STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NEW HANOVER HOUSE	3915 STEDWICK COURT WILMINGTON, NC 28412

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow-up, and complaint investigation on March 11, 2020 through March 13, 2020.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure hot water temperatures were maintained between 100 and 116 degrees (°) Fahrenheit (F) as evidenced by hot water temperatures lower than 100°F and higher than 116°F for 4 of 27 water fixtures. The findings are: Observations of water temperatures on 03/11/20 between 9:30am and 10:30am revealed: -The water temperature in the shower of Room #119 was 92º F. -The water temperature in the shower of Room #167 was 98º F. -The water temperature in the beauty salon/resident laundry room the sink was 116.7º F, and the shampoo bowl was 128.7º F. -There was visible steam when the water was	D 113		

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D 113	Continued From page 1	D 113		

running from the sink and shampoo bowl.

Interview with the Transporter on 03/13/20 at 1:20pm revealed:
-She worked at times as a personal care aide (PCA) and would assist residents with their bathing needs.
-She was not aware of any residents getting burned by hot water temperature at any of the fixtures.
-If the water "runs too long" the hot water temperature would turn cold.
-She had not seen any of the residents using the shampoo bowl fixture without staff but the residents accessed the beauty shop without staff to do laundry on the Assisted Living (AL) section of the facility.

The Administrator and Area Director of Operations were notified on 03/11/20 at 10:37am of the high-water temperatures in the salon/laundry room.

Observation of the salon/laundry room on 03/11/20 at 10:38am revealed:
-The Administrator locked the door to the salon/laundry room.
-The Administrator stated it would remain locked until the maintenance department was able to adjust the water temperatures to 100°F-116°F.
-No signs were noted to be posted.

Interview with the Administrator on 03/11/20 at 10:40am revealed she had called the maintenance supervisor to have him come adjust the water temperatures that were not in the appropriate range of 100°F - 116°F.

Observation in resident room #119 on 03/11/20 at 1:58pm revealed the hot water temperature at the

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D 113	Continued From page 2 shower was 95.2°F. Based on observations and interviews the resident assigned to resident room #119 was not interviewable. Interview with the Administrator on 03/11/20 at 2:50PM revealed she was not aware the hot water at the sink was below 100°F. Observation in resident room #167 on 03/11/20 at 9:45am revealed the hot water temperature in the shower was 98°F. Interview with the resident in Room #167 on 03/11/20 at 9:41am revealed: -The water temperature in her shower was not that hot. -It was cold during the times she took the shower. -She had to wait a long time for the water temperature to heat up. -She had no issues with the water temperatures in the sink, only the shower. Observations of re-check of water temperatures on 03/11/20 from 4:40pm to 4:48pm revealed: -The hot water temperature at the sink in the salon/laundry room was 116.8º F. -The hot water temperature at the shampoo bowl in the salon/laundry room was 108.7º F. -The hot water temperature at the shower in the bathroom of Room #119 was 100.4º F. -The hot water temperature at the shower in the bathroom of Room #167 was 109.1º F. Interview with the Maintenance Director (MD) on 03/11/20 at 2:42pm revealed: -The water temperatures were checked by the maintenance technician on a weekly basis. -The maintenance technician recorded the weekly	D 113		

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temperature checks in the "Life Safety Binder" which was kept in the Administrators office.
-He checked behind the maintenance technician to make sure they were being done.
-The maintenance technician had checked the water temperatures this morning.
-The temperatures checked were all within the range of 100°F - 116°F.
-They did not normally check the salon/laundry.
-He was not aware they had to check that room.

Interview with a personal care aide (PCA) on 03/13/20 at 9:22am revealed:
-She had not noticed the water in resident room #119 not being hot enough when she gave the resident a shower.
-She had noticed the water was cold "one week ago" in the common bathroom when she was assisting another resident with a shower.
-She stopped the residents shower because of the cold water and tried to use the residents shower in the resident's room and the water was still cold then tried the water at the resident's sink in the resident's bathroom and the water was still cold.
-She completed the resident's bath using the cold water from the sink fixture.
-She reported the issue with the water being cold to the Administrator.

Interview with the Administrator on 03/11/20 at 11:05am revealed:
-The maintenance technician came weekly to check the water temperatures.
-There was a family member who had told her that the water in resident room #118 did not get warm.
-The Administrator contacted the MD last week.
-The MD came last week and checked room #118 water temperature.

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D 113	Continued From page 4 -She could not remember the exact temperature, but it was within 100°F - 116°F. -The Life Safety Binder had room #118 water temperature checked on 03/06/20 with a reading of 101.4°F.	D 113		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow up for 1 of 5 sampled residents who was referred to the primary care provider (PCP) by an infectious disease nurse at the local health department for Streptococcus testing and for a follow up from an emergency department visit (#2). The findings are: 1. Review of Resident #2's current FL-2 dated 02/13/20 revealed: -Diagnoses included Alzheimer's disease, dysphagia, vitamin D deficiency, thrombocytopenia and urinary tract infection. -The resident was constantly disoriented and wandered. -The resident's level of care was Special Care Unit (SCU). Review of Resident #2's Assessment and Care Plan dated 07/28/19 revealed:	D 273		

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-The resident was disoriented and had a significant memory loss requiring direction.
-The resident required extensive staff assistance with toileting and bathing, limited staff assistance with dressing and grooming and was independent with ambulation and transferring.

a. Review of a "Physician Order Sheet" for Resident #2 dated 02/05/20 with a stamped received date of 02/06/20 revealed:
-The form was addressed to the resident's primary care provider (PCP).
-There was an entry in the top portion of the form with documentation that Resident #2's roommate was diagnosed with Streptococcus Pyogenes.
-The health department requested Resident #2 be tested in the PCP office.
-There was an entry signed by Resident #2's PCP's nurse had spoken with the Executive Director (ED) - "will schedule for appointment requesting test for Strep A-throat". (Group A streptococcus is a bacterium that causes infection).

Review of the PCP visit notes in Resident #2's record revealed there was documentation dated 02/12/20, the PCP saw the resident and there were no new orders.

Telephone interview with the infectious disease Nurse with the local health department on 03/12/20 at 10:56am revealed:
-She met with the ED on 02/05/20 regarding Resident #2's previous roommate that tested positive for Invasive GAS (Invasive GAS is a severe disease and sometimes life-threatening infection that invades part of the body).
-The ED was instructed that Resident #2 needed to be cultured to see if Resident #2 was positive or a carrier of GAS and to implement an

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investigation process of common signs and symptoms of Strep illness with other residents and staff.
-On 03/09/20, she had spoken with the ED and understood Resident #2 had been tested for Strep and the test result was negative.
-She requested a faxed copy of Resident #2's Strep test results, however, she had not received the results.
-When there was a positive case of Invasive GAS there was a long process of investigation required in determining if there were any further cases with any residents and staff.
-Invasive GAS was very serious for residents at the facility because the population living at the facility were vulnerable and could easily "succumb" to an infection caused by this bacterium which could result in blood infections, meningitis and a flesh-eating infection.

Review of a "Investigation of One Culture -Confirmed Invasive GAS Infection" form provided by the local health departments Infectious Disease Nurse revealed:
-Given the potential severity of GAS in residential healthcare facilities, even one case of invasive GAS should prompt an epidemiological investigation by the facility and the local health department.
-There were instructions for the identification of potential asymptomatic colonization which included to culture close contacts of the ill resident to identify colonization.
-Close contacts included roommates.

Review of a PCP visit encounter for Resident #2 dated 02/12/20 revealed:
-The resident's visit was for a routine 4-month follow-up for chronic conditions.
-The resident felt well and had no complaints.

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-The staff member was not expressing any concerns.
-There was no documentation of any laboratory testing results documented for Strep testing.

Interview with the ED on 03/12/20 at 11:31am revealed:
-A PCP appointment was made on 02/12/20 for Resident #2 by the Special Care Unit Coordinator (SCUC) for a Strep test to be done.
-The SCUC called Resident #2's PCP this morning (03/12/20) to obtain a copy of the resident's Strep test.
-The PCP did not perform Resident #2's Strep test on 02/12/20, she knew the test was needed but did not know why the test was not performed.
-Resident #2 nor any other residents or staff had shown any signs or symptoms of Strep.

Telephone interview with a Nurse with Resident #2's PCP on 03/12/20 at 11:34am revealed:
-On 02/12/20, Resident #2 was not tested for Strep because staff from the facility did not report to the PCP the Strep test was needed.
-She responded to a faxed request from the facility for a Strep test to be done on 02/05/20 for Resident #2, however, the PCP and office staff depended on staff to update the PCP on what was going on at the time of the visit including the purpose of the visit when staff brought residents into the office especially residents from the SCU.
-When the PCP saw Resident #2 on 02/12/20, there were no complaints and no acute issues reported for Resident #2.
-She was not sure why the facility never contacted and questioned about the Strep test for Resident #2 after the visit on 02/12/20 until today (03/12/20).

A second interview with the ED on 03/12/20 at

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12:10pm revealed:
-She realized a few days after Resident #2's appointment on 02/12/20 that a follow up was needed for Resident #2's Strep test that was supposed to have been done on 02/12/20.
-She told the SCUC to follow-up and obtain a copy of Resident #2's results.
-She could not answer why there was no additional follow-up on Resident #2's Strep test after that.

Interview with the SCUC on 03/13/20 at 9:54am revealed:
-She was aware on 02/05/20 Resident #2 should have been tested for Strep.
-She sent a fax request and contacted Resident #2's PCP on 02/05/20 to inform the PCP and schedule an appointment for a Strep test for Resident #2.
-The Transporter went with Resident #2 to the PCP on 02/12/20, however, she was unsure if the Transporter went in the exam room when the PCP saw the resident.
-She "updated" the Transporter on 02/12/20 that Resident #2's roommate had been diagnosed with Strep and the resident was going to the PCP to be tested.
-When Resident #2 and the Transporter returned to the facility after the PCP appointment on 02/12/20 she asked the Transporter how the appointment went, and the Transporter told her "fine" and there were no new orders.
-She did not think to question the Transporter specifically for the results of Resident #2's Strep testing.
-The Transporter was "clear" there were no new orders when she was asked the Transporter about new orders for Resident #2.
-She provided the ED a copy of the PCP's visit notation that included there were no new orders

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when Resident #2 returned to the facility after the appointment on 02/12/20.
-She thought "maybe" she should have called Resident #2's PCP after the appointment on 02/12/20 to follow-up on the resident's Strep testing.

Interview with the Transporter on 03/13/20 at 1:20pm revealed:
-The Assisted Living Unit Coordinator (ALUC), the SCUC and herself made medical appointments for the residents.
- "Nobody told me" Resident #2 needed to be tested for Strep on 02/12/20.
-If she had been told she would have made sure the PCP was aware so the test could have been done for Resident #2 during the appointment on 02/12/20.
-She remembered the ED asked about the Strep test for Resident #2 when she and the resident returned the facility on 02/12/20 after the appointment.
-She told the ED she was unaware of the testing need for Resident #2.
-The ED did not respond when she told her she was unaware of the needed testing for Resident #2.
-She was not instructed to reschedule an appointment for Resident #2 after 02/12/20.
-The SCU residents had to depend on staff when they saw their medical providers because the residents could not voice what was going on with them without staff assistance.

Interview with the ED on 03/13/20 at 2:28pm revealed:
-The SCUC was responsible to ensure Resident #2's Strep testing was done on 02/12/20 when the resident saw the PCP.
-Resident #2 did not show any signs of illness

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between 02/05/20 through present.
-Resident #2 was sent for Strep testing today, (03/18/20).
-She expected all referral and follow up needs to be done as ordered.

Review of a Rapid Strep test for Resident #2 from a local urgent care clinic dated 03/12/20 revealed a negative result.

Based on observations, interviews and record review Resident #2 was not interviewable.

Attempted telephone interview with Resident #2's health care power of attorney on 03/12/20 at 9:49am was unsuccessful.

b. Review of Resident #2's electronic progress notes revealed:
-On 12/19/19 at 10:30am, there was an entry the resident was not her normal self and needed help from staff when ambulating. The resident was complaining of pain in her throat, right knee, and some chest pain. The resident's primary care provider (PCP) was contacted and instructed for the resident to be sent to the Emergency Room (ER).
-On 12/19/19 at 3:16pm, there was an entry the resident had returned from he ER, no new orders.

Review of an ER visit for Resident #2 dated 12/19/19 revealed:
-The reason for the visit was "medical problem-minor" and the resident was diagnosed with chest pain.
-There were instructions to schedule an appointment with the resident's PCP as soon as possible for a visit.

Interview with the Transporter on 03/13/20 at

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D 273	Continued From page 11 1:20pm and at 2:17pm revealed: -She did not have an ER follow-up scheduled for Resident #2 from the ER visit on 12/19/19 because she did not know the resident had gone to the ER. -The Special Care Unit Coordinator (SCUC) provided her with the residents ER follow-up needs and she or the SCUC would be responsible for scheduling any upcoming needs for follow-up appointments. -It must have been a miscommunication for the need for a follow-up visit from Resident #2's visit to the ER. Telephone interview with a Nurse with Resident #2's primary care provider (PCP) on 03/13/20 at 2:14pm revealed: -The PCP's office had received Resident #2's documentation from the local hospital for the resident's visit to the ER on 12/19/19. -There was documentation the PCP's office contacted the facility and spoke with a staff (named) on 12/20/19 to schedule a follow visit from the ER but there was no appointment made for the resident to be seen. -On 12/23/19, a second call was placed to the facility regarding the residents need for a follow-up appointment but there was no appointment made for the resident to be seen. -There was documentation for a every 4-month follow-up appointment on 01/23/20, however, the resident was not seen by the PCP and was marked as a "no show". -Routinely, it was expected for the PCP to follow-up with residents within 5 days after being treated and evaluated in the ER in order to follow-up with the specific issues of the issues that prompted the ER visit and to provide possible additional care and treatment.	D 273		

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Review of the Transportation staff's resident appointment calendar revealed there was no scheduled appointment for the Resident #2 on 01/23/20.

Interview with the SCUC on 03/13/20 at 9:54am and at 2:14pm revealed:
-She and the Transporter were responsible for making the residents' follow up appointments.
-She was not sure why Resident #2 was not scheduled for the follow-up appointment from the ER visit on 12/19/19.
-She had not received any telephone calls from Resident #2's PCP after 12/19/19 for the need for a follow-up appointment.
-The staff (named) contacted by the PCPs office on 12/20/19 no longer worked at the facility.

Interview with the Executive Director (ED) on 03/13/20 at 2:28pm revealed:
-She was not aware Resident #2 was not seen for a follow-up appointment with her PCP after the resident had an ER visit on 12/12/19.
-She expected the SCUC to assure all referral and follow up needs were done as ordered for the residents.

Based on observations, interviews and record review Resident #2 was not interviewable.

Attempted telephone interview with Resident #2's health care power of attorney on 03/12/20 at 9:49am was unsuccessful.

_____

The facility failed to ensure referral and follow up was done for Resident #2 as directed on 02/05/20 by an infectious disease Nurse from the local Health Department for Strep testing after Resident #2's roommate tested positive for Invasive Group A Strep (GAS) infection. Resident

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NEW HANOVER HOUSE	3915 STEDWICK COURT WILMINGTON, NC 28412

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D 273	Continued From page 13 #2 was not tested until 30 days later which posed a health risk to all the residents residing in the facility. 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 03/12/20 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 27, 2020	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the refrigerator, kitchen, and food storage areas were cleaned and free of contamination related to accumulations of sticky substances, grime and food debris on pantry shelving and containers, floors in the kitchen and pantry, stove, oven and walls in the kitchen. The findings are: Interview with the ED on 03/13/20 at 1:24pm	D 282		

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D 282	Continued From page 14 revealed: -She was not aware the Food Establishment Inspection Report had expired. -The county automatically visits the facility for an inspection every year. -She thought corporate was keeping track of the inspection reports. -It was not kitchen staff's responsibility to keep track of the inspection report. Observations of the kitchen on 03/12/20 at 8:39am revealed: -There was a sticky substance and food debris on the metal shelving in the dry storage area. -There were multiple pieces of cereal on the floor and shelving area of the pantry. -There were several pieces of loose pasta in the bottom of the storage containers where pasta was stored in the pantry area. -There were multiple splatters of various colors that consisted of orange and black tinged substance on the walls of the kitchen. -The floors in the kitchen around the sink drain, under the counter and in the pantry under the shelving were grimy with accumulations of dirt and food crumbs. -On the bottom portion of the oven near the door opening, there was a thick caked on black substance along with several different colored substances that were of an orange and white tinged color near the bottom of the oven door opening. -There was a black substance on the back wall of the stove that ran down towards to cooking area of the stove. -The interior racks of the refrigerator had a sticky white substance and food debris. -The refrigerator consisted of several rusted racks that needed to be replaced.	D 282		

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D 282	Continued From page 15 Interview with the Dietary Manager (DM) on 03/12/20 at 8:33am revealed: -All kitchen staff were responsible for keeping the kitchen clean. -There was a cleaning schedule and log for the kitchen, but there was no documentation of cleaning on yesterday (03/11/20) and new logs were started every week on Sunday. -She expected kitchen staff on duty to clean every week on Thursdays when the food truck came. -When she was scheduled to work, she would sweep and mop the floors every night before leaving. -There was no scheduled time to wipe the racks in the fridge, but she cleaned as much as she could. -She cleaned the oven once a week and the stove once every two weeks near the back splash of the stove. Interview with Executive Director (ED) on 03/12/20 at 9:26am revealed: -She inspected the kitchen daily looking for anything that needed to be cleaned. -She expected the kitchen walls to be cleaned and the floors mopped and swept daily by kitchen staff. -There was a cleaning log on the ice machine in the kitchen. -She checked the kitchen for cleanliness two to three times a day.	D 282		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic	D 296		

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D 296	Continued From page 16 diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic menu for 2 of 3 sampled residents with a physician's order for a pureed (Resident #1) and mechanical soft with pureed meats (Resident #2). The findings are: 1. Review of Resident #1 's current FL-2 dated 10/04/19 revealed: -Diagnoses included vascular dementia, left frontal lobe cerebrovascular accident, dyslipidemia, hypertension, weight loss, and history of falls. -Resident #1 was disoriented. Review of Resident #1's physician diet order dated 11/13/19 Regular/No added table salt (NATS)/Mechanical soft. Review of Resident #1's Assessment and Care Plan dated 07/11/19 revealed: -The resident was always disoriented and had significant memory loss requiring redirection. -The resident required extensive staff assistance with feeding. Review of the "Weekly Menu" diet menu spreadsheet dated 03/11/20 revealed there was no therapeutic menu for the lunch meal on 03/11/20 which consisted of 3 oz of baked ham, ½ cup of rice and gravy, ½ cup of okra and tomatoes, ½ cup of seasoned broccoli, and 1	D 296		

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D 296	Continued From page 17 baked roll. Observation of the lunch meal service on 03/12/20 from 11:33am-12:45pm revealed: -Resident #1 was served 1 roll, 1 cup of pureed chicken, 1 cup of mashed potatoes, and 1 cup of green beans, water and milk. -Staff assisted Resident #1 with eating lunch; the resident ate 100% chicken, 100% mashed potatoes, and 5% green beans without difficulty. -The consistency of each item served was pureed not mechanical soft. Based on observations on 03/12/20 at 4:38pm Resident #1 was served a thick consistency of pureed chicken, pureed green beans and pureed mashed potatoes which was more a pureed consistency not mechanical soft as ordered by the physician. Based on observations, interviews and record review, Resident #1 was not interviewable. Refer to observation of the kitchen during the initial tour on 03/11/20 at 10:34am. Refer to interview with the Dietary Aide (DA) on 03/11/20 at 10:24am. Refer to interview with Dietary Manager (DM) on 03/12/20 at 4:05pm. 2. Review of Resident #2's current FL-2 dated 02/13/20 revealed: -Diagnoses included Alzheimer's disease, dysphagia, Vitamin D deficiency, thrombocytopenia and urinary tract infection. -The resident was constantly disoriented and wandered. -There was no diet order on the FL-2.	D 296		

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Review of a Resident #2's physician diet order dated 12/03/19 Regular/Mechanical soft/Pureed meats only.

Review of Resident #2's Assessment and Care Plan dated 07/28/19 revealed:
-The resident was disoriented and had a significant loss requiring direction.
-The resident's eating ability was not provided.

Review of a Speech Therapy (ST) Plan of Care for Resident #2 dated 02/24/20 revealed:
-The resident was referred to ST due to staff reports of swallowing difficulty for 2 weeks during meals.
-The resident was ordered pureed meats and mechanical soft with other food.

Review of the "Weekly Menu" diet menu spreadsheet dated 03/12/20 revealed there was no therapeutic menu the dinner meal on 03/12/20 which consisted of 1 deluxe hamburger, ½ cup of baked beans, ½ cup of coleslaw, 1 cup of milk and a fudge bar.

Interview with a personal care aide (PCA) on 03/12/20 at 9:23am revealed.
-Resident #2 was able to feed herself during meals.
-Resident #2 was served all of her foods in a pureed consistency.

Observation of the dinner meal service on 03/12/20 from 4:40pm - 5:02pm revealed:
-Resident #2 was served 1 cup of pureed green beans, 1 cup of mashed potatoes, 1 cup of pureed chicken, pureed brownie, water and lemonade.
-Resident #2 ate 100% chicken, 100% mashed

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potatoes, 100% green beans and 100% brownie.
-The resident consumed the dinner meal without difficulty.
-The consistency of each item served was pureed not mechanical soft.

Based on observations on 03/12/20 at 4:58pm Resident #2 was served a thick consistency of pureed chicken, pureed green beans and pureed mashed potatoes which was more a pureed consistency not mechanical soft as ordered by the physician.

Based on observations, interviews and record review, Resident #2 was not interviewable.

Refer to observation of the kitchen during the initial tour on 03/11/20 at 10:34am.

Refer to interview with the Dietary Aide (DA) on 03/11/20 at 10:24am.

Refer to interview with Dietary Manager (DM) on 03/12/20 at 4:05pm.

_____

Observation of the kitchen during the initial tour on 03/11/20 at 10:34am revealed:
-There was a dietary check list hanging on the bulletin board.
-There were no therapeutic menus available.
-There were no instructions or guidelines for residents who had physician's orders for ordered pureed or mechanical soft diets.

Interview with the Dietary Aide (DA) on 03/11/20 at 10:24am am revealed:
-The facility did not have a therapeutic diet menu for staff guidance.
-She had a few residents that were on pureed and mechanical soft diets.

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D 296	Continued From page 20 -The facility did not have a Registered Dietician (RD). -She used an online website to make the monthly menus. Interview with the Dietary Manager (DM) on 03/12/20 at 4:05pm revealed: -There was no therapeutic diet menu spreadsheet. -She had no training on how to prepare a pureed or mechanical soft diet. -Her experience came from working at other long-term care facilities. -The menus were made based on her prior knowledge.	D 296		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	D 344		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the failed to ensure medication orders were clarified with the prescribing practitioner for 3 of 5 sampled residents related to Vitamin D2 (#1); orders for pain medications (#5); and a medication to treat constipation (#4).

The findings are:

1. Review of Resident #1's most recent FL2 dated 10/04/19 revealed diagnoses included vascular dementia, left frontal lobe cerebrovascular accident, dyslipidemia, hypertension, weight loss, and history of falls.

Review of Resident #1's subsequent physician's order dated 10/04/19 revealed there was on order for Vitamin D2 50,000 unit take 1 capsule every Monday and Thursday once a day at 8:00am.

Review of January 2020 electronic medication administration record (eMARs) revealed there was no entry for Vitamin D2 50,000.

Review of February 2020 electronic medication administration record (eMARs) revealed there was no entry for Vitamin D2 50,000.

Review of March 2020 electronic medication administration record (eMARs) revealed there was no entry for Vitamin D2 50,000.

Review of Resident #1's PCP signed visit report dated 02/27/20 revealed Vitamin D2 50,000 unit was an active medication for the resident.

Observation of Resident #1's medication on hand for administration on 03/12/20 at 11:00am

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revealed:
-There was a medication punch card dated 10/30/19 for Vitamin D2 50,000 units.
-There were 4 of 4 capsules left in the 10/30/19 Vitamin D2 medication punch card.
-There was a medication punch card dated 03/14/19 for Vitamin D2 50,000 unit.
-There were 7 of 8 capsules left in the 03/14/19 Vitamin D2 punch card.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/12/20 at 3:57pm revealed:
-The pharmacy dispensed a 2-week supply of Vitamin D2 50,000 units on 10/30/19.
-The 2-week supply had been delivered to the on 10/31/19 at 3:31am.
-The facility staff was supposed to contact the pharmacy to have the medication dispensed to the facility.
-The facilities contracted pharmacy had not received any communication from the facility to dispense Vitamin D2 since 10/30/19.

Interview with the Special Care Unit Coordinator (SCUC) on 03/13/20 at 8:52am revealed:
-Vitamin D2 50,000 unit had shown as an active physician order for Resident #1.
-She did not think the Vitamin D2 order was unclear.
-She did not know why the Vitamin D2 had not appeared on the resident's eMARs.
-She had sent new medication orders to the facility's contracted pharmacy.
-The facilities contracted pharmacy would enter the medication into a resident's eMAR.
-The SCUC would then approve the eMARs for the medication aide (MA) to see the added medication.
-She was the only to approve medications that

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the pharmacy entered on resident's eMARs.
-She performed cart audits every Monday to ensure each resident had medications on hand to match their eMARs.
-Her last cart audit was 03/09/20.
-She had not noticed Vitamin D2 50,000 unit was not on Resident #1's eMARs.
-It was her responsibility to get orders clarified by the physician.
-She did not now why she did not get the Vitamin D2 orders clarified.

Interview with a first shift MA on 03/13/20 at 10:10am revealed:
-She did not remember administering Vitamin D2 50,000 units to Resident #1.
-She did not remember seeing Vitamin D2 on the cart for Resident #1.
-If she had found a medicine on the medication cart for a resident that was not on the residents eMARs should would leave the medication on the cart.
-She would not report there was additional medication on the cart to the SCUC or the pharmacy.
-It was the SCUC responsibility to clarify orders with the physician.

Telephone interview with Resident 1#'s primary care provider (PCP) on 03/13/20 at 11:00am revealed:
-She had ordered the vitamin D2 50,00 units for Vitamin D deficiency for Resident #1.
-She had last had her vitamin d levels checked in August 2019 and Resident #1's Vitamin d levels were in normal range.
-She was not aware that Vitamin D2 was not shown as an active medication on Resident #1's eMARs.
-She had not received any communication from

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the facility for clarification of Vitamin Dfor Resident #1.
-She was not aware that Vitamin D2 was not on hand for Resident #1.
-She had no concern that Resident #1 had not received her Vitamin D2 because her Vitamin d levels were in normal range.
-She had not changed the Vitamin D2 orders since Resident #1 Vitamin D levels were in normal range.
-She did not know why she had not changed the Vitamin D2 50,000 unit take 1 capsule every Monday and Thursday once a day at 8:00am order.

Interview with the Area Wellness Director on 03/13/20 at 10:30am revealed:
-It was the SCUC's responsibility for clarifying medication orders.
-When the SCUC approved the medication entry for Vitamin D2 50,000 units the pharmacy she had not selected the dates of administration.
-Vitamin D2 was an active order but it did not show on the eMARs because the SCUC had not approved the medication entry from the pharmacy accurately.
-She expected the SCUC to clarify medication orders with the resident's physician.

2. Review of Resident #5's current FL-2 dated 04/12/19 revealed diagnoses included chronic obstructive pulmonary disease, kidney disease, left knee amputation, chronic respiratory failure with hypoxia.

a. Review of Resident #5's physician orders revealed an order on 11/06/19 for hydrocodone acetaminophen 10-325 mg one tablet three times a day as needed (PRN).

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D 344	Continued From page 25 Review of Resident #5's January 2020 electronic medication administration records (eMARs) revealed: -There was an entry for hydrocodone-acetaminophen 10-325 mg to give 1 tablet three times a day as needed. -There was no reason noted for the need for the medication as required for PRN medications. -There was no frequency of how often the medication was to be given other than three times a day. Review of Resident #5's February 2020 electronic medication administration records (eMARs) revealed: -There was an entry for hydrocodone-acetaminophen 10-325 mg to give 1 tablet three times a day as needed. -There was no reason noted for the need for the medication as required for PRN medications. -There was no frequency of how often the medication was to be given other than three times a day. -There were entries on 02/05/20 at 9:21am and 12:21pm the oxycodone 10 mg had been administered (3 hours elapsed between the first dose and the second dose). -There were entries on 02/06/20 at 9:41am and 2:30pm the oxycodone 10 mg had been administered (4 hours and 49 minutes elapsed between the first dose and the second dose). -There were entries on 02/11/20 at 7:19am and 10:00am the oxycodone 10 mg had been administered (2 hours and 41 minutes elapsed between the first dose and the second dose). -There were entries on 02/12/20 at 6:59am, 7:50am and 1:04pm the oxycodone 10 mg had been administered (59 minutes elapsed between the first dose and the second dose and 5 hours and 14 minutes between the second dose and	D 344		

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D 344	Continued From page 26 the third dose). -There were entries on 02/13/20 at 7:07am and 8:41am the oxycodone 10 mg had been administered (2 hours and 41 minutes elapsed between the first dose and the second dose). -There were entries on 02/15/20 at 3:12pm, 6:36pm, and 9:50pm the oxycodone 10 mg had been administered (3 hours and 24 minutes elapsed between the first dose and the second dose and 3 hours and 14 minutes between the second dose and the third dose). -There were entries on 02/17/20 at 8:50am, 11:31am, and 8:17pm the oxycodone 10 mg had been administered (2 hours and 41 minutes elapsed between the first dose and the second dose and 8 hours and 46 minutes between the second dose and the third dose). -There were entries on 02/19/20 at 8:26am and 11:47am the oxycodone 10 mg had been administered (3 hours and 05 minutes elapsed between the first dose and the second dose). -There were entries on 02/27/20 at 10:49am, 2:27pm, and 8:13pm the oxycodone 10 mg had been administered (5 hours and 38 minutes elapsed between the first dose and the second dose and 3 hours and 46 minutes between the second dose and the third dose). b. Review of Resident #5's physician orders revealed an order on 01/29/20 for oxycodone 10 mg one tablet three times a day as needed (PRN) for severe pain. Review of Resident #5's January 2020 electronic medication administration records (eMARs) revealed: -There was an entry for oxycodone 10 mg to give 1 tablet three times a day as needed for severe pain. -There was no frequency of how often the	D 344		

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medication was to be given other than three times a day.

Review of Resident #5's February 2020 electronic medication administration records (eMARs) revealed:
-There was an entry for oxycodone 10 mg one tablet three times a day as needed (PRN) for severe pain.
-There was no frequency of how often the medication was to be given other than three times a day.

Review of Resident #5's physician orders revealed an order on 02/27/20 for oxycodone 10 mg one tablet every 6 hours as needed (PRN) for severe pain.

Review of Resident #5' February 2020 electronic medication administration records (eMARs) revealed:
-There was an entry for oxycodone 10 mg one tablet every 6 hours as needed (PRN) for severe pain.

Review of Resident #5's March 2020 electronic medication administration records (eMARs) revealed:
-There was an entry for oxycodone 10 mg one tablet every 6 hours as needed (PRN) for severe pain.

c. Review of Resident #5's physician orders revealed an order on 02/26/20 for gabapentin 600 mg one tablet twice a day as needed (PRN).

Review of Resident #5's February 2020 electronic medication administration records (eMARs) revealed:
-There was an entry for gabapentin 600 mg to

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D 344	Continued From page 28 give 1 tablet twice a day as needed. -There was no reason noted for the need for the medication as required for PRN medications. -There was no frequency of how often the medication was to be given other than twice a day. Review of Resident #5's March 2020 electronic medication administration records (eMARs) revealed: -There was an entry for gabapentin 600 mg to give 1 tablet twice a day as needed. -There was no reason noted for the need for the medication as required for PRN medications. -There was no frequency of how often the medication was to be given other than twice a day. 3. Review of Resident #4's current FL-2 dated 12/12/19 revealed diagnoses included Alzheimer's, congestive heart failure, chronic kidney disease stage 4, hyperlipidemia, diabetes mellitus-2 with complications, heart disease of native coronary, and left bundle branch block. Review of Resident #4's current FL-2 dated 12/12/19 revealed: -There was an order for polyethylene glycol 3350 (polyethylene glycol is an over the counter (OTC) laxative used to treat constipation.) powder mix 17 gram with liquid every day as needed (PRN). -There was no reason noted for the need for the medication as required for PRN medications.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358		

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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 B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a prescribing physician for 2 of 5 sampled residents related to not administering doses of an antibiotic to treat an infection (Resident #1) and a resident not having a blood pressure, a medicine for chest pain, an anti inflammatory, a pain reliver, a vitamin to help with bone density, and a medication to treat dry eyes (Resident #4).

The findings are:

1. Review of Resident #1's most recent FL2 dated 10/04/19 revealed:
-Diagnoses included vascular dementia, left frontal lobe cerebrovascular accident, dyslipidemia, hypertension, weight loss, and history of falls.
-There was an order for sulfamethoxazole-trimethoprim 800-160mg (an antibiotic used to treat bacterial infections) 1 tablet twice daily for 10 days for infection, for administration at 8:00am and 8:00pm daily.

a. Review of Resident #1's March 2020 electronic Medication Administration Record (emar) revealed:
-There was a computer-generated entry for

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sulfamethoxazole-trimethoprim 800-160mg (an antibiotic used to treat bacterial infections) 1 tablet twice daily for 10 days for infection, for administration at 8:00am and 8:00pm daily.
-Sulfamethoxazole-trimethoprim 800-160mg was documented as administered twice daily from 03/05/20 to 03/10/20, and it was documented as given once at 8:00am on 03/11/20.

Observation of Resident #1's medication on hand for administration on 03/12/20 at 11:00am revealed:
-There were 17 of 20 sulfamethoxazole-trimethoprim 800-160mg available for administration.
-The sulfamethoxazole-trimethoprim 800-160mg was dispensed on 03/02/20.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/12/20 at 3:57pm revealed:
-Resident #3's order for sulfamethoxazole-trimethoprim 800-160mg was faxed to the pharmacy by the resident's hospice provider on 03/02/20.
-The order was for the sulfamethoxazole-trimethoprim 800-160mg 1 tablet twice daily for 10 days for infection, the quantity dispensed was 20 tablets.
-The sulfamethoxazole-trimethoprim 800-160mg was delivered to the facility on 03/03/20 at 2:09am.

Interview with an on-call Hospice nurse on 03/12/20 at 4:25pm revealed:
-Resident #1's primary Hospice Nurse was on leave.
-She had seen Resident #1 on 03/10/20 as a part of her routine hospice visits.
-Resident #1 received a Hospice nurse visit once

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a week.
-Medication aides (MA) and the Special Care Unit Coordinator (SCUC) would notify the Hospice Nurse if the resident needed any medication refilled.
-She did a full assessment of the resident, looked for medication changes, and talked to the staff about the resident's behaviors.
-She had not been alerted to any medication changes or issues by staff on her visit on 03/10/20.
-The Hospice Nurse had contacted the Hospice Director on 03/02/20 and advised Resident #1 had a forehead wound that had a purulent discharge and her urine had a strong odor.
-She did not know if a urine analysis had been done.
-On 03/02/20 the Hospice Director ordered the sulfamethoxazole-trimethoprim 800-160mg to start on 03/05/20.
-The order for the sulfamethoxazole-trimethoprim 800-160mg was sent to the facility's contracted pharmacy on 03/03/20.
-She was not aware that as of 03/11/20 Resident #1 had only been administered 3 of the 20 capsules.

Interview with the Executive Director of the facility's Hospice provider on 03/12/20 at 5:01pm revealed:
-She was a Registered Nurse.
-Resident #1's regular Hospice Nurse was out on leave.
-Every week the hospice nurses asked the MAs or the SCUC if Resident #1 need a refill of any medications.
-The hospice nurses had not been alerted to any medication concerns for Resident #1.
-She was not aware that Resident #1 had not been receiving the

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sulfamethoxazole-trimethoprim 800-160mg as ordered.
-She was concerned beacause untreated infections can lead to sepsis and death.

Interview with the Special Care Unit Coordinator (SCUC) on 03/13/20 at 8:52am revealed:
-She had worked on the medication cart as a MA occasionally in the last 3 to 4 weeks.
-She had worked as a MA to fill in when the Special Care Unit (SCU) was short a MA.
-She remembered administering the sulfamethoxazole-trimethoprim 800-160mg to Resident #1.
-She could not remember the exact dates she had administered it.
-On the March 2020 eMAR, she had documented administering the sulfamethoxazole-trimethoprim 800-160mg 5 times from 03/05/20 to 03/11/20.
-She was not aware that Resident #1 had 17 of 20 sulfamethoxazole-trimethoprim 800-160mg still on hand on 03/11/20.
-She expected the sulfamethoxazole-trimethoprim 800-160mg to be administered as ordered by the physician.
-She preformed medication cart audits every Monday.
-Her last medication cart audit was 03/09/20.
-When she performed medication cart audits, she checked each resident in the SCU medications on hand with their current medication orders.
-She had not found issues with Resident #1's medications on hand.

Interview with a first shift MA on 03/13/20 at 10:10am revealed:
-She always worked first shift in the SCU.
-She had not remembered administering sulfamethoxazole-trimethoprim 800-160mg to Resident #1.

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D 358	Continued From page 33 -She had not remembered sulfamethoxazole-trimethoprim 800-160mg being on hand for Resident #1. -On the March 2020 eMAR she had documented administering the sulfamethoxazole-trimethoprim 800-160mg 5 times from 03/05/20 to 03/11/20. -She had not remembered administering the sulfamethoxazole-trimethoprim 800-160mg any of those 5 times between 03/05/20 to 03/11/20. Telephone interview with Resident 1#'s primary care provider (PCP) on 03/13/20 at 11:00am revealed: -She had not ordered the sulfamethoxazole-trimethoprim 800-160mg. -She would be concerned Resident #1 had not received her sulfamethoxazole-trimethoprim 800-160mg as ordered. -Another practitioner with her practice had seen Resident #1 was 02/27/20. -The practitioner had not documented any concerns at that time. Interview with the Executive Director (ED) on 03/13/20 at 2:28pm revealed: -She was not aware that Resident #1 had not received her sulfamethoxazole-trimethoprim 800-160mg as ordered -She was concerned that Resident #1 had not received her sulfamethoxazole-trimethoprim 800-160mg as ordered. -She expected staff to administer medications as ordered by the physician. b. Reveiw of Resident #1's physicians order dated 10/04/19 revealed an order for Acetaminophen (a pain reliever) 500mg tablet every 6 hours while awake scheduled at 12:00am, 6:00am, 9:00am, and 6:00pm.	D 358		

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D 358	Continued From page 34 Review of the January 2020 eMARs for Resident #1 revealed: -There was an entry for 1 Acetaminophen (a pain reliever) 500mg tablet every 6 hours while awake scheduled at 12:00am, 6:00am, 9:00am, and 6:00pm. -There were staff initials documenting administration of the Acetaminophen 500mg from 01/01/20 through 01/31/20. -There were parentheses around the staff initials documenting administration for the Acetaminophen 500mg at 12:00am on 01/02/20, 01/04/20, 01/06/20, 01/10/20 - 01/13/20, 01/15/20 - 01/20/20, 01/22/20 - 01/23/20, and 01/26/20. -There was an "information key" printed on the eMARs indicating the parenthesis around the staff initials meant "the medication was not administered or not charted, see reasons/comments." -The doses with the parentheses from 01/02/20 through 01/26/20 was documented as refused. Review of February 2020 eMARs for Resident #1 revealed: -There was an entry for 1 Acetaminophen 500mg tablet every 6 hours while awake scheduled at 12:00am, 6:00am, 9:00am, and 6:00pm. -There were staff initials documenting administration of the Acetaminophen 500mg from 02/01/20 through 02/29/20. -There was parentheses around the staff initials for documenting administration of the Acetaminophen at 12:00am on 02/03/20, 02/08/20, 02/09/20, 02/12/20, 02/18/20, and 02/26/20 - 02/28/20. -There was an "information key" printed on the eMARs indicating the parenthesis around the staff initials meant "the medication was not administered or not charted, see reasons/comments."	D 358		

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D 358	Continued From page 35 -The doses with the parentheses from 02/03/20 through 02/28/20 was documented as refused. Review of March 2020 eMARs for Resident #1 revealed: -There was an entry for 1 Acetaminophen 500mg tablet every 6 hours while awake scheduled at 12:00am, 6:00am, 9:00am, and 6:00pm. -There were staff initials documenting administration of the acetaminophen 500mg from 03/01/20 through 03/11/20. -There was parenthesis around the staff initials for documenting administration of the Acetaminophen at 12:00am on 03/03/20, 03/04/20, 03/06/20 - 03/08/20, and 03/10/20. -There was an "information key" printed on the eMARs indicating the parenthesis around the staff initials meant "the medication was not administered or not charted, see reasons/comments." -The doses with the parentheses from 03/03/20 through 03/10/20 was documented as refused. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/12/20 at 3:57pm revealed: -The pharmacy dispensed a 15-day supply of acetaminophen 500mg for Resident #1 on 12/24/19. -The 15-day supply was delivered to the facility on 12/27/19 at 12:27am. -The pharmacy dispensed a 30-day supply of acetaminophen 500mg on 02/18/20. -The 30-day supply was delivered to the facility on 02/19/20. -The facility staff was supposed to contact the pharmacy to have the medication dispensed to the facility. Observation of Resident #1's medication on hand	D 358		

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for administration on 03/12/20 at 11:00am revealed:
-There was a medication punch card dated 12/24/19 for acetaminophen 500mg 15-day supply with two tablets left.
-There were 4 medication punch cards dated 02/18/20 for acetaminophen 500mg.
-The first acetaminophen punch card dated 02/18/20 had 23 of 30 tablets remaining.
-The second acetaminophen punch card dated 02/18/20 had 30 of 30 tablets remaining.
-The third acetaminophen punch card dated 02/18/20 had 30 of 30 tablets remaining.
-The fourth acetaminophen punch card dated 02/18/20 had 25 of 30 tablets remaining.

Telephone interview with Resident #1's primary care provider (PCP) on 03/13/20 at 11:00am revealed:
-She had ordered the Acetaminophen 500mg in the past for pain management for Resident #1.
-Resident #1 was no longer able to verbalize when she was in pain.
-She was not concerned that Resident #1 had not been receiving her acetaminophen because the facility had not reported any concerns that the resident was in pain.
-The last time she saw the resident was December 2019.
-Another practitioner saw Resident #1 on 02/27/20 and she had reported no concerns of pain.
-She was not aware that Resident #1 had missed several doses of acetaminophen at 12:00am.

Interview with the Executive Director of the Hospice provider on 03/12/20 at 5:01pm revealed:
-She was a Registered Nurse.
-Resident #1's regular Hospice Nurse was out on

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D 358	Continued From page 37 leave. -The hospice nurses had not been alerted to any medication concerns for Resident #1. -She was not aware that Resident #1 had not been receiving her acetaminophen 500mg. -The medication was prescribed by Resident #1's PCP. -The hospice nurse had tried to get the 12:00am dose for acetaminophen changed by Resident #1's PCP. -The hospice nurse had been unsuccessful in getting the order changed. -The Hospice Director did not want to change a medication that the resident's PCP had ordered. Interview with the SCUC on 03/13/20 at 8:52am revealed: -She had to manually order medications through the facilities contracted pharmacy. -The medication orders had to be written and then faxed to the pharmacy. -The pharmacy would enter the medication into the eMARs. -She would then have to approve the entry on the eMARs before the MAs could see the added entry. -She reported to the Resident Care Coordinator and the ED. -The MAs could have administered the stock acetaminophen after the 15 day supply filled in December 2019 was exhausted. -She had not used the house stock of acetaminophen to administer Resident #1's scheduled dose. -She expected MAs to use the resident's medication card to administer medications, not the house stock. Interview with a first shift MA on 03/13/20 at 10:10am revealed:	D 358		

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-She remembered administering acetaminophen 500mg to Resident #1.
-She had used the house stock of acetaminophen 500mg to administer Resident #1's scheduled dose.
-She did not know why she documented refused.
-She had not remembered the last time she had used the house stock of acetaminophen for Resident #1's scheduled dose of acetaminophen 500mg.
-She had not been told by the SCUC to only use Resident #1's medication card for acetaminophen 500mg not the house stock of acetaminophen 500mg.

Interview with the ED on 03/13/20 at 2:28pm revealed:
-She was not aware that Resident #1 had not received her acetaminophen 500mg as ordered.
-She expected staff to administer medications as ordered by the physician.

Attempted telephone interview with Resident #1's family member on 03/13/20 at 8:18am was unsuccessful.

Attempted interview with Resident #1 on 03/13/20 at 9:45am was unsuccessful.

2. Review of Resident #4's current FL-2 dated 12/12/19 revealed diagnoses included Alzheimer's disease, congestive heart failure, chronic kidney disease stage 4, hyperlipidemia, diabetes mellitus-2 with complications, heart disease of native coronary, and left bundle branch block.

a. Review of Resident #4's current FL-2 dated 12/12/19 revealed an order for Nitroglycerin 0.4

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mg sublingual 1 tablet every 5 minutes x 3 doses as needed for chest pain. (Nitroglycerin is a prescription medication used to stop or prevent chest pain.)

Review of Resident #4's March 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for nitroglycerin tablet sublingual 0.4 mg with directions to give 1 tablet sublingual every 5 minutes for 3 doses as needed for chest pain.
-If no relief, call the primary care provider (PCP).

Observation of Resident #4's medications on hand on 03/12/2020 at 4:35pm revealed there were no nitroglycerin tablets on hand for administration if needed for chest pain.

Interview with a medication aide (MA) on 03/12/2020 at 4:51pm revealed:
-She was not sure why there was not any nitroglycerin available for administration if Resident #4 had chest pain.
-Prescription medications were ordered from the facility pharmacy.
-The MAs or the Special Care Unit Coordinator (SCUC) were responsible to reorder medications from the pharmacy when they noticed there were about 5-7 days remaining.

b. Review of Resident #4's current FL-2 dated 12/12/19 revealed there was an order for Lisinopril 5 mg 1 tablet every morning. (Lisinopril is a prescription medication used to treat high blood pressure, heart failure and after heart attack).

Review of Resident #4's March 2020 electronic

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medication administration record (eMAR) revealed;
-There was an entry for Lisinopril 5 mg 1 tablet every morning.
-There were staff initials for documentation of Lisinopril 5 mg being administered on the following dates at 8:00am: 03/01/20 through 03/10/20.
-There were parentheses around the staff initials documenting administration for the Lisinopril on 03/05/20, 03/11/20 and 03/12/20.
-There was an "information key" printed on the eMARs indicating the parenthesis around the staff initials meant the "medication was not administered or not charted, see reasons/comments".
-Each dose on 03/05/20, 03/11/20 and 03/12/20 was documented in the comments as refused.

Observation of Resident #4's medications on hand on 03/12/2020 at 4:35pm revealed there were no Lisinopril tablets on hand for administration.

c. Review of Resident #4's current FL-2 dated 12/12/19 revealed an order for Aspirin delayed release 81 mg one every morning. (Aspirin is an over the counter medication (OTC) used to treat pain, prevent heart attacks, strokes, and chest pain).

Review of Resident #4's March 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for aspirin 81 mg delayed release 1 tablet every morning.
-There were staff initials for documentation of aspirin 81 mg being administered on the following dates at 8:00am: 03/01/20 through 03/10/20.
-There were parentheses around the staff initials

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documenting administration for the aspirin on 03/05/20, 03/11/20 and 03/12/20.
-There was an "information key" printed on the eMARs indicating the parenthesis around the staff initials meant the "medication was not administered or not charted, see reasons/comments".
-Each dose on 03/05/20, 03/11/20 and 03/12/20 was documented in the comments as refused.

Observation of Resident #4's medications on hand on 03/12/2020 at 4:35pm revealed there was no aspirin 81 mg on hand for administration.

d. Review of Resident #4's current FL-2 dated 12/12/19 revealed an order for Flonase nasal spray 50 mcg/actuation to instill 2 sprays into each nostril twice a day. (Flonase is an over the counter medication (OTC) used to relieve seasonal and ear round allergic and non-allergic nasal symptoms such as stuffy/runny nose, itching, and sneezing).

Review of Resident #4's March 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for Flonase nasal spray 50 mcg/actuation to instill 2 sprays into each nostril twice a day.
-There were staff initials for documentation of Flonase being administered on the following dates at 8:00am: 03/01/20 through 03/10/20.
-There were staff initials for documentation of Flonase being administered on the following dates at 8:00pm on 03/01/20 through 03/11/20.
-There were parentheses around the staff initials documenting administration for the 8:00am Flonase on 03/05/20, 03/11/20 and 03/12/20.
-There was an "information key" printed on the eMARs indicating the parenthesis around the

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staff initials meant the "medication was not administered or not charted, see reasons/comments".
-Each dose at 8:00am on 03/05/20, 03/11/20 and 03/12/20 was documented in the comments as refused.

Observation of Resident #4's medications on hand on 03/12/2020 at 4:35pm revealed there was no Flonase on hand for administration.

e. Review of Resident #4's current FL-2 dated 12/12/19 revealed an order for magnesium oxide 400 mg take one tablet twice a day. (Magnesium oxide is an over the counter medication (OTC) vital for healthy muscles and bones).

Review of Resident #4's March 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for magnesium oxide 400 mg take one tablet twice a day.
-There were staff initials for documentation of magnesium oxide being administered on the following dates at 8:00am: 03/01/20, 03/02/20, 03/03/20, 03/04/20, 03/06/20, 03/07/20, 03/08/20, 03/09/20, and 03/10/20.
-There were staff initials for documentation of magnesium oxide being administered on the following dates at 8:00pm on 03/01/20 through 03/11/20.
-There were parentheses around the staff initials documenting administration for the 8:00am magnesium oxide on 03/05/20, 03/11/20 and 03/12/20.
-There was an "information key" printed on the eMARs indicating the parenthesis around the staff initials meant the "medication was not administered or not charted, see reasons/comments".

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D 358	Continued From page 43 -Each dose at 8:00am on 03/05/20, 03/11/20 and 03/12/20 was documented in the comments as refused. Observation of Resident #4's medications on hand on 03/12/2020 at 4:35pm revealed there was no magnesium oxide on hand for administration. f. Review of Resident #4's current FL-2 dated 12/12/19 revealed an order for melatonin 3 mg take one at bedtime. (Melatonin is an over the counter medication (OTC) used to help fall asleep and stay asleep). Review of Resident #4's March 2020 electronic medication administration record (eMAR) revealed: -There was an entry for melatonin 3 mg 1 tablet at bedtime. -There were staff initials for documentation of melatonin 3 mg being administered on the following dates at 8:00pm on 03/01/20 through 03/10/20. -There were no doses documented in the comments as refused. -The melatonin 3 mg was discontinued on 03/11/2020. Observation of Resident #4's medications on hand on 03/12/2020 at 4:35pm revealed there was no melatonin on hand for administration. g. Review of Resident #4's current FL-2 dated 12/12/19 revealed an order for Refresh Tears 0.5% instill one drop into both eyes three times a day. (Refresh Tears is an over the counter medication (OTC) used for the temporary relief of burning, irritation, and discomfort due to dryness of the eye).	D 358		

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D 358	Continued From page 44 Review of Resident #4's March 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Refresh Tears instill 1 drop to each eye three times a day. -There were staff initials for documentation of Refresh Tears being administered on the following dates at 8:00am on 03/01/20 through 03/10/20. -There were staff initials for documentation of Refresh Tears being administered on the following dates at 12:00pm on 03/01/20 through 03/10/20. -There were staff initials for documentation of Refresh Tears being administered on the following dates at 8:00pm on 03/01/20 through 03/10/20. -There were parentheses around the staff initials documenting administration for the 12:00pm Refresh Tears on 03/11/20. -There were parentheses around the staff initials documenting administration for the 8:00am Refresh Tears on 03/05/20, 03/11/20 and 03/12/20. -There was an "information key" printed on the eMARs indicating the parenthesis around the staff initials meant the "medication was not administered or not charted, see reasons/comments". -Each dose at 8:00am on 03/05/20, 03/11/20 and 03/12/20 was documented in the comments as refused. Observation of Resident #4's medications on hand on 03/12/2020 at 4:35pm revealed there was no Refresh Tears on hand for administration. h. Review of Resident #4's current FL-2 dated 12/12/19 revealed an order for Theragran-M	D 358		

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D 358	Continued From page 45 Premier 5 Plus 400-250-375 mcg take one tablet every morning. (Theragran-M is an over the counter medication (OTC) a multivitamin and iron supplement used to prevent vitamin deficiency). Review of Resident #4's March 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Theragran-M Premier 5 Plus 400-250-375 mcg 1 tablet every morning. -There were staff initials for documentation of Theragran-M Premier 5 Plus 400-250-375 mcg being administered on the following dates at 8:00am on 03/01/20 through 03/10/20. -There were parentheses around the staff initials documenting administration for the Theragran-M on 03/05/20 and 03/11/20. -There was an "information key" printed on the eMARs indicating the parenthesis around the staff initials meant the "medication was not administered or not charted, see reasons/comments". -Each dose on 03/05/20 and 03/11/20 was documented in the comments as refused. Observation of Resident #4's medications on hand on 03/12/2020 at 4:35pm revealed there was no Theragran-M on hand for administration. i. Review of Resident #4's current FL-2 dated 12/12/19 revealed an order for acetaminophen 500 mg take one every 4 hours as needed for mild to moderate pain. (Acetaminophen is an over the counter medication (OTC) used to treat pain and fever). Observation of Resident #4's medications on hand on 03/12/2020 at 4:35pm revealed there was no acetaminophen on hand for administration if needed.	D 358		

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D 358	Continued From page 46 Based on observation, interviews and record reviews it was determined that Resident #4 was not interviewable Attempted interview with Resident #4's power of attorney on 03/13/2020 at 10:07am was unsuccessful. _____ The facility failed to ensure medications were administered as ordered for a resident (#1), who was prescribed an antibiotic and a resident (#4), who did not have 10 of her 27 medications on hand. The failure of the facility to ensure medications were administered as ordered was detrimental to the health and wellness of the residents (#1 and #4), which constitutes a Type B Violation. _____ The facility provided a Plan of Protection on 03/12/20 in accordance with G. S. 131D-34. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 27, 2020.	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;	D 367		

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D 367	Continued From page 47 (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 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, interviews, and record reviews, the failed to ensure the medication administration records were accurate for 3 of 5 residents sampled including documentation of a vitamin D2 (Resident #1, Resident #2) and documentation of hydrocodone acetaminophen, oxycodone, and gabapentin (Resident #5). The findings are: 1. Review of Resident #1's most recent FL2 dated 10/04/19 revealed diagnoses included vascular dementia, left frontal lobe cerebrovascular accident, dyslipidemia, hypertension, weight loss, and history of falls. Review of Resident #1's subsequent physician's order dated 10/04/19 revealed there was on order	D 367		

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D 367	Continued From page 48 for Vitamin D2 50,000 unit take 1 capsule every Monday and Thursday once a day at 8:00am. Review of January 2020 electronic medication administration record (eMARs) revealed: -There was no entry for Vitamin D2 50,000. -There was no documentation Vitamin D2 50,000 was administered from 01/01/20 through 01/31/20. -There was no documentation for the reason Resident #1's was not administered Vitamin D2 on the back of the January 2020 eMARs. Review of February 2020 electronic medication administration record (eMARs) revealed: -There was no entry for Vitamin D2 50,000. -There was no documentation Vitamin D2 50,000 was administered from 02/01/20 through 02/29/20. -There was no documentation for the reason Resident #1's was not administered Vitamin D2 on the back of the February 2020 eMARs. Review of March 2020 electronic medication administration record (eMARs) revealed: -There was no entry for Vitamin D2 50,000. -There was no documentation Vitamin D2 50,000 was administered from 03/01/20 through 03/11/20. -There was no documentation for the reason Resident #1's was not administered Vitamin D2 on the back of the March 2020 eMARs. Review of Resident #1's PCP signed visit report dated 02/27/20 revealed Vitamin D2 50,000 unit was an active medication order for the resident. Observation of Resident #1's medication on hand for administration on 03/12/20 at 11:00am revealed:	D 367		

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-There was a medication punch card dated 10/30/19 for Vitamin D2 50,000 unit.
-There were 4 of 4 capsules left in the 10/30/19 Vitamin D2 medication punch card.
-There was a medication punch card dated 03/14/19 for Vitamin D2 50,000 unit.
-There were 7 of 8 capsules left in the 03/14/19 Vitamin D2 punch card.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/12/20 at 3:57pm revealed:
-The pharmacy dispensed a 2-week supply of Vitamin D2 50,000 unit on 10/30/19.
-The 2-week supply had been delivered to the on 10/31/19 at 3:31am.
-The facility contracted pharmacy had not received any communication from the facility to dispense Vitamin D2 since 10/30/19.

Interview with the Special Care Unit Coordinator (SCUC) on 03/13/20 at 8:52am revealed:
-Vitamin D2 50,000 unit had shown as an active physician order for Resident #1.
-She did not know why the Vitamin D2 had not appeared on the resident's eMARs.
-She had sent new medication orders to the facility's contracted pharmacy.
-The facilites contracted pharmacy would enter the medication into a resident's eMAR.
-The SCUC would then approve the eMARs for the medication aides (MA) to see the added medication.
-She was the only to approve medications that the pharmacy entered on resident's eMARs.
-She would check the orders the pharmacy entered on the eMARs against the physician orders whenever a new order was sent to the pharmacy.
-She did not check the orders against the eMARs

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at the end of each month.
-She performed cart audits every Monday to ensure each resident had medications on hand to match their eMARs.
-Her last cart audit was 03/09/20.
-She had not noticed Vitamin D2 50,000 unit was not on Resident #1's eMARs.

Interview with the Area Wellness Director(AWD) on 03/13/20 at 10:30am revealed:
-When the SCUC approved the medication entry for Vitamin D2 50,000 units from the pharmacy she had not selected the dates of administration.
-The entry had not gone through because the SCUC had not selected the dates of administration.
-Vitamin D2 was an active order but it did not show on the eMARs because the SCUC had not approved the medication entry from the pharmacy accurately.
-The SCUC was suppose to send a copy of her cart audit to her every Friday starting in November 2019.
-The SCUC had never sent a copy of her cart audit.
-She had notified the Executive Director that she had not received any cart audits from the SCUC several times.
-She had last notfied the ED in the past week.
-She had expected the ED to follow up with the SCUC about the cart audits.

2. Review of Resident #'2's current FL-2 dated 02/13/20 revealed:
-Diagnoses included Alzheimer's disease, dysphagia, vitamin D deficiency, thrombocytopenia and urinary tract infection.
-There was an order for Vitamin D2 50,000units every Wednesday once a day. (Vitamin D2 is a fat-soluble vitamin that helps the absorption

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D 367	Continued From page 51 calcium and phosphorus). Review of a subsequent primary care provider (PCP) order for Resident #2 dated 12/03/19 revealed an order for Vitamin D2 50,000 units every Wednesday once a day. Review of Resident #2's January 2020 electronic medication administration record (eMAR) revealed: -There was a computer printed entry for Vitamin D2 50,000 units every Wednesday once a day with a scheduled administration time 8:00am. -There was documentation the Vitamin D2 50,000 units was administered daily at 8:00am from 01/01/20 - 01/30/20. Review of Resident #2's February 2020 eMAR revealed: -There was a computer printed entry for Vitamin D2 50,000 units every Wednesday once a day with a scheduled administration time 8:00am. -There was documentation the Vitamin D2 50,000 units was administered daily at 8:00am from 02/01/20 - 02/29/20 with an exception documented on 02/10/20 at 8:00am the resident refused the medication. Review of Resident #2's March 2020 eMAR revealed: -There was a computer printed entry for Vitamin D2 50,000 units every Wednesday once a day with a scheduled administration time 8:00am. -There was documentation the Vitamin D2 50,000 units was administered daily at 8:00am from 03/01/20 - 03/10/20. Review of Resident #2's medications on hand revealed: -Vitamin D2 50,000 units take one every	D 367		

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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
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Wednesday was on hand in an individual punch card with a dispensing date of 03/10/20 and quantity of 4 capsules.
-The remainder of the resident's medications were in a multidose packaging for administration in the morning and at bedtime with one exception of an individual punch card for another medication.

Interview with a medication aide (MA) on 03/13/20 at 9:36am revealed:
-Resident #2 was given Vitamin D2 once a week.
-The facility's contracted pharmacy provider was responsible for entering the resident's medications into the eMAR system.
-The Special Care Unit Coordinator (SCUC) was responsible for approving the residents' medications before the MAs would be able to document the administration of the medication.
-She was not sure why Resident #2's Vitamin D2 50,000 units was documented as administered daily.
-The daily documentation of Resident #2's Vitamin D2 50,000 units was an oversight.
-She had documented the administration of Resident #2's Vitamin D2 50,000 units on Saturday, 02/29/20 and thought she was just clicking through each medication because the only medications given on 02/29/20 were in the multi-dose packaging.
-She did not perform cart audits because the SCUC was responsible for that.

Interview with the SCUC on 03/13/20 at 9:54am revealed:
-The facility's contracted pharmacy provider was responsible for entering the residents' medications into the eMAR.
-The SCUC and the Assisted Living Unit Coordinator (ALUC) on the Assisted Living side of

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the facility were the only staff that approved medication orders in the eMAR system, then the MA could document the administration of that medication.
-She performed medication cart audits every Monday by comparing the medication order to the residents' eMAR with the medications on hand.
-She was not sure why the daily administration documentation of Resident #2's Vitamin D2 50,000 units was not caught during her audits but it should have been.

Interview with the Area Director of Operations (ADO) on 03/12/20 at 10:21am revealed Resident #2's Vitamin D2 50,000 units was marked as daily in the eMAR system and should have only populated for one time a week administration on Wednesdays.

Interview with the Executive Director (ED) on 03/13/20 at 2:28pm revealed:
-She performed record reviews occasionally which included reviewing and comparing medication orders, reviewing medications in the eMAR system to assure medications were entered correctly and she checked the residents medications on hand.
-Her last record review was one record last week; one per week was her goal because the SCUC and the ALUC did more.
-Her record reviews were sporadic; she did not document when medication record reviews were done.
-She did not review the eMARs for medication documentation accuracy.
-She expected staff to administer medications as ordered and to document when the medication was administered to the resident.

3.Review of Resident #5's current FL-2 dated

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D 367	Continued From page 54 04/12/19 revealed diagnoses included chronic obstructive pulmonary disease, kidney disease, left knee amputation, chronic respiratory failure with hypoxia. a. Review of Resident #5's physician orders revealed an order on 11/06/19 for hydrocodone acetaminophen 10-325 mg one tablet three times a day as needed (PRN). Review of Resident #5's January 2020 electronic medication administration records (eMARs) revealed: -There was an entry for hydrocodone-acetaminophen 10-325 mg to give 1 tablet three times a day as needed. -There was no reason noted for the need for the medication as required for PRN medications. -There was no frequency of how often the medication was to be given other than three times a day. Review of Resident #5's February 2020 electronic medication administration records (eMARs) revealed: -There was an entry for hydrocodone-acetaminophen 10-325 mg to give 1 tablet three times a day as needed. -There was no reason noted for the need for the medication as required for PRN medications. -There was no frequency of how often the medication was to be given other than three times a day. -There were entries on 02/05/20 at 9:21am and 12:21pm the oxycodone 10 mg had been administered (3 hours elapsed between the first dose and the second dose). -There were entries on 02/06/20 at 9:41am and 2:30pm the oxycodone 10 mg had been administered (4 hours and 49 minutes elapsed	D 367		

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D 367	Continued From page 55 between the first dose and the second dose). -There were entries on 02/11/20 at 7:19am and 10:00am the oxycodone 10 mg had been administered (2 hours and 41 minutes elapsed between the first dose and the second dose). -There were entries on 02/12/20 at 6:59am, 7:50am and 1:04pm the oxycodone 10 mg had been administered (59 minutes elapsed between the first dose and the second dose and 5 hours and 14 minutes between the second dose and the third dose). -There were entries on 02/13/20 at 7:07am and 8:41am the oxycodone 10 mg had been administered (2 hours and 41 minutes elapsed between the first dose and the second dose). -There were entries on 02/15/20 at 3:12pm, 6:36pm, and 9:50pm the oxycodone 10 mg had been administered (3 hours and 24 minutes elapsed between the first dose and the second dose and 3 hours and 14 minutes between the second dose and the third dose). -There were entries on 02/17/20 at 8:50am, 11:31am, and 8:17pm the oxycodone 10 mg had been administered (2 hours and 41 minutes elapsed between the first dose and the second dose and 8 hours and 46 minutes between the second dose and the third dose). -There were entries on 02/19/20 at 8:26am and 11:47am the oxycodone 10 mg had been administered (3 hours and 05 minutes elapsed between the first dose and the second dose). -There were entries on 02/27/20 at 10:49am, 2:27pm, and 8:13pm the oxycodone 10 mg had been administered (5 hours and 38 minutes elapsed between the first dose and the second dose and 3 hours and 46 minutes between the second dose and the third dose). b. Review of Resident #5's physician orders revealed an order on 01/29/20 for oxycodone 10	D 367		

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mg one tablet three times a day as needed (PRN) for severe pain.

Review of Resident #5's January 2020 electronic medication administration records (eMARs) revealed:
-There was an entry for oxycodone 10 mg to give 1 tablet three times a day as needed for severe pain.
-There was no frequency of how often the medication was to be given other than three times a day.

Review of Resident #5's February 2020 electronic medication administration records (eMARs) revealed:
-There was an entry for oxycodone 10 mg one tablet three times a day as needed (PRN) for severe pain.
-There was no frequency of how often the medication was to be given other than three times a day.

Review of Resident #5's physician orders revealed an order on 02/27/20 for oxycodone 10 mg one tablet every 6 hours as needed (PRN) for severe pain.

Review of Resident #5's February 2020 electronic medication administration records (eMARs) revealed:
-There was an entry for oxycodone 10 mg one tablet every 6 hours as needed (PRN) for severe pain.

Review of Resident #5's March 2020 electronic medication administration records (eMARs) revealed:
-There was an entry for oxycodone 10 mg one tablet every 6 hours as needed (PRN) for severe

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D 367	Continued From page 57 pain. c. Review of Resident #5's physician orders revealed an order on 02/26/20 for gabapentin 600 mg one tablet twice a day as needed (PRN). Review of Resident #5's February 2020 electronic medication administration records (eMARs) revealed: -There was an entry for gabapentin 600 mg to give 1 tablet twice a day as needed. -There was no reason noted for the need for the medication as required for PRN medications. -There was no frequency of how often the medication was to be given other than twice a day. Review of Resident #5's March 2020 electronic medication administration records (eMARs) revealed: -There was an entry for gabapentin 600 mg to give 1 tablet twice a day as needed. -There was no reason noted for the need for the medication as required for PRN medications. -There was no frequency of how often the medication was to be given other than twice a day.	D 367		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the	D 463		

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D 463	Continued From page 58 resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled residents (#1, #2) residing in the Special Care Unit (SCU) had a pre-screening for appropriate placement. The findings are: 1. Review of Resident #1's most recent FL2 dated 10/04/19 revealed: -Diagnoses included vascular dementia, left frontal lobe cerebrovascular accident, dyslipidemia, hypertension, weight loss, and history of falls. -Memory care was documented as the recommended level of care. -There was documentation Resident #1 was intermittently disoriented. Interview with the Executive Director (ED) on 03/13/20 at 2:45pm revealed: -She did not know Resident #1 did not have the pre admission screening in her record.	D 463		

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-It was her responsibility to ensure that resident records had all required information in them.
-Before accepting a resident, the marketer would visit the resident at another facility, their home, or hospital.
-The marketer used the same assessment tool when she visited prospective assisted living or SCU residents.
-The facility would review the prospective resident's history and physical, FL2, tuberculosis skin testing, and flu testing before she admitted a resident.
-The Special Care Unit Coordinator (SCUC) would assess the resident once the new resident was on the SCU.

Review of the documents in Resident #1's record revealed there was no pre-admission screening.

2. Review of Resident #'2's current FL-2 dated 02/13/20 revealed:
-Diagnoses included Alzheimer's disease, dysphagia, vitamin D deficiency, thrombocytopenia and urinary tract infection.
-The resident was constantly disoriented and wandered.
-The resident's level of care was Special Care Unit (SCU).

Review of Resident #2's Assessment and Care Plan dated 07/28/19 revealed:
-The resident was disoriented and had a significant loss requiring direction.
-The resident required extensive staff assistance with toileting and bathing, limited staff assistance with dressing and grooming and was independent with ambulation and transferring.

Review of Resident #2's record revealed there was no documentation of a pre-admission

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D 463	Continued From page 60 screening prior to admission to the SCU. Interview with the Area Director of Operations (ADO) on 03/12/20 at 10:21am revealed she had reviewed Resident #2's record and the only form she could locate for Resident #2's placement in the SCU on admission. Interview with the Executive Director (ED) on 03/13/20 at 2:45pm revealed: -She was not aware Resident #2 did not have the preadmission screening in her record. -She became the ED for the facility in April of 2018 and prior to that she was employed by the facility as the Business Office Manager (BOM) and would not have been responsible for preadmission screenings. -The Special Care Unit Coordinator would have been responsible for that.	D 463		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration, health care, and other requirements.	D912		

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D912	Continued From page 61 The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a prescribing physician for 2 of 5 sampled residents related to not administering doses of an antibiotic to treat an infection (Resident #1) and a resident not having a blood pressure, a medicine for chest pain, an anti inflammatory, a pain reliver, a vitamin to help with bone density, and a medication to treat dry eyes (Resident #4).[Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow up for 1 of 5 sampled residents who was referred to the primary care provider (PCP) by an infectious disease nurse at the local health department for Streptococcus testing and for a follow up from an emergency department visit (#2).Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		