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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on September 28, 2021 - September 29, 2021.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 1 of 5 residents sampled (#4) by failing to notify a resident's primary care provider of multiple medication refusals including medications to treat high blood pressure, depression, a dietary supplement to treat high cholesterol, supplemental vitamins and a prescription toothpaste to prevent tooth decay. The findings are: Review of the facility's medication policy dated "2010-2011" revealed: -If a resident consistently refused medications the physician would be notified. -The policy did not specify how many medication refusals required notification to the residents' prescribing practitioner. Review of Resident #4's current FL-2 dated 08/18/21 revealed diagnoses included dementia and hypertension. Based on observations, interviews and record reviews, Resident #4 was not interviewable.	D 273		

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D 273	Continued From page 1 Attempted telephone interview with Resident #4's family member on 09/29/21 at 8:15am was unsuccessful. a. Review of Resident #4's current FL-2 dated 08/18/21 revealed there was an order for Calcium 600 with Vitamin D2 400mg daily. (Calcium with Vitamin D2 is a supplemental vitamin). Review of a previous medication order for Resident #4 dated 07/01/21 revealed an order for Calcium 600 with Vitamin D2 400mg daily. Review of Resident #4's July 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Calcium 600 with Vitamin D2 400mg daily scheduled at 8:00am. -There was documentation the resident refused Calcium 600 with Vitamin D2 400mg on 07/17/21, 07/21/21, 07/24/21, 07/27/21, and 07/31/21 at 8:00am. -There was a total of 5 times documented the resident refused Calcium 600 with Vitamin D2 400mg and no documentation Resident #4's primary care provider (PCP) was notified. Review of Resident #4's August 2021 eMAR revealed: -There was an entry for Calcium 600 with Vitamin D2 400mg daily scheduled at 8:00am. -There was documentation the resident refused Calcium 600 with Vitamin D2 400mg on 08/02/21, 08/09/21, 08/10/21, 08/13/21, 08/16/21, 08/17/21, 08/26/21, 08/28/21, and 08/31/21 at 8:00am. -There was a total of 9 times documented the resident refused Calcium 600 with Vitamin D2 400mg and no documentation Resident #4's PCP was notified.	D 273		

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Review of Resident #4's September 2021 eMAR revealed:
-There was an entry for Calcium 600 with Vitamin D2 400mg daily scheduled at 8:00am.
-There was documentation the resident refused Calcium 600 with Vitamin D2 400mg on 09/01/21, 09/02/21, 09/06/21- 09/08/21, 09/10/21, 09/13/21 - 09/17/21, 09/21/21, and 09/23/21 at 8:00am from 09/01/21 - 09/28/21.
-There was a total of 13 times documented the resident refused Calcium 600 with Vitamin D2 400mg and no documentation Resident #4's PCP was notified.

Review of Resident #4's progress notes revealed there was no further documentation of medication refusals and no documentation the PCP was notified.

Refer to the interview with a medication aide (MA) on 09/28/21 at 3:31pm.

Refer to the interview with a second MA on 09/29/21 at 10:23am.

Refer to the interview with the Resident Services Director (RSD) on 09/28/21 at 2:58pm.

Refer to the interview with the Administrator on 09/29/21 at 11:31am.

Refer to the telephone interview with Resident #4's PCP on 09/29/21 at 1:40pm.

b. Review of Resident #4's current FL-2 dated 08/18/21 revealed there was an order for Fish Oil 1000mg daily. (Fish Oil is a dietary supplement used to treat high cholesterol).

Review of a previous medication order for

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Resident #4 dated 07/01/21 revealed an order for Fish Oil 1000mg daily.

Review of Resident #4's July 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Fish Oil 1000mg daily scheduled at 8:00am.
-There was documentation the resident refused Fish Oil 1000mg on 07/01/21, 07/02/21, 07/05/21, 07/06/21, 07/08/21, 07/13/21, 07/15/21, 07/16/21, 07/17/21, 07/19/21, 07/21/21, 07/22/21, 07/24/21, 07/26/21, 07/27/21, and 07/31/21 at 8:00am.
-There was a total of 16 times documented the resident refused Fish Oil 1000mg and no documentation Resident #4's primary care provider (PCP) was notified.

Review of Resident #4's August 2021 eMAR revealed:
-There was an entry for Fish Oil 1000mg daily scheduled at 8:00am.
-There was documentation the resident refused Fish Oil 1000mg on 08/02/21, 08/09/21, 08/10/21, 08/13/21, 08/16/21, 08/17/21, 08/24/21, 08/26/21, 08/28/21, and 08/31/21 at 8:00am.
-There was a total of 10 times documented the resident refused Fish Oil 1000mg and no documentation Resident #4's PCP was notified.

Review of Resident #4's September 2021 eMAR revealed:
-There was an entry for Fish Oil 1000mg daily scheduled at 8:00am.
-There was documentation the resident refused Fish Oil 1000mg 13 times on 09/01/21, 09/02/21, 09/06/21 - 09/08/21, 09/10/21, 09/13/21, 09/14/21 - 09/17/21, 09/21/21, and 09/23/21 at 8:00am from 09/01/21 -09/28/21.
-There was a total of 13 times documented the

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resident refused Fish Oil 1000mg and no documentation Resident #4's PCP was notified.

Review of Resident #4's progress notes revealed there was no further documentation of medication refusals and no documentation the PCP was notified.

Refer to the interview with a medication aide (MA) on 09/28/21 at 3:31pm.

Refer to the interview with a second MA on 09/29/21 at 10:23am.

Refer to the interview with the Resident Services Director (RSD) on 09/28/21 at 2:58pm.

Refer to the interview with the Administrator on 09/29/21 at 11:31am.

Refer to the telephone interview with Resident #4's PCP on 09/29/21 at 1:40pm.

c. Review of Resident #4's current FL-2 dated 08/18/21 revealed there was an order for Losartan 50mg daily. (Losartan is a medication used to treat hypertension).

Review of a previous medication order for Resident #4 dated 07/01/21 revealed an order for Losartan 50mg daily.

Review of Resident #4's July 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Losartan 50mg daily scheduled at 8:00am.
-There was documentation the resident refused Losartan 50mg daily on 07/22/21, 07/24/21, 07/27/21, and 07/31/21 at 8:00am.

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-There was a total of 3 times documented the resident refused Losartan 50mg and no documentation Resident #4's primary care provider (PCP) was notified.

Review of Resident #4's August 2021 eMAR revealed:
-There was an entry for Losartan 50mg daily scheduled at 8:00am.
-There was documentation the resident refused Losartan 50mg daily on 08/02/21, 08/09/21, 08/17/21, 08/26/21, 08/28/21 at 8:00am.
-There was a total of 5 times documented the resident refused Losartan 50mg and no documentation Resident #4's PCP was notified.

Review of Resident #4's September 2021 eMAR revealed:
-There was an entry for Losartan 50mg daily scheduled at 8:00am.
-There was documentation the resident refused Losartan 50mg daily on 09/16/21, 09/17/21, 09/21/21, and 09/23/21 at 8:00am from 09/01/21 - 09/28/21.
-There was a total of 4 times documented the resident refused Losartan 50mg and no documentation Resident #4's PCP was notified.

Review of Resident #4's progress notes revealed there was no further documentation of medication refusals and no documentation the PCP was notified.

Telephone interview with Resident #4's PCP on 09/29/21 at 1:40pm revealed:
-Resident #4 was prescribed Losartan to control elevated blood pressures.
-Resident #4 was at risk of uncontrolled blood pressures when doses of Losartan were missed.

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Refer to the interview with a medication aide (MA) on 09/28/21 at 3:31pm.

Refer to the interview with a second MA on 09/29/21 at 10:23am.

Refer to the interview with the Resident Services Director (RSD) on 09/28/21 at 2:58pm.

Refer to the interview with the Administrator on 09/29/21 at 11:31am.

Refer to the telephone interview with Resident #4's PCP on 09/29/21 at 1:40pm.

d. Review of Resident #4's current FL-2 dated 08/18/21 revealed there was an order for a Multivitamin one daily. (Multivitamin is a supplemental vitamin).

Review of a previous medication order for Resident #4 dated 07/01/21 revealed an order for Multivitamin one daily.

Review of Resident #4's July 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for a Multivitamin one daily scheduled at 8:00am.
-There was documentation the resident refused the Multivitamin on 07/14/21, 07/22/21, 07/24/21, 07/27/21, and 07/31/21 at 8:00am.
-There was a total of 5 times documented the resident refused the Multivitamin and no documentation Resident #4's primary care provider (PCP) was notified.

Review of Resident #4's August 2021 eMAR revealed:
-There was an entry for a Multivitamin one daily

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scheduled at 8:00am.
-There was documentation the resident refused the Multivitamin on 08/02/21, 08/09/21, 08/13/21, 08/17/21, 08/26/21, 08/28/21, and 08/31/21 at 8:00am.
-There was a total of 7 times documented the resident refused the Multivitamin and no documentation Resident #4's PCP was notified.

Review of Resident #4's September 2021 eMAR revealed:
-There was an entry for a Multivitamin one daily scheduled at 8:00am.
-There was documentation the resident refused the Multivitamin on 09/01/21, 09/02/21, 09/06/21 - 09/08/21, 09/10/21, 09/13/21 - 09/17/21, 09/21/21, and 09/23/21 at 8:00am from 09/01/21 -09/28/21.
-There was a total of 13 times documented the resident refused the Multivitamin and no documentation Resident #4's PCP was notified.

Review of Resident #4's progress notes revealed there was no further documentation of medication refusals and no documentation the PCP was notified.

Refer to the interview with a medication aide (MA) on 09/28/21 at 3:31pm.

Refer to the interview with a second MA on 09/29/21 at 10:23am.

Refer to the interview with the Resident Services Director (RSD) on 09/28/21 at 2:58pm.

Refer to the interview with the Administrator on 09/29/21 at 11:31am.

Refer to the telephone interview with Resident

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D 273	Continued From page 8 #4's PCP on 09/29/21 at 1:40pm. e. Review of Resident #4's current FL-2 dated 08/18/21 revealed there was an order for Paroxetine 20mg daily. (Paroxetine is a medication used to treat depression). Review of a previous medication order for Resident #4 dated 07/01/21 revealed an order for Paroxetine 20mg daily. Review of Resident #4's July 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Paroxetine 20mg daily scheduled at 8:00am. -There was documentation the resident refused Paroxetine 20 mg on 07/22/21, 07/24/21, 07/27/21, and 07/31/21 at 8:00am. -There was a total of 4 times documented the resident refused Paroxetine 20 mg and no documentation Resident #4's primary care provider (PCP) was notified. Review of Resident #4's August 2021 eMAR revealed: -There was an entry for Paroxetine 20mg daily scheduled at 8:00am -There was documentation the resident refused Paroxetine 20 mg on 08/02/21, 08/09/21, 08/17/21, 08/26/21, and 08/28/21 at 8:00am. -There was a total of 5 times documented the resident refused Paroxetine 20 mg and no documentation Resident #4's PCP was notified. Review of Resident #4's September 2021 eMAR revealed: -There was an entry for Paroxetine 20mg daily scheduled at 8:00am -There was documentation the resident refused	D 273		

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Paroxetine 20 mg on 09/16/21, 09/17/21, 09/21/21, and 09/23/21 at 8:00am from 09/01/21 - 09/28/21.
-There was a total of 4 times documented the resident refused Paroxetine 20 mg and no documentation Resident #4's PCP was notified.

Review of Resident #4's progress notes revealed there was no further documentation of medication refusals and no documentation the PCP was notified.

Telephone interview with Resident #4's PCP on 09/29/21 at 1:40pm revealed:
-Resident #4 was prescribed Paroxetine for depression.
-Resident #4 was at risk for increased depression if the resident was not taking the medication as ordered.

Refer to the interview with a medication aide (MA) on 09/28/21 at 3:31pm.

Refer to the interview with a second MA on 09/29/21 at 10:23am.

Refer to the interview with the Resident Services Director (RSD) on 09/28/21 at 2:58pm.

Refer to the interview with the Administrator on 09/29/21 at 11:31am.

Refer to the telephone interview with Resident #4's PCP on 09/29/21 at 1:40pm.

f. Review of Resident #4's current FL-2 dated 08/18/21 revealed there was an order for Prevident 6000 sensitive toothpaste twice daily. (Prevident is a toothpaste used to prevent tooth decay).

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D 273	Continued From page 10 Review of a previous medication order for Resident #4 dated 07/01/21 revealed an order for Prevident 6000 sensitive toothpaste twice daily. Review of Resident #4's July 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Prevident 6000 sensitive toothpaste twice daily scheduled at 8:00am and 8:00pm. -There was documentation the resident refused Prevident 6000 sensitive toothpaste on 07/22/21, 07/24/21, 07/26/21, 07/27/21, and on 07/31/21 at 8:00am. -There was a total of 5 times documented the resident refused Prevident 6000 sensitive toothpaste and no documentation Resident #4's primary care provider (PCP) was notified. Review of Resident #4's August 2021 eMAR revealed: -There was an entry for Prevident 6000 sensitive toothpaste twice daily scheduled at 8:00am and 8:00pm. -There was documentation the resident refused Prevident 6000 sensitive toothpaste on 08/02/21, 08/09/21, 08/17/21, 08/26/21, 08/28/21, and 08/31/21 at 8:00am. -There was a total of 6 times documented the resident refused Prevident 6000 sensitive toothpaste and no documentation Resident #4's PCP was notified. Review of Resident #4's September 2021 eMAR revealed: -There was an entry for Prevident 6000 sensitive toothpaste twice daily scheduled at 8:00am and 8:00pm. -There was documentation the resident refused	D 273		

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D 273	Continued From page 11 Prevident 6000 sensitive toothpaste on 09/01/21, 09/02/21, 09/06/21, 09/07/21, 09/08/21, 09/10/21, 09/13/21, 09/14/21, 09/15/21- 09/17/21, 09/21/21, 09/23/21 at 8:00am from 09/01/21 - 09/28/21. -There was a total of 13 times documented the resident refused Prevident 6000 sensitive toothpaste and no documentation Resident #4's PCP was notified. Review of Resident #4's progress notes revealed there was no further documentation of medication refusals and no documentation the PCP was notified. Refer to the interview with a medication aide (MA) on 09/28/21 at 3:31pm. Refer to the interview with a second MA on 09/29/21 at 10:23am. Refer to the interview with the Resident Services Director (RSD) on 09/28/21 at 2:58pm. Refer to the interview with the Administrator on 09/29/21 at 11:31am. Refer to the telephone interview with Resident #4's PCP on 09/29/21 at 1:40pm. _____ Interview with a medication aide (MA) on 09/28/21 at 3:31pm revealed: -When a resident refused medications, the MAs were responsible to make a second attempt to administer the medications to the resident a "few minutes later". -If the resident continued to refuse the medications the MA documented the resident's refusal on the resident's electronic medication administration record (eMAR) and in the resident's progress notes.	D 273		

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-When a resident consistently refused medications the resident's primary care provider (PCP) was notified.
-There were no specific times when the PCP was contacted regarding a resident's medication refusals.
-Resident #4 did not usually refuse medications when she administered medications to the resident.
-She had not received any reports from other MAs that Resident #4 was refusing medications.

Interview with a second MA on 09/29/21 at 10:23am revealed:
-MAs were responsible to encourage residents to take their medication.
-When a resident refused a scheduled medication, MAs were responsible to attempt to offer the refused medications again 30 minutes later to the resident.
-If the resident continued to refuse the medication, the residents' refusal was documented on the residents' eMAR.
-She notified the Resident Services Director (RSD) and the next shift MA when a resident refused medications during her shift.
-She had never contacted a PCP regarding residents' mediation refusals.

Interview with the RSD on 09/28/21 at 2:58pm revealed:
-She was not aware Resident #4 was refusing doses of her scheduled medications in July, August and September 2021.
-She expected the MAs to alert her if Resident #4 was refusing medication and she would assess the reason or cause of the resident's medication refusals.
-MAs were responsible to notify her when a resident refused medications.

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D 273	Continued From page 13 -The residents' PCP should have been notified when a resident refused medications, however, there was no specific medication refusal times or consecutive doses when the PCP should have been notified. -She would have notified Resident #4's PCP if she had known the resident was refusing her medications. A second interview with the RSD on 09/29/21 at 4:45pm revealed she performed resident record audits to review the residents' eMARs but had not performed any in a few months due to other job responsibilities related to resident care. Interview with the Administrator on 09/29/21 at 11:31am revealed: -She expected the residents' PCP to be notified when a resident refused medications as ordered. -The facility's policy included the PCP would be notified when residents' refused medications however there was no time frame as to when the residents' PCP should have been notified. -She and the RSD performed random resident record audits, which included reviewing the residents' eMAR for any blanks to ensure medications were documented as being administered to the residents as ordered. -She had not performed any resident record audits in approximately 6 months. -She was not sure when the RSD last performed resident record audits. -Resident #4 had dementia and if approached correctly, the resident did not have any issues taking her ordered medications. -She thought most of the medication refusals for Resident #4 was related to a named MA who needed additional training on how to approach residents with dementia when administering medications.	D 273		

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D 273	Continued From page 14 Telephone interview with Resident #4's PCP on 09/29/21 at 1:40pm revealed: -He was not notified by the facility that Resident #4 was refusing her medications in July, August and September 2021. -He expected staff to notify him when a resident was routinely refusing ordered medications in order to know what was going on with the resident and how to treat the resident.	D 273		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record	D 367		

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reviews, the facility failed to ensure medication administration records were accurate for 3 of 5 residents sampled including medications for anxiety (#2, #5) and pain (#1).

The findings are:

1. Review of Resident #2's current FL-2 dated 10/05/21 revealed:
-Diagnoses included: mental retardation, gastroesophageal reflux disease (GERD), chronic bronchitis, headaches, chronic constipation, asthma, diabetes mellitus type II, hypertension (HTN) and hypercholesterolemia.
-There was an order for Lorazepam 1mg tablet three times a day as need for anxiety.
(Lorazepam is a controlled medication used to treat anxiety.)

Observation of Resident #2's medications on hand on 09/29/21 at 11:49am revealed there were 16 of 30 tablets of Lorazepam 1mg from the supply dispensed on 11/18/20.

Review of Resident #2's controlled substance (CS) log for Lorazepam on 09/29/21 at 11:49am revealed:
-There were 30 tablets of Lorazepam 1mg dispensed on 11/18/20.
-Lorazepam was documented using this controlled substance log from 05/10/21 - 09/08/21.
-On 05/10/21 at 10:00am, Lorazepam 1 tablet was signed as administered and 29 tablets remained.
-On 07/03/21 at 10:00am, Lorazepam 1 tablet was signed as administered and 28 tablets remained.
-On 07/15/21 at 8:00am, Lorazepam 1 tablet was signed as administered and 27 tablets remained.

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-On 07/27/21 at 8:00am, Lorazepam 1 tablet was signed as administered and 26 tablets remained.
-On 08/05/21 at 10:00am, Lorazepam 1 tablet was signed as administered and 25 tablets remained.
-On 08/10/21 at 8:00am, Lorazepam 1 tablet was signed as administered and 24 tablets remained.
-On 08/11/21 at 8:00am, Lorazepam 1 tablet was signed as administered and 23 tablets remained.
-On 08/12/21 at 8:00am, Lorazepam 1 tablet was signed as administered and 22 tablets remained.
-On 08/19/21 at 9:30am, Lorazepam 1 tablet was signed as administered and 21 tablets remained.
-On 08/20/21 at 8:00am, Lorazepam 1 tablet was signed as administered and 20 tablets remained.
-On 09/08/21 at 8:00am, Lorazepam 1 tablet was signed as administered and 19 tablets remained.

Review of Resident #2's July 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 1mg three times a day as needed for anxiety.
-Lorazepam was not documented as administered from 07/01/21 - 07/31/21.

Review of Resident #2's August 2021 eMAR revealed:
-There was an entry for Lorazepam 1mg three times a day as needed for anxiety.
-Lorazepam was not documented as administered from 08/01/21 - 08/31/21.

Review of Resident #2's September 2021 eMAR revealed:
-There was an entry for Lorazepam 1mg three times a day as needed for anxiety.
-Lorazepam was not documented as administered from 09/01/21 - 09/28/21.

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

Refer to interview with the medication aide (MA) on 09/29/21 at 11:48am.

Refer to interview with the Resident Service Director (RSD) on 09/29/21 at 11:53am.

Refer to interview with the Administrator on 09/29/21 at 1:21pm.

2. Review of Resident #1's current FL-2 dated 11/24/20 revealed diagnoses included: chronic obstructive pulmonary disease (COPD), noninfective disorder of lymphatic, myocardial infarction (MI), congestive heart failure (CHF), shortness of breath (SOB), end stage renal disease (ESRD), dependence on renal dialysis and hypertension (HTN).

Review of Resident #1's physician's orders dated 06/25/21 revealed there was an order for Percocet 5-325mg 1 tablet every 6 hours as needed for pain.

Observations of Resident #1's medications on hand on 09/29/21 at 11:04am revealed there were 6 of 10 tablets of Percocet 5-325mg from the supply dispensed on 08/31/21.

Review of Resident #1's controlled substance (CS) log for Percocet on 09/29/21 at 11:04am revealed:
-There were 10 tablets of Percocet 5-325mg dispensed on 08/31/21.
-Percocet was documented using this CS log from 09/03/21 - 09/28/21.
-On 09/03/21 at 8:00pm, Percocet 1 tablet was

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signed as administered and 9 tablets remained.
-On 09/04/21 at 8:00pm, Percocet 1 tablet was signed as administered and 8 tablets remained.
-On 09/25/21 at 8:00pm, Percocet 1 tablet was signed as administered and 7 tablets remained.
-On 09/28/21 at 8:00pm, Percocet 1 tablet was signed as administered and 6 tablets remained.

Review of Resident #1's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Percocet 5-325mg 1 tablet every 6 hours as needed for pain.
-Percocet was not documented as administered from 09/01/21 - 09/28/21.

Based on observations and interviews it was determined that Resident #1 was not available for an interview.

Refer to interview with the medication aide (MA) on 09/29/21 at 11:48am.

Refer to interview with the Resident Service Director (RSD) on 09/29/21 at 11:53am.

Refer to interview with the Administrator on 09/29/21 at 1:21pm.
3. Review of Resident #5's current FL-2 dated 12/17/20 revealed:
-Diagnosis included hypertension, arteriosclerotic disease, diastolic heart failure, hyperlipidemia, dementia, osteoarthritis, pacemaker, atrial fibrillation, goiter and seizures.
-The resident was intermittently disoriented.
-There was an order for Lorazepam 0.5mg every 8 hours as needed for anxiety. (Lorazepam is a medication used to treat anxiety).

Observation of Resident #5's medications on

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hand on 09/29/21 at 10:53am revealed:
-The punch cards containing 90 tablets of Lorazepam 0.5mg was dispensed on 04/09/21.
-A Lorazepam 0.5mg tablet punch card labeled as 1 of 3 was dispensed on 04/09/21 for a total of 90 tablets.
-Of the 30 tablets available on the current 1 of 3 punch cards, 10 tablets had been dispensed, 20 tablets remained.

Interview with the medication aide (MA) on 09/29/21 at 10:53am revealed there were no additional punch cards of Lorazepam 0.5mg for Resident #5.

Review of Resident #5's controlled substance (CS) log for Lorazepam 0.5mg on 09/29/21 at 10:53am revealed:
-The first dose documented as administered was on 07/12/21 at 2:00pm and the last dose was documented as administered on 07/28/21 in July 2021.
-There was no signature of the MA, date, time or amount remaining for the first dose subtracted from the 90 tablets of the Lorazepam 0.5mg on the CS log.
-Lorazepam 1 tablet was signed as administered to the resident on 07/18/21, 07/20/21, 07/23/21, and 07/25/21 at 8:00am and on 07/15/21 at 11:00pm.
-Lorazepam 1 tablet was signed as administered to the resident on 07/12/21, 07/14/21, 07/19/21, 07/21/21, 07/27/21 and 07/28/21 at 2:00pm.
-On 07/22/21 there was an unreadable time, Lorazepam 1 tablet was signed as administered and 81 tablets remained.
-There was a handwritten entry with 1 dose given, 76 tablets remaining, signed by a MA however, there was no date documented for the administered dose in the next space below

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D 367	Continued From page 20 07/28/21 and above 08/01/21. -From 07/12/21 to 07/28/21 a total of 12 tablets were documented as dispensed to the resident. Review of Resident #5's July 2021 electronic medication administration (eMAR) record from 07/12/21 - 07/29/21 revealed: -There was an entry for Lorazepam 0.5mg tablet take one tablet every 8 hours as needed for anxiety. -From 07/12/21 to 07/29/21 a total of 10 doses of Lorazepam 0.5mg were documented as administered to the resident. -There was no documentation that Lorazepam had been administered on 07/18/21, 07/20/21, and 07/25/21 at 8:00am. -There was documentation that Lorazepam had been administered on 07/29/21 at 7:20am that did not match the CS log. Review of Resident #5's CS log for Lorazepam 0.5mg on 09/29/21 at 10:53am revealed: -The first dose documented as administered in August 2021 was on 08/01/21 at 8:00am and the last dose was documented as administered on 08/30/21 at 2:00pm. -Lorazepam 1 tablet was signed as administered to the resident on 08/01/21, 08/04/21, 08/06/21 - 08/08/21, 08/18/21 - 08/23/21, 08/25/21, and 08/29/21 at 8:00am and on 08/12/21 at 9:30am. -Lorazepam 1 tablet was signed as administered to the resident on 08/04/21, 08/07/21, 08/09/21, 08/10/21, 08/12/21, 08/16/21 - 08/18/21, 08/22/21, 08/23/21, 08/25/21, and 08/30/21 at 2:00pm. -There was a handwritten entry with 1 dose given, 71 tablets remaining, however, there was no date and time documented and no signature for the MA who administered the dose in the next space below 08/06/21 and above 08/07/21 at 8:00am.	D 367		

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D 367	Continued From page 21 -There was a handwritten entry with a MAs signature, 1 dose given at 8:00am, 49 tablets remaining, however, there was no date documented in the next space below 08/29/21 and above 08/30/21. -From 08/01/21 to 08/30/21 a total of 26 tablets were documented as dispensed to the resident. Review of Resident #5's August 2021 eMAR revealed: -There was an entry for Lorazepam 0.5mg tablet take one tablet every 8 hours as needed for anxiety. -From 08/03/21 to 08/30/21 a total of 15 doses of Lorazepam 0.5mg were documented as administered to the resident. -There was no documentation that Lorazepam had been administered on 08/01/21, 08/07/21, 08/19/21, 08/20/21, 08/23/21 and 08/29/21 at 8:00am and on 08/12/21 at 9:30am. -There was no documentation that Lorazepam had been administered on 08/10/21, 08/17/21, 08/18/21, 08/22/21, 08/23/21, and 08/25/21 at 2:00pm. Review of Resident #5's CS log for Lorazepam 0.5mg on 09/29/21 at 10:53am revealed: -The punch cards containing 90 tablets of Lorazepam 0.5mg was dispensed on 04/09/21. -The first dose documented as administered in September 2021 was on 09/09/21 at 12:00pm and the last dose was documented as administered on 09/28/21 at 2:00pm. -Lorazepam 1 tablet was signed as administered to the resident on 09/10/21, 09/11/21, 09/13/21 - 09/24/21, 09/27/21, and 09/28/21 at 8:00am. -Lorazepam 1 tablet was signed as administered to the resident on 09/10/21, 09/13/21, 09/14/21, 09/16/21, 09/23/21, 09/27/21 and 09/28/21 at 2:00pm.	D 367		

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D 367	Continued From page 22 -Lorazepam 1 tablet was signed as administered to the resident on 09/09/21 at 12:00pm, 09/15/21 at 3:00pm and on 09/16/21, 09/17/21, and 09/19/21 at 8:00pm. -From 09/09/21 to 09/28/21 a total of 28 tablets were documented as dispensed to the resident. Review of Resident #5's September 2021 eMAR revealed: -There was an entry for Lorazepam 0.5mg tablet take one tablet every 8 hours as needed for anxiety. -From 09/09/21 to 09/28/21 a total of 19 doses of Lorazepam 0.5mg were documented as administered to the resident. -There was no documentation that Lorazepam had been administered on 09/11/21, 09/18/21-09/20/21 at 8:00am. -There was no documentation that Lorazepam had been administered on 09/14/21, 09/27/21, and 09/28/21 at 2:00pm and on 09/16/21 and 09/17/21 at 8:00pm. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. Refer to interview with the medication aide (MA) on 09/29/21 at 11:48am. Refer to interview with the Resident Service Director (RSD) on 09/29/21 at 11:53am. Refer to interview with the Administrator on 09/29/21 at 1:21pm. _____ Interview with the medication aide (MA) on 09/29/21 at 11:48am revealed it was the responsibility of the MA to document on the	D 367		

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D 367	Continued From page 23 controlled substance (CS) log at the time the medication is prepared and document on the electronic medication administration record (eMAR) after the medication is administered. Interview with the Resident Service Director (RSD) on 09/29/21 at 11:53am revealed it was the responsibility of the MA to document on the resident's CS log when the medication was prepared and document on the resident's eMAR after the medication is administered. Interview with the Administrator on 09/29/21 at 1:21pm revealed it was the responsibility of the MA to document on the resident's CS log and in the resident's eMAR when a controlled substance is administered.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the disposition and administration of controlled substances for 1 of 5 residents sampled (#2) for a medication used to treat anxiety.	D 392		

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D 392	Continued From page 24 The findings are: Review of Resident #2's current FL-2 dated 10/05/21 revealed: -Diagnoses included: mental retardation, gastroesophageal reflux disease (GERD), chronic bronchitis, headaches, chronic constipation, asthma, diabetes mellitus type II, hypertension (HTN) and hypercholesterolemia. -There was an order for Lorazepam 1mg tablet three times a day as need for anxiety. (Lorazepam is a controlled medication used to treat anxiety.) Observation of Resident #2's medications on hand on 09/29/21 at 11:49am revealed there were 16 of 30 tablets of Lorazepam 1mg from the supply dispensed on 11/18/20. Review of Resident #2's controlled substance (CS) log for Lorazepam on 09/29/21 at 11:49am revealed: -There were 30 tablets of Lorazepam 1mg dispensed on 11/18/20. -Lorazepam was documented using this CS log from 05/10/21 - 09/08/21. -The last entry documented was 09/08/21 at 8:00am for the administration of 1 tablet of Lorazepam 1mg with 19 tablets remaining. Interview with the medication aide (MA) on 09/29/21 at 11:48am revealed: -The MAs counted the controlled substances during change of shift with the MA accepting the assignment. -There were 2 MAs scheduled to work first shift on 09/29/21 but the other MA had to leave work early. -She did not count the controlled substances with the other MA on 09/29/21 prior to that MA leaving.	D 392		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 25 -She was not aware that Resident #2's Lorazepam count was incorrect. -It was the responsibility of the MAs to document on the CS log at the time the medication is administered. -She had not had any other incidents where the controlled substance count was incorrect. -If the controlled substance count was incorrect, the MA would check to see if the medication came out of the bubble packaging by searching the area the controlled substances were kept. -It was the responsibility of the MAs to notify the Resident Service Director (RSD) if the controlled substance count was incorrect. Interview with the RSD on 09/29/21 at 11:53am revealed: -It was the responsibility of the MAs to count the controlled substances during change of shift. -It was the responsibility of the MAs to notify the RSD of incorrect controlled substance counts. -It was the responsibility of the MAs to document on the CS logs when the medication is prepared for administration. -She was not aware that Resident #2's Lorazepam count was incorrect. -She believed that the MAs administered prn Lorazepam to Resident #2 and forgot to document on the CS log making the count incorrect. -She did not have a process to monitor the CS logs for accuracy. Interview with the Administrator on 09/29/21 at 1:21pm revealed: -It was the responsibility of the MAs to count the controlled substances during change of shift. -She was not aware that Resident #2's Lorazepam count was incorrect. -She believed that Resident #2's incorrect	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070006	A. BUILDING: _____ B. WING _____	C 09/29/2021

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D 392	Continued From page 26 Lorazepam count was a documentation error. -The facility had not had any issues with incorrect controlled substance counts. Based on observations, interviews, and record reviews it was determined that Resident #2 was not interviewable.	D 392		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) initial and 5-day investigation reports for 1 of 5 sampled residents (#3) who had an injury of unknown origin in the form of bruising to the left eye. The findings are: Review of Resident #3's current FL-2 dated 07/16/21 revealed: -Diagnoses included asthma, history of pulmonary embolism, and history of hip fracture. -The resident was intermittently disoriented, verbally abusive, and semi-ambulatory. -Medication orders included Warfarin Sodium 2mg tablet weekly of Saturday and Warfarin Sodium 4mg tablet daily on Sunday through Friday (Warfarin Sodium is a medication used to treat blood clots and prevent new clots from	D 438		

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D 438	Continued From page 27	D 438		

forming).

Review of a "Nurses Notes" dated 05/12/21 for 12:30pm revealed:
-The resident had a bruise on left eye, unknown origin, and the resident was unable to state what happened.
-The eye had no discharge or drainage and ice compression was applied to the eye; will continue to monitor.
-On 05/13/21 at 8:30am the resident had a diminishing bruise noted above the left eye but denied pain or headache.

Review of an accident/incident report dated 05/12/21, (no time documented), for Resident #3 revealed:
-The resident had a bruise to left eye of unknown origin.
-The resident was unable to explain what happened.
-An ice compression was applied to the resident's eye.
-The resident's family member was notified and stated to not send the resident out at this time.

Interview with Resident #3's family member on 09/29/21 at 8:10am revealed:
-He remembered the staff had reported the incident of a black eye on 05/12/21 to him, but he was unsure of how it happened.
-The resident bruised easily and the family member did not know if the resident was taking any medications that might cause bruising.
-The resident could walk, but mostly propelled herself in a wheelchair.

Interview with Resident #3 on 09/29/21 at 10:05am revealed:
-The staff treated her okay and she got along with

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D 438	Continued From page 28	D 438		

her new roommate.
-She moved to this room after an argument with another resident that tried "to be the boss".
-She remembered she had a bruised foot from kicking the other resident and a bruised eye but could not recall the date of the incident.

Interview with a personal care aide (PCA) on 09/29/21 at 10:58am revealed:
-She had been working at the facility for two years.
-She did not recall the incident involving Resident #3 on 05/12/21 because she was on leave during that time.
-PCAs reported accidents or injuries to a medication aide (MA) or the Resident Services Director (RSD).
-The MA or RSD was responsible for completing an accident/incident report.
-She had not seen other staff mistreating residents but if she did, she would report it to the RSD or the Administrator.
-Residents had not reported being mistreated to her.

Interview with the RSD on 09/29/21 at 11:09am revealed:
-She remembered Resident #3 had a black eye, but she did not know how it happened.
-The MA called her to report the incident the same day it happened.
-She did a Facetime interview with the resident and the MA that reported the incident.
-She noticed a dark ring around the outside of the resident's eye.
-The MA was instructed to interview other staff concerning the injury and how it happened.
-Whenever a resident experienced an injury, an accident/incident report was completed, and the MA or RSD faxed it to the department of social

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services (DSS).
-There was no documentation that the accident/incident report for Resident #3 dated 05/12/2021 was sent to the DSS.
-She did not know of the requirements for reporting and investigating injuries of an unknown origin to HCPR.
-The Administrator was responsible for completing and sending reports to HCPR.

Attempted interview with the MA who completed the accident/incident report for Resident #3 dated 05/12/21 was unsuccessful on 09/29/21.

Interview with the Administrator on 09/29/21 at 11:32am revealed:
-She vaguely remembered when Resident #3 had the incident with the black eye.
-The staff did not see everything that happened to residents.
-The resident bruised easily because she is on Warfarin.
-The resident provoked others by hitting, kicking, and throwing water on them, and going into other resident's rooms to start trouble.
-Accident/incident reports were completed and sent to DSS by MAs or RSD.
-She was not aware of reporting and investigating requirements and had not had to report anything to HCPR in years.
-The initial HCPR report and 5 Day Investigation report were not completed because she did not have any alleged staff to report and she thought the injury was not anything more than bruising due to the Warfarin.

Telephone interview with the medical assistant for Resident #3's primary care provider on 09/29/21 at 1:21pm revealed:
-An incident report or note about the 05/12/21

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D 438	Continued From page 30 incident was not in the resident's chart at the office. The provider would expect to be notified of any injury, problems or concerns to be addressed for the well-being and safety of the resident. -It was expected the facility would report injuries to the HCPR as required.	D 438		