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Division of Health Service Regulation
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RECEIVED
SEP 20 2021
Adult Care Licensure Section
Raleigh

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	08/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(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 and the Department of Social Services conducted an annual and follow-up survey and a complaint investigation, onsite 08/17/21-08/18/21, desk review on 08/19/21 and telephone exit on 08/20/21.	D 000	*Responses to the cited deficiences do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of correction is prepared solely as a matter of compliance with the state law.	
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	D 273	1) A weekly listing of all residents on therapy caseloads will be provided to the Executive Director, Care Coordinators and Area Clinical Director with start of care date and date therapy are discontinued, as applicable	10/1/21
	Based on observations, record reviews and interviews the facility failed to ensure referral to meet the acute healthcare needs for 1 of 3 sampled residents (#3) who had an order for physical therapy. The findings are: Review of Resident #3's current FL2 dated 03/18/21 revealed diagnoses included chronic obstructive pulmonary disease (COPD), atrial fibrillation, peripheral neuropathy, heart failure and osteoarthritis. Review of Resident #3's care plan dated 04/12/21 revealed: -He had limited ambulation abilty and used a walker. -He had limited range of motion in his upper extremities. Review of Resident #3's record revealed:		2) Therapy provider will provide weekly documentation of progress notes to the Care Coordinators for each Resident on caseload. 3) The Care Coodinators will update their listings of all residents	10/1/21 10/1/21

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. Jennifer Angel
TITLE: ED
(X6) DATE: 9/20/2021.

STATE FORM 6899 U63B11 If continuation sheet 1 of 20

Marcus Arnett

reviewed & acknowledged 09/28/21 LSB

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D 273	Continued From page 1 -There was an order dated 06/04/21 to consult physical therapy (PT) due to poor posture, poor balance and upper extremity weakness. -There was no documentation Resident #3 was evaluated by physical therapy. Interview with Resident #3 on 08/17/21 at 10:23am revealed: -He used oxygen sometimes due to shortness of breath. -He used a walker because he could not get around without it. -He thought he had pneumonia because he was "coughing up stuff " and felt bad for the last few days. Observation of Resident #3 on 08/18/21 at 1:30pm revealed: -He was using a walker to walk down the hallway. -He was leaning over the walker and moving slowly. Interview with Resident #3 on 08/18/21 at 1:30pm revealed: -Staff brought lunch to his room because he did not feel like getting out of bed and going to the dining room. -He did not get out of bed earlier for breakfast. -He requested PT at one time but since he never heard anything about it he assumed it was never ordered. Interview with the Resident Care Coordinator (RCC) on 08/18/21 at 3:26pm revealed: -She was responsible for processing orders and following up as needed. -She had called the agency who provided PT services for the facility to obtain evaluation and therapy notes because she could not locate any in Resident #3's record.	D 273	3) on Therapy Caseload on a weekly basis once the current Caseload and therapy progress notes are received.	10/1/21

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D 273	Continued From page 2 Telephone interview with a local home health agency on 08/19/21 at 8:57am revealed: -They provided PT services to residents at the facility. -They received the order for PT services for Resident #3 on 06/07/21. -They received a call on 08/18/21 requesting PT records on Resident #3 and they were unable to locate where Resident #3 had been treated after the 06/07/21 order was processed. -They informed the facility on 08/18/21 that they had "overlooked" the order and never treated Resident #3. Telephone interview with Resident #3's Nurse Practitioner (NP) on 08/19/21 at 11:00am revealed: -A PT consult was ordered due to extremity weakness with the hope that it would rebuild his strength. -Resident #3 was weak, often refused to leave his room, was less active than before he had COVID and was not as engaged in the community as he had been previously. -He had pneumonia multiple times in the past few months and it may have been due to his reduction in activity. -Resident #3 also thought PT would be beneficial as he would receive strengthening exercises. -Resident #3 would have benefited from PT if it had been started after the 06/04/21 order was written. -She received reports from the facility after orders were completed. -She was informed on 08/18/21 that the PT order had been overlooked and PT had never been initiated. Telephone interview with the RCC on 08/19/21 at	D 273		

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D 273	Continued From page 3 12:57pm revealed: -She received a call from the home health agency on 08/18/21 reporting the PT order had been overlooked. -She never followed-up after she contacted the agency to inform them of the PT consult. -The PT order "fell through the cracks". -The facility did not have any system in place to ensure orders were completed. -The only way she knew an order was completed was when she received the report. -When she received a report she sent it to the NP and then filed a copy of the report in the resident's record. -If she never received a report, there was no process in place to alert her to look into it. Telephone interview with the Administrator on 08/19/21 at 2:36pm revealed: -She was unaware a PT order for Resident #3 had been overlooked until the RCC told her on 08/18/21. -She did not think there was any specific process in place to ensure orders were completed. -The RCC was responsible for ensuring orders were processed and completed. The facility failed to ensure Resident #3 was evaluated and treated by physical therapy after a consult was written by the Nurse Practitioner due to resident weakness, refusal to leave his room with reduced activity and engagement in the community. This failure resulted in the continuation of reduced activity, was detrimental to the health of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/18/21 for this violation.	D 273		

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D 273	Continued From page 4 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 4, 2021.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358	(1) The care coordinator will conduct a weekly Cart audit of all residents with prescribed medications. The Executive Director will hold a meeting to discuss the weekly audit with the Care Coordinators and the Area Clinical Director.	10/1/21
	This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were available for administration for 3 of 5 sampled residents (Resident #1, #2, and #4) related to an eye drop used for allergies (#1), a cream used for incontinence care (#2), and a medication used to increase appetite (#4). The findings are: Review of the facility's policy on Medication Management dated 07/2020 revealed: -The facility was responsible for ensuring medication orders were processed and implemented based on physician orders. -Medication Cart Audits are completed to ensure medications are in the community and available for administration. -Medication Cart Audits are completed every Wednesday.		(2) The Area Clinical Director will recheck off and train all Med Tech's. (3) The Care Coordinator will observe medication administration passes on a daily bases.	10/1/21 10/1/21

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D 358	Continued From page 5 1. Review of Resident #4's current FL-2 dated 01/14/21 revealed diagnoses included dementia, hypothyroidism, hypertension, and hyperlipidemia. Review of a Progress Note for Resident #4 dated 07/08/21 revealed a physician's order for Remeron (used to increase appetite and improve mood) 15mg take half of a tablet at bedtime. Review of Resident #4's July 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Remeron 15mg take ½ tablet at bedtime scheduled to administer at 8:00pm daily. -Remeron 15mg half tablet at bedtime was documented as administered daily at 8:00pm from 07/09/21 to 07/31/21 except on 07/14/21, 07/15/21, 07/19/21, and 07/20/21 where it was documented as refused. Review of Resident #4's August 2021 eMAR revealed: -There was a computer-generated entry for Remeron 15mg take ½ tablet at bedtime scheduled to administer at 8:00pm daily. -Remeron 15mg take half tablet at bedtime was documented as administered daily at 8:00pm daily from 08/01/21 to 08/16/21. Observation of medication on hand on 08/17/21 at 3:15pm revealed Remeron 15mg was not available to administer to Resident #4. Telephone interview with pharmacy technician from Resident #4's pharmacy on 08/17/21 at 3:33pm revealed: -Remeron 15mg was filled today (08/17/21) and	D 358		

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D 358	Continued From page 6 was ready to be picked up at the pharmacy. -Remeron 15mg was last filled on 07/09/21 for a 30-day supply. -The pharmacy did not make deliveries to the facility. Telephone interview with the responsible person for Resident #4 on 08/17/21 at 3:42pm revealed: -The facility was responsible for calling in medications to the pharmacy for Resident #4. -A medication aide (MA) or the Special Care Coordinator (SCC) would call and let her know if she needed to pick up a medication for Resident #4. -The facility had called her a few minutes before this conversation to let her know there was a medication for Resident #4 at the pharmacy that was ready to pick up. -She was not able to go pick up the medication today (08/17/21). Interview with a MA on 08/17/21 at 4:22pm revealed: -Resident #4 had all medications available to administer when she last worked on 08/15/21. -Either a MA or the SCC was responsible for calling in medications to Resident #4's pharmacy when the medications needed to be refilled. -Either a MA or the SCC was responsible for calling Resident #4's responsible person to let her know she needed to pick up medications from the pharmacy and bring them to the facility. Interview with a second MA on 08/19/2 at 12:56pm revealed: -The SCC was responsible for processing new medication orders. -The MAs were responsible for contacting the pharmacy for Resident #4 when she needed medications refilled.	D 358		

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D 358	Continued From page 7 -Medication carts were audited weekly. -The MA was responsible for printing the eMAR for each resident and comparing it to the medication cart to make sure all medications were available for administration. Interview with the SCC on 08/18/21 at 11:10am revealed: -She called Resident #4's responsible person on 08/17/21 to let her know Resident #4 was out of Remeron and it was ready to be picked up at the pharmacy. -The responsible person said she would pick up the medication and deliver it to the pharmacy. -Resident #4 was still out of Remeron and did not receive the scheduled dose on 08/17/21. -She did not know why the responsible person did not bring the medication to the facility. -If the medication did not get delivered to the facility then they "sometimes" borrow it from another resident. -She thought the Remeron was prescribed to Resident #4 to treat dementia related behaviors. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 08/19/21 at 11:00am revealed: -Resident #4 was prescribed Remeron because she was losing weight. -Resident #4 started losing weight over the past several months. -The Remeron was used to increase Resident #4's appetite to prevent further weight loss. -Resident #4 was at an increased risk for continued weight loss and increased weakness if she was not administered the medication as prescribed. Interview with the Administrator on 08/18/21 at 12:00pm revealed:	D 358		

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D 358	Continued From page 8 -The SCC was responsible for medication cart audits weekly and requesting refills for medications that were low, expired, or missing from the cart. -The last medication cart audit was completed last week but she did not know the date. -She did not know why the Remeron for Resident #4 was missing from the medication cart. -The MA's were responsible for relaying to the SCC when a medication was needed so the SCC could request a medication refill from the pharmacy. Review of Resident #4's record revealed weight was documented as 150 lbs on 06/12/21, 141 lbs on 07/07/21, and 118 lbs on 08/10/21. Based on observations, interviews, and record reviews, Resident #4 was not interviewable. 2. Review of Resident #1's current FL-2 dated 03/28/21 revealed diagnoses included Alzheimer's, depression, chronic kidney disease stage 3, cerebrovascular accident, congestive heart failure, and dysphagia. Review of a physician's order dated 03/28/21 revealed a medication order for azelastine eye drops (used to treat itching eyes caused by allergies) 0.05% instill 1 drop in each eye twice daily at 9:00am and 9:00pm. Observation of Resident #1 on 08/17/21 at 9:45am revealed: -She was sitting in a recliner chair with the feet reclined and pillows propped around her on both sides. -Her eyes and eyelids were bright red, and eyes were watery. -She was unable to converse.	D 358		

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D 358	Continued From page 9 Review of Resident #1's July 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for azelastine drops 0.05% instill 1 drop both eyes twice daily. -Azelastine eye drops 0.05% were documented as administered twice daily at 8:00am and 8:00pm from 07/01/21 through 07/31/21. Review of Resident #1's August 2021 eMAR revealed: -There was a computer-generated entry for azelastine drops 0.05% instill 1 drop both eyes twice daily. -Azelastine eye drops 0.05% were documented as administered twice daily at 8:00am and 8:00pm from 08/01/21 through 08/16/21 and at 8:00am on 08/17/21. Observation of Resident #1's medications on hand on 08/17/21 at 4:20pm revealed azelastine eye drops 0.05% were not available for administration. Interview with a medication aide (MA) on 08/17/21 at 4:20pm revealed: -Azelastine eye drops were administered to Resident #1 this morning (08/17/21) at 8:00am by the first shift MA. -She did not know why the bottle of azelastine eye drops for Resident #1 were missing from the medication cart. Telephone interview with a representative from the facility's contracted pharmacy for Resident #1 on 08/19/21 at 9:31am revealed: -Azelastine eye drops 0.05% was last dispensed on 08/17/21 after a request for refill was faxed by	D 358		

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D 358	Continued From page 10 the facility on 08/17/21. -The previous dispense date for azelastine eye drops was completed on 06/19/21 and would have lasted for 28 days if the eye drops were administered as ordered. -Resident #1 had missed 29 days of administration of azelastine eye drops. -Azelastine eye drops 0.05% were not on a cycle fill and must be requested by the facility to be dispensed. Telephone interview with a second MA on 08/19/21 at 12:52pm revealed: -She last administered azelastine eye drops to Resident #1 on 08/15/21. -There were "at least 2 or 3 more doses" of Resident #1's azelastine eye drops available for administration on 08/15/21.	D 358		
	Telephone interview with the Special Care Coordinator (SCC) on 08/19/21 at 1:03pm revealed: -She had administered azelastine eye drops to Resident #1 on 08/06/21, 08/08/21, and 08/12/21. -She did not know why Resident #1's azelastine eye drops were missing from the medication cart and not available for administration on 08/17/21. -She was responsible for the medication cart audit weekly and requested refills from the pharmacy when a medication was low or about to expire. -She did not know if azelastine eye drops for Resident #1 had been requested to be dispensed by the pharmacy. -She could not find a refill request faxed to the pharmacy for azelastine eye drops for Resident #1. -MA's were responsible for requesting refills for medications from the pharmacy when a medication was low or ran out.			

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D 358	Continued From page 11 Telephone interview with the Administrator on 08/19/21 at 1:16pm revealed: -She did not know how the MA's were administering azelastine eye drops to Resident #1 from 07/18/21 through 08/17/21 when the last dispensed eye drops would have run out on 07/17/21. -A medication cart audit was completed weekly by the SCC and any medications needing refilled, expired, or missing from the cart were reordered. -She did not know if the MA's or SCC had requested a refill from the pharmacy for Resident #1's azelastine eye drops since the last dispense date on 08/19/21. -The facility faxed a refill request for Resident #1's azelastine eye drops to the pharmacy on 08/17/21 when found not available for administration. -The pharmacy dispensed Resident #1's azelastine eye drops on 08/17/21 and delivered them to the facility. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 08/19/21 at 11:45am was unsuccessful. 3. Review of Resident #2's current FL-2 dated 10/22/20 revealed: -Diagnoses included schizophrenia-paranoid type, dementia, and hypothyroidism. -Incontinent of bowel and bladder. Review of a physician's order dated 03/25/21 revealed an order for triamcinolone acetonide cream (used to treat redness, swelling,	D 358		

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D 358	Continued From page 12 inflammation, and itching skin caused by various conditions) apply to rash twice daily as needed for itching or irritation. Review of Resident #2's July 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for triamcinolone acetonide cream apply to rash twice daily as needed for itching or irritation. -There was no documentation triamcinolone acetonide cream was administered. Review of Resident #2's August 2021 eMAR revealed: -There was a computer-generated entry for triamcinolone acetonide cream apply to rash twice daily as needed for itching or irritation. -There was no documentation triamcinolone acetonide cream was administered. Observation of Resident #2's medications on hand on 08/18/21 at 10:57am revealed triamcinolone acetonide cream was not available for administration. Interview with a medication aide (MA) on 08/18/21 at 10:57am revealed: -She did not know why Resident #2's triamcinolone acetonide cream was not on the medication cart. -She had never used the triamcinolone acetonide cream on Resident #2. -Resident #2 was incontinent of bowel and bladder but did not have any skin issues that she was aware of. Interview with the Special Care Coordinator (SCC) on 08/18/21 at 11:25am revealed: -She did not know why Resident #2's	D 358		

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	HAL061011	A. BUILDING: _____ B. WING _____	08/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13661 HWY 226 SOUTH SPRUCE PINE, NC 28777

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D 358	Continued From page 13 triamcinolone acetonide cream was not available for administration. -She would call the Nurse Practitioner (NP) to get a discontinue order for the triamcinolone acetonide cream for Resident #2 since it was not on the medication cart. -Resident #2 would not allow the triamcinolone acetonide cream to be applied. -She was responsible for completing a medication cart audit weekly and did not realize Resident #2's triamcinolone acetonide cream was not available. -Herself and the MA's were responsible for requesting medication refills from the pharmacy when the medications were low, expired, or unavailable. -She had not requested a medication refill from the pharmacy for Resident #2's triamcinolone acetonide cream. Interview with the Administrator on 08/18/21 at 12:00pm revealed: -The SCC was responsible for medication cart audits weekly and to request refills for medications that were low, expired, or missing from the cart. -The last medication cart audit was completed last week but she did not know the date. -She did not know why the triamcinolone acetonide cream for Resident #2 was missing from the medication cart. -The MA's were responsible for relaying to the SCC when a medication was needed so the SCC could request a medication refill from the pharmacy. Telephone interview with a representative from the facility's contracted pharmacy on 08/19/21 at 9:31am revealed: -The triamcinolone acetonide cream for Resident	D 358		

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D 358	Continued From page 14 #2 was last dispensed on 04/30/20. -The triamcinolone acetonide cream was not on a cycle fill and a refill must be requested by the facility. -The pharmacy had not received a refill request for Resident #2's triamcinolone acetonide cream. Telephone Interview with Resident #2's NP on 08/19/21 at 11:00am revealed: -She did not know why she had ordered triamcinolone acetonide cream on 03/25/21 for Resident #2. -She may have ordered Resident #2 triamcinolone acetonide cream for a rash caused by Resident #2's incontinence and refusal to change her under garments. -She did not know if the facility had ever applied the triamcinolone acetonide cream to Resident #2. -Resident #2 refused her ordered medications. -The facility had not previously contacted her for a discontinue medication order for Resident #2's triamcinolone acetonide cream. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Attempted telephone interview with Resident #2's responsible person on 08/19/21 at 9:15am was unsuccessful.	D 358		
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:	D 367		

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D 367	Continued From page 15 (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 accuracy of the electronic Medication Administration Record (eMAR) for 1 of 5 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 03/28/21 revealed diagnoses included Alzheimer's, depression, chronic kidney disease stage 3, cerebrovascular accident, congestive heart failure, and dysphagia. Review of a physician's order dated 03/28/21 revealed a medication order for azelastine eye drops (used to treat itching eyes caused by allergies) 0.05% instill 1 drop in each eye twice daily at 9:00am and 9:00pm.	D 367	(1) The Care Coordinator will conduct a weekly cart audit and inventory of all prescribed medications. Medications in the cart will be compared with the MAR. (2) Med Techs will fill out a end of shift report on each resident. The report will be given and reviewed by the Care Coordinator and Head Supervisor In Charge ~~to assure~~ all medications are readily available.	10/1/21 10/1/21

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D 367	Continued From page 16 Observation of Resident #1 on 08/17/21 at 9:45am revealed: -She was sitting in a recliner chair with the feet reclined and pillows propped around her on both sides. -Her eyes and eyelids were bright red, and eyes were watery. -She was unable to converse. Review of Resident #1's July 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for azelastine drops 0.05% instill 1 drop both eyes twice daily. -Azelastine eye drops 0.05% were documented as administered twice daily at 8:00am and 8:00pm from 07/01/21 through 07/31/21. Review of Resident #1's August 2021 eMAR revealed: -There was a computer-generated entry for azelastine drops 0.05% instill 1 drop both eyes twice daily. -Azelastine eye drops 0.05% were documented as administered twice daily at 8:00am and 8:00pm from 08/01/21 through 08/16/21 and at 8:00am on 08/17/21. Observation of Resident #1's medications on hand on 08/17/21 at 4:20pm revealed azelastine eye drops 0.05% were not available for administration. Interview with a medication aide (MA) on 08/17/21 at 4:20pm revealed: -Azelastine eye drops were administered to Resident #1 this morning (08/17/21) at 8:00am by another first-shift MA.	D 367		

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D 367	Continued From page 17 -She did not know why the bottle of azelastine eye drops for Resident #1 were missing from the medication cart. Telephone interview with a representative from the facility's contracted pharmacy for Resident #1 on 08/19/21 at 9:31am revealed: -Azelastine eye drops 0.05% was last dispensed on 08/17/21 after a request for refill was faxed by the facility on 08/17/21. -The previous dispense date for azelastine eye drops was completed on 06/19/21 and would have lasted for 28 days if the eye drops were administered as ordered. -Resident #1 would have missed 29 days of administration of azelastine eye drops if the eye drops were administered as ordered. -Azelastine eye drops 0.05% were not on a cycle fill and must be requested by the facility to be dispensed. Telephone interview with a second MA on 08/19/21 at 12:52pm revealed: -She last administered azelastine eye drops to Resident #1 on 08/15/21. -There were "at least 2 or 3 more doses" of Resident #1's azelastine eye drops available for administration on 08/15/21. Telephone interview with the Special Care Coordinator (SCC) on 08/19/21 at 1:03pm revealed: -She had administered azelastine eye drops to Resident #1 on 08/06/21, 08/08/21, and 08/12/21. -She did not know why Resident #1's azelastine eye drops were missing from the medication cart and not available for administration. -She was responsible for the medication cart audit weekly and requested refills from the pharmacy when a medication was low or about to	D 367		

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D 367	Continued From page 18 expire. -She did not know if azelastine eye drops for Resident #1 had been requested to be dispensed by the pharmacy since the last dispense date of 06/19/21. -She could not find a refill request faxed to the pharmacy for azelastine eye drops for Resident #1. -MA's were responsible for requesting refills for medications from the pharmacy when a medication was low or ran out. Telephone interview with the Administrator on 08/19/21 at 1:16pm revealed: -She did not know how the MA's were administering azelastine eye drops to Resident #1 from 07/18/21 through 08/17/21 when the last dispensed eye drops would have run out on 07/17/21 if administered as ordered. -A medication cart audit was completed weekly by the SCC and any medications needing refilled, expired, or missing from the cart were reordered. -She did not know if the MA's or SCC had requested a refill from the pharmacy for Resident #1's azelastine eye drops since the last dispense date on 06/19/21. -The facility faxed a refill request for Resident #1's azelastine eye drops to the pharmacy on 08/17/21 when found not available for administration. -The pharmacy dispensed Resident #1's azelastine eye drops on 08/17/21 and delivered them to the facility. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 08/19/21 at	D 367		

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D 367	Continued From page 19 11:45am was unsuccessful.	D 367		
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 all residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to heath care referral. The findings are: Based on observations, record reviews and interviews the facility failed to ensure referral to meet the acute healthcare needs for 1 of 3 sampled residents (#3) who had an order for physical therapy. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation).]	D912	1) All staff will be immediately retrained on Resident Rights. A training has been scheduled for October 22, 2021 with the Ombudsmen.	10/1/21