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| C 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on 04/23/21 and 04/26/21. The Durham County Department of Social Services was present for the survey on 04/23/21. | C 000 | | |
| C 249 | 10A NCAC 13G .0902(c)(3)(4) Health Care<br><br>10A NCAC 13G .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure implementation of orders for 1 of 3 sampled residents related to finger stick blood sugar (FSBS) checks (#3).<br><br>The findings are:<br><br>1. Review of Resident #3's current FL2 dated 09/24/20 revealed:<br>-Diagnoses included schizophrenia, high blood pressure, diabetes, and dyslipidemia.<br>-There was an order for finger stick blood sugar (FSBS) checks before meals and at bedtime.<br><br>Review of an after visit summary from Resident #3's primary care provider (PCP) dated 02/24/21 revealed FSBS checks before meals and at bedtime was listed as an active order. | C 249 | | |

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Review of Resident #3's February 2021 medication administration record (MAR) revealed:
-There was an entry for FSBS checks two times daily scheduled at 8:00am and 5:00pm.
-There was documentation Resident #3's FSBS was checked twice daily from 02/01/21-02/28/21 at 8:00am and 5:00pm.

Review of Resident #3's March 2021 and April 2021 MARs revealed:
-There was an entry for FSBS checks two times daily scheduled at 8:00am and 8:00pm.
-There was documentation Resident #3's FSBS was checked twice daily from 03/01/21-04/22/21 at 8:00am and 8:00pm.
-There was documentation Resident #3's FSBS was checked once on 04/23/21 at 8:00am.

Observation of Resident #3's medication on hand on 04/26/21 at 12:20pm revealed:
-There were two boxes with a label indicating 100 FSBS test strips were dispensed by the pharmacy on 06/04/19.
-The instructions on the label read check blood sugar two times daily and record.
-There was a glucometer and several test strips in a case.

Telephone interview with a representative from the facility's contracted pharmacy on 04/26/21 at 1:51pm revealed:
-Resident #3's FSBS had been ordered twice daily since October 2019.
-The pharmacy had not received any other orders related to Resident #3's FSBS checks.

Telephone interview with a Supervisor-in-Charge (SIC) on 04/26/21 at 2:50pm revealed Resident #3's FSBS checks were conducted two times each day.

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| C 249 | Continued From page 2<br><br>Interview with the Administrator on 04/26/21 at 3:55pm revealed:<br>-She did not know Resident #3 had FSBS checks ordered before meals and at bedtime.<br>-She thought Resident #3's FSBS were ordered twice a day.<br>-She could not find the order for FSBS checks twice a day.<br>-She had not noticed Resident #3's order for FSBS checks before meals and at bedtime on Resident #3's FL2 or the PCP after visit summary dated 02/24/21.<br><br>Attempted telephone interviews with Resident #3's PCP's office on 04/23/21 at 2:41pm and 04/26/21 at 2:07pm were unsuccessful. | C 249 | | |
| C 330 | 10A NCAC 13G .1004(a) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br>(a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure the administration of medication was in accordance with orders by a licensed prescribing practitioner for 2 of 3 sampled residents (#2 and #3) related to a medication used to treat schizophrenia and a | C 330 | | |

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nicotine lozenge (#2) and medications used for treatment of psychiatric conditions (#3).

The findings are:

1. Review of Resident #3's current FL2 dated 09/24/20 revealed diagnoses included schizophrenia, high blood pressure, diabetes, and dyslipidemia.

a. Review of Resident #3's current FL2 dated 09/24/20 revealed there was an order for divalproex (used to treat psychiatric conditions) 500mg take two tablets twice a day.

Review of Resident #3's February 2021-April 2021 medication administration records (MARs) revealed there was no entry for divalproex 500mg.

Observation of Resident #3's medication available for administration on 04/26/21 at 12:20pm revealed there was no divalproex 500mg available for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/26/21 at 2:10pm revealed Resident #3's divalproex was discontinued on 12/10/20.

Review of a medication summary for Resident #3 sent via fax to the facility from Resident #3's mental health (MH) provider on 04/26/21 revealed there was an order dated 01/28/21 for divalproex 500mg take two tablets twice daily.

Interview with the Administrator on 04/26/21 at 3:55pm revealed she did not know Resident #3 had an active order for divalproex.

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Attempted telephone interview with Resident #3's MH provider on 04/26/21 at 5:08pm was unsuccessful.

Refer to the telephone interview with the RN on 04/23/21 at 4:25pm.

Refer to the interviews with the Administrator on 04/26/21 at 9:09am and 3:55pm.

Refer to the telephone interview with the RN on 04/26/21 at 3:12pm.

b. Review of Resident #3's current FL2 dated 09/24/20 revealed there was an order for paliperidone (used to treat schizophrenia) 3mg take one tablet every morning.

Review of Resident #3's February 2021-April 2021 medication administration records (MARs) revealed there was no entry for paliperidone 3mg.

Observation of Resident #3's medication available for administration on 04/26/21 at 12:20pm revealed there was no paliperidone 3mg available for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/26/21 at 2:10pm revealed Resident #3's paliperidone was discontinued on 10/07/20.

Review of a medication summary for Resident #3 sent via fax from Resident #3's mental health (MH) provider to the facility on 04/26/21 revealed there was an order dated 01/28/21 for paliperidone 3mg take two tablets twice daily.

Interview with the Administrator on 04/26/21 at 3:55pm revealed she did not know Resident #3

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had an active order for paliperidone.

Attempted telephone interview with Resident #3's MH provider on 04/26/21 at 5:08pm was unsuccessful.

Refer to the telephone interview with the RN on 04/23/21 at 4:25pm.

Refer to the interviews with the Administrator on 04/26/21 at 9:09am and 3:55pm.

Refer to the telephone interview with the RN on 04/26/21 at 3:12pm.

2. Review of Resident #2's current FL2 dated 09/03/20 revealed diagnoses included schizoaffective disorder, bipolar type, high blood pressure, chronic obstructive pulmonary disease (COPD), chronic kidney disease, tobacco use disorder, and Von Willebrand disease (a blood clotting disorder).

a. Review of an after visit summary from Resident #2's primary care provider (PCP) dated 12/14/20 revealed there was an order for fluphenazine (used to treat schizophrenia) 25mg/milliliter (ml) injection, inject one ml every four weeks.
Review of an after visit summary from Resident #2's PCP dated 04/20/21 revealed there were instructions to discontinue fluphenazine 25mg/ml injection.
Review of Resident #2's April 2021 medication administration record (MAR) revealed:
-There was an entry for fluphenazine 25mg/ml inject one ml every four weeks.
-There was no documentation fluphenazine 25/ml had been discontinued.
-There was documentation fluphenazine had

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been administered on 04/26/21 at 8:00am.

Observation of Resident #2's medication available for administration on 04/26/21 at 10:55am revealed there was no fluphenazine 125/5ml available for administration.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/26/21 at 1:51pm revealed:
-Facility staff were responsible for sending medication orders to the pharmacy.
-The pharmacy did not receive an order to discontinue Resident #2's fluphenazine 25mg/1ml injection.

Interview with the SIC on 04/23/21 at 2:17pm revealed:
-He accompanied Resident #2 to his PCP appointment on 04/20/21.
-The PCP's staff routinely sent orders to the pharmacy.
-The facility's Registered Nurse (RN) was responsible for transcribing the orders on the MARs.
-Either the Administrator or the Director provided copies of the orders to the RN.

Interview with the SIC on 04/26/21 at 2:25pm revealed:
-He took Resident #2 to the PCP on 04/20/21.
-He filed the after visit summary in Resident #2's record.
-The Director, RN, or Administrator were supposed to review the after visit summary.
-The Director, RN, and Administrator knew Resident #2 had an appointment because there was a calendar listing all the appointments for the residents.
-The Director, RN, or Administrator were

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responsible for transcribing orders on the MARs.
-The RN visited the facility weekly.

Telephone interview with the RN on 04/26/21 at 3:12pm revealed:
-The after visit summary from Resident #2's PCP's appointment on 04/20/21 was supposed to be faxed to the pharmacy by staff.
-She did not know Resident #2's orders had changed after his 04/20/21 PCP appointment; no one had told her.

Interview with the Administrator on 04/26/21 at 3:55pm revealed she was not aware of Resident #2's medication changes after his PCP's appointment on 04/20/21.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

Attempted interview with Resident #2's PCP on 04/26/21 at 1:47pm was unsuccessful.

Attempted interview with the Director on 04/26/21 at 2:30pm was unsuccessful.

Refer to the telephone interview with the RN on 04/23/21 at 4:25pm.

Refer to the interviews with the Administrator on 04/26/21 at 9:09am and 3:55pm.

Refer to the telephone interview with the RN on 04/26/21 at 3:12pm.

b. Review of an after visit summary from Resident #2's primary care provider (PCP) dated 12/05/21 revealed there was an order for nicotine 4mg lozenge dissolve one lozenge slowly every

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two to four hours.

Review of an after visit summary from Resident #2's primary care provider (PCP) dated 04/20/21 revealed there were instructions to discontinue nicotine 4mg lozenge.

Review of Resident #2's April 2021 medication administration record (MAR) on 04/23/21 revealed:
-There was an entry for nicotine 4mg lozenge dissolve one lozenge slowly in the mouth every two to four hours.
-There was no documentation nicotine 4mg had been discontinued.
-There was no documentation related to the administration of nicotine 4mg.

Review of Resident #2's April 2021 MAR on 04/26/21 revealed:
-There was an entry for nicotine 4mg lozenge dissolve one lozenge slowly in the mouth every two to four hours scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was no documentation nicotine 4mg had been discontinued.
-A Supervisor-in-Charge's (SIC) initials were documented from 04/01/21-04/22/21 for all administration times.
-The Administrator's initials were documented from 04/23/21-04/25/21 for all administration times.
-There was documentation in the exception notes indicating Resident #2 had refused the nicotine 4mg lozenge from 04/01/21-04/19/21.
-There were no initials indicating who had documented Resident #2's refusals of nicotine 4mg.

Observation of Resident #2's medication

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available for administration on 04/26/21 at 10:55am revealed:
-There was one box containing an unknown amount of nicotine 4mg lozenges dispensed by the pharmacy on 05/07/20 available for administration.
-There were two unopened boxes, each containing 72 nicotine 4mg lozenges dispensed by the pharmacy on 10/20/20 available for administration.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/26/21 at 1:51pm revealed:
-Facility staff were responsible for sending medication orders to the pharmacy.
-The pharmacy did not receive an order to discontinue Resident #2's nicotine 4mg lozenge.

Interview with the SIC on 04/26/21 at 2:25pm revealed:
-He took Resident #2 to the PCP on 04/20/21.
-He filed the after visit summary in Resident #2's record.
-The Director, RN, or Administrator were supposed to review the after visit summary.

Telephone interview with the RN on 04/26/21 at 3:12pm revealed the after visit summary was supposed to be faxed to the pharmacy by staff.

Interview with the Administrator on 04/26/21 at 3:55pm revealed she was not aware of Resident #2's medication changes after his PCP's appointment on 04/20/21.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

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| C 330 | Continued From page 10<br>Attempted interview with Resident #2's PCP on 04/26/21 at 1:47pm was unsuccessful.<br><br>Attempted interview with the Director on 04/26/21 at 2:30pm was unsuccessful.<br><br>Refer to the telephone interview with the RN on 04/23/21 at 4:25pm.<br><br>Refer to the interviews with the Administrator on 04/26/21 at 9:09am and 3:55pm.<br><br>Refer to the telephone interview with the RN on 04/26/21 at 3:12pm.<br><br>_____<br>Telephone interview with the RN on 04/23/21 at 4:25pm revealed:<br>-She reviewed the MARs monthly.<br>-When she reviewed the MARs, she would make sure the MARs matched the PCP's orders.<br>-The last time she was at the facility was sometime in March 2021.<br><br>Interviews with the Administrator on 04/26/21 at 9:09am and 3:55pm revealed:<br>-Staff were responsible for accompanying residents to PCP appointments.<br>-Changes to residents' medications were sent electronically from the PCP to the pharmacy.<br>-She checked in daily and visited the facility twice each week.<br>-The Director was at the facility almost every day.<br>-The RN visited the facility weekly.<br>-She was a medication aide (MA), but the Director and RN had more experience than she did.<br>-She relied on the professional experience of the RN and the Director related to medication orders.<br>-The RN and the Director were responsible for overseeing the administration of medication. | C 330 | | |

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| C 330 | Continued From page 11<br>-She needed to take a more active role related to keeping track of medication orders.<br><br>Telephone interview with the RN on 04/26/21 at 3:12pm revealed:<br>-Staff were supposed to contact her for guidance if they did not understand or know what to do about an order.<br>-She checked to make sure orders were up-to-date once or twice each month and as needed.<br>-She provided training on transcribing orders to the SICs during orientation when each was first hired at the facility.<br>-The Administrator was at the facility one day each week.<br>-The Director was at the facility more frequently than the Administrator. | C 330 | | |
| C 342 | 10A NCAC 13G .1004(j) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and | C 342 | | |

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| C 342 | Continued From page 12<br>(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).<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure the medication administration records (MARs) were accurate for 3 of 3 sampled residents (#1, #2, and #3) including an order for an a medication used to treat agitation (#1), a medication used to treat schizophrenia, a nicotine lozenge, and a medication used to treat inflammation and itching (#2), and medications used to treat schizophrenia (#3).<br><br>The findings are:<br><br>1. Review of Resident #1's current FL-2 dated 09/21/20 revealed diagnoses included bipolar disorder, type II, traumatic brain injury, spinal injury with sequela, and hypothyroidism.<br><br>Review of Resident #1's physician's orders revealed there was an order dated 02/26/21 for ativan (used to treat agitation) 0.5mg take one tablet twice a day as needed for agitation.<br><br>Review of Resident #1's medication administration record (MAR) for February 2021 revealed:<br>-There was a handwritten entry for lorazepam (ativan) 0.5mg take one tablet daily scheduled for administration at 12:00pm.<br>-There was documentation ativan 0.5mg had been administered at 12:00pm from 02/26/21-02/28/21 for "aggravation." | C 342 | | |

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| C 342 | Continued From page 13<br><br>Review of Resident #1's MAR for March 2021 revealed:<br>-There was an electronically printed entry for ativan 0.5mg take one tablet twice a day as needed.<br>-There was no documentation ativan 0.5mg had been administered during March 2021.<br><br>Review of Resident #1 MAR for April 2021 revealed:<br>-There was an electronically printed entry for ativan 0.5mg take one tablet twice a day as needed.<br>-There was documentation ativan 0.5mg had been administered at 5:00pm on 04/19/21 for agitation.<br><br>Observation of Resident #1's medication on hand on 04/23/21 at 5:22pm revealed:<br>-The pharmacy dispensed 30 ativan 0.5mg tablets on 02/26/21.<br>-There were 22 ativan 0.5mg tablets available for Administration to Resident #1.<br><br>Review of a controlled substance count sheet for Resident #1's ativan 0.5mg on 04/26/21 revealed:<br>-There was documentation Resident #1 received ativan 0.5mg at 8:00am and 8:00pm each day from 02/26/21-02/28/21.<br>-There was documentation Resident #1 received ativan 0.5mg at 5:00pm on 04/19/21.<br>-There was documentation Resident #1 received ativan 0.5mg at 8:00am on 04/20/21.<br><br>Interview with the Administrator on 04/26/21 at 9:09am revealed Resident #1's ativan was administered more frequently than documented on the MARs. | C 342 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| C 342 | Continued From page 14<br><br>Interview with the facility's Registered Nurse (RN) on 04/26/21 at 9:10am revealed she did not review the February 2021 MAR after Resident #1's ativan order was transcribed on the MAR.<br><br>Interview with a Supervisor-in-Charge (SIC) on 04/26/21 at 2:25pm revealed he forgot to document the administration of Resident #1's ativan 0.5mg on the MAR on 04/20/21 because things were "busy" when Resident #1 was agitated.<br><br>Interview with the Administrator on 04/26/21 at 3:55pm revealed staff were "comfortable" and forgot to document on the MARs in a timely manner.<br><br>Attempted interview with the Director on 04/26/21 at 2:30pm was unsuccessful.<br><br>Refer to the interview with the SIC on 04/23/21 at 2:17pm.<br><br>Refer to the interview with a second SIC on 04/23/21 at 2:29pm.<br><br>Refer to the interview with the RN on 04/23/21 at 4:25 pm.<br><br>Refer to the interview with the Administrator on 04/26/21 at 9:09am.<br><br>Refer to the interview with the RN on 04/26/21 at 9:10am.<br><br>Refer to the interview with the first SIC on 04/26/21 at 2:25pm.<br><br>Refer to the telephone interview with the RN on 04/26/21 at 3:12pm. | C 342 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| C 342 | Continued From page 15<br><br>Refer to the second interview with the Administrator on 04/26/21 at 3:55pm.<br><br>2. Review of Resident #3's most current FL2 dated 09/24/20 revealed diagnoses included schizophrenia, diabetes, high blood pressure, and dyslipidemia<br><br>a. Review of Resident #3's most current FL2 dated 09/24/20 revealed there was an order for divalproex (used to treat psychiatric conditions) 500mg take two tablets twice a day.<br><br>Review of a medication summary for Resident #3 revealed there was an order dated 01/28/21 for divalproex 500mg take two tablets twice a day.<br><br>Review of Resident #3's February 2021-April 2021 medication administration records (MAR) revealed there was no entry for divalproex 500mg take two tablets twice a day.<br><br>Observation of Resident #3's medication available for administration on 04/26/21 at 12:20pm revealed there was no divalproex 500mg available for administration.<br><br>Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/26/21 at 2:10pm revealed Resident #3's divalproex was discontinued on 12/10/20.<br><br>Interview with the Administrator on 04/26/21 at 3:55pm revealed she did not know Resident #3 had an active order for divalproex.<br><br>Attempted telephone interview with Resident #3's primary care provider (PCP) on 04/26/21 at 2:41pm was unsuccessful. | C 342 | | |

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| C 342 | Continued From page 16<br><br>Attempted telephone interview with Resident #3's mental health (MH) provider on 04/26/21 at 5:08pm was unsuccessful.<br><br>Attempted interview with the Director on 04/26/21 at 2:30pm was unsuccessful.<br><br>Refer to the interview with the SIC on 04/23/21 at 2:17pm.<br><br>Refer to the interview with a second SIC on 04/23/21 at 2:29pm.<br><br>Refer to the interview with the RN on 04/23/21 at 4:25 pm.<br><br>Refer to the interview with the Administrator on 04/26/21 at 9:09am.<br><br>Refer to the interview with the RN on 04/26/21 at 9:10am.<br><br>Refer to the interview with the first SIC on 04/26/21 at 2:25pm.<br><br>Refer to the telephone interview with the RN on 04/26/21 at 3:12pm revealed:<br><br>Refer to the second interview with the Administrator on 04/26/21 at 3:55pm.<br><br>b. Review of Resident #3's most current FL2 dated 09/24/20 revealed there was an order for paliperidone (used to treat schizophrenia) 3mg take one tablet every morning.<br><br>Review of a medication summary for Resident #3 revealed there was an order dated 01/28/21 for paliperidone take one tablet every morning. | C 342 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| C 342 | Continued From page 17<br><br>Review of Resident #3's February 2021-April 2021 medication administration records (MAR) revealed there was no entry for paliperidone 3mg take one tablet every morning.<br><br>Review of Resident #3's medication available for administration on 04/26/21 at 12:20pm revealed there was no paliperidone available for administration.<br><br>Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/26/21 at 2:10pm revealed Resident #3's paliperidone was discontinued on 10/07/20.<br><br>Interview with the Administrator on 04/26/21 at 3:55pm revealed she did not know Resident #3 had an active order for paliperidone.<br><br>Attempted telephone interview with Resident #3's primary care provider (PCP) on 04/26/21 at 2:41pm was unsuccessful.<br><br>Attempted telephone interview with Resident #3's mental health (MH) provider on 04/26/21 at 5:08pm was unsuccessful.<br><br>Attempted interview with the Director on 04/26/21 at 2:30pm was unsuccessful.<br><br>Refer to the interview with the SIC on 04/23/21 at 2:17pm.<br><br>Refer to the interview with a second SIC on 04/23/21 at 2:29pm.<br><br>Refer to the interview with the RN on 04/23/21 at 4:25 pm. | C 342 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| C 342 | Continued From page 18<br>Refer to the interview with the Administrator on 04/26/21 at 9:09am.<br><br>Refer to the interview with the RN on 04/26/21 at 9:10am.<br><br>Refer to the interview with the first SIC on 04/26/21 at 2:25pm.<br><br>Refer to the telephone interview with the RN on 04/26/21 at 3:12pm revealed:<br><br>Refer to the second interview with the Administrator on 04/26/21 at 3:55pm.<br><br>3. Review of Resident #2's most current FL2 dated 09/03/20 revealed diagnoses included schizoaffective disorder, bipolar type, high blood pressure, chronic obstructive pulmonary disease (COPD), chronic kidney disease, tobacco use disorder, and Von Willebrand disease (a blood clotting disorder).<br><br>a. Review of an after visit summary from Resident #2's primary care provider (PCP) dated 12/14/20 revealed there was an order for fluphenazine (used to treat schizophrenia) 25mg/milliliter (ml) injection, inject one ml every four weeks.<br><br>Review of an after visit summary from Resident #2's PCP dated 04/20/21 revealed there were instructions to discontinue fluphenazine 25mg/ml injection.<br><br>Review of Resident #2's April 2021 medication administration record (MAR) revealed:<br>-There was an entry for fluphenazine 25mg/ml inject one ml every four weeks.<br>-There was no documentation fluphenazine 25/ml | C 342 | | |

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had been discontinued.
-There was documentation fluphenazine had been administered on 04/26/21 at 8:00am.

Observation of Resident #2's medication available for administration on 04/26/21 at 10:55am revealed there was no fluphenazine 125/5ml available for administration.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/26/21 at 1:51pm revealed:
-Facility staff were responsible for sending medication orders to the pharmacy.
-The pharmacy did not receive an order to discontinue Resident #2's fluphenazine 25mg/1ml injection.

Interview with the SIC on 04/26/21 at 2:25pm revealed:
-He took Resident #2 to his PCP appointment on 04/20/21.
-He filed the after visit summary in resident #2's record.
-The Director, the facility's Registered Nurse (RN), or the Administrator were supposed to review the after visit summary.

Telephone interview with the RN on 04/26/21 at 3:12pm revealed:
-The after visit summary from Resident #2's 04/20/21 PCP's appointment was supposed to be faxed to the pharmacy by staff.
-She did not know Resident #2's orders had changed after his 04/20/21 appointment; no one had told her.

Interview with the Administrator on 04/26/21 at 3:55pm revealed she was not aware of Resident #2's medication changes after his PCP

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| C 342 | Continued From page 20<br>appointment on 04/20/21.<br><br>Attempted interview with the Director on 04/26/21 at 2:30pm was unsuccessful.<br><br>Refer to the interview with the SIC on 04/23/21 at 2:17pm.<br><br>Refer to the interview with a second SIC on 04/23/21 at 2:29pm.<br><br>Refer to the interview with the RN on 04/23/21 at 4:25 pm.<br><br>Refer to the interview with the Administrator on 04/26/21 at 9:09am.<br><br>Refer to the interview with the RN on 04/26/21 at 9:10am.<br><br>Refer to the interview with the first SIC on 04/26/21 at 2:25pm.<br><br>Refer to the telephone interview with the RN on 04/26/21 at 3:12pm.<br><br>Refer to the second interview with the Administrator on 04/26/21 at 3:55pm.<br><br>b. Review of an after visit summary from Resident #2's primary care provider (PCP) dated 12/05/21 revealed there was an order for nicotine 4mg lozenge dissolve one lozenge slowly every two to four hours.<br><br>Review of an after visit summary from Resident #2's PCP dated 04/20/21 revealed there were instructions to discontinue nicotine 4mg lozenge.<br><br>Review of Resident #2's April 2021 medication | C 342 | | |

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administration record (MAR) on 04/23/21 revealed:
-There was an entry for nicotine 4mg lozenge dissolve one lozenge slowly in the mouth every two to four hours.
-There was no documentation nicotine 4mg had been discontinued.
-There was no documentation related to the administration of nicotine 4mg.

Review of Resident #2's April 2021 MAR on 04/26/21 revealed:
-There was an entry for nicotine 4mg lozenge dissolve one lozenge slowly in the mouth every two to four hours scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was no documentation nicotine 4mg had been discontinued.
-An SIC's initials were documented from 04/01/21-04/22/21 for all administration times.
-The Administrator's initials were documented from 04/23/21-04/25/21 for all administration times.
-There was documentation in the exception notes indicating Resident #2 had refused the nicotine 4mg lozenge from 04/01/21-04/19/21.
-There were no initials indicating who had documented Resident #2's refusals of nicotine 4mg.

Observation of Resident #2's medication available for administration on 04/26/21 at 10:55am revealed:
-There was one box containing an unknown amount of nicotine 4mg lozenges dispensed by the pharmacy on 05/07/20 available for administration.
-There were two unopened boxes containing 72 nicotine 4mg lozenges dispensed by the pharmacy on 10/20/20 available for

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| C 342 | Continued From page 22<br>administration.<br><br>Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/26/21 at 1:51pm revealed:<br>-Facility staff were responsible for sending medication orders to the pharmacy.<br>-The pharmacy did not receive a discontinue order for Resident #2's nicotine 4mg lozenge.<br><br>Interview with the SIC on 04/26/21 at 2:25pm revealed the Director, the facility's Registered Nurse (RN), or the Administrator were supposed to review the after visit summary.<br><br>Telephone interview with the RN on 04/26/21 at 3:12pm revealed the after visit summary was supposed to be faxed to the pharmacy by staff.<br><br>Interview with the Administrator on 04/26/21 at 3:55pm revealed:<br>-She documented Resident #2's refusal of nicotine 4mg lozenge after she had provided copies of the MAR to the surveyor.<br>-"We documented and he didn't even have an order for it."<br>-She documented the refusals because the RN told her the MARs would be accurate if she added the information.<br><br>Attempted interview with a second SIC on 04/26/21 at 3:10pm was unsuccessful.<br><br>Attempted interview with the Director on 04/26/21 at 2:30pm was unsuccessful.<br><br>Refer to the interview with the SIC on 04/23/21 at 2:17pm.<br><br>Refer to the interview with a second SIC on | C 342 | | |

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| C 342 | Continued From page 23<br>04/23/21 at 2:29pm.<br><br>Refer to the interview with the RN on 04/23/21 at 4:25 pm.<br><br>Refer to the interview with the Administrator on 04/26/21 at 9:09am.<br><br>Refer to the interview with the RN on 04/26/21 at 9:10am.<br><br>Refer to the interview with the first SIC on 04/26/21 at 2:25pm.<br><br>Refer to the telephone interview with the RN on 04/26/21 at 3:12pm.<br><br>Refer to the second interview with the Administrator on 04/26/21 at 3:55pm.<br><br>c. Review of an after visit summary from Resident #2's primary care provider (PCP) dated 04/20/21 revealed there was an order for triamcinolone 0.1% cream (used to treat inflammation and itching) apply two times each day.<br><br>Review of Resident #2's April 2021 medication administrator record (MAR) on 04/23/21 revealed there was no entry for triamcinolone 0.1% cream.<br><br>Observation of Resident #2's medication available for administration on 04/26/21 at 10:55am revealed there were three unopened 15 gram tubes of triamcinolone 0.1% cream dispensed by the pharmacy on 04/20/21.<br><br>Interview with the SIC on 04/26/21 at 2:25pm revealed:<br>-Resident #2's triamcinolone 0.1% cream was delivered to the facility on 04/21/21. | C 342 | | |

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-He had been applying Resident #2's triamcinolone twice a day as ordered.
-There was an open tube of Resident #1's triamcinolone in the facility.
-The facility's Registered Nurse (RN), Director, or Administrator should have written the order on Resident #2's April 2021 MAR.
-He knew he was supposed to apply the triamcinolone because it was written on the after visit summary from Resident #2's PCP appointment on 04/20/21.
-He did not tell the RN, Director, or Administrator to write the order on Resident #2's April 2021 MAR.
-"I thought they would write it like they always do."

Observation and interview on 04/26/21 at 3:00pm revealed:
-The SIC brought an unlabeled tube of triamcinolone from the staff bedroom.
-The SIC said the triamcinolone was for Resident #2.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

Attempted interview with Resident #2's PCP on 04/26/21 at 1:47pm was unsuccessful.

Attempted interview with the Director on 04/26/21 at 2:30pm was unsuccessful.

Refer to the interview with the SIC on 04/23/21 at 2:17pm.

Refer to the interview with a second SIC on 04/23/21 at 2:29pm.

Refer to the interview with the RN on 04/23/21 at

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| C 342 | Continued From page 25<br>4:25 pm.<br><br>Refer to the interview with the Administrator on 04/26/21 at 9:09am.<br><br>Refer to the interview with the RN on 04/26/21 at 9:10am.<br><br>Refer to the interview with the first SIC on 04/26/21 at 2:25pm.<br><br>Refer to the telephone interview with the RN on 04/26/21 at 3:12pm revealed:<br><br>Refer to the second interview with the Administrator on 04/26/21 at 3:55pm.<br>_____<br>Interview with the Supervisor-in-Charge (SIC) on 04/23/21 at 2:17pm revealed:<br>-The facility's RN was responsible for transcribing new orders on the MAR.<br>-The Administrator or the Director gave the orders to the RN to enter on the MAR.<br>-The Administrator reviewed the MARs each day.<br><br>Interview with a second SIC on 04/23/21 at 2:29pm revealed:<br>-The other SIC was responsible for transcribing orders on the MAR.<br>-The Director was responsible for keeping the MARs up-to-date.<br>-The Director reviewed the MARs weekly and the Administrator double checked the MARs.<br><br>Telephone interview with the RN on 04/23/21 at 4:25pm revealed:<br>-She reviewed the MARs monthly.<br>-She matched the MARs with the medication orders when she reviewed the MARs.<br>-The last time she was at the facility was in March | C 342 | | |

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| C 342 | Continued From page 26<br>2021.<br><br>Interview with the Administrator on 04/26/21 at 9:09am revealed, as the Administrator, she was responsible for the accuracy of the MARs.<br><br>Interview with the RN on 04/26/21 at 9:10am revealed:<br>-The SICs needed more training on transcribing orders on the MARs; training had "slowed down" because of the coronavirus (COVID-19) pandemic.<br>-The Director and the Administrator also reviewed the MARs for accuracy.<br><br>Interview with the first SIC on 04/26/21 at 2:25pm revealed:<br>-The Director, RN, or Administrator were responsible for transcribing orders on the MARs.<br>-The Director and the RN routinely reviewed the MARs.<br>-The RN visited the facility weekly.<br><br>Telephone interview with the RN on 04/26/21 at 3:12pm revealed both of the SICs were trained by her on transcribing orders to the MARs during their initial orientation.<br><br>Second interview with the Administrator on 04/26/21 at 3:55pm revealed:<br>-The SICs were responsible for transcribing new orders on the MARs.<br>-The Director and RN were responsible for the accuracy of the MARs.<br>-She was at the facility 1-2 times each week.<br>-The RN visited the facility weekly.<br>-The Director was at the facility almost every day.<br>-She expected the MARs to reflect current orders.<br>-She relied on the professional experience of the RN and the Director related to accuracy of the | C 342 | | |

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| C 342 | Continued From page 27<br>MARs.<br>-She needed to take a more active role related to medication orders and accuracy of the MARs. | C 342 | | |
| C 912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Resident's Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration training.<br><br>The findings are:<br><br>Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and B) who administered medications had successfully completed the required state medication aide (MA) examination. [Refer to Tag C935, G.S. 131D-4.5(B)(b) ACH Medication Aides; Training and Competency Evaluation Requirements (Type B Violation)]. | C 912 | | |
| C935 | G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency<br><br>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. | C935 | | |

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| C935 | Continued From page 28<br>(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:<br>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:<br>a. The key principles of medication administration.<br>b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.<br>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.<br>(3) Within 60 days from the date of hire, the individual must have completed the following:<br>a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:<br>1. The key principles of medication administration.<br>2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.<br>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION | C935 | | |

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| C935 | Continued From page 29<br><br>Based on interviews and record reviews, the facility failed to ensure 2 of 2 sampled staff (Staff A and B) who administered medications had successfully completed the required state medication aide (MA) examination.<br><br>1. Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed:<br>-Staff A was hired on 07/11/20.<br>-There was documentation Staff A completed the medication clinical skills competency validation on 07/11/20.<br>-There was documentation signed by the facility's Registered Nurse (RN) that Staff A completed the 15-hour medication administration training on 07/13/20.<br>-There was no documentation Staff A passed the written medication aide (MA) examination.<br><br>Interview with Staff A on 04/26/21 at 2:25pm revealed:<br>-He had not taken the written MA examination.<br>-The coronavirus (COVID-19) pandemic made it difficult to secure a spot for the written MA examination.<br>-Neither the Administrator nor the facility's RN told him there was a time limit for him to take the written MA examination after he had completed the medication clinical skills competency validation.<br>-He had been working alone in the facility and independently administering medication to the residents without having attempted and passed the written MA examination.<br><br>Refer to the interview with the RN on 04/26/21 at 3:12pm.<br><br>Refer to the interview with the Administrator on 04/26/21 at 3:55pm. | C935 | | |

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| C935 | Continued From page 30<br><br>2. Review of Staff B's, Supervisor-in-Charge (SIC), personnel record revealed:<br>-Staff B was hired on 02/01/21.<br>-There was documentation Staff B completed the medication clinical skills competency validation on 01/29/21.<br>-There was documentation signed by the facility's Registered Nurse (RN) that Staff B completed the 15-hour medication administration training on 01/29/21.<br>-There was no documentation Staff B passed the written medication aide (MA) examination.<br><br>Interview with Staff B on 04/26/21 at 2:50pm revealed:<br>-He could not remember the date he attempted the written MA examination; he did not pass the examination.<br>-He knew he was not supposed to independently administer medication if he had not passed the written MA examination.<br>-The Administrator told him he needed to take the written MA examination.<br>-He was scheduled to take the written MA examination "sometime" in May 2021.<br>-He did not independently administer medication to the residents at the facility; there was always another person qualified to oversee medication administration when he administered medication.<br><br>Interview with Staff A on 04/26/21 at 3:32pm revealed Staff B had worked alone in the facility over the previous weekend, 04/24/21-04/25/21, and independently administered medication to the residents.<br><br>Interview with the Administrator on 04/26/21 at 3:55pm revealed:<br>-She had been trying to get Staff B registered for | C935 | | |

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| C935 | Continued From page 31 | C935 | | |

the written MA examination.
-Staff B "was hardly ever here," but independently administered medication whenever he worked at the facility.
-Staff B worked the previous weekend, 04/24/21-04/25/21, and independently administered medication.
-Staff B administered medication independently at another facility and she did not think about Staff B's lack of completion of the written MA examination when he was scheduled to work at the facility.

Refer to the interview with the RN on 04/26/21 at 3:12pm.

Refer to the interview with the Administrator on 04/26/21 at 3:55pm.

_____

Interview with the facility's RN on 04/26/21 at 3:12pm revealed:
-She provided medication administration training and conducted the medication clinical skills competency validation for Staff A and during their initial orientation periods.
-She did not know if Staff A or B had successfully completed the written MA examination.

Interview with the Administrator on 04/26/21 at 3:55pm revealed:
-There were no available MA test dates during the COVID-19 pandemic.
-She had been trying to get Staff A and B registered for the written MA examination.

Refer to Tag C0330 10A NCAC 13G .1004(a) Medication Administration.

Refer to Tag C0342 10A NCAC 13G .1004(j) Medication Administration.

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| C935 | Continued From page 32<br><br>The facility failed to ensure 2 of 2 sampled staff who administered medications successfully completed the required state medication aide examination prior to administering medications and this failure resulted in medication errors, including a resident not receiving two medications used to treat schizophrenia (#3) and a resident receiving a medication used to treat schizophrenia after the medication was discontinued (#2), and was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/26/21 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 10, 2021. | C935 | | |