STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060111	A. BUILDING: _____ B. WING _____	R-C 11/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE ASSISTED LIVING	2140 MILTON ROAD CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a follow up survey and complaint investigation on 11/0719 through 11/08/19.	{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 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 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: Based on observations, interviews and record reviews, the facility failed to assure the administration of medications by staff were in accordance with orders by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #5) related to a medication used to treat insomnia. The findings are: Review of Resident #5's current FL2 dated 09/26/19 revealed: -Diagnoses included dementia and schizophrenia. -There was a medication order for melatonin 3mg one tablet at bedtime (a medication used to treat insomnia). Review of Resident #5's subsequent physician's	{D 358}	10 A NCAC 13F.1004(a)Medication Administration 1. In-service provided for all Medication Aides on Medication Administration and Documentation. 11.13/19 2.Medication Aides will complete the administration compliance at the end of every shift. 3, The Bucket System will continue to be implemented to ensure new orders are followed to the MAR 4.Chart Audit completed to ensure Medication orders are being followed as prescribed any concerns noted will be addressed with the residents Primary MD . 5.SIC and RCC to complete weekly E-Mar reviews to follow-up on any concerns and address with Primary MD, and identify medication are being given according to MD orders 6.ED along with RCC to complete random medications administration audits to Assure Medication aides are using appropriate.techniques and following E-Mar when administering medications.	

Mary R Agena

Reviewed and Accepted by Mary Agena/MA on 12/30/19

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{D 358}	Continued From page 1 orders dated 09/30/19 revealed a medication order for melatonin 3mg one tablet at bedtime for 7 days. Review of Resident 5's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for melatonin 3mg to be administered daily at 8:00pm with a start date of 10/01/19 and no "end" date. -The entry for melatonin had "special instructions" with documentation to take 1 tablet at bedtime for 7 days. -There was documentation Resident #5 was administered melatonin 3mg daily at 8:00pm from 10/02/19-10/04/19, 10/06/19-10/22/19, 10/24/19-10/28/19 and again on 10/30/19. -There was documentation Resident #5 was not administered melatonin on 10/05/19, 10/11/19, 10/23/19, and 10/29/19 due to the resident refused. Review of Resident 5's November 2019 eMAR (11/01/19-11/07/19) revealed: -There was an entry for melatonin 3mg to be administered daily at 8:00pm with a start date of 10/01/19 and no "end" date. -The entry for melatonin had "special instructions" with documentation to take 1 tablet at bedtime for 7 days. -There was documentation Resident #5 was administered melatonin 3mg daily at 8:00pm from 11/01/19-11/02/19 and again from 11/04/19-11/06/19. -There was documentation Resident #5 was not administered melatonin on 11/03/19 due to the resident refused. Observation of Resident #5's medications on hand on 11/07/19 at 1:18pm revealed there was	{D 358}		

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{D 358}	Continued From page 2 no melatonin available for administration. Interview with a morning shift medication aide (MA) on 11/07/19 at 1:18pm revealed: -She did not work during the time Resident #5's melatonin was administered. -She thought Resident #5's order for melatonin had been discontinued. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/07/19 at 2:46pm revealed: -Resident #5 did not have a current order for melatonin. -The pharmacy had an order for Resident #5 dated 09/30/19 for melatonin 3mg daily at bedtime for 7 days. -They had dispensed 7 tablets of melatonin 3mg for Resident #5 on 10/01/19. -They had not dispensed melatonin for Resident #5 since 10/01/19. Interview with an evening shift MA on 11/07/19 at 3:31pm revealed: -She thought Resident #5 had an order for melatonin 3mg daily at bedtime. -She had administered melatonin 3mg to Resident #5 two times in November and seventeen times in October. -She had administered the last of Resident #5's melatonin from her bubble pack yesterday (11/06/19) and had requested a refill from the pharmacy. -She could not locate documentation of the melatonin refill request. -The facility kept a "house stock" of over the counter melatonin and would administer the melatonin to residents if they did not have a bubble pack from the pharmacy.	{D 358}		

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{D 358}	Continued From page 3 Interview with a second evening shift MA on 11/07/19 at 3:45pm revealed: -His initials were documented as administering melatonin 3mg to Resident #5 on 11/01/19 and 11/04/19. -He could not remember administering any medications to Resident #5 because "she normally refused her bedtime medications." -He thought he might have forgotten to sign out of the computer and another MA might have documented the administration of melatonin to Resident #5 under his initials. Interview with the Administrator on 11/07/19 at 4:00pm revealed: -She thought she had contacted Resident #5's primary care physician (PCP) after 09/30/19, and he had provided an order to continue melatonin beyond the 7 days. -MAs would use the "house stock" of melatonin for residents if they ran out. A second interview with the Administrator on 11/08/19 at 8:50am revealed: -She could not locate documentation for Resident #5's melatonin to continue beyond the 7 days ordered on 09/30/19. -The pharmacy was responsible for entering new orders onto the eMAR. -The Memory Care Coordinator (MCC) was responsible for approving the orders entered by the pharmacy to allow the medications to populate on the eMAR for the MAs to administer. -The MAs had continued to administer melatonin to Resident #5 from 10/09/19-11/06/19 without an order because the MCC was new when she approved the melatonin order, and she did not add a stop date of 10/08/19. Telephone interview with Resident #5's PCP on	{D 358}		

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{D 358}	Continued From page 4 11/08/19 at 10:30am revealed: -He did not know Resident #5 returned from the hospital with a medication order dated 09/30/19 for melatonin 3mg at bedtime for 7 days. -There was no risk in Resident #5 being administered melatonin 3mg daily from 10/09/19-11/07/19. A second observation of Resident #5's medications on hand on 11/08/19 at 10:33am revealed a bottle of over the counter melatonin 3mg tablets available for administration with no resident's name on the bottle. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.	{D 358}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering	D 367	10A NCAC 13 F 1004(j) Medication Administration 1. In-service provided for all Medication Aides on Medication Administration and Documentation. 11.13/19 In-service how to correctly complete a Paper MAR. 11/20/19 2.Medication Aides will make sure paper MAR must be clear, accurate and up to date. and all information on MAR should contain the patient full name, date of birth and weight ,and include known allergies . name of medication or treatment,strength and dosage of quanity of medication administered, route of administration,reason for administration or treatment and the date of administration. or omission. 3.Two Medication Aides must check MAR to make sure it is clear and accurate. 4.Medication aides need to print and sign their names on MAR in order to recognize the aide giving the medication. 5..ED along with RCC to complete random medications administration audits to Assure Medication aides are using appropriate.techniques and following E-Mar when administering medications.	

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D 367	Continued From page 5 the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 2 of 5 sampled residents (#2 & #5) related to the omission of documentation of all medication administered, documentation of signature and initials of staff administering medications (#2) and related to documentation of medication used to treat schizophrenia (#5). The findings are: 1. Review of Resident #2's current FL2 dated 10/02/19 revealed diagnoses included dementia, alcohol abuse, congestive heart failure, bipolar disorder. Review of Resident #2's Resident Register revealed an admission date of 10/26/19. a. Review of Resident #2's current FL2 dated 10/02/19 revealed an order for carvedilol 6.24mg (to treat hypertension) take one tablet twice daily. Review of Resident #2's October 2019	D 367		

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D 367	Continued From page 6 hand-written Medication Administration Record revealed: -There was an entry for carvedilol 6.24mg twice daily beginning on 10/26/19 at 8:00pm and documented as administered 10/26/19 at 8:00pm until 10/27/19 at 8:00pm. -There was no documentation carvedilol 6.24mg was administered on 10/28/19 at 8:00am to 10/31/19 at 8:00pm. -There was no documentation of signatures with the initials of the staff administering the medications. Review of Resident #2's October 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for carvedilol 6.24mg take one tablet twice daily and was documented as administered beginning on 10/30/19 at 8:00pm to 10/31/19 at 8:00pm. -There was documentation with the initials and full names of the staff administering the medications. Review of the comparison between Resident #2's October 2019 hand-written and eMAR revealed there was no documentation of carvedilol 6.24mg twice daily beginning 10/28/19 at 8:00pm until 10/30/19 at 8:00am. Review of Resident #2's November 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for carvedilol 6.24mg take one tablet twice daily and was documented as administered on 11/01/19 at 8:00am to 11/02/19 at 8:00pm. -There was an entry for carvedilol 6.24mg take one tablet twice daily and was documented as not administered beginning 11/03/19 at 8:00am to	D 367		

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D 367	Continued From page 7 11/07/19 because Resident #2 was hospitalized. -There was documentation with the initials and full names of the staff administering the medications. Observation on 11/07/19 at 9:17am of Resident #2's medications on hand for administration for Resident #2 revealed there was eleven of thirty carvedilol 6.24mg tablets available with a dispense date of 10/28/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19 at 11:00am revealed the pharmacy had dispensed thirty carvedilol 6.24mg tablets on 10/28/19. b. Review of Resident #2's current FL2 dated 10/02/19 revealed an order for digoxin 125mcg (to treat irregular heartbeat) take one tablet daily. Review of Resident #2's October 2019 hand-written Medication Administration Record revealed: -There was an entry for digoxin 125mcg daily beginning on 10/26/19 and documented as administered 10/27/19 at 8:00am until 10/28/19 at 8:00am. -There was no documentation digoxin 125mcg was administered on 10/28/19 at 8:00am to 10/31/19 at 8:00am. -There was no documentation of signatures with the initials of the staff administering the medications. Review of Resident #2's October 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for digoxin 125mcg mg daily and was documented as administered beginning	D 367		

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D 367	Continued From page 8 on 10/30/19 at 8:00am to 10/31/19 at 8:00am. -There was documentation with the initials and full names of the staff administering the medications. Review of the comparison between Resident #2's October 2019 hand-written and eMAR revealed there was no documentation of digoxin 125mcg daily beginning 10/29/19 at 8:00am until 10/30/19 at 8:00am. Review of Resident #2's November 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for digoxin 125mcg daily and was documented as administered on 11/01/19 at 8:00am to 11/02/19 at 8:00am. -There was an entry for digoxin 125mcg daily and was documented as not administered beginning 11/03/19 at 8:00am to 11/07/19 because Resident #2 was hospitalized. -There was documentation with the initials and full names of the staff administering the medications. Observation on 11/07/19 at 9:17am of Resident #2's medications on hand for administration for Resident #2 revealed there was twenty-four of thirty digoxin 125mcg tablets available with a dispense date of 10/28/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19 at 11:00am revealed the pharmacy had dispensed thirty digoxin 125mcg tablets on 10/28/19. c. Review of Resident #2's current FL2 dated 10/02/19 revealed an order for fluticasone propionate nasal spray (to treat seasonal	D 367		

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D 367	Continued From page 9 allergies) instill two sprays into each nostril once daily. Review of Resident #2's October 2019 hand-written Medication Administration Record revealed: -There was an entry for fluticasone propionate nasal spray instill two sprays into each nostril once daily beginning 10/26/19 at 8:00pm and documented as administered 10/27/19 at 8:00am until 10/28/19 at 8:00am. -There was no documentation fluticasone propionate nasal spray was administered on 10/29/19 at 8:00am to 10/31/19 at 8:00am. -There was no documentation of signatures with the initials of the staff administering the medications. Review of Resident #2's October 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for fluticasone propionate nasal spray instill two sprays into each nostril once daily and documented as administered beginning on 10/30/19 at 8:00am to 10/31/19 at 8:00am. -There was documentation with the initials and full names of the staff administering the medications. Review of the comparison between Resident #2's October 2019 hand-written and eMAR revealed there was no documentation of fluticasone propionate nasal spray daily beginning 10/29/19 at 8:00am until 10/30/19 at 8:00am. Review of Resident #2's November 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for fluticasone propionate	D 367		

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D 367	Continued From page 10 nasal spray instill two sprays into each nostril once daily and was documented as administered on 11/01/19 at 8:00am to 11/02/19 at 8:00am. -There was an entry for fluticasone propionate nasal spray instill two sprays into each nostril once daily and was documented as not administered beginning 11/03/19 at 8:00am to 11/07/19 because Resident #2 was hospitalized. -There was documentation with the initials and full names of the staff administering the medications. Observation on 11/07/19 at 9:17am of Resident #2's medications on hand for administration for Resident #2 revealed there was one bottle of fluticasone propionate nasal spray available with a dispense date of 10/28/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19 at 11:00am revealed the pharmacy had dispensed one bottle of fluticasone propionate nasal spray on 10/28/19. d. Review of Resident #2's current FL2 dated 10/02/19 revealed an order for furosemide (to treat fluid retention) 40mg take one tablet daily. Review of Resident #2's October 2019 hand-written Medication Administration Record revealed: -There was an entry for furosemide 40mg daily beginning 10/26/19 and documented as administered 10/27/19 at 8:00am until 10/28/19 at 8:00am. -There was no documentation furosemide 40mg was administered on 10/29/19 at 8:00am to 10/31/19 at 8:00am. -There was no documentation of signatures with the initials of the staff administering the	D 367		

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D 367	Continued From page 11 medications. Review of Resident #2's October 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for furosemide 40mg daily and documented as administered beginning on 10/30/19 at 8:00am to 10/31/19 at 8:00am. -There was documentation with the initials and full names of the staff administering the medications. Review of the comparison between Resident #2's October 2019 hand-written and eMAR revealed there was no documentation of furosemide 40mg daily beginning 10/29/19 at 8:00am until 10/30/19 at 8:00am. Review of Resident #2's November 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for furosemide 40mg daily and was documented as administered on 11/01/19 at 8:00am to 11/02/19 at 8:00am. -There was an entry for furosemide 40mg daily and was documented as not administered beginning 11/03/19 at 8:00am to 11/07/19 because Resident #2 was hospitalized. -There was documentation with the initials and full names of the staff administering the medications. Observation on 11/07/19 at 9:17am of Resident #2's medications on hand for administration for Resident #2 revealed there was one of seven furosemide 40mg tablets available with a dispense date of 10/28/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19	D 367		

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D 367	Continued From page 12 at 11:00am revealed the pharmacy had dispensed seven furosemide 40mg tablets on 10/28/19. e. Review of Resident #2's current FL2 dated 10/02/19 revealed an order for montelukast (to treat allergies) 40mg take one take at bedtime. Review of Resident #2's October 2019 hand-written Medication Administration Record revealed: -There was an entry for montelukast 40mg daily beginning on 10/26/19 and documented as administered 10/26/19 at 8:00pm until 10/28/19 at 8:00pm. -There was no documentation montelukast 40mg was administered on 10/29/19 at 8:00pm to 10/31/19 at 8:00pm. -There was no documentation of signatures with the initials of the staff administering the medications. Review of Resident #2's October 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for montelukast 40mg daily with documentation as administered beginning on 10/30/19 at 8:00pm to 10/31/19 at 8:00pm. -There was documentation with the initials and full names of the staff administering the medications. Review of the comparison between Resident #2's October 2019 hand-written and eMAR revealed there was no documentation of montelukast 40mg daily beginning 10/29/19 at 8:00pm until 10/30/19 at 8:00pm. Review of Resident #2's November 2019 electronic Medication Administration	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060111	A. BUILDING: _____ B. WING _____	R-C 11/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE ASSISTED LIVING	2140 MILTON ROAD CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 13 Record(eMAR) revealed: -There was an entry for montelukast 40mg daily and was documented as administered on 11/01/19 at 8:00pm to 11/02/19 at 8:00pm. -There was an entry for montelukast 40mg daily and was documented as not administered beginning 11/03/19 at 8:00am to 11/07/19 because Resident #2 was hospitalized. -There was documentation with the initials and full names of the staff administering the medications. Observation on 11/07/19 at 9:17am of Resident #2's medications on hand for administration for Resident #2 revealed there was one of seven montelukast 40mg tablets available with a dispense date of 10/28/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19 at 11:00am revealed the pharmacy had dispensed seven montelukast 40mg tablets on 10/28/19. f. Review of Resident #2's current FL2 dated 10/02/19 revealed an order for oxcarbazepine (to treat seizures) 300mg take one tablet three times a day. Review of Resident #2's October 2019 hand-written Medication Administration Record revealed: -There was an entry for oxcarbazepine 300mg three times daily beginning 10/26/19 and documented as administered 10/27/19 at 8:00am until 10/28/19 at 8:00pm. -There was no documentation oxcarbazepine 300mg was administered on 10/29/19 at 8:00am to 10/31/19 at 8:00pm. -There was no documentation of signatures with	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060111	A. BUILDING: _____ B. WING _____	R-C 11/08/2019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 14 the initials of the staff administering the medications. Review of Resident #2's October 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for oxcarbazepine 300mg three times daily and documented as administered beginning on 10/30/19 at 8:00am to 10/31/19 at 8:00pm. -There was documentation with the initials and full names of the staff administering the medications. Review of the comparison between Resident #2's October 2019 hand-written and eMAR revealed there was no documentation of oxcarbazepine 300 mg daily beginning 10/29/19 at 8:00am until 10/30/19 at 8:00pm. Review of Resident #2's November 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for oxcarbazepine 300mg three times daily and was documented as administered on 11/01/19 at 8:00am to 11/02/19 at 8:00pm. -There was an entry for oxcarbazepine 300mg three times daily and was documented as not administered beginning 11/03/19 at 8:00am to 11/07/19 because Resident #2 was hospitalized. -There was documentation with the initials and full names of the staff administering the medications. Observation on 11/07/19 at 9:17am of Resident #2's medications on hand for administration for Resident #2 revealed there was three of twenty-one oxcarbazepine 300mg tablets available with a dispense date of 10/28/19.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 367	Continued From page 15 Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19 at 11:00am revealed the pharmacy had dispensed twenty-one oxcarbazepine 300mg tablets on 10/28/19. g. Review of Resident #2's current FL2 dated 10/02/19 revealed an order for lamotrigine (to treat bipolar)100mg take one tablet daily. Review of Resident #2's October 2019 hand-written Medication Administration Record revealed: -There was an entry for lamotrigine 100mg daily beginning on 10/26/19 and documented as administered 10/27/19 at 8:00am until 10/28/19 at 8:00am. -There was no documentation lamotrigine 100mg was administered on 10/29/19 at 8:00am to 10/31/19 at 8:00am. -There was no documentation of signatures with the initials of the staff administering the medications. Review of Resident #2's October 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for lamotrigine 100mg daily and documented as administered beginning on 10/30/19 at 8:00am to 10/31/19 at 8:00am. -There was documentation with the initials and full names of the staff administering the medications. Review of the comparison between Resident #2's October 2019 hand-written and eMAR revealed there was no documentation of lamotrigine 100mg daily beginning 10/29/19 at 8:00am until 10/30/19 at 8:00am.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 16 Review of Resident #2's November 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for lamotrigine 100mg daily and was documented as administered on 11/01/19 at 8:00am to 11/02/19 at 8:00am. -There was an entry for lamotrigine 100mg daily and was documented as not administered beginning 11/03/19 at 8:00am to 11/07/19 because Resident #2 was hospitalized. -There was documentation with the initials and full names of the staff administering the medications. Observation on 11/07/19 at 9:17am of Resident #2's medications on hand for administration for Resident #2 revealed there was one of seven lamotrigine 100mg tablets available with a dispense date of 10/28/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19 at 11:00am revealed the pharmacy had dispensed seven lamotrigine 100mg tablets on 10/28/19. h. Review of Resident #2's current FL2 dated 10/02/19 revealed an order for lisinopril (to treat hypertension) 5mg take one tablet daily. Review of Resident #2's October 2019 hand-written Medication Administration Record revealed: -There was an entry for lisinopril 5mg daily beginning 10/26/19 and documented as administered 10/27/19 at 8:00am until 10/28/19 at 8:00am. -There was no documentation lisinopril 5mg was administered on 10/28/19 at 8:00am to 10/31/19	D 367		

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D 367	Continued From page 17 at 8:00am. -There was no documentation of signatures with the initials of the staff administering the medications. Review of Resident #2's October 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for lisinopril 5mg daily and documented as administered beginning on 10/30/19 at 8:00am to 10/31/19 at 8:00am. -There was documentation with the initials and full names of the staff administering the medications. Review of the comparison between Resident #2's October 2019 hand-written and eMAR revealed there was no documentation of lisinopril 5mg daily beginning 10/29/19 at 8:00am until 10/30/19 at 8:00am. Observation on 11/07/19 at 9:17am of Resident #2's medications on hand for administration for Resident #2 revealed there was one of seven lisinopril 5mg tablets available with a dispense date of 10/28/19. Review of Resident #2's November 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for lisinopril 5mg daily and was documented as administered on 11/01/19 at 8:00am to 11/02/19 at 8:00am. -There was an entry for lisinopril 5mg daily and was documented as not administered beginning 11/03/19 at 8:00am to 11/07/19 because Resident #2 was hospitalized. -There was documentation with the initials and full names of the staff administering the medications.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 18 Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19 at 11:00am revealed the pharmacy had dispensed seven lisinopril 5mg tablets on 10/28/19. i. Review of Resident #2's current FL2 dated 10/02/19 revealed an order for melatonin (a hormone supplement) 10mg take one tablet at bedtime. Review of Resident #2's October 2019 hand-written Medication Administration Record revealed: -There was an entry for melatonin 10mg at bedtime beginning 10/26/19 and documented as administered 10/26/19 at 8:00pm until 10/28/19 at 8:00pm. -There was no documentation melatonin 10mg was administered on 10/29/19 at 8:00pm to 10/31/19 at 8:00am. -There was no documentation of signatures with the initials of the staff administering the medications. Review of Resident #2's October 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for melatonin 10mg at bedtime and no documentation as administered beginning on 10/30/19 at 8:00pm to 10/31/19 at 8:00pm. -There was documentation with the initials and full names of the staff administering the medications. Review of the comparison between Resident #2's October 2019 hand-written and eMAR revealed there was no documentation of melatonin 10mg	D 367		

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	HAL060111	A. BUILDING: _____ B. WING _____	R-C 11/08/2019

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D 367	Continued From page 19 at bedtime beginning 10/29/19 at 8:00pm until 10/30/19 at 8:00pm. Review of Resident #2's November 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for melatonin 10mg at bedtime and was documented as administered on 11/01/19 at 8:00pm to 11/02/19 at 8:00pm. -There was an entry for melatonin 10mg at bedtime and was documented as not administered beginning 11/03/19 at 8:00am to 11/07/19 because Resident #2 was hospitalized. -There was documentation with the initials and full names of the staff administering the medications. Observation on 11/07/19 at 9:17am of Resident #2's medications on hand for administration for Resident #2 revealed there was one of seven melatonin 10mg tablets available with a dispense date of 10/28/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19 at 11:00am revealed the pharmacy had dispensed seven melatonin 10mg tablets on 10/28/19. j. Review of Resident #2's current FL2 dated 10/02/19 revealed an order for senna (a stool softener) 8.6mg take one tablet daily. Review of Resident #2's October 2019 hand-written Medication Administration Record revealed: -There was an entry for senna 8.6mg daily beginning 10/26/19 with and documented as administered 10/27/19 at 8:00am until 10/28/19 at 8:00am.	D 367		

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D 367	Continued From page 20 -There was no documentation senna 8.6mg was administered on 10/29/19 at 8:00am to 10/31/19 at 8:00am. -There was no documentation of signatures with the initials of the staff administering the medications. Review of Resident #2's October 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for senna 8.6mg daily and documented as administered beginning on 10/30/19 at 8:00am to 10/31/19 at 8:00am. -There was documentation with the initials and full names of the staff administering the medications. Review of the comparison between Resident #2's October 2019 hand-written and eMAR revealed there was no documentation of senna 8.6mg daily beginning 10/29/19 at 8:00am until 10/30/19 at 8:00am. Review of Resident #2's November 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for senna 8.6mg daily and was documented as administered on 11/01/19 at 8:00am to 11/02/19 at 8:00am. -There was an entry for senna 8.6mg daily and was documented as not administered beginning 11/03/19 at 8:00am to 11/07/19 because Resident #2 was hospitalized. -There was documentation with the initials and full names of the staff administering the medications. Observation on 11/07/19 at 9:17am of Resident #2's medications on hand for administration for Resident #2 revealed there was one of seven	D 367		

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D 367	Continued From page 21 senna 8.6mg tablets available with a dispense date of 10/28/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19 at 11:00am revealed the pharmacy had dispensed seven senna 8.6mg tablets on 10/28/19. k. Review of Resident #2's current FL2 dated 10/02/19 revealed an order for spironolactone (to treat fluid retention) 25mg take one tablet daily. Review of Resident #2's October 2019 hand-written Medication Administration Record revealed: -There was an entry for spironolactone 25mg daily beginning on 10/26/19 and documented as administered 10/27/19 at 8:00am until 10/28/19 at 8:00am. -There was no documentation spironolactone 25mg was administered on 10/28/19 at 8:00am to 10/31/19 at 8:00am. -There was no documentation of signatures with the initials of the staff administering the medications. Review of Resident #2's October 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for spironolactone 25mg daily and was documented as administered beginning on 10/30/19 at 8:00am to 10/31/19 at 8:00am. -There was documentation with the initials and full names of the staff administering the medications. Review of the comparison between Resident #2's October 2019 hand-written and eMAR revealed	D 367		

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D 367	Continued From page 22 there was no documentation of spironolactone 25mg daily beginning 10/29/19 at 8:00am until 10/30/19 at 8:00am. Review of Resident #2's November 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for spironolactone 25mg daily and was documented as administered on 11/01/19 at 8:00am to 11/02/19 at 8:00am. -There was an entry for spironolactone 25mg daily and was documented as not administered beginning 11/03/19 at 8:00am to 11/07/19 because Resident #2 was hospitalized. -There was documentation with the initials and full names of the staff administering the medications. Observation on 11/07/19 at 9:17am of Resident #2's medications on hand for administration for Resident #2 revealed there was one of seven spironolactone 25mg tablets available with a dispense date of 10/28/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19 at 11:00am revealed the pharmacy had dispensed seven spironolactone 25mg tablets on 10/28/19. I. Review of Resident #2's current FL2 dated 10/02/19 revealed an order for multivitamin (a vitamin supplement) take one tablet daily. Review of Resident #2's October 2019 hand-written Medication Administration Record revealed: -There was an entry for multivitamin daily beginning 10/26/19 and documented as administered 10/27/19 at 8:00am until 10/28/19 at	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 23 8:00am. -There was no documentation multivitamin was administered on 10/28/19 at 8:00am to 10/31/19 at 8:00am. -There was no documentation of signatures with the initials of the staff administering the medications. Review of Resident #2's October 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for multivitamin daily and was documented as administered beginning on 10/30/19 at 8:00am to 10/31/19 at 8:00am. -There was documentation with the initials and full names of the staff administering the medications. Review of the comparison between Resident #2's October 2019 hand-written and eMAR revealed there was no documentation of multivitamin daily beginning 10/29/19 at 8:00am until 10/30/19 at 8:00am. Review of Resident #2's November 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for multivitamin daily and was documented as administered on 11/01/19 at 8:00am to 11/02/19 at 8:00am. -There was an entry for multivitamin daily and was documented as not administered beginning 11/03/19 at 8:00am to 11/07/19 because Resident #2 was hospitalized. -There was documentation with the initials and full names of the staff administering the medications. Observation on 11/07/19 at 9:17am of Resident #2's medications on hand for administration for	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 24 Resident #2 revealed there was one of seven multivitamin tablets available with a dispense date of 10/28/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19 at 11:00am revealed the pharmacy had dispensed seven multivitamin tablets on 10/28/19. m. Review of Resident #2's current FL2 dated 10/02/19 revealed an order for trazadone (to treat insomnia) 100mg take one tablet at bedtime. Review of Resident #2's October 2019 hand-written Medication Administration Record revealed: -There was an entry for trazadone 100mg at bedtime beginning 10/26/19 and documented as administered 10/27/19 at 8:00pm until 10/28/19 at 8:00pm. -There was no documentation trazadone 100mg was administered on 10/28/19 at 8:00pm to 10/31/19 at 8:00pm. -There was no documentation of signatures with the initials of the staff administering the medications. Review of Resident #2's October 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for trazadone 100mg at bedtime and documented as administered beginning on 10/30/19 at 8:00pm to 10/31/19 at 8:00pm. -There was documentation with the initials and full names of the staff administering the medications. Review of the comparison between Resident #2's	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 25 October 2019 hand-written and eMAR revealed there was no documentation of trazadone 100mg at bedtime beginning 10/29/19 at 8:00pm until 10/30/19 at 8:00pm. Review of Resident #2's November 2019 electronic Medication Administration Record(eMAR) revealed: -There was an entry for trazadone 100mg at bedtime and was documented as administered on 11/01/19 at 8:00pm to 11/02/19 at 8:00pm. -There was an entry for trazadone 100mg at bedtime and was documented as not administered beginning 11/03/19 at 8:00pm to 11/07/19 because Resident #2 was hospitalized. -There was documentation with the initials and full names of the staff administering the medications. Observation on 11/07/19 at 9:17am of Resident #2's medications on hand for administration for Resident #2 revealed there was one of seven trazadone 100mg tablets available with a dispense date of 10/28/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19 at 11:00am revealed the pharmacy had dispensed seven trazadone 100mg tablets on 10/28/19. Interview with the second shift MA on 11/07/19 at 3:15pm revealed: -She documented Resident #2's medication administration on the hand-written MAR on 10/26/19. -Resident #2 was admitted to the facility over the weekend, and the hand-written MAR was created to document his medications. -She wrote her initials on the hand-written MAR.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060111	A. BUILDING: _____ B. WING _____	R-C 11/08/2019

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D 367	Continued From page 26 -She did not sign her name and initials at the bottom of the MAR because there was not a spot to put it. -She worked on 10/28/19 on second shift but did not know why her initials did not appear on the hand-written MAR or eMAR. -She gave Resident #2 his medications, but she must have forgotten to document it on the MAR. Interview with the first shift MA on 11/08/19 at 8:35am revealed: -She initialed Resident #2's hand-written MAR but did not sign her name and initials at the bottom of it. -She had not signed her name and initials on the back of the hand-written MAR because the back was blank. -She did not know why she had not initialed administering Resident #2's medications on 10/29/19. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/08/19 at 9:39am revealed: -The pharmacy had received Resident #2's FL2 on 10/28/19. -The pharmacy entered orders into the eMAR system for Resident #2. -Someone at the facility would then approve the order so it would display for the MAs during medication administration times. -Resident #2 had only one profile in the system. -Resident #2 never had more than one profile. -If Resident #2 had more than one profile a deleted profile would be viewable, and he did not see a deleted profile. Interview with the Resident Care Coordinator (RCC) on 11/08/19 at 10:00am revealed: -She did not know Resident #2's October 2019	D 367		

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D 367	Continued From page 27 hand-written MAR was not signed by the MAs. -She did not review the documentation of Resident #2's MARs. -When she was shown the discrepancies today, she contacted the pharmacy. -She was told Resident #2 had two profiles set up in eMAR preventing the MAs from documenting his medications. -She had not performed routine medication cart audits to ensure medications on the cart matched the orders and the entries on the eMAR. Interview with the Administrator on 11/08/19 at 10:45am revealed: -She did not know Resident #2's October 2019 hand-written MAR entries by the MAs consisted of only initials and no signatures on it. -The MAs were expected to document all medications administered and initial and sign the MARs. -She did not know Resident #2's MARs had missing documentation by the MAs. -She performed routine audits of the MARs, but she did not have a chance to review Resident #2's MARs. -She was in the process of training the RCC to perform duties she needed to delegate to her. 2. Review of Resident #5's current FL2 dated 09/26/19 revealed: -Diagnoses included dementia and schizophrenia. -There was a medication order for risperidone 1.5mg two times daily (a medication used to treat schizophrenia). Review of Resident #5's subsequent physician's orders dated 09/30/19 revealed a medication order for risperidone 1mg 1.5 tablets twice daily and 0.5 tablet twice a day as needed.	D 367		

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D 367	Continued From page 28 Review of Resident #5's "non-covered medication notification" from the pharmacy dated 10/04/19 revealed: -There was documentation the pharmacy had initiated a prior authorization request for the risperidone because the medication was not covered by Resident #5's insurance company. -There was documentation from Resident #5's primary care provider (PCP) to "hold medication until seen by psychiatrist for evaluation." Review of Resident 5's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for risperidone 1mg take 1.5 tablets twice daily to be administered at 8:00am and 8:00pm with a start date of 10/04/19. -There was documentation risperidone 1mg 1.5 tablets was administered to Resident #5 six times in October 2019 on 10/04/19 at 8:00pm, 10/06/19 at 8:00pm, 10/07/19 at 8:00am, 10/13/19 at 8:00pm, 10/15/19 at 8:00pm and 10/21/19 at 8:00pm. -There was an entry for risperidone 1mg 0.5 tablet to be administered twice daily as needed. -There was no documentation risperidone 1mg 0.5 tablet had been administered to Resident #5. Review of Resident 5's November 2019 eMAR (11/01/19-11/07/19) revealed: -There was an entry for risperidone 1mg take 1.5 tablets twice daily to be administered at 8:00am and 8:00pm with a start date of 10/04/19. -There was documentation risperidone 1mg 1.5 tablets was administered to Resident #5 on 11/01/19 at 8:00pm and 11/04/19 at 8:00pm. -There was an entry for risperidone 1mg 0.5 tablet to be administered twice daily as needed. -There was no documentation risperidone 1mg 0.5 tablet had been administered to Resident #5.	D 367		

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D 367	Continued From page 29 Observation of Resident #5's medications on hand on 11/07/19 at 1:18pm revealed there was no risperidone available for administration. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/07/19 at 1:56pm revealed the pharmacy had not dispensed risperidone for Resident #5 due to her insurance company not covering the medication. Interview with an evening shift MA on 11/07/19 at 3:31pm revealed: -Resident #5's risperidone was placed on hold because her insurance company would not cover the medication. -She knew she could not have administered risperidone to Resident #5 because it was never filled by the pharmacy. -She did not know why she had documented she administered risperidone to Resident #5 two times in October 2019. Interview with a second evening shift MA on 11/07/19 at 3:45pm revealed: -His initials were documented as administering risperidone to Resident #5 on 11/01/19 at 8:00pm and on 11/04/19 at 8:00pm. -He could not remember administering any medications to Resident #5 because "she normally refused her bedtime medications." -He thought he might have forgotten to sign out of the computer and another MA might have documented the administration of risperidone to Resident #5 under his initials. Interview with the Administrator on 11/08/19 at 9:45am revealed: -Resident #5's PCP had placed her risperidone on hold on 10/04/19 due to a lack of insurance	D 367		

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D 367	Continued From page 30 coverage for the medication. -She did not know why the MAs had documented administration of risperidone to Resident #5 a total of 8 times when the medication was not available for administration. -She expected MAs to only document the administration of medications after they had administered them. A second interview with the Administrator on 11/08/19 at 11:22am revealed: -The MAs were responsible for pulling daily reports to show any medications not administered and auditing the eMARs daily. -They must not "have picked up on" documentation of risperidone being administered to Resident #5 with the medication not being available for administration. -She did not know until today (11/08/19), the MAs were documenting the administration of risperidone to Resident #5. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.	D 367		