Vogel, Abigail L

From: Tyrrell House, ADM - Wallace, LaVonna <tyre.adm@algsenior.com>
Sent: Thursday, March 11, 2021 2:29 PM
To: Vogel, Abigail L
Cc: Tyrrell House, RCC - Atkins, Tara; Tyrrell House, BOM - Wynn, Monica; Nina Warwick-Joyner
Subject: [External] POC
Attachments: POC(1).pdf

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LaVonna

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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
	Hal089002	A. BUILDING: C B. WING	R-C 01/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	950 HWY 64 EAST COLUMBIA, NC 27925

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation with an onsite visit on 01/20/21 to 01/21/21, and a desk review survey on 01/22/21, 01/25/21 to 01/28/21, and a telephone exit on 01/28/21.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or conclusions, set forth in the statement of deficiencies, the plan of corrections is perpared soley as a matter of compliance with the law.	
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure 1 of 5 residents sampled (#1) received assistance with showering. The findings are: Review of Resident #1's current FL-2 dated 06/04/20 revealed diagnoses included dementia with behavioral disturbances, agitation, memory loss, hypothyroidism, hyperlipidemia, hypertension, renal insufficiency, and diverticulosis. Review of Resident #1's care plan dated 06/09/20 revealed: -Resident #1 required extensive assistance with bathing. -Resident #1 required extensive assistance with grooming.	D 269	10A NCAC 13F .0901(a) Personal Care and Supervision Facility Executive Director (ED) and Care Manager (CM) have audited all resident care plans to assure care plans reflect personal care needs of residents. Facility ED and Care Manager have completed necessary revisions and/or updated to all residents care plans to reflect needed assistance. Facility Care Manager will complete resident care plan upon admission, annually and in the event of significant change. Facility care staff will complete observation shower skin assessments for each residents shower. Facility Care Manager will review observations shower skin assessments daily and complete follow-up on any noted concerns. Any follow-up will be documented in resident progress notes. Facility ED and Care Manager have reviewed/ revised assigment sheets to assure residents care needs are listed according to resident care plans. Facility care staff will notify Medication Tech for any resident who refuses personal care Medication Tech will contact Care Manager and/or Lead SIC of all refusals. Medication Tech, Lead SIC and/or Care Manager will document in resident progress notes resident refusals of personal care.	2/12/2021 2/12/2021 2/12/2021 2/12/2021 2/12/2021 2/12/2021 2/12/2021

Reviewed and Accepted with revisions ABV 03/17/21

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D 269	Continued From page 1 Observation of Resident #1 on 01/20/21 at 12:50pm revealed: -He was sitting on a chair inside the door of the suite. -He was wearing a shirt that had dried food and stains on the breast area. -He had a shoe on his lap. -He was wearing a baseball cap. -He had substantial facial hair. -He had dirt under his nails and his hands were dirty. Observation of Resident #1 on 01/21/21 at 7:30am revealed: -He was wearing a baseball cap and oversized jacket. -He was wearing the same pants as the previous day. -He had not been shaven since yesterday. Interview with a personal care aide (PCA) on 01/21/21 at 7:55am revealed: -Resident #1 was scheduled for showers on Tuesday, Thursday and Saturday. -Resident #1's linens were changed, and laundry was done on Tuesday, Thursday, and Saturday. -Resident #1 required standby assistance in the shower. -Resident #1 required a lot of encouragement to shower and would sometimes refuse. -If Resident #1 refused she would document it in his care record and notify the medication aide on duty. Review of Resident #1's Progress Note on 01/2/21 at 12:45pm revealed the Memory Care Manager (MCM) documented the resident refused multiple attempts on different shifts for personal care assistance including assistance with shaving.	D 269	Continued from page 1 Facility ED, Care Manager and/or Lead SIC will notify residents responible party and residents primary care physican of any residents continued refusals to receive personal care. Notification and communication will be documented in residents progress notes. Facility ED and Care Manager will review any needed care plan updates and refusals of personal care needeeds daily in Stand-up meetings. Care Staff have been in-serviced on resident personal care needs, observation skin assessments and process of reporting refusals In-service provided by Care Manager and ED.	2/21/2021 2/21/2021 2/21/2021

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D 269	Continued From page 2 Telephone interview with the Lead Medication Aide (LMA) on 01/27/21 at 1:33pm revealed: -If Resident #1 refused his shower on his scheduled day the PCA would document that in the electronic care record. -The PCA was supposed to notify the MA when a resident refused a shower. -When Resident #1 refused his shower, she would encourage the PCA to try again later. -Resident #1 had certain staff members that he responded better to for getting him to shower. Telephone interview with Resident #1's family member on 01/22/21 at 10:47am revealed: -She had only been able to visit with the resident through the window since he came to the facility in June 2020. -She had noticed times when she had been to visit him, and he had the same clothes on as the previous visit which was a few days earlier. -She had noticed times when she had been to visit him, and he was not shaved. -She could not recall the specific dates of the visits where she had noticed the same clothing. -She was told there were times when he was given a sponge bath instead of a shower. -She knew he was modest and suggested a male staff member attempt to give him assistance in the shower. -The resident needed assistance getting into the shower and encouraging him to wash. -The resident wasn't steady and needed someone standing by to assist him in the shower. Telephone interview with MCM on 01/28/21 at 10:38am revealed: -She had spoken with his family member recently and found out that he responded better to specific staff members.	D 269		

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D 269	Continued From page 3 -The PCP recently evaluated Resident #1 to move to the Assisted Living (AL) side of the facility which would hopefully improve the resident's motivation. Telephone interview with the Administrator on 01/28/21 at 3:19pm revealed: -Her expectation if a resident refuses a shower was for a different staff member to attempt to assist the resident. -If the resident still refused after trying a different staff member, she expected the staff to document the refusal. -She expected staff to notify the LMA. -It was the resident's right to refuse and the staff could not force him to shower. Telephone interview with Resident #1's primary care provider (PCP) on 01/27/21 at 9:03am revealed: -She had not noticed any residents that appeared to be unkempt during her facility rounds. -The MCM rounds with her during visits and if a resident is needing assistance, staff responds timely. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	D 269		
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: Based on interviews and record review, the	D 273	10A NCAC 13F.0902(b) Health Care Facility ED, Care Manager and/or designee will assure referral and follow-up to the meet the routine and acute health care needs of the residents. Facility will conduct daily stand up meetings, weekly at risk and monthly QA meeting. Acute and routine health care needs of residents are discussed during meetings .	2/12/2021 2/12/2021

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D 273	Continued From page 4 facility failed to ensure notification of the primary care provider (PCP) for 3 of 5 residents related to weight loss (#1), a broken nebulizer machine (#2), and a missed PCP follow-up appointment (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 06/04/20 revealed diagnoses included dementia with behavioral disturbances, agitation, memory loss, hypothyroidism, hyperlipidemia, hypertension, renal insufficiency, and diverticulosis. Review of Resident #1's physician orders dated 11/10/20 revealed an order for a regular diet. Telephone interview with Resident #1's family physician on 01/26/21 at 10:26am revealed: -Resident #1 had an appointment on 04/30/20. -Resident #1 weighed 178.2 pounds at the appointment. Review of Resident #1's Resident Register revealed an admission date to the facility of 06/04/20. Review of Resident #1's August 2020 electronic care record dated 08/13/20 at 10:06am revealed: -Resident #1 was weighed by the facility. -Resident #1's weight was documented as 162 pounds. Review of Resident #1's October 2020 electronic care record dated 10/11/20 at 8:14am revealed: -Resident #1 was weighed by the facility. -Resident #1's weight was documented as 164 pounds.	D 273	Continued from page 3 Facility will assure weights are done no less than monthly or as prescribe by physican on all residents. Documentation of weights will be maintaned in residents record. Facility Medication Techs, Lead SIC and/or Care Manager will initiate a Health Notfication Event for any residents with signifant weight loss/gain or any missed appointments. Medication Techs, Lead SIC and/or Care Manager will assure the Health Notification Event is sent to residents primary care physician Documentation of notification along with any follow-up and/or recommendations will be documented in resident progress notes. Facility Care Manager will review facility activity reports daily, including but not limited to resident progress notes and health notification events. Facility Medication Techs, Lead SICs and/or Care Manager will notify residents primary care physician of any durable medical equiment which is not operational. Facility Care Manager and/or ED will contact durable medical supplier or phamarcy to request immedate replacement of equirement. Documentation of all notifications,communication and follow-up will be documented in residents progress notes. Staff in-serviced on health care referral and follow-up and health notification events. In-serviced conducted by ED and Care Manager. Care Manager and Adminstrator will complete a chart audit of all resident records to ensure referral and follow up needs have been addressed. ——— Added to phone conversation 3.17.21@ 11:15am to RCC and Adm/ABV	2/12/2021 2/12/2021 2/12/2021 2/12/2021 2/12/2021 2/12/2021 2/12/2021

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D 273	Continued From page 5 Telephone interview with Resident #1's family physician on 01/26/21 at 10:26am revealed: -Resident #1 had an appointment on 11/09/20. -Resident #1 weighed 143.6 pounds at the appointment. Review of Resident #1's November 2020 electronic care record dated 11/10/20 at 6:05pm revealed: -Resident #1 was weighed by the facility. -Resident #1's weight was documented as 164 pounds. Telephone interview with Resident #1's family member on 01/26/21 at 9:14am revealed: -She called the facility on 11/20/20 and requested the facility weigh the resident. -She was told the resident weighed 143 pounds. -She did not remember who she spoke with at the facility. Review of Resident #1's Physician notification form dated 12/09/20 revealed a notification made by the Memory Care Manager (MCM) to the physician stating: "Resident has lost weight, a lot of weight. May we have an order for a supplement?" Review of Resident #1's December 2020 electronic care record dated 12/10/20 at 5:10pm revealed: -Resident #1 was weighed by the facility. -Resident #1's weight was documented as 132 pounds. Review of Resident #1's physician's orders dated 12/15/20 revealed an order to start nutritional supplement shakes, to be given three times a day with meals.	D 273		

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D 273	Continued From page 6 Review of Resident #1's Emergency Room Visit Summary dated 12/24/20 at 11:36pm revealed: -A weight was recorded a weight of 60.1 kg (132.2 pounds) -The family member reported a loss of greater than 40 pounds of weight in recent months. Review of Resident #1's January 2021 electronic care record dated 01/10/21 at 4:00pm revealed: -Resident #1 was weighed by the facility. -Resident #1's weight was documented as 152 pounds. Telephone interview with Resident #1's family member on 01/26/21 at 9:14am revealed: -She was concerned about the amount of weight Resident #1 has lost since admission into the facility. -During window visits with Resident #1 she could tell his clothes are becoming increasingly looser. -She had talked to a number of previous Administrators about her concerns with Resident #1's weight but did not feel that the facility staff was doing anything to address it. Interview with a personal care aide (PCA) 01/27/21 at 10:24am revealed: -Residents were weighed monthly on day shift. -Residents were weighed using a stand-up scale. -Medication aides (MA) were responsible for documenting weights. -She was not aware of any issues with the scale being broken. Telephone interview with the Lead Medication Aide on 01/27/21 at 1:33pm revealed: -Residents were weighed monthly. -Weights were entered into the computer system by the MA. -There was an issue with the power cord for the	D 273		

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D 273	Continued From page 7 scale, but she didn't remember when that was. -She was unsure of the exact amount of weight fluctuation that the primary care provider (PCP) would need to be notified of, but the computer system notified you if there is a 'drastic' weight change. -If the computer system notified her that there was a drastic weight change, she would alert the PCP. -She had not notified the PCP of any weight change for Resident #1 prior to the 12/09/20 notification. Telephone interview with the MCM on 01/28/21 at 10:38am revealed: -The facility weighed all residents monthly. -A standing scale was used to weigh residents. -There was an issue with the scale functioning correctly and the scale was recalibrating in December of 2020. -It was her expectation that staff would notify the PCP of a 3 to 5 pounds weight change per month. -She weighed Resident #1 on 01/27/21 after talking with his family member and he weighed 151.5 pounds. Telephone interview with the Administrator on 01/28/21 at 3:19pm revealed: -It was her expectation that all residents were to be weighed monthly. -It was her expectation that staff would notify the PCP if a resident's weight fluctuated more than 5 pounds per month. -She was not aware of any issues with the scale at the facility. -It was her expectation that staff would notify her of any issues with the facility's equipment so that she can address the problem.	D 273		

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D 273	Continued From page 8 Telephone interview with Resident #1's PCP on 01/27/21 at 9:03am: -She would expect staff to notify her of any weight change of 5 pounds or more. -She had spoken with Resident #1's family member about their concerns related to Resident #1 losing weight in January of 2021. -She started him on medication in January of 2021 to help stimulate his appetite. -She questioned the staff about the December 2020 weight because they may have entered it incorrectly. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. 2. Review of Resident #2's current FL2 dated 02/25/20 revealed diagnoses included central demyelination of corpus callosum, hypomagnesemia, candidiasis, hypo-osmolality and hyponatremia, alcohol abuse, major depressive disorder, insomnia, and hypertension. Interview with Resident #2 on 01/19/21 at 1:44pm revealed: -Her nebulizer machine stopped working on Christmas Day (12/25/20) and the facility had no back-up nebulizer machines. -Her relative obtained a used nebulizer machine from a local drug store within 24 hours which stopped working a couple of days later. Her sister then obtained a new nebulizer machine. -She was not without a nebulizer machine for more than 24 hours when the nebulizer first stopped working and just a few hours when the second nebulizer stopped working. -The MAs knew the nebulizer was not working because they were responsible for administering the medication to the resident.	D 273		

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D 273	Continued From page 9 -She said the Lead Med Aide offered to send her to the emergency department (ED) but she refused because she thought the ED would just send her back to the facility. Telephone interview with Resident #2's family member on 01/26/21 at 9:06am revealed: -She talked to the resident weekly on the resident's cell phone. -On Christmas morning (12/25/20) around 9:00am, she received a telephone call from Resident #2 notifying her of the broken nebulizer machine. -She was informed by Resident #2 that facility staff had been notified and staff said they would "look into it on Monday (12/27/20)". -She visited several drug stores and obtained a refurbished nebulizer machine in which she delivered to resident #2 at the facility by approximately 2:00pm on 12/25/20. -On 12/28/20, the refurbished nebulizer machine stopped working. -She purchased a new nebulizer machine and delivered it to Resident #2 at the facility within a few hours. -She had been concerned about the unavailability of a back-up nebulizer machine at the facility, but she did not talk with facility staff concerning this situation. Telephone interview with Resident #2's Primary Care Provider (PCP) on 01/26/21 at 1:39pm revealed: -Resident #2 was prescribed Albuterol Sulfate Solution as needed for wheezing. -She would expect the facility to have a back-up nebulizer machine or have the means to obtain another nebulizer for Resident #2. -She was not notified that the machine stopped working.	D 273		

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D 273	Continued From page 10 Telephone interview with a Personal Care Aide (PCA) on 01/26/21 at 2:02pm revealed: -She could not remember the date Resident #2's nebulizer machine stopped working. -She notified the Lead Med Aide whom advised her to look in the medication room for a back-up nebulizer machine. -There should have been a back-up nebulizer machine but there was not one available. -She worked first shift and did not know how long Resident #2 waited for another nebulizer machine. -Facility management was not working and the pharmacy was not open on Christmas Day. -She was instructed by the LMA to dispense Pro-Air as needed in which Resident #2 had available. Telephone interview with a Medication Aide (MA) on 01/26/21 at 3:23pm revealed: -She was not working when Resident #2's nebulizer machine stopped working but was notified when she returned to work by Resident #2. -She did not know how long Resident #2 was without her nebulizer machine, but she thought it was at least a day. -A family member brought another nebulizer machine to Resident #2,(not sure which day). -She did not know if management tried to obtain another nebulizer machine. -Facility protocol was to notify management (Memory Care Manager, Administrator, Business Manager) when a situation such as this occurred. -Management already knew the nebulizer machine was not working when she found out. Telephone Interview with a second MA on 01/27/21 at 11:33am revealed:	D 273		

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D 273	Continued From page 11 -She was not working when Resident #2's nebulizer machine stopped working and could not remember the date it occurred. -She returned to work on 12/28/20 at which time Resident #2 had another nebulizer machine. -Protocol would have been to call the Memory Care Manager (MCM) to report the situation. -She would check the med room for a back-up nebulizer machine, then call the pharmacy to order one. Telephone interview with the Lead Medication Aide on 01/27/21 at 1:00pm revealed: -She was notified around noon on 12/25/20 by a MA that Resident #2's nebulizer machine stopped working. -The pharmacy was closed but she instructed the MA to call the PCP's office to see if the PCP could send an order to the pharmacy when they opened. -She later called the facility and the MA said a family member brought a used nebulizer machine to Resident #2 on the same day. -The used nebulizer stopped working a day later and the family member brought a new nebulizer machine to Resident #2 on 12/26/20. -There are no procedures in place to handle the situation of the nebulizer machine not working. Telephone interview with the MCM on 01/28/21 at 10:40am revealed: -She began working at the facility on 01/11/21. -Her expectations would be for staff to call the store in which Resident #2's nebulizer machine was bought for a replacement and get the nebulizer machine to the facility as soon as possible. -Other medical supply companies could have been contacted for an emergency order. -The PCP's office should have been notified as	D 273		

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D 273	Continued From page 12 soon as it stopped working so the PCP could give a back-up plan. -She accessed the records for the PCP and determined the PCP's office was not notified. Telephone interview with the Administrator on 01/28/21 at 3:19pm revealed: -She was not aware that Resident #2's nebulizer machine stopped working. -She expected staff to notify the MCM or the Administrator but she was not notified . -Staff should have documented in the progress notes that the nebulizer machine stopped working and who was notified. 3. Review of Resident #3's current FL-2 dated 01/15/21 revealed diagnoses included diabetes, hypertension, anxiety and major depressive disorder, chronic kidney disease, gastro-esophageal reflux disease, hyperlipidemia, and high risk medication. Review of a primary care physician (PCP) encounter for Resident #3 dated 08/18/20 revealed: -The resident was seen for a wellness check. -The resident had no issues or concerns. -Examination of the resident's respiratory status revealed "soft scattered wheezes". -The PCP encounter documented a plan for a recheck in three months for Resident #3. Review of Resident #3's record revealed there were no additional PCP encounter visit notes dated after the 08/18/20 visit. Review of progress notes for Resident #3 dated 08/08/20 through 01/20/21 revealed there was no documentation for a three month recheck by the PCP as per the PCP plan.	D 273		

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D 273	Continued From page 13 Interview with Resident #3 on 01/20/21 at 2:22pm revealed: -He was doing alright, and things were going okay. -The PCP visited him at the facility. -He did not remember when he last saw the PCP. Telephone interview with the Memory Care Manager (MCM) on 01/22/21 at 3:30pm revealed: -She was responsible for residents' medical needs. -She did not know about the three months follow up appointment from the 08/08/20 PCP visit for Resident #3. -She had placed Resident #3 on the list to see the PCP on 01/26/21. -She did not see anything in Resident #3's record showing that he had seen the PCP since the 08/2020 visit. -She would research to see if she could find out more about the PCP planned follow up visit. Second telephone interview with the MCM on 01/28/21 at 1:08pm revealed: -Resident #3 did not have the three months recheck PCP visit but was seen on 01/26/21 by the current Nurse Practitioner. -The MCM was responsible for ensuring follow up appointments were scheduled for residents seen by the PCP visiting the facility. -She did not know what process was used by the previous MCM to ensure resident follow up appointments occurred as planned by the PCP. Telephone interview with the PCP's office assistant supervisor on 01/26/21 at 11:41am revealed: -Resident #3 was supposed to have a recheck PCP visit in three months according to the PCP	D 273		

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D 273	Continued From page 14	D 273		

notes for the 08/20/20 visit encounter.
-Resident #3 was not seen for the three months recheck visit.
-If the PCP had cancelled the three months recheck visit, the PCP would have created an encounter visit for that date which would have indicated why the resident was not seen.
-The PCP would have expected the facility to schedule Resident #3 to be seen for the recheck visit by placing the resident's name on a list prepared for the PCP.
-The facility was responsible for making sure the resident was placed on the PCP visit list sent to the PCP office.
-The PCP's office usually received the visit list the day before the PCP was scheduled to visit the facility.
-The PCP visited the facility on 11/03/20, 11/10/20, 11/17/20, and 11/24/20, and Resident #3 was not on the PCP's schedule to be seen.
-The facility's "Care Coordinator" usually sent the resident visit list to the PCP's office.

Telephone interview with the PCP's Nurse Practitioner on 01/26/21 at 12:27pm revealed:
-She did not see any notes in the electronic office notes that Resident #3 was seen by the PCP in November 2020.
-She thought the August visit was for a wellness check.
-She could not research why the November 2020 recheck visit did not occur and thought Resident #3 was probably stable and nothing was going on at that time.

Telephone interview with the Administrator on 01/28/21 at 3:45pm revealed:
-She was not aware Resident #3 had missed a follow up appointment with the PCP.
-She expected the MCM or lead medication aide

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D 273	Continued From page 15 to review physician encounter visit notes and follow up with recommendations. -She did not expect there to be any missed medical appointments.	D 273		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure water was served with meals to all residents. The findings are: Review of the 01/18/2021 through 01/24/2021 menu posted in the kitchen on 01/20/21 at 2:00pm revealed: -There was a listing for a beverage of choice for the lunch meal -There was no water listed on the menu on any day of the week to be served at either of the three meal deliveries. Interview with the dietary aide on 01/20/21 at 2:00pm revealed the Cook served meals to the residents living in the assisted living (AL) section of the facility while the dietary aide served meals to the residents living in the memory care unit (SCU) section of the facility.	D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service Facility ED, Dining Service Manager and/or designee will assure each resident is served water at each meal, in addition to other beverages. Facility ED, Care Manager and/or Dietary Manager will monitor no less than one meal service daily for one month, then no less than 3 times weekly. Facility ED and/or Dietary Manager will assure that menus are posted on both Assisted Living and Memory Care units. Menus will be visiable to residents, and include notation on "water severed 3 times a day with meals and milk twice a day" Dietary staff have been in-serviced on the rules and guidelines for Nutrition and Food Services. Inservice completed on 2/01/2021. In-service conducted by Executive Director	2/12/2021 2/12/2021 2/12/2021 2/12/2021

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D 306	Continued From page 16 Observation in the AL section dining room on 01/21/21 at 7:32am revealed: -There were five residents seated at individual tables that were socially distanced more than six feet apart. -There were one of the five residents being fed who had water served. A second observation of the AL section dining room on 01/21/21 at 7:42am revealed: -There were four residents eating in the dining hall at four separate tables. -There was one resident drinking a glass of water with her food. -A second resident asked a personal care aide (PCA) to fill her personal cup up with ice and water after eating her food. -The remaining two residents were not offered water. Observation of a resident dining on the SCU in his bedroom on 01/21/21 at 7:30am revealed two empty glasses with juice residue in the cups and one empty glass of a nutritional supplement chocolate shake. Observation of five residents dining in the SCU dining room on 01/21/21 at 7:38am revealed: -One resident was served coffee, milk, and juice with their breakfast. -A second resident was served coffee and juice with their breakfast. -A third resident was served coffee with their breakfast. -A fourth resident was served coffee and juice with their breakfast. -A fifth resident was served juice and milk with their breakfast.	D 306		

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D 306	Continued From page 17 Observation of a staff member pushing a cart to the kitchen on 01/21/21 at 7:40am revealed: -The cart contained pre-poured cups of coffee, juice, and milk. -There were no glasses of water on the cart. Observations of the Dietary Manager on 01/21/21 from 7:40am to 8:03am revealed: -The meal delivery cart she used to serve breakfast meals in the AL section of the facility included four glasses of water. -She served breakfast plates and beverages to thirteen residents in the AL section of the facility. -Two of the thirteen residents she served a breakfast meal were served a glass of water. -The remaining eleven residents were not offered or served water with their breakfast meal. Interview with the Dietary Manager on 01/21/21 at 8:05am revealed: -The four cups of water on the breakfast meal delivery cart was not enough water for all the residents living in the AL section of the facility. -Water was supposed to be offered with every meal. -She had not offered water at the breakfast meal on 01/21/21 because when she offered water the residents would say take it back and the water was refused. -She did not offer water to the AL section residents during the breakfast meal delivery on 01/21/21 because it was "normal thing for them to refuse it". -The residents had a choice of "either milk or water". Interview with a resident who resided in the AL section on 01/21/21 at 9:10am revealed: -He did not know why water was not served. -When he used to eat in the dining room, water	D 306		

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D 306	Continued From page 18 was served. -He had been eating his meals in his room since March 2020 because of COVID-19. -He would drink the water, if served. Interview with a second resident who resided in the AL section on 01/21/21 at 10:21am revealed: -She did not get water served with her meals. -She was served coffee and cranberry juice for breakfast. -Most of the time, she was served tea for lunch. -She could get water from the bathroom. Telephone interview with the Memory Care Manager (MCM) on 01/22/21 at 3:30pm revealed: -Water was supposed to be offered/served with all meals. -She expected the residents to be offered water with each meal because she worried about dehydration and urinary tract infections. -The residents residing in the SCU could not ask for water, so water should be given to those residents. Telephone interview with the Administrator on 01/22/21 at 3:50pm revealed: -The Dietary Manager had informed her that water was not served to all residents at breakfast on 01/21/21. -She (Administrator) had "skimmed" over the menus but had not looked at them in any detail. -She expected water to be served at every meal. -The residents might not want the water but should know they could have water. -Four glasses of water was not enough water to serve at meal delivery for all the residents residing in the assisted living section of the facility.	D 306		

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D 358	Continued From page 19	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 6 residents (#9, #10) observed during the medication pass including errors with a medication for constipation (#9) and a medication used to lower cholesterol and triglycerides (#10); and for 4 of 6 residents sampled (#1, #4, #5, #7) including errors with medications for glaucoma (#7), high blood pressure (#1, #5), blood thinning (#5), mood disorders (#5), insomnia (#4), constipation (#4, #5), iron supplement (#5), calcium supplement (#4), and a Vitamin B supplement (#5). The findings are: 1. The medication error rate was 6% as evidenced by the observation of 2 errors out of 30 opportunities during the 2:00pm medication pass	D 358	10A NCAC 13F .1004(a) Medication Administration Facility Care Manager and/or Lead SIC will complete weekly medication audits along with weekly Medication Storage Audit. Care Manager and/or Lead SIC will review inventory of supplies to assure medication carts have all nessracy supplies, including but not limited to proper measuring cups.	2/12/2021
			Facility Care Manager will review Medication Cart Audits, Medication Storage Audit and inventory with facility ED weekly upon completion of audits.	2/12/2021
			Facility Medication Techs are responible for assuring preparation and administration of medication as prescribed by practitioner. Any discrepancies found while prepping medication, the Medication Tech will immediately contact the Care Manager or Lead SIC.	2/12/2021
			Care Manager and/or Lead SIC will contact prescribing practitioner for claification and notification. Care Manager and/or Lead SIC will assure documentation of claification/notification is documented in resident progress notes.	2/12/2021
			Care Manager, Lead SIC and/or Medication Techs are responible for notifing pharmacy of any medication changes.	2/12/2021
			Facility Medication Techs will notify Care Manager or Lead SIC for any resident whom refuses or does not want to eat within time frame of any medications that are ordered with food. Facility Care Manager and/or Lead SIC will Contact Prescribing Practitioner. Documentation of contact will be noted in resident progress notes.	2/12/2021

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D 358	Continued From page 20 on 01/20/21 and the 8:00am medication pass on 01/21/21. a. Review of Resident #10's current FL-2 dated 06/20/20 revealed: -Diagnoses included Parkinson's disease, type 2 diabetes mellitus without complications, hypertension, acute kidney injury, bipolar disorder, dorsalgia, and malignant neoplasm of epididymis. -There was an order for Fenofibrate 145mg take 1 tablet with breakfast. (Fenofibrate lowers cholesterol and triglycerides. Fenofibrate is absorbed better when there is some food on the stomach so it should be taken with a meal.) Review of Resident #10's January 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Fenofibrate 145mg take 1 tablet with breakfast with a scheduled administration time of 8:00am. -Fenofibrate was documented as administered daily with breakfast at 8:00am from 01/01/21 - 01/19/21. Observation of the 8:00am medication pass on 01/21/21 revealed: -The medication aide (MA) prepared Resident #10's 8:00am medications for administration, including Fenofibrate. -Resident #10 was lying in bed when the MA entered the room and administered his morning medications, including Fenofibrate at 7:45am. -The resident laid back down in the bed after swallowing the medications to go back to sleep. Attempted interview with Resident #10 on 01/21/21 at 7:45am was unsuccessful.	D 358	Continued from page 20 Facility Care Manager and/or Lead Supervisor is responible for assuring all medications are approved accuately on the EMAR. Care Manager is responible for assuring that Medication Techs are aware when residents should a prescribing pracititioner change, prescribed or place medications on hold. Medication Techs, Lead SIC and Care Manager have received training on the following: - 6 rights of Medication Administration - Clarification of Medication Orders - Controlled Substance - Medication Errors - Medication Storage - Proper Medication Storage and Disposal Training Conducted by RN on 1/27/2021, 2/11/2021	2/12/2021 2/12/2021

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D 358	Continued From page 21 Interview with the MA on 01/21/21 at 7:46am revealed: -The residents currently ate all meals in their rooms due to the pandemic. -Breakfast was usually served at 7:30am but she had not seen the food cart deliver trays yet. -Resident #10 never ate breakfast because he liked to sleep late. Observation on 01/21/21 at 7:57am revealed the food cart arrived to the doorway of Resident #10's room but no food was served or offered to Resident #10. Based on observations and interviews, Resident #10's Fenofibrate was not administered with breakfast as ordered. A second interview with the MA on 01/21/21 at 1:36pm revealed: -If a medication was ordered with a meal, she tried to administer it while the resident was eating or after the meal. -She had not notified Resident #10's primary care provider (PCP) that the resident did not eat breakfast. Interview with the Memory Care Manager (MCM) on 01/21/21 at 2:09pm revealed: -If a medication was ordered with a meal, it should be administered at meal time when the resident was eating. -She was not aware Resident #10 did not usually eat breakfast. -The MAs should let her know so she could contact the PCP to have the order changed. Telephone interview with Resident #10's PCP on 01/27/21 at 9:04am revealed: -She was contacted last week by the facility staff	D 358		

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D 358	Continued From page 22 who reported Resident #10 did not eat breakfast and the order for Fenofibrate needed to be changed. -She changed the order for Fenofibrate to be administered with a meal so the facility could change the administration time to a meal the resident did eat. -She had not been notified prior to last week about the resident not eating breakfast and receiving Fenofibrate on an empty stomach. b. Review of Resident #9's current FL-2 dated 01/12/21 revealed: -Diagnoses included dementia, hypertension, anxiety, elevated cholesterol, and lipoprotein deficiency. -There was an order for Miralax mix 8.5gm in 4 ounces of water and drink every day for constipation. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the cap on the bottle has one marking for 17 grams that should be used to measure the dosage at the top of the white section of the cap.) Review of Resident #9's January 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Miralax mix 8.5gm in 4 ounce of water and drink every day for constipation with a scheduled administration time of 8:00am. -Miralax was documented as administered from 01/01/21 - 01/19/21. Observation of the 8:00am medication pass on 01/21/21 revealed: -There was a white section lining the inside of the cap on Resident #9's Miralax bottle. -There was "17g" imprinted near the top of the white section and an arrow pointing up to indicate	D 358		

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D 358	Continued From page 23 the measurement for 17 grams was at the top of the white section inside the cap. -The medication aide (MA) poured the Miralax powder to the line marking 17gm and put the powder in a 5 ounce cup filled near the top with water. -The MA stirred the water with the Miralax powder for only a few seconds, leaving ½ inch of white powder undissolved in the bottom of the cup. -The MA did not measure the Miralax correctly and the full dosage was not mixed in the water. -The MA held the cup to the resident's mouth and the resident took 2 swallows at 8:10am then a quick third sip before the resident started walking back down the hall. -The MA approached the resident again as she walked down the hall and the resident took 2 more swallows at 8:11am, with the white powder still undissolved in the bottom of the cup. -The cup was approximately half full of liquid when the MA walked away to go to the kitchen to get some applesauce to crush the resident's other morning medications. -She did not attempt to offer or encourage the resident to drink the remainder of the Miralax prior to walking away. -When the MA returned at 8:13am, she did not have the cup of Miralax with her. -The MA clicked on the eMAR and documented the resident did not drink the full amount. Based on observations, interviews, and record review, it was determined Resident #9 was not interviewable. Interview with the MA on 01/21/21 at 1:57pm revealed: -She usually measured the resident's Miralax powder to the line marking 17gm because that was what she thought the instructions indicated.	D 358		

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D 358	Continued From page 24 -She did not realize she had been looking at the wrong place on the label and did not see 8.5gm in the instructions. -There was no device marked with 8.5gm to administer that amount. -She usually mixed the Miralax and gave it time to dissolve before administering it and she was administer it with the resident's breakfast so she would drink it better. -She was running behind that morning on 01/21/21 so she did not get to the resident before she ate breakfast. -She did not attempt to administer the remaining amount of Miralax because she had carried the cup through the building when she walked to the kitchen and she did not think it was sanitary to offer it to the resident. Interview with the Memory Care Manager (MCM) on 01/21/21 at 2:09pm revealed: -She did not realize Resident #9's Miralax order was for 8.5gm and she was not aware of a device to measure that amount. -She would contact the resident's primary care provider (PCP) to get the order changed. -She expected the MAs to mix the Miralax until all of the powder had dissolved and the water was clear. -She expected the MAs to encourage all residents to drink the full amount of the medication. Telephone interview with Resident #9's PCP on 01/27/21 at 9:04am revealed: -She expected the MAs to read the eMARs and follow the instructions to administer the correct amount of Miralax. -She was recently contacted by the facility about the resident's Miralax dose and she changed it from 8.5gm to 17gm.	D 358		

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D 358	Continued From page 25 -Miralax should be mixed well and the resident needed to be prompted and encouraged to drink the Miralax. -She was not aware of any concerns with the resident having problems with constipation or diarrhea. 2. Review of Resident #4's current FL-2 dated 04/21/20 revealed diagnoses included Parkinson's disease, status post liver transplant, right and left artificial knees, benign prostatic hypertrophy, chronic viral Hepatitis C, tension-type headache, muscle spasms, thrombocytopenia, and insomnia. a. Review of Resident #4's current FL-2 dated 04/21/20 revealed an order for Melatonin 10mg 1 tablet at bedtime for insomnia. (Melatonin is a hormone used to treat insomnia.) Review of Resident #4's November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Melatonin 10mg 1 tablet every night at bedtime scheduled to be administered at 8:00pm. -Melatonin 10mg was documented as administered every night at 8:00pm from 11/01/20 - 11/30/20. Review of Resident #4's December 2020 eMAR revealed: -There was an entry for Melatonin 10mg 1 tablet every night at bedtime scheduled to be administered at 8:00pm. -Melatonin 10mg was documented as administered every night at 8:00pm from 12/01/20 - 12/16/20 and 12/21/20 - 12/31/20. -Melatonin was not documented as administered on 4 nights from 12/17/20 - 12/20/20 due to the	D 358		

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D 358	Continued From page 26 medication being unavailable. Review of Resident #4's January 2021 eMAR revealed: -There was an entry for Melatonin 10mg 1 tablet every night at bedtime scheduled to be administered at 8:00pm. -Melatonin 10mg was documented as administered every night at 8:00pm from 01/01/21 - 01/20/21. Observation of Resident #4's medications on hand on 01/21/21 at 12:58pm revealed: -There was 1 bottle of Melatonin 3mg tablets in the original manufacturer's container with no prescription labeling and a bottle size of 180 tablets. -There were 125 of 180 tablets remaining in the bottle. -There was no Melatonin 10mg tablets on hand for the resident. Interview with a medication aide (MA) on 01/21/21 at 12:58pm revealed Melatonin 3mg tablets was the only supply of Melatonin on hand for the resident for administration. Review of Resident #4's physician's orders, eMARs, and medications on hand revealed: -The resident was receiving Melatonin 3mg tablets instead of Melatonin 10mg as ordered. -At least 55 tablets of Melatonin 3mg had been used from the supply on hand. Telephone interview with Resident #4 on 01/27/21 at 6:22pm revealed: -The MAs at the facility ordered his medications from a local pharmacy, including prescription and over-the-counter (OTC) medications. -The local pharmacy would call him and let him	D 358		

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D 358	Continued From page 27 know when the medications were ordered and when they were ready to be picked up. -The facility staff picked up his medications from the local pharmacy. -If he was out of refills, the local pharmacy would call him and he would tell the Lead MA who would contact his primary care provider (PCP). -He was a "classic insomniac". -He took Melatonin for his insomnia and it helped sometimes but not all of the time so he also took 2 other medications for insomnia. -Some nights he did not sleep at all, even when he took all of his medications. Telephone interview with a second MA on 01/26/21 at 2:02pm revealed: -Resident #4's medications came from a local pharmacy including his OTC medications. -The pharmacy would put the resident's OTC medications in the bag with his prescription medications. -She was not sure if anyone checked the resident's OTC medications when received to make sure they matched the orders. -She had not noticed any discrepancies with the resident's OTC medications. -The MAs were supposed to compare the medication labels with the MARs and let the Memory Care Manager (MCM) know if something did not match. -Resident #4 received Melatonin every night. -She was aware the resident had Melatonin 3mg tablets on hand instead of 10mg tablets. -She usually administered just one of the Melatonin 3mg tablets because the resident also received another medication for insomnia. -She had not reported the resident was receiving the wrong dose of Melatonin to anyone and she had no explanation for not reporting it. -The resident usually slept "pretty good" when	D 358		

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D 358	Continued From page 28 she was working. -Once in a while, the resident would complain and say he had not gotten enough sleep. Telephone interview with a third MA on 01/26/21 at 3:44pm revealed: -The MAs were supposed to compare the medication labels with Resident #4's OTC medications with the eMARs. -Most of the time, Resident #4's OTC medication labels matched the eMARs. -She was aware Resident #4 had Melatonin 3mg tablets on hand instead of 10mg tablets. -She usually administered two of the Melatonin 3mg tablets to the resident for a total of 6mg. -She administered 6mg because there was no way to administer 10mg from 3mg tablets. -She had not reported the discrepancy to anyone and she had no explanation for not reporting it. -Resident #4's sleep habits varied depending on his Parkinson symptoms. -Sometimes the resident had a hard time getting to sleep and other nights the resident slept "decent". Telephone interview with a fourth MA on 01/27/21 at 11:33am revealed: -Resident #4's medications came from a local pharmacy. -The pharmacy would send Resident #4's OTC medications with his prescription medications. -She had never picked up his medications from the pharmacy so she did not know who picked out which OTC medications to send for the resident. -She did not usually administer Resident #4's Melatonin because she did not usually work on night shift. -The last time she worked on night shift was before Thanksgiving and he had 10mg Melatonin	D 358		

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D 358	Continued From page 29 tablets at that time. Telephone interview with the Lead MA on 01/27/21 at 1:30pm revealed: -When Resident #4's OTC medications were low in supply, the facility staff (she or a MA) would pick up a new supply at the pharmacy. -When she picked up Resident #4's OTC medications from the pharmacy, she would write down a list of the OTC medications so she could pick up the ones she needed from the pharmacy shelves. -If she was unsure which OTC medication to get, she would ask the pharmacist. -She usually checked the OTC medications when she returned with them to make sure they matched the eMARs and were the correct dose. -She was not sure when she last picked up OTC medications for Resident #4. -The MAs were supposed to check the medication labels and the eMARs when administering medications. -The MAs were supposed to notify her or the MCM and the PCP if a resident was not receiving the correct medication. -No MAs had notified her that some of Resident #4's OTC medications on hand did not match the eMAR. -She also administered medications to Resident #4 and she had not noticed the OTC medications did not match the orders listed on the eMAR. Telephone interview with a pharmacist at Resident #4's pharmacy provider on 01/28/21 at 1:58pm revealed: -Resident #4's prescription medications were on a monthly sync program, meaning they were dispensed monthly unless the resident asked them not to fill a medication monthly. -Resident #4's OTC medications were not on the	D 358		

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D 358	Continued From page 30 monthly sync program because the OTC medications were not run through their computer system. -The pharmacy staff may assist the facility staff when picking out OTC medications for Resident #4 but some of the facility staff picked out the OTC medications on their own. -A facility staff person called the pharmacy yesterday (01/27/21) about getting the resident's OTC orders ran through the computer system so the OTC orders would be in the computer system and the pharmacist could make sure the correction OTC medications were sent to the facility. Telephone interview with the MCM on 01/26/21 at 5:45pm revealed: -Resident #4's medications were ordered by the MAs from a local pharmacy. -The pharmacy received orders for all of the resident's medications including OTC medications. -The OTC medications should have prescription labels but if not, the OTC medications were probably picked out by the MAs when the MAs went to pick up the resident's prescription medications. -The MAs were supposed to check the labels of the OTC medications to make sure they matched the orders listed on the eMARs. -If the medication label and the eMAR did not match, the MAs should stop and let her know immediately. Telephone interview with Resident #4's PCP on 01/27/21 at 9:04am revealed: -It was concerning to hear that Resident #4 was receiving the wrong dosage of Melatonin. -She expected the facility to have the correct medication on hand based on the orders.	D 358		

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D 358	Continued From page 31 A second telephone interview with the MCM on 01/28/21 at 10:41am revealed: -The MAs should compare labels on medications before administration and if it did not match, the MAs should notify her. -Some MAs were picking up Resident #4's OTC medications themselves but they were not picking up the correct medications. -She was starting a new system and from now on, all OTC medication orders would be sent to the pharmacy and processed by the pharmacy so the correct medications would be sent. b. Review of Resident #4's current FL-2 dated 04/21/20 revealed an order for Senexon-S 8.6/50mg take 2 tablets twice a day as needed for constipation. (Senexon-S contains 8.6mg of a stimulant laxative and 50mg of Docusate Sodium, a stool softener. Senexon-S is used to treat and prevent constipation.) Review of Resident #4's November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Senexon-S 8.6/50mg take 2 tablets twice a day as needed for constipation. -Senexon-S was documented as administered on 4 occasions from 11/01/20 - 11/30/20. Review of Resident #4's December 2020 eMAR revealed: -There was an entry for Senexon-S 8.6/50mg take 2 tablets twice a day as needed for constipation. -Senexon-S was documented as administered on 2 occasions from 12/01/20 - 12/31/20. Review of Resident #4's January 2021 eMAR	D 358		

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D 358	Continued From page 32 revealed: -There was an entry for Senexon-S 8.6/50mg take 2 tablets twice a day as needed for constipation. -Senexon-S was not documented as administered on any occasions from 01/01/21 - 01/21/21. Observation of Resident #4's medications on hand on 01/21/21 at 12:58pm revealed: -There were 2 bottles of Stool Softener containing Docusate Sodium 100mg softgels capsules with no stimulant laxative. (Stool Softener is not the same as Senexon-S because it does not contain a stimulant laxative and it contains 100mg of Docusate Sodium instead of 50mg in Senexon-S.) -The Stool Softeners were in the original manufacturer's containers with no prescription labeling and the bottle sizes were 100 softgel capsules each. -One bottle of 100 softgel capsules was opened but still contained 100 capsules while the other bottle had 82 of 100 capsules remaining. -There was no Senexon-S on hand for the resident. Interview with a medication aide (MA) on 01/21/21 at 12:58pm revealed Docusate Sodium 100mg was the supply on hand administered to Resident #4. Review of Resident #4's physician's orders, eMARs, and medications on hand revealed: -The resident was receiving Docusate Sodium 100mg instead of Senexon-S 8.6mg/50mg as ordered. -At least 18 softgel capsules of the Docusate Sodium had been used from the supplies on hand.	D 358		

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D 358	Continued From page 33 Telephone interview with Resident #4 on 01/27/21 at 6:22pm revealed: -The MAs at the facility ordered his medications from a local pharmacy, including prescription and over-the-counter (OTC) medications. -When he took the Senexon-S, he had to take "so much" for it to help. -He had taken Senexon-S "very little" since his primary care provider (PCP) started him on Linzess and Miralax (both used to treat and prevent constipation) about 1 to 2 months ago. -His constipation had improved with those 2 medications and he had not needed to request the Senexon-S as often. Interview with a second MA on 01/26/21 at 2:02pm revealed: -Resident #4's medications came from a local pharmacy and the pharmacy would put the resident's OTC medications in the bag with his prescription medications. -She was not sure if anyone checked the resident's OTC medications when received to make sure they matched the orders. -She had not noticed any discrepancies with the resident's OTC medications. -The MAs were supposed to compare the medication labels with the eMARs and let the Memory Care Manager (MCM) know if something did not match. -Resident #4 complained of constipation issues once or twice a week. -Resident #4 had a Stool Softener and she had administered it to the resident. -She did not notice the Stool Softener on hand for Resident #4 did not match the order for Senexon-S. Telephone interview with a third MA on 01/27/21	D 358		

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D 358	Continued From page 34 at 11:33am revealed: -She had never picked up Resident #4's medications from the pharmacy so she did not know who picked out which OTC medications to send for the resident. -Resident #4 had Senexon-S at one time but he ran out in the middle of December 2020 so she gave the Stool Softener because that was what they had on hand. -She reported it to a former supervisor (who no longer worked at the facility) who instructed her to administer what they had on hand. Telephone interview with the Lead MA on 01/27/21 at 1:30pm revealed: -When Resident #4's OTC medications were low in supply, the facility staff (she or a MA) would pick up a new supply at the pharmacy. -When she picked up Resident #4's OTC medications from the pharmacy, she would write down a list of the OTC medications so she could pick up the ones she needed from the pharmacy shelves. -If she was unsure which OTC medication to get, she would ask the pharmacist. -She usually checked the OTC medications when she returned with them to make sure they matched the eMARs and were the correct dose. -She was not sure when she last picked up OTC medications for Resident #4. -The MAs were supposed to check the medication labels and the eMARs when administering medications. -The MAs were supposed to notify her or the MCM and the PCP if a resident was not receiving the correct medication. -No MAs had notified her that some of Resident #4's OTC medications on hand did not match the eMAR. -She also administered medications to Resident	D 358		

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D 358	Continued From page 35 #4 and she had not noticed the OTC medications did not match the orders listed on the eMAR. Telephone interview with a pharmacist at Resident #4's pharmacy provider on 01/28/21 at 1:58pm revealed: -Resident #4's prescription medications were dispensed monthly unless the resident asked them not to fill a medication monthly. -Resident #4's OTC medications were not on the monthly sync program because the OTC medications were not run through their computer system. -The pharmacy staff may assist the facility staff when picking out OTC medications for Resident #4 but some of the facility staff picked out the OTC medications on their own. -A facility staff person called the pharmacy yesterday (01/27/21) about getting the resident's OTC orders ran through the computer system so the OTC orders would be in the computer system and the pharmacist could make sure the correction OTC medications were sent to the facility. Telephone interview with the MCM on 01/26/21 at 5:45pm revealed: -Resident #4's medications were ordered by the MAs from a local pharmacy. -The pharmacy received orders for all of the resident's medications including OTC medications. -The OTC medications should have prescription labels but if not, the OTC medications were probably picked out by the MAs when the MAs went to pick up the resident's prescription medications. -The MAs were supposed to check the medication labels of the OTC medications to make sure they matched the orders listed on the	D 358		

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D 358	Continued From page 36 eMARs. -If the medication label and the eMAR did not match, the MAs should stop and let her know immediately. Telephone interview with Resident #4's PCP on 01/27/21 at 9:04am revealed: -She expected the facility to have the correct medication on hand based on the orders. -She was concerned that staff did not match the medication with the orders. A second telephone interview with the MCM on 01/28/21 at 10:41am revealed: -The MAs should compare labels on medications before administration and if it did not match, the MAs should notify her. -Some MAs were picking up Resident #4's OTC medications themselves but they were not picking up the correct medications. c. Review of Resident #4's current FL-2 dated 04/21/20 revealed: -There was an order for Oysco 500mg 1 tablet twice a day. (Oysco is a calcium supplement.) -There was an order for Vitamin D3 2,000IU 1 tablet once daily. (Vitamin D3 is a supplement used to treat Vitamin D deficiency.) Review of Resident #4's November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Oysco 500mg 1 tablet twice a day scheduled to be administered at 12:00pm and 5:00pm. -Oysco 500mg was documented as administered twice daily from 11/01/20 - 11/30/20. -There was an entry for Vitamin D3 2,000IU take 1 tablet every day scheduled to be administered at 8:00am.	D 358		

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D 358	Continued From page 37 -Vitamin D3 2,000IU was documented as administered once daily from 11/01/20 - 11/30/20. Review of Resident #4's December 2020 eMAR revealed: -There was an entry for Oysco 500mg 1 tablet twice a day scheduled to be administered at 12:00pm and 5:00pm. -Oysco 500mg was documented as administered twice daily from 12/01/20 - 12/31/20. -There was an entry for Vitamin D3 2,000IU take 1 tablet every day scheduled to be administered at 8:00am. -Vitamin D3 2,000IU was documented as administered once daily from 12/01/20 - 12/31/20. Review of Resident #4's January 2021 eMAR revealed: -There was an entry for Oysco 500mg 1 tablet twice a day scheduled to be administered at 12:00pm and 5:00pm. -Oysco 500mg was documented as administered twice daily from 01/01/21 - 01/20/21. -There was an entry for Vitamin D3 2,000IU take 1 tablet every day scheduled to be administered at 8:00am. -Vitamin D3 2,000IU was documented as administered once daily from 01/01/21 - 01/21/21. Observation of Resident #4's medications on hand on 01/21/21 at 12:58pm revealed: -There was 1 bottle of Oscal with Vitamin D3 that contained 500mg of Calcium and 200IU of Vitamin D3. (Oscal with Vitamin D3 is a calcium and Vitamin D3 supplement. Oscal with Vitamin D3 is not the same as Oysco 500mg. Oysco contains 500mg of Calcium but no Vitamin D3.) -The Oscal with Vitamin D3 was in the original manufacturer's container with no prescription labeling and the bottle size was 160 tablets.	D 358		

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D 358	Continued From page 38 -There were 3 of 160 tablets remaining in the bottle. -There was no Oysco 500mg on hand for the resident. -There was also a bottle of Vitamin D3 2,000IU on hand with 70 of 150 softgels remaining. Interview with a medication aide (MA) on 01/21/21 at 12:58pm revealed Oscal with Vitamin D3 was the only supply of Calcium on hand for Resident #4 and this was the supply administered to the resident. Review of Resident #4's physician's orders, e-MARs, and medications on hand revealed: -The resident as receiving Oscal with Vitamin D3 instead of Oysco 500mg (without Vitamin D3) as ordered. -The resident was receiving an additional 400IU of Vitamin D3 daily (200IU twice daily) that was not ordered in addition to the Vitamin D3 2,000IU daily supplement that was ordered. -At least 157 tablets of Oscal with Vitamin D3 had been used from the supply on hand. Telephone interview with Resident #4 on 01/27/21 at 6:22pm revealed: -The MAs at the facility ordered his medications from a local pharmacy, including prescription and over-the-counter (OTC) medications. -The local pharmacy would call him and let him know when the medications were ordered and when they were ready to be picked up. -The facility staff picked up his medications from the local pharmacy. Interview with a second MA on 01/26/21 at 2:02pm revealed: -Resident #4's medications came from a local pharmacy and the pharmacy would put the	D 358		

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D 358	Continued From page 39 resident's OTC medications in the bag with his prescription medications. -She was not sure if anyone checked the resident's OTC medications when received to make sure they matched the orders. -She had not noticed any discrepancies with the resident's OTC medications. -She could not recall seeing Resident #4's Oscal label included Vitamin D3. -The MAs were supposed to compare the medication labels with the eMARs and let the Memory Care Manager (MCM) know if something did not match. Telephone interview with a third MA on 01/27/21 at 11:33am revealed: -Resident #4's medications came from a local pharmacy and the pharmacy sent Resident #4's OTC medications with his prescription medications. -She had never picked up his medications from the pharmacy so she did not know who picked out which OTC medications to send for the resident. -She noticed Resident #4's Oysco did not match the eMAR and she had reported it to the Lead MA over a month ago. -The Lead MA said she would take care of it but the Lead MA instructed her to go ahead and administered what was in the medication cart. Telephone interview with the Lead MA on 01/27/21 at 1:30pm revealed: -When Resident #4's OTC medications were low in supply, the facility staff (she or a MA) would pick up a new supply at the pharmacy. -When she picked up Resident #4's OTC medications from the pharmacy, she would write down a list of the OTC medications so she could pick up the ones she needed from the pharmacy	D 358		

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D 358	Continued From page 40 shelves. -If she was unsure which OTC medication to get, she would ask the pharmacist. -She usually checked the OTC medications when she returned with them to make sure they matched the eMARs and were the correct dose. -She was not sure when she last picked up OTC medications for Resident #4. -The MAs were supposed to check the medication labels and the eMARs when administering medications. -The MAs were supposed to notify her or the MCM and the primary care provider (PCP) if a resident was not receiving the correct medication. -No MAs had notified her that some of Resident #4's OTC medications on hand did not match the eMAR. -She also administered medications to Resident #4 and she had not noticed the OTC medications did not match the orders listed on the eMAR. Telephone interview with a pharmacist at Resident #4's pharmacy provider on 01/28/21 at 1:58pm revealed: -Resident #4's prescription medications were dispensed monthly unless the resident asked them not to fill a medication monthly. -Resident #4's OTC medications were not on the monthly sync program because the OTC medications were not run through their computer system. -The pharmacy staff may assist the facility staff when picking out OTC medications for Resident #4 but some of the facility staff picked out the OTC medications on their own. -A facility staff person called the pharmacy yesterday (01/27/21) about getting the resident's OTC orders ran through the computer system so the OTC orders would be in the computer system and the pharmacist could make sure the	D 358		

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D 358	Continued From page 41 correction OTC medications were sent to the facility. Telephone interview with the MCM on 01/26/21 at 5:45pm revealed: -Resident #4's medications were ordered by the MAs from a local pharmacy. -The pharmacy received orders for all of the resident's medications including OTC medications. -The OTC medications should have prescription labels but if not, the OTC medications were probably picked out by the MAs when the MAs went to pick up the resident's prescription medications. -The MAs were supposed to check the labels of the OTC medications to make sure they matched the orders listed on the eMARs. -If the medication label and the eMAR did not match, the MAs should stop and let her know immediately. -Resident #4 should not be getting Oscal with Vitamin D3 because that would be too much Vitamin D3 since the resident was already receiving Vitamin D3 2000IU. Telephone interview with Resident #4's PCP on 01/27/21 at 9:04am revealed: -She expected the facility to have the correct medication on hand based on the orders. -She was not too concerned that Resident #4 had gotten too much Vitamin D since he received the wrong calcium supplement but she was concerned that staff did not match the medication with the orders. A second telephone interview with the MCM on 01/28/21 at 10:41am revealed: -The MAs should compare labels on medications before administration and if it did not match, the	D 358		

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D 358	Continued From page 42 MAs should notify her. -Some MAs were picking up Resident #4's OTC medications themselves but they were not picking up the correct medications. -She was starting a new system and from now on, all OTC medication orders would be sent to the pharmacy and processed by the pharmacy so the correct medications would be sent. 3. Review of Resident #1's current FL-2 dated 06/04/20 revealed: -Diagnoses included dementia with behavioral disturbances, agitation, memory loss, hypothyroidism, hyperlipidemia, hypertension, renal insufficiency, and diverticulosis. -There was an order for Amlodipine 2.5 mg, with instructions to take 1 tablet daily (Amlodipine is a medication used to treat high blood pressure.) -There was an order for Hydrochlorothiazide 12.5 mg, with instructions to take 1 capsule daily (Hydrochlorothiazide is a medication used to treat high blood pressure.) Review of Resident #1's physician orders dated 12/08/20 revealed an order for weekly blood pressure and pulse. Review of Resident #1's Resident Progress Note dated 12/24/20 at 11:00pm revealed a blood pressure of 109/89. Review of Resident #1's Emergency Room Visit Note dated 12/25/20 revealed: -Resident #1 was brought in by Emergency Medical Services (EMS) with a chief complaint of altered mental status. -Resident #1's blood pressure on arrival to hospital on 12/24/20 at 11:36pm was 87/46. -Resident #1's blood pressure on 12/25/20 at 12:15am was 91/40.	D 358		

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D 358	Continued From page 43 -Resident #1's blood pressure on 12/25/20 at 1:18am was 88/52. -The resident's blood pressure medications should be held until seen by the primary care provider (PCP). Review of Resident #1's Resident Progress Note dated 12/25/20 at 4:16am revealed: -The resident returned from the hospital with instructions to hold Hydrochlorothiazide and Amlodipine until PCP was contacted. -The resident's blood pressure on return from the hospital was 103/68. -The continuation of these medications could worsen the resident's hypotension. Review of Resident #1's December 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Amlodipine 2.5 mg, with instructions to take one tablet daily. -There was documentation beside the Amlodipine entry which read "order on hold from 12/29/20 to 1/05/21." -There was an entry for Hydrochlorothiazide 12.5 mg, with instructions to take 1 capsule daily. -There was documentation beside the Hydrochlorothiazide entry which read "order on hold from 12/29/20 to 1/05/21." -Amlodipine 2.5 mg was documented as administered on 12/26/20 at 8:00am. -Hydrochlorothiazide 12.5 mg was documented as administered on 12/26/20 at 8:00am. -Amlodipine 2.5 mg was documented as administered on 12/27/20 at 8:00am. -Hydrochlorothiazide 12.5 mg was documented as administered on 12/27/20 at 8:00am. -Amlodipine 2.5 mg was documented as administered 12/28/20 at 8:00am. -Hydrochlorothiazide 12.5 mg was documented	D 358		

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D 358	Continued From page 44 as administered on 12/28/20 at 8:00am. -Amlodipine 2.5 mg was documented as administered on 12/29/20 at 8:00am. -Hydrochlorothiazide 12.5 mg was documented as administered on 12/29/20 at 8:00am. -Amlodipine 2.5 mg was documented as administered on 12/30/20 at 8:00am. -Hydrochlorothiazide 12.5 mg was documented as administered on 12/30/20 at 8:00am. Review of Resident #1's December 2020 electronic care record revealed a blood pressure reading of 121/64 on 12/31/20. Review of Resident #1's January 2021 eMAR revealed: -There was an entry for Amlodipine 2.5 mg, with instructions to take one tablet daily. -There was documentation beside the Amlodipine entry which read "order on hold from 12/29/20 to 1/05/21." -There was an entry for Hydrochlorothiazide 12.5 mg, with instructions to take 1 capsule daily. -There was documentation beside the Hydrochlorothiazide entry which read "order on hold from 12/29/20 to 1/05/21." -Amlodipine 2.5 mg was documented as administered on 01/01/21 at 8:00am. -Hydrochlorothiazide 12.5 mg was documented as administered on 01/01/21 at 8:00am. -Amlodipine 2.5 mg was documented as administered on 01/03/21 at 8:00am. -Hydrochlorothiazide 12.5 mg was documented as administered on 01/03/21 at 8:00am. -Amlodipine 2.5 mg was documented as administered on 01/04/21 at 8:00am. -Hydrochlorothiazide 12.5 mg was documented as administered on 01/04/21 at 8:00am. Review of Resident #1's Physician's Visit Note	D 358		

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D 358	Continued From page 46 -The process for a resident returning from the emergency room with new orders was that the MA receiving the resident faxed the orders to the pharmacy. -The MA or LMA would change the order on the eMAR. -The MCM would check that the order was correct on the eMAR. -The facility had a 'bucket system' in place to review new orders and discharge summaries to ensure orders are placed correctly. -The PCP was notified 01/04/21 that Resident #1 needed to be seen for a hospital follow up visit from 12/25/20. Telephone interview with the Administrator on 01/28/21 at 3:19pm revealed: -When a resident returned from the emergency room with new orders, it was the MCM's responsibility to ensure the orders are initiated and correct. -Her expectation when a resident returned to the facility from the emergency room with orders to hold a medication until seen by the PCP was that the medication would be held until seen by the PCP. Telephone interview with Resident #1's PCP on 01/27/21 at 9:06am revealed: -She was notified by the MCM that she needed to see the resident 01/04/21 for a post emergency room visit. -She examined the resident on 01/05/21 for his emergency room visit follow up. -She would expected staff to hold the residents blood pressure medication as instructed by the discharge instructions until she examined the resident. -The resident was at risk for hypotension because he was still receiving his blood pressure	D 358		

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D 358	Continued From page 47 medications. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. 4. Review of Resident #7's current FL-2 dated 01/12/21 revealed diagnoses included hypertension, cardiac dysrhythmia, osteoporosis, central opacity of right cornea, controlled type 2 diabetes without complications, and hypokalemia. Interview with Resident #7 on 01/20/21 at 12:54pm revealed: -She went to the eye doctor and "for the last couple of weeks" she had not been administered prescribed eye drops. -She used to get eye drops administered at night. -"I need my eye drops". -She did not know the name of the eye drops. -She did not have any eye pain. Review of a follow up eye examination report for Resident #7 dated 07/28/20 revealed: -Resident #7 had a diagnosis of primary open-angle glaucoma, bilateral, indeterminate stage. -The resident's eye medication plan was to continue Latanoprost (used to treat glaucoma) in the left eye at bedtime. Review of physician orders for Resident #7 revealed: -There was a physician's order dated 01/02/20 which included an order for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at bedtime. - There was a physician's order sheet dated 01/12/21 which included an order for Latanoprost drops 0.005% ophthalmic instill one drop into left	D 358		

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D 358	Continued From page 48 eye at bedtime. -There was a prescription dated 01/18/21 for Latanoprost 0.005% eye drops one drop in left eye at bedtime. There were eleven refills to the prescription. Review of the November 2020 electronic medication administration record (eMAR) for Resident #7 revealed: -There was an entry for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at bedtime with scheduled administration time of 8:00pm. -Latanoprost 0.005% was documented as administered every evening from 11/01/20 - 11/29/20. -Latanoprost 0.005% was not documented as administered on 11/30/20 due to "unable to find this cream". Review of the December 2020 eMAR for Resident #7 revealed: -There was an entry for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at bedtime with scheduled administration time of 8:00pm. -Latanoprost 0.005% was not documented as administered 8 of 31 days. -On 12/02/20 at 7:37pm, the medication aide (MA) documented "not administered: refused" for the Latanoprost 0.005% eye drops. -On 12/09/20 at 7:17pm, the MA documented "not administered: refused" for the Latanoprost 0.005% eye drops. -On 12/15/20 at 9:18pm, the MA documented "not administered: med tech overlooked meds" for the Latanoprost 0.005% eye drops. -On 12/19/20 at 8:08pm, the MA documented "not administered: med tech overlooked meds" for the Latanoprost 0.005% eye drops.	D 358		

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D 358	Continued From page 49 -On 12/20/20 at 8:12pm, the MA documented "not administered: drug/item unavailable" for the Latanoprost 0.005% eye drops. -On 12/23/20 at 7:29pm, the MA documented "not administered: med tech overlooked meds" for the Latanoprost 0.005% eye drops. -On 12/24/20 at 7:56pm, the MA documented "not administered: med tech overlooked meds" for the Latanoprost 0.005% eye drops. -On 12/29/20 at 8:30pm, the MA documented "not administered: med tech overlooked meds" for the Latanoprost 0.005% eye drops. Review of the January 2021 eMAR for Resident #7 revealed: -There was an entry for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at bedtime with scheduled administration time of 8:00pm. -Latanoprost 0.005% was not documented as administered 12 of 20 days. -On 01/03/21 at 8:15pm, the MA documented "not administered: med tech overlooked meds" for the Latanoprost 0.005% eye drops. -On 01/04/21-01/06/21, 01/10/21, and 01/18/21, the MA documented "not administered: drug/item unavailable" for the Latanoprost 0.005% eye drops. -On 01/09/21 and 01/13/21-01/16/21, the MA documented "not administered: unable to find" for the Latanoprost 0.005% eye drops. -On 01/17/21 at 8:05pm, the MA documented "not administered: drug/item unavailable: waiting on refill from [doctor]" for the Latanoprost 0.005% eye drops. Telephone interview with a MA on 01/26/21 at 2:37pm revealed: -She did not reorder medication because she worked at night and left medication bottles out for	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 50 day shift to reorder medications. -Resident #7 "recently" did not have eye drops. -The resident did not have eye drops for "a week or longer". -She was not sure what happened to Resident #7's eye drops. -If Resident #7 did not have any eye drops on hand, she was not administering any eye drops to the resident. -She did not remember documenting on the eMARs that the medication was "overlooked" by the MA. -When she documented on the eMAR "med unavailable" it meant the medication was not in the medcart. -When Resident #7 was out of eye drops, she let the previous Memory Care Manager (MCM) know. -The facility had to wait for the physician to call in a refill prescription. -She thought the MCM was responsible for contacting the primary care provider (PCP) for medication refills. Telephone interview with a second MA on 01/26/21 at 3:25pm revealed: -The MCM was responsible for reordering resident medications. -She had never reordered eye drops for Resident #7. -There had been times in the last month that there were no eye drops for Resident #7. -Resident #7's eye drops had not been available for a couple weeks - "maybe two weeks". -When she was not able to administer the eye drops she documented on the eMARs that the eye drops were not available or unable to find the medication in the medcart. Review of the provider pharmacy dispensing	D 358		

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D 358	Continued From page 51 record for Resident #7's Latanoprost eye drops revealed Latanoprost 0.005% eye drops 2.5 milliliters were dispensed on 12/20/19, 03/24/20, 04/20/20, 05/20/20, 06/20/20, and 01/15/21. Telephone interview with the provider pharmacy technician on 01/21/21 at 10:52am revealed: -The Latanoprost was filled on 01/15/21 after receiving a new prescription from the physician. -Each bottle of Latanoprost dispensed should last for six weeks when administering one drop to the left eye at bedtime according to the physician instructions. -She remembered telephone conversations with former facility staff about the Latanoprost eye drops but did not know if anyone at the facility had contacted the physician about the Latanoprost eye drops. -She would have expected the facility to call the physician. Telephone interview with Resident #7's Ophthalmologist front desk staff on 01/21/21 at 11:20am revealed: -Resident #7 had glaucoma in the left eye. -The resident was prescribed Latanoprost 0.005% eye drops instill one drop in the left eye at bedtime. -A prescription was written in August 2019 with 12 refills for the Latanoprost. -The resident had an office visit on 07/28/20 and a prescription was provided for the Latanoprost eye drops. -Two telephone calls were received on 01/15/21 from a family member for Resident #7 saying the resident needed to be seen before the eye drops could be refilled. Telephone interview with Resident #7's family member on 01/25/21 at 3:54pm revealed:	D 358		

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D 358	Continued From page 52 -She thought there had been a "mix up" with Resident #7's eye drops because the resident had been telling the family member "for a while" that she was not being administered the eye drops. -The family member spoke to the resident every day and attended physician appointments with the resident. -She got a written report from the facility of medications being administered to Resident #7. -She noticed from review of the resident's medications in November 2020 that the resident's eye drops were not being filled. -She called the provider pharmacy about the eye drops about two weeks ago and was informed a new prescription was needed. -The provider pharmacy contacted the eye doctor for a prescription refill after the family member called the eye doctor. -The facility had not reordered the Latanoprost eye drops. Telephone interview with the provider pharmacy Pharmacist on 01/26/21 at 9:35am revealed: -Resident #7's family member communicated monthly with the pharmacy about Resident #7's pharmacy bill. -Resident #7 was prescribed Latanoprost 0.005% eye drops instill one drop in left eye at bedtime. -The Latanoprost was dispensed to the facility in 2.5 milliliter bottles, which was a supply for 50 days. -There was a possibility that Resident #7 could have had an overstock of the medication. -There were no refills for the Latanoprost dispensed to the facility between 06/20/20 and 01/15/21. -She did not know if the Latanoprost had been filled for Resident #7 at another pharmacy. -The Latanoprost was used for glaucoma and if	D 358		

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D 358	Continued From page 53 not administered there could be worsening of the glaucoma. The resident may be complaining about her eye sight. Telephone interview with Resident #7's Ophthalmologist on 01/26/21 at 10:50am revealed: -Latanoprost was prescribed for glaucoma and used one time a day for increased intraocular pressure. -The resident needed to get the eye drops because there could be vision loss if not administered as ordered. -A person could go blind if the eye pressure did not come down. Telephone interview with the PCP's office assistant supervisor on 01/26/21 at 11:55am revealed: -She did not see any documentation from the facility requesting a refill prescription of the Latanoprost for Resident #7 in the office electronic system. -A prescription was written on 01/18/21 with 11 refills for Resident #7's Latanoprost 0.005% eye drops instill one drop in left eye at bedtime. -The PCP would expect the facility to contact the office if a prescription refill was needed. Telephone interview with the previous MCM on 01/27/21 at 2:03pm revealed: -She was the MCM from 06/19/20 - 01/12/21 and was now the lead MA. -She saw on Resident #7's eMARs that the resident did not get her eye drops 01/03/21 - 01/10/21 and did not know what she did to correct the issue. -She was aware Resident #7's Latanoprost eye drops were not available for administration. -She did not remember if the physician was	D 358		

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D 358	Continued From page 54 contacted about the eye drops being unavailable. -She would have been responsible to contact the physician. Telephone interview with the current MCM on 01/28/21 at 12:45pm revealed: -Upon her employment at the facility, she was informed by the MA that Resident #7 had "missed" her eye drops. -She checked the medication cart for Resident #7's Latanoprost eye drops and there were no eye drops for Resident #7. -There was an order for the eye drops on the 12/04/20 FL-2. -She thought the MAs knew to send the new FL-2 to the pharmacy. -She obtained another order from the physician on 01/18/21 for the Latanoprost eye drops. Telephone interview with the Administrator on 01/28/21 at 3:35pm revealed: -She expected all resident medications to be in the facility for administration. -The lead MA was responsible for completing medication cart audits and the MCM was responsible to follow up on the cart audits. 5. Review of Resident #5's current FL-2 dated 02/25/20 revealed diagnoses included hypertension, coronary artery disease, cirrhosis, esophageal varices, osteoarthritis, mild dementia, bipolar, and hyponatremia. Review of Resident #5's physician's orders dated 12/04/20 revealed: -There was an order for Eliquis 5mg take 1 tablet twice daily. (Eliquis is used to prevent blood clots.) -There was an order for Enulose solution 10gm/15ml take 30ml twice daily. (Enulose is a	D 358		

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D 358	Continued From page 55 laxative for constipation.) -There was an order for Ferrous Sulfate 325mg take 1 tablet twice a day. (Ferrous Sulfate is an iron supplement.) -There was an order for Gabapentin 100mg take 1 capsule 3 times a day. (Gabapentin may be used to treat mood disorders.) -There was an order for Levetiracetam 500mg take 1 table twice daily. (Levetiracetam may be used to treat mood disorders.) -There was an order for Metoprolol 50mg take 1 tablet twice daily. (Metoprolol is used to treat high blood pressure.) -There was an order for Spironolactone 25mg take 1 tablet once a day. (Spironolactone is used to treat high blood pressure.) -There was an order for Vitamin B1 100mg take 1 tablet once a day. (Vitamin B1 is a supplement.) Review of Resident #5's January 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Eliquis 5mg take 1 tablet twice daily scheduled for 8:00am and 8:00pm. -Eliquis was documented as not administered on 01/08/21 at 8:00am due to "waiting on meds". -There was an entry for Enulose solution 10gm/15ml take 30ml twice daily scheduled for 8:00am and 8:00pm. -Enulose was documented as not administered on 01/08/21 at 8:00am due to "waiting on meds". -There was an entry for Ferrous Sulfate 325mg take 1 tablet twice a day scheduled for 8:00am and 8:00pm. -Ferrous Sulfate was documented as not administered on 01/08/21 at 8:00am due to "waiting on meds". -There was an entry for Gabapentin 100mg take 1 capsule 3 times a day scheduled for 8:00am, 2:00pm, and 8:00pm.	D 358		

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D 358	Continued From page 56 -Gabapentin was documented as not administered on 01/08/21 at 8:00am and 2:00pm due to "waiting on meds". -There was an entry for Levetiracetam 500mg take 1 table twice daily scheduled for 8:00am and 8:00pm. -Levetiracetam was documented as not administered on 01/08/21 at 8:00am due to "waiting on meds". -There was an entry for Metoprolol 50mg take 1 tablet twice daily scheduled for 8:00am and 8:00pm. -Metoprolol was documented as not administered on 01/08/21 at 8:00am due to "waiting". -There was an entry for Spironolactone 25mg take 1 tablet once a day scheduled for 8:00am. -Spironolactone was documented as not administered on 01/08/21 at 8:00am due to "waiting on meds". -There was an entry for Vitamin B1 100mg take 1 tablet once a day scheduled for 8:00am. -Vitamin B1 was documented as not administered on 01/08/21 at 8:00am due to "waiting on meds". Review of Resident #5's progress notes dated 01/08/21 revealed: -Resident #5 refused to pay her current pharmacy bill and had switched to a new pharmacy today. -A physician order was sent to the new pharmacy. Telephone interview with the pharmacist on 01/28/21 at 2:29pm revealed she received an order for Resident #5 on 01/08/21 and the medications were picked up on 01/08/21 at 5:19pm by a medication aide (MA) from the facility. Telephone interview with the facility biller for Resident #5's previous pharmacy on 01/28/21 at 4:05pm revealed Resident #5's account was	D 358		

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D 358	Continued From page 57 placed on hold on 12/28/20 for nonpayment of services. Confidential interview revealed: -Resident #5 was without medications all day on 01/08/21 because the previous pharmacy did not send the multi-dose packs of medications. -Resident #5 had not paid her pharmacy bill. Telephone interview with Resident #5's PCP on 01/27/21 at 10:29am revealed: -She was not aware of Resident #5 missing doses of medications on 01/08/21. -The facility would normally notify her if a resident was out of medications. Telephone interview with the MCM on 01/28/21 at 10:40am revealed Resident #5 had accrued a high bill with the previous pharmacy. The facility failed to ensure medications were administered as ordered for 2 residents observed during the medication pass and for 4 residents sampled. The facility failed to hold 2 blood pressure medications for Resident #1 as ordered after returning to the facility from a hospital visit in which the resident was noted to have low blood pressure readings of 87/46, 91/40, and 88/52. Resident #4, who had a history of insomnia, was administered Melatonin 3mg instead Melatonin 10mg as ordered even after staff noticed the discrepancy, they continued to administer the wrong dose because that was the supply on hand. Resident #7 did not receive her eye drops for glaucoma due to the medication being unavailable placing the resident at risk of increased intraocular eye pressure in her left eye and vision loss. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B	D 358		

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D 358	Continued From page 58 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/28/21 for this violation.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication aides observed residents taking their medication for 2 of 2 residents sampled (#11, #12) one of which was on the special care unit (SCU). The findings are: Confidential interview with a resident revealed: -Medications were put in a little cup and brought in the resident's room by the medication aides (MAs). -The MAs did not always stay in the room until the resident took the medications. -The MAs would just give the resident the medication and "go on". -The MAs were supposed to "stay til I take it, but	D 366	10A NCAC 13F .1004(i) Medication Administration Medication Techs will assure documentation of administration is completed immediately following the administration. Pre-charting is prohibited Medication Techs will assure they observe all residents actually taking the medication prior to adminstration of another residents medication. Care Manager or designee will conduct weekly monitoring of medication techs administering medications to ensure residents are observed taking their medication. Addendum a RCC and Adm, via phone 03.17.21 @ 11:15 am / ABV	2/12/2021 2/12/2021 2/12/2021

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D 366	Continued From page 59 a lot of them just give it to me and go right on". -The MAs "have to keep moving". -The resident had accidentally dropped medication on the floor and would pick the medication up from the floor and take the medication. Confidential interview with a second resident revealed: -A couple of MAs would leave the medications with the resident to take without observing the resident take the medications. -The MAs knew the resident would take the medication; they "trust me". Confidential interview with a third resident revealed: -Staff left the resident's medications lying on the nightstand or table beside the resident's bed if the resident was asleep or not ready to take the medications. -Staff made sure the resident took their pain medicine while the staff was present. 1. Review of Resident #11's current FL-2 dated 07/14/20 revealed: -Diagnoses of vascular dementia, folate deficiency disease, major depressive disorder, hypertension, acute pancreatitis, and type 2 diabetes. -The resident was constantly disoriented. -There was an order for Omeprazole 20 mg capsule with instructions to administer 1 capsule by mouth every other day at 6:00am. (Omeprazole is a medication used to treat acid reflux.) Observation of Resident #11's suite on 01/20/21 at 1:42pm revealed: -There were two twin beds in room to the left and	D 366	Facility Care Manager and/or Lead Supervisor is responible for assuring all medications are approved accuately on the EMAR. Care Manager is responible for assuring that Medication Techs are aware when residents should a prescribing pracititioner change, prescribed or place medications on hold. Medication Techs, Lead SIC and Care Manager have received training on the following: - 6 rights of Medication Administration - Clarification of Medication Orders - Controlled Substance - Medication Errors - Medication Storage - Proper Medication Storage and Disposal Training Conducted by RN on 1/27/2021, 2/11/2021	2/12/2021 2/12/2021

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D 366	Continued From page 60 a couch and recliner in the room to the right. -Resident #11 and his family member stayed together in the suite as roomates in the special care unit (SCU). Telephone interview with a medication aide (MA) on 01/26/21 at 2:02pm revealed: -Resident #11 didn't like to be woken up in the morning to take his medicine. -Resident #11 asked to leave the Omeprazole on his bedside table so that he wouldn't be woken up. -When she worked the SCU, she left Resident #11's Omeprazole in a medicine cup at his bedside. -She documented Resident #11's Omeprazole as administered even though she did not observe him take the medication. -She was told that Resident #11 was only on the SCU because he wanted to stay with his family member who was confused. Review of Resident #11's December 2020 electronic medication administration record (eMAR) revealed the MA that left the Omeprazole at the bedside for the resident to take later administered the medication 5 times at 6:00am. Review of Resident #11's January 2021 eMAR revealed the MA that left the Omeprazole at the bedside for the resident to take later administered the medication 4 times at 6:00am. Based on observations, interviews, and record reviews it was determine Resident #11 was not interviewable. Refer to the telephone interview with the MA on 01/26/21 at 2:20pm.	D 366		

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D 366	Continued From page 61 Refer to the telephone interview with the Lead MA on 01/27/21 at 1:33pm. Refer to the telephone interview with the Memory Care Manager (MCM) on 01/28/21 at 10:38am. Refer to the telephone interview with the Administrator on 01/28/21 at 3:19pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 01/27/21 at 9:04am. 2. Review of Resident #12's current FL-2 dated 01/12/21 revealed: -Diagnoses of hemiplegia, hypertension, osteoarthritis, hemiplegia, muscle weakness, lack of coordination and constipation. -The resident was intermittently disoriented. -There was an order for Pantoprazole delayed release 40 mg capsule with instructions to administer 1 capsule by mouth every morning at 7:00am for gastroesophageal reflux disease (GERD). (Pantoprazole is a medication used to treat GERD.) Telephone interview with a medication aide (MA) on 01/26/21 at 2:02pm revealed: -Resident #12 didn't like to be woken up in the morning to take his medicine. -Resident #12 asked to leave the Pantoprazole on his bedside take so that he wouldn't be woken up. -She documented Resident #12's Pantoprazole as administered even though she did not observe him take the medication. Review of Resident #12's December 2020 electronic medication administration record (eMAR) revealed the MA that left the	D 366		

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D 366	Continued From page 62 Pantoprazole at the bedside for the resident to take later administered the medication 12 times at 6:00 am. Resident #12 was not available for interview. Refer to the telephone interview with the MA on 01/26/21 at 2:20pm. Refer to the telephone interview with the Lead MA on 01/27/21 at 1:33pm. Refer to the telephone interview with the Memory Care Manager (MCM) on 01/28/21 at 10:38am. Refer to the telephone interview with the Administrator on 01/28/21 at 3:19pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 01/27/21 at 9:04am. _____ Telephone interview with a medication aide (MA) on 01/26/21 at 2:02pm revealed: -She asked the Lead MA multiple times about instructions for leaving medication at the bedside for residents to take. -She asked the Lead MA if the residents needed a bedside order to leave the medication but never received a response. Telephone interview with the Lead MA on 01/27/21 at 1:33pm revealed: -MA should watch all residents swallow their medications. -If a resident did not want their medication when prepared, you were supposed to put the medication back in the locked cart and try again later. -She did not noticed any staff leaving medications	D 366		

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D 366	Continued From page 63 at residents' bedside. Telephone interview with the Memory Care Manager (MCM) on 01/28/21 at 10:38am revealed: -It was not acceptable for staff to leave medications at the bedside. -She was not aware staff was leaving medications at the bedside. -Medications should not be documented as administered until staff visualizes the resident swallowing the medication. Telephone interview with the Administrator on 01/28/21 at 3:19pm revealed: -It was not acceptable for staff to leave medications at the bedside. -She was not aware staff was leaving medications at the bedside. -She was not aware that staff was not observing residents swallow their medications. -Staff should observe residents take their medications. Telephone interview with the facility's contracted primary care provider (PCP) on 01/27/21 at 9:04am revealed: -She had concerns about the MAs leaving medications in a resident's room without observing the resident take the medication, especially in the special care unit (SCU). -Her concerns would be if the resident actually took the medication or if another resident wandered into the room and took that medication. -She was also concerned whether the resident would have enough cognition to know to take the medication.	D 366		

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D 367	Continued From page 64	D 367		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering 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 facility failed to ensure the medication administration records were accurate for 2 of 5 residents sampled (#1, #4) including inaccurate documentation of a muscle relaxer (#4) and a controlled substance medication used to treat anxiety (#1). The findings are: 1. Review of Resident #4's current FL-2 dated 04/21/20 revealed: -Diagnoses included Parkinson's disease, status	D 367	10A NCAC 13F .1004(j) Medication Administration Care Manager, ED and Lead SIC have completed audit and review of all Medication Administration Records to assure accuracy. Care Manager, ED and Lead SIC have notified and/or clarified any inacurate information on EMARs. n Documentation of notification/clarification is documented in residents progress notes. Medication Techs are responible for administration of medications, including but not limited to PRN medications. Medication Techs will assure proper documentation of administration of all medications, including PRNs. Medication Techs will assure proper documentation\ for effectiveness of PRNs. Care Manager, ED and/or Lead SIC will review Facility Activity reports during daily stand up meetings. Medication Techs, Lead SIC and Care Manager have received training on the following: - 6 rights of Medication Administration - Clarification of Medication Orders - Controlled Substance - Medication Errors - Medication Storage - Proper Medication Storage and Disposal Training Conducted by RN on 1/27/2021, 2/11/2021 - Lead SIC will complete weekly cart audits including MAR review for complete orders. Care Manager will clarify any MARS/Med orders to ensure accuracy. — Addendum to RCC and Adm. via phone on 3/17/21 @ 11:15 am ADV	2/12/2021 2/12/2021 2/12/2021 2/12/2021 2/12/2021 2/12/2021

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D 367	Continued From page 65 post liver transplant, right and left artificial knees, benign prostatic hypertrophy, chronic viral Hepatitis C, tension-type headache, muscle spasms, thrombocytopenia, and insomnia. -There was an order for Baclofen 10mg 1 tablet 3 times a day as needed for spasms. (Baclofen is a muscle relaxer used to treat muscle spasms.) Review of Resident #4's pharmacy dispensing records dated 09/01/20 - 01/26/21 revealed: -There were 90 Baclofen 10mg tablets dispensed on 11/23/20. -There were 90 Baclofen 10mg tablets dispensed on 12/19/20. Observation of Resident #4's medications on hand on 01/21/21 at 12:58pm revealed: -There was one bottle of Baclofen dispensed on 11/23/20 with 90 tablets. -There were 44 of 90 tablets remaining in the bottle dated 11/23/20. -There was a second bottle of Baclofen dispensed on 12/19/20 with 90 tablets. -There were 76 of 90 tablets remaining in the bottle dated 12/19/20. -There were 60 tablets that had been used from the supplies of Baclofen dispensed since 11/23/20. Review of Resident #4's November 2020 - January 2021 electronic medication administration records (eMARs) revealed: -There was an entry for Baclofen 10mg 1 tablet 3 times a day as needed for spasms on each of the eMARs. -Baclofen was documented as administered on 24 occasions from 11/23/20 - 01/21/21. Review of Resident #4's medications on hand, pharmacy dispensing records, and eMARs	D 367		

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D 367	Continued From page 66 revealed: -There were 180 Baclofen 10mg tablets dispensed from 11/23/20 - 01/21/21. -There were 120 of the 180 Baclofen 10mg tablets remaining on hand on 01/21/21, with a total of 60 tablets being used from the supply. -There were only 24 of 60 tablets documented as administered on the November 2020 - January 2021 eMARs. -The other 36 tablets were not documented as administered on the November 2020 - January 2021 eMARs. Telephone interview with Resident #4 on 01/27/21 at 6:22pm revealed: -He took Baclofen for spasms in his left leg especially when it would cramp up. -He sometimes took Baclofen 3 times a week and some weeks, he did not take any Baclofen. -He tried not to request and take the Baclofen in the afternoon because it made him feel "sluggish". Telephone interview with a medication aide (MA) on 01/26/21 at 3:44pm revealed: -Resident #4 was administered Baclofen as needed for spasms. -The resident sometimes took Baclofen a couple of times a week and sometimes he went "a while" without asking for it. Telephone interview with a second MA on 01/27/21 at 11:33am revealed: -Resident #4 requested Baclofen about once every 2 or 3 weeks. -The MAs were supposed to document the Baclofen on the eMAR each time it was administered. Telephone interview with the Lead MA on	D 367		

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D 367	Continued From page 67 01/27/21 at 1:30pm revealed: -She did not recall administering any Baclofen to Resident #4. -When MAs administered Baclofen as needed, it should be documented on the eMAR. -She did not know why more Baclofen had been used than had been documented on the eMAR. Telephone interview with Resident #4's primary care provider (PCP) on 01/27/21 at 9:04am revealed she expected staff to document on the eMAR when Baclofen was administered. 2. Review of Resident #1's current FL-2 dated 06/04/20 revealed diagnoses of dementia with behavioral disturbances, agitation, memory loss, hypothyroidism, hyperlipidemia, hypertension, renal insufficiency, and diverticulosis. Review of Resident #1's medication orders dated 12/08/20 revealed an order for Alprazolam 1 mg with instructions to take 1 tablet every 6 hours as needed (PRN) for agitation or anxiety. (Alprazolam is a medication used to treat agitation or anxiety). Review of Resident #1's January 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Alprazolam 1 mg tablet 1 tablet every 6 hours PRN for agitation and anxiety. -Alprazolam was documented as administered on 01/12/21 at 10:32am. -The PRN reason documented was 'pain'. Review of Resident #1's January 2021 resident progress notes revealed no entry for 01/12/21. Telephone interview with a medication aide (MA)	D 367		

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D 367	Continued From page 68 on 01/26/21 at 3:54pm revealed: -She administered Resident #1's PRN Alprazolam dose on 01/12/21 at 10:32am. -She selected the wrong PRN option on the eMAR dropdown list. -She intended to select agitation on the PRN options, not pain. -She administered the medication to Resident #1 because he started to get agitated with the staff. -She would document a note in the resident's progress notes to describe the resident's behaviors. -She did not know why there was not a resident progress note to reflect Resident #1's behaviors on 01/12/21. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the medication passes on 01/20/21 and 01/21/20 by 2 of 2 medication aides observed who failed to	D 371	10 NCAC 13F .1004(n) Medication Administration Facility Medication Techs,Care Manager, and ED will assure that medications are administrered in accordance with infection control measures. Care Manager, Lead SIC and/or ED will observe no less than one medication pass weekly, then no less than twice monthly to assure proper infection control measures are being utilized during Medication Administration Facility Care Manager and/or Lead SIC will notify ED of any Medication Tech who is found not observing residents take medication, and/or following infection control mesures pre-charting will be removed from Medication Cart til retraining has occurred and competency is validated by Licensed Health Professional.	2/12/2021 2/12/2021 2/12/2021

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D 371	Continued From page 69 wash or sanitize their hands prior to preparing and after administering insulin and oral medications to multiple residents; and sharing eye drops between two residents (#7, #13). The findings are: 1. Observation of a medication aide (MA) administering medications on the assisted living (AL) hall on 01/20/21 from 1:24pm - 1:29pm revealed: -There was no hand sanitizer on the medication cart. -The MA prepared and administered an oral medication to a resident at 1:24pm. -The MA did not sanitize or wash her hands prior to preparing the medications or after administering the medications and she was not wearing gloves. -The MA prepared and administered an oral medication to a second resident at 1:29pm. -The MA then pushed the medication cart to the nurses' station to store it in the medication room. -The MA used some hand sanitizer sitting on the desk at the nurses' station. Observation of the same MA administering medications on the AL hall on 01/21/21 from 7:39am - 7:53am revealed: -There was no hand sanitizer on the medication cart. -The MA prepared and administered oral medications to a resident at 7:45am. -The MA did not sanitize or wash her hands prior to preparing the medications or after administering the medications and she was not wearing gloves. -The MA prepared and administered oral medications to a second resident at 7:52am. -The MA did not sanitize or wash her hands prior	D 371	Continued from page 69 Medication Techs, Lead SIC and Care Manager have received training on the following: - Proper Infection Control while administrating Medications - 6 rights of Medication Administration - Clarification of Medication Orders - Controlled Substance - Medication Errors - Medication Storage - Proper Medication Storage and Disposal Training Conducted by RN on 1/27/2021, 2/11/2021 Lead SIC or care Manager will ensure hand sanitizers and gloves are on the carts during the weekly cart audits. Addendum added via phone conversation on 3/17/21 @ 11:15 am ABV	2/12/2021

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D 371	Continued From page 70	D 371		

to preparing the medications and she was not wearing gloves.
-The MA was touching the surface of the medication cart and used her hands to open and close a resident's door during this time.
-The MA then pushed the medication cart to the nurses' station and used the hand sanitizer sitting on the desk at the nurses' station.
-The MA then continued down the hall to administer more medications without taking the hand sanitizer with her.

Interview with the MA on 01/21/21 at 11:05am revealed:
-She was supposed to sanitize her hands after each resident when passing medications.
-She usually kept hand sanitizer on the medication cart but it was on the desk at the nurses' station that morning on 01/21/21.

Observation of the Lead MA administering medications in the special care unit (SCU) on 01/21/21 from 8:05am - 8:28am revealed:
-There was no hand sanitizer on the medication cart.
-The Lead MA was at the cart and had an insulin pen and some medications in a cup in her ungloved hands.
-The Lead MA entered the resident's room and when returned to the medication cart, she used her ungloved hands to unscrew the pen needle on the insulin pen and dispose of it in the sharp's container.
-The Lead MA did not sanitize or wash her hands after disposing of the pen needle.
-The Lead MA prepared 5 oral medications and crushed them and stirred them in applesauce and mixed a powdered medication (Miralax) in water for a second resident.
-The Lead MA put the cup to the resident's lips

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D 371	Continued From page 71	D 371		

multiple times for the resident to drink the Miralax at 8:10am.
-The Lead MA then fed the resident the crushed medications with a spoon at 8:15am.
-The Lead MA did not sanitize or wash her hands prior to, during or after administering medications to the second resident and she was not wearing gloves.
-The Lead MA prepared 2 oral medications for a third resident, removed the resident's facial mask with her ungloved hands, and administered the medications at 8:20am.
-The Lead MA did not sanitize or wash her hands prior to, during or after administering medications to the third resident and she was not wearing gloves.
-The Lead MA prepared 8 oral medications by crushing them and putting them in applesauce for a fourth resident.
-The Lead MA was prompted by the surveyor about hand hygiene and infection control prior to continuing the medication pass at 8:28am.

Interview with the Lead MA on 01/21/21 at 8:28am revealed:
-She usually kept hand sanitizer stored inside the medication cart but she did not see any currently.
-She would get some hand sanitizer when she finished administering medications to the fourth resident.

Observation of the Lead MA administering medications in the SCU on 01/21/21 from 8:28am - 8:33am revealed:
-The Lead MA continued the medication pass after being prompted by surveyor to sanitize or wash hands.
-The Lead MA administered the medications to the fourth resident by using a spoon to feed the crushed medications in applesauce to the

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D 371	Continued From page 72 resident after adjusting the resident's face mask with her ungloved hand. -The Lead MA then went to the nurses' station at 8:32am but could not find any hand sanitizer. -The Lead MA went outside the SCU to the Administrator's office, retrieved a bottle of hand sanitizer from the Administrator's desk, and took it to the medication cart in the SCU after sanitizing her hands. A second interview with the Lead MA on 01/21/21 at 8:33am revealed: -Staff were supposed to sanitize their hands after each contact with a resident and then wash their hands every so often but she was not sure how often. -She did not wear gloves when she administered insulin to the resident with the insulin pen since it was not a vial and she did not have to draw up the insulin. -They kept gloves at the nurses' station so the personal care aides (PCAs) could use them as well. -The reason there was no hand sanitizer inside the medication cart in the SCU was probably because someone had taken the container to fill it up using the bulk containers. Interview with the Memory Care Manager (MCM) on 01/21/21 at 2:09pm revealed: -For the medication pass, the MAs were supposed to sanitize their hands after each resident. -She thought they were supposed to wash their hands after every third resident. -Hand sanitizer and gloves were supposed to be kept on the medication carts at all times. -The MAs were supposed to wear gloves with any administration of insulin whether they used an insulin pen or a needle with vial.	D 371		

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D 371	Continued From page 73 Interview with the Administrator on 01/21/21 at 2:09pm revealed: -The MAs were supposed to sanitize their hands after each resident. -There should be hand sanitizer and gloves on the medication carts at all times. 2. Review of Resident #7's current FL-2 dated 01/12/21 revealed: -Diagnoses included hypertension, cardiac dysrhythmia, osteoporosis, central opacity of right cornea, controlled type 2 diabetes without complications, and hypokalemia. -The resident was intermittently disoriented. Review of a follow up eye examination report for Resident #7 dated 07/28/20 revealed: -Resident #7 had a diagnosis of primary open-angle glaucoma, bilateral, indeterminate stage. -The resident's eye medication plan was to continue Latanoprost (used to treat glaucoma) in the left eye at bedtime. Interview with Resident #7 on 01/20/21 at 12:54pm revealed: -She used to get eye drops administered at night. -She did not know the name of the eye drops. -"I need my eye drops". -She did not have any eye pain. Review of physician orders for Resident #7 revealed: -There was a physician's order dated 01/02/20 which included an order for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at bedtime. -There was a physician's order sheet dated 01/12/21 which included an order for Latanoprost	D 371		

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D 371	Continued From page 74 drops 0.005% ophthalmic instill one drop into left eye at bedtime. -There was a prescription dated 01/18/21 for Latanoprost 0.005% eye drops one drop in left eye at bedtime. Review of the November 2020 electronic medication administration record (eMAR) for Resident #7 revealed: -There was an entry for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at bedtime with scheduled administration time of 8:00pm. -Latanoprost 0.005% was not documented as administered on 11/30/20 due to "unable to find this cream". Review of the December 2020 eMAR for Resident #7 revealed: -There was an entry for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at bedtime with scheduled administration time of 8:00pm. -Latanoprost 0.005% was not documented as administered 8 of 31 days. -On 12/02/20 and 12/09/20, the MA documented "not administered: refused" for the Latanoprost 0.005% eye drops. -On 12/15/20, 12/19/20, 12/23/20, 12/24/20, and 12/29/20, the MA documented "not administered: med tech overlooked meds" for the Latanoprost 0.005% eye drops. -On 12/20/20 at 8:12pm, the MA documented "not administered: drug/item unavailable" for the Latanoprost 0.005% eye drops. Review of the January 2021 eMAR for Resident #7 revealed: -There was an entry for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at	D 371	ype text here	

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D 371	Continued From page 75 bedtime with scheduled administration time of 8:00pm. -Latanoprost 0.005% was not documented as administered 12 of 20 days. -On 01/03/21 at 8:15pm, the MA documented "not administered: med tech overlooked meds" for the Latanoprost 0.005% eye drops. -On 01/04/21-01/06/21, 01/10/21, and 01/18/21, the MA documented "not administered: drug/item unavailable" for the Latanoprost 0.005% eye drops. -On 01/09/21 and 01/13/21-01/16/21, the MA documented "not administered: unable to find" for the Latanoprost 0.005% eye drops. -On 01/17/21 at 8:05pm, the MA documented "not administered: drug/item unavailable: waiting on refill from [doctor]" for the Latanoprost 0.005% eye drops. Telephone interview with Resident #7's family member on 01/25/21 at 3:54pm revealed: -She thought there had been a "mix up" with Resident #7's eye drops because the resident had been telling the family member "for a while" that she was not being administered the eye drops. -A medication aide (MA) told her if she knew there was another resident at the facility with the same medication, she (MA) would use some of that. -Different facility medication aides (MAs) would tell her that Resident #7 was being administered her eye drops. -She noticed from review of the Resident #7's medications in November 2020 that the resident's eye drops were not being filled. -She called the provider pharmacy about the eye drops about two weeks ago and was informed a new prescription was needed. -The facility had not reordered the Latanoprost	D 371	TContinuype text here	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	Hal089002	A. BUILDING: _____ B. WING _____	R-C 01/28/2021

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D 371	Continued From page 76 eye drops. Telephone interview with a MA on 01/26/21 at 2:37pm revealed: -Resident #7 "recently" did not have eye drops. -The resident did not have eye drops for "a week or longer". -She knew that one of the other MA's (named) would use another "person's" eye drops because she and the named MA were the only MAs working at night and the named MA documented administering the eye drops to Resident #7. Telephone interview with a second MA on 01/26/21 at 3:25pm revealed: -There had been times in the last month that there were no eye drops for Resident #7. -Resident #7's eye drops had not been available for a couple weeks - "maybe two weeks". -There were two other residents at the facility that were prescribed the same eye drops as Resident #7. -She had used a new bottle of one the other resident's eye drops (Resident #13) to administer to Resident #7. -She dated the eye drops when she opened them and placed them in the top drawer of the medication cart with other residents' eye drops. -She used the other residents' eye drops "two or three times". -Another MA would not be able to distinguish which bottle had been used for Resident #7 because the label on the eye drops were for Resident #13. Telephone interview with the PCP's office Nurse Practitioner on 01/27/21 at 9:15am revealed eye drops should only be used for the resident prescribed the eye drop because there was potential for cross-contamination and infection.	D 371		

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D 371	Continued From page 77 Telephone interview with the previous MCM on 01/27/21 at 2:03pm revealed: -She was the MCM from 06/19/20 - 01/12/21 and was now the lead MA. -She saw on Resident #7's eMARs that the resident did not get her Latanoprost eye drops 01/03/21 - 01/10/21 and did not know what she did to correct the issue. -She was aware Resident #7's Latanoprost eye drops were not available for administration. -She would never tell anybody to give another resident's eye drops to someone else because it was "cross-contamination". Telephone interview with a provider pharmacy Pharmacist on 01/28/21 at 2:13pm revealed: -Latanoprost eye drops should not be shared. -There was no chance of cross-contamination if the eye drop container did not touch the eye. -There was potential for the eye drop to be administered wrong if the instructions for administration were different for the two residents that the eye drops were shared between. Telephone interview with the Administrator on 01/28/21 at 3:35pm revealed: -She expected all resident medications to be in the facility for administration. -She was not aware of any resident eye drops borrowed. -She would have "addressed" borrowing of eye drops because of "cross-contamination". The facility failed to ensure infection control measures were implemented during the medication passes when both medication aides observed failed to wash or sanitize their hands prior to preparing and after administering insulin and oral medications to multiple residents on the	D 371		

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D 371	Continued From page 78 AL hall and the SCU. The facility put Resident #7 and #13 at risk for cross-contamination by sharing eye drops between the two residents. 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 01/27/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 14, 2021.	D 371		
D 372	10A NCAC 13F .1004 (o) Medication Administration 10A NCAC 13F .1004 Medication Administration (o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications borrowed for administration to 2 of 2 residents sampled (#2, #7) were borrowed only in an emergency and were replaced promptly and documented, relating to staff borrowing eye drops from Resident #13 and administering to Resident #7 and borrowing nebulizer solution from Resident #14 for administering to Resident #2. The findings are:	D 372	10A NCAC 13F .1004(o) Medication Administration Facility Care Manager and/or Lead SIC will complete weekly medication audits along with weekly Medication Storage Audit. Care Manager and/or Lead SIC will review inventory of supplies to assure medication carts have all nessracy supplies. Facility ED and Care Manager will review weekly medicaition audits and Medication Stroage audits during daily stand up meetings Care Manager, Lead SIC and/or ED will observe no less than one medication pass weekly, then no less than twice monthly to assure all residents recieve the correct medications. Facility Medication Techs will not borrow any medications except in the event of emergency. Medicalton Techs are responible to immediatly report the need to borrow any medications to the Care Manager. Facility Care Manager will assure notification to ED of any medications that need to be borrwed	2/12/2021 2/12/2021 2/12/2021 2/12/2021

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D 372	Continued From page 79 1. Review of Resident #7's current FL-2 dated 01/12/21 revealed: -Diagnoses included hypertension, cardiac dysrhythmia, osteoporosis, central opacity of right cornea, controlled type 2 diabetes without complications, and hypokalemia. -The resident was intermittently disoriented. Review of physician orders for Resident #7 revealed: -There was a physician's order dated 01/02/20 which included an order for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at bedtime. -There was a physician's order sheet dated 01/12/21 which included an order for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at bedtime. Review of a follow up eye examination report for Resident #7 dated 07/28/20 revealed: -Resident #7 had a diagnosis of primary open-angle glaucoma, bilateral, indeterminate stage. -The resident's eye medication plan was to continue Latanoprost (used to treat glaucoma) in the left eye at bedtime. Interview with Resident #7 on 01/20/21 at 12:54pm revealed: -She used to get eye drops administered at night. -She did not know the name of the eye drops. -"I need my eye drops". -She did not have any eye pain. Review of physician orders for Resident #7 revealed: -There was a physician's order dated 01/02/20 which included an order for Latanoprost drops	D 372	Continued from page 79 Medication Techs, Lead SIC and Care Manager have received training on the following: - Proper Infection Control while administrating Medications - 6 rights of Medication Administration - Clarification of Medication Orders - Controlled Substance - Medication Errors - Medication Storage - Proper Medication Storage and Disposal Training Conducted by RN on 1/27/2021, 2/11/2021 Med Techs will document on the med borrowing form and the Care Mgr is responsible for ensuring residents are repaid their medications. Added on phone conversation c RCC/Adm on 03/17/21 @11:15am ABV	2/12/2021

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D 372	Continued From page 80 0.005% ophthalmic instill one drop into left eye at bedtime. - There was a physician's order dated 01/12/21 which included an order for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at bedtime. -There was a prescription dated 01/18/21 for Latanoprost 0.005% eye drops one drop in left eye at bedtime. Review of the November 2020 electronic medication administration record (eMAR) for Resident #7 revealed: -There was an entry for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at bedtime with scheduled administration time of 8:00pm. -There was documentation that the Latanoprost 0.005% was not administered on 11/30/20 due to "unable to find this cream". Review of the December 2020 eMAR for Resident #7 revealed: -There was an entry for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at bedtime with scheduled administration time of 8:00pm. -There was documentation that the Latanoprost 0.005% was administered 12/01/20, 12/03/20-12/08/20, 12/10/21-12/14/20, 12/16/20-12/18/20, 12/21/20-12/22/20, 12/25/20-12/28/20, and 12/30/20-12/31/20. -On 12/15/20, 12/19/20, 12/23/20, 12/24/20, and 12/29/20 the MA documented the Latanoprost eye drops were "not administered: med tech overlooked meds". -On 12/20/20 the medication aide (MA) documented the Latanoprost eye drops were "not administered: drug/item unavailable".	D 372		

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D 372	Continued From page 81 Review of the January 2021 eMAR for Resident #7 revealed: -There was an entry for Latanoprost drops 0.005% ophthalmic instill one drop into left eye at bedtime with scheduled administration time of 8:00pm. -There was documentation that the Latanoprost 0.005% was administered 01/01/21-01/02/21, 01/07/21-01/08/21, and 01/11/21-01/12/21. -On 01/03/21 the MA documented the Latanoprost eye drops were "not administered: med tech overlooked meds". -On 01/04/21-01/06/21, 01/10/21, and 01/18/21, the MA documented the Latanoprost eye drops were "not administered: drug/item unavailable". -On 01/09/21, and 01/13/21-01/16/21, the MA documented the Latanoprost eye drops were "not administered: unable to find". -On 01/17/21, the MA documented the Latanoprost eye drops were "not administered: drug/item unavailable: waiting on refill from [doctor]". Telephone interview with Resident #7's family member on 01/25/21 at 3:54pm revealed: -She thought there had been a "mix up" with Resident #7's eye drops because the resident had been telling the family member "for a while" that she (Resident #7) was not being administered the eye drops. -A MA told her if she knew there was another resident at the facility with the same medication, she would use some of that. -Different facility MAs would tell her that Resident #7 was being administered her eye drops. -She noticed from review of the resident's medications in November 2020 that the resident's eye drops were not being filled. -She called the provider pharmacy about the eye drops about two weeks ago and was informed a	D 372		

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D 372	Continued From page 82 new prescription was needed. -The facility had not reordered the Latanoprost eye drops. Telephone interview with a MA on 01/26/21 at 2:37pm revealed: -Resident #7 "recently" did not have eye drops. -The resident did not have eye drops for "a week or longer". -She knew that one of the other MA's (named) would use another "person's" eye drops because she and the named MA were the only MAs working at night and the named MA documented administering the eye drops to Resident #7. Telephone interview with a second MA on 01/26/21 at 3:25pm revealed: -There had been times in the last month that there were no eye drops available for Resident #7. -Resident #7's eye drops had not been available for a couple weeks - "maybe two weeks". -There were two other residents at the facility that were prescribed the same eye drops as Resident #7. -She had used a new bottle of one the other residents eye drops (Resident #13) to administer to Resident #7. -She dated the eye drops when she opened them and placed them in the top drawer of the medication cart with other residents' eye drops. -She used the other residents' eye drops "two or three times". -Another MA would not be able to distinguish which bottle had been used for Resident #7 because the label on the eye drops were for Resident #13. -She had been told by a previous staff she could borrow medications from another resident, and the staff did not specify the type of medications	D 372		

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D 372	Continued From page 83 that could be borrowed. -She did not know how borrowed eye drops from a resident would be paid back to that resident. -She had not had any training or discussion with anyone about paying back borrowed medications. -She looked for a borrowed medication form in the medication room to complete but could not find the form. Review of Resident #13's January 2021 eMAR revealed Latanoprost drops 0.005% instill one drop in both eyes at bedtime was printed to the eMAR. Telephone interview with Resident #13's pharmacy provider technician on 01/28/21 at 2:00pm revealed: -Resident #13 was prescribed Latanoprost 0.005% eye drops. -The instructions for administration of Resident #13's Latanoprost eye drops was one drop in both eyes at bedtime. -The original prescription for Resident #13's Latanoprost was dated 11/04/20. -The Latanoprost eye drops had been dispensed to the facility on 11/04/20, 12/04/20, 01/03/21, and 01/21/21, quantity of 2.5 milliliters each time dispensed which should last 50 days. Telephone interview with the PCP's office Nurse Practitioner on 01/27/21 at 9:15am revealed eye drops should only be used for the resident prescribed the eye drop because there was potential for cross-contamination and infection. Telephone interview with the current Memory Care Manager (MCM) on 01/27/21 at 11:17am revealed: -The MAs were not supposed to borrow medications of any kind.	D 372		

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D 372	Continued From page 84 -Borrowing eye drops presented an infection control issue and should not be borrowed. -The residents should not be out of any medications. -The facility had a medication borrowing form that was completed when medications were borrowed for emergencies and the forms had not been used. Telephone interview with the previous MCM on 01/27/21 at 2:03pm revealed: -She was the MCM from 06/19/20 - 01/12/21 and was now the lead MA. -She saw on Resident #7's eMARs that the resident did not get her eye drops 01/03/21 - 01/10/21 and did not know what she did to correct the issue. -She was aware Resident #7's Latanoprost eye drops were not available for administration. -She had never told anybody to give another resident's eye drops to someone else because it was cross-contamination. Telephone interview with a provider pharmacy Pharmacist on 01/28/21 at 2:13pm revealed: -Latanoprost eye drops should not be shared. -There was potential for the eye drop to be administered wrong if the instructions for administration were different for the two residents that the eye drops were shared between. Telephone interview with the Administrator on 01/28/21 at 3:40pm revealed: -She was not aware that staff had borrowed eye drops from Resident #13 to administer to Resident #7. -She expected all residents' medications to be available in the facility for administration. -She was not sure how eye drops borrowed from a resident would be paid back to that resident.	D 372		

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D 372	Continued From page 85 2. Review of Resident #2's current FL-2 dated 02/25/20 revealed diagnoses included central demyelination of corpus callosum, hypomagnesemia, candidiasis, hypo-osmolality and hyponatremia, alcohol abuse, major depressive disorder, insomnia, and hypertension. Confidential interview with a resident revealed: -A couple of weeks ago, the resident was in the hallway and overheard one medication aide (MA) ask another MA to borrow a nebulizer treatment from one resident to use for another resident. -The resident observed one MA hand a small plastic vial with a liquid inside the vial to the other MA. Review of Resident #2's physician's orders dated 02/25/20 revealed a prescription for Ipratropium-Albuterol sulfate solution for nebulization 0.5mg/3ml inhaled every 6 hours as needed for wheezing. (Ipratropium-Albuterol is a nebulizer solution that contains two medications used to treat breathing conditions and lung disease.) Confidential staff interview revealed: -She was instructed by the Lead MA to borrow medications from residents. -She borrowed Ipratropium-Albuterol sulfate solution from a resident to administer to Resident #2 because Resident #2 did not have any doses remaining. -She replaced the Ipratropium-Albuterol solution when the new supply was received. Telephone interview with the primary care provider (PCP) on 01/27/21 at 10:29am revealed: -If the facility was borrowing medications, they need to make sure it was the same dose of the	D 372		

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D 372	Continued From page 86 same medication. -It should not cause other residents to run out of their medications. -It should only be done in emergency situations. -The facility needed to do a better job of ordering medications and they needed a back-up supply of medications. Telephone interview with a MA on 01/27/21 at 11:33am revealed: -There was a borrowing form but she never completed one because she never borrowed medications. -Most of the time the medications were available in the facility. -She did not think it was permitted to borrow narcotics, blood pressure and cholesterol medications, eyedrops or nose sprays. Telephone interview with the Administrator on 01/28/21 at 3:19pm revealed: -The borrowing of medications should only been done in an emergency situation. -There was a facility borrowing form in which the Administrator and the Memory Care Manager (MCM) would need to sign but there is no policy. -The borrowing form was not completed for Resident #2. Telephone interview with the MCM on 01/28/21 at 10:41am revealed: -She was not aware staff had borrowed nebulizer medication from Resident #14 to administer to Resident #2. -The MAs should not have borrowed the medication because no resident should have been out of their medication. -If a resident was out of medication, they MAs should notify her so she could get a delivery from the pharmacy.	D 372		

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D 372	Continued From page 87 -She was not aware of the facility having a written borrowing policy because medications should only be borrowed for an emergency situation. -The facility did have a borrowing form for borrowing emergency medications like narcotics. -The Administrator, MCM, and MA had to sign the form if used. -No borrowing forms had been filled out to her knowledge.	D 372		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult 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, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt, disposition, and administration of controlled substances for 3 of 4 residents sampled (#2, #4, #5) including 2 residents receiving medications for anxiety and agitation (#2, #4); 3 residents receiving pain medications (#2, #4, #5); and 1 resident receiving a medication for insomnia (#4). The findings are: 1. Review of Resident #4's current FL-2 dated 04/21/20 revealed diagnoses included Parkinson's disease, status post liver transplant, right and left artificial knees, benign prostatic	D 392	10A NCAC 13F .1008(a) Controlled Substances Facility Medication Techs are responible for accurate reconciliation of all controlled substances Facility Care Manager and/or Lead SIC will complete weekly medication cart audits to include controll substance count. Care Manager, Lead SIC and ED will review all cart audits upon completion. Facility ED will assure that retrievable records for accurately reconciled controlled substances are maintained. Facility Medication Staff have been in-serviced on controlled substances and accurracy of records. In-serviced conducted by RN on 1/27 and 2/11/2021 Any facility Medication Staff found to not properly account for controll substances will be reported to ED for furter displinany action, including but not limited to being removed from medication cart. Care Manager will complete audits weekly of the control logs to ensure logs match count and MAR. Added on phone conversation c RCC/Adm on 03.17.21@11:15am	2/12/2021 2/12/2021 2/12/2021 2/12/2021 2/12/2021 2/12/2021

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D 392	Continued From page 88 hypertrophy, chronic viral Hepatitis C, tension-type headache, muscle spasms, thrombocytopenia, and insomnia. a. Review of Resident #4's current FL-2 dated 04/21/20 revealed an order for Lorazepam 0.5mg 1 tablet 4 times a day with Sinemet. (Lorazepam is a controlled substance used to treat anxiety. Sinemet is used to treat the symptoms of Parkinson's disease.) Review of Resident #4's pharmacy dispensing records dated 09/01/20 - 01/26/21 revealed: -There were 120 Lorazepam 0.5mg tablets dispensed on 09/24/20. -There were 120 Lorazepam 0.5mg tablets dispensed on 10/23/20. -There were 120 Lorazepam 0.5mg tablets dispensed on 11/23/20. -There were 120 Lorazepam 0.5mg tablets dispensed on 12/22/20. -There were 120 Lorazepam 0.5mg tablets dispensed on 01/18/21. Observation of Resident #4's medications on hand on 01/21/21 at 12:58pm revealed: -There were 2 supplies of Lorazepam 0.5mg tablets on hand for the resident. -Both supplies were in amber medication bottles with prescription labels. -One bottle was dispensed on 01/18/21 and had transparent tape wrapped around the lid with auxiliary stickers placed vertically under the transparent tape. -The bottle dispensed on 01/18/21 had 120 of 120 tablets remaining. -The second bottle was dispensed on 12/22/20 and had 7 of 120 tablets remaining. -There was a total of 127 Lorazepam 0.5mg tablets on hand.	D 392		

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D 392	Continued From page 89 Review of Resident #4's October 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 0.5mg take 1 tablet 4 times a day with Sinemet scheduled to be administered at 5:00am, 9:00am, 3:00pm, and 6:00pm. -There was a total of 124 Lorazepam 0.5mg tablets documented as administered from 10/01/20 - 10/31/20. Review of Resident #4's controlled substance (CS) log for October 2020 revealed: -There were 124 Lorazepam 0.5mg tablets documented as administered on the CS log and eMAR from 10/01/20 - 10/31/20. -On 10/05/20 at 4:15am, there was a balance of 132 tablets after 1 tablet was administered. -On 10/05/20 at 7:40am, 3 tablets were documented as received with no reason for the receipt documented, increasing the balance to 135 tablets. -On 10/10/20 at 7:36am, 1 tablet was documented as received with no reason for the receipt documented, increasing the balance from 115 to 116 tablets. -On 10/18/20 at 7:40am, 1 tablet was documented as wasted due to "dropped medication" with the same MA documented as the user and the verifier (witness), leaving a balance of 83 tablets. -On 10/24/20 at 7:52am, 1 tablet was documented as received with no reason for the receipt documented, increasing the balance from 59 to 60 tablets. -On 10/26/20, 120 tablets were received making the balance 170 tablets. -The last dose documented on 10/31/20 at 5:41pm left a balance of 147 tablets.	D 392		

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D 392	Continued From page 90 Review of Resident #4's November 2020 eMAR revealed: -There was an entry for Lorazepam 0.5mg take 1 tablet 4 times a day with Sinemet scheduled to be administered at 5:00am, 9:00am, 3:00pm, and 6:00pm. -There was a total of 120 Lorazepam 0.5mg tablets documented as administered from 11/01/20 - 11/30/20. Review of Resident #4's CS log for November 2020 revealed: -The CS log did not accurately reconcile with the eMAR. -There were 119 Lorazepam 0.5mg tablets documented as administered on the CS log but 120 tablets were documented as administered on the eMAR from 11/01/20 - 11/30/20. -On 11/01/20 at 7:32am, 1 tablet was documented as wasted due to "dropped medication" with the same MA documented as the user and the verifier (witness), leaving a balance of 147 tablets. -On 11/25/20, 120 tablets were received making the balance 170 tablets. -On 11/26/20 at 9:50pm, 1 tablet was documented as received with no reason for the receipt documented, increasing the balance from 164 to 165 tablets. -The last dose documented on 11/30/20 at 5:49pm left a balance of 149 tablets. Review of Resident #4's December 2020 eMAR revealed: -There was an entry for Lorazepam 0.5mg take 1 tablet 4 times a day with Sinemet scheduled to be administered at 5:00am, 9:00am, 3:00pm, and 6:00pm. -There was a total of 124 Lorazepam 0.5mg	D 392		

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D 392	Continued From page 91 tablets documented as administered from 12/01/20 - 12/31/20. Review of Resident #4's CS log for December 2020 revealed: -There were 124 Lorazepam 0.5mg tablets documented as administered on the CS log and the eMAR from 12/01/20 - 12/31/20. -On 12/24/20 at 8:46am, there was a balance of 55 tablets. -On 12/24/20 at 12:30pm, 120 tablets were received making the balance 175 tablets. -On 12/24/20 at 12:31pm, 55 tablets were documented as wasted with the reason documented as "other", leaving a balance of 120 tablets. -Two different MAs had documented in the user and verifier (witness) columns for the 55 wasted doses but no explanation of why 55 tablets were wasted or how they were wasted. -The 55 tablets were never added back into the balance of Lorazepam tablets. -The last dose documented on 12/31/20 at 5:12pm left a balance of 90 tablets. Review of Resident #4's January 2021 eMAR revealed: -There was an entry for Lorazepam 0.5mg 1 tablet 4 times a day with Sinemet scheduled to be administered at 5:00am, 9:00am, 3:00pm, and 6:00pm. -There was a total of 82 Lorazepam 0.5mg tablets documented as administered from 01/01/21 - 01/21/21 (9:00am). Review of Resident #4's CS log for January 2021 revealed: -There were 82 Lorazepam 0.5mg tablets documented as administered on the CS log and the eMAR from 01/01/21 - 01/21/21.	D 392		

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D 392	Continued From page 92 -On 01/11/21 at 7:30am, 1 tablet was documented as wasted with the reason documented as "other", leaving a balance of 48 tablets. -Two different MAs had documented in the user and verifier (witness) columns for the wasted dose but explanation of why the dose was wasted or how it was wasted was not documented. -On 01/19/21 at 4:08pm, 120 tablets were received making the balance 134 tablets. -The last dose documented on 01/21/21 at 8:48am left a balance of 127 tablets. Telephone interview with Resident #4 on 01/27/21 at 6:22pm revealed: -The medication aides (MAs) ordered his medications from a local pharmacy. -If he was out of refills, the local pharmacy would call him and he would tell the Lead MA, who would contact his primary care provider (PCP). -He usually took Lorazepam 4 times a day along with his medication for Parkinson's disease. Interview with a MA on 01/26/21 at 2:02pm revealed: -Sometimes Resident #4 did not get his Lorazepam because staff would forget to administer it. -She had made that mistake before and forgot to administer the Lorazepam even though she documented it as administered so the CS count would not match. Telephone interview with a second MA on 01/26/21 at 3:44pm revealed: -When she documented the receipt of 1 or 3 tablets for Resident #4's Lorazepam, it was because the count was over what it should be. -She did not know why the count would be over unless the resident may not have received the	D 392		

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D 392	Continued From page 93 Lorazepam even though it was documented as administered on the eMAR.. -On 01/11/21 when she documented Lorazepam as wasted with reason "other", it may have been because the CS count in the eMAR tracking system did not match. Telephone interview with a third MA on 01/27/21 at 11:33am revealed: -She thought a night shift MA sometimes did not pay attention and took Lorazepam 0.5mg from the wrong resident's bottle because there was another resident with the same strength of Lorazepam dispensed in the same type of bottle as Resident #4. -This would throw the counts off by either 1 more or 1 less of what the count should be. -This happened 2 or 3 times a month; she reported it to the Lead MA when it occurred and the last time was about 3 weeks ago. -The Lead MA just said "okay" when she reported it to her. -The MAs would put tape around a new supply of controlled medications so staff would use the previous supply first and so they would not have to count the new supplies when they did the CS shift counts. -If the bottle was taped, they MAs "assumed" it was a new supply and used the amount dispensed on the label as the count. -The Lead MA told her they could no longer keep a previous supply of medication once a new supply was received because they should start using the new supply. -The Lead MA was verifying orders and checking medications on 12/24/20, when she saw Resident #4 had two supplies of Lorazepam 0.5mg tablets. -There was a previous supply already opened that she and the Lead MA counted and both got a total of 55 tablets.	D 392		

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D 392	Continued From page 94 -Resident #4 also had a new supply of Lorazepam 0.5mg tablets that was taped around the lid and had not been used. -The Lead MA wasted the 55 Lorazepam 0.5mg tablets from the previous supply by pouring the tablets into the sharp's container and throwing the empty bottle in the trash can. -The Lead MA entered the wasted doses into the eMAR CS tracking system as the user and she verified it with her name in the verifier box. -The Lead MA checked for more "taped" bottles in the medication cart but she did not observed the Lead MA waste any other tablets. -No one else had instructed her to waste previous supplies of controlled medications and she had not wasted any since that day on 12/24/20. Telephone interview with the Lead MA on 01/27/21 at 1:30pm revealed: -On 12/24/20, the MA on duty informed her that Resident #4 had two bottles of Lorazepam 0.5mg and that prompted her to dispose of it. -She wasted Resident #4's 55 Lorazepam 0.5mg tablets on 12/24/20 because the resident received a new supply of 120 tablets. -Those 55 tablets were "old and no good". -The 55 tablets were not expired but were part of the previous month's supply. -She and the MA on duty on 12/24/20 counted Resident #4's Lorazepam 0.5mg and there were 55 in the previous supply. -She poured the 55 Lorazepam tablets into the sharp's container and entered the wasted pills into the eMAR system and both of them signed off. -When she documented the reason for wasting the tablets as "other", she should have noted a new supply came in and the previous supply was thrown out. -During a previous state survey, she remembered	D 392		

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D 392	Continued From page 95 being told multiple supplies of the same controlled substance for the same resident could not be stored in the cart. -She knew they were not supposed to pour the old supply into the new supply so she thought the 55 tablets from the previous supply needed to be wasted. -Resident #4 currently had two supplies of Lorazepam 0.5mg in the medication cart because his medications had been picked up early. -Once the resident finished the current bottle, he would start on the new supply. -She could not explain why this contradicted how she handled the resident having multiple supplies on 12/24/20, when she disposed of 55 tablets that were not expired and the resident had paid for. Telephone interview with the Memory Care Manager (MCM) on 01/27/21 at 4:20pm revealed: -Both staff reported they had put Resident #4's 55 Lorazepam tablets into the sharp's container. -She found 55 Lorazepam 0.5mg tablets in one of the facility's sharp's containers as she was instructed by the police to check the containers. Telephone interview with the MCM on 01/28/21 at 10:41am revealed: -Resident #4's 55 Lorazepam 0.5mg tablets should not have been discarded because they were not expired and the order had not changed. -The MAs should not have ordered another supply of Lorazepam if the resident still had 55 tablets on hand. Refer to confidential interview with a staff. Refer to telephone interview with a medication aide (MA) on 01/26/21 at 2:02pm. Refer to telephone interview with a second MA on	D 392		

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D 392	Continued From page 96 01/26/21 at 3:44pm. Refer to telephone interview with a third MA on 01/27/21 at 11:33am. Refer to telephone interview with the Lead MA on 01/27/21 at 1:30pm. Refer to telephone interview with the MCM on 01/28/21 at 10:41am. Refer to telephone interview with the Administrator on 01/28/21 at 3:19pm. b. Review of Resident #4's current FL-2 dated 04/21/20 revealed an order for Zolpidem 10mg 1 tablet at bedtime for insomnia. (Zolpidem is a controlled substance used to treat insomnia.) Review of Resident #4's pharmacy dispensing records dated 09/01/20 - 01/26/21 revealed: -There were 30 Zolpidem 10mg tablets dispensed on 09/24/20. -There were 30 Zolpidem 10mg tablets dispensed on 10/23/20. -There were 30 Zolpidem 10mg tablets dispensed on 11/23/20. -There were 30 Zolpidem 10mg tablets dispensed on 12/22/20. -There were 30 Zolpidem 10mg tablets dispensed on 01/18/21. Observation of Resident #4's medications on hand on 01/21/21 at 12:58pm revealed: -There were 2 supplies of Zolpidem 10mg tablets on hand for the resident. -Both supplies were in amber medication bottles with prescription labels. -One bottle was dispensed on 01/18/21 and had transparent tape wrapped around the lid with	D 392		

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D 392	Continued From page 97 auxiliary stickers placed vertically under the transparent tape. -The bottle dispensed on 01/18/21 had 30 of 30 tablets remaining. -The second bottle was dispensed on 12/22/20 and had 7 of 30 tablets remaining. -There was a total of 37 Zolpidem 10mg tablets on hand. Review of Resident #4's October 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Zolpidem 10mg 1 tablet every night at bedtime scheduled to be administered at 8:00pm. -Zolpidem 10mg was documented as administered at bedtime each day except 10/14/20 with no reason documented. -There was a total of 29 Zolpidem 10mg tablets documented as administered from 10/01/20 - 10/31/20. Review of Resident #4's controlled substance (CS) log for October 2020 revealed: -The CS log did not accurately reconcile with the eMAR. -There were 30 Zolpidem 10mg tablets documented as administered on the CS log but 29 doses were documented as administered on the eMAR from 10/01/20 - 10/31/20. -On 10/13/20, 1 dose was administered leaving a balance of 13 tablets. -The next dose documented as administered was 10/15/20, leaving a balance of -1 tablet. -On 10/16/20, 1 tablet was documented as received , leaving a balance of 0 tablets. -The next entry dated 10/16/20 at 9:52am noted 13 tablets were received and the balance was 13 again. -On 10/16/20 at 9:53am, 13 tablets were "wasted"	D 392		

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D 392	Continued From page 98 with the reason noted as "other", leaving a balance of 0. -On 10/16/20 at 8:14pm, 1 tablet was documented as administered, leaving a balance of 11 tablets. -Another tablets was documented as administered on 10/17/20, leaving a balance of 10 tablets. -On 10/18/20 at 7:40am, 1 tablet was "received", changing the balance back to 11 tablets. -There was a balance of 3 tablets on 10/25/20, then a balance of 33 tablets after 30 tablets were received on 10/26/20. -The last dose documented on 10/31/20 at 8:20pm left a balance of 27 tablets. Review of Resident #4's November 2020 eMAR revealed: -There was an entry for Zolpidem 10mg 1 tablet every night at bedtime scheduled to be administered at 8:00pm. -There was a total of 30 Zolpidem 10mg tablets documented as administered from 11/01/20 - 11/30/20. Review of Resident #4's CS log for November 2020 revealed: -There were 30 Zolpidem 10mg tablets documented as administered on the CS log and the eMAR from 11/01/20 - 11/30/20. -The last dose documented on 11/30/20 at 7:42pm left a balance of 27 tablets. Review of Resident #4's December 2020 eMAR revealed: -There was an entry for Zolpidem 10mg 1 tablet every night at bedtime scheduled to be administered at 8:00pm. -There was a total of 31 Zolpidem 10mg tablets documented as administered from 12/01/20 -	D 392		

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D 392	Continued From page 99 12/31/20. Review of Resident #4's CS log for December 2020 revealed: -There were 31 Zolpidem 10mg tablets documented as administered on the CS log and eMAR from 12/01/20 - 12/31/20. -On 12/23/20, there was a balance of 4 tablets then 30 tablets were received on 12/24/20, leaving a balance of 34 tablets. -One tablet was documented as administered on 12/24/20 at 8:00pm, leaving a balance of 33 tablets. -On 12/25/20 at 8:16am, 1 tablet was documented as received, changing the balance back to 34 tablets. -The last dose documented on 12/31/20 at 7:09pm left a balance of 27 tablets. Review of Resident #4's January 2021 eMAR revealed: -There was an entry for Zolpidem 10mg 1 tablet every night at bedtime scheduled to be administered at 8:00pm. -There was a total of 20 Zolpidem 10mg tablets documented as administered from 01/01/21 - 01/20/21. Review of Resident #4's CS log for January 2021 revealed: -There were 20 Zolpidem 10mg tablets documented as administered on the CS log and eMAR from 01/01/21 - 01/20/21. -The last dose documented on 01/20/221 at 7:39pm left a balance of 37 tablets. Refer to confidential interview with a staff. Refer to telephone interview with a medication aide (MA) on 01/26/21 at 2:02pm.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	Hal089002	A. BUILDING: _____ B. WING _____	R-C 01/28/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 100 Refer to telephone interview with a second MA on 01/26/21 at 3:44pm. Refer to telephone interview with a third MA on 01/27/21 at 11:33am. Refer to telephone interview with the Lead MA on 01/27/21 at 1:30pm. Refer to telephone interview with the MCM on 01/28/21 at 10:41am. Refer to telephone interview with the Administrator on 01/28/21 at 3:19pm. 2. Review of Resident #2's current FL-2 dated 02/25/20 revealed diagnoses included central demyelination of corpus callosum, hypomagnesemia, candidiasis, hypo-osmolality and hyponatremia, alcohol abuse, major depressive disorder, insomnia, and hypertension. a. Review of Resident #2's physician's orders revealed there was a prescription dated 09/17/20 for Alprazolam 0.25mg tablet by mouth 3 times daily. (Alprazolam is a controlled substance used to treat anxiety and agitation.) Observation of Resident #2's medications on hand on 01/21/21 at 9:51am revealed: -There was a supply of 90 Alprazolam 0.25mg tablets dispensed on 01/13/21. -There were 75 Alprazolam 0.25mg tablets remaining. Review of Resident #2's 12/01/20 - 12/31/20 electronic medication administration record (eMAR) revealed: -There was an entry for Alprazolam 0.25mg tablet	D 392		

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D 392	Continued From page 101 three times a day scheduled to be administered at 8:00am, 2:00pm, and 8:00pm. -There was a total of 93 Alprazolam 0.25mg tablets documented as administered from 12/01/20 - 12/31/20. Review of Resident #2's controlled substance (CS) log dated 12/01/20 - 12/31/20 for Alprazolam revealed: -There were 93 Alprazolam 0.25mg tablets documented as administered on the CS log and the eMAR from 12/01/20 - 12/31/20. -On 12/12/20 at 6:18pm, 1 tablet was documented as wasted due to "dropped medication", leaving a balance of 14 tablets. -On 12/15/20 at 7:00am, 90 tablets were documented as received making the balance 98 tablets. -On 12/15/20 at 7:29am, 1 tablet was documented as administered but left a balance of -1 instead of declining the count to 97 tablets. -On 12/15/20 at 11:13am, 1 tablet was documented as administered but left a balance of -2 instead of 96 tablets. -On 12/15/20 at 7:52pm, 2 tablets were documented as received leaving a balance of 0 instead of 98. -On 12/15/20 at 8:07pm, 1 tablet was documented as administered, leaving a balance of -1 instead of 97. -On 12/15/20 at 9:18pm, 1 tablet was documented as received leaving a balance of 0 instead of 98. -On 12/15/20 at 9:18pm, 95 tablets were documented as received leaving a balance of 95. -On 12/15/20 at 9:19pm, 98 tablets were documented as wasted with "other" as the reason and the same medication aide (MA) documented as the user and the verifier (witness), leaving a balance of 0.	D 392		

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D 392	Continued From page 102 -There was no explanation of why 95 doses were documented as wasted when the previous balance was 95. -On 12/16/20 at 7:58am, 1 tablet was documented as administered, leaving a balance of 94 tablets when the balance on the previous entry was 0 after 98 tablets were documented as wasted. -There was no explanation for the discrepancy documented. -The next entry on 12/16/20 at 7:58am documented 1 tablet was administered leaving a balance of 93. -On 12/24/20 at 11:49am, 1 tablet was documented as received leaving a balance of 70 tablets. -The last dose documented on 12/31/20 at 7:10pm left a balance of 47 tablets. Review of Resident #2's 01/01/21 - 01/21/21 eMAR revealed: -There was an entry for Alprazolam 0.25mg tablet 3 times a day scheduled to be administered at 8:00am, 2:00pm, and 8:00pm. -There was a total of 61 Alprazolam 0.25mg tablets documented as administered from 01/01/21 - 01/21/21. Review of Resident #2's CS log dated 01/01/21 - 01/21/21 revealed: -There were 61 Alprazolam 0.25mg tablets documented as administered on the CS log and eMAR from 01/01/21 - 01/21/21. -On 01/10/21 at 1:36pm, 1 tablet was documented as wasted due to "dropped medication" with the same MA documented as the user and the verifier (witness), leaving a balance of 17 tablets. -On 01/14/21, 90 tablets were received making the balance 97 tablets.	D 392		

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D 392	Continued From page 103 -The last dose documented on 01/21/21 at 9:22am left a balance of 75 tablets. Refer to confidential interview with a staff. Refer to telephone interview with a medication aide (MA) on 01/26/21 at 2:02pm. Refer to telephone interview with a second MA on 01/26/21 at 3:44pm. Refer to telephone interview with a third MA on 01/27/21 at 11:33am. Refer to telephone interview with the Lead MA on 01/27/21 at 1:30pm. Refer to telephone interview with the MCM on 01/28/21 at 10:41am. Refer to telephone interview with the Administrator on 01/28/21 at 3:19pm. b. Review of Resident #2's physician's orders revealed there was a prescription dated 02/11/20 for Oxycodone 10mg tablet every 6 hours. (Oxycodone is a controlled substance used to treat moderate to severe pain.) Observation of Resident #2's medications on hand on 01/21/21 at 9:51am revealed: -There was a supply of 120 Oxycodone 10mg tablets dispensed on 12/28/20. -There were 30 Oxycodone 10mg tablets remaining. Review of Resident #2's 12/01/20 - 12/31/20 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone 10mg tablet	D 392		

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D 392	Continued From page 104 scheduled to be administered every six hours at 6:00am, 12:00pm, 6:00pm, and 12:00am. -There were 31 Oxycodone 10mg tablets documented as administered from 12/01/20 - 12/08/20. -There was a second entry for Oxycodone 10mg tablet scheduled to be administered every 6 hours at 5:00am, 11:00am, 5:00pm, and 11:00pm. -There were 80 Oxycodone 10mg tablets documented as administered from 12/08/20 - 12/28/20. -There was a third entry for Oxycodone 10mg tablet scheduled to be administered every 6 hours at 6:00am, 12:00pm, 6:00pm, and 12:00am. -There were 7 Oxycodone 10mg tablets documented as administered from 12/28/20 - 12/30/20. -There was a fourth entry for Oxycodone 10mg tablet scheduled to be administered 4 times a day at 5:00am, 11:00am, 5:00pm, and 11:00pm. -There were 7 Oxycodone 10mg tablets documented as administered from 12/30/20 - 12/31/20. -There was a total of 125 Oxycodone 10mg tablets documented as administered from 12/01/20 - 12/31/20. Review of Resident #2's controlled substance (CS) log dated 12/01/20 - 12/31/20 for Oxycodone revealed: -There were 124 Oxycodone 10mg tablets documented as administered on the CS log but 125 tablets documented as administered on the eMAR from 12/01/20 - 12/31/20. -On 12/02/20 at 7:19pm, 1 tablet was documented as wasted due to "dropped medication", leaving a balance of 108. -On 12/08/20 at 12:46pm, 1 tablet was	D 392		

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D 392	Continued From page 105 documented as administered leaving a balance of 85 tablets. -On 12/08/20 at 5:19pm, 1 tablet was documented as administered but a left a balance of -1 instead of declining the count to 84. -On 12/08/20 at 5:22pm, 85 tablets were documented as received, leaving a balance of 84 tablets after the previous balance was -1. -On 12/08/20 at 5:23pm, 85 tablets were documented as wasted with "other" for the reason, leaving a balance of 0. -On 12/08/20 at 11:22pm, 1 tablet was documented as administered leaving a balance of 83 tablets. -On 12/29/20 at 6:23am, 120 tablets were documented as received, leaving a balance of 122 tablets. -The last documented dose on 12/31/20 at 11:04pm left a balance of 111 tablets. Review of Resident #2's 01/01/21 - 01/21/21 eMAR revealed: -There was an entry for Oxycodone 10mg tablet scheduled to be administered 4 times a day at 5:00am, 11:00am, 5:00pm, and 11:00pm. -There was a total of 81 Oxycodone 10mg tablets documented as administered from 01/01/21 - 01/21/21. Review of Resident #2's CS log dated 01/01/21 - 01/21/21 for Oxycodone revealed: -There were 81 Oxycodone 10mg tablets documented as administered on the CS log and the eMAR from 01/01/21 - 01/21/21. -The last documented dose on 01/21/21 at 5:02am left a balance of 30 tablets. Refer to confidential interview with a staff. Refer to telephone interview with a medication	D 392		

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D 392	Continued From page 106 aide (MA) on 01/26/21 at 2:02pm. Refer to telephone interview with a second MA on 01/26/21 at 3:44pm. Refer to telephone interview with a third MA on 01/27/21 at 11:33am. Refer to telephone interview with the Lead MA on 01/27/21 at 1:30pm. Refer to telephone interview with the MCM on 01/28/21 at 10:41am. Refer to telephone interview with the Administrator on 01/28/21 at 3:19pm. 3. Review of Resident #5's current FL-2 dated 02/25/20 revealed diagnoses included hypertension, coronary artery disease, cirrhosis, esophageal varices, osteoarthritis, mild dementia, bipolar, and hyponatremia. Review of Resident #5's physician's orders revealed there was a prescription dated 10/14/20 for Hydrocodone/Acetaminophen 5-325mg 1 tablet every 6 hours as needed (prn) for pain. (Hydrocodone/Acetaminophen is a controlled substance used to treat moderate to severe pain.) Observation of Resident #5's medications on hand on 01/21/21 at 9:51am revealed: -There was a supply of 120 Hydrocodone/Acetaminophen 5-325mg tablets dispensed on 10/14/20. -There were 35 Hydrocodone/Acetaminophen 5-325mg tablets remaining. Review of Resident #5's 12/01/20 - 12/31/20	D 392		

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D 392	Continued From page 107 electronic medication administration (eMAR) revealed: -There was an entry for Hydrocodone/Acetaminophen 5-325mg take 1 tablet every 6 hours prn pain. -There was a total of 35 Hydrocodone/Acetaminophen tablets documented as administered from 12/01/20-12/31/20. Resident #5's controlled substance (CS) log dated 12/01/20 - 12/31/20 for Hydrocodone/Acetaminophen revealed: -There were 35 Hydrocodone/Acetaminophen 5-325mg tablets documented as administered on the CS log and the eMAR from 12/01/20 - 12/31/20. -On 12/02/20 at 7:16am, 1 tablet was documented as wasted due to "dropped medication" leaving a balance of 90 tablets. -On 12/02/20 at 7:20pm, 1 tablet was documented as wasted due to "dropped medication" leaving a balance of 88 tablets. -On 12/02/20 at 7:22pm, 1 tablet was documented as received leaving a balance of 89 tablets with no explanation of how 1 tablet was received. -On 12/02/20 at 7:24pm, 1 tablet was documented as received leaving a balance of 90 tablets with no explanation of how 1 tablet was received. -On 12/30/20 at 7:16am, 1 tablet was documented as wasted due to "dropped medication" leaving a balance of 59 tablets. -The last dose documented on 12/31/20 at 7:13pm left a balance of 55 tablets. Review of Resident #5's 01/01/21 - 01/21/21 eMAR revealed: -There was an entry for	D 392		

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D 392	Continued From page 108 Hydrocodone/Acetaminophen 5-325mg take 1 tablet every 6 hours prn pain. -There was a total of 22 Hydrocodone/Acetaminophen tablets documented as administered from 01/01/21-01/21/21. Resident #5's CS log dated 01/01/21 - 01/21/21 for Hydrocodone/Acetaminophen revealed: -There were 22 Hydrocodone/Acetaminophen 5-325mg tablets documented as administered on the CS log and the eMAR from 01/01/21 - 01/21/21. -On 01/01/21 at 5:07pm, 1 tablet was documented as received leaving a balance of 55 with no explanation of how 1 tablet was received. -On 01/10/21 at 7:37am, 1 tablet was documented as received leaving a balance of 48 with no explanation of how 1 tablet was received. -The last dose documented on 01/21/21 at 9:14am left a balance of 35 tablets. Refer to confidential interview with a staff. Refer to telephone interview with a medication aide (MA) on 01/26/21 at 2:02pm. Refer to telephone interview with a second MA on 01/26/21 at 3:44pm. Refer to telephone interview with a third MA on 01/27/21 at 11:33am. Refer to telephone interview with the Lead MA on 01/27/21 at 1:30pm. Refer to telephone interview with the MCM on 01/28/21 at 10:41am. Refer to telephone interview with the	D 392		

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D 392	Continued From page 109 Administrator on 01/28/21 at 3:19pm. Confidential interview with staff revealed: -At the beginning of each shift, medication staff counted the controlled medications in the medication cart with another staff member present. - The Lead medication aide (MA) instructed staff to record doses of medications as dropped if the count in the eMAR CS log tracking system did not match the number of doses remaining. -The eMAR CS tracking system flagged the medication if the counts did not match. -When this happened, the Lead MA was called to assist in matching the medication count. -Sometimes other MAs did not count the medications prior to taking over the cart. -When wasting the medication in the eMAR system, the signature of a witness/verifier should never be the same signature as the user on the CS log. -A medication could be recorded as wasted if the medication spilled. -Small doses of medications (ex.1,2,3) were recorded as received on the CS log to make the medication count match. Telephone interview with a MA on 01/26/21 at 2:02pm revealed: -The MAs did shift counts for the controlled substances using the tracking system in the eMARs. -When she first started administering medications in October and November 2020, the CS count was "off" multiple times. -If a medication was documented as wasted and dropped on the CS log, it was not usually actually wasted or dropped. -The MAs were told by the Lead MA to document wasted if the count was off in order to get the	D 392		

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D 392	Continued From page 110 count to match. -If the MAs did the CS shift count and the numbers did not match, they had 3 attempts to enter the correct count into the eMAR tracking system. -The MAs could not see what the count was supposed to be so if it did not match, they would call the Lead MA and try to figure out why it did not match. -The Lead MA had access to see the correct count on the eMAR system and would tell the MAs the correct number to enter into the eMAR. -The pharmacy did not usually send small quantities of 1 or 3 tablets of controlled medications. -If staff documented small quantities, like 1 tablet or 3 tablets, were received on the eMARs, it was because someone actually forgot to administer the tablet so it had to be added back into the balance. Telephone interview with a second MA on 01/26/21 at 3:44pm revealed: -A medication was recorded as wasted (dropped medication) on the CS logs when a medication was dropped on the floor and then discarded. -The MA in charge of the medication cart should sign the CS log as the user and the witness to the action should sign as the verifier. -No staff should sign as a witness to their own action/documentation. -The MAs did a CS shift count at each shift change by counting the controlled medications on hand and entering the count into the eMAR tracking system. -If they entered the wrong number, the system would flag it and they would have to count a second time. -If the count did not match the second time, they had to call the Memory Care Manager (MCM)	D 392		

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D 392	Continued From page 111 because the system would lock them out after 3 attempts. -If the CS count did not match, the MAs and the MCM tried to figure out why it did not match. -If they could not figure it out, they would add or deduct from the CS count so it would match since the MCM had access to the correct number on the eMAR system. Telephone interview with a third MA on 01/27/21 at 11:33am revealed: -If a medication on the CS log was documented as wasted and dropped it was because the pill was dropped onthe floor or water was spilled on the pill. -Sometimes controlled medications dispensed in a bottle would crumble when they were doing counts with the counting tray and spatula. -If a controlled medication was wasted, 2 different MAs were supposed to documented in the user column and the verifier (witness) column. -If a medication was wasted with "other" as the reason, she would normally type the reason why into the eMAR CS tracking system. -Sometimes they had trouble with the eMAR CS tracking system subtracting dosages administered so it "throws off the count", either causing too many or not enough on the balance. -When this occurred (usually once or twice a month), she would have to waste out tablets in the eMAR system so the CS count would be correct. -When she documented 1 tablet was received on the CS log, it was because the count did not match. -Sometimes when the CS counts did not match, the MAs had to contact the Lead MA (former MCM) and the Lead MA instructed the MAs to add or deduct the balance on the CS logs so the count would match up.	D 392		

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D 392	Continued From page 112 -She had not noticed any discrepancies with the CS counts since the new MCM started (about 2 weeks ago.) Telephone interview with the Lead MA on 01/27/21 at 1:30pm revealed: -When wasted and "other" was documented on the CS log, it was because a new supply of the controlled medication had been received. -The eMAR CS tracking system auto-generated a new order in the system when a new supply was received. -They had to take the old supply out of the system by documenting wasted/other and put the new order in the system. -The only time you would actually waste a controlled medication was if it was old or expired. -When the eMAR system generated a new order for a new supply, they just added the previous supply count with the new supply count. -For CS shift counts, the oncoming MA counted the controlled medications and the MA going off duty entered the count numbers into the eMAR tracking system. -If the CS count did not match, the MAs had 3 attempts to get it right before the system would lock them out. -The MAs had to call the MCM if the count did not match so the MCM could see why it did not match. -The CS count might not match if the MAs miscounted the tablets or if someone dropped a tablet. -The MAs may have to "waste" a dose or receive 1 dose back into the eMAR system to get the count to match back up. Telephone interview with the MCM on 01/28/21 at 10:41am revealed: -Some MAs did not understand how to document	D 392		

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D 392	Continued From page 113 information in the eMAR CS tracking system. -When "other" was documented, there was supposed to be a reason documented in the comment section. -If a new supply of a controlled medication was received, the eMAR CS tracking system would discontinue the old order from the system and that balance would be added to the count for the new supply. -The MAs had 3 attempts for the CS shift counts and if it did not match, only she, the Administrator and the Lead MA could see what the actual count should be in the eMAR system. -Sometimes the eMAR system would freeze up because of internet issues and a dose might not get deducted in the eMAR CS tracking system. -The MAs would have to document that reason in the comment section. -The MAs should not be taping the lids of new supplies of controlled medications dispensed in bottles. -She thought the MAs did this because the MAs did not want to count all of those tablets each time they did CS shift counts but anyone could remove the tape and tablets from the bottle and then re-tape it. Telephone interview with the Administrator on 01/28/21 at 3:19pm revealed: -There should be a comment on the CS logs to explain what "other" meant. -When the MAs did CS shift counts and the count did not match, she expected the MA not to accept the keys to the cart and they should get her or the MCM to verify the count. -Sometimes if a new supply of controlled medication was received, the remainder from the previous supply may be added to the new count. -The user and the verifier on the CS log should be 2 different staff because one had to be the	D 392		

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D 392	Continued From page 114 witness.	D 392		
D 618	10A NCAC 13F .1802 (a) Report & Notification of a Outbreak (temp) 10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK (a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in Rules 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the local health department (LHD) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents including reporting of a suspected outbreak to the LHD when two staff members tested positive for COVID-19. The findings are: Review of CDC Considerations for Preventing	D 618	10A NCAC 13F .1802 (a) Report & Notification of an Outbreak (temp) Weekly mass/rapid testing are conducted to help prevent the spread of Covid-19 or other communicable diseases. Executive Director is responsible for reporting test results weekly for all staff and residents to DVPO and Senior Vice President of Emergency Management. When the facility have a positive staff or resident the Executive Director is responsible for notifying the LHD, DVPO, Senior Vice President of Emergency Management and resident responsible party about the positive staff or resident from the date that they tested positive. Information consist of residents name, date of birth, specification of "resident" or "staff" and the date they tested positive. Care Manager will ensure Administrator has made Health Department notifications by confirming receipt of notification & Health Dept. Added on 03.17.21 @ 11:15am on phone & RCC and Adm — Adv	2/12/2021 2/12/2021

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D 618	Continued From page 115 Spread of COVID-19 in Assisted Living Facilities dated 05/20/20 revealed: -Assisted living facilities should identify a point of contact at the local health department to facilitate prompt notification including immediately notify the health department if COVID-19 is suspected or confirmed among residents or facility personnel. -Prompt notification of the health department about residents and personnel with suspected or confirmed COVID-19 is critical. -The health department can help ensure all recommended infection prevention and control measures are in place. -Rapid action to identify, isolate, and test others who might be infected is critical to prevent further spread. Review of the North Carolina Division Health and Human Services (NC DHHS) Guidelines for the Prevention and Spread of COVID-19 in Long Term Care Facilities dated 11/20/20 revealed a confirmed or suspected case of COVID-19 in a resident or staff of a long-term care setting should be immediately reported to the LHD. Review of NC DHHS COVID-19 Long-Term Care Infection Control Assessment and Response (ICAR) Tool revealed when a new facility-onset case is identified, the facility should consult with public health and follow testing guidance. Review of the facility's COVID-19 infection control policy dated 10/21/20 revealed: -Residents and/or Community staff with Coronavirus-like illness, especially if there is a cluster (two or more cases of Coronavirus-like illnesses within 72 hours) should be tested for Coronavirus. -Contact the local health department via	D 618		

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D 618	Continued From page 116 telephone for appropriate diagnostic laboratory test recommendations. -Upon the receipt of any positive test results for residents or employees, the local health department should be immediately notified via telephone and documentation of this notification should be maintained by the Executive Director. -Health department personnel can provide information about Coronavirus activity in the area and about diagnostic specimen collection and coordination. -Once an outbreak has been identified, outbreak prevention and control measures should be implemented immediately; and the local health department must be notified. Review of the facility's resident roster revealed the facility's current census was 38 residents. Interview with the Administrator on 01/21/21 at 10:14am revealed: -The facility was conducting weekly staff COVID-19 testing using the rapid test. -The Administrator and Memory Care Manager (MCM) were trained on performing the tests. -The facility received guidance on COVID-19 from their corporate office and the NC DHHS updates. -There were two staff that tested positive for COVID-19 in December of 2020. -One of the staff members tested positive for COVID-19 at their family physician's office on 12/16/20. -The second staff member tested positive for COVID-19 during a routine weekly test at the facility on 12/28/20. -Both staff members stayed out of work for over 21 days after their positive results. -She notified the Clinical Director of the two staff who tested positive for COVID-19. -She sent the positive results to the corporate	D 618		

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D 618	Continued From page 117 Senior Vice President of Emergency Management. -The Senior Vice President of Emergency Management was responsible for notifying agencies including the LHD. -She did not notify the LHD of the two staff who tested positive for COVID-19. -She responded to a weekly email inquiry from the ombudsman about the number of positive diagnoses in the facility. Telephone interview with the LHD communicable disease nurse on 01/25/21 at 11:12am revealed: -The facility had not contacted the LHD about the two staff members who tested positive for COVID-19 in December of 2020. -The LHD attempted to contact the staff member that had a positive result from the local hospital lab twice by phone and once by letter with no response. -She was not aware that the person they were trying to contact was a staff member of the facility. -The LHD was aware of the positive case because the local hospital lab notified them. -The facility would be considered in 'outbreak' status because of the proximity of the two positive staff case dates. -The facility should follow the guidelines provided by the CDC and NC DHHS related to LHD notification. Telephone interview with the Administrator on 01/26/21 at 8:40am revealed: -The Administrator was responsible for notifying the LHD of positive COVID-19 results. -She was not aware in December 2020 that she was responsible for notifying the LHD. -A resident on the Special Care Unit (SCU) was sent to the emergency room on 01/25/21 and	D 618		

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D 618	Continued From page 118 tested positive for COVID-19. -She notified the LHD today (01/26/21) that the facility had a positive resident. Telephone interview with the facility's Clinical Director on 01/28/21 at 2:01pm revealed: -The process for reporting positive COVID-19 results for residents and staff was for the Administrator to notify her and the Senior Vice President of Emergency Management by completing the facility's COVID-19 spreadsheet. -The Senior Vice President of Emergency Management was responsible for reporting the information to the different agencies including the LHD. Telephone interview with the facility's Senior Vice President of Emergency Management on 01/28/21 at 4:09pm revealed: -When there was a resident or staff who tested positive for COVID-19, the Administrator was responsible for completing and sending the COVID-19 spreadsheet to their supervisor and him. -It was the responsibility of the Administrator to notify the LHD of staff and residents who tested positive for COVID-19. Second telephone interview with the LHD communicable disease nurse on 01/26/21 at 1:44pm revealed: -If the LHD was aware of the staff that tested positive for COVID-19 they would have provided additional guidance to the facility to include routine mass testing of all residents and staff members. -The facility would have remained in outbreak status for at least 28 days. -She received a call this morning from the facility's Administrator reporting the two staff that	D 618		

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D 618	Continued From page 119 tested positive for COVID-19 in December 2020 and the resident that tested positive for COVID-19 during their emergency room visit this morning. The facility failed to follow the Centers for Disease Control (CDC) and North Carolina Department of Health and Human Services (NC DHHS) guidelines for notification of the local health department (LHD) of staff and residents with confirmed COVID-19 diagnoses. The facility's failure resulted in the facility not receiving guidance from the LHD on measures for preventing and decreasing transmission and infection, and mass testing not being coordinated timely resulting in a delay in testing which placed the residents at increased risk for contracting and transmitting COVID-19. The facility's failure was detrimental to the residents' health, safety and welfare and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/27/21 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 14, 2021.	D 618		
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:	D912	GS 131D-21(2) Declaration of Resident Rights Facility has implemented systems and procedures to ensure residents will receive personal care services that includes adequate, appropriate care within compliance of federal and state laws, rules and regulations.	2/12/2021

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D912	Continued From page 120 Based on observations, interviews, and record reviews, the facility failed to ensure 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 and reporting and notification of a suspected or confirmed communicable disease outbreak. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 6 residents (#9, #10) observed during the medication pass including errors with a medication for constipation (#9) and a medication used to lower cholesterol and triglycerides (#10); and for 4 of 6 residents sampled (#1, #4, #5, #7) including errors with medications for glaucoma (#7), high blood pressure (#1, #5), blood thinning (#5), mood disorders (#5), insomnia (#4), constipation (#4, #5), iron supplement (#5), calcium supplement (#4), and a Vitamin B supplement (#5). [Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the medication passes on 01/20/21 and 01/21/20 by 2 of 2 medication aides observed who failed to wash or sanitize their hands prior to preparing and after administering insulin and oral medications to multiple residents; and sharing eye drops between two residents (#7, #13). [Refer to Tag D0371 10A NCAC 13F .1004(n) Medication Administration (Type B Violation).]	D912	Continued From Page 120 Facility staff have made revisions to all residents care plans, in-services to all staff, conduct daily walk-throughs and consult with resident's concerning their needs. Ensure all referrals and follow-up on routine/acute care needs. Also, conduct daily stand-up and at-risk weekly minutes. In-serviced staff on medication administration, infection control and Residents Rights.	2/12/2021 2/12/2021

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D912	Continued From page 121 3. Based on interviews and record reviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the local health department (LHD) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents including reporting of a suspected outbreak to the LHD when two staff members tested positive for COVID-19. [Refer to Tag D0618 10A NCAC 13F .1802(a) Reporting and Notification of a Suspected or Confirmed Communicable Disease Outbreak (Type B Violation).]	D912		