NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

December 27, 2019

Roseline Nwadigo, Executive Officer
Rose Hill #2
2305 Glascock St.
Raleigh, NC 27610

email address: rosenwadigo@yahoo.com

Re: Receipt of Plan of Correction (Event ID B2YF11)
Facility: Rose Hill #2
Licensure Number: FCL-092-234
County: Wake

Dear Ms. Nwadigo:

Based on our telephone conversation on December 27, 2019, there was an addendum to the Plan of Correction for the Statement of Deficiencies dated November 14, 2019. The pages noting the addendum are provided for your records.

Please do not hesitate to contact us at 984-365-2578, if you have questions or we may be of further assistance.

Sincerely,

Shonda Stacey

Shonda Stacey, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosure

cc: Catherine Goldman, Supervisor, **Wake** County DSS
Bridget Rackley, Team 4 Supervisor, Central Branch Regional Office, Adult Care Licensure Section
Raleigh Facility File

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL09234	A. BUILDING: _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL # 2	2305 GLASCOCK STREET RALEIGH, NC 27610

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on November 12-14, 2019.	C 000		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to implement a physician's order for fingerstick blood sugar (FSBS) checks ordered for four times per day for 1 of 1 sampled resident (#1). The findings are: Review of Resident #1's current FL-2 dated 08/09/19 revealed: -Diagnoses included schizophrenia disorder bipolar type, intellectual development disorder, diabetes mellitus type 2, gastro-esophageal reflux disease (GERD), hypertension, and glaucoma. -There was an order for Novolog 12 units before meals and bedtime hold if blood sugar is less than 100 or if not eating plus sliding scale insulin as follows: less than 150 = 0 units, 151- 200 = 2 units, 201- 250 = 3 units, 251-300 = 4 units, 301 - 350 = 6 units, 351- 400 = 8 units, above 400 call physician or emergency room as needed.	C 249	1. The administrator shall ensure Nurse Staff implement Physician's Order for finger stick blood Sugar (FSBS) is checked four times per day as ordered and documented accordingly in the Resident's record. 1. The administrator shall Periodically Compare the FSBS documented reading with the glucometer ready to ensure accuracy. Administrator will monitor monthly.	11/28/19 amended 12/27/19 SS

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Covadgo — TITLE: Administrator/Owner — (X6) DATE: 12/4/19

Reviewed and accepted with revisions- 12/27/19 SS

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C 249	Continued From page 1 Review of Resident #1's physician's order revealed an order dated 07/23/19 for fingerstick blood sugars (FSBS) before meals and bedtime. Review of Resident #1's FSBS log for October 2019 revealed: -There were columns at the top of the log for the date, time (8:00 am, 12:00 pm, 4:00 pm and 8:00 pm) unit and initials. -There were FSBS values documented four times per day for each day of October 2019. -There were FSBS results documented four times per day from 10/12/19 to 10/13/19. -There were FSBS values documented on 10/14/19 not found in Resident #1's glucometer. -There were FSBS results documented four times per day from 10/15/19 to 10/20/19. -There were FSBS values documented on 10/21/19 not found in Resident #1's glucometer. -There were FSBS values documented on 10/22/19 not found in Resident #1's glucometer. -There were FSBS values documented on 10/23/19 not found in Resident #1's glucometer. -There were FSBS results documented four times per day from 10/24/19 to 10/28/19. -There was documentation on 10/29/19 at 8:00 am - 128 and no other FSBS were documented for 10/29/19. -There were FSBS values documented on 10/30/19 not found in Resident #1's glucometer. -There was documentation of FSBS on 10/31/19 at 8:00 am -136, 12:00 pm - 125, 4:00 pm - 179, and 8:00 pm - 200. Review of Resident #1's FSBS log for November 2019 revealed: -There were FSBS results documented four times per day from 11/01/19 to 11/03/19. -There were FSBS values documented on 11/04/19 not found in Resident #1's glucometer.	C 249		

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C 249	Continued From page 2 -There were FSBS values documented on 11/05/19 not found in Resident #1's glucometer. -There were FSBS results documented four times per day from 11/06/19 to 11/07/19. -There were FSBS values documented on 11/08/19 not found in Resident #1's glucometer. -There were FSBS results documented four times per day from 11/09/19 to 11/12/19. -There was documentation on 11/13/19 of no FSBS value at 6:00 am. Interview with the Supervisor in Charge (SIC)/medication aide (MA) on 11/13/19 at 10:25 am revealed Resident #1's FSBS for 11/13/19 before breakfast was 166. Observation of Resident #1's glucometer on 11/13/19 at 12:00 pm revealed: -Resident #1's glucometer was in a plastic bin with her name on it and other FSBS supplies. -Resident #1's glucometer was not set to the current date and a year was not indicated. -The most recent reading in Resident #1's glucometer was dated 05/02, which was equivalent to 11/13/19. -There were 38 of 66 times not matching from 10/12/19 to 11/13/19. -For example, on 05/01 at 1:30 pm there was a FSBS reading of 193, and the FSBS log had 192 documented. -For example, on 04/29 at 10:02 am there was a FSBS reading of 144, and the FSBS log had 145 documented. -For example, on 04/26 at 9:07 pm there was a FSBS reading of 226, and the FSBS log had 259 documented. -For example, 04/26 at 7:30 pm there was a FSBS reading of 282 and the FSBS log had 201 documented. -There were no other glucometers provided by	C 249		

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C 249	Continued From page 3 staff for Resident #1. Interview with Resident #1 on 11/13/19 at 3:50 pm revealed staff obtained her FSBS but she did not know how many times per day. Interview with a representative from the contracted pharmacy on 11/13/19 at revealed the pharmacy placed FSBS on the medication administration records (MARs) for the facility. Attempted interview with Resident #1's physician on 11/13/19 at 7:50 am was unsuccessful. Interview with the SIC/MA on 11/13/19 at 11:26 am revealed: -She did not obtain Resident #1's FSBS each time it was ordered, because of various reasons. -Some of the reasons she did not obtain Resident #1's FSBS was because she was visiting her family, her family did not want to wait for her to obtain Resident #1's FSBS, and because she may be taking care of another resident.. -She did not know why the documentation for some of the dates and time did not match the glucometer FSBS readings. -She did not know why there were more FSBS readings documented on Resident #1's FSBS logs than Resident #1's glucometer. -Resident #1's FSBS log was taken to physician's office visits for the physician to review. -There were no other glucometers available in the facility. -There were no other residents who had orders for FSBS monitoring. Interview with the Director on 11/13/19 at 12:29 pm revealed: -She created the FSBS logs used by staff to document Resident #1's FSBS.	C 249		

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C 249	Continued From page 4 -She did not always provide one of the logs she made to staff and the staff used a blank piece of paper to document Resident #1's FSBS and this may be the reason some of the FSBS values were not documented. -She was not aware that Resident #1's FSBS were not obtained as ordered. -She reviewed Resident #1's FSBS logs but she did not compare it to the glucometer. -She assumed Resident #1's FSBS were done as ordered and she took Resident #1's log to physician's office visits for him to review. -She thought staff needed further training on FSBS, because Resident #1' FSBS log documentation did not match Resident #1's glucometer readings. Interview with the Administrator on 11/13/19 at 5:10 pm revealed: -She expected staff to obtain FSBS as ordered by the physician. -She came to the facility once a week or every other week and reviewed the paperwork. -She did not know Resident #1's glucometer held the previous FSBS in memory and she did not compare the glucometer with the FSBS log. -Staff on duty were responsible for obtaining Resident #1's FSBS.	C 249		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph	C 254	1, the administrator shall ensure that a quarterly Licenced Health Professional Support (LHPS) Evaluation task is completed for Resident 1 that need finger stick blood sugar check and documents records are kept on file	11/20/19

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C 254	Continued From page 5 (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure a quarterly Licensed Health Professional Support (LHPS) evaluation was completed for 1 of 2 sampled residents (#1) with a LHPS task for fingerstick blood sugars. The findings are: Review of Resident #1's current FL-2 dated 08/09/19 revealed: -Diagnoses included schizophrenia disorder bipolar type, intellectual development disorder, diabetes mellitus type 2, gastro-esophageal reflux disease (GERD), hypertension, and glaucoma. --There was an order for Novolog 12 units before meals and bedtime hold if blood sugar is less than 100 or if not eating plus sliding scale insulin as follows: less than 150 = 0 units, 151- 200 = 2 units, 201- 250 = 3 units, 251-300 = 4 units, 301 - 350 = 6 units, 351- 400 = 8 units, above 400 call physician or emergency room as needed.	C 254		

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C 254	Continued From page 6 Review of Resident #1's physician's order revealed an order dated 07/23/19 for fingerstick blood sugars (FSBS) before meals and bedtime. Review of Resident #1's care plan dated 04/24/19 revealed there was documentation that Resident #1 had an order for FSBS. Review of Resident #1's Licensed Health Professional Support (LHPS) quarterly reviews for 2019 revealed: -The most current LHPS review was dated 06/30/19 and the tasks were FSBS and medication administration through injections. -There was no LHPS review for September 2019. Interview with Resident #1 on 11/13/19 at 3:50 pm revealed staff obtained her FSBS. Interview with the Supervisor in Charge (SIC)/medication aide (MA) on 11/13/19 at 11:36 am revealed: -The administrator came to the facility twice a week and she checked residents' records. -She did not know about LHPS reviews or tasks. Interview with the Director on 11/13/19 at 12:29 pm revealed: -The Administrator completed the LHPS quarterly reviews for residents. -She assisted the Administrator with tracking the residents' LHPS quarterly review. -She thought the Administrator had done the LHPS quarterly reviews and she thought she had sent a text message to the Administrator to remind her. -She kept the pharmacy reviews and LHPS quarterly reviews in the same place in the residents' records.	C 254		

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C 254	Continued From page 7 -She was not able to locate a quarterly review for September 2019 for Resident #1. -She thought she had seen a LHPS quarterly review for September 2019 for Resident #1 previously. -The Administrator was responsible for ensuring the quarterly LHPS reviews were completed. Interview with the Administrator on 11/13/19 at 5:10 pm revealed: -She did the quarterly LHPS reviews and each resident who had a LHPS task should have one in their record. -She remembered completing all of them in October 2019 and she placed the LHPS quarterly reviews in the records with the care plans. -She did not realize Resident #1 did not have a LHPS quarterly review completed for September 2019. -She took responsibility for this oversight and she was responsible for completing the LHPS quarterly reviews.	C 254		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 record reviews, observations, and	C 330	I, the administrator shall ensure that medications are administered as ordered by the doctor. I shall ~~ensure~~ continue to review Doctor's orders every 1-2 wks to ensure that administration of medication and treatment by the staff are in accordance with	11/18/19

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C 330	Continued From page 8 interviews, the facility failed to administer medications as ordered by a licensed practitioner for 2 of 3 sampled residents (#1 and #3) including a medication to treat constipation, and regarding a new prescription for a medication to treat gastro-esophageal reflux disease (GERD) (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 08/09/19 revealed: -Diagnoses included history of hypertension, paranoid schizophrenia, bradycardia, and major depression. -There was a medication order for polyethylene glycol 3350 powder (used to treat constipation) mix 17 grams in 8 ounces of fluid and drink at bedtime. Review of Resident #3's August/September 2019 combination medication administration record (MAR) -There was an entry for polyethylene glycol 3350 powder mix 17 grams in 12 ounces of fluid at bed time, scheduled at 8:00 pm. -There was documentation of administration with staff initials from 08/26/19 to 09/24/19 at 8:00 pm. -There was a line from the entry to the top of the MAR with a handwritten note "2 X week in morning". Review of Resident #3's September/October 2019 combination MAR revealed: -There was an entry for polyethylene glycol 3350 powder mix 17 grams in 12 ounces of fluid at bedtime, scheduled for 8:00 pm. -There was a line from the entry to the top of the MAR with a handwritten note "2 X week in morning". -There was an X documented from 09/25/19 to	C 330	The Doctor's Order and Fax Copy are Maintained in Resident's record. 11/27/19	

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C 330	Continued From page 9	C 330		

09/28/19, from 09/30/19 to 10/02/19, from 10/04/19 to 10/06/19, from 10/08/19 to 10/10/19, from 10/12/19 to 10/14/19, 10/16/19 to 10/18/19, from 10/20/19 to 10/22/19, and 10/24/19.
-There was documentation of administration with staff initials twice a week on 09/29/19, 10/03/19, 10/07/19, 10/11/19, 10/15/19, 10/19/19, and 10/23/19.

Review of Resident #3's October/November 2019 combination MAR revealed:
-There was an entry for polyethylene glycol 3350 powder mix 17 grams in 12 ounces of fluid at bedtime, scheduled for 8:00 pm.
-There was a line from the entry to the top of the MAR with a handwritten note "2 X week in morning".
-There was documentation of administration with staff initials twice a week on 10/28/19, 11/03/19, 11/06/19, and 11/11/19.
-The dates on the MAR in between 10/25/19 and 10/27/19, 10/29/19 and 11/02/19, 11/04/19 and 11/05/19, 11/07/19 and 11/10/19 did not have any documentation.

Observation of Resident #3's medication on hand on 11/12/19 at 3:43 pm revealed there was one bottle of polyethylene glycol available for administration with approximately one-half bottle remaining.

Attempted interview with Resident #3's physician on 11/13/19 at 7:50 am was unsuccessful.

Interview with Resident #3 on 11/13/19 at 3:50 pm revealed she took a medication for constipation, but she did not take it daily.

Interview with a representative from the facility contracted pharmacy on 11/13/19 at 9:02 am

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C 330	Continued From page 10 revealed: -The facility did refills for most medications by cycle fill, but not for Resident #3's polyethylene glycol 3350 mix. -Resident #3 had an active order for polyethylene glycol 3350 mix 17 grams in water and drink every night at bedtime with an order date of 04/24/19. -The medication was last dispensed on 08/21/19. Interview with the Supervisor in Charge (SIC)/medication aide (MA) on 11/13/19 at 10:04 am revealed: -She placed new and changed medication orders on the MARs when residents returned from the physician, but she was not the only staff who entered orders on the MAR. -She did not know who wrote the handwritten note of "2 X week in morning" on the MARs. -Resident #3 only took the polyethylene glycol at night and the resident had told her previously. -She gave the medication twice a week because there were Xs documented on the MAR and she thought someone had told her to give it that way. -Resident #3 did not always take the medication. Interview with the Director on 11/13/19 at 12:29 pm revealed: -She expected the staff to review new MARs and compare them to the medication delivered from the pharmacy or the medication already in the facility. -If the MAR was not accurate, she expected staff to contact pharmacy or make her aware. -She assisted staff sometimes when the medications and MARs were delivered for the cycle fill. -She did write the handwritten note "2 X week in morning" on Resident #3's MARs because she thought that was the physician's order.	C 330		

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C 330	Continued From page 11 -She thought Resident #3 had a previous physician's order for polyethylene glycol twice a week. -She did not realize the new order for polyethylene glycol was for each night at bedtime. -She and staff were responsible for ensuring medications were administered as ordered. Interview with the Administrator on 11/13/19 at 5:10 pm revealed: -She expected staff to administer medications as ordered by the physician. -She did not know Resident #3's polyethylene glycol was not administered as ordered. -She thought Resident #3's polyethylene glycol was ordered for as needed. -She reviewed the orders once a week or every other week. -She and staff were responsible for ensuring medications were administered as ordered. 2. Review of Resident #1's current FL-2 dated 08/09/19 revealed: -Diagnoses included schizophrenia disorder bipolar type, intellectual development disorder, diabetes mellitus type 2, gastro-esophageal reflux disease (GERD), hypertension, and glaucoma. -There was a medication order for ranitidine 150 mg (used to treat GERD) twice daily. Review of Resident #1's August/September 2019 combination medication administration record (MAR) revealed: -There was an entry for ranitidine 150 mg take one tablet twice daily, scheduled for 8:00 am and 8:00 pm. -There was documentation of administration with staff initials from 08/25/19 to 09/24/19 at 8:00 am and 8:00 pm.	C 330		

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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
C 330	Continued From page 12 Review of Resident #1's September/October 2019 combination MAR revealed there was no entry for ranitidine. Review of Resident #1's October/November 2019 combination MAR revealed there was no entry for ranitidine. Observation of the medications on hand for Resident # on 11/12/19 at 3:38 pm revealed there was no ranitidine available for administration. Review of Resident #1's pharmacy document revealed there was a refill request authorization for ranitidine sent to Resident #1's physician dated 11/12/19. Attempted interview with Resident #1's provider on 11/13/19 at 7:50 am was unsuccessful. Interview with the facility contracted pharmacist on 11/13/19 at 9:02 am revealed: -The pharmacy made refill requests when there were zero refills remaining for a medication. -A refill authorization request was made for Resident #1's ranitidine in July 2019 and on 11/12/19. -The last order date for Resident #1's ranitidine was 09/07/18 with 11 refills. -Resident #1's FL-2 was used for medication orders on admission to a facility and after the admission date a prescription was required for medications. -Resident #1's ranitidine was last dispensed 07/20/19 and it was a 30-day supply. -The pharmacy made every effort to obtain refills from residents' physicians, but the pharmacy was busy with other duties. -Ranitidine was used to treat GERD and if Resident #1 did not receive ranitidine in October	C 330		

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C 330	Continued From page 13 2019 and November 2019 she may have increased symptoms of GERD. Interview with the Supervisor in Charge (SIC)/medication aide (MA) on 11/13/19 at 10:04 am revealed: -The pharmacy sent residents' pills in pill packs where multiple pills were placed in one bubble and organized by the time of day the pills were administered. -The process used by the facility to obtain refills from residents' physicians was to detach the top portion of the multi-pills package that listed the medications placed in the bubble packs and highlight the medication which needed refills. -The list of highlighted medications was placed into the resident's travel folder which was sent to the physician's office with residents when they had a physician office visit. -She did not accompany residents to their physician office visit, and this was the Director's responsibility. -The SIC/MAs checked the medications and MARs when delivered to the facility. -If a medication dropped off the MAR, the pharmacy was called and she told the Director. Interview with the Director on 11/13/19 at 12:34 pm revealed: -She took residents to their physicians' appointments. -The resident's medication list from the top portion of the multiple pill packs sent from the pharmacy was detached and placed in the travel folder when a medication needed to be refilled. -The medication was highlighted by the SIC/MAs or herself on the list and she presented the list to the physician during the office visit. -Resident #1 had a physician office visit on 10/15/19 and 10/22/19.	C 330		

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C 330	Continued From page 14 -She did not obtain a refill order for Resident #1's ranitidine because the list of medications in Resident #1's travel folder did not have ranitidine on it. -She did not talk with the physician about Resident #1's ranitidine and it was an oversight. -Resident #1 had the diagnosis of GERD. -She was responsible for ensuring the physician was told about the need for a new prescription or refills for a medication . Interview with the Administrator on 11/13/19 at 5:10 pm revealed: -Staff was expected to tell the Director when there was less than 7 days of medication left so that a refill prescription could be obtained. -She supervised the staff, but the staff was responsible to communicate when there were no refills for a medication. -The pharmacy also tried to obtain refills or a prescription from residents' physicians. -She did not know a refill authorization was not obtained for Resident #1's ranitidine.	C 330		
C 367	10A NCAC 13G .1006(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the	C 367	1, the administrator and staff will ensure that a retrievable record of controlled substances are maintained and reconciled accurately with the documented receipt and administration of controlled substances. With the help of the Pharmacist, Documentation paper work have been	11/20/19

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C 367	Continued From page 15 retrievable record of controlled substances were maintained and reconciled accurately with the documented receipt and administration of controlled substances for 1 of 1 sampled resident (#2). The findings are: Review of Resident #2's current of FL-2 dated 08/31/19 revealed diagnoses included lithium toxicity, acute encephalopathy, acute kidney injury, bipolar disorder, chronic back pain, and hypothyroidism. Review of Resident #2's physician orders revealed: -There was a physician's order dated 09/12/19 for lorazepam 1 mg (used to treat drug withdrawal, insomnia) give one tablet three times daily. -There was a physician's order dated 09/16/19 for lorazepam 1 mg give one-half tablet three times daily and discontinue lorazepam 1 mg one tablet three times daily. -There was a physician's order dated 09/30/19 to start lorazepam 1 mg give one tablet three times daily and discontinue lorazepam 1 mg give one-half tablets three times daily. Review of Resident #2's September 2019 medication administration record (MAR): -There was a handwritten entry for lorazepam 1 mg one-half tablet three times daily, scheduled for 8:00 am, 12:00 pm, and 8:00 pm. -There was documentation of administration with staff initials from 09/16/19 to 09/24/19 at 8:00 am, 12:00 pm, and 8:00 pm. Review of Resident #2's September/October 2019 combination MAR revealed: -There was an entry for lorazepam 1 mg take	C 367	modified to enhance and support accurate documentation. The administrator will work to review the these documentation to ensure accuracy. Administrator will monitor monthly.	11/20/19 amended 12/27/19 SS

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C 367	Continued From page 19 random count since August 2019. -She did not know Resident #2's controlled substance log and quantity of lorazepam did not match. -She counted 85 tablets of lorazepam remaining for Resident #2 and she did not know why the amount did not match the controlled substance log. -She knew staff sometimes miscounted and documented the wrong number for the remaining tablets. -Staff on duty were responsible for counting when they arrived and left duty. -The staff coming on duty was responsible for any missing tablets because staff should not assume the shift if the count was incorrect. Interview with the Administrator on 11/13/19 at 5:10 pm revealed: -She expected staff to document when administering controlled substances as ordered by the physician. -She expected staff to count the controlled substances and the pharmacy placed dates on the back of each controlled medication bubble pack so it was easy for staff to administer. -Staff counted when they arrived and left shift. -She audited the controlled medications and the last time she audited the controlled medication was September 2019. -She did not know there was a discrepancy between Resident #2's lorazepam quantity on hand and the controlled substance log.	C 367		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or	C 375	1, the administrator shall ensure that quarterly Pharmaceutical reviews are completed on-site. The administrator have	11/22/19

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C 375	Continued From page 20 registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure quarterly pharmaceutical review were completed on-site for 3 of 3 sampled residents (#1, #2, and #3). The findings are:	C 375	Contracted for pharmacy and agreement have been made for on-site quarterly review. The Administrator & Staff will ensure that this is maintained. 11/22/19 amended 12/27/19 SS Administrator will monitor quarterly.	

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C 375	Continued From page 21 1. Review of Resident #1's current FL-2 dated 08/09/19 revealed diagnoses included schizophrenia disorder bipolar type, intellectual development disorder, diabetes mellitus type 2, gastro-esophageal reflux disease (GERD), hypertension, and glaucoma. Review of Resident #1's pharmacy reviews revealed there was a pharmacy review dated 03/22/19 and 06/09/19. Refer to interview with the contracted facility pharmacist on 11/13/19 at 9:02 am. Refer to interview with the Supervisor in Charge (SIC)/medication aide (MA) on 11/13/19 at 10:25 am. Refer to interview with the Director on 11/13/19 at 12:34 pm. Refer to interview with the Administrator on 11/13/19 at 5:10 pm. 2. Review of Resident #2's current of FL-2 dated 08/31/19 revealed diagnoses included lithium toxicity, acute encephalopathy, acute kidney injury, bipolar disorder, chronic back pain, and hypothyroidism. Review of Resident #2's pharmacy reviews revealed there was a pharmacy review dated 03/22/19 and 06/09/19. Refer to interview with the contracted facility pharmacist on 11/13/19 at 9:02 am. Refer to interview with the Supervisor in Charge (SIC)/medication aide (MA) on 11/13/19 at 10:25 am.	C 375		

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C 375	Continued From page 22 Refer to interview with the Director on 11/13/19 at 12:34 pm. Refer to interview with the Administrator on 11/13/19 at 5:10 pm. 3. Review of Resident #3's current FL-2 dated 08/09/19 revealed diagnoses included history of hypertension, paranoid schizophrenia, bradycardia, and major depression. Review of Resident #3's pharmacy reviews revealed there was a pharmacy review dated 03/22/19 and 06/09/19. Refer to interview with the contracted facility pharmacist on 11/13/19 at 9:02 am. Refer to interview with the Supervisor in Charge (SIC)/medication aide (MA) on 11/13/19 at 10:25 am. Refer to interview with the Director on 11/13/19 at 12:34 pm. Refer to interview with the Administrator on 11/13/19 at 5:10 pm. _____ Interview with the contracted facility pharmacist on 11/13/19 at 9:02 am revealed: -He completed the pharmacy reviews for the facility in March, June and September 2019, but he had never been at the facility. -He completed the pharmacy reviews by doing a desk review using the orders sent to the pharmacy for residents. -He was oriented by the pharmacist who previously did the reviews and he was aware he was to come to the facility to complete the	C 375		

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C 375	Continued From page 23 pharmacy reviews. -He was unable to complete the pharmacy reviews at the facility because they were busy at the pharmacy. Interview with the Supervisor in Charge (SIC)/medication aide (MA) on 11/13/19 at 10:25 am revealed: -The pharmacy delivered medications once a month. -A brown envelope containing the pharmacy reviews was delivered with medication deliveries. -She placed the brown envelope in the Director's box. -She last saw the pharmacist in the summer of 2019, she did not recall the date. Observation of a brown envelope retrieved by the Director revealed the envelope contained the residents' September 2019 pharmacy reviews. Interview with the Director on 11/13/19 at 12:34 pm revealed: -The pharmacy sent the pharmacy reviews to the facility in a brown envelope. -The pharmacist came to the house to do the reviews but did not leave the pharmacy reviews at the facility. -She had not seen the pharmacist at the facility in 2019. -She knew the pharmacy reviews were supposed to be done every 3 months. -She did not know the pharmacist had not come to the facility for 2019. -Her responsibility was to place the pharmacy reviews into the residents' records. Interview with the pharmacist who previously completed the pharmacy reviews on 11/13/19 at 3:13 pm revealed:	C 375		

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C 375	Continued From page 24 -He oriented the new pharmacist and he last visited the facility six months ago to specifically look at one resident's medications and orders. -He had not done a pharmacy review at the facility since 2018. -The reason the new pharmacist was not able to complete the pharmacy reviews at the facility was because of the pharmacy workload and new process of multi-pill packs. -The multi-pill packs had to be verified by a pharmacist and this was time consuming. Interview with the Administrator on 11/13/19 at 5:10 pm revealed: -The agreement with the pharmacy was to complete the pharmacy reviews quarterly. -The pharmacist called her if there were any major concerns. -She did not know the pharmacist was not completing the pharmacy reviews at the facility. -She saw the pharmacy reviews for the residents, and she reviewed them. -She was responsible to ensure the pharmacy reviews were completed.	C 375		
C 381	10A NCAC 13G .1009(b) Pharmaceutical Care 10A NCAC 13G .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 assure there was documentation of physician notification of the pharmaceutical findings for 2 of 3 sampled residents (#2 and #3).	C 381	1, the administrator shall work with staff to ensure that action is taken as needed to ensure that there is documentation of physician notification of pharmaceutical findings when necessary.	11/22/19

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C 381	Continued From page 25 The findings are: 1. Review of Resident #2's current of FL-2 dated 08/31/19 revealed diagnoses included lithium toxicity, acute encephalopathy, acute kidney injury, bipolar disorder, chronic back pain, and hypothyroidism. Review of Resident #2's pharmacy reviews revealed: -There was a pharmacy review dated 03/22/19, 06/09/19 and 09/29/19. -The pharmacy reviews for Resident #2 indicated a potential drug-drug interaction between ibuprofen and paroxetine; it may lead to increase risk for gastro-intestinal bleed, watch for signs of gastro-intestinal bleed. Review of Resident #2's record revealed there was no documentation that the physician reviewed the pharmacist recommendations/notes or the staff contacting the physician concerning the pharmacist recommendations/notes. Interview with the Director on 11/13/19 at 12:29 pm revealed she did not know the pharmacy documented recommendations/notes on Resident #2's pharmacy reviews for each review in 2019. Interview with the Administrator on 11/13/19 at 5:10 pm revealed she did not know the pharmacy documented recommendations/notes on Resident #2's pharmacy reviews for each review in 2019. Refer to interview with the facility contracted pharmacist on 11/13/19 at 9:02 am.	C 381	Physician shall be notified via fax and Phone call and documented. In addition, Pharmacy review Paper work shall be taken pt's appointment visit when fax and phone call attempts are not enough. Administrator will monitor quarterly.	11/22/19 amended 12/27/19 SS

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C 381	Continued From page 26 Refer to interview with the Supervisor in Charge (SIC)/medication aide (MA) on 11/13/19 at 11:32 am. Refer to interview with the Director on 11/13/19 at 12:29 pm. Refer to interview with the Administrator on 11/13/19 at 5:10 pm. 2. Review of Resident #3's current of FL-2 dated 08/09/19 revealed diagnoses included history of hypertension, paranoid schizophrenia, bradycardia, and major depression. Review of Resident #3's pharmaceutical reviews revealed: -There was a pharmacy review dated 03/22/19, 06/09/19 and 09/29/19. -The pharmacy reviews for Resident #3 indicated a potential drug-drug interaction between aspirin and escitalopram, may increase risk of gastro-intestinal bleeding. Review of Resident #3's record revealed there was no documentation that the physician reviewed the pharmacist recommendations/notes or the staff contacting the physician concerning the pharmacist recommendations/notes. Interview with the Director on 11/13/19 at 12:29 pm revealed she did not know the pharmacy documented recommendations/notes on Resident #3's pharmacy reviews for each review in 2019. Interview with the Administrator on 11/13/19 at 5:10 pm revealed she did not know the pharmacy documented recommendations/notes on Resident #3's pharmacy reviews for each review	C 381		

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C 381	Continued From page 27 in 2019. Refer to interview with the facility contracted pharmacist on 11/13/19 at 9:02 am. Refer to interview with the Supervisor in Charge (SIC)/medication aide (MA) on 11/13/19 at 11:32 am. Refer to interview with the Director on 11/13/19 at 12:29 pm. Refer to interview with the Administrator on 11/13/19 at 5:10 pm. _____ Interview with the contracted facility pharmacist on 11/13/19 at 9:02 am revealed: -He completed the pharmacy reviews and sent the documents in a brown envelope to the facility via the pharmacy courier with the medication deliveries. -He did not contact the residents' physicians regarding his recommendations. Interview with the Supervisor in Charge (SIC)/medication aide (MA) on 11/13/19 at 11:32 am revealed: -The Director was responsible for taking residents to their physician appointments. -The Director took the travel folders for the resident who had a physician appointment. -Any information needed to show to the physician was placed in the residents' travel folders. Interview with the Director on 11/13/19 at 12:29 pm revealed: -She placed the pharmacy reviews in the residents' records and faxed them to the physician's office -She did not retain the fax verification and she did	C 381		

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C 381	Continued From page 28 not document discussing any of the pharmacy recommendations or notes with the physician. Interview with the Administrator on 11/13/19 at 5:10 pm revealed: -She reviewed the residents pharmacy reviews and the pharmacist contacted her if there were any major concerns. -The pharmacist recommendations/notes were faxed to the physician. -She did not have any documentation notifying the physician of the pharmacy recommendations/notes. -She was responsible for ensuring the physician was made aware of the pharmacy recommendations/notes.	C 381		