am revealed: -The DRC and the Resident Care Coordinator (RCC) were responsible for reviewing new physician's orders that came in from providers outside of the facility. -New orders were faxed to the pharmacy and the pharmacy would deliver the medication to the facility and key the medication in on the eMAR. -She was responsible for completing record audits once a month. -She did not know when Resident #3's chart was last audited. -She did not remember seeing the physician's order for incruse for Resident #3. -The physician's order for incruse dated 08/07/19 had not been initialed to indicate it had been reviewed and sent to the pharmacy. -The physician's order for incruse had not been sent to the pharmacy and Resident #3's physician had not been notified she had not been	{D 358}		

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{D 358}	Continued From page 17 administered incruse as ordered. Interview with the Administrator on 10/04/19 at 10:33am revealed: -The DRC was responsible for reviewing new orders from outside physician's visits. -Reviewing new orders included looking for changes in medications, new medications and discontinued medications. -She did not know Resident #3 had an order for incruse once daily dated 08/07/19. -She did not now incruse had not been requested from the pharmacy and was not available in the facility for administration to Resident #3. -She expected medication to be administered as ordered by the physician. Interview with Resident #3's Primary Care Provider (PCP) on 10/04/19 at 11:23am revealed: -He made the referral for Resident #3 to see a pulmonologist due to her COPD and he knew the pulmonologist wrote an order for incruse for Resident #3. -Resident #3 had a physician's order for incruse due to her COPD. -Resident #3 had been hospitalized several times for COPD exacerbation and he expected the facility to administer the incruse as ordered by the pulmonologist. Interview with a nurse from Resident #3's pulmonologist's office on 10/04/19 at 12:29pm revealed: -Resident #3 was seen by the pulmonologist on 08/07/19 and an order for incruse was written for 1 inhalation daily. -The pulmonologist wrote an order for incruse because her regimen of Symbicort had not been effective for her COPD and asthma. -The pulmonologist had not been informed	{D 358}		

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{D 358}	Continued From page 18 Resident #3 had not been administered incruse since it he ordered it on 08/07/19. -The pulmonologist expected for Resident #3 to take incruse 1 inhalation daily as ordered. -The pulmonologist was aware of Resident #3's hospitalizations in August and September 2019 due to COPD exacerbation. -Not taking incruse could lead to increased shortness of breath and exacerbation of COPD. Refer to interview with the MA on 10/04/19 at 12:40pm. Refer to interview with the RCC on 10/04/19 at 12:50pm. Refer to interview with the Administrator on 10/04/19 at 3:10pm. 2. Review of Resident #4's current FL-2 dated 08/21/19 revealed diagnoses included non-insulin dependent diabetes mellitus, rheumatoid arthritis, schizoaffective disorder, hypertension, depression, chronic pain, and obesity. a. Review of Resident #4's after visit summary from a local hospital dated 09/18/19 revealed: -Resident #4 had been inpatient from 09/16/19-09/18/19 for epigastric pain. -Medication changes were to stop Resident #4's Prednisone 10 mg. (Prednisone is a steroid medication). Review of Resident #4's September 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Prednisone 10 mg daily with a scheduled administration time at 8:00 am. -Prednisone 10 mg was documented as administered from 09/01/19-09/16/19 and from	{D 358}		

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{D 358}	Continued From page 19 09/19/19-09/30/19. -Prednisone 10 mg was not documented as administered from 09/17/19-09/18/19. -Resident #4 was administered 12 doses of Prednisone 10 mg after the medication had been discontinued. Review of Resident #4's October 2019 eMAR revealed: -There was an entry for Prednisone 10 mg daily with a scheduled administration time at 8:00 am. -Prednisone 10 mg was documented as administered from 10/01/19-10/03/19. -There was an electronic "x" on 10/04/19. -Resident #4 was administered 3 doses of Prednisone 10 mg after the medication had been discontinued. Observation of Resident #4's medications on hand on 10/03/19 at 2:57 pm revealed: -There was a bubble pack of thirty Prednisone 10 mg tablets dispensed on 08/01/19. -Twenty-eight tablets had been administered; two tablets were available to be administered. -There was a second bubble pack of Prednisone 10 mg tablets dispensed on 08/30/19. -Twenty-nine tablets had been administered; one tablet was available to be administered. Interview with Resident #4 on 10/03/19 at 5:58 pm revealed: -She had been taking Prednisone for a long time. -She did not know if she was still taking Prednisone, but she thought she was. Interview with a nurse from the local hospital on 10/04/19 at 11:20 am revealed: -Resident #4's Prednisone was stopped because the Prednisone could have been contributing to her gastric irritation.	{D 358}		

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{D 358}	Continued From page 20 -The emergency department physician expected the Prednisone order to have been stopped per his instruction. -Resident #4 should not be taking Prednisone and it should be stopped if it was still being administered. Interview with a medication aide (MA) on 10/04/19 at 10:00 am revealed: -She administered Prednisone 10 mg to Resident #4 because it was on the eMAR. -She did not know Prednisone 10 mg had been stopped by the hospital physician. -She did not receive orders or make changes in the eMAR. Interview with the Director of Resident Care (DRC) on 10/04/19 at 1:43 pm revealed: -She was concerned there was an order to stop Prednisone and it was not stopped. -When the physician's summary came in with Resident #4 it should have been reviewed and the medication changes made. -The DRC was ultimately responsible for reviewing the hospital discharge summary and making changes as needed. -She initialed at the bottom when she had reviewed and made the changes on any orders received. -She did not know who reviewed Resident #4's hospital discharge summary since her initials were not on it. Interview with the Administrator on 10/04/19 at 3:10 pm revealed: -She did not know Resident #4's Prednisone had been discontinued by a hospital physician and was still being administered. -She was concerned the instructions in the hospital discharge summary had not been	{D 358}		

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{D 358}	Continued From page 21 reviewed and followed. Refer to interview with the MA on 10/04/19 at 12:40 pm. Refer to interview with the RCC on 10/04/19 at 12:50 pm. Refer to interview with the Administrator on 10/04/19 at 3:10 pm. b. Review of Resident #4's signed physician's orders dated 08/21/19 revealed an order for Pantoprazole 40 mg twice daily. (Pantoprazole is used to treat acid reflux). Review of Resident #4's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Pantoprazole 40 mg twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Pantoprazole 40 mg was documented as administered from 08/01/19-08/22/19 at 8:00 am and 8:00 pm. -Pantoprazole 40 mg was documented as administered on 08/23/19 at 8:00 am. -Pantoprazole 40 mg was not documented as administered on 08/23/19 at 8:00 pm and 08/24/19-08/26/19 at 8:00 am and 8:00 pm; the reason documented was medication unavailable. -Pantoprazole 40 mg was documented as administered from 08/27/19-08/31/19 at 8:00 am and 8:00 pm. -There was a second entry to administer Pantoprazole 20 mg daily with a scheduled administration time at 8:00 am. -The dates of 08/01/19-08/04/19 and 08/06/19-08/31/19 were electronically marked out with an "X" for Pantoprazole 20 mg.	{D 358}		

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{D 358}	Continued From page 22 -The date of 08/05/19 was documented as not administered; the reason documented was resident was unavailable. Interview with a representative from the facility's contracted pharmacy on 10/03/19 at 4:24 pm revealed: -On 07/27/19, a physician's summary was received from Resident #4's primary care provider (PCP) from a patient encounter dated 07/24/19; the encounter showed Pantoprazole listed as 20 mg daily; therefore, the Pantoprazole order was changed, and Pantoprazole 20 mg was sent to the facility with directions to be administered daily. -Nine Pantoprazole 20 mg tablets were dispensed on 07/27/19 and on 08/07/19 an additional thirty Pantoprazole 20 mg tablets were dispensed. -On 08/20/19 Pantoprazole 20 mg was discontinued, and Pantoprazole 40 mg twice daily was entered into the eMAR. -On 08/26/19 eighteen Pantoprazole 40 mg tablets were dispensed. -There was no record of Pantoprazole 20mg tablets being returned to the pharmacy. Based on record reviews and interviews Resident #4 missed 7 doses of Pantoprazole 40 mg due to medication not being available; and was administered Pantoprazole 20 mg when the current order was for Pantoprazole 40 mg. Review of a physician's summary from Resident #4's gastroenterologist dated 09/24/19 revealed: -Resident #4 was seen for a follow-up visit. -Resident #4 continued to complain of epigastric pain which was intermittent in nature. -On Resident #4's previous visit (not dated) Resident #4 had ran out of her Proton-pump	{D 358}		

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inhibitor (PPI) for a week and had started having epigastric discomfort and nausea. (PPI is a medication whose main action is a pronounced and long-lasting reduction of stomach acid production).
-Treatment was to continue Pantoprazole 40 mg twice daily.

Telephone interview with Resident #4's gastroenterologist's medical assistant on 10/03/19 at 4:17 pm revealed:
-Resident #4 was seen by the gastroenterologist on 08/27/19.
-Resident #4 complained of epigastric discomfort and nausea.
-Treatment was to start Pantoprazole 40 mg once daily.
-She did not know why the Pantoprazole was changed from twice daily to once daily on 08/27/19.
-Resident #4 was seen by the gastroenterologist on 09/18/19.
-Treatment was to continue Pantoprazole 40 mg twice daily.
-She did not know why Resident #4's treatment was documented as continue Pantoprazole 40 mg twice daily when the last order in Resident #4's record was documented as Pantoprazole 40 mg once daily.
-Resident #4's current order was for Pantoprazole 40 mg twice daily.
-She did not see any documentation the PCP had been notified Resident #4 had missed 7 doses of Pantoprazole.

Interview with a Medication Aide (MA) on 10/03/19 at 3:30 pm revealed:
-When she administered medications, she pulled all the punch cards out of the medication cart.
-She compared each punch card to the eMAR

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twice to make sure the punch card was accurate.
-She did not recall seeing a punch card for Pantoprazole 20 mg for Resident #4.
-She would not have administered Pantoprazole 20 mg to Resident #4 when the eMAR had it listed as Pantoprazole 40 mg.
-If she had saw the Pantoprazole 20 mg she would have called the PCP for clarification.
-If she had seen Pantoprazole 20 mg and it was not the correct dosage, she would have sent it back to the pharmacy.

Interview with a second MA on 10/04/19 at 10:00 am revealed:
-She did not recall Resident #4 missing her Pantoprazole in August 2019.
-Pantoprazole was a cycled medication; cycled medication usually came in without any problems.
-She did not recall seeing a change in Resident #4's Pantoprazole dosage or scheduled administration time.
-She administered medication based on the eMAR.
-If she would have seen a prescription package for Pantoprazole 20 mg, she would have clarified the order before administering the medication.

Interview with Resident #4's PCP on 10/03/19 at 4:55 pm revealed:
-She saw Resident #4 for a visit on 07/01/19 and there were no medication changes.
-Resident #4 was last taking Pantoprazole 20mg in March 2018.
-The Pantoprazole 20mg was carried over in her note in error; Resident #4 was not prescribed Pantoprazole 20mg in July 2019.
-She did not know Pantoprazole 20 mg had been sent to the facility from a physician's summary in July 2019 for Resident #4; she had Resident #4 documented as taking Pantoprazole 40 mg twice

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 25 daily. -On 09/24/19 she received a clarification note from staff at the facility for Resident #4's Pantoprazole; Resident #4 had been taking Pantoprazole 40 mg twice daily and the order was clarified. -She did not know the gastroenterologist had changed Resident #4's Pantoprazole 40 mg to daily. -Resident #4 had severe gastritis and her gastritis could get worse if she did not get the correct treatment. Interview with the Resident Care Coordinator (RCC) on 10/03/19 at 5:00 pm revealed: -A fax had come in from the pharmacy for Resident #4 for Pantoprazole 40 mg daily (she did not recall the date). -She called Resident #4's PCP for clarification. -Resident #4's PCP sent in a clarification order for Resident #4 to take Pantoprazole 40 mg twice daily. -She did not see a previous order for Pantoprazole 20 mg; she only saw the order that had come in for Pantoprazole 40 mg. -She did not see in the pharmacy returns notebook where Pantoprazole 20 mg was returned to the pharmacy. Interview with Resident #4 on 10/03/19 at 5:58 pm revealed: -She took Pantoprazole for her stomach pain. -She did not take Pantoprazole for about 5 days in August 2019 (she did not recall the exact dates) because the medication "cycled" and had ran out. -She asked the staff about the Pantoprazole several times because her stomach was hurting, and they told her she would have to wait until the next cycle. (She did not recall who she talked to).	{D 358}		

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{D 358}	Continued From page 26 -She had not missed any doses of Pantoprazole since August 2019. Interview with the Director of Resident Care (DRC) on 10/04/19 at 1:43 pm revealed: -She was not aware Resident #4 had missed 7 doses of Pantoprazole in August 2019 because it was not available. -She was not aware Resident #4 had received Pantoprazole 20mg twice daily when the eMAR had the order as Pantoprazole 40mg twice daily. -She was not aware an order for Pantoprazole 20mg daily had been delivered to the facility and administered. -The MAs should have made sure the Pantoprazole package matched the order on the eMAR and clarified any discrepancies. -If Resident #4 did not receive her Pantoprazole as ordered she would have increased gastritis pain. Interview with the Administrator on 10/04/19 at 3:10 pm revealed: -She was not aware Resident #4 missed 7 doses of Pantoprazole due to medication being unavailable. -The MAs should never allow a medication to reach a zero balance; the MAs should have called the pharmacy and if the medication did not arrive, they should have notified the RCD immediately. -She was not aware Resident #4 did not receive her Pantoprazole as ordered. -She was concerned the Pantoprazole was not verified for accuracy before being administered when the medication package did not match the eMAR. Refer to interview with the MA on 10/04/19 at 12:40 pm.	{D 358}		

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{D 358}	Continued From page 27 Refer to interview with the RCC on 10/04/19 at 12:50 pm. Refer to interview with the Administrator on 10/04/19 at 3:10 pm. 3. Review of Resident #5's current FL-2 dated 08/13/19 revealed diagnoses depression, diabetes, diabetic neuropathy, high cholesterol, hypertension, and reactive airway disease. a. Review of Resident #5's signed physician's orders dated 08/13/19 revealed an order for Ibuprofen 600 mg take 1 tablet every 8 hours as needed for pain. (Ibuprofen is used to treat pain). Review of Resident #5's hospital discharge summary dated 07/30/19 revealed an order to stop taking Ibuprofen 600 mg. Review of Resident #5's hospital discharge summary dated 09/01/19 revealed an order to stop taking Ibuprofen 600 mg. Review of Resident #5's August 2019 electronic medication administration record (eMAR) revealed: -There was an order for Ibuprofen 600 mg every 8 hours as needed. -One dose of Ibuprofen 600 mg was documented as administered on 08/03/19, 08/06/19, 08/07/19, 08/12/19, 08/18/19 and 08/30/19 for a total of 6 doses. Medications on hand were not available for review due to Resident #5 being on therapeutic leave and had her medications with her. Review of Resident #5's medication release form dated 08/21/19 revealed Resident #5 was given a	{D 358}		

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{D 358}	Continued From page 28 bottle of Ibuprofen to take with her on therapeutic leave. Review of Resident #5's medication release form dated 10/03/19 revealed Resident #5 was not given a bottle of Ibuprofen to take with her on therapeutic leave. Interview with a representative from the facility's contracted pharmacy on 10/04/19 at 1:15 pm revealed: -There were 30 tablets of Ibuprofen dispensed for Resident #5 on 07/18/19. -There were 15 tablets of Ibuprofen dispensed for Resident #5 on 08/13/19 and an additional 15 were dispensed on 08/27/19. Interview with a medication aide on 10/04/19 at 12:20 pm revealed: -She had administered Ibuprofen to Resident #5 in August 2019. -She was not aware Resident #5 had orders to stop taking Ibuprofen. -If she had known Resident #5 was not supposed to take Ibuprofen she would not have administered it. -She administered medication from the eMAR; she did not make changes in the eMAR. Interview with Resident #5's primary care provider (PCP) on 10/04/19 at 11:37 am revealed: -Resident #5 took Xarelto (a blood thinner) and he, therefore would prefer Resident #5 not take Ibuprofen because it could increase her risk of bleeding. -He would have expected the facility staff to discontinue Resident #5's Ibuprofen per the hospital discharge summary orders. -He would have been concerned if Resident #5 took Ibuprofen every day.	{D 358}		

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{D 358}	Continued From page 29 Interview with the Director of Resident Care on 10/04/19 at 4:48 pm revealed: -She was concerned there was an order to stop Ibuprofen on 07/30/19 and the Ibuprofen was not stopped. -When the physician's summary came in with Resident #5 it should have been reviewed and the Ibuprofen stopped. -The DRC was ultimately responsible for reviewing the hospital discharge summary and making changes as needed. -She initialed at the bottom when she had reviewed and made the changes on any orders received. -She did not know who reviewed Resident #5's hospital discharge summary since her initials were not on it. Interview with the Administrator on 10/04/19 at 3:10 pm revealed: -She was not aware Resident #5 had been administered Ibuprofen after the medication had been stopped. -She was concerned the discharge summary was not reviewed. -She expected orders to be followed as written. Attempted telephone interview with Resident #5 on 10/04/19 at 10:03 am and 1:02 pm were unsuccessful. Refer to interview with the MA on 10/04/19 at 12:40 pm. Refer to interview with the RCC on 10/04/19 at 12:50 pm. Refer to interview with the Administrator on 10/04/19 at 3:10 pm.	{D 358}		

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{D 358}	Continued From page 30 b. Review of Resident #5's signed physician's orders dated 08/13/19 revealed an order for Novolog U-100 inject 5 units before meals, hold for a finger stick blood sugar (FSBS) of less than 90 or if the resident did not plan to eat. (Novolog is a fast acting insulin). Review of Resident #5's August 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog inject 5 units 15 minutes before meals with a scheduled administration time at 7:00 am, 5:00 pm and 11:00 pm. -Novolog 5 units was documented as administered at 7:00 am and 5:00 pm from 08/01/19-08/31/19 except when Resident #5 was on therapeutic leave or unavailable. -Novolog 5 units was documented as administered 13 times at 11:00 pm from 08/01/19 through 08/29/19 when the order was for Novolog 5 units was to be administered with meals. Medications on hand were not available for review due to Resident #5 being on therapeutic leave and had her medications with her. Review of Resident #5's medication release form dated 10/03/19 revealed Resident #5 was not given a Novolog flex pen to take with her on therapeutic leave. Interview with a representative from the facility's contracted pharmacy on 10/04/19 at 1:15 pm revealed: -One pen of Novolog was dispensed on 07/30/19; the pen would last fourteen days if Novolog was administered three times per day as ordered. -Two pens of Novolog were dispensed on	{D 358}		

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{D 358}	Continued From page 31 09/13/19. Telephone interview with a medication aide (MA) on 10/04/19 at 1:08 pm revealed: -She did not know why she documented she had administered Resident #5's Novolog at 11:00 pm; Resident #5 did not receive any type of insulin at 11:00 pm. -She may have documented wrong; she must have selected the Novolog wrong at her medication pass. Telephone interview with a second MA on 10/04/19 at 2:56 pm revealed: -He had worked 3rd shift as a medication aide. -He did not administer insulin to any resident at 11:00 pm; if he documented he administered Novolog at 11:00 pm it was in error. -He recalled the time being wrong and mentioned it to the next shift (he did not recall who he mentioned it to). -He thought the Supervisor had told the Director of Resident Care (DRC) about the time being wrong in the eMAR. Telephone interview with the Supervisor on 10/04/19 at 5:02 pm revealed: -She did not recall anyone telling her directly about Novolog being scheduled on the eMAR at 11:00 pm. -She did recall, "over-hearing" a group conversation about the Novolog being scheduled on the eMAR at 11:00 pm; she thought someone had told the DRC (she did not recall who). Telephone interview with Resident #5's primary care provider (PCP) on 10/04/19 at 4:36 pm revealed: -Novolog should only be administered when Resident #5 was provided a meal.	{D 358}		

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{D 358}	Continued From page 32 -He would be concerned if Resident #5's Novolog was administered at 11:00 pm because her blood sugar could have "bottomed out." -He did not recall any times Resident #5's FSBS had been low in the mornings during the time period Novolog was documented as administered at 11:00 pm. -He would have expected the facility staff to have clarified the time of administration. Interview with the DRC on 10/04/19 at 4:48 pm revealed: -She would be concerned if Novolog was administered to Resident #5 at 11:00 pm. -If Resident #5 was administered Novolog at 11:00 pm her FSBS would have dropped. -She did not think any medication aides would administer Novolog at 11:00 pm. -The MAs should not have documented they administered Novolog at 11:00 pm if it was not administered. Interview with the Administrator on 10/04/19 at 3:10 pm revealed: -There were no residents who were administered insulin at night. -She expected the MAs to notify the DRC when a time was entered wrong on the eMAR. -She was concerned the MAs were not paying close attention to the eMAR when signing off on a medication pass. Attempted telephone interview with Resident #5 on 10/04/19 at 10:03 am and 1:02 pm were unsuccessful. Refer to interview with the MA on 10/04/19 at 12:40 pm. Refer to interview with the RCC on 10/04/19 at	{D 358}		

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{D 358}	Continued From page 33 12:50 pm. Refer to interview with the Administrator on 10/04/19 at 3:10 pm. 4. Review of Resident #1's current FL2 dated 08/13/19 revealed diagnoses included diabetes mellitus, bipolar disorder, hypertension, hyperlipidemia, gastroesophageal reflux disease, vitamin D deficiency, polyneuropathy, and hypothyroidism. a. Review of Resident #1's current FL2 dated 08/13/19 revealed an order for Humalog mix 75/25 (a medication used to treat and manage diabetes) kwik pen 100 units/ml, inject 32 units subcutaneously twice a day. Review of Resident #1's subsequent physician's order dated 08/20/19 revealed an order for Humalog mix 75/25 kwik pen 100 units/ml, inject 20 units subcutaneously twice a day. Review of Resident #1's subsequent physician's order dated 09/03/19 revealed Humalog mix 75/25 kwik pen 100 units/ml, inject 20 units subcutaneously twice a day should be administered at 8:00 am and 4:00 pm. Review of Resident #1's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Humalog mix 75/25 kwik pen 100 units/ml, inject 32 units subcutaneously twice a day scheduled at 11:00 am and 5:00 pm. -Humalog mix 75/25 was documented as administered per orders from 08/01/19 through 08/22/19. -There was a second entry for Humalog mix 75/25 kwik pen 100 units/ml, inject 20 units	{D 358}		

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{D 358}	Continued From page 34 subcutaneously twice a day scheduled at 7:00 am and 5:00 pm. -Humalog mix 75/25 was documented as administered per orders from 08/22/19 through 08/25/19. -There was a third entry for Humalog mix 75/25 kwik pen 100 units/ml, inject 20 units subcutaneously twice a day scheduled at 8:00 am and 8:00 pm. -Humalog mix 75/25 was documented as not administered 5 of 12 opportunities from 08/26/19 through 08/31/19. -Resident #2's fingerstick blood sugar (FSBS) range for August 2019 was 68-334. Observation of Resident #1's medications on hand on 10/04/19 at 10:15 am revealed: -There was one Humalog mix 75/25 kwik pen (3 ml - 100 units/ml) dispensed on 08/22/19 available to be administered. -There was 100 units remaining. Interview with Resident #1 on 10/04/19 at 9:35 am revealed: -The medication aides (MA) administered her all ordered medications, including insulin. -She was administered Humalog mix three times a day. -She remembered missing doses of Humalog in August 2019. -She thought she missed Humalog because the staff did not have a current order. -She did not remember experiencing symptoms of hyperglycemia. Telephone interview with Resident #1's Primary Care Provider (PCP) on 10/04/19 at 11:12 am revealed: -He expected staff to administer Humalog as ordered.	{D 358}		

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{D 358}	Continued From page 35 -He expected staff to notify him if there were any issues with medication orders or medications were missed. -Staff did not notify him that Resident #1 missed several days of Humalog in August 2019. -He was concerned Humalog was missed and could have increased Resident #1's blood sugar. -He was currently pleased with Resident #1's most recent hemoglobin A1C (test evaluates the average amount of glucose in the blood over the last 2 to 3 months) of 5.1 on 08/14/19 and FSBS range. Telephone interview with a representative from the contracted pharmacy on 10/04/19 at 12:10 pm revealed: -The current order in the pharmacy system was Humalog mix 75/25, inject 20 units subcutaneously twice a day at 8:00 am and 4:00 pm. -Humalog mix 75/25 was dispensed on 07/11/19 (5 cartridges of 300 units each). -Humalog mix 75/25 was dispensed on 08/22/19 (5 cartridges of 300 units each). -The pharmacy attempted to fill the Humalog mix 75/25 on 09/03/19 but Resident #1 was "profile only". -Profile only meant the Humalog mix 75/25 was entered into the pharmacy system but the pharmacy did not fill the Humalog. Interview with the MA on 10/04/19 at 12:40 pm revealed: -She did not remember Humalog mix 75/25 being discontinued in August 2019. -She did not remember documenting discontinued on the eMAR for Humalog mix 75/25 in the month of August 2019. Interview with the Director of Resident Care	{D 358}		

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{D 358}	Continued From page 36 (DRC) on 10/04/19 at 2:15 pm revealed: -She remembered Humalog mix 75/25 decreased to 20 units twice a day in August 2019. -She did not know who changed the scheduled times for the Humalog mix 75/25 in August 2019. -She did not know staff documented the Humalog mix 75/25 was discontinued on several occasions the last week of August 2019. -She expected staff to administer Resident #1's medications as ordered. -She did not know if staff notified the PCP that the Humalog was not administered for several days in August 2019. -She was concerned because Resident #1 could have experienced higher than normal blood sugars. -She expected staff to speak with her if they thought the Humalog was discontinued. Interview with the Administrator on 10/04/19 at 3:00 pm revealed: -She expected the MAs to administer Resident #1's medications as ordered and make her aware of any issues or concerns. -She did not know Resident #1 was not administered several doses of Humalog mix 75/25 in August 2019. Refer to interview with the MA on 10/04/19 at 12:40 pm. Refer to interview with the RCC on 10/04/19 at 12:50 pm. Refer to interview with the Administrator on 10/04/19 at 3:10 pm. b. Review of Resident #1's current FL2 dated 08/13/19 revealed an order for Hydrocodone (a medication used to treat pain) 5/325 mg daily.	{D 358}		

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{D 358}	Continued From page 37 Review of Resident #1's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Hydrocodone 5/325 mg, one tablet daily. -Hydrocodone was not documented as administered for 5 of 31 opportunities. -Staff documented Hydrocodone was not administered on 08/23/19 and 08/27/19 through 08/30/19. Observation of Resident #1's medications on hand on 10/04/19 at 10:15 am revealed: -Hydrocodone 5/325 mg was available to be administered. -The were 30 tablets of Hydrocodone 5/325 mg dispensed on 09/27/19. -There were 27 tablets remaining. Interview with Resident #1 on 10/04/19 at 9:35 am revealed: -The medication aides (MA) administered her all ordered medications. -She was ordered Hydrocodone but she did not know what the medication was used for. -She remembered not receiving Hydrocodone in August 2019 but was not able to recall the dates or how many doses were missed. -Her right knee caused her a great deal of pain. -She experienced pain on a daily basis when getting up and down. -She knew she took medications to help manage her pain. Telephone interview with Resident #1's Primary Care Provider (PCP) on 10/04/19 at 11:12 am revealed: -He expected staff to administer Hydrocodone as ordered.	{D 358}		

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{D 358}	Continued From page 38 -He prescribed Hydrocodone to manage Resident #1's chronic knee pain. -Resident #1 was seen last week. -Resident #1 did not mention increased pain during last visit. -Staff did not notify him that Resident #1 ran out of Hydrocodone in August 2019. -He expected the staff to request refills in time to prevent Resident #1 from running out of Hydrocodone. -If Resident #1 did not receive Hydrocodone as ordered she could have experienced increased knee pain. Telephone interview with a representative from Resident #1's contracted pharmacy on 10/04/19 at 11:55 am revealed: -The current order on file was Hydrocodone 5/325 mg, one tablet daily. -There were 30 tablets of Hydrocodone 5/325 mg dispensed on 07/18/19, 8/30/19, and 09/27/19. -Resident #1 would have ran out of Hydrocodone in August 2019. Interview with the MA on 10/04/19 at 10:25 am revealed: -The facility was required to obtain a written prescription for all narcotic refills. -Resident #1's PCP visited the facility weekly and MA should have obtained a written prescription for the Hydrocodone refill when he was in the building. -If a written prescription was not obtained while the PCP was in the building the MA/Supervisor would be responsible for calling the PCP to request a refill. -She did not remember contacting the pharmacy or PCP regarding a refill request for Resident #1's Hydrocodone order. -She would not have documented the	{D 358}		

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{D 358}	Continued From page 39 Hydrocodone was administered on the eMAR if she did not administer the Hydrocodone to Resident #1. -If she documented she administered the Hydrocodone the count would have been off at the end of the shift. -However, if there were no Hydrocodone on the medication cart there would have been no Hydrocodone to count at the end of the shift. -MAs did not count narcotics after each dose was administered. -MAs counted narcotics at the end of every shift. -She remembered Resident #1 ran out of Hydrocodone in August 2019. -She did remember speaking with a Supervisor regarding the Hydrocodone not being available. Interview with the Resident Care Coordinator (RCC) on 10/04/19 at 12:45 pm revealed: -Resident #1's PCP came to the facility once a week. -She implemented a narcotic refill book in March 2019 to ensure narcotics were refilled and prevent narcotics from running out. -She counted all narcotics weekly and documented the amount in a book for the PCP to review. -The narcotic refill book was implemented to make PCPs aware when a refill prescription was needed. -The MA should have made the RCC and Director of Resident Care (DRC) aware when the Hydrocodone ran out. -On 08/21/19, the book reflected Resident #1 had 1 tablet of Hydrocodone 5/325 mg remaining. -Resident #1's name had a line drawn through it. -She was not sure why Resident #1's name had a line drawn through it. -She recalled Resident #1 changed PCPs at the end of July 2019.	{D 358}		

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{D 358}	Continued From page 40 -The narcotic request was given to the previous PCP and so no refill prescription was obtained. Review of the narcotic refill request book revealed: -On 08/21/19, the book reflected Resident #1 had 1 tablet of Hydrocodone 5/325 mg remaining. -Resident #1's name had a line drawn through it. Interview with the DRC on 10/04/19 at 2:15 pm revealed: -She did not know Resident #1 ran out of Hydrocodone in August 2019. -The MA was expected to contact the PCP for a refill request with no less than 8 tablets remaining. -The RCC implemented a narcotic refill book to keep a count of narcotics weekly and request refills when needed to ensure narcotics did not run out. -She did not remember Resident #1 experiencing increased pain in August 2019. Interview with the Administrator on 10/04/19 at 3:00 pm revealed: -The PCP should be writing narcotic refills when he visited the facility weekly. -The MA/Supervisor was responsible for contacting the PCP for narcotic refills if not obtained during weekly visits. -She expected the MA to request a refill when 10 tablets were left. -She expected the MA to make the RCC and DRC aware when the Hydrocodone ran out. -A narcotic refill request book was implemented after the previous survey to ensure narcotics were available. -Narcotics were counted on all residents weekly. Refer to interview with the MA on 10/04/19 at	{D 358}		

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{D 358}	Continued From page 41 12:40 pm. Refer to interview with the RCC on 10/04/19 at 12:50 pm. Refer to interview with the Administrator on 10/04/19 at 3:10 pm. 5. Review of Resident #2's current FL2 dated 08/21/19 revealed: -Diagnoses included unspecified dementia without behaviors, chronic pain syndrome, hypertension, chronic embolism and thrombosis, constipation, restless leg syndrome, and anxiety. -There was an order for Duloxetine DR (a medication used to treat anxiety and depression) 60 mg daily. Review of Resident #2's July 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Duloxetine DR 60 mg daily scheduled at 8:00 pm. -Staff documented Duloxetine DR was not administered from 07/22/19 through 07/30/19. -On 07/22/19, Duloxetine DR was not administered due to "reordered". -On 07/23/19, Duloxetine DR was not administered due to "on order". -On 07/24/19, Duloxetine DR was not administered due to "need new physician order, will contact NP to follow up to get new order". -On 07/25/19, Duloxetine DR was not administered due to "reordered". -On 07/26/19 through 07/28/19, Duloxetine DR was not administered due to "delivery". -On 07/29/19, Duloxetine DR was not administered due to "awaiting". -On 07/30/19, Duloxetine DR was not administered due to "ordered again on 7/29".	{D 358}		

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{D 358}	Continued From page 42 Observation of Resident #2's medications on hand on 10/04/19 at 10:15 am revealed Resident #2's medications were unavailable. Telephone interview with Resident #2's Primary Care Provider (PCP) on 10/03/19 at 4:48 pm revealed: -She was not notified Resident #2 was not administered Duloxetine DR as ordered in July 2019. -She prescribed Resident #2 Duloxetine DR for peripheral neuropathy. -The Mental Health Provider requested she increase Duloxetine DR due to increased behaviors because Resident #2 was more receptive to PCP orders. -She expected the staff to administer the Duloxetine DR as ordered. -She was concerned Resident #1 did not receive Duloxetine DR because she could have experienced increased depression, behaviors, and peripheral neuropathy. -She did not remember an increase of depression or peripheral neuropathy in July 2019. Telephone interview with Resident #2's Mental Health Provider on 10/03/19 at 5:30 pm revealed: -Resident #2 was last seen on 09/27/19. -She was not notified Resident #2 was not administered Duloxetine DR as ordered. -She was concerned Resident #2 was not administered Duloxetine DR as ordered. -If Resident #2 did not receive Duloxetine DR as prescribed, she could experience increased behaviors and change in mood. -She remembered in July 2019 Resident #2 was experiencing an increase in behaviors and was delusional. -On 09/27/19 Resident #2 appeared stable and	{D 358}		

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{D 358}	Continued From page 43 was not delusional. Telephone interview with a representative from the contracted pharmacy on 10/04/19 at 10:55 am revealed: -The current order in the pharmacy system was Duloxetine DR 60 mg daily. -There were 30 tablets of Duloxetine DR dispensed on 05/22/19, 08/04/19, 08/30/19, and 09/30/19. -There were 6 tablets of Duloxetine DR dispensed on 07/30/19. -Duloxetine DR was a cycle fill medication but got off schedule due to the pharmacy was waiting on a new prescription. -The facility was required to call when a refill was needed. Interview with the MA on 10/04/19 at 12:40 pm revealed: -She remembered Duloxetine DR was not available in July 2019. -She did not remember why it was not available. -She informed the Resident Care Coordinator (RCC) the Duloxetine DR was not available. -She did not remember any change in mood, increased depression or increased behaviors. -The MAs were responsible for contacting the pharmacy or the PCP for refill request. -The MA was responsible for following up with the pharmacy if a medication was not received within a few days. -She administered medications according to the eMAR. -The MA conducted cart audits on all residents every week. -She did not know if anyone was responsible for conducting eMAR audits. Interview with the RCC on 10/04/19 at 12:45 pm	{D 358}		

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{D 358}	Continued From page 44 revealed: -She did not remember any issues with Resident #2's Duloxetine DR order in July 2019. -She did not know Resident #2 needed a refill for Duloxetine DR in July 2019. -If there was any issue with Duloxetine not being available or issue getting Duloxetine filled the MAs should have notified her or the Director of Resident Care (DRC). Interview with the DRC on 10/04/19 at 2:15 pm revealed: -She did not know Resident #2 missed several doses of Duloxetine DR in July 2019. -She was given a noncompliance report daily which included medications not available to be administered. -She did not remember Duloxetine being listed on the report in July 2019. -She expected the MAs to send a refill request to the pharmacy with no less than 8 days of medication available. -The MA was responsible for contacting the pharmacy or the PCP (if necessary) to request refills. -The Duloxetine should have been requested in time to get the Duloxetine refilled and ensure there were no doses missed. -Staff should have informed her or the RCC if there were issues refilling Resident #2's Duloxetine DR. Interview with the Administrator on 10/04/19 at 3:00 pm revealed: -She expected the MAs to administer Resident #2's medications as ordered and make her aware of any issues or concerns. -She did not know Resident #2 was not administered several doses of Duloxetine DR in July 2019.	{D 358}		

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{D 358}	Continued From page 45 Attempted interview with Resident #2's family member on 10/04/19 at 3:30 pm. Refer to interview with the MA on 10/04/19 at 12:40 pm. Refer to interview with the RCC on 10/04/19 at 12:50 pm. Refer to interview with the Administrator on 10/04/19 at 3:10 pm. Interview with the medication aide (MA) on 10/04/19 at 12:40pm revealed:. -She administered medications according to the eMAR. -Pharmacy entered orders into the eMAR system. -MAs conducted cart audits on all residents every week. -She did not know if anyone completed eMAR audits. Interview with the Resident Care Coordinator (RCC) on 10/04/19 at 12:50pm revealed: -The RCC, DRC, and the Administrator had access to make changes in the eMAR system. -She did not know if anyone conducted eMAR audits. -The RCC, DRC, and MAs conducted cart audits. -The MA was responsible for contacting the pharmacy or the PCP for refill request. -The MA should inform the RCC and DRC if there were issues with refill request or orders. Interview with the Administrator on 10/04/19 at 3:10pm revealed: -She conducted eMAR to chart audits every month. -She completed eMAR to chart audits on all	{D 358}		

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{D 358}	Continued From page 46 residents for June 2019 through August 2019. -They used the most current physician's orders for the audit. -The staff had been retrained on how to do a proper audit. -They printed off the current eMAR, the signed physician's orders and the resident record to make sure anything new was on the eMAR since the physician's orders were signed. -They did not look back at any orders prior to the signed physician's orders. -The DRC completed 5 resident cart audits on each cart every day. -By the end of each week all residents on each medication cart would be completed. -The Supervisor and MA was responsible for calling the pharmacy for refill request. -The MA should contact the pharmacy if a medication was not received the next day. -The MA were expected to notify the DRC with any issues filling or receiving a medication. The facility failed to assure medications were administered as ordered for 5 of 5 sampled residents, including an order for reflux for a resident who had a history of gastritis who experienced increased abdominal discomfort and nausea and who was administered a steroid medication for thirty one days after it was discontinued because the physician thought it could be contributing to her gastritis (#4); and a medication used to treat COPD was not administered as ordered to Resident #3, who had frequent hospitalizations due to exacerbation of COPD. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a Plan of Protection on 10/03/19 in accordance with G. S. 131D-34.	{D 358}		

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{D 358}	Continued From page 47 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 21, 2019.	{D 358}		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to obtain a self-administer medication physician's order for 1 of 1 sampled resident (#3) who self-administered medication. The findings are: Review of Resident #3's current FL-2 dated 06/10/19 revealed: -Diagnoses included chronic obstructive pulmonary disease exacerbation, hypertension, sleep apnea, chronic lower extremity edema, and	D 375	Training to all staff on medication self administration policies and procedures to be conducted on 11/11/19 by LHPS nurse. A "self administration" checklist will be conducted by the Director or Resident Care with the resident every 90 days to ensure compliance. This will be placed in resident's chart. For residents choosing to self administer, resident's physician will complete assessment to assure the resident has the ability to self administer medication.	

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D 375	Continued From page 48 type II diabetes mellitus. -There was an order for Symbicort 160-4.5mcg inhale 2 puffs twice daily. -There was no order for self-administration of medications. Observation of Resident #3's room on 10/03/19 at 12:13pm revealed: -There were 2 containers of Symbicort in a plastic basket on Resident #3's nightstand. -She picked 1 container up from the top of the basket and moved items in the basket around in order to pick up the second container. -Neither container of Symbicort was labeled with Resident #3's name or instructions on administration. -One container had 29 puffs remaining and the other container of Symbicort had 34 puffs remaining. -One container had a sticker with an expiration date of 09/05, but there was no year indicated. Review of Resident #3's electronic Medication Administration Record (eMAR) for July 2019 revealed: -There was an entry for Symbicort inhaler 160-4.25mcg inhale 2 puffs into the lungs twice daily to be administered at 9:00am and 9:00pm -There was documentation Symbicort was administered daily at 9:00am and 9:00pm from 07/01/19 through 07/31/19 with the exceptions of 07/08/19 at 9:00am (It was documented Resident #3 was not available), 07/09/19 at 9:00pm through 07/10/19 at 9:am and 9:00pm (Resident was documented as being in the hospital.), 07/11/19 at 9:00am (Resident was documented as being in the hospital). Review of Resident #3's eMAR for Augusut 2019 revealed:	D 375		

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D 375	Continued From page 49 -There was an entry for Symbicort inhaler 160-4.25mcg inhale 2 puffs into the lungs twice daily to be administered at 9:00am and 9:00pm. -There was documentation Symbicort was administered daily from 08/01/19 through 08/31/19 with exceptions on 08/21/19 through 08/26/19. -There was documentation Symbicort was not administered on 08/21/19 at 9:00pm with the reason being Resident #3 was in the hospital. -There was documentaiton Symbicort was not administered from 08/22/19 through 08/25/19 at 9:00am and 9:00pm with the reason being Resident #3 was in the hospital. -There was documentation Symbicort was not administerd on 08/26/19 at 9:00am with the reason being Resident #3 was in the hospital. Review of Resident #3's eMAR for September 2019 revealed: -There was an entry for Symbicort inhaler 160-4.25mcg inhale 2 puffs into the lungs twice daily to be administered at 9:00am and 9:00pm. -There was documentation Symbicort was administered daily from 09/01/19 through 09/30/19 with exceptions on 09/05/19 and 09/07/19 through 09/11/19. -There was documentation Symbicort was not administered on 09/05/19 at 9:00am with the reason being Symbicort was not available. -There was documentaiton Symbicort was not administered from 09/07/19 at 9:00pm with the reason being Resident #3 was in the hospital. -There was documentation Symbicort was not administerd on 09/08/19 through 09/10/19 at 9:00am and 9:00pm with the reason being Resident #3 was in the hospital. -There was documentaiton Symbicort was not administered from 09/11/19 at 9:00am witt the reason being Resident #3 was in the hospital.	D 375		

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D 375	Continued From page 50 Based on observations and record reviews, there were no physician orders or assessments in Resident #3's record for self-administration of medication. Observation of Resident #3's medication on the medication cart on 10/03/19 at 5:22pm revealed: -There was a container of Symbicort dispensed by the pharmacy on 08/01/19 for 120 puffs and 90 puffs remained. -There was a container of Symbicort dispensed by the pharmacy on 09/20/19 for 120 puffs and 75 puffs remained. Interview with Resident #3 on 10/03/19 at 12:11pm at revealed: -She had two containers of Symbicort in a basket on her nightstand. -She brought the containers of Symbicort back to the facility from the hospital. -One container was brought back to the facility in August 2019 and the other one was brought back to the facility in September 2019. -She had not told staff she had the two containers of Symbicort and she did not know if staff knew about the Symbicort in her room. -She did not know she needed to be assessed and needed a physician's order to keep medication in her room and self-administer it. -She liked having the Symbicort in her room because staff sometimes forgot to administer the Symbicort. -If staff forgot to give her the Symbicort, she did not request it, but used the Symbicort in her room. -She self-administered the Symbicort only when staff forgot to give it to her. -Her Symbicort should be administered 2 puffs twice a day.	D 375		

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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 375	Continued From page 51 Interview with a medication aide (MA) on 10/03/19 at 5:27pm revealed: -She administered Resident #3 Symbicort during her shift. -Resident #3 had not missed any doses of Symbicort. -She did not know of any residents who kept medication in their room or had physician's orders to self-administer medication. Interview with a second MA on 10/04/19 at 9:03am revealed: -She had administered medication to Resident #3 including Symbicort. -She did not remember Resident #3 missing a dose of Symbicort unless she was in the hospital. -There was only one resident who had physician's orders to self-administer medication and it was not Resident #3. -In order for a resident to be able to self-administer medication and keep the medication in the room, the resident had to have a physician's order and have an assessment completed. Interview with the Director of Resident Care (DRC) on 10/04/19 at 9:30am revealed: -Resident #3 did not have physician's orders to self-administer medication and should not have had medication in her room. -Residents who self-administered medication should have a physician's order, be assessed by a nurse, and have a locked box to store their medication in their room. -She did not know Resident #3 had 2 containers of Symbicort in her room. -MAs and personal care aides (PCA) should be in residents' rooms daily and observing for any medications that should not be in the room.	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 10/07/2019

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D 375	Continued From page 52 Interview with the Administrator on 10/04/19 at 10:33am revealed: -She did not know Resident #3 had 2 containers of Symbicort in her room and self-administered it when staff forgot to give the Symbicort to her. -She did not know how Resident #3 brought the Symbicort to the facility from the hospital. -Residents who self-administered medication needed a written physician's order, an assessment checklist completed by the DRC in their record, and the medication should be kept in a locked room. -There was not a scheduled time to look for prescribed or over the counter medication in a resident's room. -Staff should look for medication in residents' rooms each time they enter the room. Interview with Resident #3's Primary Care Provider (PCP) on 10/04/19 at 11:23am revealed: -Resident #3 had physician's orders for Symbicort due to diagnoses of chronic obstructive pulmonary disease. -He did not know Resident #3 had Symbicort in her room and self-administered it at times. -He had not written an order for Resident #3 to self-administer her medication. -Resident #3 was alert, oriented and he would not have a problem with her administering her Symbicort, but he preferred staff to administer all Resident #3's medications including the Symbicort.	D 375	Staff to be trained on Resident Rights immediately by Administrator, and and annually to follow. Community staff to review Resident Rights agreement and sign/date.	
{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	{D912}	Adminstrator to conduct random resident interviews to assure Resident Rights are being maintained at all times.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D912}	Continued From page 53 adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to assure every resident had the right to receive care and services which were adequate, and in compliance with rules and regulations as related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 5 of 5 residents sampled for record review (#1, #2, #3, #4, #5) including errors with a reflux medication and a steroid medication (#4), a diabetic medication and an anti-inflammtory medication (#5), a diabetic medication and a pain medication (#1), an antidepressant medication (#2), and a medication used to treat chronic obstructive pulmonary disease (#3). [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	{D912}		