East Towne Assisted Living
4815 North Sharon Amity Rd
Charlotte, NC 28205
Phone: 704-531-0948
Fax: 704-531-6009
Cell: 828-775-3893
Email: estn.adm@affinitylivinggroup.com or nwj@affinitylivinggroup.com

November 22, 2019

Ms. Renee Howard
2708 Mail Service Center
Raleigh, NC 27699-2708

Re: Follow-up Survey and Complaint Investigation completed October 18, 2019
ASPEN Event ID: PHEM12
Facility: East Towne
Licensure Number: HAL-06-149
County: Mecklenburg

Dear Ms. Howard

Attached is the Plan of Correction in reference to the Statement of Deficiencies for East Towne Assisted Living regarding the follow-up survey and complaint investigation which was completed on October 18, 2019. Please feel free to contact me at any of the phone numbers or email addresses listed above.

Thank you,

Nina Warwick-Joyner, Executive Director/Area Director of Operations

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
	HAL060149	A. BUILDING: _____ B. WING _____	R 10/18/2019

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EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

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{D 000}	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a follow-up survey and complaint investigation on October 15, 2019 to October 18, 2019 with an exit conference via telephone on October 18, 2019. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on October 8, 2019.	{D 000}	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or conclusions; set forth in the statement of deficiencies, the plan of correction is perpared soley as a matter of compliance with the law.	
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Follow-up to a Type A1 violation. The previous Type A1 violation was abated. Non-compliance continues. THIS IS A TYPE A2 VIOLATION The facility failed to assure the acute and chronic health care needs were met for 1 of 6 sampled residents (Resident #7) related to primary care provider (PCP) notification of increase of a rash and itching, not receiving a topical steroid cream as ordered for psoriasis, and coordination of a	{D 273}	10A NCAC 13F .0902(b) Health Care Facility will assure it provides healthcare referral and follow-up to meet the routine and acute health care needs of residents. Facility has implemented Daily Staff Stand-up meetings with staff. Staff Stand-up Meetings are held no less than 5 days a week. All staff will sign in for meetings. ED, RCC, and/or DRC will conduct Daily Staff Stand-up. Daily Stand Up Binder is available for all staff to review if unable to attend. Residents health care needs and concerns are discussed at each meeting. Staff are asked during meeting if there are any resident concerns (Illness, Behaviors, Skin issues etc.) ED,RCC,DRC and/or Designee will follow-up on any residents concerns.	11/17/19 11/17/19 11/17/19 11/17/19 11/17/19

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] Executive Director/AD — TITLE — (X6) DATE: 11/22/19

Reviewed and Accepted 11/26/19 RH

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{D 273}	Continued From page 1 return appointment to the dermatologist. The findings are: Review of Resident #7's FL2 dated 09/04/19 revealed diagnoses included chronic obstructive pulmonary disease, major depressive disorder, heart failure and muscle weakness. Review of Resident #7's hospital discharge dated 08/20/19 revealed diagnoses included diabetes type 2, peripheral artery disease, gout, hypertension, coronary artery disease and congestive heart failure. Observation on 10/16/19 between 10:15am and 10:25am revealed: -Resident #7 was in his room, sitting on his bed with a brief and a T-shirt on. -Resident #7 was scratching his right inner thigh area. -There were flakes of dead skin that had shedded of Resident #7's laying on the bed and on the floor. -Resident #7 had a rash to his legs, inner thighs, bilateral arms, abdominal area and back area. -The rash was bright red in some areas and dry patches in other areas. -Several areas were inflamed and aggravated. Interview with Resident #7 on 10/16/19 at 10:15am revealed: -He had the rash for about a month. -The rash had spread all over his body and the rash "itched all the time." -He was constantly scratching the rash and dried skin would "come off "on the bed sheets and floor. -He had told the staff he was itching but they had not given him anything for the itching.	{D 273}	Continued from page 1 ED,RCC, DRC and/or Designee will notify residents Primary Care Provider with any residents health care concerns. ED, RCC, DRC and/or Designee will document residents health care concern, notication to provider, and follow-up in residents progress notes Facility Staff have been trained on Daily Staff Stand-up Meetings and the importance of attending. Training included what would be considered a "resident health care concern" Facility has Shower and Body Observation form which is completed by staff each time a resident showers Shower and Body Observation forms will be completed any time staff observes changes or concerns with residents skin or body All completed Shower and Body Observation Sheet will be placed in DRC wall box. Facility RCC and/or DRC will review Shower and Body Observation forms no less than three times weekly for sixty days, then weekly there after for any needed follow-up with body/skin concerns. Facility ED will review Shower and Body Observation forms no less than weekly for 30 days, then radomly there after.	11/17/19 11/17/19 11/17/19 11/17/19 11/17/19 11/17/19 11/17/19

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{D 273}	Continued From page 2 -Staff had applied a cream to his rash a few weeks ago but the staff told him he did not have any left. -His physician knew about the rash but had not seen his skin in about a month. -He was unsure what the rash was, but his physician had told him he was not contagious. Interview with a personal care aide (PCA) on 10/16/19 at 10:20am revealed: -She knew Resident #7 had a rash to his body, and he had the rash for about a month. -The rash had spread to other parts of Resident #7's body. -Resident #7 complained of itching all the time. -She was unsure if Resident #7 had anything ordered for the itching. -She was unsure what the rash was. -She had heard it might be methicillin resistant staphylococcus aureus (MRSA) or shingles. -She was told to wear gloves and to wash her hands often. -The medication aides (MA) were applying cream but it was on back order for about 3 days. -She had never applied the cream. Review of Resident #7's electronic progress notes for September 2019 and October 2019 revealed there was no documentation about psoriasis or itching. Review of Resident #7's dermatology report dated 07/03/19 revealed: -Resident #7 was seen for rash on his arms and back. -The rash was documented as psoriasis (an autoimmune disease that affects the skin) red itchy, scaly plaques to shins, arms, and back. -An order for betamethasone dipropionate (a steroid cream used to treat psoriasis) 0.05%	{D 273}	Continued from page 2 Facility ED, RCC, DRC and/or Designee will notify residents Primary Care Provider of any skin/body concerns. Notification to primary care provider will be documented in resident's progress notes Facility ED, RCC and/or DRC will review resident progress notes weekly to assure notification and follow-up is completed. Facility has impletemented rounding with primary care providers during on-site visits. Facility DRC, RCC and/or Desigee will complete rounds with primary care provider. Facility DRC, RCC and/or Designee will review with primary care provider any resident health care concerns, needed follow-up or referrrals to outside healthcare providers. Facility DRC, RCC and/or Designee will document and schedule needed follow-up and/or referrals in residents progress notes. Facility staff have received training on different types of skin condictions, and the importance of documentation. Training provided by a Physician. Facility staff have received training on Shower and Body Observation forms. Training included observing, reporting, and recording of resident health care concerns. Training provided by Licensed RN and ED	11/17/19 11/17/19 11/17/19 11/17/19 11/17/19 11/17/19 11/14/19 10/17/19 10/18/19 11/15/19

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{D 273}	Continued From page 3 apply two times daily as needed, avoid the face, start on 07/03/19. Review of Resident #7's Primary Care Physician visit note dated 08/07/19 revealed a review of system skin; patient denies itching, rash and dryness. Review of Resident #7's Primary Care Physician visit notes for Resident #7 dated 09/18/19 revealed: -Chief complaint was documented as a rash on skin, psoriasis. -There was documentation the rash had spread from right lower extremity (shin) to abdomen, right arm and right shoulder. -There was documentation the rash was round, scaly, and crusted patches that ranged in size. -There was documentation the largest patch was on the right lower extremity (shin) and measured 2 inches by 1 inch and was red, round, scaly and crusted. -There was documentation Resident #7 complained the rash itched continuously but was not painful. -There was documentation Resident #7 was referred to the dermatologist (July 2019) and was prescribed Betamethasone cream, which was effective for 2-3 weeks. -There was documentation Resident #7 was having a "flare" and the cream would be reinstated. -An order for betamethasone 0.05% cream apply two times daily, for 2 weeks,avoid the face; then as needed thereafter for flares. Review of Resident #7's Primary Care Physician visit note dated 09/25/19 revealed: -Chief complaint diabetic shoes evaluation. -Documented review of his skin; patient	{D 273}	continued from page 3 Facility Medication Staff received training on medication administration. Training included Importance of PRN Usage. Training provided by Licensed RN Facility staff have received training on Health care and follow-up needs. Training provided by ED and Licensed RN Facility staff have received training on resident rights and dignity. Training provided by ED.	10/17/19 10/18/19 10/30/19 11/14/19 11/15/19 11/15/19

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{D 273}	Continued From page 4 complains of dryness, itching and rash (toe deformity, ulcer and callus). Review of Resident #7's order dated 09/25/19 revealed: -Concerns were documented as worsening psoriasis and diabetic shoes evaluation. -Orders were to start prednisone 10mg three times a day for one day, prednisone 10mg two times for the second day, then prednisone 10mg daily, orders also included vitamin C 100mg daily and vitamin B 25,000 units once weekly. Review of Resident #7's order dated 09/26/19 revealed an order for Vistaril 50mg daily for one month. Interview on 10/16/19 at 10:40am with the facility Physician Assistant (PA) revealed: -He had referred Resident #7 to a dermatologist in July 2019 for a rash and the dermatologist diagnosed the rash as psoriasis. -The dermatologist ordered betamethasone cream for Resident #7's psoriasis. -He had seen Resident #7 09/18/19 because the psoriasis had returned. -He had ordered to restart the betamethasone cream for 2 weeks and as needed for flares on 09/18/19. -He was not aware the facility staff were not applying the betamethasone cream as ordered for Resident #7's psoriasis flare. -The facility had not contacted him about Resident #7's constant itching in October 2019. Review of Resident #7's Primary Care Physician visit note dated 10/07/19 revealed: -There was a documented sentence "patient complains of rash" chronic rash on skin. -There was no documentation of a skin	{D 273}		

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{D 273}	Continued From page 5	{D 273}		

assessment of Resident #7's psoriasis.
-There were no additional recommendations or orders for the psoriasis or itching.
-There was no documentation for a referral back to the dermatologist.

Telephone interview with the Home Health (HH) skilled nurse on 10/16/19 at 3:35pm revealed:
-She was seeing Resident #7 two times weekly for a small decubitus ulcer to his left toe region.
-The decubitus ulcer would heal then reoccur.
-She noticed the rash to Resident #7's body three weeks ago.
-On 10/15/19, she noticed Resident #7 was extremely itchy and the rash appeared to be spreading more.
-She thought the facility staff were utilizing and applying a steroid cream to the rash.
-She contacted the PA on 10/15/19 regarding Resident #7's rash had increased, and the cream was not working.
-She had told the Director of Resident Care (DORC) on 10/15/19 Resident #7's rash had increased, and a different medication should be considered.
-She was not sure when the PA had actually seen Resident #7's rash, but he was aware of the rash.
-The facility staff or the PA never informed her of the diagnosis of the rash on Resident #7.

Interview with another HH skilled nurse on 10/17/19 at 10:20am revealed:
-She had filled in for the skilled nurse who normally saw Resident #7.
-She completed a skilled nurse visit on 10/17/19 for Resident #7.
-She had seen Resident #7 the first time on 09/17/19.
-She had assessed his skin on 09/17/19.
-Resident #7 complained of itching on 10/17/19.

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{D 273}	Continued From page 6 -She could not believe the rash on 10/17/19 compared to Resident #7's skin on 09/17/19. -The rash on Resident #7's body had become significantly worse between her 09/17/19 assessment as compared with her 10/17/19 assessment. Interview with the Director of Resident Care (DORC) on 10/16/19 at 11:05am revealed: -She was also a Registered Nurse (RN) and assessed the residents in the facility daily. -The MAs came to her with any resident concern or issue. -She assessed Resident #7 about a month ago for psoriasis and it was on his arms. -She had contacted the PA for Resident #7's psoriasis in September 2019. -The HH nurse had reported to her on 10/15/19 Resident #7's rash had increased and spread, and she thought the medication was not working. -The DORC never contacted the PA to discuss the HH nurse assessment and suggestion for medication changes. -She had not re-assessed Resident #7 skin on 10/15/19 after HH had informed her of the increase in rash and the medication was not effective. -She was not aware Resident #7 complained of constant itching or that his psoriasis had spread to other areas of his body. -The staff completed a facility form "shower sheet and body observation" after each shower for each resident in the facility and documented any skin changes. -She was responsible for reviewing the shower sheets daily and following-up on each documented skin concern. -Resident #7 had a chronic condition psoriasis, the DORC had not thought to re-assess his skin or document after her assessment in September	{D 273}		

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{D 273}	Continued From page 7 2019 because Resident #7's condition was chronic and not acute. -She relied on the MAs to inform her of any changes in Resident #7's psoriasis. Review of the September 2019 and October 2019 shower sheet and body observation forms for Resident #7 revealed: -On 09/30/19 at 6:30pm there was documentation of sores on his skin, scars and discoloration. -On 10/11/19 at 4:00pm there was documentation his skin was irritated. -There was no documentation of a skin assessment or notification to the PA of Resident #7's skin issues. Interview with the PA on 10/16/19 at 12:15pm revealed: -He had seen Resident #7 today for his psoriasis and itching. -Resident #7 had a history of chronic psoriasis. -Resident #7 was not having a flare up of psoriasis. -Resident #7 was complaining of itching. -The facility staff had not contacted him regarding Resident #7's itching or the increase of psoriasis. -If the staff had contacted him, he would have ordered something for Resident #7's itching. -He would contact Resident #7's dermatologist and get Resident #7 seen as soon as possible. Interview with Resident #7 on 10/16/19 at 3:15pm revealed: -"It is all over my body." -The PA had seen him today and the PA could not believe the rash had spread everywhere on his body. -In July 2019 he had seen a dermatologist for the rash, but it was not all over his body. -He was not sure if the staff had told the PA about	{D 273}		

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{D 273}	Continued From page 8 the spread of the rash or the itching. -"I don't think they want to touch me because they think I am contagious, but I am not." Interview with two MAs on 10/16/19 at 3:25pm revealed: -They were not aware of Resident #7's itching. -They were not aware Resident #7 had psoriasis all over his body. -They did know Resident #7 had psoriasis on his arms. -They applied a cream last month (September) to the psoriasis but had not applied any more since then. -They had not contacted the PA for Resident #7's itching or increase in psoriasis. -The DORC was responsible for skin assessments and contacting the physician's office for orders. -They were not responsible for scheduling appointment with the dermatologist office. Telephone interview with the dermatologist office Nurse Practitioner (NP) on 10/17/19 at 8:50am revealed: -Resident #7 had been seen in the office in July 2019 for psoriasis. -The facility contacted the office on 10/16/19 to schedule an appointment for Resident #7. -Resident #7 had an appointment for 10/17/19 at 1:30pm. Telephone interview with another NP at the dermatologist office on 10/17/19 at 3:15pm revealed: -She and the dermatologist completed Resident #7's examination on 10/17/19. -Resident #7's psoriasis was "severe and involved" there were patches on his legs, arms, abdominal area, arms and back area.	{D 273}		

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{D 273}	Continued From page 9 -Resident #7 was having a psoriasis flare which covered over 50% of his body. -Resident #7 "looked uncomfortable and was constantly inching." -Resident #7 was prescribed prednisone 10 mg daily by the facility PA, the dermatologist was concerned the oral prednisone daily was exacerbating the psoriasis. -Resident #7 should had been seen sooner to avoid the spread and compilations of psoriasis. -She had concerns Resident #7 had not seen a rheumatologist in 3 years. -The facility staff or the facility PA never reached out to the office for an appointment for Resident #7 until 10/16/19. -The office was open 6 days weekly and they offered same day appointments. -Resident #7 condition was compromised already due to his history of smoking, diabetes and COPD. -Resident #7's was definitely at risk for infection due to his already compromised immune system. -The facility should have contacted the office sooner for Resident #7's psoriasis flare. -The facility should have Resident #7 seen by a rheumatologist for a medication evaluation as soon as possible. Review of Resident #7's visit note date 10/17/19 from the dermatologist office revealed: -The skin assessment was documented as follows: "psoriasis, red, itchy, scaly plaques. Lower legs, thighs, gluteal, dorsal hands, forearms, upper arms, trunk, pink scaling papules and thin plaques guttate pattern (red bumps, teardrop-shaped spots) in areas. Over 50% of BSA (body service area), patient seen scratching." -There was documentation Resident #7 had not seen a rheumatologist in 3 years, "patient needs	{D 273}		

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{D 273}	Continued From page 10 follow-up with rheumatologist ASAP to consider change in medications." -There was documentation Resident #7 was on prednisone daily, which can cause exacerbations in psoriasis. Interview with the Executive Director on 10/17/19 at 12:20pm revealed: -She did not know Resident #7's psoriasis had spread or that he had complained of itching for 3 weeks. -She did not know there was no documentation of a skin assessment in September 2019 or October 2019 in Resident #7's progress notes or in his record. -She relied or the facility DORC to complete a skin assessment and to document if any resident had issues regarding skin or wounds. -She expected the DORC to complete a skin assessment on 09/30/19 and 10/11/19 when the staff addressed skin concerns for Resident #7 on the daily shower sheet and body observation form. She expected the DORC to document the skin assessments even if the condition was chronic. -She did not know on 10/15/19 the HH nurse had informed the DORC Resident #7's rash had spread, and the medication was not effective in the treatment of the rash. -When Resident #7's psoriasis had spread, and he complained of itching the staff should have followed-up and contacted the PA for further orders. -She did not think it was the facility's place to contact the dermatologist office first without contacting the facility PA for another order or referral. -The PA never mentioned Resident #7 returning to the dermatologist office because of the increase in psoriasis or itching.	{D 273}		

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{D 273}	Continued From page 11 -She relied on the PA to communicate with the staff if a resident needed medication changes or referral to a specialist. -She thought the PA had known about Resident #7's psoriasis flare and itching and had treated Resident #7. The facility failed to assure the acute and chronic health care needs were met for Resident #7 who was diagnosed with psoriasis and experienced a flare-up which consisted of constant itching for 3 weeks and multiple areas of psoriasis plaques which covered over 50% body surface area without notification to the physician assistant or the dermatologist for an evaluation and treatment. The red and inflamed areas that developed as a result of untreated psoriasis and the history of diabetes, coronary artery disease, chronic obstructive pulmonary disease, and compromised immune system increased the risk for infections. The failure of the facility to assure referral and follow up to meet Resident #7's health care needs resulted in delay of treatment and placed Resident #7 at a substantial risk for neglect which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 10/17/19. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2019.	{D 273}		
{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	{D 338}		

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{D 338}	Continued From page 12 and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure a resident (Resident #2) received adequate and appropriate care and services as related to ordering medications from the preferred pharmacy. The findings are: Interview with Resident #2 on 10/16/19 at 10:20am revealed: -He received a pharmacy bill for $117.00 on 10/10/19 from the Business Office Manager (BOM). -He was received veteran affairs (VA) benefits and his medications were free. -He did not understand why he had received a bill for the facility's contracted pharmacy. -He did not understand why the facility was ordering medications from their contracted pharmacy. -His preferred pharmacy was the VA and he only wanted to use the facility's pharmacy for short term supply and not ongoing. - "They order for the whole month and stick me with the bill, it's not fair". -He had not realized the facility ordered $117.00 worth of medications. -The VA mailed his medications, the staff were "not on top of it, they run out". Interview with the billing specialist at the facility's contracted pharmacy on 10/16/19 revealed: -The pharmacy was not the primary pharmacy for Resident #2. -All medications for Resident #2 was filled as requested by the facility. -There were 30 tablets of atorvastatin 20mg	{D 338}	Facility will assure residents receive adequate and appropiate care and services related to ordering medications from the preferred pharmacy. Facility ED and RCC have reviewed medication orders for residents who currently use an outside preferred pharmacy, including VA. Facility RCC has completed a medication cart audit which included review/audit of all medications provided by the VA. Facility has assigned a Lead SIC to assist with managing, ordering, communitcating and auditing of all VA medications. Facility ED and RCC have contacted facility's contracted pharmacy to assure awareness of residents who use preferred outside pharmacies. Facility ED will approve any medications ordered from facility's contracted pharmacy, for residents who have/use outside preferred pharmacy, prior to medications being sent. Facility ED and/or Designee will document in residents progress notes reasons why medications could not be obtained from residents preferred pharmacy.	11/17/19 11/17/19 11/17/19 11/17/19 11/17/19 11/17/19 11/17/19

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{D 338}	Continued From page 13 dispensed for Resident #2 on 6/20/19, 07/22/19, 08/15/19. -There were 7 tablets of atorvastatin 20mg dispensed on 09/16/19. -There were 20 tablets of carvedilol 3.125mg dispensed on 05/15/19. -There were 28 tablets of carvedilol 3.125mg dispensed on 05/30/19. -There were 60 tablets of carvedilol 3.125mg dispensed on 06/20/19, 07/30/19, and 09/04/19. -The facility could send medications back to the pharmacy to get a credit if the medication was no longer needed. -Resident #2 had an outstanding balance of $117.52 for medications dispensed May-August of 2019. -The bill was sent to the facility on 09/28/19. -She did not have a record of any other pharmacy bills sent for Resident #2. Observation of medications available for administration on 10/15/19 at 3:03pm revealed: -There was a bottle of atorvastatin 40mg with a label indicating the 90 tablets was dispensed from the VA pharmacy on 07/01/19. -There were 63 tablets of atorvastatin 40mg remaining in the bottle. -There was a bottle of carvedilol 3.125mg dispensed from the VA pharmacy on 06/25/19 with a label indicating 180 tablets were dispensed. -There were 82 tablets of carvedilol 3.125mg remaining in the bottle. -There was a bubble pack from the facility's contracted pharmacy dispensed on 09/04/19 with 34 tablets of carvedilol 3.125mg remaining. Telephone interview with a pharmacy representative at the VA pharmacy on 10/17/19 at 9:45am revealed:	{D 338}	contiuned from page 13 Facility ED and Business Office Manager have reviewed all VA residents trust fund records related to any pervious medications ordered from contracted pharmacy. Facility Business Office Manager has been instructed to notify ED if any VA residents receive bills/invoices from contracted pharmacy. Facility staff have received training on Residents Rights. Training provided by ED and Licensed RN Facility RCC, DRC, and Lead Medication Staff have received training on Medication Cart Audits	11/17/19 11/17/19 11/15/19 10/18/19

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{D 338}	Continued From page 14 -The Resident #2's medications were free at the VA. -There were 90 tablets of atorvastatin 40mg was dispensed on 04/16/19, 07/01/19, and 10/03/19. -There were 180 tablets of carvedilol 3.125mg dispensed on 01/17/19, 06/21/19, and 09/09/19. -Medications were dispensed once an order was received from the physician. -If a veteran did not have medication, a partial supply could be sent until the medication could be filled. Interview with the Business Office Manager (BOM) on 10/17/19 at 9:17am revealed; -She did not have any cash transaction logs signed by Resident #2 for October 2019. -She never presented Resident #2 with a bill from the facility's contracted pharmacy. -She never received a bill from the facility's contracted pharmacy for Resident #2. Interview with Resident #2 on 10/17/19 at 8:05am revealed: -On 10/10/19 he signed a transaction log for $117.00 to be deducted from his account for a bill from the facility's contracted pharmacy. -The BOM gave him the bill, he consented to paying the bill because he did not want to be in any debt to the pharmacy. A second interview with the BOM on 10/17/19 at 3:55pm revealed: -She managed funds for residents that consented to the facility managing funds. -If she received a bill from the pharmacy, she would inform the resident and have them to sign a transaction log for any funds paid to pharmacy. -She completed a request for the corporate office to send a check to the pharmacy. -She was not sure what to do with a pharmacy bill	{D 338}		

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{D 338}	Continued From page 15 from the contracted pharmacy for a resident whose primary pharmacy was the VA. -She had not had any bills received from the facility's contracted pharmacy for any of the residents with the VA. -She did not have a signed transaction log for Resident #2 for October 2019. Review of Resident #2's Resident Trust Fund Statement from 07/01/19-10/31/19 revealed no funds were withdrawn from the account to pay for pharmacy bills. Review of the statement provided by the facility dated 10/16/19 revealed the resident had not withdrawn money during the period of 08/19 [sic] until current the last providing money withdrawal was in July 2019. Interview with the lead MA/supervisor on 10/16/19 at 10:45am revealed: -She was responsible for ensuring medications were ordered from the VA. -If a medication was not available from the VA, she ordered from the facility's contracted pharmacy because she had a hard time getting in contact with the VA. -She did not realize Resident #2 had an excess of atorvastatin and carvedilol ordered, "it was probably overlooked". Interview with a 2nd lead MA/supervisor on 10/16/19 at 12:10pm revealed: -She was previously responsible for ordering medications for Resident #2 from the VA. -She could not remember the exact date that she stopped ordering medications for VA residents. -She recalled ordering Resident #2's medications from the VA. -She did not know exactly why Resident #2's	{D 338}		

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{D 338}	Continued From page 16	{D 338}		

medications were ordered from the facility's pharmacy in addition to the VA.
-At times they were waiting on medications from the VA, and a short-term supply was requested, and the facility would incur the cost.
-If there was an excess of medication, the facility could send back to the contracted pharmacy and the resident could receive a credit.
-The bubble packs received from the facility's contracted pharmacy should have been sent back so that the resident could receive a credit.

Interview with the Resident Care Coordinator (RCC) on 10/16/19 at 3:05pm revealed:
-Resident #2's primary pharmacy was the VA.
-Resident #2's medications were ordered from the facility's contracted pharmacy when they were running low or out and the medication was not received from the VA.
-The facility was supposed to pay the supply of medication ordered from the facility's contracted pharmacy so the resident would not incur a bill.
-She did not know why the facility's contracted pharmacy was sending some of Resident #2's medications routinely, she had not noticed.

Interview with the Director of Resident Care (DORC) on 10/16/19 at 3:25pm revealed:
-The RCC and the lead medication aides (MAs)/supervisor were responsible for making sure medications were ordered from the VA pharmacy.
-They were responsible for ensuring medications were reordered immediately after a supply was received by mailing the refill slip back to the pharmacy,
-If there was a problem getting the medication from the VA then a short-term supply is requested from the facility's contracted pharmacy.
-If the facility had the medication available from

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{D 338}	Continued From page 17 the VA, then any additional submitted sent from the facility's contracted pharmacy should be sent back. Interview with the Administrator on 10/17/19 at 11:30am revealed: -If a resident incurred a bill from the facility's contracted pharmacy, the BOM would be responsible for having the resident to sign to agree to pay the bill before the pharmacy was paid. -If a resident was with the VA and a supply was sent from the facility's contracted pharmacy, the facility would be responsible for the bill. -She did not know Resident #2 was presented with a pharmacy bill on 10/10/19. -The expectation was that the facility would pay the charges.	{D 338}		
{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 a Type A1 violation. The previous Type A1 violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION	{D 358}	10A NCAC 13F .1004(a) Medication Administration Facility Management will 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	12/2/19

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{D 358}	Continued From page 18 Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 3 of 6 sampled residents (Resident #2, #3, and #7) related to a steroid cream used to treat psoriasis (#7) and administering the incorrect dose of a medication used to treat high cholesterol (#2 and #3). The findings are: 1. Review of Resident #7's current FL2 dated 09/04/19 revealed diagnoses included chronic obstructive pulmonary disease, major depressive disorder, heart failure and muscle weakness. Observation on 10/16/19 between 10:15am and 10:25am revealed: -Resident #7 was in his room, sitting on his bed with only a brief and a T-shirt on. -Resident #7 was scratching his right inner thigh area. -Resident #7 had a rash that covered his legs, inner thighs, bilateral arms, abdominal area and back area. -The rash was bright red in some areas and dry patches in other areas. -Several areas were inflamed and aggravated. Interview on 10/16/19 at 10:15am with Resident #7 revealed: -He had the rash for about a month and the rash had spread. -The rash itched all the time. -He told the staff he was itching every day but they had not given him anything for the itching. -Staff applied a cream to his rash a few weeks ago, but the staff told him he did not have any left.	{D 358}	Continued from page 18 Facility RCC and Lead SIC have conducted complete medication cart audits. Facility Lead SIC's will complete weekly medication cart audits review findings with RCC and/or DRC to assure any areas of concern are addressed with residents Primary Care Provider In addition, facility RCC and/or DRC will complete Bi-Monthly medication cart audits for 2 months, then ramdonly there after. RCC, DRC and/or Designee will assure discontinued medications are removed from medication carts upon approval of discontinue order. Facility RCC has clarified medication orders with licensed prescribing practitioner for all VA residents to assure correct dosing. All new prescriptions will be reviewed by RCC, DRC and/or Lead SIC for accuracy of dosage and instructions present on medicaiton label Facility has assigned a Lead SIC to assist with managing, communicating, and auditing of all VA medications. Lead SIC will review/report any areas of concern to RCC and/or DRC.	12/2/19 12/2/19 12/2/19 12/2/19 11/17/19 12/2/19 11/17/19

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{D 358}	Continued From page 19 Interview with a personal care aide (PCA) present in Resident #7's room on 10/16/19 at 10:20am revealed: -Resident #7 had the rash for about a month. -Resident #7 complained of itching all the time. -The medication aides (MA) were applying a cream but it was on back order for about 3 days. -She had never applied the cream. Review of Resident #7's dermatology report dated 07/03/19 revealed: -Resident #7 was seen for rash on his arms and back. -The Dermatologist diagnosed the rash as psoriasis (an autoimmune disease that affects the skin). -There was a physician's order for betamethasone dipropionate (a steroid cream used to treat psoriasis) 0.05% apply two times daily, as needed, not to face started on 07/03/19. Review of Resident #7's Primary Care Physician visit notes for Resident #7 dated 09/18/19 revealed: -Chief complaint was rash on skin, psoriasis. -There was documentation Resident #7 complained the rash itched continuously but was not painful. -There was documentation Resident #7 was referred to the dermatologist (July 2019) and prescribed Betamethasone cream, which was effective for 2-3 weeks. -There was documentation Resident #7 was having a "flare" and the cream would be reinstated. -There was a physician's order for betamethasone 0.05% cream apply two times daily for 2 weeks, do not apply to face; then as needed thereafter for flares.	{D 358}	Continued from page 19 Facility ED, RCC,DRC and/or License Health Professional RN will conduct ramdon medication pass observations Facility ED,RCC,DRC and/or Designee will review PRN usage every 30 days for 1 quarter and quarterly thereafter with any concerns addressed for non-usage with medical provider Facility medication staff have received training on Medication Adminstration with focus on: 1) 3 checks on medication label verses MAR 2) Medications on hand 3) Importance of PRN usage training completed by Licensed RN Facility ED, RCC, DRC and Lead SICs have received training on Medication Cart Audits. Trraining completed by Licensed RN Facility Medication Staff have received training on Documentation, Medications and Resident Rights. Training completed by Licensed RNs Facility staff have received training on Resident Rights and Dignity. Training provided by facility ED and Licensed RN	12/2/19 12/2/19 10/17/19 10/18/19 10/18/19 10/30/19 11/15/19

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{D 358}	Continued From page 20 Review of Resident #7's electronic Medication Administration Record (eMAR) for September 2019 revealed: -There was a computer-generated entry for betamethasone dipropionate cream 0.05% apply to affected area topically twice daily they were no scheduled times for administering the cream. -There was documentation betamethasone 0.05% was administered form 09/19/19 to 09/30/19 two times daily. -There was an order entry for betamethasone 0.05% cream apply to affected area topically twice daily as needed for flares. -There was no documentation betamethasone was administered as needed the month of September 2019. Review of Resident #7's eMAR for October 2019 revealed: -There was a computer-generated entry for betamethasone dipropionate cream 0.05% apply to affected area topically twice daily with no scheduled times for administering the cream. -There was documentation betamethasone 0.05% was administered on 10/01/19 and on 10/02/19 two times daily. -There was a computer-generated entry for betamethasone 0.05% cream apply to affected area topically twice daily as needed for flares. -There was documentation betamethasone 0.05% cream was administered as needed on 10/05/19 at 12:08am and the results documented "not effective". -There was no other documentation betamethasone 0.05% was administered. Observation on 10/16/19 at 2:45pm of the medications on hand for Resident #7 revealed a partially used tube of betamethasone 0.05% cream was available for administering.	{D 358}		

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{D 358}	Continued From page 21 Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/16/19 at 2:50pm revealed: -There was an active order dated 09/18/19 for betamethasone 0.05% cream apply two times daily for 2 weeks then as needed for flares. -The last dispensed date for the betamethasone cream for Resident #7 was 10/06/19. Interview with a day shift MA on 10/16/19 at 11:10am revealed: -She knew Resident #7 had psoriasis but thought it had "cleared up". -She did not know the betamethasone cream was ordered as needed for psoriasis flares. -She administered the betamethasone 0.05% cream once as needed on 10/05/19 to Resident #7's psoriasis, but it was not effective. -On 10/05/19 Resident #7's psoriasis spread more to his body. -She knew the betamethasone 0.05% cream was available to administer to Resident #7. Interview with another day shift MA on 10/16/19 at 11:35am revealed: -She did not know Resident #7's psoriasis had spread. -She did not know the betamethasone cream was to be applied as needed for psoriasis flares. -"A flare would be an increase in the rash." -She had not administered the betamethasone cream to Resident #7 as needed during the month of October 2019. Interview on 10/16/19 at 10:40am with the facility's contracted Nurse Practitioner (NP) revealed: -He had seen Resident #7 09/18/19 because the psoriasis had returned.	{D 358}		

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{D 358}	Continued From page 22 -He had ordered to restart the betamethasone cream for 2 weeks and for as needed psoriasis flares. -He was not aware the MAs were not administering the betamethasone cream as ordered for flares. -He would expect the MAs to apply the cream as he had ordered. -He was not aware of the increase spread of Resident #7's psoriasis or the constant itching. -The facility had not contacted him regarding Resident #7's psoriasis or the constant itching. -He had seen Resident #7 on 10/07/19 but did not address his skin or the psoriasis. Interview with the Director of Resident Care (DORC) on 10/16/19 at 11:05am revealed: -The MAs came to her with any resident's concerns or issues. -She was not aware Resident #7 complained of constant itching or that his psoriasis had spread to other areas of his body. -She had assessed Resident #7's psoriasis in September 2019 and contacted the PA due to the psoriasis had returned. -She had not completed a re-assessment for Resident #7 skin in October 2019. -Resident #7 had a chronic condition psoriasis, she did not think she needed to re-assess his skin or document after her assessment in September 2019. Interview with the facility's contracted NP on 10/16/19 at 12:15pm revealed: -He had seen Resident #7 today for his psoriasis and itching. -Resident #7 had chronic psoriasis. -Resident #7 was complaining of itching. -He would contact Resident #7's dermatologist and get Resident #7 seen out as soon as	{D 358}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 23 possible. Interview with Resident #7 on 10/16/19 at 3:15pm revealed: -"It is all over my body." -He told the staff he was itching every day, but the staff had not done anything for him. -"I don't think they want to touch me because they think I am contagious, but I am not." Telephone interview with the dermatologist office Nurse Practitioner (NP) on 10/17/19 at 8:50am revealed Resident #7 had an appointment for 10/17/19 at 1:30pm. Telephone interview with another dermatologist office NP on 10/17/19 at 3:15pm revealed: -She and the dermatologist completed an examination of Resident #7 on 10/17/19. -Resident #7 diagnoses was psoriasis and he was having flare which covered over 50% of his body. -The psoriasis was "sever and involved" on his legs, arms, abdominal, arms and back area. -Resident #7 looked uncomfortable and was constantly inching. -She did not know the betamethasone cream was not being administered as ordered to Resident #7's psoriasis. -"The cream should be applied with psoriasis flares and even applied on the dry scaly areas". -The betamethasone cream should be applied for 2 weeks, off for two weeks; then can be reapplied for two weeks. -The facility should had contacted our office sooner for Resident #7 psoriasis flare. Interview with the Executive Director (ED) on 10/17/19 at 12:20pm revealed: -She expected the MAs to follow the physician's	{D 358}		

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{D 358}	Continued From page 24	{D 358}		

orders and to read the eMAR for instructions on how and when to administer medications.
-She expected the MAs to apply the cream to Resident #7 psoriasis as needed for flares.
-She relied on her Director of Resident Care (DORC) to follow up on orders and to assure the MAs were administering medications orders correct.

Refer to the interview with a MA on 10/16/19 at 10:05am.

Refer to the interview with the RCC on 10/16/19 at 11:44am.

Refer to the interview with the DORC on 10/17/19 at 11:48am.

Refer to the interview with the ED on 10/16/19 at 4:22pm.

Refer to the interview with the Administrator on 10/17/19 at 4:59pm.

2. Review of Resident #2's current FL2 dated 09/04/19 revealed diagnoses included degenerative disease of basal ganglea, cardiac myopathy ischemic and diabetes mellitus type 2.

a. Review of Resident #2's current FL2 dated 09/04/19 revealed an order for atorvastatin 20mg one tab every day (a medication used to treat high cholesterol and triglyceride levels) daily.

Review of Resident #2's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for atorvastatin 20mg once daily scheduled at 9:00pm.
-Atorvastatin was documented as administered

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{D 358}	Continued From page 25 daily at 9:00pm from 08/01/19 -08/31/19. Review of Resident #2's September 2019 eMAR revealed: -There was an entry for atorvastatin 20mg once daily scheduled at 9:00pm. -Atorvastatin was documented as administered daily at 9:00pm from 09/01/19-09/30/19. Review of Resident #2's October 2019 eMAR revealed: -There was an entry for atorvastatin 20mg once daily scheduled at 9:00pm. -Atorvastatin was documented as administered daily at 9:00pm from 10/01/19-10/14/19. Observation of Resident #2's medications available for administration on 10/15/19 at 3:03pm revealed: -Atorvastatin 40mg was available to be administered. -There was a bottle of atorvastatin 40mg, one tablet daily with a dispense date of 07/01/19, 90 pills were filled. -There was a handwritten note on the bottle "bedtime". -There were 63 whole tablets of atorvastatin remaining. -There should have been 78.5 atorvastatin 40mg tablets remaining. Telephone interview with a pharmacy representative at Resident #2's contracted pharmacy with veteran affairs (VA) on 10/17/19 at 9:45am revealed: -The most recent order received 04/11/19 for atorvastatin 20mg once daily. -There were 90 tablets of atorvastatin 40mg was dispensed on 07/01/19 and 10/03/19. -Orders were received electronically from the VA	{D 358}		

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{D 358}	Continued From page 26 physician and medications were filled when a refill request was received. Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/16/19 at 8:34am revealed: -The pharmacy had an order for Resident #2 dated 09/19/18 for atorvastatin 20mg once daily. -The pharmacy dispensed 30 tablets of atorvastatin 20mg on 06/20/19, 07/22/19, 08/15/19. -The pharmacy dispensed 7 tablets of atorvastatin 20mg on 09/16/19. -The pharmacy had not dispensed any tablets since 09/16/19. -Resident #2 was "profile only" because the resident used another pharmacy, medications were only filled at the request of the facility. Interview with the medication aide (MA) on 10/15/19 at 3:05pm revealed: -She administered Resident #2's medications during second shift. -She never had to cut any of his medications in half. -She administered medications as ordered per the eMAR. -MAs were supposed to read the medication label and administer medications according to the eMAR. -She had not noticed that Resident #2's atorvastatin were 40mg tablets. -Resident #2 never refused his medications. Interview with another MA on 10/16/19 at 11:10am revealed: -She administered Resident #2's medications when she worked second shift. -She remembered cutting Resident #2's atorvastatin in half because it was 40mg instead	{D 358}		

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{D 358}	Continued From page 27 of 20mg. -She did not know who ordered Resident #2's medications and did not understand why the medication was 40mg instead of 20mg. -Resident #2 never refused his medications. Interview with the Resident Care Coordinator (RCC) on 10/16/19 at 3:05pm revealed: -She did not know Resident #2 was administered the incorrect dose of atorvastatin. -She did not know atorvastatin 40mg was available for administration on the medication cart. -MAs were responsible for completing cart audits weekly, and she had not noticed atorvastatin 40mg was on the cart. Interview with Resident #2 primary care provider (PCP) on 10/16/19 at 3:29pm revealed: -Resident #2 was ordered atorvastatin to treat high triglycerides and high cholesterol. -She expected Resident #2 to receive the ordered dosage of atorvastatin. -She expected to be notified if the resident received the incorrect dose. Interview with Resident #2 on 10/16/19 at 10:20am revealed: -Staff administered his medications daily. -He received atorvastatin 40mg daily at bedtime. -None of his medications were cut in half when administered. Refer to the interview with a MA on 10/16/19 at 10:05am. Refer to the interview with the RCC on 10/16/19 at 11:44am. Refer to the interview with the Director of	{D 358}		

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{D 358}	Continued From page 28 Resident Care (DORC) on 10/17/19 at 11:48am. Refer to the interview with the Executive Director (ED) on 10/16/19 at 4:22pm. Refer to the interview with the Administrator on 10/17/19 at 4:59pm. b. Review of Resident #2's current FL2 dated 09/14/19 revealed an order for metformin 500mg (a medication used to diabetes), twice daily with food. Review of Resident #2's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for metformin 500mg to be administered twice daily at 9:00am and 5:00pm. -Metformin 500mg was documented as administered twice daily at 9:00am and 5:00pm from 08/01/19- 08/31/19. Review of Resident #2's September 2019 eMAR revealed: -There was an entry for metformin 500mg to be administered twice daily at 9:00am and 5:00pm. -Metformin 500mg was documented as administered twice daily at 9:00am and 5:00pm from 09/01/19 -09/30/19. Review of Resident #2's October 2019 eMAR revealed: -There was an entry for metformin 500mg to be administered twice daily at 9:00am and 5:00pm. -Metformin 500mg was documented as administered twice daily at 9:00am and 5:00pm from 10/01/19- 10/15/19. Observation of Resident #2's medications available for administration on 10/15/19 at	{D 358}		

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{D 358}	Continued From page 29 3:03pm revealed: -Metformin 500mg was available to be administered. -There were 180 tablets of metformin 500mg was dispensed on 07/10/19. -There were 33 tablets of metformin 500mg available for administration. -There should not have been any metformin 500mg remaining from the bottle dispensed 07/10/19. Telephone interview with a pharmacy representative at Resident #2's pharmacy with veteran affairs (VA) on 10/17/19 at 9:45am revealed: -The current order received was for metformin 500mg twice daily. -There were 180 tablets of metformin 500mg dispensed on 07/10/19. -There were 180 tablets of metformin 500mg dispensed on 10/12/19. -Medications were dispensed when requested by the patient. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/16/19 at 8:34am revealed: -There was an order for metformin 500mg twice daily for Resident #2 received on 10/19/18. -Metformin was "profile only" for Resident #2 because he used another pharmacy as primary. -Medications were only filled per the request of the facility. -Metformin 500mg had not been dispensed by the pharmacy. Interview with the medication aide (MA) on 10/15/19 at 3:05pm revealed: -She administered Resident #2's medications during second shift.	{D 358}		

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{D 358}	Continued From page 30 -She administered medications as ordered per the eMAR. -Resident #2 never refused his medications. -She always administered Resident #2 medications as ordered. -She did not know why Resident #3 had 33 pills of metformin 500mg remaining on the medication cart. Interview with another MA on 10/16/19 at 11:10am revealed: -She administered Resident #2's medications when she worked first and second shift. -Resident #2 never refused his medications. -She had not realized Resident #2 had 33 pills of metformin remaining on the medication cart. -Cart audits were completed weekly by the lead MAs, she did not know why they had not noticed 33 pills were remaining. Interview with the Lead MA/supervisor on 10/16/19 at 12:10pm revealed: -She was responsible for completing cart audits weekly. -She always ensured medications were available for administration. -She did not count medications available for administration. -Resident #2 never refused his medication. -She did not know why 33 tablets of metformin 500mg was remaining if they were dispensed 07/10/19. Interview with the Resident Care Coordinator (RCC) on 10/16/19 at 3:05pm revealed: -She did not know Resident #2 had 33 pills of metformin 500mg available for administration. -MAs were responsible for administering medications as ordered. -Resident #2 never refused his medications.	{D 358}		

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{D 358}	Continued From page 31 -She expected MAs to administer medications daily as ordered. Interview with Resident #2 primary care provider (PCP) on 10/16/19 at 3:29pm revealed: -Resident #2 was ordered metformin to treat diabetes. -She expected Resident #2 to receive all medications as ordered. -If Resident #2 missed metformin as ordered, it could cause his blood sugar to be elevated. -She expected to be notified if the resident did not receive medications as ordered. Interview with Resident #2 on 10/16/19 at 10:20am revealed: -Staff administered his medications daily. -He thought he received his medications as ordered. Refer to the interview with a MA on 10/16/19 at 10:05am. Refer to the interview with the RCC on 10/16/19 at 11:44am. Refer to the interview with the Director of Resident Care (DORC) on 10/17/19 at 11:48am. Refer to the interview with the Executive Director (ED) on 10/16/19 at 4:22pm. Refer to the interview with the Administrator on 10/17/19 at 4:59pm. 3. Review of Resident #3's current FL2 dated 09/14/19 revealed: -Diagnoses included hypertension, cerebral infarction, anxiety, depression, pulmonary disease, and hypokalemia.	{D 358}		

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{D 358}	Continued From page 32 -There was a physician's order for atorvastatin 20mg take 1 tablet one hour before bedtime (used to treat high cholesterol). Review of Resident #3's record revealed a physician's order dated 10/02/19 to decrease atorvastatin to 10mg take 1 tablet daily. Review of Resident #3's September 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for atorvastatin 20mg scheduled to administer at 7:00pm. -Atorvastatin was documented as administered daily at 7:00pm from 09/01/19 to 09/30/19. Review of Resident #3's October 2019 eMAR revealed: -There was a computer-generated entry for atorvastatin 20mg scheduled to administer daily at 7:00pm. -Atorvastatin 20mg was documented as administered at 7:00pm on 10/01/19 and was documented as discontinued on 10/02/19. -There was a computer-generated entry for atorvastatin 10mg scheduled to administer daily at 8:30pm. -Atorvastatin 10mg was documented as administered daily at 8:30pm from 10/03/19 to 10/15/19. Observation of medications on hand for Resident #3 on 10/16/19 at 10:05am revealed: -There was a medication card containing 14 tablets of atorvastatin 10mg dispensed on 10/02/19 available for administration with an original dispensed quantity on the label of 15 tablets. -There was a medication card containing 2 tablets	{D 358}		

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{D 358}	Continued From page 33 of atorvastatin 20mg dispensed on 09/19/19 available for administration with an original dispensed quantity on the label of 30 tablets.. -The medication card containing atorvastatin 20mg tablets was attached in front of the medication card containing atorvastatin 10mg with a rubber band. Telephone interview a pharmacist from the facility's contracted pharmacy on 10/16/19 at 11:10am revealed: -The pharmacy sent out 28 tablets of atorvastatin 20mg on 09/12/19 as a cycled medication. -The pharmacy received an order on 10/02/19 to discontinue atorvastatin 20mg and start atorvastatin 10mg daily dated 10/02/19. -The pharmacy sent out 15 tablets of atorvastatin 10mg on 10/02/19 when they received the new medication order lowering the dose of atorvastatin. Interview with a medication aide (MA) on 10/16/19 at 10:05am: -Resident #3 was supposed to be administered atorvastatin 10mg daily based on the eMAR. -During the last medication cart audit, the MA did not notice the two medication cards of atorvastatin were different strengths. -The MA "must have thought" the two medication cards were the same medications and attached the cards together with a rubber band. Interview with a 2nd Shift MA on 10/16/19 at 5:00pm revealed: -She knew Resident #3's atorvastatin order had changed. -She did not know what strength of atorvastatin she had administered to Resident #3. -She administered the medication that was available in the medication cart for Resident #3.	{D 358}		

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{D 358}	Continued From page 34 Interview with the Resident Care Coordinator (RCC) on 10/16/19 at 11:44am revealed: -She did not know Resident #3 was administered the incorrect dose of atorvastatin . -She did not know Resident #3's atorvastatin 20mg was still available on the medication cart. Interview with the Director of Resident Care (DORC) on 10/17/19 at 11:48am revealed: -She did not know Resident #3 was receiving the wrong dose of atorvastatin . -The RCC or the MAs were responsible for removing discontinued medications from the medication cart. -It was the RCC or the MAs responsibility to catch errors during the weekly medication cart audit. Interview with the facility's contracted Nurse Practitioner (NP) on 10/16/19 at 10:50am revealed: -Resident #3 was supposed to be administered atorvastatin 10mg daily. -He had lowered the dose of atorvastatin for Resident #3 because her blood work showed her cholesterol levels to be in the normal range and she did not currently need as much medication. -The facility should be following the medication orders as prescribed. Interview with the Executive Director (ED) on 10/16/19 at 4:22pm revealed she did not know Resident #3 was administered the incorrect dose of Lipitor. Refer to the interview with a MA on 10/16/19 at 10:05am. Refer to the interview with the RCC on 10/16/19 at 11:44am.	{D 358}		

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{D 358}	Continued From page 35 Refer to the interview with the DORC on 10/17/19 at 11:48am. Refer to the interview with the ED on 10/16/19 at 4:22pm. Refer to the interview with the Administrator on 10/17/19 at 4:59pm. Interview with a medication aide (MA) on 10/16/19 at 10:05am revealed: -The Resident Care Coordinator (RCC) or the Director of Resident Care (DORC) was responsible for approving medication orders for the electronic Medication Administration Record (eMAR). -The RCC and the DORC were responsible for making sure all medication orders on the eMAR were correct. -The MAs were responsible for auditing the medication carts compared to the eMAR weekly. -She did not administer any medications that did not have an active order listed on the eMAR. -The MAs were responsible for making sure all medications were available to be administered. -Medications were refilled on a cycle fill system every 28 days. Interview with the RCC on 10/16/19 at 11:44am revealed: -She was responsible for processing new medication orders. -She was responsible for faxing new medication orders or discontinuation orders to the pharmacy. -Once the pharmacy entered the order into the eMAR software, the order would "pop" on the eMAR. -She was responsible for comparing the entered medication order to the written order she had	{D 358}		

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{D 358}	Continued From page 36 faxed to the pharmacy to make sure the order was entered correctly. -She was responsible for approving all medication orders for the eMAR. -She was responsible for following up with the MAs the following day to make sure the new medication was available to be administered. -A discontinuation order was processed with the same procedure as a new order. -The MAs were responsible for scanning all medication cards from the facility contracted pharmacy before administration to make sure the medication was correct. -The MAs were responsible for auditing the medication carts weekly to make sure all medications were available to be administered and no expired medications were on the cart. Interview with the DORC on 10/17/19 at 11:48am revealed: -The RCC was responsible for medication administration processes, including medication order approved for the eMAR. -She could approve medication orders but the RCC was usually at work and completed all approvals. -The RCC and MAs were responsible for removing discontinued medications from the medication cart. Interview with the Executive Director (ED) on 10/16/19 at 4:22pm revealed: -The RCC were responsible for processing new medication orders and clarifying any medication orders. -She or the DORC would fill in for the RCC to process medication orders if the RCC was out of work. -The MAs were responsible for making sure the corrected medication was administered to the	{D 358}		

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{D 358}	Continued From page 37 resident based on the eMAR. -The MAs were responsible for scanning each medication card before administration. -The medication did not have an active order on the eMAR then the eMAR software would alert the MA that the medication should not be administered. Interview with the Administrator on 10/17/19 at 4:59pm revealed: -The ED had called her and informed her about the findings during the survey process. -She tried to visit the facility weekly but was always available by phone. -The ED was responsible for the day to day operations of the facility. -The ED was responsible for making sure the staff followed facility policies. -The ED would call her if she needed any help with anything going on in the facility. The facility failed to administer medications as ordered for Resident #7 related to not administering a steroid cream used for the treatment of psoriasis resulting in an increased risk of infection, worsened itching and spread of rash, Resident #2 related to not administering atorvastatin and metformin as ordered, and giving the incorrect dose of atorvastatin to Resident #3 after a physician's order to decrease dose. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 10/17/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER	{D 358}		

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{D 358}	Continued From page 38 2, 2019.	{D 358}		
D 430	10A NCAC 13F .1106 (d) Settlement Of Cost Of Care 10A NCAC 13F .1106 Settlement Of Cost Of Care (d) When a resident gives notice of leaving the facility, as may be required by the facility according to Rule .0702(h) of this Subchapter, and leaves at the end of the notice period, the facility shall refund the resident the remainder of any advance payment within 14 days from the date of notice. If notice is not required by the facility, the refund shall be made within 14 days after the resident leaves the facility. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview and record review, the facility failed to assure the settlement of cost of care was refunded within 14 days of discharge for six out of eight sampled residents (Residents #8, #9, #10, #11, #12, and #14). The findings are: 1. Review of Resident #8's Resident Register revealed the resident was admitted to the facility on 09/01/16 and discharged on 05/28/19. Review of Resident #8's Move-Out Room & Board Refund Form revealed: -Resident #8 was discharged from the facility on 05/28/19.	D 430	10A NCAC 13F .1106(d) Settlement of Cost of Care Facility Management will assure that resident refunds are processed and refunded according to the rule .1106 Settlement of Cost of Care Facility ED, Business Office Manager, and Divisionall Business Office Manager have complete review/audit of discharged residents in regards to residents settlement of cost of care. Facility will submit resident room and board refund request upon discharge of resident to the accounting office (home office) for processing. Facility Business Office Manager will use a tracking system to record the date of the room and board request and date due for final processing of refund according to regulatory standards Facility Business Office Manager will review the room and board refunds weekly with ED to assure timely processing Facility ED will follow-up weekly with the Divisional Business Director and/or Accounting Office Manager and obtain the status of refunds due for the week to assure timely processing	12/2/19 11/19/19 12/2/19 12/2/19 12/2/19 12/2/19

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D 430	Continued From page 39 -The form documented Resident #8's new placement. -Resident #8 was due a refund of $152.52. Review of Resident #8's Resident Trust Fund Statement Form documented dated 10/16/19 documented an Resident Trust Account Ending Balance of $933.75. Telephone interview with the Administrative-in-Charge at Resident #8's current placement on 10/16/19 at 10:45am revealed: -Resident #8 moved into the facility on 05/28/19. -Resident #8 was missing a May refund from the previous facility in the amount of $153. -Resident #8 was also missing her June 2019 Supplemental Security Income, SSI, in the amount of $771. -The current facility could not assess the funds because the previous facility had not returned the funds. -The current facility had contacted the previous facility numerous times about the resident's money and got a different excuse why the money was not forwarded to Resident #8 or the facility would not return phone calls. -Resident #8 would accuse the current facility's staff of taking her money when advised she did not have any funds available. -The facility had been giving personal funds to Resident #8 from their own account to purchase her personal items since the resident had no personal available and to prevent her from becoming verbally aggressive with staff and other residents. Telephone interview with Resident #8's legal guardian representative on 10/17/19 at 9:45am revealed the current placement was owed money for May and June.	D 430	continued from 39 Facility Business Office Manager has received training on resident room and board refund process/procedure. Training provided by facility ED Facility ED and Business Office Manager have received training on Resident Refunds. Training provided by Divisional Business Director	10/18/19 11/19/19

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D 430	Continued From page 40 Interview with a representative from the Social Security Administration Office on 10/17/19 at 11:45am revealed: -Resident #8's SSI check for the month of June 2019 in the amount of $771 was issued to the previous facility. -On 07/03/19, Resident #8's current facility became her payee. -October 17, 2019 was 141 days after the 05/28/19 discharge date that the previous facility had not issued Resident #8 her refund. Refer to the telephone interview with the Senior Vice President of Operation on 10/16/19 at 2:45pm. Refer to interview with the Administrator on 10/08/19 at 10:43am 10/17/19 at 3:42pm. Refer to interview with Divisional Business Office Manager on 10/08/19 at 10:56am. 2. Record review of Resident #9's Resident Register revealed he was admitted to the faciliy on 09/01/16 and disharged on 05/24/19. Review of Resident #9's Move-Out Room & Board Refund Form revealed: -Resident #9 was discharged from the facility on 05/24/19. -The form documented Resident #9's estate to disperse a refund. -Resident #9 was due a refund of $305.03. Review of Resident #9's Resident Trust Fund Statement Form documented dated 10/16/19 from the previous facility documented an Resident Trust Account Ending Balance of $771.	D 430		

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D 430	Continued From page 41 Telephone interview with the Administrative-in-Charge at Resident #9's current placement on 10/16/19 at 10:45am revealed: -Resident #9 moved into the facility on 05/24/19. -Resident #9 was missing a May refund from the previous facility in the amount of $305. -Resident #9 was also missing her June and July 2019 Supplemental Security Income, SSI, in the amount of $771 for each month. -The current facility could not assess the funds because the previous facility had not returned the funds. -The current facility had contacted the previous facility numerous times about the resident's money and got a different excuse why the money was not forwarded to Resident #9 or the facility would not return phone calls. -Resident #9 moved to skilled nursing in August of 2019. Telephone interview with Resident #9's legal guardian representative on 10/17/19 at 9:45am revealed: -Resident #9's recently passed away in a skilled nursing facility. -Resident #9's previous placement prior to being admitted to skilled nursing was owed money for May, June, and July. Interview with a representative from the Social Security Administration Office on 10/17/19 at 11:45am revealed Resident #9's SSI check for the months of June and July 2019 in the amount of $771 each was issued to the previous facility. -October 17, 2019 was 143 days after the 05/28/19 discharge date that the previous facility had not issued Resident #8 her refund. Refer to the telephone interview with the Senior	D 430		

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D 430	Continued From page 42 Vice President of Operation on 10/16/19 at 2:45pm. Refer to interview with the Administrator on 10/08/19 at 10:43am 10/17/19 at 3:42pm. Refer to interview with Divisional Business Office Manager on 10/08/19 at 10:56am. 3. Review of Resident #10's Resident Register revealed Resident #10 was admitted to the facility on 10/04/18 and discharged on 07/23/19. Review of Resident #10's Move-Out Room & Board Refund Form revealed: -Resident #10 was discharged from the facility on 07/23/19. -The form documented no current address for Resident #10's refund to be disbursed. -Resident #10 was due a refund of $343.15. Review of Resident #10's Resident Trust Fund Statement Form documented dated 10/16/19 documented from the previous facility a Resident Trust Account Ending Balance of $1604.04. Telephone interview with the Administrative-in-Charge at Resident #8's current placement on 10/16/19 at 10:45am revealed: -Resident #10 moved into the facility on 07/23/19. -Resident #10 was missing a July refund from the previous facility in the amount of $343. -The current facility could not assess the funds because the previous facility had not returned the funds. -The current facility could not assess the funds because the previous facility had not returned the funds. -The current facility had contacted the previous facility numerous times about the resident's	D 430		

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D 430	Continued From page 43 money and got a different excuse why the money was not forwarded to Resident #10. -Resident #10 was given personal funds by the facility to purchase her personal items. Telephone interview with Resident #10's legal guardian representative on 10/17/19 at 9:45am revealed the current placement was owed money for July. -October 17, 2019 was 86 days after the 07/23/19 discharge date that the previous facility had not issued Resident #10 her refund. Refer to the telephone interview with the Senior Vice President of Operation on 10/16/19 at 2:45pm. Refer to interview with the Administrator on 10/08/19 at 10:43am 10/17/19 at 3:42pm. Refer to interview with Divisional Business Office Manager on 10/08/19 at 10:56am. 4. Record review revealed Resident #11's Resident Register revealed Resident #11 was admitted to the facility on 09/01/16 and discharged on 08/08/19. -Review of Resident #11's Move-Out Room & Board Refund Form revealed: -Resident #11 was discharged from the facility on 08/08/19. -The form documented the Department of Social Service as the address for Resident #11's refund to be disbursed. -Resident #11 was due a refund of $915.10. -Review of Resident #11's Resident Trust Fund Statement Form documented dated 10/08/19 from the previous facility documented a Resident	D 430		

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D 430	Continued From page 44 Trust Account Ending Balance of zero. Telephone interview with the Administrator-in-Charge for Resident 11's current placement on 10/16/19 at 10:20am revealed: -Resident #11 was admitted to the facility on 08/08/19. -The facility had not received his social security check for September 2019. -The facility had contacted the Social Security Administration Office on 10/11/19 and was told that their office could not reroute Resident #11's social security check for September until the money was received from his previous placement. -The facility had contacted Resident #11's previous placement on 10/11/19 and told her Resident #11's check was sent back to social security. -The Administrator gave Resident 11's his personal fund money to purchase razors, soap and deodorant. -Resident #11 accused the facility of stealing his money. -Resident #11 was verbally aggressive and difficult to direct because he wanted his spending money. -The Administrator provided the personal funds out of his own pocket in order to calm the resident down. Telephone interview with Resident #11's legal guardian representative on 10/17/19 at 9:45am revealed the current placement was owed money for September. Interview with a representative from the Social Security Administration Office on 10/17/19 at 11:45am revealed: -Resident #11's SSI check for the month of	D 430		

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D 430	Continued From page 45	D 430		

September 2019 in the amount of $906 was issued to the previous facility.
-There was no documentation to support that the September 2019 check was returned to agency.

October 17, 2019 was 47 days after the 08/08/19 discharge date that the previous facility had not issued Resident #11 his refund.

Refer to the telephone interview with the Senior Vice President of Operation on 10/16/19 at 2:45pm.

Refer to interview with the Administrator on 10/08/19 at 10:43am 10/17/19 at 3:42pm.

Refer to interview with Divisional Business Office Manager on 10/08/19 at 10:56am.

5. Record review revealed Resident #12's Resident Register revealed Resident #12 was admitted to the facility 03/30/18 and discharged on 08/09/19.

Review of Resident #12's Move-Out Room & Board Refund Form revealed:
-Resident #12 was discharged from the facility on 08/09/19.
-The form documented no address for Resident #11's refund to be disbursed.
-Resident #12 was due a refund of $876.96.

Review of Resident #12's Resident Trust Fund Statement Form documented dated 10/08/19 from the previous facility documented a Resident Trust Account Ending Balance of zero.

Interview with a representative from the Social Security Administration Office on 10/17/19 at 11:45am revealed Resident #12's social security

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D 430	Continued From page 46 checks were being sent to the previous facility, and the facility had not returned any funds to the agency. Interview with the Business Office Manager for Resident #12's current placement revealed: -Resident #12 currently owed the facility a total of #2,387 for the months of August and September. -She was unable to provide the specific amounts for each month due to the facility being under new ownership, and the new company uses a different billing system. -Resident #12 had requested money to purchase personal items. -The facility provided the funds because she did not want to punish the resident for the previous provider not returning the refund. October 17, 2019 was 46 days after the 08/09/19 discharge date that the previous facility had not issued Resident #12 her refund. Refer to the telephone interview with the Senior Vice President of Operation on 10/16/19 at 2:45pm. Refer to interview with the Administrator on 10/08/19 at 10:43am 10/17/19 at 3:42pm. Refer to interview with Divisional Business Office Manager on 10/08/19 at 10:56am. 6. Record review revealed Resident #14's Register Register revealed Resident #14 was admitted to the facility on 3/12/19 and discharged on 08/08/19. Review of Resident #14's Move-Out Room & Board Refund Form revealed: -Resident #14 was discharged from the facility on	D 430		

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D 430	Continued From page 47 08/08/19. -The form documented no address for Resident #11's refund to be disbursed. -Resident #14 was due a refund of $826.10. Review of Resident #14's Resident Trust Fund Statement Form documented dated 10/08/19 from the previous facility documented a Resident Trust Account Ending Balance of zero. Interview with a representative from the Social Security Administration Office on 10/17/19 at 11:45am revealed Resident #14's social security checks were being sent to East Town, and the facility had not returned any funds to the agency for the month of August. Interview with Resident #14's administrator for her current placement revealed: -Resident #14 as admitted to the facility on 08/08/19. -She had not received the August funds for Resident #14 from her previous placement. -She would receive the funds from social security for the months of September and October once she was approved as Resident #14's payee. -Resident #14 had requested her personal funds money. -She provided Resident #14's personal money to prevent her from becoming agitated by not having money when going on outings. October 17, 2019 was 47 days after the 08/08/19 discharge date that the previous facility had not issued Resident #14 her refund. Refer to the telephone interview with the Senior Vice President of Operation on 10/16/19 at 2:45pm.	D 430		

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D 430	Continued From page 48 Refer to interview with the Administrator on 10/08/19 at 10:43am 10/17/19 at 3:42pm. Refer to interview with Divisional Business Office Manager on 10/08/19 at 10:56am. Telephone interview with the Senior Vice President of Operation on 10/16/19 at 2:45pm revealed: -She was made aware that the facility was not processing resident's refunds timely on 10/02/19. -The refund process should start once a person gave notice or upon death. -The Move-Out Room and Board Refund Form was sent to the home office to process. -The refunds should be processed within 14-days of discharge or within 30-days of death to the clerk of court. Interview with the Administrator on 10/08/19 at 10:43am 10/17/19 at 3:42pm revealed: -The facility completed a Move-Out Room and Board Refund Form to calculate how much of a refund was owed to the resident upon discharge. -The Move-Out Room and Board Refund Form was sent to the cooperate office to issue a check for the refund amount. -Cooperate office would then issue a refund check and send to the facility to disburse any refunds. -If Special Assistance Medicaid was owed, the facility hand-delivered the check to the Department of Social Service. -If the Social Security Check was owed, the facility hand-delivered the check to the Social Security Office. -Any personal funds to be refunded to the resident upon discharge were sent to the resident at their new placement or returned to the Clerk of Court if the resident was deceased.	D 430		

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D 430	Continued From page 49 Interview with the Divisional Business Office Manager on 10/08/19 at 10:56am revealed: -When a resident was removed from the facility's census, "the program makes you complete a room and board refund." -The Move-Out Room and Board Refund Form was calculated on an Excel Spread Sheet and the refund was based on the number of days in the facility times the daily rate. -The refund was calculated by the computer. -The form allowed the input of the address where the refund check was to be mailed. -The completed form showed what funds were owed back to the resident. -Social Security funds were returned to the Social Security Administration Office. -Special Assistance Medicaid funds were returned to the county in which the county was a resident. -Resident funds were returned to the resident. -She was aware that refunds should be processed within 14-days of discharge and within 30-days of a resident's death. -She did not have an explanation of why the refunds were not being processed except that the entire accounting department was completely new staff. Interview with the Divisional Business Office Manager on 10/08/19 at 10:56am revealed: -When a resident was removed from the facility's census, "the program makes you complete a room and board refund." -The Move-Out Room and Board Refund Form was calculated on an computer spreadsheet and the refund was based on the number of days in the facility times the daily rate. -The refund was calculated by the computer. -The form allowed the input of the address where the refund check was to be mailed.	D 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060149	A. BUILDING: _____ B. WING _____	R 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

(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 430	Continued From page 50 -The completed form showed what funds were owed back to the resident. -Social Security funds were returned to the Social Security Administration Office. -Special Assistance Medicaid funds were returned to the county in which the county was a resident. -Resident funds were returned to the resident. The facility failed to return refunds to assure the settlement of cost of care was refunded within 14-days of discharge related to the residents not having appropriate funding for their room and board costs at their new facilities along with no funding available to purchase personal care items without the help of their current facility for Residents #8, #9, #10, #11, #12, and #14. This failure was detrimental to the health, safety and welfare for the residents and constitutes a Type B violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 10/17/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 2, 2019.	D 430		
{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.	{D912}	G.S 131d-21(2) Declaration of Residents' Rights Facility Management will assure that all residents receive care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations.	11/17/19

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
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{D912}	Continued From page 51 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 medication as ordered by a physician and assure settlment of cost of care. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 3 of 6 sampled residents (Resident #2, #3, and #7) related to a steroid cream used to treat psoriasis (#7) and administering the incorrect dose of a medication used to treat high cholesterol (#2 and #3). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 2. Based on interview and record review, the facility failed to assure the cost of care settlement was refunded within 14-days of discharge for six out of eight sampled residents (Residents #8, #9, #10, #11, #12, and #14). [Refer to Tag 430, 10A NCAC 13F .1106(d) Settlment of Cost of Care (Type B Violation)].	{D912}	Facility Management will assure it provides health care referral and follow-up to meet the routine and acute health care needs of residents. Refer to Plan of Correction for tag D 273	11/17/19
			Facility Management will 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 residents record; and 2) rules in this section and the facility's policies and procedures Refer to Plan of Correction for tag D 358	12/2/19
			Facility Management will assure that resident refunds are processed and refunded according to state rules and regulations. Refer to Plan of Correction for tag D 430.	12/2/19
			All facility staff have received training in Resident Rights. Training provided by ED and Licensed RN.	11/15/19