email rec'd RP 12/16/21

PRINTED: 12/03/2021
FORM APPROVED

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
	HAL057010	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARS HILL RETIREMENT COMMUNITY	170 SOUTH MAIN STREET MARS HILL, NC 28754

(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 an annual survey on 12/01/21 to 12/02/21.	D 000		
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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by a physician for 2 of 5 sampled residents related to a resident (Resident #2) not receiving an antidepressant and a resident (Resident #5) not receiving a vitamin supplement. The findings are: 1. Review of the current FL2 for Resident #2 dated 01/28/21 revealed: -Diagnoses of Parkinson's disease, major depressive disorder, type 2 diabetes, anxiety, and neuromuscular dysfunction of the bladder. -An order for bupropion HCL (antidepressant) 75mg one tablet daily. Review of physician orders for Resident #2 revealed there were no orders to discontinue the bupropion HCL 75mg one tablet daily.	D 358	**Plan of Correction** 1. QMar Training for all Medication Aides by Blue Ridge Pharmacy (Kendra Goulding) including review of proper process of approving new, discontinued orders and reordering medication. 2. Medication administration education class scheduled by Tony Sherrill,RN Blue Ridge Pharmacy. 3. Monthly Med. Cart audits to remove discontinued, expired drugs by Tony Sherrill, RN Blue Ridge Pharmacy. 4. New medication aide training to be conducted by lead Medication Aide, Whitney Roberts	12/30/21 12/20/21 12/20/21 12/15/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE ADMINISTRATOR (X6) DATE 12/16/21

STATE FORM 6899 U1QA11 If continuation sheet 1 of 7

Reviewed and acknowledged RP 12/16/21

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D 358	Continued From page 1 Review of the electronic Medication Administration Record (eMAR) for October 2021 for Resident #2 revealed there was no entry for bupropion HCL 75mg one tablet daily. Review of the eMAR for November 2021 for Resident #2 revealed there was no entry for bupropion HCL 75mg one tablet daily. Review of the eMAR for December 2021 for Resident #2 revealed there was no entry for bupropion HCL 75mg one tablet daily. Observation of medications available for administration for Resident #2 on 12/02/21 at 9:45am revealed there was no bupropion HCL 75mg one tablet daily available. Interview with the Resident Care Coordinator (RCC) on 12/01/21 at 3:30pm revealed: -The order for bupropion HCL 75mg one tablet daily had not been brought forward on the eMAR in February of 2021. -The order for bupropion HCL 75mg one tablet daily was only administered from 01/28/21 through 02/25/21. -There had been a "glitch" in the eMAR system and the order had been dropped. -Resident #2 had not received the bupropion HCL 75mg one tablet daily since 02/25/21. Interview with the Medication Aide (MA) on 12/02/21 at 9:45am revealed: -She did not recall an order for bupropion HCL 75mg one tablet daily. -She did not have any bupropion HCL 75mg one tablet daily to administer to Resident #2. Telephone interview with a pharmacy technician with the facility's contracted pharmacy on	D 358		

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12/02/31 at 10:07am revealed:
-Resident #2 had been readmitted to the facility on 01/28/21 with an order for bupropion HCL 75mg one tablet daily.
-The pharmacy received and filled the order on 02/02/21.
-The facility received the order for bupropion HCL 75mg one tablet daily on 02/02/21 at 10:48pm.
-There were 30 tablets dispensed.
-There had been no further refill request for the bupropion HCL 75mg one tablet daily.
-The facility was responsible for requesting the refill for this medication.

Telephone interview with the nurse at the physician's office for Resident #2 on 12/02/21 at 10:42am revealed:
-Resident #2 had been prescribed the bupropion HCL 75mg one tablet daily and Prozac 40mg one tablet daily for anxiety and depression.
-She had experienced no detrimental effects from not receiving the bupropion as she was receiving Prozac.
-Resident #2 had followed up with the physician after the medication was prescribed on 01/28/21 in May 2021, July 2021, and September 2021 and the physician had not felt the need to increase or change Resident #5's medication related to anxiety and depression that she had experienced for years.
-She would be evaluated for anxiety and depression again at her next visit in February 2022.

Interview with the Medication Aide (MA) on 12/02/21 at 9:45am revealed:
-She did not recall an order for bupropion HCL 75mg one tablet daily.
-She did not have any bupropion HCL 75mg one tablet daily to administer to Resident #2.

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D 358	Continued From page 3 Review of the facility's Medication Administration Policy titled "Med Pass Technique" under item number 15 revealed: -The eMAR system was linked directly to the pharmacy. -Medication refills should be obtained by staff when the medication had an approximate 8 day supply left. -Staff were directed to call the pharmacy directly to request a refill and through the eMAR to obtain refills. -Documentation was to be made in the observation notes for the resident. Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable. 2. Review of the current FL2 for Resident #5 dated 05/07/21 revealed: -Diagnoses of right femur fracture with right hip pain, osteoporosis, Vitamin D deficiency, Parkinson's Disease, generalized weakness and history of falls. -An order for vitamin D2 1.25mg (50,000 units) (vitamin supplement) one capsule weekly every Friday. Review of the electronic Medication Administration Record (eMAR) for October 2021 for Resident #5 revealed: -There was an electronic entry for vitamin D2 1.25mg (50,000 units) one capsule every week on Friday. -There was documentation of administration at 9:00am on 10/01/21, 10/08/21, 10/15/21, 10/22/21 and 10/29/21. Review of the eMAR for November 2021 for	D 358	**Plan of Correction** 1. QMar Training for all Medication Aides by Blue Ridge Pharmacy (Kendra Goulding) including review of proper process of approving new, discontinued orders and reordering medication. 2. Medication administration education class scheduled by Tony Sherrill,RN Blue Ridge Pharmacy. 3. Monthly Med. Cart audits to remove discontinued, expired drugs by Tony Sherrill, RN Blue Ridge Pharmacy. 4. New medication aide training to be conducted by lead Medication Aide, Whitney Roberts	12/30/21 12/20/21 12/20/21 12/15/21

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Resident #5 revealed:
-There was an electronic entry for vitamin D2 1.25mg (50,000 units) one capsule every week on Friday.
-There was documentation of administration on at 9:00am on 11/05/21, 11/12/21, 11/19/21 and 11/26/21.

Review of the eMAR for December 2021 for Resident #5 revealed there was an electronic entry for vitamin D2 1.25mg (50,000 units) one capsule every week on Friday.

Observation of the medications available for administration for Resident #5 on 12/02/21 at 10:56am revealed:
-There was no medication bubble card pack for vitamin D2 50,000 units dispensed by the facility's contracted pharmacy available for administration.
-There was a bottle of vitamin D2 1250mcg dispensed on 04/24/21 quantity 13 capsules with 12 capsules remaining in the bottle.
-There was a bottle of vitamin D3 125mcg dispensed on 04/24/21.

Interview with a Medication Aide (MA) on 12/02/21 at 11;15am revealed:
-She did not have Resident #5's vitamin D2 available for administration on the medication cart.
-There were two old bottles of vitamin D2 and vitamin D3 on the medication cart that Resident #5 brought with her to the facility when she was admitted in May 2021.
-She did not know how she had administered vitamin D2 50,000 units to Resident #5 on 11/05/21 at 9:00am since there were no available doses of vitamin D2 since 10/01/21.

Interview with the Resident Care Coordinator on

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12/02/21 at 11:55am revealed:
-The MA's were responsible to pull old or discontinued medications from the medication cart.
-She did not know why Resident #5 had old and discontinued medications on the medication cart available for administration when the medications should have been pulled from the cart to prevent "confusion" and medication errors.
-The vitamin D2 50, 000 units for Resident #5 was last requested by the facility to be dispensed by the contracted pharmacy was on 09/03/21 and was dispensed in the quantity of 4 tabs.
-There was no alternate source of medications except those dispensed by the contracted pharmacy.
-She did not know how Resident #5's vitamin D2 50, 000 units was administered on 10/08/21, 10/15/21, 10/22/21, 10/29/21, 11/05/21, 11/12/21, 11/19/21, and 11/26/21 since the last dose available for administration was administered on 10/01/21.
-The facility did not have a system in place for medication cart audits or to make sure medications were ordered, reordered, and received by the contracted pharmacy.

Interview with a second MA on 12/02/21 at 12:09pm revealed:
-She could not remember which vitamin D she administered to Resident #5 on 11/19/21 at 9:00am.
-She did not know if she administered Resident #5's vitamin D2 from the medication card dispensed by the facility's contracted pharmacy or if it was from one of the old vitamin D2 or D3 medication bottles stored on the medication cart.
-The MA was responsible for reordering medications for residents when they were low or run out on the medication cart.

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Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 12/02/21 at 11:31am revealed:
-The original order date for vitamin D2 1.25mg (50,000 units) one capsule every week on Friday was 05/13/21.
-The last fill date was 09/03/21.
-There were 4 tablets of vitamin D2 1.25mg (50,000 units) one capsule every week on Friday dispensed for a coverage of 28 days.
-The facility received the vitamin D2 1.25mg (50,000 units) on 09/03/21 at 10:42pm.
-A new refill should have been requested by the facility on 10/03/21 but no refill request had been made as of 12/02/21.

A review of the facility's Medication Administration Policy titled "Med Pass Technique" under item number 15 revealed:
-The eMAR system was linked directly to the pharmacy.
-Medication refills should be obtained by staff when the medication had an approximate 8 day supply left.
-Staff were directed to call the pharmacy directly to request a refill and through the eMAR to obtain refills.
-Documentation was to be made in the observation notes for the resident.

Attempted telephone interview with the physician for Resident #5 on 12/02/21 at 11:44am was unsuccessful.