Division of Health Service Regulation

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OCT 11 2019
ADULT CARE LICENSURE SECTION
RALEIGH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R-C 08/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

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D 000	Initial Comments The Adult Care Licensure Section and the Wayne County Department of Social Service conducted an annual survey and a complaint investigation from August 20,2019 - August 23,2019 and August 26, 2019. The complaint investigations were initated by the Wayne County Department of Social Services on 06/20/19and 08/07/19.	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 the 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 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule	D 188		

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

Martin Fleischhacker, Executive Director 10/2/2019

Reviewed and accepted with addendum
Sharon Simmons
10/14/19

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D 188	Continued From page 1 .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure aide hours met the minimum requirements on 08/10/19 and 08/11/19 for 2 of 15 shifts sampled. The findings are: Review of the facility's 2019 license revealed the facility was licensed for a capacity of 104 residents. Review of the facility's roster dated 08/20/19 revealed the facility had a current census of 88 residents. Review of the facility's daily census for August 2019 revealed: -The total census was 87 on 08/08/19. -The total census was 88 from 08/09/19 through 08/12/19. Confidential interviews with staff revealed:	D 188	10/10/19 The Resident Care Coordinator (RCC) will prepare the staffing schedule at least 2 weeks in advance ensuring appropriate staffing levels have been scheduled. The ED will review to ensure compliance and initial as reviewed. The schedule will be reviewed daily in morning stand up and all call-outs discussed and promptly replaced to ensure compliance with regulatory requirements. The RCC/designee will be responsible for replacing staff for call-outs and the ED will initial daily schedule as reviewed and compliant during morning stand up	

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D 188	Continued From page 2 -There were times when there were not enough staff working. -Sometimes there was one personal care aide (PCA) working on the 100-hall section of the facility. -There were residents on the 100-hall that required two person transfers. -Staff had to wait for assistance from another section of the facility sometimes in order to provide personal care. -Staff had transferred two persons assist residents alone at times when there was no other staff to assist. -There was usually one medication aide (MA) working on the 7:00pm to 7:00am shift and was responsible for managing three medication carts. -Staff had worked alone on the locked unit with 20 residents. Interview with a resident on 08/20/19 at 10:31am revealed: -The facility was sometimes understaffed because the resident would have to wait when the resident pressed the call bell. -The resident could not state an average wait time for the call bell. -Sometimes staff did not respond to the call bell. Interview with a second resident on 08/20/19 at 10:32am revealed: -There was not enough staff at night. -She pulled her call bell for help on 08/19/19 at 5:30am staff responded at 6:30am. Interview with a third resident on 08/20/19 at 11:02am revealed: -There was not enough staff especially on the weekend. -The staff would tell her there was only one PCA sometimes on the weekend.	D 188	The ED will be responsible for reviewing time records daily and following up tardies and absenteeism. ED or designee will provide staff training regarding attendance expectations, answering call bells timely, ensuring constant staff coverage of assignment during meal breaks, and promptly responding to resident needs and requests. Documentation of training will be maintained in the community for review.	

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D 188	Continued From page 3 -When there was not enough staff, it took a while for the staff to answer her call bell. Interview with a fourth resident on 08/20/19 at 11:45am revealed: -There was not enough staff on weekends. -Sometimes the staff would tell her they were short staffed. Confidential interview with a resident's family member revealed: -The facility had "inadequate staffing". -The facility was short staffed during the evening hours after dinner and around bedtime, especially on the weekends. -On the weekend of 08/11/19, a family member had to assist a resident in getting into bed at 9:30pm because no staff had been around to assist the resident. -The resident was still wearing day clothes because no staff had assisted the resident in changing into night clothes. Confidential interview with a second family member revealed: -The family member was concerned there was not enough staff to supervise residents. -The family member had voiced a concern to the Administrator and was told the facility was understaffed at times. Confidential interview with a third family member revealed: -The facility was short-staffed. -There was not enough staff to do what needed to be done. -The family member had been at the facility when there were two PCAs "trying to take care of 60 people". -The resident's "basic necessity" was being	D 188		

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D 188	Continued From page 4 provided for. -There was a lot of staff turnover and staff were "spread thin" and "stressed". Confidential interview with a fourth family member revealed they assisted with feeding residents when they noticed there was not enough staff coverage for feeding all the residents requiring feeding assistance. Confidential interview with a fifth family member revealed: -There might be two staff passing out plates in the dining room. -There were times observed when one PCA assisted a resident requiring two-person assistance. -The family member observed two days ago one staff person come to assist a two-person assist resident with care. -The facility had recently started hiring new staff. Review of facility's staff time cards and resident census revealed the facility was short personal care aide and supervisor staff hours as follows: -On 08/10/19 for third shift, staff members total work hours equalled to 25 hours and 20 minutes. The facility was required to have 24 aide hours and 4 hours of supervisor time in the facility and 4 hours of supervisor time within 500 feet of the facility. The facility was short 2 hours and 40 minutes of personal care aide and supervisor hours. -On 08/11/19 for third shift, staff members total work hours equalled to 25 hours and 57 minutes. The facility was required to have 24 aide hours and 4 hours of supervisor time in the facility and 4 hours of supervisor time within 500 feet of the facility. The facility was short 2 hours and 3 minutes of personal care aide and supervisor	D 188		

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D 188	Continued From page 5 hours. Interview with the Administrator on 08/22/19 at 4:30pm revealed the Resident Care Coordinator (RCC) was responsible for completing the staff work schedule. Interview with the Administrator on 08/26/19 at 12:10pm revealed: -The RCC was responsible for the schedule. -Some staff working 12 hours shifts took two one-hour breaks during their shift, which was one hour for every six hours worked. -Night shift staff clocked out "religiously" for two hours and there was additional coverage for that. -There was usually an extra person scheduled to work on the night shift. -Some staff that worked only 11:00pm - 7:00am may take a 30-minute break and not a full one-hour break. -The number of care staff were adjusted based on resident census in the facility. -There were some new staff working who were still in training. -If there was an additional staff scheduled to work, that person would be listed on the schedule. Interview with the RCC on 08/26/19 at 12:10pm revealed she did not have an additional staff scheduled to work on the 11:00pm -7:00am shift on 08/10/19 or 08/11/19. Interview with the Administrator-In-Training (AIT) on 08/26/19 at 12:25pm revealed: -She reviewed the work schedules. -The August 2019 schedule must have "slipped by" her. -The facility was "usually" staffed.	D 188		

Guardian Phar 10929 GA Hwy 877-736-2233 866-534-5566 Jodi DiNello 912-536-1795 Jodi.Dinello@e Summer's of V Guardian Phar 10929 GA Hwy

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D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 2 of 7 residents sampled (#1, #6) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Resident #1's current FL-2 dated 05/01/19 revealed diagnoses included dementia, chronic pain, muscle weakness, abnormal weight loss, anorexia, dysphagia, obesity, and history of seizures. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 11/15/17 from a skilled nursing facility. Review of Resident #1's tuberculosis (TB) skin test records revealed:	D 234	The RCC/ED/designees will audit all resident records to ensure documentation of two-step TB testing. Any residents without required documentation will be re-tested and documentation placed in the resident's record. The RCC will be responsible for ensuring all residents have documentation of a TB skin test prior to or at the time of admission with a second step administered at least 2 weeks after the date of the first test. The RCC will be responsible for maintaining a resident tickler for all residents to ensure compliance with all required documentation, including but not limited to TB skin testing. The ED will review the Resident Tickler at least monthly to ensure ongoing compliance.	10-10-19

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D 234	Continued From page 7 -There was a computer printed document with a fax stamp date of 11/15/17 at the top of the page. -There was one TB skin test with a "date given" of 08/24/17 that was negative. -There was no date to indicate when the TB skin test placed on 08/24/17 was read. -There was one TB skin test with "date give" of 09/07/17 that was negative. -There was no date to indicate when the TB skin test placed on 09/07/17 was read. -There was a computer printed entry beside each TB skin test given with a person's name listed in the "administered by" column. -There were no computer printed credentials listed beside the person's name. -The letters "RN" were handwritten beside the person's name. -There was no documentation of any other TB skin tests for Resident #1. Based on observations, record reviews, and interviews, it was determined Resident #1 was not interviewable. Interview with the Administrator on 08/26/19 at 4:00pm revealed: -Resident #1 as admitted from a skilled nursing facility (SNF). -The computer printed form with TB skin test documentation was from the SNF. -She did not know who handwrote "RN" on the form. -She contacted the SNF today and they were supposed to fax more information for Resident #1's TB skin tests. -She had not received any additional information from the SNF. Refer to Interview with the Administrator on 08/26/19 at 4:00pm.	D 234		

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D 234	Continued From page 8 2. Review of Resident #6's current FL-2 dated 07/24/19 revealed diagnoses included malignant neoplasm of the meninges, secondary neoplasms of the brain, lung and bone, hypertension, and type 2 diabetes mellitus. Review of Resident #6's Resident Register revealed she was admitted to the facility on 06/27/19. Review of Resident #6's tuberculosis (TB) skin test records revealed: -There was a TB skin test placed on 06/26/19 at 8:30am while Resident #6 was at another facility. -It was documented that the TB skin test was to be read on 06/28/19 (the documentation area for the reading was blank). -There was no documentation the TB skin test was read in the record. -There was a second TB skin test placed on 08/20/19 that was read on 08/22/19 as 0 mm-negative. -There was no other documentation of TB skin tests for Resident #6. Interview with the Resident Care Coordinator (RCC) on 08/26/19 at 3:45pm revealed: -She was out on leave when Resident #6 was admitted to the facility. -The Administrator-in-Training (AIT) took the admitting orders and they should be in a file in her office that may have TB skin tests for Resident #6. Interview with the Administrator on 08/26/19 at 4:20pm revealed: -They had been unable to locate any other TB testing information for Resident #6. -The AIT and /or the RCC should have been	D 234		

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D 234	Continued From page 9 responsible for making sure TB skin tests were completed as required when Resident #6 was admitted to the facility. -She would check to see if any other TB skin test information was available for Resident #6. A second interview with the Administrator on 08/26/19 at 6:13pm revealed she had been unable to locate any other TB testing information for Resident #6. Refer to interview with the Administrator on 08/26/19 at 4:00pm. Interview with the Administrator on 08/26/19 at 4:00pm revealed: -The Director of Resident Care (DRC) was responsible for assuring residents had the required TB skin testing upon admission. -The former DRC was no longer employed with the facility and that position was currently still vacant. -They were currently working on getting a system in placed to monitor TB skin testing.	D 234		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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D 273	Continued From page 10 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure health care referral and follow up for 2 of 8 sampled residents (#1, #6) including failure to notify Resident #6's primary care provider (PCP) of an emergency room visit on 08/11/19 for right leg swelling and fluid weeping from the right leg; and failure to notify Resident #1's PCP of unexplained bruising. The findings are: 1. Review of Resident #6's current FL-2 dated 07/24/19 revealed diagnoses included malignant neoplasm of the meninges, secondary neoplasms of the brain, lung and bone, hypertension, and type 2 diabetes mellitus. Review of Resident #6's hospital discharge summary dated 08/11/19 revealed: -The resident was admitted on 08/11/19 with chief complaint of right leg swelling. -The resident's right leg was swollen and had drainage from a small open area over her right shin. -Resident #6 was started on Lasix (used to treat fluid build-up). Review of Resident #6's physician visit notes and resident care notes revealed no documentation Resident #6's primary care provider (PCP) was notified of the emergency room visit in 08/11/19. Interview with Resident #6 on 08/23/19 at 9:12am revealed: -She had gone out with a family member on 08/11/19. -She noticed her right sock and shoe were wet as if she "had stepped in a mud puddle" when she	D 273	10-10-19 All resident records will be audited to identify any issues requiring referral, follow up, or physician notification. Any identified issues will be followed up immediately. Staff will be re-trained regarding the consistent use of the 24hr monitoring log to document any/all issues occurring during their shift . TDocumentation of the training will be maintained in the community for review. The RCC will be responsible for reviewing the 24hr log daily and following up on all issues. The RCC will initial the log as reviewed daily and will take the log to morning stand up to be discussed/reviewed with the management team. The RCC will be responsible for ensuring all ER post visit information is placed in the physician's folder for review during his/her next scheduled visit.	

Addendum Records were audited by QP & will be audited Randomly each week 10/11/19

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D 273	Continued From page 11 arrived at her family members home. -Her family member noticed fluid weeping from her right shin area. -She had her family bring her back to the facility. -The facility had emergency medical services (EMS) transport her to the local emergency room (ER) for the right leg swelling and fluid weeping from her right shin. -She had first noticed the swelling on 08/10/19 but thought it was just from her sitting with her right leg down instead of elevating her right leg. Observation of Resident #6 on 08/23/19 at 9:12am revealed: -Her right lower leg remained swollen. -The area of her right shin was not weeping. Telephone interview with Resident #6's PCP on 08/26/19 at 5:25pm revealed: -She had not been notified of Resident #6 going to the ER on 08/11/19. -She had not seen Resident #6 for a follow-up after being seen in the ER on 08/11/19. -Resident #6 should have been on the list to be seen that week following the ER visit. -She had not been receiving accurate information regarding Resident #6; as she was not aware of any leg swelling or weeping. -She expected to be notified by the facility staff when residents were sent out to the ER and the resident should be placed on the following weeks schedule for her to see them. Telephone interview with a medication aide (MA) on 08/26/19 at 5:58pm revealed: -She was not working when Resident #6 went to the emergency room (ER). -She worked the next day and had been told Resident #6 had been seen in the ER for her leg swelling and had been given Lasix.	D 273	All staff will be re-trained regarding completing incident reports for all events including but not limited to visits to the ER. The RCC will be responsible for reviewing daily to ensure proper MD notification is documented on the incident reports as well as in the resident progress notes. The ED will review all completed incident reports daily to ensure ongoing compliance.	

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D 273	Continued From page 12 Interview with the Administrator in Training (AIT) 08/26/19 at 7:01pm revealed she was not sure if Resident #6's PCP was notified of the ER visit on 08/11/19 but she would check on it. Interview with the Administrator 08/26/19 at 6:13pm revealed: -She was not sure if Resident #6's PCP was notified of the ER visit on 08/11/19 but she would check on it. -She would check some paperwork that had not been filed yet. 2. Review of Resident #1's current FL-2 dated 05/01/19 revealed diagnoses included dementia, chronic pain, muscle weakness, abnormal weight loss, anorexia, dysphagia, obesity, and history of seizures. Review of Resident #1's assessment and care plan dated 03/28/19 revealed: -The resident was non-ambulatory and used a wheelchair. -The resident had limited range of motion, limited strength, and limited eye-hand coordination. -The resident had daily incontinence of bowel and bladder. -The resident was always disoriented and had significant memory loss. -The resident required extensive assistance from staff with toileting, bathing, dressing, and grooming. -The resident was totally dependent upon staff with ambulation and transferring. Interview with Resident #1's family member on 08/20/19 at 2:10pm revealed: -She was at the facility this past Sunday, 08/18/19, and saw bruises on Resident #1's	D 273		

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D 273	Continued From page 13 knees and thighs. -She notified the medication aide (MA) on duty but she could not recall the MA's name. -The MA called the Administrator-in-Training (AIT) the same day and notified the AIT of the bruises. -The facility staff did not know how the resident got the bruises. Observation of Resident #1 on 08/23/19 at 2:21pm revealed: -The resident had two bruises above each knee approximately 1.5 inches x 2.5 inches in size. -The bruises were purple around the edges with yellowish green discoloration in the center of each bruise. -There were four smaller bruises (the size and shape of fingerprints) on the right inner thigh and one smaller bruise on the left inner thigh that were light purple with yellowish green discoloration. Interview with a MA on 08/26/19 at 4:10pm revealed: -The family of Resident #1 showed her bruises on the resident's thighs on 08/11/19. -The resident did not complain of pain. -She did a skin assessment. -The AIT was notified and came to the facility. -She did not know if the AIT looked at Resident #1's bruises. Interview with a personal care aide (PCA) on 08/23/19 at 2:20pm revealed: -She first noticed bruises on Resident #1's inner thighs "last week". -She did not report the bruises to anyone because she thought other staff were already aware. -Resident #1 was "not very verbal" and could not tell how she got the bruises.	D 273		

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D 273	Continued From page 14 -She did not know how the resident got the bruises. Review of Resident #1's progress notes dated 03/01/19 - 08/21/19 revealed: -The last progress note charted was dated 07/22/19. -There was no documentation of Resident #1's unexplained bruising on her thighs identified in August 2019. -There was no documentation Resident #1's primary care provider (PCP) was notified of the bruising on the resident's thighs in August 2019. Interview with the Resident Care Coordinator (RCC) on 08/26/19 at 5:00pm revealed: -Resident #1's family made the facility aware of the bruising about 1 to 2 weeks ago. -The resident's family reported the resident had bruising on her thighs. -She had not looked at the resident's thighs, so she had not seen the bruising. -The Administer-in-Training (AIT) came to the facility and looked at the resident's bruising on the weekend before last. -She did not notify Resident #1's PCP of the bruising since she did not see it. -The AIT would be responsible for reporting it to the PCP since she observed the bruising. Interview with the AIT on 08/26/19 at 5:57pm revealed: -The RCC contacted the her on 08/18/19 to notify her that Resident #1 had bruising on her inner thighs that looked like fingerprints. -A MA had reported it to the RCC. -The AIT went to the facility that day on 08/18/19 and immediately interviewed staff but no one knew what happened. -She did not report the bruising to Resident #1's	D 273		

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D 273	Continued From page 15 PCP. -She thought the RCC reported it to the PCP. Interviews with the Administrator on 08/26/19 at 4:00pm and 6:25pm revealed: -The resident was currently total care and required 2-person assistance and sometimes 3-person assistance for transferring and incontinence care. -They thought the bruising may have occurred when staff were providing personal care and trying to turn the resident. -She did not know if the resident's PCP had been notified of the bruises. Telephone interview with Resident #1's PCP on 08/26/19 at 3:01pm revealed: -Resident #1 had bruising on her thighs in April 2019 that appeared to occur during personal care when staff were changing the resident. -She did not see any signs of abuse at that time. -It looked like someone had lifted her to wash between her legs. -She last saw Resident #1 during a visit in June 2019 and she had no bruises. -She was at the facility last week to see other residents, but no one mentioned Resident #1 had any current bruising. -She expected the facility to notify her of any bruising on Resident #1.	D 273		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for	D 298		

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D 298	Continued From page 16 a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure snacks were offered or made available to all residents three times a day The findings are: Review of the facility's weekly menu for week four, 08/25/19 to 08/31/19 revealed there were no listed snack options or snack times posted. Observation on 08/20/19 at 10:10am revealed: -In the lobby of the assisted living "bistro" area, there was a tray of snacks sitting on a counter. -There were 3 oranges, 8 small bags of chips, 6 granola bars, 6 packages of large cookies and 6 packages of 6 small peanut butter crackers. -Two residents were observed getting an orange and a pack of peanut butter crackers. Observation of a resident in her room on 08/20/19 at 10:40am revealed a personal care aide (PCA) offered the resident snacks and the resident responded, "That's a first I've ever seen that". Interview with a resident on 08/20/19 at 10:14am revealed: -The residents used to get snacks. -They stopped getting snacks "about 6 months ago". -They used to get a punch drink with their snacks. -The resident was told by staff (no names provided) that the residents could not get snacks anymore because they were making a mess with	D 298	The Dietary Manager (DM) will ensure the snack menu along with the dietary extensions are posted weekly for guidance of food service staff. The ED will verify posting weekly during walk-throughs of the community. The dietary manager (DM) will ensure a variety of snack options are prepared three times daily at 10am, 2pm, and 8 pm. The RCC will be responsible for ensuring snacks are offered/provided for all residents at these time. The RCC will ensure care staff deliver snacks room-to-room for those residents who choose not to go to the dining room for snacks. Care staff will be re-trained regarding tid snack delivery and process for ensuring appropriate snacks and beverages are available and provided/offered to all residents.	10-10-19

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D 298	Continued From page 17	D 298		

the punch and spilling it.
-The resident was not aware that snacks were available at the front "bistro" area of the assisted living.

Interview with a second resident on 08/20/19 at 10:19am revealed:
-"Snacks were at the front."
-No one came to the room with snacks.

Interview with a third resident on 08/20/19 at 10:31am revealed:
-No snacks were offered to the resident.
-The resident bought and kept a supply of snacks in the resident's room.

Interview with a fourth resident on 08/20/19 at 10:32am revealed:
-No staff brought snacks to the resident's rooms.
-Snacks were in the lobby at the front of the building.

Interview with a fifth resident on 08/20/19 at 10:49am revealed:
-The resident had just finished eating an oatmeal cookie the facility provided as a snack.
-The staff usually brought snacks to the resident's room 1 or 2 times a day.
-They did not offer any liquids to drink with the snacks.

Interview with a sixth resident on 08/20/19 at 11:02am revealed:
-She had never had snacks brought to her room until today.
-She had to go to the front of the building in order to get a snack.
-Snacks were kept at the front in the lobby.

Interview with a seventh resident on 08/20/19 at

Jodi DiNello 912-536-1795 Jodi.Dinello@e Summer's of V Guardian Phar 10929 GA Hwy 877-736-2233 866-534-5566 Jodi DiNello 912-536-1795

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D 298	Continued From page 18 11:45am revealed: -Snacks were never brought to her room. -She had to go to the front to get snacks. Interview with an eighth on 08/21/19 at 8:42am revealed: -She was offered a snack in her room on 08/20/19 around 10:30am for the first time since she had been living there. -She was not offered a snack in her room any other time on 08/20/19. Interview with the Kitchen Manager on 08/23/19 at 1:30pm revealed: -Snacks were served or made available by the dietary aides to residents at 10:00am, 2:00pm and 8:00pm. -The snacks were placed out in the "bistro" area at the front lobby of the assisted living (AL) side. -For the residents known to not get out of their room, then the snacks were brought to their room and offered. -She thought all residents were informed upon admission that the snacks are offered in the "bistro" area but she did not know for certain. -In the locked unit, the snacks were served to all residents in the dining room. Interview with the Resident Care Coordinator (RCC) on 08/23/19 at 2:10pm revealed: -The dietary aides were responsible for offering all snacks to the residents at 10:00am, 2;00pm and 8:00pm. -In May 2019 she remembered they had run out of snacks, but that had only happened one day that she could remember. -Residents were told upon admission that snacks were left out at the "bistro" area on the assisted living side and were served to the residents on the locked unit.	D 298		

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D 298	Continued From page 19 Interview with the Administrator on 08/26/19 at 4:00pm revealed: -The dietary staff were responsible for offering snacks each day at 10:00am, 2:00pm and 8:00pm. -On the AL side, the snacks were made available in the "bistro" area or a dietary aide went and offered the snacks to those residents known to not leave their rooms. -On the locked unit, all residents were served their snacks in the dining room. -She did not know there were resident complaints that snacks were not available. -She did not know that the facility ever ran out of snacks.	D 298		
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 1 of 2 sampled residents (#11) was served honey-thickened liquids as ordered. The findings are: Review of Resident #11's current FL-2 dated 07/06/19 revealed: -Diagnoses included gastro-esophageal reflux, acute kidney failure, anemia, hypertension,	D 310	All resident records/dietary orders will be audited to ensure all diet orders are accurately entered into the Matrix (computer) system. Any discrepancies will be corrected immediately.	10-10-19

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D 310	Continued From page 20 chronic kidney disease and hypomagnesaemia. -There was an order for a regular diet. Review of Resident #11's progress notes revealed: -On 08/03/19, a medication aide (MA) noted Resident #11 was having difficulty swallowing medications and food. A notification fax was sent to the primary care provider's (PCP) office. -On 08/05/19, a second MA noted Resident #11 was still having difficulty swallowing medication. There was no documentation regarding PCP notification. -On 08/06/19, a third MA documented the PCP was notified and an order was received for mechanical soft diet, honey-thickened liquids and a speech evaluation. Review of a physician order dated 08/05/19 on 08/21/19 at 11:00am revealed: -There was an order for honey thickened all liquids. -There was an order to change diet to mechanical soft. -There was an order for home health speech therapy referral. Review of the facility's therapeutic diet list posted in the kitchen on 08/21/19 at 11:15am revealed: -Resident #11 was listed to have thickened liquids but the consistency was not specified. -The therapeutic diet list was not dated. Observation in the kitchen on 08/21/19 at 11:30am revealed there were two 46-ounce containers each of nectar-thickened orange juice, nectar-thickened tea and nectar-thickened water in the refrigerator. Interview with the dietary aide on 08/21/19 at	D 310	When a new diet order is received, the RCC will input the order into the Matrix system and give a copy to the Dietary Manager (DM), who will update the list posted in the kitchen. The RCC will be responsible for ensuring a newly printed, current, accurate list of residents on therapeutic diets and/or thickened liquids will be posted weekly in the kitchen for guidance of food service staff. The DM will be responsible for ensuring an adequate supply of pre-thickened liquids are on hand for each consistency ordered by the physician. The DM will be responsible for ensuring an adequate supply of thickening agent is on hand to ensure the ability to properly thicken any beverage of residents' choice which is not available in pre-thickened form Dietary and care staff will receive re-training regarding thickened liquids to include how to properly mix to ordered consistency. Training will be provided by the DM or other qualified person as designated by the ED and documentation of training will be maintained in the community for review	

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D 310	Continued From page 21 11:30am revealed: -Resident #11 was supposed to have nectar-thickened liquids. -The Kitchen Manager updated the dietary orders on the posted therapeutic diet list whenever there were new or changed diet orders. -Resident #11 was listedon the therapeutic diet list as on thickened liquids. -She was told by the Kitchen Manager that only two residents (one was Resident #11) were on thickened liquids which were to be nectar-thick. -The facility stocked pre-made nectar thickened liquids that included orange juice, tea and water. -The facility did not stock nectar-thickened milk. -If a resident had an order for nectar-thickened liquids, and the resident wanted milk, then the staff would mix half of the nectar thickened water with half of the regular milk. -Resident #11 did not like milk. -The dietary aides were responsible to pour and serve any thickened liquids Resident #11 drank to the personal care aides (PCA) who would give it to the resident. Interview with the Kitchen Manager on 08/22/19 at 11:30am revealed: -The process for new diet orders was the Resident Care Coordinator (RCC) or the Medication Aide (MA) would process the order by putting it in the electronic medication administration record (eMAR). -The hard copy of the dietary order would then be delivered to the Kitchen Manager who would put it in the diet book. -If a resident was on thickened liquids, that resident's name would be put on the posted therapeutic diet list under "thickened liquids". -She updated the posted therapeutic diet list whenever there were new or changed diet orders. -The facility only stocked nectar thickened liquids	D 310		

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D 310	Continued From page 22 because they only had two residents ordered that consistency. Observation of Resident #11 during the lunch meal service on 08/22/19 from 12:00pm to 12:40pm revealed: -Resident #11 was sitting at the dining room table in the locked unit and was served an eight-ounce glass of nectar-thickened tea and an eight-ounce glass of nectar-thickened water by the staff. -Resident #11 drank two sips of nectar-thickened tea. -The surveyor intervened and informed the Kitchen Manager immediately of the nectar-thickened tea and water that had been ordered to be honey-thickened. -A dietary aide removed the glasses of tea and water from Resident #11 and took them back to the kitchen. Interview with the Kitchen Manager on 08/22/19 at 12:05pm revealed: -She did not know that Resident #11 had an order for honey-thickened liquids. -She had been told by the RCC that the order was for nectar-thickened liquids. Interview with the Administrator on 08/22/19 at 12:10pm revealed: -She did not know that Resident #11 had an order for honey-thickened liquids. -She thought the order was for nectar-thickened liquids since that was what the dietary staff had been stocking for the two residents on thickened liquids. -She would get honey-thickened liquids immediately for Resident #11. Observation on 08/22/19 at 12:15pm in the kitchen revealed:	D 310		

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D 310	Continued From page 23 -The dietary aide mixed the tea to show the process that was followed to produce honey-thickened tea. -Mixing instructions for the instant food and beverage thickener for honey consistency were to "mix four to five teaspoons of thickener with four ounces of tea using the enclosed scoop for level measuring". -The dietary aide used five teaspoons of the enclosed scoop of thickener with four ounces of tea to produce a honey-thick consistency. -The honey-thickened tea was served to Resident #11. -Resident #11 drank all the tea and all the water without any difficulty with swallowing or coughing noted. Interview with a MA on 08/22/19 at 5:00pm revealed: -Resident #11 had trouble swallowing before he was ordered thickened liquids. -She thought his order was for nectar-thickened liquids because that was what he had been served by the dietary staff. -She did not know the order was for honey-thickened liquids. -She had not been informed or witnessed any choking or trouble swallowing with Resident #11 since he had started the nectar-thickened liquids in early August 2019. Interview with the Administrator on 08/23/19 at 10:00am revealed: -The facility had now stocked pre-made honey-thickened apple juice, milk, orange juice and tea. -The staff would use the instant food and beverage thickener for honey-thickened water. -The facility had now stocked pre-made nectar thickened milk.	D 310		

Jodi.Dinello@s Summer's of V Guardian Phar 10929 GA Hwy 877-736-2233 866-534-5566 Jodi DiNello 912-536-1795 Jodi.Dinello@s Summer's of V

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D 310	Continued From page 24 -All staff received training on 08/23/19 for thickened liquids and how to mix them. Observation of the refrigerator in the kitchen on 08/23/19 at1:52pm revealed: -There were two 46-ounce containers each of honey-thickened orange juice, apple juice and tea. -There were ten 8-ounce containers each of honey-thickened milk and nectar-thickened milk. Telephone interview with a speech therapist for Resident #11 on 08/23/19 at 10:45am revealed: -She completed an initial evaluation for Resident #11 on 08/15/19. -A follow-up visit was made with Resident #11 on 08/20/19. -She was told by the MA that Resident #11 had been on honey-thickened liquids since it was ordered on 08/05/19. -She observed that Resident #11 had delayed swallowing on 08/20/19. -Resident #11 was on dysphagia therapy and aspiration precautions. -She had not requested any change in Resident #11's honey-thickened liquids order since she last saw him on 08/20/19. Interview with the Kitchen Manager on 08/23/19 at 1:30pm revealed: -The diet orders for all residents were printed out every Monday and given to her by the Resident Care Coordinator (RCC). -It was the RCC's responsibility to give her any new order changes. -Resident #11's diet order now reflected honey-thickened liquids in the dietary order book and on the posted therapeutic diet list . -The facility now stocked pre-made honey-thickened tea, milk, apple juice and orange	D 310		

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D 310	Continued From page 25 juice. Interview with a second MA on 08/23/19 at 1:50pm revealed: -He did not know that Resident #11 was on any kind of thickened liquids. -He did not know how to mix thickened liquids. -He did not know if there was any thickener on the medication cart. -He had been administering medications for the month of August to Resident #11 with regular non-thickened water. -He had not known about or witnessed Resident #11 choking or having trouble swallowing. Interview with the RCC on 08/23/19 at 2:10pm revealed: -She knew Resident #11 was ordered honey-thickened liquids but did not know he was getting nectar-thickened liquids instead. -When a dietary order was new, she made a copy and gave it to the Kitchen Manager. -Since yesterday, 08/22/19, all MAs knew about Resident #11's honey-thickened liquids and had been trained on how to mix them if they did now have any pre-made in stock. Interview with Resident #11's Primary Care Provider (PCP) on 08/26/19 at 11:15am revealed: -She was not aware that Resident #11 was getting nectar-thickened liquids and not honey-thickened liquids. -She had not received any reports that Resident #11 had any choking eposodes since she wrote an order on 08/05/19 for honey-thickened liquids. -She would expect Resident #11 to continue to receive honey-thickened liquids until she could re-evaluate him at his next visit. Interview with Resident #11's family member on	D 310		

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D 310	Continued From page 26 08/26/19 at 12:02pm revealed: -She knew that Resident #11 was placed on a mechanical soft diet and thickened liquids in early August 2019 because he had trouble swallowing. -She did not know what consistency of thickened liquids Resident #11 was supposed to be on. -She had not been informed of any further trouble swallowing or choking since the thickened liquids were started. Based on observations, interviews and record reviews, it was determined Resident #11 was not interviewable.	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: TYPE A1 VIOLATION	D 358		

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D 358	Continued From page 27 Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 4 of 4 residents (#1, #13, #14, #20) observed during the medication passes including errors with insulin (#1, #20), inhalers for breathing problems (#13), a diuretic/blood pressure medication (#14), a fish oil supplement (#14), and a vitamin supplement (#13); and for 6 of 9 residents sampled (#2, #3, #4, #6, #7, #9) for record review including errors with medications for pain (#6), high blood pressure (#2, #6, #9), diabetes (#6), blood thinner (#9), Parkinson's disease (#3), anxiety (#4), muscle spasms (#9), Alzheimer's dementia (#9), acid reflux (#7), gout (#2), and low potassium levels (#7). The findings are: 1. The medication error rate was 25% as evidenced by the observation of 7 errors out of 27 opportunities during the 8:00am medication pass on 08/21/19 and the 12:00pm medication pass on 08/22/19. a. Review of Resident #1's current FL-2 dated 05/01/19 revealed: -Diagnoses included dementia, chronic pain, muscle weakness, abnormal weight loss, anorexia, dysphagia, obesity, and history of seizures. -There was an order for Humalog insulin 3 units 3 times a day with meals. (Humalog is rapid-acting insulin that lowers blood sugar. Humalog is available in vial or insulin pen.) Review of Resident #1's August 2019 electronic medication administration record (e-MAR) revealed:	D 358	ED/RCC/audit team members will audit all resident records and clarify physiian orders. Clarified orders will be compared to eMAR to ensure orders have been entered correctly. A revised med cart auditing schedule will be developed and implemented to ensure all resident's medications are audited weekly and sufficient supply is on hand for administration. The RCC will be responsible for reviewing cart audits daily to ensure completion and appropriate and timely follow up. The RCC will initial each cart audit as reviewed and compliant. Med fill/refill requests will be faxed to the pharmacy and placed through the bucket order processing system. Upon med delivery, meds will be checked against fill requests tby the receiving MA to ensure ordered meds were delivered. The RCC will be responsible for reviewing bucket system folders daily to ensure follow up The supervisor on each shift will review medication administration compliance reports for the shift and follow up with all identified issues as well as promptly report all noted issues to the RCC. The RCC will be responsible for ensuring timely and appropriate followup as well as identify ongoing training needs and provide training based on assessed needs.	9-25-19 audits initiated by ED 10/4/19 weekly random chart audits. MA responsible for med cart audit. 10/4/19

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D 358	Continued From page 28 -There was an entry for Humalog insulin inject 3 units 3 times daily with meals. -Humalog was scheduled to be administered at 8:00am, 12:00pm, and 5:00pm. -Three units of Humalog were documented as administered 3 times daily from 08/01/19 - 08/21/19. -The resident's blood sugar ranged from 128 - 296 from 08/01/19 - 08/22/19. Interview with the medication aide (MA) on 08/22/19 at 11:34am revealed she was going to prepare 3 units of Humalog insulin to administer to Resident #1. Observation of the medication pass on 08/22/19 at 11:35am revealed: -The MA got Resident #1's Humalog insulin vial and an insulin syringe from the medication cart. -The insulin syringe was 1ml with lines marking 2 units from 0 to 100 units. -The MA drew up Humalog insulin to the line marking 4 units. -The MA approached the resident to administer 4 units of Humalog insulin. -Surveyor intervened and asked the MA to step back to the medication cart. Interview with the MA on 08/22/19 at 11:35am revealed: -When questioned, the MA stated there were 3 units in the syringe. -The MA pointed to the line marking 0 units and counted that line as 1 unit, then proceeded to count each line in 1-unit increments. -There were no lines marking 1 unit increments on the insulin syringe. -She did not realize the first line marked on the syringe was the line for 0; she thought it was 1 unit.	D 358	The RCC will bring all med administration compliance reports to morning stand up daily to report all issues to management team and daily plans for correction/improvement. ED will be responsible for overseeing this process to ensure ongoing training needs are met and improvements/ corrections are made. The ED will initial as reviewed each Med Admin Compliance Report daily. Re-training of medication aides began prior to survey team exit and will continue ongoing based on assessed needs to ensure compliance is achieved and maintained on an ongoing basis. All documentation of training will be maintained oin the community for review The ED will schedule additional retraining of med aides to be conducted by a Pharmacy representative and/or a Registered nurse. Training to include but not limited to the following: Med Admin Process Infection Control Diabetic Training Insulin prep and administration (vial & pen) Proper Documentation Crushing medications Use of proper measuring devices Proper reporting procedures Accuracy of dosage measuring Acceptable med admin time frames	

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D 358	Continued From page 29 -She counted each line as 1 unit and had not noticed each line was marking 2 units. -When asked how she would measure 3 units now, the MA stated she would have to estimate the dosage of Humalog between the lines marking 2 and 4 units. -When she first started working at the facility in 2017, they had insulin syringes that were marked in 1-unit increments. -There had not been any insulin syringes with 1 unit increments for over a year. -The only insulin syringes in the facility for any diabetic resident was the 1ml syringe with 2-unit markings. -She would ask the Resident Care Coordinator (RCC) what to do about the syringes. Interview with the RCC on 08/22/19 at 11:43am revealed: -The 1ml syringes with 2-unit markings were the only ones available in the facility. -If a resident needed 3 units of insulin, the MAs would have to estimate between the lines marking 2 and 4 units. -She did not realize the syringes were only marked in 2-unit increments and could not accurately measure odd number of insulin unit doses. -The MAs had been trained by a nurse on how to administer insulin using insulin syringes and they should know how to read the markings on the syringes. -She did not know the MA thought the first line marked on the syringe was 1 instead of 0. Interview with the Administrator on 08/22/19 at 11:47am revealed: -The MAs had been trained by a nurse and should know how to read the markings on the insulin syringe.	D 358		

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D 358	Continued From page 30 -They would contact Resident #1's primary care provider (PCP) regarding the insulin. A second interview with the Administrator on 08/22/19 at 12:05pm revealed: -Staff had been to 2 different pharmacies and could not find insulin syringes that would measure in 1-unit increments. -She contacted the PCP and got an order for a one-time dose of 4 units of Humalog until they could locate the correct syringes. Review of a telephone order for Resident #1 dated 08/22/19 revealed: -There was a one time order to administer 4 units of Humalog insulin, recheck blood sugar, and report to the primary care provider (PCP). -The rechecked blood sugar was documented as 199 on the telephone order form. b. Review of Resident #20's current FL-2 dated 04/26/19 revealed: -Diagnoses included diabetes mellitus, chronic obstructive pulmonary disease, fibromyalgia, major depressive disorder, hypomagnesemia, and urinary tract infection. -There was an order for Humalog insulin 2 units 4 times a day with meals and at bedtime. (Humalog is rapid-acting insulin used to lower blood sugar.) Review of Resident #20's physician's orders dated 07/19/19 revealed an order to change Humalog to Novolog insulin. (Novolog is rapid-acting insulin used to lower blood sugar. According to the manufacturer, the Novolog Flexpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.)	D 358		

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D 358	Continued From page 31 Review of Resident #20's August 2019 electronic medication administration record (e-MAR) revealed: -There was an entry for Novolog Flexpen inject 2 units 3 times daily with meals. -Novolog Flexpen was scheduled to be administered at 7:30am, 12:00pm, and 5:30pm. -The resident's blood sugar ranged from 121 - 250 from 08/01/19 - 08/22/19. Observation of the 12:00pm medication pass on 08/22/19 revealed: -The medication aide (MA) dialed to 2 units on the Novolog Flexpen and performed an air shot. -The MA then removed the pen needle and applied a new pen needle to the tip of the insulin pen. -The MA then dialed to 2 units and administered it to Resident #20 at 11:58am. -The MA did not perform a 2-unit air shot prior to dialing the dose after applying a second pen needle to assure there were no air bubbles and the insulin was flowing through the pen. Interview with the MA on 08/22/19 at 11:15am and 1:17pm revealed: -She had training on diabetes including the use of insulin pens. -She was supposed to dial 2 units and "shoot it in the trash" to make sure the pen worked. -She changed the pen needle today because she thought the needle looked bent. -She did not do an air shot with the second pen needle because she thought it would work since the first one worked. Interview with the Administrator on 08/22/129 at 3:50pm revealed: -The MAs had been trained to perform a 2 unit air	D 358		

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D 358	Continued From page 32 shot after a pen needle was applied to the insulin pen. -She would have the MAs retrained on the use of insulin pens. Interview with a second MA on 08/23/19 at 10:23am revealed: -She would perform either a 1-unit or 2-unit air shot when she used an insulin pen to administer insulin to residents. -She was told in an in-service yesterday (08/22/19) that she was supposed to do a 2-unit air shot when using insulin pens. Interview with Resident #20 on 08/22/19 at 3:50pm revealed: -Her blood sugar was checked daily in the morning. -She received insulin before meals, but sometimes after the meals. -She was not sure if staff performed an air shot prior to administering her insulin with the insulin pen. c. Review of Resident #14's current FL-2 dated 04/03/19 revealed: -Diagnoses included Alzheimer's disease early onset, hypertension, multiple myeloma, depression, and osteoarthritis. -There was an order for Omega-3 take 2 capsules daily. (Omega-3 is a fish oil supplement that may be used to prevent heart disease.) -There was an order for Spironolactone 25mg 1 tablet daily. (Spironolactone is a diuretic used to treat swelling and high blood pressure.) Review of Resident #14's August 2019 electronic medication administration record (e-MAR) revealed: -There was an entry for Omega-3 capsule 1	D 358		

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D 358	Continued From page 33 gram, take 2 capsules every day with a scheduled administration time of 8:00am. -Omega-3 was documented as administered daily from 08/01/19 - 08/21/19. -No refusals were documented. -There was an entry for Spironolactone 25mg take 1 tablet every day with a scheduled administration time of 8:00am. -Spironolactone was documented as administered daily from 08/01/19 - 08/21/19. Observation of the 8:00am medication pass on 08/21/19 revealed: -The medication aide (MA) prepared morning medications for Resident #14 in a paper medication cup, including 2 Omega-3 capsules and Spironolactone 25mg. -The MA poured all medications in a plastic sleeve to crush except the 2 Omega-3 capsules which she poured into another paper medication cup. -The MA crushed the medications but left the paper cup with the Omega-3 capsules sitting on the medication cart. -Upon further observation, the Spironolactone 25mg tablet was stuck on the underside of the Omega-3 capsules. -The MA administered the crushed medications to Resident #14 at 8:37am. -The MA left the cup with the Omega-3 capsules and the Spironolactone table sitting on top of the medication cart. -The Omega-3 capsules and the Spironolactone tablet were not offered or administered as ordered. -The MA threw the paper medication cup with the Omega-3 capsules and the Spironolactone tablet in the trash can on the medication cart. Interviews with the MA on 08/21/19 at 8:45am	D 358		

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D 358	Continued From page 34 and 4:20pm revealed: -She did not administer the Omega-3 capsules because the resident usually refused to take her medications if she opened the capsules and mixed the liquid with the crushed medications. -She was not aware the Spironolactone tablet was stuck on the bottom of the Omega-3 capsules and had been thrown away with the Omega-3 capsules. -The Spironolactone should have been crushed and administered with the other medications. Interview with the Resident Care Coordinator (RCC) on 08/21/19 at 4:26pm revealed: -She administered medications 4 or 5 days a week and Resident #14 had never refused the Omega-3 capsules when she administered medications. -No one had reported the resident refused any medications. -The MAs were supposed to check the medications cups when they administered medications to make sure all medications were taken. -Medications should be offered as ordered to the residents. Based on observations, interviews, and record reviews, it was determined Resident #14 was not interviewable. Attempted telephone interview with Resident #14's primary care provider (PCP) on 08/22/19 at 4:13pm was unsuccessful. d. Review of Resident #13's current FL-2 dated 05/09/19 revealed: -Diagnoses included atrial fibrillation, vascular dementia, atherosclerotic heart disease, heart failure, and polyuria.	D 358		

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D 358	Continued From page 35 -There was an order for Spiriva 18mcg with Handihaler, inhale the contents of 1 capsule once every day by taking 2 separate inhalations via Handihaler device. (Spiriva is used to treat chronic obstructive pulmonary disease. According to the manufacturer, the recommended dosage is 2 inhalations of 1 capsule to ensure the full contents of the capsule are inhaled.) -There was an order for Symbicort 80/4.5mcg inhaler, inhale 1 puff twice daily, rinse mouth with water after use, do not swallow. (Symbicort is used to treat chronic obstructive pulmonary disease. According to the manufacturer, rinsing the mouth after use will help prevent fungal infections of the mouth and throat.) Review of Resident #13's August 2019 electronic medication administration record (e-MAR) revealed: -There was an entry for Spiriva with Handihaler, inhale the contents of 1 capsule once every day by taking 2 separate inhalations via Handihaler device with a scheduled administration time of 8:00am. -Spiriva was documented as administered daily from 08/01/19 - 08/21/19. -There was an entry for Symbicort 80/4.5mcg inhaler, inhale 1 puff twice daily, rinse mouth with water after use, do not swallow with scheduled administration times of 8:00am and 8:00pm. -Symbicort was documented as administered from 08/01/19 - 08/21/19. Observation of the 8:00am medication pass on 08/21/19 revealed: -The medication aide (MA) handed the Symbicort 80/4.5mcg inhaler to Resident #13 and the resident inhaled 1 puff. -The resident did not rinse his mouth with water	D 358		

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D 358	Continued From page 36 after the use of the Symbicort inhaler. -The MA did not offer or instruct the resident to rinse his mouth after using the Symbicort inhaler as ordered. -The MA handed the Spiriva inhaler to the resident and the resident took 1 inhalation using the Handihaler device and gave it back to the MA. -The MA did not instruct the resident to take 2 inhalations of Spiriva as ordered. Interview with the MA on 08/21/19 at 12:00pm revealed: -She was not aware Resident #13 was supposed to rinse his mouth with water after using the Symbicort inhaler. -She had not seen the instructions on the e-MAR. -The resident usually did 1 inhalation of the Spiriva instead of 2. -She did not instruct the resident to take 2 inhalations today because he would usually just do 1 inhalation even if she told him to do 2. Interview with Resident #13 on 08/21/19 at 11:06am revealed: -He did not rinse his mouth with water after the use of Symbicort because he did not know he was supposed to do it. -The MAs had not instructed him to rinse his mouth. -He had not had any problems with fungal problems in his mouth or throat. -He usually took 1 inhalation of Spiriva because he did not know he was supposed to take 2. The MAs had not instructed him to take 2 inhalations. Interview with the Administrator on 08/21/19 at 1:48pm revealed: -The MAs had been trained to read the e-MARS and follow the instructions.	D 358		

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D 358	Continued From page 37 -Medications should be administered as ordered. Telephone interview with Resident #13's primary care provider (PCP) on 08/23/19 at 2:00pm revealed: -She expected Resident #13's Symbicort and Spiriva to be administered as ordered. -It was necessary to rinse the resident' mouth with water after use of Symbicort to prevent thrush (a fungal infection in the mouth). -The resident needed to take 2 inhalations of the Spiriva to ensure the full dose of medication was received. e. Review of Resident #13's current FL-2 dated 05/09/19 revealed: -Diagnoses included atrial fibrillation, vascular dementia, atherosclerotic heart disease, heart failure, and polyuria. -There was an order for Vitamin B1 100mg take 1 tablet every day (Vitamin B1 is a vitamin supplement.) Review of Resident #13's June 2019 electronic medication administration record (e-MAR) revealed: -There as an entry for Vitamin B1 100mg take 1 tablet every day with a scheduled administration time of 8:00am. -Vitamin B1 was documented as administered daily from 06/01/19 - 06/30/19. Review of Resident #13's July 2019 electronic medication administration record (e-MAR) revealed: -There as an entry for Vitamin B1 100mg take 1 tablet every day with a scheduled administration time of 8:00am. -Vitamin B1 was documented as administered daily from 07/01/19 - 07/31/19.	D 358		

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D 358	Continued From page 38 Review of Resident #13's August 2019 electronic medication administration record (e-MAR) revealed: -Vitamin B1 was documented as administered from 08/01/19 - 08/20/19. -Vitamin B1 was documented as refused on 08/21/19. Observation of the 8:00am medication pass on 08/21/19 revealed: -The medication aide (MA) prepared and administered 8:00am medications for Resident #13 and administered them to the resident at 8:24am. -Vitamin B1 was not prepared or offered to the resident as ordered. Interview with the MA on 08/21/19 at 12:00pm revealed: -She did not notice that Resident #13's Vitamin B1 tablet was not included in the multidose medication pack with the other morning medications. -She thought Resident #13's Vitamin B1 tablet usually came in a different multidose pack but she could not find it in the cart. -There was no Vitamin B1 to administer to the resident. Interview with Resident #13 on 08/21/19 at 11:06 am revealed: -He did not think he usually received Vitamin B1. -He had not refused any medications. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 08/26/19 at 2:30pm revealed: -There were 30 tablets of Vitamin B1 100mg dispensed on 04/25/19, 05/22/19, and 06/20/19	D 358		

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D 358	Continued From page 39 for Resident #13. -There were 29 tablets of Vitamin B1 100mg dispensed on 07/24/19. -No Vitamin B1 100mg tablets had been dispensed since 07/24/19. Interview with the Administrator on 08/21/19 at 1:48pm revealed: -The MAs and Resident Care Coordinator (RCC) did weekly medication cart audits to check for unavailable medications. -If a medication was unavailable, the MAs should contact the pharmacy. Telephone interview with Resident #13's primary care provider (PCP) on 08/23/19 at 2:00pm revealed: -She expected the resident's medications to be administered as ordered. -She thought the resident was taking Vitamin B1 for neuropathy. 2. Review of Resident #6's current FL-2 dated 07/24/19 revealed diagnoses included malignant neoplasm of meninges, secondary neoplasms of the brain, lung and bone, hypertension, and type 2 diabetes mellitus. a. Review of Resident #6's current FL-2 dated 07/24/19 revealed there was an order for Norco 10-325 mg one tablet by mouth every six hours (Norco is a controlled substance used to treat moderate to severe pain.). Review of Resident #6's July 2019 hand written MAR revealed: -There was an entry for Norco 10-325 mg one tablet every six hours with scheduled administration times of 12:00am, 6:00 am, 12:00pm and 6:00pm. -There was documentation Norco 10-325 mg was	D 358		

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D 358	Continued From page 40 not administered on 07/01/19 due to the drug not being available. -There was documentation Norco 10-325 mg was not administered on 07/03/19 due to the drug not being available. -There were 12 opportunities with 6 missed doses from 07/01/19-07/03/19. Review of Resident #6's July 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Norco 10-325 mg one tablet every six hours with scheduled administration times of 12:00am, 6:00 am, 12:00pm and 6:00pm. -There was documentation Norco 10-325 mg was not administered on 07/10/19 due to the drug not being available. -There was documentation Norco 10-325 mg was not administered on 07/11/19-07/14/19 due to the drug not being available. -There was documentation Norco 10-325 mg was not administered on 07/24/19 through 07/31/19 due to the drug not being available. -There were 112 opportunities with 49 missed doses from 07/04/19-07/31/19. Review of Resident #6's control substance (CS) log dated 07/03/19 - 08/23/19 revealed: -The first entry for Norco was dated 07/03/19 at 6:00pm. -There was a balance of 0 on 07/09/19 at 11:57pm. -There were 24 doses of Norco not documented as being administered from 07/10/19 at 6:00am until 07/16/19 at 12:00am. -There was a balance of 0 on 07/23/19 at 6:05pm. -There were 12 doses of Norco not documented as being administered from 07/23/19 at 12:00am	D 358		

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D 358	Continued From page 41 until 07/25/19 at 6:00pm. -There was no controlled substance log prior to 07/03/19. Review of Resident #6's August 2019 eMAR revealed: -There was an entry for Norco 10-325 mg one tablet every six hours with scheduled administration times of 12:00am, 6:00 am, 12:00pm and 6:00pm. -There was documentation Norco 10-325 mg was not administered on 08/01/19 through 08/03/19 due to the drug not being available. -There was documentation Norco 10-325 mg was not administered on 08/18/19 due to the drug not being available. -There were 92 opportunities with 11 missed doses from 08/01/19 through 08/23/19. Interview with Resident #6 on 08/23/19 at 9:12am revealed: -She described her pain, (on a scale of 0 - 5 with 0 being no pain and 5 being the worst pain possible) as a 3 when she missed doses of Norco. -She always had some pain due to having brain cancer and 2 bad rotator cuffs. -She was unable to get up to go to breakfast in the morning if she did not get her morning dose of pain medication. Review of Resident #6's pharmacy dispensing records for Norco for July 2019 and August 2019 from the facility's contracted pharmacy revealed: -There were 60 Norco tablets dispensed on 07/15/19. -There were 60 Norco tablets dispensed on 08/02/19. Review of Resident #6's pharmacy dispensing	D 358		

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D 358	Continued From page 42 records for Norco for August 2019 from a second pharmacy revealed there were 120 Norco tablets dispensed on 08/18/19. Interviews with the Resident Care Coordinator (RCC) on 08/23/19 at 1:33pm and 08/26/19 at 3:45pm revealed: -She was out on leave when Resident #6 was admitted to the facility. -The Administrator-in-Training (AIT) took Resident #6's admitting orders and there should be in a file in her office that may have admission paperwork for Resident #6. -She is not sure what medications came with Resident #6 upon admission. -She was not aware that Resident #6 had missed doses of medications. -The medication aides (MA) were instructed to reorder medications when a 7-day supply remained, especially the controlled substances which would require getting a written prescription from the PCP. Telephone interview with Resident #6's family member on 08/23/19 at 10:47am revealed: -He was concerned about Resident #6 not getting her medications as ordered and about her being in pain, since she had brain cancer that has metastasized to several parts of her body. -He had called several times to speak with someone at the facility regarding the missed doses of medications especially her pain medication. -He had talked to several people at the facility before reaching the RCC. -No one at the facility whom he spoke with was aware of the missed doses of medications. -He was not aware of anything being done to correct his family members medication problems as she continued to have problems getting her	D 358		

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D 358	Continued From page 43 pain medications. Telephone interview with Resident #6's Primary Care Provider (PCP) on 08/26/19 at 11:15am and 5:25pm revealed: -She had not been notified of Resident #6 had missed any doses of her medications. -She expected her residents to receive their medications on time. -She would expect the facility to notify her of missed doses of these medications since the resident had a diagnosis of brain cancer with metastasis. b. Review of Resident #6's current FL-2 dated 07/24/19 revealed there was an order for Atenolol 50 mg one tablet by mouth every morning (Atenolol is used to treat high blood pressure). Review of Resident #6's July 2019 hand written MAR revealed there was no documentation of Atenolol being administered at 8:00am on 07/01/19 with no reason why it was not administered. Interview with Resident #6 on 08/20/19 at 10:23am revealed: -She had missed several of her medications since she had been at the facility. -It took a while for her routine medications to get straight when she first arrived, but they still do not have her pain medication right. Telephone interview with Resident #6's Primary Care Provider (PCP) on 08/26/19 at 11:15am and 5:25pm revealed: -She had not been notified of Resident #6 had missed any doses of her medications. -She expected her residents to receive their medications on time.	D 358		

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D 358	Continued From page 44 -She would expect the facility to notify her of missed doses of these medications since the resident had a diagnosis of primary hypertension. c. Review of Resident #6's current FL-2 dated 07/24/19 revealed there was an order for Amlodipine 10 mg one tablet by mouth daily (Amlodipine is used to treat high blood pressure). Review of Resident #6's July 2019 hand written MAR revealed there was no entry of documentation of Amlodipine being administered at 8:00am on 07/01/19 with no reason why it was not administered. Interview with Resident #6 on 08/20/19 at 10:23am revealed she had missed several of her medications since she had been at the facility. Telephone interview with Resident #6's Primary Care Provider (PCP) on 08/26/19 at 11:15am and 5:25pm revealed: -She had not been notified of Resident #6 had missed any doses of her medications. -She expected her residents to receive their medications on time. -She would expect the facility to notify her of missed doses of these medications since the resident had a diagnosis of primary hypertension. d. Review of Resident #6's current FL-2 dated 07/24/19 revealed there was an order for Enalapril 20 mg one tablet by mouth twice a day (Enalapril is used to treat high blood pressure). Review of Resident #6's July 2019 hand written MAR revealed there was no entry of documentation of Enalapril being administered at 8:00am and 8:00pm on 07/01/19 no reason why it was not administered.	D 358		

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D 358	Continued From page 45 Telephone interview with Resident #6's Primary Care Provider (PCP) on 08/26/19 at 11:15am and 5:25pm revealed: -She had not been notified of Resident #6 had missed any doses of her medications. -She expected her residents to receive their medications on time. -She would expect the facility to notify her of missed doses of these medications since the resident had a diagnosis of primary hypertension. e. Review of Resident #6's current FL-2 dated 07/24/19 revealed there was an order for Glipizide 10 mg 2 tablets by mouth every day (Glipizide is used to treat diabetes). Review of Resident #6's July 2019 hand written MAR revealed there was no entry of documentation of Glipizide being administered at 8:00am on 07/01/19 with no reason why it was not administered. Interview with Resident #6 on 08/20/19 at 10:23am revealed she had missed several of her medications since she had been at the facility. Telephone interview with Resident #6's Primary Care Provider (PCP) on 08/26/19 at 11:15am and 5:25pm revealed: -She had not been notified of Resident #6 had missed any doses of her medications. -She would expect the facility to notify her of missed doses of Glipizide since the resident had a diagnosis of type 2 diabetes. f. Review of Resident #6's hospital discharge summary dated 08/11/19 revealed: -The resident was admitted on 08/11/19 with chief complaint of right leg swelling.	D 358		

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D 358	Continued From page 46 -The resident's right leg was swollen and had drainage from a small open area over her right shin. -Resident #6 was started on Lasix 20 mg daily for five days (Lasix is a diuretic-fluid pill used to treat fluid retention and edema). Review of Resident #6's August 2019 electronic medication administration record (eMAR) revealed: -There was an entry for furosemide 20 mg one tablet every day for 5 days with scheduled administration time of 8:00am (furosemide is generic for Lasix). -There was documentation furosemide was administered for four days on 08/13/19, 08/14/19, 08/15/19, and 08/16/19 at 8:00am. Observation of Resident #6's medication on hand on 08/26/19 at 11:47am revealed there was one card of Lasix 20 mg, with a dispense date of 08/12/19, for a total of 5 tablets dispensed with two tablets remaining on the card. Telephone interview with Medication Aide (MA) on 08/26/19 at 5:58pm revealed: -She was not working when Resident #6 went to the emergency room (ER) on 08/11/19. -She worked the next day (08/12/19) and had been told Resident #6 had been seen in the ER for her leg swelling and had been given Lasix. -She remembers administering Resident #6 Lasix. Telephone interview with second MA on 08/26/19 at 6:01pm revealed: -She was not working when Resident #6 went to the ER on 08/11/19, -She did not remember administering Resident #6 Lasix.	D 358		

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D 358	Continued From page 47 -She did know that Resident #6 had some leg swelling. Telephone interview with Resident #6's Primary Care Provider (PCP) on 08/26/19 at 11:15am and 5:25pm revealed: -She had not seen Resident #6 since her ER visit on 08/11/19. -She was not aware Resident #6 had any edema. -She had not been notified of Resident #6 had missed any doses of her medications. -She expected her residents to receive their medications as ordered. Interviews with the Resident Care Coordinator (RCC) on 08/23/19 at 1:33pm and 08/26/19 at 3:45pm revealed: -She and the Administrator in Training were responsible for medication orders and assuring they were followed through. -She was not aware that Resident #6 had missed doses of medications. Interview with the Administrator on 08/26/19 at 11:17am revealed: -There should not be any missed doses of medication. -The physician should be notified if any medications were not administered. 3. Review of Resident #2's current FL-2 dated 03/23/19 revealed a diagnosis of diarrhea. Review of Resident #2's previous FL-2 dated 02/11/19 revealed diagnoses included pneumonia, hypertension, obstructive sleep apnea, ambulatory dysfunction, gastroesophageal reflux disease, and esophagitis.	D 358		

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D 358	Continued From page 48 a. Review of a physician's order for Resident #2 revealed there was an order dated 07/04/19 for Lasix 40mg take 1 tablet daily. (Lasix is used to treat fluid retention). Review of Resident #2's August 2019 electronic medication administration record (eMAR) revealed: -There was a computer printed entry for Lasix 40mg to be administered daily at 8:00am. -Lasix was not documented as administered on 08/01/19 and 08/02/19 due to "drug unavailable." Observation of medications on hand for Resident #2 on 08/23/19 revealed there were 30 Lasix 40mg tablets dispensed on 07/22/19 with 11 tablets remaining. Interview with Resident #2 on 08/22/16 at 12:16pm revealed: -She ran out of Lasix for several days. -She was unable to recall how many days she was out of Lasix. -She had called her own medications in when staff would tell her she was out. -She knew what medications she was supposed to take. -She counted the pills during the medication pass to see if they were all there. Telephone interview with a pharmacist at the retail pharmacy used by Resident #2 on 08/23/19 at 1:28pm revealed: -There was a prescription for Lasix 40 mg filled on 07/22/19 with 30 tablets dispensed. -The facility was supposed to call in the prescription refills. -If there were no refills, the facility had to get a new prescription from the physician and fax it to	D 358		

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D 358	Continued From page 49 the pharmacy. -The resident had called in her prescription refills when the facility was out of her medication. -If the prescription was called in to the pharmacy by 2:30pm it would be delivered the same day. -If the prescription was called in after 2:30pm it would be delivered the next day. -The side effects of missed doses of Lasix would cause fluid to build up and create edema. Attempted telephone interview with Resident #2's primary care provider (PCP) on 08/26/19 at 3:20pm was unsuccessful. Interview with the Administrator on 08/26/19 at 11:17am revealed: -She was not aware Resident #2 had missed any doses of Lasix. -Medications should be called in to the pharmacy when there were 7 days left. -There should not be any missed doses of medication. -The physician should be notified if any medications were not administered. Refer to the interview with the Administrator on 08/21/19 at 1:49pm. Refer to the interview with the Medication Aide on 08/23/19 at 1:10pm. Refer to the interview with the Administrator on 08/26/19 at 12:05pm. b. Review of Resident #2's physician's orders dated 05/10/19 revealed there was an order for Colcrys 0.6mg take 1 tablet two times a day. (Colcrys is used to treat gout.) Review of Resident #2's June 2019 electronic	D 358		

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D 358	Continued From page 50 medication adminisration recod (eMAR) revealed: -There was a computer printed entry for Colcrys 0.6 mg to be administered twice a day at 9:30am and 9:00pm. -Colcrys was not documented as administered on 06/09/19 at 9:00pm, 06/10/19 9:30am and 9:00pm, 06/11/19 9:00pm and 06/12/19 9:30am and 9:00 pm dose due to "drug unavailable." Review of Resident #2's August 2019 eMAR revealed: -There was a computer printed entry for Colcrys 0.6mg to be administered two times a day at 9:30am and 9:00pm. -Colcrys was not documented as administered on 08/09/19 at 9:00pm due to "drug unavailable." Observation of Resident #2's medications on hand on 08/23/19 revealed there were 60 tablets of Colcrys 0.6mg tablets dispensed on 08/10/19 with 14 tablets. Interview with Resident #2 on 08/22/16 at 12:16pm revealed: -The facility ran out of some of her medications. -She was unable to recall how many days she was out of Colcrys. Telephone interview with a pharmacist at the retail pharmacy used by Resident #2 on 08/23/19 at 1:28pm revealed: -There was a prescription for Colcrys 0.6 mg filled on 06/10/19, 07/11/19, and 08/10/19 with 60 tablets dispensed each time. -The facility was supposed to call in the prescription refills. -If there were no refills, the facility had to get a new prescription from the physician and fax it to the pharmacy. -The resident had called in her prescription refills	D 358		

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D 358	Continued From page 51 when the facility was out of her medication. -If the prescription was called in to the pharmacy by 2:30pm it would be delivered the same day. -If the prescription was called in after 2:30pm it would be delivered the next day. -The side effects of missed doses of Colcrys could cause gout to flare up. Interview with the Administrator on 08/26/19 at 11:17am revealed: -She was not aware Resident #2 had missed any doses of Colcrys. -Medications should be called in to the pharmacy when there were 7 days left. -There should not be any missed doses of medication. Attempted telephone interview with Resident #2's primary care provider (PCP) on 08/26/19 at 3:20pm was unsuccessful. Refer to the interview with the Administrator on 08/21/19 at 1:49pm. Refer to the interview with the Medication Aide on 08/23/19 at 1:10pm. Refer to the interview with the Administrator on 08/26/19 at 12:05pm. c. Review of Resident #2's current FL-2 dated 03/23/19 revealed there was a medication order for Cardizem 300mg take 1 tablet daily. (Cardizem is used to treat high blood pressure.) Review of Resident #2's June 2019 electronic medication administration records (eMAR) revealed: -There was a computer printed entry for Cardizem 300 mg to be administered daily at	D 358		

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D 358	Continued From page 52 8:00am. -Cardizem was not documented as administered on 06/28/19 and 06/30/19 at 8:00am due to "drug unavailable." Observation of Resident #2's medications on hand on 08/23/19 revealed there were 30 tablets of Cardizem 300mg tablets dispensed on 07/27/19 with 9 tablets remaining. Interview with Resident #2 on 08/22/16 at 12:16pm revealed: -The facility ran out of some of her medications. -She was unable to recall how many days she was out of Cardizem. Interview with a medication aide on 08/22/19 at 11:30am revealed: -If a resident was out of a medication, the pharmacy was contacted to see if it had been called in. -If it had not been called in for refill,a refill request was faxed to the pharmacy. -The MAs were supposed to notify the Resident Care Coordinator (RCC) when a medication was out. -The RCC did the follow ups on the medications. Telephone interview with a pharmacist at the retail pharmacy used by Resident #2 on 08/23/19 at 1:28pm revealed: -There was a prescription for Cardizem filled on 05/28/19, 07/02/19, and 07/27/19 with 30 tablets dispensed each time. -The facility was supposed to call in the prescription refills. -If there were no refills, the facility had to get a new prescription from the physician and fax it to the pharmacy.	D 358		

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D 358	Continued From page 57 revealed: -There was an entry for Lorazepam 0.5mg take one tablet three times daily with a scheduled administration time of 8:00am, 2:00pm and 8:00pm. -Lorazepam was documented as administered three times daily from 07/1/19 - 07/16/19 and documented as not administered/unavailable from 07/17/19-07/31/19. Review of Resident #4's August 2019e MAR revealed: -There was an entry for Lorazepam 0.5mg take one tablet three times daily with a scheduled administration time of 8:00am, 2:00pm and 8:00pm. -Lorazepam was documented as administered three times daily from 08/07/19 - 08/20/19 and documented as not administered/unavailable from 08/01/19-08/06/19. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Interview with the Medication Aide (MA) on 08/21/19 at 5:00pm revealed: -Resident #4's Lorazepam had run out at the end of July 2019 because it took awhile for her primary care provider (PCP) to get the prescription completed and sent to the pharmacy. -She had a new PCP and there had been delays. Telephone interview with a pharmacist at the facility's primary pharmacy on 08/22/19 at 3:40pm revealed: -The pharmacy had last dispensed 90 tablets of Lorazepam for Resident #4 on 08/06/19. -On 07/17/19 an order had been sent from the PCP for Lorazepam, but they could not fill it	D 358		

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D 358	Continued From page 58 without the actual original hard copy of the prescription showing the number of refills. -The pharmacy sent the facility a fax on 07/17/19 at 4:17pm notifying them that they were unable to dispense the Lorazepam and needed their assistance. -The pharmacy received the prescription from the facility on 08/06/19 and was able to dispense 90 Lorazepam. Interview with the Resident Care Coordinator (RCC) on 08/23/19 at 2:10pm revealed: -She had called the PCP to get the Lorazepam filled but did not have documentation of when she called. -She also faxed the information to the PCP and did not have that documentation. -The PCP did not respond back with the script until 08/06/19. Attempted interview with Resident.#4's primary care provider on 08/26/19 at 11:30am was unsuccessful. Refer to the interview with the Administrator on 08/21/19 at 1:49pm. Refer to the interview with the Medication Aide on 08/23/19 at 1:10pm. Refer to the interview with the Administrator on 08/26/19 at 12:05pm. 6. Review of Resident #7's current FL-2 dated 05/08/19 revealed diagnoses included Alzheimer's disease, hypertension, gastro-esophageal reflux disease, coronary artery disease, osteoarthritis, and recurrent urinary tract infection.	D 358		

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D 358	Continued From page 59 a. Review of physician orders for Resident #7 dated 05/08/19 revealed an order for Potassium Chloride tablet Extend Release (a dietary supplement used in treatment of heart disorders and high blood pressure) 20 meq (milli-equivalent) tablet every day. Review of the August 2019 electronic medication administration records (eMARs) for Resident #7 revealed: -There was an entry for Potassium Chloride tablet ER 20mEq one tablet every day scheduled at 8:00am. -There was documentation of "not administered: drug/item unavailable" for 8 doses from 08/18/19 through 08/26/19. -There was documentation of administration for 08/25/19 on the eMAR. Observation of medications on hand for Resident #7 on 08/21/19 at 1:15pm revealed there was no Potassium Chloride available for administration. Interview with the medication aide (MA) on 08/21/19 at 1:15pm revealed: -The Resident Care Coordinator (RCC) asked her to order the Potassium Chloride for Resident #7. -She had called the provider pharmacy on 08/21/19 and was told the potassium would be in the facility the night of 08/21/19. Interview with another MA on 08/26/19 at 10:42am revealed: -Resident #7 did not have any Potassium Chloride on the medication cart. -She called the pharmacy several times last night [08/25/19] and was waiting for the Potassium Chloride to be delivered. -She could not say when Resident #7 had last been administered the Potassium Chloride.	D 358		

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D 358	Continued From page 60 Interview with a representative of the provider pharmacy on 08/26/19 at 9:55am revealed: -There was a possible lapse in administering the potassium chloride to Resident #7 every day based on review of the dispensing history for the medication. -Resident #7's Potassium Chloride 20meq was last dispensed on 08/26/19 for a quantity of 15 tablets, which was a 15-day supply. -Prior to 08/26/19, the Potassium Chloride 20meq tablet was dispensed on 08/01/19 for a quantity of 15 tablets, which was a 15-day supply. -Prior to 08/01/19, the Potassium Chloride 20meq tablet was dispensed on 06/20/19 for a quantity of 30 tablets, which was a 30-day supply. -The pharmacy required a written request from the facility to refill medication. -A request for a refill of the Potassium Chloride for Resident #7 was sent to the pharmacy on 08/25/19 at 9:18pm. -There was no documentation on the pharmacy profile for Resident #7 showing a request for a refill of the Potassium Chloride 20meq tablet prior to 08/25/19. Review of a physician's order for Resident #7 dated 08/26/19 revealed the Potassium Chloride was discontinued by a local hospice agency physician. Interview with the Primary Care Provider (PCP) for Resident #7 on 08/23/19 at 10:45am revealed: -She did not know Resident #7's medications were unavailable for administration. -She was concerned if Resident #7 was going without prescribed medications. -Resident #7 has a history of heart disease. -If Resident #7's potassium got too low, the resident could have cardiac arrhythmias which	D 358		

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D 358	Continued From page 61 could lead to heart attack or death. -Resident #7 needed the medications as ordered. Refer to the interview with the Administrator on 08/21/19 at 1:49pm. Refer to the interview with the Medication Aide on 08/23/19 at 1:10pm. Refer to the interview with the Administrator on 08/26/19 at 12:05pm. b. Review of physician orders on the current FL-2 for Resident #7 dated 05/08/19 for Resident #7 revealed a physician's order for Ranitidine 150mg tablet (used to treat stomach disorders) twice a day. Review of a physician's order for Resident #7 dated 08/17/19 revealed a physician's order for Ranitidine 150mg tablet at bedtime with a start date of 06/28/19. Review of the June 2019 electronic medication administration records (eMARs) for Resident #7 revealed: -There was an entry for Ranitidine 150mg take one tablet twice a day scheduled at 8:00am and 8:00pm. -There was documentation of "not administered: drug/item unavailable" for 7 doses scheduled from 06/23/19 at 8:00pm through 06/26/19 at 8:00pm. Review of the July 2019 eMARs for Resident #7 revealed: -There was an entry for Ranitidine 150mg take one tablet every day scheduled at 8:00pm. -There was documentation of "not administered: drug/item unavailable" for 5 doses on 07/11/19,	D 358		

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D 358	Continued From page 62 07/28/19, 07/29/19, 07/30/19, and 07/31/19. Review of the August 2019 eMARs for Resident #7 revealed: -There was an entry for Ranitidine 150mg take one tablet at bedtime scheduled at 8:00pm. -There was documentation of "not administered: drug/item unavailable" for 3 doses 08/01/19, 08/03/19, and 08/05/19. Interview with the Primary Care Provider (PCP) for Resident #7 on 08/23/19 at 10:45am revealed: -She did not know of Resident #7's medications being unavailable for administration. -She was concerned if Resident #7 was going without prescribed medications. -Ranitidine was used for reflux. -Resident #7 could not express if there were any symptoms, so staff may or may not be able to know if the resident was having reflux. -Resident #7 needed the medications as ordered. Interview with a provider pharmacy representative on 08/26/19 at 9:55am revealed: -There would have been a lapse in the availability of the Ranitidine 150mg at bedtime for Resident #7 based on review of the dispensing history for the medication. -Resident #7's Ranitidine 150mg tablet was last dispensed on 08/25/19 for a quantity of 15 tablets, which was a 15-day supply. -Prior to 08/26/19, the Ranitidine 150mg tablet was dispensed on 08/06/19 for a quantity of 15 tablets, which was a 15-day supply. -Prior to 08/01/19, the Ranitidine 150mg tablet was dispensed on 07/10/19 for a quantity of 15 tablets, which was a 15-day supply. -The pharmacy required a written request from the facility to refill medication.	D 358		

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D 358	Continued From page 63 Refer to the interview with the Administrator on 08/21/19 at 1:49pm. Refer to the interview with the Medication Aide on 08/23/19 at 1:10pm. Refer to the interview with the Administrator, with Resident Care Coordinator present, on 08/26/19 at 12:05pm. 7. Review of Resident #9's current FL-2 dated 01/22/19 revealed diagnoses included cerebral infarction, dementia, hypertension, chronic obstructive pulmonary disease, and constipation. a. Review of physician orders for Resident #9 dated 01/22/19 and 05/20/19 revealed an order for Eliquis (used for preventing blood clots) 2.5mg tablet two times a day. Review of the June 2019 electronic medication administration rcods (eMARs) for Resident #9 revealed: -There was an entry for Eliquis tablet 2.5mg one tablet twice a day scheduled at 7:00am and 7:00pm. -There was documentation of "not administered: drug/item unavailable" for 5 doses on 06/22/19 at 7:00pm, 06/23/19 at 7:00pm, 06/24/19 at 7:00am, 06/24/19 at 7:00pm, and 06/26/19 at 7:00pm. Interview with a Medical Assistant for Resident #9's Primary Care Provider (PCP) on 08/23/19 at 10:33am revealed: -The PCP had no prior knowledge of Resident #9's missed doses of the Eliquis. -If Resident #9 was not being administered the Eliquis as prescribed, there could be clot formation.	D 358		

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D 358	Continued From page 64 Interview with Resident #9's PCP on 08/23/19 at 11:45am revealed: -Missed doses of Eliquis was concerning. -Resident #9 had a history of strokes. -The Eliquis was prescribed to prevent strokes. Interview with a representative for Resident #9's provider pharmacy on 08/26/19 at 10:45am revealed: -The pharmacy dispensed 60 tablets of Eliquis 2.5mg tablets for a 30-day supply, on 05/20/19, which should have lasted until 06/20/19. -The facility would have been out of the Eliquis for Resident #9 from 06/20/19 through 06/26/19 when the Eliquis was delivered. -Resident #9's Eliquis 2.5mg tablet was dispensed on 06/26/19 and 7/22/19 for a 30-day supply each time. -The Eliquis would be dispensed again today (08/26/19). -A refill request was sent by the facility on 08/25/19. Interview with Resident #9 on 08/21/19 at 12:41pm revealed: -He was administered medications in the mornings. -He did "not really" know if he was administered medications at any other time of the day. -He did not provide a response about the names of medications he was administered. Interview with a family member for Resident #9 on 08/22/19 at 11:30am revealed: -About two Sunday's ago, there was a "fairly new" MA working. -Resident #9 did not receive his night medications about two Sunday's ago. -A second family member was visiting Resident	D 358		

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D 358	Continued From page 65 #9 at 8:15pm and called the first family member to inquire if the resident had been administered medication when the first family member had visited the same day. -The second family member contacted the Administrator-In-Training (AIT) and was told Resident #9 had his medications administered. Refer to the interview with the Administrator on 08/21/19 at 1:49pm. Refer to the interview with the Medication Aide on 08/23/19 at 1:10pm. Refer to the interview with the Administrator on 08/26/19 at 12:05pm. b. Review of physician orders for Resident #9 dated 05/20/19 revealed an order for Diltiazem HCL (used to treat heart disorders) 240mg capsule every day. Observation of medications on hand for Resident #9 on 08/21/19 at 1:30pm revealed the Diltiazem was available. Review of the July 2019 electronic medication administration records (eMARs) for Resident #9 revealed: -There was an entry for Diltiazem HCL 240mg capsules every day scheduled at 7:00am. -There was documentation of "not administered: drug/item unavailable" for 5 doses on 07/12/19, 07/14/19, 07/15/19, 07/16/19, and 07/17/19. Interview with a Medical Assistant for the Primary Care Provider (PCP) on 08/23/19 at 10:33am revealed the PCP did not know of Resident #9 missing doses of the Diltiazem.	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 66 Interview with Resident #9's PCP on 08/23/19 at 11:45am revealed: -Resident #9 was on a high dose of Diltiazem. -Missed doses of Diltiazem (Cardizem) was concerning. -Resident #9 had a history of strokes. -Resident #9 was at high risk for strokes. Interview with a representative for Resident #9's provider pharmacy on 08/26/19 at 10:45am revealed: -Resident #9's current order for Cardizem was 240mg extend release capsule every day. -The pharmacy dispensed a 30-day supply of Cardizem 240mg capsule on 05/09/19, 06/12/19, 07/17/19, and 08/11/19. -The 30-day supply dispensed on 06/12/19 would have lasted until 07/12/19. -The facility did not call for a refill of the Cardizem until 07/17/19. -The facility could fax or call a request for a medication refill, and once the request was received the medication should be filled the same day. If a refill request was received after 2:00pm, the medication would be delivered to the facility the next day. Interview with Resident #9 on 08/21/19 at 12:41pm revealed: -He was administered medications in the mornings. -He did "not really" know if he was administered medications at any other time of the day. -He did not provide a response about the names of medications he was administered. Interview with a family member for Resident #9 on 08/22/19 at 11:30am revealed: -About two Sunday's ago, there was a "fairly new" MA working.	D 358		

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D 358	Continued From page 67 -Resident #9 did not receive his night medications about two Sunday's ago. -A second family member was visiting Resident #9 at 8:15pm and called the first family member to inquire if the resident had been administered medication when the first family member had visited the same day. -The second family member contacted the Administrator-In-Training (AIT) and was told Resident #9 had his medications administered. Refer to the interview with the Administrator on 08/21/19 at 1:49pm. Refer to the interview with the Medication Aide on 08/23/19 at 1:10pm. Refer to the interview with the Administrator on 08/26/19 at 12:05pm. c. Review of physician orders for Resident #9 dated 01/22/19 and 05/20/19 revealed a medication order for Baclofen (used to treat pain) 10mg tablet ½ tablet two times a day. Review of the June 2019 electronic medication administration records (eMARs) for Resident #9 revealed: -There was an entry for Baclofen 10mg tablet take 0.5 tablet (5mg) two times a day scheduled at 7:00am and 7:00pm. -There was documentation of "not administered: drug/item unavailable" for 10 doses beginning on 06/21/19 at 7:00pm through 06/26/19 at 7:00pm. Dates and times included 06/21/19 at 7:00pm, 06/22/19 at 7:00pm, 06/23/19 at 7:00am, 06/23/19 at 7:00pm, 06/24/19 at 7:00am, 06/24/19 at 7:00pm, 06/25/19 at 7:00am, 06/25/19 at 7:00pm, 06/26/19 at 7:00am, and 06/26/19 at 7:00pm.	D 358		

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D 358	Continued From page 68 Interview with a Medical Assistant for the Primary Care Provider (PCP) on 08/23/19 at 10:33am revealed the PCP had no prior knowledge of Resident #9's missed doses of the Baclofen. Interview with Resident #9's PCP on 08/23/19 at 11:45am revealed: -The missed doses of Baclofen was not a big deal. -The Baclofen was prescribed for muscles spasms. -Resident #9 was probably less comfortable on days the Baclofen was missed. Interview with a provider pharmacy representative for Resident #9 on 08/26/19 at 10:45am revealed: -Resident #9's current order for Baclofen was 10mg tablet 1/2 tablet (5mg) two times a day. -The pharmacy dispensed a 30-day supply of Baclofen on 05/20/19, 06/26/19, and 07/26/19. Interview with Resident #9 on 08/21/19 at 12:41pm revealed: -He was administered medications in the mornings. -He did "not really" know if he was administered medications at any other time of the day. -He did not provide a response about the names of medications he was administered. Interview with a family member for Resident #9 on 08/22/19 at 11:30am revealed: -About two Sunday's ago, there was a "fairly new" MA working. -Resident #9 did not receive his night medications about two Sunday's ago. -A second family member was visiting Resident #9 at 8:15pm and called the first family member to inquire if the resident had been administered	D 358		

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D 358	Continued From page 69 medication when the first family member had visited the same day. -The second family member contacted the Administrator-In-Training (AIT) and was told Resident #9 had his medications administered. Refer to the interview with the Administrator on 08/21/19 at 1:49pm. Refer to the interview with the Medication Aide on 08/23/19 at 1:10pm. Refer to the interview with the Administrator on 08/26/19 at 12:05pm. d. Review of physician orders for Resident #9 dated 01/22/19 and 05/20/19 revealed an order for Memantine (generic for Namenda and used to treat dementia) 10mg tablet every day at bedtime. Observation of medications on hand for Resident #9 on 08/21/19 at 1:30pm revealed the Namenda was available. Review of the July 2019 eMARs for Resident #9 revealed: -There was an entry for Memantine 10mg tablet every day at bedtime scheduled at 7:00pm. -There was documentation of "not administered: drug/item unavailable" for 3 doses on 07/25/19, 07/26/19, and 07/27/19. Interview with a Medical Assistant for the Primary Care Provider (PCP) on 08/23/19 at 10:33am revealed the PCP had no prior knowledge of Resident #9 missed doses of the Memantine. Interview with a provider pharmacy representative for Resident #9 on 08/26/19 at 10:45am revealed: -Resident #9's current order for Memantine was	D 358		

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D 358	Continued From page 70 10mg tablet at bedtime. -The pharmacy dispensed a 30-day supply of Memantine on 05/20/19, 06/17/19, and 07/27/19. -The 06/17/19 supply was delivered to the facility on 06/18/19 at 12:10am. -The facility was "probably out 10 days". Interview with Resident #9 on 08/21/19 at 12:41pm revealed: -He was administered medications in the mornings. -He did "not really" know if he was administered medications at any other time of the day. -He did not provide a response about the names of medications he was administered. Interview with a family member for Resident #9 on 08/22/19 at 11:30am revealed: -About two Sunday's ago, there was a "fairly new" MA working. -Resident #9 did not receive his night medications about two Sunday's ago. -A second family member was visiting Resident #9 at 8:15pm and called the first family member to inquire if the resident had been administered medication when the first family member had visited the same day. -The second family member contacted the Administrator-In-Training (AIT) and was told Resident #9 had his medications administered. Refer to the interview with the Administrator on 08/21/19 at 1:49pm. Refer to the interview with the Medication Aide on 08/23/19 at 1:10pm. Refer to the interview with the Administrator on 08/26/19 at 12:05pm.	D 358		

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D 358	Continued From page 71 Interview with the Administrator on 08/21/19 at 1:49pm revealed: -All MAs received training on medication administration prior to administering medications. -She expected the MAs to administer medications according to physician's orders. -MAs completed a medication cart audit weekly. -The Resident Care Coordinator (RCC) was responsible for completing follow up of medication cart audits. -The RCC pulled a report every morning of medications unavailable. -If medications were unavailable, the MAs were supposed to document who was notified and what the MA did to get the medication into the facility. -The MAs were supposed to call the pharmacy or physician if resident medications were not available. -The facility was responsible to ensure resident medications were available, either by ordering from the provider pharmacy or local backup pharmacy. Interview with a Medication Aide (MA) on 08/23/19 at 1:10pm revealed: -The MAs were responsible for ensuring medications had been ordered and received in the facility. -The MAs were trained and knew when medications were down to a "certain amount" the medication needed to be reordered. -Medications were to be refilled when there was a 7 day supply remaining. -Sometimes the pharmacy did not refill medication because the refill request was too early, or the pharmacy was out of the medication, so she selected "drug unavailable" on the eMAR. -She called "back and forth" to the pharmacy when medications were not in the facility for	D 358		

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D 358	Continued From page 72 administration. -She might would have to get the supervisor involved to get medications refilled. -She would fax a medication refill request to the provider pharmacy when she saw a medication was "low" because she did not know if the medication had previously been ordered. Interview with the Administrator on 08/26/19 at 12:05pm revealed: -She was not aware of any missed medications of residents. -The RCC pulled an unavailable medication report every Monday. -A lot of times, staff did not look for the medications in the medication cart. -Sometimes the MA would document medication administered, then a MA would document the next dose unavailable, and another MA would document the next dose available. -There had been staff meetings (no dates provided) and more training (no dates provided) when management saw trends. -Medications were supposed to be reordered from the pharmacy when a resident had to a 7-day supply remaining on hand. -There were no monthly eMAR reviews performed. -The eMARS were reviewed through reports for late medication administration, early medication administration, missed medications, and unavailable medications. -She assisted sometimes with review of the weekly reports. -She had not noticed any missed medications since the system was put in place to review reports, which started the third week of July 2019. -The only system in place prior to July 2019 to assure resident medications were on hand, were the MAs cart audits and MAs ordering the	D 358		

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D 358	Continued From page 73 residents medications. The facility failed to administer medications as ordered for 4 of 4 residents observed during the medication passes resulting in a 25% medication error rate with 7 errors out of 27 opportunities. The medication aide (MA) measured the wrong amount of rapid-acting insulin for Resident #1 due to not accurately reading the scale on the insulin syringe and the facility did not have a syringe with marking to accurately measure the ordered dose of 3 units. Resident #6 missed 2 doses of a diuretic ordered during a hospital visit for leg swelling. Residents #2, #3, #4, #6, #7, and #9 missed doses of multiple medications due to medications being unavailable. Resident #2 who was diagnosed with metastatic brain cancer missed multiple doses of a pain medication resulting in significant pain and the resident being unable to get up for breakfast when morning doses of pain medication were missed. The facility's failure resulted in the residents not receiving the medications necessary to maintain their physical and mental health which resulted in serious physical harm and neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/22/19 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2019.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 364		

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D 364	Continued From page 74 (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications were administered within one hour before or after the prescribed or scheduled times for 4 residents (#2, #17, #18, #19) during the morning medication pass on 08/26/19 and for 7 of 8 residents sampled (#1, #2, #3, #4, #6, #7, #9) for record review resulting in medications with multiple administration times being administered too close to the next scheduled administration times and medications such as insulin being administered too early or too late. The findings are: Review of the facility's resident census report dated 08/20/19 revealed: -The current census was 88 residents; there was 1 resident in the hospital so there were 87 residents in the facility. -There were 63 residents residing on the 100 hall. -There were 25 residents residing on the 200 hall. 1. Observation of the 100 hall on 08/26/19 at 9:50am revealed there was one medication aide (MA) passing medications. Interview with the 100 hall MA on 08/26/19 at 9:50am revealed: -There were some staff who called out that	D 364	The ED/RCC/designated team members will review medication administration schedules to ensure appropriately scheduled administration times and adjust/stagger med admin times as needed. The supervisor on each shift will review the med admin compliance reports, to include late administration, for the shift and follow up to correct all identified issues. The RCC will bring all med administration compliance reports to morning stand up daily to report all issues to management team and daily plans for correcting. ED will be responsible for overseeing this process to ensure ongoing training needs are met and corrections made. The ED will initial each Med Admin Com;liance report daily to indicate review and f/u The ED will schedule additional retraining of med aides to be conducted by a Pharmacy representative and/or a Registered nurse. Training will include acceptable med admin time frames, proper documentation, and proper reporting procedures.	10-10-19

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D 364	Continued From page 75 morning (08/26/19) so she was the only MA administering medications for the 100 hall. -She still had 4 residents to administer medications to on the 100 hall including Residents #2, #17, #18, and #19. -These residents' medications were late because they were scheduled for 8:00am and she was the only MA on the 100 hall. Observation of the 100 hall on 08/26/19 at 10:05am revealed the MA was still in the hallway with the medication cart administering medications. Observation of the 100 hall on 08/26/19 at 10:18am revealed the MA finished administering medications at 10:18am. A second interview with the 100 hall MA on 08/26/19 at 10:19am revealed: -She just finished administering morning medications to residents on the 100 hall. -When the other MA scheduled to work today, 08/26/19, called out, that left her as the only MA to administer medications on the 100 hall. -If medications were administered late, it was usually because the facility was short-staffed. -The Resident Care Coordinator (RCC) was aware she was the only MA on the 100 hall. -The RCC could not assist her with the 100 hall because the RCC was administering medications on the 200 hall. Interview with the RCC on 08/26/19 at 9:55am revealed: -She had finished administering medications on the 200 hall about 9:30am. -There was 1 MA currently administering medications on the 100 hall and those medications were going to be late.	D 364		

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D 364	Continued From page 76 -When MAs were running late with the medications, they were supposed to let the RCC know. -She knew the medications on the 100 hall were going to be late today, 08/26/19, because there was only 1 MA but 2 medication carts on 100 hall. -There was 1 MA out on vacation and another MA called out late. -There was not enough MAs to cover the shifts if there were call outs or if a MA was on vacation. -She usually had to administer medications 4 or 5 days per week to help cover the shortages. Interview with the Administrator on 08/26/19 at 10:40am revealed: -They usually had 3 MAs administering medications on first shift, 1 MA on 200 hall and 2 MAs on 100 hall. -The RCC was scheduled to administer medications on 200 hall today (08/26/19) but she was also scheduled to come into work late that morning. -Another MA was supposed to come in to cover the RCC's time until she arrived but that MA did not show up. -This was currently the only MA assigned to the 100 hall. -The Administrator was a qualified MA and could have helped with the medication pass but she arrived late to the facility at 9:36am. -The MAs should let the Administrator know when they were late administering medications so she could get someone to help them. a. Review of Resident #2's current FL-2 dated 03/23/19 revealed a diagnosis of diarrhea. Review of Resident #2's August 2019 electronic medication administration record (e-MAR) revealed:	D 364		

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D 364	Continued From page 77 -There were 6 medications scheduled to be administered once a day at 8:00am including Diltiazem and Losartan (both for high blood pressure); Furosemide (diuretic for swelling); Loratadine (for seasonal allergies); Montelukast (for allergies/asthma); and Myrbetriq (for overactive bladder). -Allopurinol (for gout) was scheduled twice a day at 8:00am and 8:00pm. -Primidone (for seizures) was scheduled 3 times a day at 8:00am, 12:00pm, and 4:00pm. -Clonidine (for high blood pressure) was scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm. -All of the medications scheduled for 8:00am on 08/26/19 were documented as administered at 10:20am, 1 hour and 20 minutes beyond the allowed 1-hour time frame. -The medications scheduled for 8:00am were documented as being administered late on 6 other days, up to 43 minutes beyond the 1-hour time frame allowed. -Symbicort (for asthma and lung disease) was scheduled to be administered twice a day at 9:00am and 8:00pm. -Gabapentin (for seizures/mood disorders) was scheduled to be administered 3 times a day at 9:00am, 2:00pm, and 9:00pm. -All of the medications scheduled for 9:00am on 08/26/19 were documented as administered at 10:20am, 20 minutes beyond the allowed 1-hour time frame. Interview with Resident #2 on 08/26/19 at 11:25am revealed: -There had been times when she received her morning medication at 10:00am or 11:00am. -She had medication that she was supposed to get at 3:00pm but she typically received it around lunch time.	D 364		

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D 364	Continued From page 78 -Her bedtime medication was also typically given late. -She sometimes had to stay awake until midnight to receive her night medication. Attempted interview with Resident #2's primary care provider (PCP) on 08/26/19 at 3:29pm was unsuccessful. b. Review of Resident #17's current FL-2 dated 07/10/19 revealed diagnoses included essential hypertension, atherosclerotic heart disease, atrioventricular block second degree, and gastroesophageal reflux disease without esophagitis. Review of Resident #17's August 2019 electronic medication administration record (e-MAR) revealed: -There were 7 medications scheduled to be administered once a day at 8:00am including Losartan (for high blood pressure); Aripiprazole (for psychosis); Loratadine (for seasonal allergies); Acetaminophen (for minor aches and pains); Famotidine (for acid reflux); Miralax (for constipation); and Aspirin (for prevention of heart disease). -All of the medications scheduled for 8:00am on 08/26/19 were documented as administered at 10:05am, 1 hour and 5 minutes beyond the allowed 1-hour time frame. -The medications scheduled for 8:00am were documented as being administered late on 4 other days, up to 1 hour and 1 minute beyond the 1-hour time frame allowed. Interview with Resident #17 on 08/26/19 at 12:20pm revealed he usually received medications in the morning and at bedtime but he did not recall what time he usually received them.	D 364		

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D 364	Continued From page 79 Telephone interview with Resident #17's primary care provider (PCP) on 08/26/19 at 3:01pm revealed: -She expected Resident #17's medications to be administered on time. -If medications were administered late on an ongoing basis, it could affect the resident getting consistent levels of medications. c. Review of Resident #18's current FL-2 dated 05/24/19 revealed diagnoses included dementia, hypertension, diabetes mellitus, and coronary artery disease. Review of Resident #18's August 2019 electronic medication administration record (e-MAR) revealed: -There were 8 medications scheduled to be administered once a day at 8:00am including Metoprolol, Imdur, and Lisinopril (all for high blood pressure/heart); Plavix (prevents blood clots); Donepezil (for Alzheimer's disease); Januvia (for diabetes); Sertraline (for depression); and Flomax (for enlarged prostate). -Glimepiride and Metformin (both for diabetes) were scheduled to be administered twice daily at 8:00am and 5:00pm. -The medications scheduled for 8:00am on 08/26/19 were documented as administered at 10:03am, 1 hour and 3 minutes beyond the allowed 1-hour time frame. -The medications scheduled for 8:00am were documented as being administered late on 2 other days, up to 34 minutes beyond the 1-hour time frame allowed. Interview with Resident #18 on 8/26/19 at 10:14am revealed: -He received his medication around 8:00am or	D 364		

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D 364	Continued From page 80 9:00am this morning (08/26/19). -He received his medication around the same time every morning. -His medications were not late to his knowledge. Attempted interview with Resident #18's primary care provider (PCP) on 08/26/19 at 3:35pm was unsuccessful. d. Review of Resident #19's current FL-2 dated 05/09/19 revealed diagnoses included dementia, atrial fibrillation, and psoriasis. Review of Resident #19's August 2019 electronic medication administration record (e-MAR) revealed: -There were 5 medications scheduled to be administered once a day at 8:00am including Digoxin (for heart rhythm problems); Diltiazem and Metoprolol (both for high blood pressure); Zyrtec (for seasonal allergies); and Lexapro (for depression). -Medications scheduled for 8:00am on 08/26/19 were documented as administered at 10:24am, 1 hour and 24 minutes beyond the allowed 1-hour time frame. -Medications scheduled for 8:00am were documented as being administered late on 2 other days, up to 1 hour and 10 minutes beyond the 1-hour time frame allowed. Interview with Resident #19 on 08/26/19 at 10:33am revealed: -She usually received about five pills in the morning and two pills around supper time. -She received her medication after breakfast around 8:00am or 9:00am this morning. -She received her medications late during second shift sometimes depending on which medication aide was working.	D 364		

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D 364	Continued From page 81 -She did not experience any symptoms when her medications were late. Telephone interview with Resident #19's primary care provider (PCP) on 08/26/19 at 3:36pm revealed: -She expected Resident #19's medications to be administered on time. -She was not as concerned about medications being administered once a day being late as she was medications administered multiple times a day. 2. Review of Resident #1's current FL-2 dated 05/01/19 revealed diagnoses included dementia, chronic pain, muscle weakness, abnormal weight loss, anorexia, dysphagia, obesity, and history of seizures. Review of Resident #1's June 2019 electronic medication administration record (e-MAR) revealed: -Gabapentin (for seizures) was scheduled to be administered 3 times a day at 8:00am, 2:00pm, and 8:00pm. -Lantus (long-acting insulin used to lower blood sugar) and Zocor (lowers cholesterol) were scheduled to be administered at 8:00pm. -Medications scheduled for administration at 8:00pm were documented as administered/charted late on at least 13 occasions, up to 3 hours and 36 minutes beyond the allowed 1-hour time frame. Review of Resident #1's July 2019 e-MAR revealed: -Humalog (rapid-acting insulin that lowers blood sugar) was scheduled to be administered at 7:30am, 12:00pm, and 5:30pm with meals. -The 7:30am dosage of Humalog was	D 364		

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D 364	Continued From page 82 documented as administered early due to resident requested early on 2 occasions. -For example, the 7:30am dosage of Humalog was administered at 5:25am on 07/18/19, over 2 hours prior to the scheduled breakfast time at 7:30am. -The resident had the following medications scheduled for administration at 8:00am: Allopurinol (for gout); Aspirin (for prevention of heart disease); Plavix (prevents blood clots); Duloxetine (for depression); Imdur, Valsartan, and Metoprolol (all for heart/high blood pressure); Calcitriol (used to treat low calcium); Keppra (for seizures), and Linzess (for irritable bowel syndrome). -The medications scheduled for 8:00am were documented as administered early due to resident request on 3 occasions, up to 1 hour 25 minutes prior to the allowed 1-hour time frame. Interview with a medication aide (MA) on 08/26/19 at 10:19am revealed: -If medications were administered late, it was because the facility was short-staffed with MAs. -She documented the medications as being administered on the e-MAR as soon as she observed a resident take their medications prior to preparing medications for the next resident. -She did not know why there was documentation on the e-MAR that Resident #1 requested medications early. -Resident #1 was not cognitively able to request medications early. Interview with the Administrator on 08/26/19 at 4:00pm revealed: -Resident #1 had dementia and was not cognitively able to request medications early. -She did not know why the MAs would administer Resident #1's medications early.	D 364		

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D 364	Continued From page 83 -The MAs should not administer medications more than 1 hour before or after the scheduled time. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Refer to the interview with a Medication Aide (MA) on 08/21/19 at 1:36pm. Refer to the interview with a second MA on 08/23/19 at 1:10pm. Refer to the interview with the Resident Care Coordinator (RCC) on 08/23/19 at 1:50pm. Refer to the interview with the Administrator on 08/26/19 at 11:40am. 3. Review of Resident #6's current FL-2 dated 07/24/19 revealed diagnoses included malignant neoplasm of meninges, secondary neoplasms of the brain, lung and bone, hypertension, and type 2 diabetes mellitus. Review of Resident #6's July 2019 hand written medication administration records (MAR) and electronic MAR (eMAR) revealed: -There was an entry for Norco 10-325 mg one tablet every six hours with scheduled administration times of 12:00am, 6:00 am, 12:00pm and 6:00pm with documentation of late administration on 07/04/19 at 1:40pm with the comment of patient care. -There were entries for Atenolol 50 mg one tablet every morning with scheduled administration time of 8:00am with documentation of early administration on 07/18/19 at 5:01am and 07/19/19 at 6:03am with the comment of resident	D 364		

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D 364	Continued From page 84 requested early administration, and documentation of late administration on 07/26/19 at 9:52am with the comment of administered late. -There were entries for Amlodipine 10 mg one tablet daily with scheduled administration time of 8:00am with documentation of early administration on 07/18/19 at 5:01am and 07/19/19 at 6:03am with the comment of resident requested early, and documentation of late administration on 07/26/19 at 9:52am with the comment of administered late. -There were entries for Enalapril 20 mg one tablet twice a day with the scheduled administration times of 8:00am and 8:00pm there was documentation of early administration on 07/18/19 at 5:01am and 07/19/19 at 6:03am with the comment of resident requested early and documentation of late administration on 07/26/19 at 9:52am with the comment of administered late. -There were entries for Glipizide 10 mg 2 tablets every day with scheduled administration time of 8:00am with documentation of early administration on 07/18/19 at 5:01am and 07/19/19 at 6:03am with the comment of resident requested early and documentation of late administration on 07/26/19 at 9:52am with the comment of administered late. Review of Resident #6's August 2019 eMAR revealed: -There was an entry for Atenolol 50 mg one tablet every morning with the scheduled administration time of 8:00am with documentation of late administration on 08/06/19 at 9:08am with the comment of administered late. -There was entry for Amlodipine 10 mg one tablet by mouth daily with scheduled administration time of 8:00am with documentation of late administration on 08/06/19 at 9:08am with the comment of administered late	D 364		

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D 364	Continued From page 85 -There was entry for Enalapril 20 mg one tablet twice a day with scheduled administration times of 8:00am with documentation of late administration on 08/06/19 at 9:08am with the comment of administered late. -There were entries for Glipizide 10 mg 2 tablets every day with scheduled administration time of 8:00am with documentation of late administration on 08/06/19 at 9:08am with the comment of administered late Interviews with Resident #6 on 08/20/19 at 10:23am and 08/23/19 at 9:12am revealed: -She had several of her medications being given late since she had been at the facility. -She denied requests for medications to be given early. -She described the following if her medications were late, unable to get up to go to breakfast on the mornings she did not get her morning dose of pain medication on time and had problems with her blood pressure when those medications were late, that was why she took several medicines for it. Telephone interviews with Resident #6's Primary Care Provider on 08/26/19 at 11:15am and 5:25pm revealed: -She had not been notified of Resident #6's medications being administered late. -She expected Resident #6 to receive her medications on time. Refer to the interview with a Medication Aide (MA) on 08/21/19 at 1:36pm. Refer to the interview with a second MA on 08/23/19 at 1:10pm. Refer to the interview with the Resident Care	D 364		

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D 364	Continued From page 86 Coordinator (RCC) on 08/23/19 at 1:50pm. Refer to interview with the Administrator on 08/26/19 at 11:40am. 4. Review of Resident #2's current FL-2 dated 03/23/19 revealed the resident's diagnosis included diarrhea. Review of Resident #2's previous FL-2 dated 02/11/19 revealed diagnoses included pneumonia, hypertension, obstructive sleep apnea, ambulatory dysfunction, gastroesophageal reflux disease, and esophagitis. Review of Resident #2's June 2019 electronic medication administration record (e-MAR) revealed: -There were 6 medications scheduled to be administered at 8:00am including Cardizem (for high blood pressure), Lasix (for edema), Metoprolol (for high blood pressure), Montelukast (for prevention of asthma), Clonidine (for high blood pressure) and Primidone (for seizures). -The medications scheduled for 8:00am on 06/07/19 were documented as administered at 12:35pm, 3 hours and 35 minutes beyond the allowed 1-hour time frame. -The medications scheduled for 8:00am were documented as being administered late on 5 other days, up to 3 hours and 22 minutes beyond the 1-hour time frame. -There were 2 medications scheduled for 9:00am including Gabapentin (for nerve pain) and Symbicort (to treat chronic obstructive pulmonary disease). -The medications scheduled for 9:00am were documented as being administered on 06/07/19 at 12:35pm, 2 hours and 35 minutes beyond the	D 364		

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D 364	Continued From page 87 allowed 1- hour time frame. -The medications scheduled for 9:00am were documented as being administered late on 2 other days up to 2 hours and 22 minutes beyond the 1-hour time frame. -The medications scheduled for 9:00am were documented as being administered early on 06/05/19 at 7:39am, 21 minutes before the 1-hour time frame. -The medications scheduled for 9:00am were documented as being administered early on 2 other days up to 22 minutes before the 1-hour time frame. -There were 3 medications scheduled to be administered at 8:00pm including Clonidine, Primidone, and Symbicort. -The medications scheduled for 8:00pm were documented as being administered late on 06/03/19 at 11:00pm, 2 hours beyond the 1-hour time frame. -The medications scheduled for 8:00pm were documented as being administered late on 10 other days, up to 3 hours and 10 minutes beyond the 1-hour time frame. Review of Resident #2's July 2019 e-MAR)revealed: -There were 6 medications scheduled to be administered at 8:00am including Cardizem, Lasix , Metoprolol, Montelukast, Clonidine, and Primidone. -The medications scheduled for 8:00am on 07/03/19 were documented as administered at 9:48am, 48 minutes beyond the allowed 1-hour time frame. -The medications scheduled for 8:00am were documented as being administered late on 10 other days, up to 3 hours and 51 minutes beyond the 1-hour time frame. -There were 2 medication scheduled for 9:00am	D 364		

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D 364	Continued From page 88 including Gabapentin and Symbicort. -The medications scheduled for 9:00am were documented as being administered early on 07/18/19 at 6:00am, 2 hours before the scheduled time. -There were 3 medications scheduled to be administered at 8:00pm including Clonidine, Primidone, and Symbicort. -The medications scheduled for 8:00pm were documented as being administered late on 07/12/19 at 10:39pm, 1 hour and 39 minutes beyond the 1-hour time frame. -The medications scheduled for 8:00pm were documented as being administered late on 6 other days, up to 1 hour and 39 minutes beyond the 1-hour time frame. Review of Resident #2's August 2019 electronic medication administration record (e-MAR) revealed: -There were 6 medications scheduled to be administered at 8:00am including Cardizem, Lasix , Metoprolol, Montelukast, Clonidine, and Primidone. -The medications scheduled for 8:00am on 08/03/19 were documented as administered at 9:29am, 29 minutes beyond the allowed 1-hour time frame. -The medications scheduled for 8:00am were documented as being administered late on 5 other days, up to 43 minutes beyond the 1-hour time frame. -There were 3 medications scheduled to be administered at 8:00pm including Clonidine, Primidone, and Symbicort. -The medications scheduled for 8:00pm were documented as being administered late on 08/03/19 at 10:56pm, 1 hour and 56 minutes beyond the 1-hour time frame. -Clonidine which was scheduled for 8:00pm was	D 364		

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D 364	Continued From page 89 documented as being administered late on 9 other days, up to 2 hours and 42 minutes beyond the 1-hour time frame. -Primidone which was scheduled for 8:00pm was documented as being administered late on 2 other days, up to 1 hours and 10 minutes beyond the 1-hour time frame. -Symbicort which was scheduled for 8:00pm was documented as being administered late on 5 other days, up to 52 minutes beyond the 1- hour time frame. Interview with Resident #2 on 08/22/19 at 12:16pm revealed: -She could not remember the last time her medications were late. -She got her medications late frequently. -She could not name the ones that were late last. Interview with a nurse at the primary care provider's office on 08/26/19 at 3:10pm revealed: -Medications should not be given late. -If it was a medication, that was given more than once a day, you would not want the resident to get them too close together. -The facility staff had not notified the PCP office that the resident was receiving medications late. Refer to the interview with a Medication Aide (MA) on 08/21/19 at 1:36pm. Refer to the interview with a second MA on 08/23/19 at 1:10pm. Refer to the interview with the Resident Care Coordinator (RCC) on 08/23/19 at 1:50pm. Refer to the interview with the Administrator on 08/26/19 at 11:40am.	D 364		

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D 364	Continued From page 90 5. Review of Resident #3's current FL-2 dated 05/22/19 revealed diagnoses included Parkinson's disease, dementia, hip pain, and knee pain. Review of Resident #3's June 2019 electronic medication administration record (e-MAR) revealed: -There were 3 medications scheduled to be administered at 8:00am including Finasteride (for enlarged prostrate), Carbidopa Levodopa (for Parkinson's disease), and Rivastigmine (for dementia). -The medications scheduled for 8:00am on 06/28/19 were documented as administered at 10:44am, 1 hour and 44 minutes beyond the allowed 1-hour time frame. Review of Resident #3's July 2019 e-MAR revealed: -There were 3 medications scheduled to be administered at 8:00am including Finasteride, Carbidopa Levodopa, and Rivastigmine. -The medications scheduled for 8:00am on 07/12/19 were documented as administered at 11:36am, 2 hours and 26 minutes beyond the allowed 1-hour time frame. -There were 2 medications scheduled to be administered at 8:00pm including Carbidopa -Levodopa and Rivastigmine. -The medications scheduled for 8:00pm on 07/06/19 were documented as administered at 10:05pm, 1 hour and 5 minutes beyond the allowed 1-hour time frame. -The medications scheduled for 8:00pm were documented as being administered late on 5 other days, up to 1 hour and 25 minutes beyond the 1-hour time frame. Review of Resident #3's August 2019 electronic medication administration record (e-MAR)	D 364		

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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 364	Continued From page 91	D 364		

revealed Rivastigmine which was scheduled to be administered at 8:00pm was documented as administered on 08/01/19 at 12:33am, 3 hour and 33 minutes beyond the allowed 1-hour time frame.

Interview with a medication aide MA on 08/23/19 at 1:45pm revealed:
-Morning medication pass was the longest so sometimes the medications were late.
-The Resident Care Coordinator (RCC) was to be notified of any problems with medications.

Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable

Attempted telephone interview with Resident #3's primary care provider (PCP) on 08/26/19 at 3:15pm was unsuccessful.

Refer to the interview with a Medication Aide (MA) on 08/21/19 at 1:36pm.

Refer to the interview with a second MA on 08/23/19 at 1:10pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 08/23/19 at 1:50pm.

Refer to the interview with the Administrator on 08/26/19 at 11:40am.

6. Review of Resident #4's current FL-2 dated 12/27/18 revealed diagnoses included Alzheimer's Disease, hyperlipidemia, osteopenia, and vitamin D deficiency.

Review of Resident #4's June 2019 electronic medication administration record (e-MAR)

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D 364	Continued From page 92 revealed: -Lorazepam (for seizure disorders and anxiety) was scheduled to be administered three times a day at 8:00am, 2:00pm and 8:00pm. -Lorazepam scheduled for 8:00pm on 06/06/19 was documented as administered at 12:37am, 3 hours and 37 minutes beyond the allowed 1-hour time frame. -Lorazepam was documented as administered late on 17 other occasions, up to 2 hours and 45 minutes beyond the 1-hour time frame allowed. -Lorazepam was documented as administered early on 5 occasions, up to 1 hour prior to the 1-hour time frame allowed. Review of Resident #4's July 2019 e-MAR revealed: -Lorazepam was scheduled to be administered three times a day at 8:00am, 2:00pm and 8:00pm. -Lorazepam scheduled for 2:00pm on 07/03/19 was documented as administered at 3:40pm, 40 minutes beyond the allowed 1-hour time frame. -Lorazepam was documented as administered late on 2 other occasions, up to 25 minutes beyond the 1-hour time frame allowed. -Lorazepam was documented as administered early on 2 occasions, up to 45 minutes prior to the 1-hour time frame allowed. -Quetiapine (for depression, bipolar and schizophrenia) was scheduled to be administered two times a day at 9:00am and 9:00pm. -Quetiapine was documented as administered at 12:41am on 07/21/19, 2 hours and 41 minutes beyond to the 1-hour time frame allowed. -Quetiapine was documented as administered late on 3 other occasions, up to 31 minutes beyond to the 1-hour time frame allowed Review of Resident #4's August 2019 e-MAR	D 364		

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D 364	Continued From page 93 revealed: -Lorazepam was scheduled to be administered three times a day at 8:00am, 2:00pm and 8:00pm. -Lorazepam scheduled for 8:00pm on 08/14/19 was documented as administered at 9:36pm, 36 minutes beyond the allowed 1-hour time frame. -Lorazepam was documented as administered late on 5 other occasions, up to 31 minutes beyond the 1-hour time frame allowed. -Quetiapine was scheduled to be administered two times a day at 8:00am and 8:00pm. -Quetiapine was documented as administered at 11:40am on 08/03/19, 2 hours and 40 minutes beyond to the 1-hour time frame allowed. -Quetiapine was documented as administered late on 3 other occasions, up to 31 minutes beyond to the 1-hour time frame allowed Interview with a medication aide (MA) on 08/23/19 at 1:50pm revealed: -Medications were administered late because many residents' medications were scheduled for the same administration time. -Sometimes the shift changes were delayed and he started giving medications late. Interview with the Resident Care Coordinator (RCC) on 08/26/19 at 10:50am revealed: -There should be no reason medications were given late or early to any resident. -She ran weekly reports to monitor and track those MAs who gave their medications early or late and performed counseling and retraining with them if needed. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.	D 364		

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D 364	Continued From page 94 Attempted telephone interview with Resident #4's primary care provider on 08/26/19 at 11:30am was unsuccessful. Refer to the interview with a Medication Aide (MA) on 08/21/19 at 1:36pm. Refer to the interview with a second MA on 08/23/19 at 1:10pm. Refer to the interview with the Resident Care Coordinator (RCC) on 08/23/19 at 1:50pm. Refer to the interview with the Administrator on 08/26/19 at 11:40am. 7. Review of Resident #7's current FL-2 dated 05/08/19 revealed diagnoses included Alzheimer's disease, hypertension, gastro-esophageal reflux disease (GERD), coronary artery disease, osteoarthritis, and recurrent urinary tract infection. Review of Resident #7's June 2019 electronic medication administration records (eMARs) revealed: -There was an entry for potassium chloride tablet ER 20mEq (a supplement) one tablet every day scheduled at 8:00am with documentation of late administration 06/19/19 and 06/28/19, with charted times of 31 minutes and 2 hours outside the allowed 1-hour before and 1-hour after time frame. -There was an entry for Ranitidine 150mg (used to treat GERD) take one tablet twice a day scheduled at 8:00am and 8:00pm with documentation of late administration on 06/19/19 and 06/28/19, with a range of charted times of 31 minutes to 2 hours outside the allowed 1-hour before and 1-hour after time frame.	D 364		

Division of Health Service Regulation

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D 364	Continued From page 95 Review of Resident #7's July 2019 eMARs revealed there was an entry for potassium chloride tablet ER 20mEq one tablet every day scheduled at 8:00am with documentation of "early administration, due to condition" on 07/18/19, with a charted time of 5:00am, 2 hours before the allowed 1-hour before time frame. Interview with the Primary Care Provider (PCP) for Resident #7 on 08/23/19 at 10:45am revealed: -Resident #7's medications were ordered for every day. -The time of the administration of medications ordered every day did not present a big issue. Interview with a Medication Aide (MA) on 08/23/19 at 1:30pm revealed: -She did not intentionally administer medications late. -She would rather administer medications early than late. Refer to the interview with a Medication Aide (MA) on 08/21/19 at 1:36pm. Refer to the interview with a second MA on 08/23/19 at 1:10pm. Refer to the interview with the Resident Care Coordinator (RCC) on 08/23/19 at 1:50pm. Refer to interview with the Administrator on 08/26/19 at 11:40am. 8. Review of Resident #9's current FL-2 dated 01/22/19 revealed diagnoses included cerebral infarction, dementia, hypertension, chronic obstructive pulmonary disease, and constipation.	D 364		

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D 364	Continued From page 96 Review of Resident #9's June 2019 electronic medication administration records (eMARs) revealed: -There was and entry for Eliquis (a blood thinner used to prevent blood clots) with scheduled administration times of 7:00am and 7:00pm every day with documentation of early administration on 7 occasions with a charted time range of 6 to 23 minutes, and late administration on 2 occasions with a charted time range of 14 minutes to 1 hour 11 minutes beyond the allowed 1-hour time frame. -There were entries for Diltiazem HCL (used for cardiac dysrhythmias), Wellbutrin (used for mood disorder and depression), and Omeprazole (used to reduce stomach acid) with scheduled administration times of 7:00am every day. -There was documentation of early administration of Diltiazem HCL, Wellbutrin, and Omeprazole on 8 occasions with a charted time range of 6 to 23 minutes beyond the allowed 1-hour time frame. Review of Resident #9's July 2019 eMARs revealed: -There was scheduled administration times for Eliquis of 7:00am and 7:00pm every day with documentation of early administration on 13 occasions with a charted time range of 4 minutes to 1 hour 7 minutes beyond the allowed 1-hour time frame. -There were entries for Diltiazem HCL, Wellbutrin, and Omeprazole of 7:00am every day. -There was documentation for early administration of Diltiazem on 11 occasions with a charted time range of 3 to 23 minutes beyond the allowed 1-hour time frame. -There was documentation for early administration of Wellbutrin on 12 occasions with a charted time range of 3 to 23 minutes beyond the allowed 1-hour time frame.	D 364		

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D 364	Continued From page 97 -There was documentation for early administration of Omeprazole on 6 occasions with a charted time range of 3 to 29 minutes beyond the allowed 1-hour time frame. Interview with a family member for Resident #9 on 08/22/19 at 11:30am revealed: -Resident #9 needed to be administered his medication on time. -Another family member had talked to the Administrator and Administrator-In-Training about the time Resident #9's medications were being administered, and since then the MAs had been more conscientious about the time of Resident #9's medication administration. Interview with Resident #9's primary care provider (PCP) on 08/23/19 at 11:45am revealed he was not too concerned with early or late administration of Resident #9's medications. Interview with a MA on 08/22/19 at 4:50pm revealed she selected early administration of medications on the eMAR when the resident or family member requested the medication to be administered early. Refer to the interview with a Medication Aide (MA) on 08/21/19 at 1:36pm. Refer to the interview with a second MA on 08/23/19 at 1:10pm. Refer to the interview with the Resident Care Coordinator (RCC) on 08/23/19 at 1:50pm. Refer to the interview with the Administrator on 08/26/19 at 11:40am. Interview with a Medication Aide (MA) on	D 364		

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D 364	Continued From page 98 08/21/19 at 1:36pm revealed: -When she administered medications, she selected "complete" on the eMAR screen which indicated she had completed the medication pass for the resident, including watching the resident swallow the medication. -The "date/charted time" on the eMAR would be the date and time the medication was administered and automatically populated to the eMAR once "complete" was selected. -She was not able to assign a "date/charted time" to populate to the eMAR. -If the administration of medication charted time was after the scheduled time, the charted time would be the time the medication was administered. Interview with a second MA on 08/23/19 at 1:10pm revealed: -She selected "early administration" when the family member or the resident requested the medication to be administered early, or if the resident was going out with family and would not be back in the facility at the scheduled administration of medication time. -The "charted time" was the time the MA selected "complete" meaning she had given the resident the medication. -Sometimes she was able to administer medications on time, and sometimes not. There might be interruptions or phone calls, and she also provided "patient care" to residents. -She sometimes had to manage three medication carts. -She documented "late administration" of medication when she was going back and forth between two medication carts administering medications. -She started administering medications scheduled for 6:00am at 5:00am.	D 364		

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D 364	Continued From page 99 -If a resident asked for medication early, she would administer the medication because "that's their right to ask for them early". -The RCC had talked to the MA about administering medications early and late and told her medications should not be administered early and late. Interview with the RCC on 08/23/19 at 1:50pm revealed: -She was aware MAs were documenting on the eMAR early administration because she pulled an eMAR report daily. -She had talked to individual MAs and told them medications had to be administered on time and could not be administered early or late. Interview with the Administrator on 08/26/19 at 11:40am revealed: -If the MAs documented "early administration", the MAs would have to add a comment indicating a reason for the early administration of medication. -The MAs should always select "complete" in the eMAR system before moving to the next resident to administer medication. -The "charted time" on the eMAR would be when the MA selected "complete" but may not be when the MA administered the resident's medication. The facility failed to assure medications were administered within 1 hour before or 1 hour after the scheduled administration times resulting an increased risk for inconsistencies in the amount of the drug in the bloodstream and residents with medications ordered multiple times daily being administered medication doses too close together to include medications used to lower blood sugar and blood pressure and prevent seizures and blood clots. Resident #1 was administered	D 364		

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D 364	Continued From page 100 Humalog (a rapid-acting insulin used to lower blood sugar), over 2 hours prior to the scheduled time, placing the resident at risk for low blood sugar. Resident #9 received a blood thinner up to 6 hours prior to the 1-hour allowed time frame. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/26/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 10, 2019.	D 364		
D 370	10A NCAC 13F .1004 (m) Medication Administration 10A NCAC 13F .1004 Medication Administration (m) Medication administration supplies, such as graduated measuring devices, shall be available and used by facility staff in order for medications to be accurately and safely administered. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure proper graduated measuring devices were available for 3 of 3 diabetic residents (#1, #15, #16) who required the use of insulin syringes in order for insulin to be accurately and safely administered.	D 370	Proper measuring devices, including insulin syringes, were obtained prior to survey exit A revised cart auditing schedule will be developed and implemented to include ensuring proper med admin measuring devices and supplies are available. This audit will be completed weekly by assigned staff and will be reviewed each day as completed by the RCC. The RCC will initial each cart audit to indicate review and follow up as needed.	10-10-19

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D 370	Continued From page 101 The findings are: Observation of the medication carts on 08/22/19 at 11:35am revealed: -There was only one type of insulin syringe on hand for use for all 3 diabetic residents with insulin vials requiring the use of insulin syringes for administration of insulin. -The syringes were in the plastic manufacturer bags and no resident names were labeled on the syringes. -The insulin syringes on hand were 1ml, 31-gauge syringes. -The scale on the syringes had markings starting at 0 through 100 with numbers 10, 20, 30, 40, 50, 60, 70, 80, 90, and 100 units marked on the syringe. -There were lines marking 2-unit increments starting after the 0 line all the way down the syringe to the 100 line. -There were no lines on the syringe marked in order to accurately measure 1-unit increments, or odd numbers. Interview with a medication aide (MA) on 08/22/19 at 11:35am revealed: -When she first started working at the facility in 2017, they had insulin syringes that were marked in 1-unit increments. -There had not been any insulin syringes with 1 unit increments for over a year. -The only insulin syringes in the facility for any diabetic resident was the 1ml syringe with 2-unit markings. -When asked how she would measure 3 units now, the MA stated she would have to estimate the dosage of Humalog between the lines marking 2 and 4 units. -She would ask the Resident Care Coordinator	D 370		

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D 370	Continued From page 102 (RCC) what to do about the syringes. Interview with a second MA on 08/23/19 at 10:23am revealed: -The facility only currently had insulin syringes that were marked with 2-units increments. -There were no 1-unit increments marked on the insulin syringes. -When she administered insulin using the insulin syringes, she would estimate between the marked lines if the order required odd units of insulin. -If a resident required 3 units of insulin, she would estimate between the lines marked 2 and 4. -If a resident required 5 units of insulin, she would estimate between the lines marked 4 and 6. -They just received new insulin syringes yesterday, 08/22/19. -The new insulin syringes were marked in 1 unit increments and could accurately measure odd dosages. -Prior to yesterday (08/22/19), the insulin syringes came in bulk and they used the same syringes for any diabetic resident that had insulin vials instead of insulin pens. -She did not know where the syringes came from because the Resident Care Coordinator (RCC) ordered the insulin syringes. -She thought the RCC was aware the insulin syringes did not have markings for odd numbered dosages. -The facility used to have insulin syringes with 1-unit increments but it had been a month or longer since they had them. -She did not know why they no longer had the syringes marked with 1-unit increments. Interview with the RCC on 08/22/19 at 11:43am revealed: -The 1ml syringes with 2-unit markings were the	D 370		

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D 370	Continued From page 103 only ones available in the facility. -If a resident needed 3 units of insulin, the MAs would have to estimate between the lines marking 2 and 4 units. -She usually ordered the insulin syringes from a medical supply company and they came in bulk supply and were used for all residents. -She did not realize the syringes were only marked in 2-unit increments and could not accurately measure odd dosages. -She would contact the facility's contracted pharmacy to obtain some new syringes. Interview with the Administrator on 08/22/19 at 11:47am revealed: -She was not aware the facility did not have a supply of insulin syringes that would accurately measure odd dosages of insulin. -There should have been a supply on hand because MAs should not estimate dosages. -They would contact the pharmacy to obtain the correct insulin syringes. Observation on 08/22/19 at 1:52pm revealed: -The facility had obtained a supply of 1/2 ml, 29-gauge syringes. -The scale on the syringes had markings starting at 0 through 50 with numbers 10, 15, 20, 25, 30, 35, 40, 45, and 50 units marked on the syringe. -There were lines marking 1-unit increments starting after the 0 line all the way down the syringe to the 50 line. -These syringes could be used to accurately measure 1-unit increments, or odd numbers. Interview with the RCC on 08/26/19 at 5:00pm revealed: -She usually ordered insulin syringes for the diabetic residents from a medical supply company.	D 370		

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D 370	Continued From page 104 -The syringes were sent in bulk and were not labeled with residents' names. -The medical supply company sent the same kind of syringes, the 1ml syringes. -They had obtained some 1/2ml syringes from the primary pharmacy on 08/22/19. -She did not know if they would continue to order the syringes from the primary pharmacy or if they would be able to get the 1/2ml syringes from the medical supply company. Review of a printed list of diabetic residents dated 08/23/19 revealed: -There were 7 diabetic residents who received insulin. -Three of the 7 diabetic residents used insulin vials requiring the use of insulin syringes for the administration of insulin. a. Review of Resident #1's current FL-2 dated 05/01/19 revealed diagnoses included dementia, chronic pain, muscle weakness, abnormal weight loss, anorexia, dysphagia, obesity, and history of seizures. Observation of Resident #1's medications on hand on 08/22/19 at 11:35am revealed: -There was a bulk supply of 1ml insulin syringes with no resident's name. -There were no insulin syringes that accurately measured 1-unit increments, or odd dosages. Review of Resident #1's August 2019 electronic medication administration record (e-MAR) revealed: -There was an entry for Humalog insulin inject 3 units 3 times daily with meals. -Humalog was scheduled to be administered at 8:00am, 12:00pm, and 5:00pm. -Three units of Humalog were documented as	D 370		

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D 370	Continued From page 105 administered 3 times daily from 08/01/19 - 08/21/19. -The resident's blood sugar ranged from 128 - 296 from 08/01/19 - 08/22/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 08/26/19 at 2:30pm revealed: -The pharmacy had ½ml insulin syringes available at the pharmacy. -The pharmacy dispensed one box of 100 1/2ml, 29-gauge insulin syringes for Resident #1 on 09/18/18. -No other insulin syringes were dispensed again for Resident #1 until 08/22/19 when requested by the facility. -There was one box of 100 1/2ml insulin syringes dispensed on 08/22/19. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. Telephone interview with Resident #1's primary care provider (PCP) on 08/22/19 at 4:28pm revealed: -The facility staff notified her today (08/22/19) that they were not using the proper insulin syringe to accurately measure Resident #1's dosage. -She was concerned because estimating insulin dosage could cause hypoglycemia or hyperglycemia if the resident was getting too much or not enough insulin. b. Review of Resident #15's current FL-2 dated 11/13/18 revealed diagnoses included dementia, hyperlipidemia, diabetes, and hypertension. Observation of Resident #15's medications on hand on 08/22/19 at 11:35am revealed:	D 370		

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D 370	Continued From page 106 -There was a bulk supply of 1ml insulin syringes with no resident's name. -There were no insulin syringes that accurately measured 1-unit increments, or odd dosages. Review of Resident #15's physician's order dated 05/31/19 revealed an order to start Levemir insulin 5 units every morning. (Levemir is long-acting insulin used to lower blood sugar. Levemir is available in an insulin pen or vial.) Review of Resident #15's June 2019 electronic medication administration record (e-MAR) revealed: -There was an entry for Levemir FlexTouch pen, give 5 units every morning and it was documented as administered from 06/01/19 - 06/25/19. -There was an entry for Levemir insulin (vial) inject 5 units every morning with a scheduled administration time of 8:00am. -Levemir insulin (vial) 5 units was documented as administered from 06/26/19 - 03/30/19. -The resident's blood sugar ranged from 137 - 293 from 06/01/19 - 06/30/19. Review of Resident #15's July 2019 e-MAR revealed: -There was an entry for Levemir insulin inject 5 units every morning with a scheduled administration time of 8:00am. -Levemir 5 units was documented as administered from 07/01/19 - 07/31/19. -The resident's blood sugar ranged from 126 - 266 from 07/01/19 - 07/31/19. Review of Resident #15's August 2019 e-MAR revealed: -There was an entry for Levemir insulin inject 5 units every morning with scheduled	D 370		

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D 370	Continued From page 107 administration time of 8:00am. -Levemir 5 units was documented as administered from 08/01/19 - 08/23/19. -The resident's blood sugar ranged from 99 - 200 from 08/01/19 - 08/23/19. Interview with Resident #15 on 08/23/19 at 10:56am revealed: -She did not know how often her blood sugar was checked. -She received insulin, but she was not sure how much or how often. -The MAs used insulin syringes, not an insulin pen, when they administered insulin to her. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 08/26/19 at 2:30pm revealed: -The pharmacy had ½ml insulin syringes available at the pharmacy. -The pharmacy had no active order on file for insulin syringes for Resident #15. -According to the pharmacy records from 2017 - 2019, they had never dispensed any insulin syringes for Resident #15. Telephone interview with Resident #15's primary care provider (PCP) on 08/26/19 at 2:57pm revealed: -She was not aware the facility had not been using insulin syringes that would accurately measure Resident #15's ordered dosage of insulin. -The dosage of insulin should not be estimated. -If the resident received too much insulin, it could cause hypoglycemia. -If the resident did not receive enough insulin, it could cause hyperglycemia. -Resident #15's blood sugar had been running high.	D 370		

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D 370	Continued From page 108 c. Review of Resident #16's current FL-2 dated 02/27/19 revealed: -Diagnoses included diabetes mellitus, hypertension, hyperlipidemia, anxiety, hemoptysis, congestive heart failure, cirrhosis, and pneumonia involving left lung. Observation of Resident #16's medications on hand on 08/22/19 at 11:35am revealed: -There was a bulk supply of 1ml insulin syringes with no resident's name. -There were no insulin syringes that accurately measured 1-unit increments, or odd dosages. Review of Resident #16's physician's order dated 06/28/19 revealed: -There was an order for Novolog insulin 4 times a day use sliding scale coverage as follows: 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units; 401 and above = call primary care provider (PCP). (Novolog is rapid-acting insulin used to lower blood sugar. Novolog is available in an insulin pen and a vial.) Review of Resident #16's June 2019 electronic medication administration record (e-MAR) revealed: -There was an entry for Novolog insulin 4 times a day use sliding scale coverage as follows: 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units; 401 and above = call PCP. -There were 3 units of Novolog insulin documented as administered on 06/11/19 at 5:00pm. -The resident's blood sugar ranged from 82 - 282 from 06/01/19 - 06/30/19. Review of Resident #16's July 2019 e-MAR	D 370		

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D 370	Continued From page 109 revealed: -There was an entry for Novolog insulin 4 times a day use sliding scale coverage as follows: 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units; 401 and above = call PCP. -There were 6 occasions when an odd number of units of Novolog were documented as administered from 07/01/19 - 07/31/19. -Three units of Novolog insulin were documented as administered on 07/06/19 (8:00pm), 07/14/19 (8:00pm), 07/16/19 (8:00pm), and 07/30/19 (8:00pm). -Five units of Novolog insulin were documented as administered on 07/09/19 (11:00am) and 07/15/19 (8:00pm). -The resident's blood sugar ranged from 86 - 386 from 07/01/19 - 07/31/19. Review of Resident #16's August 2019 e-MAR revealed: -There was an entry for Novolog insulin 4 times a day use sliding scale coverage as follows: 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units; 401 and above = call PCP. -There were 2 occasions when an odd number of units of Novolog were documented as administered from 08/01/19 - 08/23/19. -Three units of Novolog insulin were documented as administered on 08/05/19 (11:00am) and 08/22/19 (11:00am). -The resident's blood sugar ranged from 87 - 281 from 08/01/19 - 08/23/19. Interview with Resident #16 on 08/23/19 at 10:50am revealed: -Her blood sugar was checked 3 times a day and it runs "a little high". -She received insulin occasionally depending on	D 370		

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D 370	Continued From page 110 her blood sugar. -She was not sure how much insulin she usually received. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 08/26/19 at 2:30pm revealed: -The pharmacy had ½ml insulin syringes available at the pharmacy. -The pharmacy had no active order on file for insulin syringes for Resident #16. -According to the pharmacy records from 2018 - 2019, they had never dispensed any insulin syringes for Resident #16. The facility failed to have a supply of insulin syringes that accurately measured 1-unit increments, or odd dosages. There were 3 diabetic residents who had insulin vials and required the use of insulin syringes. All 3 diabetic residents were ordered and received odd dosages that would have required 1-unit marking to accurately measure the insulin. The MAs were estimating the dosages of insulin for Resident #1, #15, and #16. The residents were at risk of hypoglycemia and hyperglycemia due to estimated dosages that were either more or less of the dosages ordered to be administered. The facility's failure to maintain and use the proper measuring devices for the accurate and safe administration of insulin was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/26/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER	D 370		

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D 370	Continued From page 111 10, 2019.	D 370		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow-up on medication review recommendations for 2 of 5 sampled residents (#4, #6) related to medications for moderate to severe pain (#6) and skin rash/allergies (#4). The findings are: 1. Review of Resident #6's current FL-2 dated 07/24/19 revealed: -Diagnoses included malignant neoplasm of the meninges, secondary neoplasms of the brain, lung and bone, hypertension, and type 2 diabetes mellitus. -There was an order for Norco 10-325 mg one tablet by mouth every six hours (Norco is a controlled substance used to treat moderate to severe pain.) Review of Resident #6's Resident Register revealed she was admitted to the facility on 06/27/19. Review of Resident #6's medication review dated	D 406	The RCC will be responsible for ensuring review of all pharmacy recommendations upon receipt, initiating follow up immediately with all follow up to be completed within 2 weeks of receipt. The bucket order processing system will be utilized for all recommendations requiring MD review and response. The ED will monitor consistent use of the bucket order processing system and review completed pharmacy recommendations quarterly to ensure ongoing compliance	10-10-19

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D 406	Continued From page 112 07/25/19 revealed: -The pharmacist recommended for the facility to notify the prescriber of the missed Norco doses. -There was no documentation by the prescriber that the recommendation was received or followed. Review of Resident #6's July 2019 hand written medication administration records (MARs) revealed: -There was an entry for Norco 10-325 mg one tablet by mouth every six hours with scheduled administration times of 12:00am, 6:00 am, 12:00pm and 6:00pm. -There were 4 doses of Norco not administered on 07/01/19 at 12:00am, 6:00 am, 12:00pm and 6:00pm with documentation the drug item was not available. -There was 1 dose of Norco not administered on 07/03/19 at 12:00am with documentation the drug item was not available. -Total missed doses of Norco was 5. Review of Resident #6's July 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Norco 10-325 mg one tablet by mouth every six hours with scheduled administration times of 12:00am, 6:00 am, 12:00pm and 6:00pm. -There were 3 doses of Norco not administered on 07/10/19 at 6:00am, 12:00pm and 6:00pm with documentation the drug item was not available. -There were 16 doses of Norco not administered on 07/11/19 through 07/14/19 at 12:00am, 6:00 am, 12:00pm and 6:00pm with documentation the drug item was not available. -There were 8 doses of Norco not administered on 07/24/19 through 07/25/19 at 12:00am, 6:00	D 406		

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D 406	Continued From page 113 am, 12:00pm and 6:00pm with documentation the drug item was not available. -There were 6 doses of Norco not administered on 07/26/19 through 07/27/19 at 6:00 am, 12:00pm and 6:00pm with documentation the drug item was not available. -There were 16 doses of Norco not administered on 07/28/19 through 07/31/19 at 12:00am, 6:00 am, 12:00pm and 6:00pm with documentation the drug item was not available. -Total missed doses of Norco was 49. Review of Resident #6's August 2019 eMAR revealed: -There was an entry for Norco 10-325 mg one tablet by mouth every six hours with scheduled administration times of 12:00am, 6:00 am, 12:00pm and 6:00pm. -There were 8 doses of Norco not administered on 08/01/19 through 08/02/19 at 12:00am, 6:00 am, 12:00pm and 6:00pm with documentation the drug item was not available. -There was 1 dose of Norco on not administered on 08/03/19 at 12:00am with documentation the drug item was not available. -There were 2 doses of Norco not administered on 08/18/19 at 12:00pm and 6:00pm with documentation the drug item was not available. -Total missed doses of Norco was 11. Review of Resident #6's medical record revealed there was no documentation the pharmacist's recommendation had been forwarded to the primary care provider (PCP). Telephone interviews with Resident #6's PCP on 08/26/19 at 11:15am and 5:25pm revealed: -She had not been notified of Resident #6 missing any doses of Norco. -She would expect the facility to notify her of the	D 406		

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D 406	Continued From page 115 duplicate therapy of Cetirizine and Hydroxyzine HCL. -The pharmacist recommended the Cetirizine order be discontinued. -The section for the physician's response and signature was blank. Review of Resident #4's physician's orders dated 07/26/19 revealed an order for Hydroxyzine HCL 25mg tablet every four hours. Review of Resident #4's July 2019 medication administration record (MAR) revealed: -There was an entry for Cetirizine 10mg tablet every day. -Cetirizine 10mg was documented as administered every day at 8:00am. -There was an entry for Hydroxyzine HCL 10mg tablet every four hours as needed for itching. - Hydroxyzine HCL 10mg was documented as administered on 07/05/19 at 10:00am and on 07/20/19 at 2:14pm. -There was an entry for Hydroxyzine HCL 25mg tablet every four hours. - Hydroxyzine HCL 25mg was documented as administered on 07/28/19 thru 07/30/19 at 12:00am, 4:00am, 8:00am 12:00pm, 4:00pm, and 8:00pm, and on 07/31/19 at 12:00am, 8:00am and 8:00pm. Review of Resident #4's August 2019 MAR revealed: -There was an entry for Cetirizine 10mg tablet every day. -Cetirizine 10mg was documented as administered every day at 8:00am except on 08/10/19 and 08/19/19 the medication was documented as not administered/unavailable. -There was an entry for Hydroxyzine HCL 10mg tablet every four hours as needed for itching and	D 406		

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D 406	Continued From page 114 missed doses of the Norco since Resident #6 had a diagnosis of brain cancer with metastasis. Interviews with the Resident Care Coordinator (RCC) on 08/21/19 at 12:33pm and 08/26/19 at 3:45pm revealed: -She was responsible for getting the medication review recommendations to the PCPs. -She had signed the pharmacy recommendations on 08/07/19 but she did not recall sending them to the PCP. Interview with the Administrator on 08/26/19 at 6:13pm revealed: -She was not sure if Resident #6's PCP was notified of the medication review recommendations on 07/25/19 but she would check on it. -She would check some paperwork that had not been filed yet. 2. Review of Resident #4's current FL-2 dated 12/27/18 revealed diagnoses included Alzheimer's Disease, hyperlipidemia, osteopenia, and vitamin D deficiency. Review of Resident #4's physician's orders dated 04/10/19 revealed an order for Cetirizine 10mg tablet every day. (Cetirizine is for allergy symptoms, hives and itching.) Review of Resident #4's physician's orders dated 05/08/19 revealed an order for Hydroxyzine HCL10mg tablet every four hours as needed for itching. (Hydroxyzine is for itching caused by allergies.) Review of Resident #4's medication review dated 07/26/19 revealed: -The pharmacist noted Resident #4 received	D 406		

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D 406	Continued From page 116 none was documented as administered. -There was an entry for Hydroxyzine HCL 25mg tablet every four hours. - Hydroxyzine HCL 25mg was documented as administered every day at 12:00am, 4:00am, 8:00am 12:00pm, 4:00pm, and 8:00pm, except on 08/03/19 the medication was documented as not administered/unavailable. Review of Resident #4's physician's orders revealed there was no documentation the pharmacist's recommendations had been forwarded to the primary care provider (PCP). Interview with the Resident Care Coordinator (RCC) on 08/26/19 at 10:30am revealed: -She was responsible for getting the pharmacy medication reviews to the PCP for sign-off. -She faxed the 07/26/19 pharmacy medication review for Resident #4 to the PCP on 08/21/19 but had not heard back. -She did not know why it was not faxed in July when it was completed; it may have been misplaced. -She had not followed up with a phone call to the PCP. Attempted phone interview with Resident #4's PCP on 08/26/19 at 11:30am was unsuccessful. Interview with the Administrator on 08/26/19 at 4:00pm revealed: -The RCC was responsible for follow-up with the PCPs for all pharmacy medication reviews the day the reviews were completed. -The pharmacy medication reviews were faxed to PCPs and usually a response was received within a week. -She was not aware the 07/26/19 pharmacy medication review was not signed by the PCP for	D 406		

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D 406	Continued From page 117 Resident #4.	D 406		
D 486	10A NCAC 13F .1501 (e) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (e) All instances of the use of physical restraints and alternatives shall be documented by the facility in the resident's record and include the following: (1) restraint alternatives that were provided and the resident's response; (2) type of restraint that was used; (3) medical symptoms warranting restraint use; (4) the time the restraint was applied and the duration of restraint use; (5) care that was provided to the resident during restraint use; and (6) behavior of the resident during restraint use. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure documentation of a restraint while it was in use for 1 of 1 resident sampled with restraints (#4). The findings are: Review of Resident #4's current FL-2 dated 12/27/18 revealed: -Diagnoses included Alzheimer's Disease, hyperlipidemia, osteopenia, and vitamin D deficiency.	D 486	The RCC will maintain an updated list of any residents with physician ordered restraints. Care staff will utilize a specific form for documenting restraint checks and releases as ordered by the physician. The form will be turned in to the RCC at the end of each shift for review. The RCC will initial each sheet to indicate review and compliance. Care staff will receive additional training regarding use of restraints, restraint checks and releases, and proper documentation of checks and releases. Training will be conducted by the ED/RCC/designee and documentation of training will be maintained in the community for review	10-10-19

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D 486	Continued From page 118 -Resident #4 was ambulatory with no assistive device listed. -Resident #4 was constantly disoriented. Review of the physician's restraint order for Resident #4 dated 05/01/19 revealed: -There was an order for a geri-chair. -The reason for the restraint was due to falls secondary to Alzheimer's resulting in unsteady gait, impaired memory and not being able to call for assistance. -The geri-chair was to be used when the resident was out of bed. -The restraint was to be checked every 30 minutes, released every 2 hours and as needed and removed while in bed. -The resident was to be toileted every 2 hours. Review of Resident #4's restraint use disclosure statement revealed the guardian signed consent for restraint usage on 05/02/19. Review of the facility's Restraint Policy revealed: -The resident with the restraint should be checked every 30 minutes and released every 2 hours and care provided. -The documentation shall include alternatives provided and responses; type used; medical symptoms warranting use, time and duration, care provided during restraint use and resident behaviors during use of restraint. Review of Resident #4's restraint assessment dated 05/01/19 revealed: -The assessment was performed by the registered nurse. -Medical symptoms that warranted the use of the restraint included: Weakness and falls secondary to Alzheimer's resulting in unsteady gait, impaired memory and not being able to call for assistance.	D 486		

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Jodi DiNello 912-536-1795 Jodi.DiNello@s Summer's of V Guardian Phar	HAL096051	A. BUILDING: _____ 10929 GA Hwy 877-736-2233 866-534-5566 Jodi DiNello B. WING _____	912-536-1795 R-C 08/26/2019

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D 486	Continued From page 119 -Medical symptoms occurred daily. -Previous alternatives were listed a "geri-chair is in place". -The resident was unable to communicate with the staff due to Alzheimer's disease. Review of the facility's June 2019 restraint and release record revealed there was not one available for Resident #4. Review of Resident #4's July 2019 restraint and release record revealed: -The record had blocks for a staff signature every 30 minutes for the entire month. -There was no documentation on 07/01/19 to 07/24/19. -There was no documentation on 07/25/19 to 07/31/19 from 12:30pm to 4:00pm. Review of Resident #4's August 2019 restraint and release record revealed: -The record had blocks for a staff signature every 30 minutes for the entire month. -There was no documentation for the month of August except on four days: 08/04/19 from 7:00pm to 11:00pm, 08/07/19 from 7:00am to 8:30 am, 08/16/19 at 7:00am-7:30am and 08/26/19 at 10:30am.. Observation of Resident #4 on 08/20/19 at 1:00pm revealed the resident was in her geri-chair reclined at a sixty degree angle with no tray on the chair. Interview with a personal care aide (PCA) on 08/26/19 at 10:15am revealed: -She changed Resident #4 every two hours. -She did not know to document on a restraint and release record when she got Resident #2 out of the geri-chair..	D 486		

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D 486	Continued From page 120 -She walked with her sometimes in the mornings. Interview with a second PCA on 08/26/19 at 11:00am revealed: -Resident #4 was walked every two hours. -They had not been documenting it on the restraint and release record when they got Resident #4 out of the geri-chair because they have limited staff and not enough time in the day to do it. Interview with the Resident Care Coordinator (RCC) on 08/26/19 at 10:50am revealed: -The PCAs should check on Resident #4 every 30 minutes and get her up every 2 hours and document the restraint checks and releases on the restraint flow record. -They should sign the sheet every 2 hours and use the appropriate code listed to allow reader to know if Resident #4 was up in the geri-chair or in bed. -She was not aware Resident #4's check and release record was not signed. -She would speak to staff regarding the missing signatures. Attempted phone interview with Resident #4's PCP on 08/26/19 at 11:30am was unsuccessful. Interview with Resident #4's family member on 08/26/19 at 2:35pm revealed she knew the staff got Resident #4 out of the geri-chair and walked with her every two hours when she was not in her bed. Interview with the Administrator on 08/26/19 at 4:00pm revealed: -She did not know that the documentation was not being completed when Resident #4 was in her geri-chair and checked every 30 minutes, and	D 486		

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D 486	Continued From page 121 when the staff got Resident #4 out of her geri-chair every two hours. -The PCAs were required to document, and the medication aides (MA) were required to validate documentation was completed each shift.	D 486		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility neglected to provide the services necessary to maintain the residents' health as related to medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered within one hour before or after the prescribed or scheduled times for 4 residents (#2, #17, #18, #19) during the morning medication pass on 08/26/19 and for 7 of 8 residents sampled (#1, #2, #3, #4, #6, #7, #9) for record review resulting in medications with multiple administration times being administered too close to the next scheduled administration times and medications such as insulin being administered too early or too late. [Refer to Tag D364, 10A NCAC 13F .1004(g) Medication Administration (Type B Violation)]. 2. Based on observations, interviews, and record	D914	Refer to Plans of Correction for individual citations above	

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D914	Continued From page 122 reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 4 of 4 residents (#1, #13, #14, #20) observed during the medication passes including errors with insulin (#1, #20), inhalers for breathing problems (#13), a diuretic/blood pressure medication (#14), a fish oil supplement (#14), and a vitamin supplement (#13); and for 6 of 9 residents sampled (#2, #3, #4, #6, #7, #9) for record review including errors with medications for pain (#6), high blood pressure (#2, #6, #9), diabetes (#6), blood thinner (#9), Parkinson's disease (#3), anxiety (#4), muscle spasms (#9), Alzheimer's dementia (#9), acid reflux (#7), gout (#2), and low potassium levels (#7). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)].	D914		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5	D934	An audit of all MA personnel/training records began prior to survey exit and will be completed to identify any MAs who have not had the mandated Infection Control training within the previous 12 months. Any MA without the training within the previous 12 months will be removed from the med cart until training is completed	10-10-19

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D934	Continued From page 123 This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to assure 2 of 3 staff sampled (Staff A and Staff B) who were medication aides completed the state approved annual infection control training. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired 02/27/17 as a personal care aide/medication aide. -There was documentation Staff A passed the medication examination on 01/12/15. -There was documentation a medication clinical skills checklist was completed for Staff A on 03/01/17. -There was documentation Staff A's most recent infection control training was completed 01/31/18. Interview with Staff A on 08/22/19 at 1:00pm revealed: -She worked as a medication aide (MA). -She remembered completing an infection control training last year but did not remember when the training was completed last year. -There were two infection control trainings done - one on the computer that printed a certificate, and one completed by a nurse who signed a certificate. -She had completed both infection control trainings "last year".	D934	The BOM will maintain a staff training tickler to ensure all MA qualifications and training have been met and annual Infection Control training is completed timely. MAs will be removed from the medication cart until all qualifications have been met. audit of weekly reviews of tickler. Med expiration date, all requirements completed dates 10/4/19 AS	

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D934	Continued From page 124 -She was not sure but thought the infection control training completed by the nurse was done at the beginning of last year (2018). -The Administrator or Business Office Manager (BOM) would know about the infection control training she had completed. -She was supposed to complete infection control training once a year and within 30 days of being hired. Refer to the interview with the Administrator on 08/22/19 at 4:25pm. Refer to the interview with the Business Office Manager (BOM) on 08/22/19 at 4:35pm. 2. Review of Staff B's personnel record revealed: -Staff B was hired from 02/01/17 to 06/14/18 and rehired on 07/19/18. -There was documentation Staff B passed the medication examination on 04/14/03. -There was documentation a medication clinical skills checklist was completed for Staff B on 02/02/17. -There was documentation Staff A's most recent infection control training was completed 01/31/18. Interview with Staff B on 08/22/19 at 12:45pm revealed: -She worked as a medication aide/supervisor. -She had been working at the facility since 02/01/17. -She had completed an infection control training at the beginning of the year through the online training system used at the facility. -She remembered completing an infection control training with a corporate nurse between the first and end of December 2018. -There should be a certificate in her employee personnel record for the completed infection	D934		

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D934	Continued From page 125 control training. -She was aware she had to complete infection control training annually. Refer to the interview with the Administrator on 08/22/19 at 4:25pm. Refer to the interview with the Business Office Manager (BOM) on 08/22/19 at 4:35pm. Interview with the Administrator on 08/22/19 at 4:25pm revealed: -Staff A and Staff B completed annual infection control training in January 2018 and had not completed another annual infection control training in 2019. -The facility used an online training system that should notify staff when training was needed. -She "generally" kept up with staff training. -She had not put a system in place at the facility to keep up with continuing education units for staff at this facility since becoming employed on 03/17/19. -She "generally" came to the facility every day. -There was an Administrator-In-Training (AIT) in the facility who had been there since 05/01/19. -The Business Office Manager (BOM) was responsible for completing employee record audits, and was performing weekly audits "right now". -An auditing of personnel records started about two weeks ago. -Staff A and Staff B personnel records had not been audited yet. -She did not know Staff A and Staff B had not completed annual infection control since January 2018. Interview with the Business Office Manager (BOM) on 08/22/19 at 4:35pm revealed:	D934		

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D934	Continued From page 126 -She and the Administrator were responsible for maintaining personnel files. -She enrolled staff in the online computer system that automatically enrolled staff in an online infection control class. -She saw on a perpetual staffing log she received from the AIT last month that Staff A and Staff B needed an annual infection control training. -She understood that a corporate nurse came to the facility to teach annual infection control training. -There had not been an infection control training by a corporate nurse since her employment began on 02/04/19. -She would assume the Administrator would request the nurse to come to the facility and teach a class.	D934		