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THE LANDINGS OF SWANSBORO	280 SWANSBORO LOOP ROAD SWANSBORO, NC 28584

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D 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on July 21, 2021 - July 23, 2021.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116°F for 8 of 11 fixtures with hot water temperatures ranging from 77.3 to 90 degrees F which resulted in some residents avoiding baths in the shower and/or being uncomfortable during bathing. The findings are: Review of the facility's Hot Water Temperature Checklist revealed: -There was an entry "hot water temperature weekly". -Check at least 6 locations or 10% of the bed capacity (whichever was greater). -Report any temperatures out of range to the Administrator/Executive Director and the	D 113		

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D 113	Continued From page 1 Divisional Maintenance Director. -Create a work order for service and resolve any out of range values. -Sample different rooms each week. Do not sample the same rooms over and over. -Chose locations that were near and far from the central water heaters. -Sample common area faucets (public bathroom, sinks, etc.) from time to time. -The minimum for hot water temperatures was 100 degrees Fahrenheit (F). -The maximum for hot water temperatures was 116 degrees F. -Measurements outside the range for resident-accessible hot water outlets were a safety issue and must be resolved immediately. Review of the facility's weekly water temperature checks revealed: -On 04/06/21, 04/13/21, 04/21/21 and 04/29/21 hot water temperatures were taken on the 100, 200, 300, 400 and 500 hallways of the facility with a documented range of 107 F - 108 degrees F. -On 05/03/21, 05/11/21, 05/19/21 and 05/26/21 hot water temperatures were taken on the 100, 200, 300, 400 and 500 hallways of the facility with a documented range of 107 F - 109 degrees F. -On 06/03/21, 06/10/21, 06/15/21, 06/21/21 and 06/30/21 hot water temperatures were taken on the 100, 200, 300, 400 and 500 hallways of the facility with a documented range of 107 F - 108 degrees F. -On 07/06/21 and 07/14/21 hot water temperatures were taken on the 100, 200, 300, 400 and 500 hallways of the facility with a documented 107 - 108 degrees F. Review of the facility's current license effective 03/29/21 revealed the facility was licensed for a capacity of 80 residents.	D 113		

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D 113	Continued From page 2 Review of the facility's census report dated 07/21/21 revealed: -The facility's in-house census was 26 residents. -There were 10 residents residing on the 100 hall of the facility. -There were 5 residents residing on the 200 hall of the facility. -There were 11 residents residing on the 300 hall of the facility. Observation in resident room #102 on 07/21/21 at 9:41am revealed: -The hot water temperature at the sink was 90 degrees F. -The hot water temperature at the shower was 90 degrees F. Interview with the resident residing in room #102 on 07/22/21 at 11:28am revealed: -She took her showers in the bathroom in her room. -The water was warm when she took her showers. -She had not noticed the water being too cold. Observation in resident room #309 on 07/21/21 at 10:11am revealed: -The hot water temperature at the sink was 85.9 degrees F. -The hot water temperature at the shower was 86.0 degrees F. Interview with the resident residing in room #309 on 07/21/21 at 10:11am revealed: -The water was always cold. -He had to go to the spa room on the 100 hall to get a hot shower. Observation in resident room #109 on 07/21/21 at	D 113		

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D 113	Continued From page 3 10:17am revealed: -The hot water temperature at the sink was 85.5 degrees F. -The hot water temperature at the shower was 84.7 degrees F. Interview with the resident residing in room #109 on 07/21/21 at 10:05am revealed: -The hot water was "absolutely" cold. -She could not take a shower and allow cold water to run over her. -Monday, 07/19/21 was the first shower she had taken in 3 weeks because of the lack of hot water. -She had been taking sponge baths instead of showers because of the lack of hot water. -When she bathed, the hot water was "tepid" at best after allowing the hot water to run for 20 minutes prior to bathing, -She had not talked to the Administrator about the hot water temperatures but had discussed the hot water being cold with the PCAs and other residents. -The PCAs told her they did not blame her for not wanting to take a cold shower. Observation in resident room #305 on 07/21/21 at 10:29am revealed: -The hot water temperature at the sink was 87.8 degrees F. -The hot water temperature at the shower was 77.8 degrees F. Interview with the resident residing in room #305 on 07/21/21 at 10:29 revealed: -She had taken 1 hot shower in the last 6 weeks. -She had talked with the Administrator about the hot water concerns but felt he had not been receptive. -The Administrator told her to run the hot water	D 113		

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before her shower so it would have time to get warm.
-She allowed the hot water to run for 45 minutes, but the hot water did not get warm.

Observation of the 100 hall spa room on 07/21/21 at 10:50am revealed:
-The hot water was turned on at the sink, tub and shower fixtures at 10:40am.
-The hot water temperature at the sink reached 107.3 degrees F after the hot water had been on for 10 minutes.
-The hot water temperature at the shower reached 107.4 degrees F after the hot water had been on for 10 minutes.
-The hot water temperature at the tub reached 108.3 degrees F after the hot water had been on for 10 minutes.

Observation in resident room #207 on 07/21/21 at 10:53am revealed:
-The hot water temperature at the sink was 89.4 degrees F.
-The hot water temperature at the shower was 88.7 degrees F.

Interview with a resident residing in room #207 on 07/21/21 at 10:53am revealed:
-She had to let the water in her bathroom run for approximately 15 minutes before she could shower.
-The hot water was "barely tepid" after waiting 15 minutes for it to warm up.
-She had complained to various staff including the Administrator about the lack of hot water.

A second interview with the resident residing in room #207 on 07/23/21 at 8:53am revealed:
-She tried taking showers at different times in the day hoping the hot water would be warmer at

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different intervals during the day however, she had not found any consistency in the availability of the the hot water.
-The lack of hot water in the facility made her not want to take a bath and made bathing an unpleasant experience.

Interview with Administrator on 07/21/21 at 11:46am revealed:
-He was responsible for checking the hot water temperatures in the facility.
-The hot water had to run approximately 15 minutes before the water would become hot.
-The residents had voiced complaints about the hot water being cold since the facility opened in May 2021.
-He had instructed staff to turn on the hot water 15 minutes before assisting the residents with a bath to allow the hot water to reach the area of the residents' rooms after the residents had voiced complaints.
-The hot water availability was delayed because of the distance of location from the residents' rooms to the location of the hot water heaters.
-The facility had 10 "on demand" hot water heaters located on the back right section of the facility.
-He had notified the facility's Corporate office about the residents' complaints of the hot water delay in the residents' rooms (no dated provided).
-He was advised by the facility's Corporate office that the delay in hot water reaching resident rooms was caused by the location/distance of the hot water heaters from the currently occupied resident rooms and the demand for hot water usage would increase when more residents were admitted to the facility.

Observation of the 100 hall spa room on 07/22/21 at 7:10am revealed:

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D 113	Continued From page 6 -The hot water was running in the spa tub. -There was no staff or resident in the spa room. Observation of an unoccupied resident room #101 on 07/22/21 at 7:37am revealed: -The hot water was running at the sink. -The hot water was running at the shower. Interview with the Administrator on 7/22/21 at 7:37am revealed: -Today (07/22/21), he allowed the hot water to run for 15 minutes, then rechecked all the hot water fixtures in the residents' areas. -The hot water temperatures ranged from 107 degrees F to 111 degrees F. -He would designate a staff to turn on the hot water fixtures in the unoccupied, designated resident rooms at intervals throughout the day to flush the water lines to keep the hot water readily available to the residents. Interview with a resident on 07/23/21 at 8:34am revealed: -The hot water was not good enough for a bath because sometimes the hot water would warm up and sometimes the hot water stayed too cold to bathe in. -There had been times it had taken the hot water 45 minutes to one hour to warm up enough to take her bath. -The lack of readily available hot water had been an issue since she moved into the facility. Interview with a second resident on 07/23/21 at 8:40am revealed she had not taken a hot bath since she was admitted in May 2021 and was happy to have had hot water that morning for her shower. Interview with a medication aide (MA) on	D 113		

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D 113	Continued From page 7 07/22/21 at 4:47pm revealed: -She had never felt hot water at the facility. -The Administrator told her to let the water run until it got hot, but it did not seem to help when she did. Confidential interview with a staff revealed: -Residents had complained that the hot water never getting hot enough for bathing. -The residents had voiced concerns about the hot water since the staff started working at the facility. -The staff told the Administrator about the lack of hot water for residents to use for their bathing and grooming needs (no date provided). -The Administrator instructed staff to turn the hot water on in empty rooms adjacent to the residents' rooms. -The staff estimated it took at least 20 - 25 minutes for the hot water to get warm enough for the residents' bathing needs. -Staff and residents could not always wait 20 -25 minutes for the hot water to warm up to take a shower. -The staff heard residents complaining that "they were sick and tired" of taking cold showers. Interview with a resident's family member on 07/22/21 at 4:30pm revealed the resident reported to her it had been a couple of weeks since her last "real" shower. Observation with the Administrator on 07/23/21 at 4:55pm revealed: -The facility's digital thermometer and the surveyor's digital thermometer were calibrated using an ice water slurry. -The facility's thermometer displayed 32.4 degrees F. -The surveyor's thermometer displayed 32 degrees F.	D 113		

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-At 5:00pm, the Administrator turned on the hot water and left the room with the water running at the sink and shower fixture in the unoccupied resident room #101.
-At 5:02pm, in resident room #102, the hot water temperature at the bathroom sink and shower was cool to touch.
-At 5:12pm, the hot water at the shower fixture in the unoccupied resident room #101 was 82.3 degrees F with the facility thermometer and 84 degrees F with the surveyor's thermometer.
-At 5:09pm, in resident room #109, the hot water temperature at the bathroom sink and shower was cool to touch.
-At 5:11pm, the hot water temperature in the walk-in tub of the 100 hall spa room was 82 degrees F.
-At 5:14pm, the hot water at the sink in the Activity room (located on the back side of the facility) was 110 degrees F with the with the facility thermometer and 108 degrees F with the surveyor's thermometer.
-At 5:16pm, the hot water temperature at the shower in resident room #309 (located on the back side of the facility) was 109 degrees F with the with the facility thermometer and 108 degrees F with the surveyor's thermometer.
-At 5:18pm, in resident room #305 (located on the back side of the facility), the hot water temperature at the shower was 106 degrees F with the with the facility thermometer and 104 degrees F with the surveyor's thermometer.
-At 5:20pm, a second hot water check was done (approximately 9 minutes later) at the walk-in tub fixture in the 100 hall spa room with a reading of 110 degrees F with the facility thermometer and 108 degrees F with the surveyor's thermometer.
-At 5:21pm, a second hot water check (approximately 12 minutes later) was done in resident room #109 at the shower with a reading

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D 113	Continued From page 9 of 106 degrees F with the facility thermometer and 102 degrees F with the surveyor's thermometer. -At 5:23pm, a second hot water check (approximately 21 minutes later) was done in resident room #102 at the shower fixture with a reading of 106 degrees F with the facility thermometer and 104 degrees F with the surveyor's thermometer. Interview with the Administrator on 07/23/21 at 5:34pm revealed: -On Thursday (07/22/21), he started turning the hot water on in the spa room on 100 hall and was doing this 3-4 times a day to keep hot water circulating in the facility. -He had no concerns about the hot water temperature in the facility but saw it a hassle for the residents. -It was a resident's right to have hot water for a shower.	D 113		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the home health provider was notified for 1 of 3 residents sampled (#1) related to skin breakdown on her sacrum. The findings are:	D 273		

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D 273	Continued From page 10 Review of Resident #1's current FL-2 dated 07/09/21 revealed: -Diagnoses included heart failure, hypertension, gastroesophageal reflux disease, anemia, degenerative joint disease and stage 4 sacral ulcer. -Resident #1 was totally dependent on staff for ambulation, transfers, toileting, dressing and bathing. -Resident #1 was incontinent of bladder and continent of bowel. -Resident #1 had a stage 4 pressure ulcer that required sterile dressing changes every day "or less". Review of Resident #1's FL-2 from admission dated 05/14/21 revealed: -Diagnoses included lack of coordination, other abnormalities of gait and mobility, unspecified fracture of T7-T8 and displaced subtrochanteric fracture of the right femur. -Ambulation status was listed as a semi-ambulatory with a walker. -Resident #1 required limited assistance with toileting, ambulation, transfer, bathing, dressing and grooming. -Resident #1 was incontinent of bowel and bladder. Review of Resident #1's Resident Register dated 05/13/21 revealed she was admitted to the facility on 05/13/21. Review of Resident #1's body evaluations and observation form dated 05/13/21 revealed: -Resident #1 had a dressing over an open area on her left lower leg and a blister on her upper left calf. -There was no documentation of a skin lesion or	D 273		

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D 273	Continued From page 11 redness of the sacral area. Review of a physician order sheet for Resident#1 dated 06/11/21 revealed an order was for home health to evaluate and treat coccyx area. Review of a home health provider note for Resident #1 dated 06/11/21 revealed: -There was documentation the home health nurse had seen Resident #1 for wound care to her left lower leg. -There was no documentation of evaluation or treatment to the sacral or coccyx area. Review of home health provider note for Resident #1 dated 06/16/21 revealed: -There were two areas of pressure noted on Resident #1's coccyx area. -One area was documented as a stage II with minimal "slough" present that measured 2.5 by 2.0. (no unit of measure was indicated in the measurements). -A second area is was documented as measuring 3 by 3 on the lower coccyx with an irregular shape. -There was documentation that new would orders were pending. Interview with a medication aide (MA) on 07/22/21 at 4:47pm revealed: -Resident #1's skin had always been fragile. -The sacral wound was worse when she returned from a hospital stay on 07/13/21. Interview with a second MA on 07/23/21 at 2:40pm revealed she reported to the RCC that there was a "red spot" on Resident #1's coccyx before leaving duty on the morning of 06/11/21 but she did not document the notification.	D 273		

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Telephone interview with the contracted home health agency on 07/23/21 at 9:45am revealed:
- Slough was dead white tissue that was not viable.
- Eschar was dark, "scabby" tissue that covered a wound and should be removed for the wound to heal.
-Per a note from the home health nurse dated 06/16/21, the sacral wound was unstageable, with slough and eschar present.

Telephone interview with a wound care nurse with the contracted home health agency on 07/23/21 at 9:55am revealed:
-A stage I pressure ulcer meant that an area was reddened and non-blanchable (does not turn white when light pressure is applied to the area.)

Interview with the home health nurse on 07/23/21 at 12:10pm revealed:
-Resident #1 had skin conditions causing her to develop wounds quickly.
-A rapid decline in skin condition could occur in some residents due to age, medical diagnoses and continuous pressure on the sight of the wound.
-Skin integrity could deteriorate within hours for some residents in poor health .
-The facility should notify home health of all reddened areas on a resident's skin as soon as they are identified.
-She received an email from her office on 06/15/21 at 5:10pm regarding the order for evaluation and treatment.
-She saw new areas of skin breakdown on Resident #1's coccyx on 06/16/21.
-She did not receive a call regarding an order for referral to evaluate and treat the area of skin breakdown for Resident #1 on 06/11/21.
-The RCC did not notify her of the referral when

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she was in the facility on 06/11/21.
-If home health had received notification on 06/11/21, someone would have been out to facility to evaluate the area the following day even on a Saturday.

Interview with the RCC on 07/32/21 at 10:43 revealed:
-The home health nurse was in the facility to see Resident #1 two to three times a week for leg wounds.
-A personal care aide (PCA) reported to her (the RCC) that she thought Resident #1 was developing a pressure sore on her coccyx on 06/11/21.
-She remembered the area over Resident #1's coccyx was red and blanchable.
-She contacted the PCP for Resident #1 by telephone on 06/11/21 and received an order for a referral to home health for evaluation and treatment of the wound.
-She made a copy of the order to give to the home health nurse on her next visit but did not remember when the next visit took place.
-She did not remember calling the home health nurse on 06/11/21.
-She did not remember if she gave the home health nurse a copy of the order while she was in the facility on 06/11/21.
-She would have made notifications on 06/11/21 by call, fax or in-person per her standard process.
-She did not document the notification to the home health agency.
-She did not know why there was 5 days from the date of the order and the time home health completed the evaluation.
-She did not call to follow-up because the home health nurse had been in the facility to see Resident #1 for other wounds.

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D 273	Continued From page 14 Second interview with the RCC on 07/23/21 at 4:12pm revealed: -She remembered seeing the home health nurse in the facility on 06/11/21 and reporting the skin breakdown on Resident #1's coccyx at that time. -She did not document the notification anywhere. -Skin changes should be reported to a provider as well as orders faxed. -She expected notifications to providers to be documented in the progress notes but that was not always done. Interview with the Administrator on 07/23/21 at 5:34pm revealed: -He expected notification to be made immediately to providers when there was a change in health status including skin integrity. -Notifications should be documented in the resident record. _____ The facility failed to ensure the acute and routine health care needs were met for 1 of 3 sampled residents including not reporting to the home health provider for 4 days when Resident #1 began showing signs of skin breakdown. The facility's failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 07/23/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2021.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 15 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 4 residents (#4) observed during the medication pass including errors with 2 medications ordered to be administered with food and an inhaler with instructions to rinse the mouth after use; and for 2 of 3 residents sampled for record review including errors with a vitamin supplement (#2) and a medication to treat an abnormal heartbeat (#3). The findings are: 1. The medication error rate was 12% as evidenced by the observation of 3 errors out of 25 opportunities during the 7:30am and 8:00am-9:00am medication passes on 07/22/21. Review of Resident #4's current FL-2 dated 05/13/21 revealed diagnoses included chronic obstructive pulmonary disease, idiopathic gout, vitamin B12 deficiency, cataract and anxiety. a.Review of Resident #4's physician orders dated 05/26/21 revealed an order for Breo Ellipta inhaler 200-25mcg, inhale 1 puff by mouth once daily with instructions to rinse mouth after use. (Breo Ellipta is used to treat chronic obstructive	D 358		

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pulmonary disease. According to the manufacturer, rinsing the mouth after use will help prevent fungal infections of the mouth and throat.)

Observation of the 8:00am medication pass on 07/22/21 at 8:01am revealed:
-The medication aide (MA) prepared Resident #4's routine medications for administration.
-The MA provided Resident #4 with the Breo Ellipta inhaler; the resident completed 1 inhalation and gave the inhaler back the MA.
-The resident did not rinse his mouth with water after the use of the Breo Ellipta inhaler.
-The MA did not offer instructions to rinse the mouth after the administration of the inhaler.

Review of Resident #4's July 2021 electronic medication administration record (eMAR) revealed:
-There was a computerized entry for Breo Ellipta 200-25mcg, inhale 1 puff into the lungs daily.
-There were no instructions to rinse the mouth after use on the eMAR.
-Breo Ellipta was documented as administered on 07/22/21 at 8:00am.

Interview with Resident #4 on 07/23/21 at 3:00pm revealed:
-She received all of her medications from the MAs.
-She had used Breo Ellipta independently prior to being admitted to the facility.
-She had never rinsed her mouth out after using the Breo Ellipta inhaler and wanted to know why rinsing the mouth after each use of the inhaler was indicated.
-She had never been told by any of the MAs she needed to rinse her mouth after using the inhaler.

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D 358	Continued From page 17 Interview with the MA on 07/22/21 at 4:47pm revealed: -She had not been trained to rinse out the mouth of the resident after administering an inhaler. -She did not remember if instructions to rinse the mouth after administering Breo inhaler were on the eMAR. Interview with a second MA on 07/23/21 at 2:40pm revealed: -She was not aware there was an order for the resident's mouth to be rinsed out after the administration of Breo Ellipta. -She did not remember being taught to rinse the resident's mouth after the administration of inhalers during her training. Interview with the Resident Care Coordinator (RCC) on 07/23/21 at 4:12pm revealed: -She had not noticed the order for Breo Ellipta had instructions to rinse the resident's mouth after administration. -She expected the pharmacy to have added the instructions to the eMAR. Interview with the Administrator on 07/23/21 at 8:07am revealed: -The pharmacy should have placed the instructions to rinse the resident's mouth after use when they put the order for Breo Ellipta on the eMAR. -Instructions for administration of medications should be completed as ordered. b. Review of Resident #4's physician orders dated 05/26/21 revealed an order for hydroxychloroquine tab 200mg, take 2 capsules (800mg) twice daily with instructions to take with food or milk. (Hydroxychloroquine is used to reduce skin problems and prevent pain and	D 358		

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swelling in people diagnosed with lupus and other autoimmune diseases.)

Observation of the 8:00am medication pass on 07/22/21 at 8:01am revealed:
-The medication aide (MA) prepared Resident #4's routine medications for administration.
-Resident #4 counted the pills in her medicine cup and consumed all morning medications at 8:03am with water that was provided by the MA.

Review of Resident #4's July 2021 electronic medication administration record (eMAR) revealed:
-There was a computerized entry for hydroxychloroquine 200mg to be administered twice daily with food or milk.
-Hydroxychloroquine was documented as administered on 07/22/21 at 8:00am.

Interview with Resident #4 on 07/22/21 at 8:03am revealed she had not had breakfast but would be going to the dining room to eat.

A second interview with Resident #4 on 07/23/21 at 3:00pm revealed:
-She took Hydroxychloroquine for an autoimmune disorder.
-The MAs usually administered her 8:00am morning medications when she was in the dining room when she was eating breakfast.
-She was not sure why she received her 8:00am medications from the MA in her room yesterday, (07/22/21) instead of in the dining room.

Interview with the MA on 07/22/21 at 4:47pm revealed:
-Resident #4's medications were dispensed in a multi-dose pack.
-There was a medication ordered for

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administration on an empty stomach in the multi-dose pack with medications to be administered with food.
-She always administered the medications in the multi-dose pack together.
-There was a medication in the multi-dose pack for the morning medication pass that was given on an empty stomach and she had not questioned why medications with contradicting instructions were packaged together.

Interview with a second MA on 07/23/21 at 2:40pm revealed:
-She was familiar with Resident #4's medications and pulled out the medication that was to be administered on an empty stomach to administer it first.
-She administered Resident #4's other medications when she was eating.
-She never informed the Resident Care Coordinator (RCC) of the medications with contradicting instructions being dispensed together in the multidose pack.

Interview with the RCC on 07/23/21 at 4:12pm revealed:
-Medications with instructions to be administered with food or milk should be administered during mealtimes.
-Medication to be administered on an empty stomach should be administered 30 minutes before the meal was served.
-She observed medication passes sometimes but she did not document those audits.
-She gave corrections to the MAs because they would "go too fast" and did not fully read the instructions on the eMAR.

Interview with the Administrator on 07/23/21 at 8:07am revealed:

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-Instructions for administration of medications should be completed as ordered.
-Medication to be administered with food should be administered at mealtime.

c. Review of Resident #4's physician orders dated 05/26/21 revealed an order for mycophenolate tablet 500mg, take twice a day with instructions to take with food. (Mycophenolate is a medication used to suppress the immune system in people diagnosed with Lupus.)

Observation of the 8:00am medication pass on 07/22/21 at 8:01am revealed:
-The medication aide (MA) prepared Resident #4's routine medications for administration.
-Resident #4 counted the pills in her medicine cup and consumed all morning medications at 8:03am with water that was provided by the medication aide.

Review of Resident #4's July 2021 electronic medication administration record (eMAR) revealed:
-There was a computerized entry for mycophenolate mofetil tab 500mg, take twice daily with a meal.
-Mycophenolate was documented at administered on 07/22/21 at 8:00am.

Interview with Resident #4 on 07/22/21 at 8:03am revealed she had not had breakfast but would be going to the dining room to eat.

A second interview with Resident #4 on 07/23/21 at 3:00pm revealed:
-She took Mycophenolate for an autoimmune disorder.
-Mycophenolate was the only medication she took in the morning that had to be taken with food.

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D 358	Continued From page 21 -The MAs usually administered her 8:00am morning medications when she was in the dining room when she was eating breakfast. -She was not sure why she received her 8:00am medications from the MA in her room yesterday, (07/22/21) instead of in the dining room. Interview with the MA on 07/22/21 at 4:47pm revealed: -Resident #4's medications were dispensed in a multi-dose pack. -There was a medication ordered for administration on an empty stomach in the multi-dose pack with medications to be administered with food. -She always administered the medications in the multi-dose pack together. -There was a medication in the multi-dose pack for the morning medication pass that was given on an empty stomach and she had not questioned why medications with contradicting instructions were packaged together. Interview with a second MA on 07/23/21 at 2:40pm revealed: -She was familiar with her medications and pulled out the medication that was to be administered on an empty stomach to administer it first. -She administered Resident #4's other medications when she was eating. -She never informed the Resident Care Coordinator (RCC) of the medications with contradicting instructions being dispensed together in the multidose pack. Interview with the RCC on 07/23/21 at 4:12pm revealed: -Medications with instructions to be administered with food or milk should be administered during mealtimes.	D 358		

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-Medication to be administered on an empty stomach should be administered 30 minutes before the meal was served.
-She observed medication passes sometimes but she did not document those audits.
-She gave corrections to the MAs because they would "go too fast" and did not fully read the instructions on the eMAR.

Interview with the Administrator on 07/23/21 at 8:07am revealed:
-Instructions for administration of medications should be completed as ordered.
-Medication to be administered with food should be administered at mealtime.

2. Review of Resident #3's current FL-2 dated 05/06/21 revealed:
-Diagnoses included atrial fibrillation, congestive heart failure, coronary artery disease, anemia, chronic lower extremity edema, dementia and pleural effusion.
-The resident was intermittently disoriented.
-There was an order for Dofetilide 125mcg one capsule twice daily. (Dofetilide is a medication used to treat an irregular heartbeat such as atrial fibrillation which is an irregular and often rapid heart rate that can increase risks of strokes, heart failure and other heart-related issues).

Review of a subsequent order for Resident #3 dated 06/11/21 revealed an order for Dofetilide 125mcg one capsule twice daily.

Review of Resident #3' Resident Register revealed the resident was admitted to the facility on 05/28/21.

Review of Resident #3's May 2021 medication administration record (MAR) revealed:

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D 358	Continued From page 23 -The resident's medications were handwritten on the MAR. -There was no entry for Dofetilide 125mcg one capsule twice daily. -There was no documentation Dofetilide 125mcg one capsule twice daily was administered from 05/28/21 - 05/31/21 (for a total of 8 doses). Review of Resident #3's June 2021 (MAR) revealed: -The resident's medications were handwritten on the MAR. -There was no entry for Dofetilide 125mcg one capsule twice daily. -There was no documentation Dofetilide 125mcg one capsule twice daily was administered from 06/01/21 - 06/06/21. Review of Resident #3's June 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Dofetilide 125mcg one capsule twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Dofetilide 125mcg was administered at 8:00pm on 06/02/21, at 8:00am on 06/03/21 and 8:00am and 8:00pm from 06/04/21 - 06/30/21. Review of Resident #3's electronic July 2021 MAR revealed: -There was an entry for Dofetilide 125mcg one capsule twice daily with a scheduled administration time of 8:00am and 8:00pm. The scheduled 8:00am administration time changed to 9:00am on 07/10/21. -There was documentation Dofetilide 125mcg was administered from 07/01/21 - 07/09/21 at 8:00am; and 9:00am from 07/10/21 - 07/21/21; and at 8:00pm from 07/01/21 - 07/20/21.	D 358		

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D 358	Continued From page 24 Observation of Resident #3's medication on hand on 07/23/21 revealed there were 7 of 14 capsules of Dofetilide 125mcg dispensed on 07/16/20 with 5 capsules remaining in the medication card. Based on observations, interviews and record reviews, Resident #3 was not interviewable. Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 07/23/21 at 2:01pm revealed: -On 05/31/21, the pharmacy received documentation that Resident #3 was a new admission. -Medications were filled from the residents' FL-2 according to the PCP orders on 05/31/21. -The resident's Dofetilide 125mcg twice daily was filled on 05/31/21 with the resident's other prescribed medications and the medications were delivered to the facility on 06/01/21. -Resident #3's medications were filled in a multi-dose packaging system with the scheduled administration times. -Resident #3's Dofetilide 125mcg twice daily had been delivered to the facility on a 7-day cycle since 06/01/21 without any lapses in the medication. -Medication orders were faxed to the pharmacy from the facility. -The pharmacy entered the medication orders into the eMAR, and the facility received the medication in the eMAR system as a pending medication order for approval. -Dofetilide was an antiarrhythmic medication to keep the heart in rhythm. -She reviewed the package insert and she did not find any information what to do when doses were missed. -She could not provide any information regarding	D 358		

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her concerns if the resident missed doses on 05/28/31 to 05/31/21; she only could refer to the medications package insert.
-It was "definitely" not ideal to miss a medication used to treat heart arrhythmias or miss any medication.

Interview with the Resident Care Coordinator (RCC) on 07/23/21 at 4:12pm revealed:
-When Resident #3 was admitted to the facility, the POA brought the resident's medications in and gave to staff until the pharmacy could start delivering the resident's medication.
-She thought Resident #3's POA reported that she did not provide any doses of the Dofetilide 125mcg because the resident's PCP had discontinued the medication.
-She could not recall if she contacted Resident #3's PCP regarding the order on Resident #3's current FL-2 or to clarify the order.

Interview with the Administrator on 07/23/21 at 5:34pm revealed:
-When Resident #3 was admitted to the facility, he thought there were no doses of Dofetilide 125mcg for the family to bring because the resident's previous PCP had discontinued the medication.
-He could not provide an answer why there was an order written on Resident #3's current FL-2 dated 05/06/21 when the resident was admitted, and a subsequent order written by the PCP dated 06/11/21 for Dofetilide 125mcg twice daily.
-He would follow-up with Resident #3's PCP to ensure the PCP was aware of the missed medication doses in May 2021 and clarify the order for Dofetilide 125mcg twice daily.
-He expected staff to administer all residents' mediations as ordered, when scheduled and follow the 6 residents rights including the right

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resident, right medication, right dose, right time, right route and the right documentation.

Attempted telephone interview with Resident #2's PCP was unsuccessful on 07/22/21 at 4:10pm.

3. Review of Resident #2's current FL-2 dated 05/11/21 revealed diagnoses included hemiplegia of dominant side as late effect of cerebrovascular disease and anemia.

Review of a primary care provider's (PCP's) order for Resident #2 dated 06/09/21 revealed an order for Vitamin D2 1,250mcg one capsule once weekly for low vitamin D. (Vitamin D2 is a supplement that helps the body absorb calcium and phosphorus to promote strong bones).

Review of a subsequent medication order for Resident #2 dated 07/13/21 revealed an order for Vitamin D2 1,250mcg one capsule once weekly for low vitamin D.

Review of Resident #2's June 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin D2 1,250mcg with a scheduled administration time of 9:00am daily and special instructions to take one capsule once a week for low vitamin D and a scheduled administration of 9:00am.
-Vitamin D2 1,250mg was documented as administered daily at 8:00am from 06/16/21 - 06/30/21 with an exception on 06/29/21 the medication was unavailable/awaiting arrival.

Review of Resident #2's July 2021 eMAR revealed:
-There was an entry for Vitamin D2 1,250mcg with a scheduled administration time of 9:00am

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	HAL067025	A. BUILDING: _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SWANSBORO	280 SWANSBORO LOOP ROAD SWANSBORO, NC 28584

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once daily on Friday with special instructions to take one capsule once a week for low vitamin D and a scheduled administration.
-There was documentation Vitamin D2 1,250mcg was administered on 07/09/21.
-The entry for Vitamin D2 1,250mcg with a scheduled administration time of 9:00am once daily on Friday with special instructions to take one capsule once a week for low vitamin D was discontinued on 07/15/21.
-There was a second entry for Vitamin D2 1,250mcg with a scheduled administration time of 9:00am once daily on Friday with special instructions to take one capsule once a week for low vitamin D.
-There was documentation Vitamin D2 1,250mcg was administered on 07/16/21.

Observation of Resident #4's medications on hand on 07/22/21 at 11:46am revealed:
-12 capsules of Vitamin D2 1,250mcg was dispensed on 05/18/21 and available for administration.
-There were no Vitamin D2 1,250mcg capsules remaining in the medication bottle.
-There was an undated handwritten note "discard when filled by family" that was attached to the bottle with a rubber band.

Interview with the medication aide (MA) on 07/22/21 at 11:46am revealed she was not sure why there was no Vitamin D2 1,250mcg capsules on hand or who wrote the handwritten note attached to the medication bottle.

Telephone interview with Resident #2's family member on 07/22/21 at 4:16pm revealed:
-The family brought the resident's medications to the facility because the resident received his medications through Veteran Affairs (VA).

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D 358	Continued From page 28 -The resident was taking Vitamin D2 due to low vitamin D levels. -When the resident was first admitted to the facility, staff at the facility were administering the Vitamin D2 1,250mcg daily instead of every week. -She had spoken with the Resident Care Coordinator (RCC) about the resident's Vitamin D2 1,250mcg and advised the RCC the resident's VA pharmacy would not refill and send more of the Vitamin D2 1,250mcg yet because it was too early to fill the medication. Interview with a MA on 07/23/21 at 3:24pm revealed: -She administered medications to Resident #2 today, (07/23/21) at 8:00am. -Resident #2 did not receive Vitamin D2 1,250mcg because the resident was out of the medication. -The resident had not received any Vitamin D2 1,250mcg in July 2021 because all the resident's Vitamin D2 1,250mcg on hand was used in June 2021. -Resident #2 should have received Vitamin D2 1,250mcg weekly instead of daily. -Her initials were documented on Resident #2's eMAR on 07/16/21 as administering the resident's Vitamin D2 1,250mcg; however, she inadvertently marked Vitamin D2 1,250mcg as administered instead of unavailable. -She thought she informed the RCC that she inadvertently documented Vitamin D2 1,250mcg was administered to Resident #2 on 07/16/21 and that the medication was not available. -When she administered medications to residents, she compared the resident's medication on the eMAR to the dispensing label on the resident's medication prior to administering the medication to the residents. -Resident #2's Vitamin D2 1,250mcg was	D 358		

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"popping up" daily in the computer and she never questioned why but she should have.

Interview with the RCC on 07/23/21 at 4:12pm revealed:
-The facility's contracted pharmacy entered Resident #2's Vitamin D2 1,250mcg daily instead of weekly.
-The entry for Resident #2's Vitamin D2 1,250mcg daily instead of weekly was an oversight.
-She performed record audits in June 2021.
-She could not say if she had done a record audit for Resident #2's record in June 2021.
-When a medication order was received, the MA on duty was responsible to fax the medication order to the pharmacy.
-The MAs were responsible for placing the residents' order in her box.
-The residents' order would go through the facility's "Bucket System" until the order was processed and ready to be filed in the residents' record.
-The facility's contracted pharmacy staff entered the medication orders in eMAR system.
-The new medications added to the eMAR by the facility's contracted pharmacy would be labeled as needing approval.
-She was responsible for reviewing and approving the pending medication orders in the eMAR system.
-Once approved, the order would flow over to the resident's eMAR and the MA could administer the medication and could document the administration.
-She and the Administrator were the only staff that could approve orders added to the eMAR system.
-She had performed residents' record audits in June 2021 comparing the FL-2 with the

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D 358	Continued From page 30 subsequent orders with the medications on hand; however, she was unsure if record audits were done all on all residents. Interview with the Administrator on 07/23/21 at 5:34pm revealed: -He would ensure follow-up was done with Resident #2's PCP regarding the administration of Vitamin D2 1,250mcg daily instead of weekly. -He expected staff to administer all residents' mediations as ordered, when scheduled and follow the 6 residents rights including the right resident, right medication, right dose right time, right route and the right documentation. Based on observations, interviews and record reviews, Resident #2 was not interviewable. Attempted telephone interview a pharmacist at Resident #2's VA pharmacy was unsuccessful on 07/22/21 at 5:45pm and 07/23/21 at 1:52pm. Attempted telephone interview with Resident #2's PCP was unsuccessful on 07/22/21 at 4:10pm.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate,	D912		

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D912	Continued From page 31 appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure the home health provider was notified for 1 of 3 residents sampled (#1) related to skin breakdown on her sacrum. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		