Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074042	A. BUILDING: _____ B. WING _____	R 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS GLEN RETIREMENT COMMUNITY MEMORI	100 HICKORY STREET GREENVILLE, NC 27858

(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 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey and complaint investigation on 05/27/21.	D 000	This plan of correction is submitted in compliance with statutory and regulatory requirements and should not be construed as an admission or agreement with the findings,	
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, record reviews and interviews, the facility failed to ensure the medication administration records (MAR) were accurate for 1 of 3 sampled resident (Residents #1) related to consumption of an alcoholic beverage as needed.	D 367	scope, or severity of any of the deficiencies cited. Cypress Glen Memory Care will administer and record medication and treatment orders on the Medication Administration Record and shall be accurate and include all required components. Immediate Action: All medication and treatment orders will be transcribed electronically by a RN or LPN. A new order report will be completed by the Administrator weekly to check for accuracy of transcription and access to documentation of administration. All Memory Care Medication Aide staff will be provided an in-service provided by the Nurse Manager on medication administration and documentation.	6/1/2021-12/1/2021 6/28/2021-7/15/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Morgan N. Reese — TITLE: MC Admin — (X6) DATE: 6/25/21

Reviewed & Accepted
07/09/21 - Nola Wiggins

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D 387	Continued From page 1 1. Review of Resident #1's current FL2 dated 02/22/21 revealed diagnoses included dementia with behavioral disturbances, mild cognitive impairment, delusional disorder and hallucinations, spasmodic torticollis, hypertension. Review of Resident #1's physician order dated 03/24/21 revealed there was an order for limited consumption of 5oz of wine per day. Review of Resident #1's March 2021 MAR revealed: -The limited consumption of 5oz wine order was not documented on the MAR. -The was not an entry for administering of 5oz of wine. Review of Resident #1's April 2021 MAR revealed: -The limited consumption of 5oz wine order was not documented on the MAR. -The was not an entry for administering of 5oz of wine. Interview with Resident #1's on 05/25/21 at 9:48am revealed: -She had drunk wine at times. -Her doctor said she could drink 2 to 3 glasses of wine whenever she wanted to drink wine. -She did not know the last time she had consumed some wine. Telephone interview with a family member on 05/27/21 at 9:39am revealed: -She knew the doctor had given Resident #1 permission to have wine. -She did not know how often Resident #1 drank wine but thought it was daily.	D 387	Widespread Corrective Action and Systemic Change: The Administrator will complete a new order report weekly. During this weekly audit, the Administrator will confirm that all orders are properly showing on the MAR and available to document as required. The Staff Development Coordinator/Nurse Manager will provide medication administration and documentation training for all staff on an annual basis and as needed. Review will include the following procedure. This procedure implemented will include the following: - A physician's order is required to administer all medication/treatments including, but not limited to, oral tablets, capsules, liquid, sublingual, topical, transdermal, intramuscular, injection, alcohol, over-the-counter, wound care, etc.	7/15/2021-1/15/2022 7/15/2022

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D 367	Continued From page 2 Interview with a Medication Aide (MA) on 05/25/21 at 4:23pm revealed: -Resident #1 had an order to have wine once a day. -She had given Resident #1 only 5oz of wine. -She thought the order for the wine was written on 03/20/21. -She did not see the order for the wine on the March 2021 MAR. -She did not document giving Resident #1 wine on the MAR or in the resident's notes. -She did not remember the last time when she had given Resident #1 the wine. -The order for the wine was supposed to be on the MAR. -She could not remember if she had documented administering the 5oz wine in the resident's notes. Interview with a second MA on 05/26/21at 9:39am revealed: -There was an order for Resident #1 for the wine, but she did not know the amount to be given. -She had not given Resident #1 any alcohol but knew Resident #1 requested it at night. -All orders were to be on the MAR. -If the order was supposed to be on the MAR, the wine was not to be given. Interview with a third MA on 05/26/21 at 9:47am revealed: -Resident #1 had an order for 5oz of wine per day. -She had not given Resident #1 wine. -All orders including the order for wine, should to be on the MAR. Interview with a fourth MA on 05/27/21 at 11:50am revealed: -She had not given Resident #1 wine. -The order for 5 oz of wine was on the MAR.	D 367	- All medication administration must be documented in the residents MAR. If the order is not present or has inaccuracies, this should be brought to the attention of the Nurse Manager or Administrator. - All inaccuracies will be brought to the attention of the Administer/Nurse Manager and corrected immediately at the time of discovery. **Monitoring:** The Administrator will complete a monthly audit of all new orders for the prior month to ensure that each order is accurately appearing and being documented as appropriate. This audit will be reported in the monthly and quarterly QAPI report.	7/8/2021-1/8/2022

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D 357	Continued From page 3 Telephone interview with the Primary Care Physician (PCP) on 05/27/21 at 10:08am revealed: -Resident #1 had an order to be given only 5oz of wine one time per day per Resident #1's request. -He could not remember if the order was written to be given per Resident #1's request but the order was written for 5oz of wine per day. -He considered the order per the family's request. -He considered the order to assist with Resident's #1's "quality of Life". Interview with the Administrator on 05/25/21 at 5:11pm revealed: -The order for wine was written on 03/24/21. -The order had been entered as an ancillary order on 03/24/21 which was the reason it had not populated on the March 2021 and April 2021 MAR. -She changed the order to a nursing order on 05/20/21 which caused it to populate on the May 2021 MAR. -She did not know how often Resident #1 was given wine. -Staff had not offered the 5oz of wine to Resident #1 daily, Resident #1 had to request the 5oz of wine. -Resident #1 had complained about not receiving the wine	D 357		