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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on November 9, 2021 through November 10, 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: The findings are: Based on interviews, and record reviews, the facility failed to ensure referral and follow-up for 2 of 6 sampled residents (#4, #5) related to a pulmonology appointment (#5) and a mental health referral appointment (#4). 1. Review of Resident #5's current FL-2 dated 07/01/21 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension, and muscle weakness. -She was intermittently disoriented. Review of a primary care provider (PCP) note for Resident #5 dated 08/05/21 revealed: -The resident was experiencing congestive heart failure with shortness of breath and peripheral swelling. -The resident had a chest x-ray that revealed heart enlargement and fluid congestion in the chest. -The resident required 2 liters (L) of oxygen to maintain an oxygen saturation of 96% (95% or greater is ideal).	D 273		

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-There was an order to send the resident out to the hospital for evaluation.

Review of Resident #5's hospital discharge summary dated 08/05/21-08/11/21 revealed:
-The resident was diagnosed with respiratory failure due to an asthma exacerbation, viral pneumonia, and chronic CHF.
-There was an order on 08/11/21 for the resident to follow up with the pulmonologist (respiratory specialist) that consulted her care in the hospital within 3-weeks of discharge from the hospital.

Review of a PCP note for Resident #5 dated 10/05/21 revealed there was an order to refer the resident to the pulmonologist due her to history of COPD, recent hospitalization, and her dependence of supplemental oxygen.

Review of Resident #5's resident record revealed there was no documentation the resident had seen the pulmonologist.

Interview with Resident #5 on 11/09/21 at 9:03am revealed:
-She wore 2L of oxygen most of the time to treat her heart and lungs.
-She was unaware if she saw any specialty providers such as a pulmonologist.

Interview with Administrator from a sister facility filling in for the facility Administrator on 11/10/21 at 11:15am revealed:
-Resident #5 had an appointment with the pulmonologist on 11/24/21.
-She was unsure why the resident had not followed up with the pulmonologist sooner.

Interview with the appointment coordinator at Resident #5's pulmonology provider's office on

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11/10/21 at 2:06pm revealed:
-Resident #5's pulmonology appointment for 11/24/21 was made that today, 11/10/21, by the facility.
-The Resident had missed two previous appointments without notice from the facility on 08/27/21 and 10/24/21.
-The facility never called to reschedule Resident #5's appointment until that today, 11/10/21.
-The Pulmonologist told her he was moderately concerned she had missed her appointments due to having hypoxemia (low oxygen) when he saw her in the hospital in August 2021 and expected her to follow-up.

Interview with Resident #5's Pulmonologist on 11/10/21 at 4:31pm revealed:
-He saw and treated Resident #5 in the hospital in August 2021 for pneumonia, asthma, and COPD.
-He expected the resident to follow up within 2-3 weeks to ensure her pneumonia was cleared up and her asthma was under control.
-It was important for her to follow up to re-evaluate her and manage her oxygen levels.

Interview with the Resident Care Coordinator (RCC) on 11/10/21 at 3:06pm revealed:
-It was her responsibility to ensure residents attended their appointments as scheduled.
-She was not sure how she missed ensuring Resident #5 did not attend her appointments as scheduled and was unsure why she had not called to reschedule the appointment until it has been brought to her attention today, 11/10/21.
-She was not sure if she was even aware of Resident #5's pulmonology appointments as there was no structured process in place to keep track of resident appointments.
-Resident #5's pulmonology appointments were probably missed on 08/27/21 and 10/24/21 due to

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the facility being short staffed and without someone who could transport the resident.
-The facility's transportation coordinator retired in April 2021 and the transportation program was disorganized with no centralized process in place.
-It was concerning that Resident #5 had missed her pulmonology appointments because she was frequently short of breath and had recently been hospitalized due to pneumonia.

Attempted telephone interview with Resident #5's family member on 11/10/21 at 9:28am was unsuccessful.

Attempted telephone interview with Resident #5's PCP on 11/10/21 at 12:00pm and 2:39pm was unsuccessful.

Attempted telephone interview with the Administrator on 11/10/21 at 12:30pm and 4:30pm was unsuccessful.

2. Review of Resident #4's current FL-2 dated 08/19/21 revealed diagnoses included seizure disorder, frequent falls and gait disturbance.

Review of a primary care provider (PCP) visit note for Resident #4 dated 12/17/20 revealed:
-The resident was assessed to have mild cognitive impairment.
-There was a referral for a mental health psychiatric assessment.

Review of Resident #4's resident record revealed there was no documentation the resident had seen the psychiatrist.

Interview with Resident #4 on 11/10/21 at 10:12am revealed she only saw her PCP for treatment, she was unaware of a mental health

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referral.

Interview with Administrator from a sister facility filling in for the facility Administrator on 11/10/21 at 11:15am revealed Resident #4's referral to the mental health provider was never completed and she was unsure why.

Telephone interview with Resident #4's Guardian on 11/10/21 at 1:23pm revealed:
-The resident had a history of being non-compliant with her care due to a lack of understanding and ability to comprehend.
-She was not aware of a mental health referral for the resident but expected the facility to ensure the resident's referrals and care were completed as ordered by her PCP.

Interview with the Resident Care Coordinator on 11/10/21 at 3:06pm revealed:
-She was responsible to make resident referral appointments as ordered.
-Resident #4's mental health referral was made prior to her employment with the facility.
-There was no process in place to audit charts or previous orders to ensure orders did not get missed.
-She was unaware Resident #4 had a mental health referral until it was brought to her attention on 11/09/21, she was unsure how the order had been missed.

Attempted telephone interview with Resident #5's PCP on 11/10/21 at 12:00pm and 2:39pm was unsuccessful.

Attempted telephone interview with the Administrator on 11/10/21 at 12:30pm and 4:30pm was unsuccessful.

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D 296	Continued From page 5	D 296		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to have a therapeutic diet menu for 2 of 5 sampled residents with a diet order for mechanical soft diet (#1,#3). The findings are: 1. Review of Resident #1's current FL2 dated 06/03/21 revealed: -Diagnoses included dementia, hypertension, dyslipidemia, diabetes and dehydration. -There was an order for a regular diet. Review of Resident #1's physician's orders dated 11/04/21 revealed there was an order to change the resident's diet to mechanical soft consistency. Refer to interview with the cook on 11/10/21 at 7:44am. Refer to the interview with the kitchen manager on 11/10/21 at 10:17am. Attempted telephone interviews with the Administrator on 11/10/21 at 12:30pm and 4:30pm were unsuccessful.	D 296		

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D 296	Continued From page 6 2. Review of Resident #3's current FL2 dated 08/12/21 revealed: -Diagnoses included hypertension and Gastroesophageal reflux disease. -There was no diet specified. Review of Resident #3's current diet order dated 10/05/21 revealed a mechanical soft diet with no added table salt was prescribed. Refer to interview with the cook on 11/10/21 at 7:44am. Refer to the interview with the kitchen manager on 11/10/21 at 10:17am. Attempted telephone interviews with the Administrator on 11/10/21 at 12:30pm and 4:30pm were unsuccessful. _____ Interview with the cook on 11/10/21 at 7:44am revealed: -There was no therapeutic diet menu available. -She did not remember ever seeing a therapeutic diet menu since she began working for the facility. Interview with the Kitchen Manager on 11/10/21 at 10:17am revealed: -There was no therapeutic diet menu available. -Staff knew the residents and relied on memory for residents' diet orders. -She knew there should be a therapeutic diet menu available for kitchen staff. -She had not asked the Administrator for a therapeutic diet menu. -She did not know who was responsible for posting a therapeutic diet menu and had never seen one posted.	D 296		

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D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to maintain an accurate and current list of residents with physician-ordered therapeutic diet for guidance of food service staff for 1 of 5 residents with an order for a mechanical soft diet (#1). The findings are: Review of Resident #1 current FL2 dated 06/03/21 revealed: -Diagnoses included dementia, hypertension, dyslipidemia, diabetes and dehydration. -There was an order for a regular diet. Review of Resident #1's physician orders dated 11/04/21 revealed there was an order to change the resident's diet to a mechanical soft diet. Review of the diet lists in the kitchen on 11/10/21 at 7:45am revealed: -A general diet order list for residents was kept in a folder for staff reference. -There was a resident diet order list in sleeve protectors dated 06/24/20-07/24/20. -There was no diet listed for Resident #1.	D 309		

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D 309	Continued From page 8 -There was a resident diet order list in the side pocket of the folder dated 02/04/21-03/04/21 behind several diet order sheets for various residents. -A regular diet with no added table salt was listed as ordered for Resident #1. -There was a diet order for Resident #1 dated 11/04/21 to change diet to mechanical soft. Interview with the cook on 11/10/21 at 7:44am revealed: -The Administrator brought Resident #1's new diet order dated 11/04/21 to this kitchen after the lunch service on 11/09/21. -Resident #1 had received a regular diet until the evening meal of 11/09/21. -There was no therapeutic diet list available in the kitchen but she knew what diets the residents were on because she had worked there for a long time. Interview with the Kitchen Manager on 11/10/21 at 10:17am revealed: -There was no therapeutic diet list available. -There was no current list of residents' diets in the kitchen. -Staff knew the residents and relied on memory for residents' diet orders. -She knew there should be a therapeutic diet list available for kitchen staff. -She had not asked the Administrator for a current order diet list. -The Administrator or the business office manager (BOM) would bring the diet orders to kitchen staff when new diet orders were received. -She did not know who was responsible for posting a therapeutic diet list and ensuring accuracy of the diets. Interview with a medication aide (MA) on 11/10/21	D 309		

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D 309	Continued From page 9 at 10:30am revealed Resident #1 received a regular diet with no added salt that was not altered in consistency. Attempted telephone interviews with the Administrator on 11/10/21 at 12:30pm and 4:30pm were unsuccessful.	D 309		
D 350	10A NCAC 13F .1002 (g) Medication Orders 10A NCAC 13F .1002 Medication Orders (g) In addition to the requirements as stated in Paragraph (c) of this Rule, psychotropic medications ordered "as needed" by a prescribing practitioner, shall not be administered unless the following have been provided by the practitioner or included in an individualized care plan developed with input by a registered nurse or licensed pharmacist: (1) detailed behavior-specific written instructions, including symptoms that might require use of the medication; (2) exact dosage; (3) exact time frames between dosages; and (4) the maximum dosage to be administered in a twenty-four hour period This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure psychotropic medications ordered prn (as needed) for 1 of 2 sampled residents (#4) included a detailed behavior-specific written instructions with symptoms that would require use, exact time frames between dosages, or maximum dose for a controlled substance.	D 350		

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The findings are:

Review of Resident #4's current FL-2 dated 07/01/21 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension, type 2 diabetes, Alzheimer's, and muscle weakness.
-She was intermittently disoriented.
-There was an order for Diazepam 5mg take 1 tablet three times daily as needed. (Diazepam is a controlled substance used to treat anxiety and agitation.)

Review of Resident #4's physician's orders dated 08/31/21 revealed:
-There was an order for Diazepam 5mg take 1 tablet three times daily as needed.
-There were no behavior specific instructions on when to administer the prn Diazepam order.
-There were no exact time frames between dosages of the prn Diazepam order.
-There was no maximum dosage to be administered in a 24-hour period included in the prn Diazepam order.

Review of Resident #4's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Diazepam 5mg take 1 tablet three times daily as needed.
-The Diazepam was documented as administered on 10/01/21 at 8:05am and 6:36pm, 10/02/21 at 7:49am, 5:06pm, and 9:28pm, 10/03/21 at 7:47am and 5:10pm, 10/04/21 at 8:48am and 5:11pm, 10/05/21 at 9:14am and 5:33pm, and 10/06/21 at 2:40pm for anxiety and each occurrence had documentation that the dose was effective at relieving the anxiety.
-There were no behavior specific instructions on

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when to administer the prn Diazepam entry.
-There were no exact time frames between dosages of the prn Diazepam entry.
-There was no maximum dosage of prn Diazepam entry.
-The prn Diazepam was documented as administered on 12 occasions from 10/01/21-10/06/21.

Review of Resident #4's record revealed there was no clarification request or order from the resident's primary care provider (PCP) for the prn Diazepam order.

Observation of Resident #4's medications on hand on 11/10/21 at 9:38am revealed there was no Diazepam available for administration.

Interview with Resident #4 on 11/09/21 at 9:03am revealed she was unsure what medications she received from the facility.

Interview with a medication aide (MA) on 11/10/21 at 7:39am revealed:
-She was unsure why Resident #4's Diazepam was not complete.
-It was the Resident Care Coordinator's (RCC) responsibility clarify Resident #4's prn Diazepam order.
-When MAs administered medications, they were to pull the medication, compare it to the eMAR for accuracy, then administer the medication if everything was correct.
-If a medication was incorrect or a medication was unavailable, the MAs were supposed to call the pharmacy to clarify the issue and ask management for help.
-She did not realize Resident #4's Diazepam was missing any required information on the eMAR.
-She administered Resident #4's last Diazepam

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earlier that morning and had already disposed of the medication label and was unsure what the label said.

Interview with a pharmacist from the facility's contracted pharmacy on 11/10/21 at 12:02pm revealed:
-The most recent order on file for Resident #4's Diazepam was 5mg three times daily as needed on 10/06/21.
-It was the facility's responsibility to clarify the order with Resident #4's PCP, or the facility had the ability to fix or edit an order themselves.

Interview with the Resident Care Coordinator (RCC) on 11/10/21 at 3:06pm revealed:
-When an order was received for a resident, it was faxed to the pharmacy and the pharmacy would enter the order onto the eMAR.
-The facility then compared the original order to the order entered by the pharmacy prior to approving the order so the medication could be placed on the cart for administration.
-It was her responsibility to ensure orders were accurate and complete per the rules.
-She should have caught the error when she approved the order from the pharmacy, but she must have missed it.

Attempted telephone interview with Resident #5's family member on 11/10/21 at 9:28am was unsuccessful.

Attempted telephone interview with Resident #5's PCP on 11/10/21 at 12:00pm and 2:39pm was unsuccessful.

Attempted telephone interview with the Administrator on 11/10/21 at 12:30pm and 4:30pm was unsuccessful.

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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 and in accordance with the facility's policy for 1 of 5 sampled residents (#4) including errors with an antiviral medication, an anti-anxiety medication, and not having ordered medications on hand and available for administration. The findings are: Review of the facility's medication administration policy dated November 2018 revealed: -The facility would maintain the equipment or supplies necessary for the preparation and administration of medications to residents. -The medication administration record (MAR) would be employed during medication administration for reference in accurate medication administration. -Medications were administered in accordance with written orders by the prescriber. -The individual who administered the medication dose would record the administration on the resident's MAR directly after the medication was given.	D 358		

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D 358	Continued From page 14 Review of Resident #4's current FL-2 dated 07/01/21 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension, type 2 diabetes, Alzheimer's, and muscle weakness. -She was intermittently disoriented. 1. Review of a primary care provider (PCP) visit note for Resident #4 dated 10/05/21 revealed: -The resident was diagnosed with Herpes Zoster (shingles). -There was an order for Valacyclovir 1 gram every 8 hours for 7 days (Valacyclovir is an antiviral used to treat shingles). Review of Resident #4's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Valacyclovir 1 gram, take 1 tablet every 8 hours for 7 days at 6:00am, 2:00pm, and 10:00pm. -The Valacyclovir was administered on 10/06/21 at 2:00pm and 10:00pm. -The Valacyclovir was administered from 10/07/21-10/10/21 as ordered. -The Valacyclovir was administered on 10/11/21 at 6:00am and 2:00pm. -The resident only received 16 out of 21 doses of the Valacyclovir. Observation of Resident #4's medications on hand on 11/10/21 at 9:38am revealed there was no Valacyclovir leftover or available for administration. Interview with Resident #4 on 11/09/21 at 9:03am revealed: -She always had itchy skin.	D 358		

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D 358	Continued From page 15 -She was unsure if the shingles were resolved and what other medications or treatments she had received for the shingles. Interview with a medication aide (MA) on 11/10/21 at 7:39am revealed: -She was unsure why Resident #4 only received 16 out of 21 doses of Valacyclovir in October 2021. -When MAs administered medications, they were to pull the medication, compare it to the eMAR for accuracy, then administer the medication if everything was correct. -If a medication was incorrect or a medication was unavailable, the MAs were supposed to call the pharmacy to clarify the issue and ask management for help. Interview with a pharmacist from the facility's contracted pharmacy on 11/10/21 at 12:02pm revealed: -An order Valacyclovir 1 gram, take one tablet by mouth for 7 days, for Resident #4 was received by the pharmacy on 10/05/21. -A 2-day supply of Valacyclovir was delivered to the facility via the back-up pharmacy and the order was entered onto Resident #4's eMAR for facility approval on 10/06/21. -The other 5-day supply of Valacyclovir was sent later to the facility for Resident #4 on 10/07/21. -There should have been two separate entries for the administration of the Valacyclovir on Resident #4's eMAR; one for the 2-day administration, and one for the 5-day administration. -If both entries were not showing up on the eMAR, the facility may not have approved both. -Valacyclovir was an antiviral medication typically prescribed for shingles and Resident #4 should have received all 7-days of the medication.	D 358		

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D 358	Continued From page 16 Interview with a pharmacy technician from the facility's back-up pharmacy revealed the 2-day supply of Valacyclovir for Resident #4 was filled and picked up on 10/06/21. Interview with the Resident Care Coordinator on 11/10/21 at 3:06pm revealed: -She remembered Resident #4's order for Valacyclovir and an MA telling her there we not enough pills to fulfill the order. -It was her responsibility to follow-up and ensure Resident #4 received all her Valacyclovir in October 2021, but it must have been forgotten or overlooked. -She was unsure why Resident #4 did not receive the full dose of Valacyclovir as ordered by her PCP. -She was unsure what happened to Resident #4's missing pills of the Valacyclovir. -There was no good system in place to ensure orders were completed and followed up on. -It was concerning that Resident #4 did not receive all her Valacyclovir because this was the second time in a year the resident had been diagnosed with shingles. Attempted telephone interview with Resident #5's family member on 11/10/21 at 9:28am was unsuccessful. Attempted telephone interview with Resident #5's PCP on 11/10/21 at 12:00pm and 2:39pm was unsuccessful. Attempted telephone interview with the Administrator on 11/10/21 at 12:30pm and 4:30pm was unsuccessful. 2. Review of a prescription for Resident #4 dated 08/31/21 revealed there was an order for	D 358		

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Diazepam 5mg 3 times per day as needed (Diazepam is a medication used to treat anxiety).

Review of a Primary Care Provider (PCP) visit note Resident #4 dated 10/05/21 revealed:
-The resident had generalized anxiety disorder.
-There was an order to refill her Diazepam 5mg 3 times per day as needed.

Review of Resident #4's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Diazepam 5mg, take 1 tablet three times daily as needed for anxiety from 10/01/21-10/07/21.
-There was another entry for scheduled Diazepam beginning 10/07/21-10/31/21, take one tablet three times daily at 8:00am, 12:00pm, and 8:00pm.
-The Diazepam 5mg was documented as administered as needed 2-3 times per day from 10/01/21-10/07/21 and scheduled 3 times daily from 10/08/21-10/31/21 at 8:00am, 12:00pm, and 8:00pm.

Review of Resident #4's November 2021 eMAR revealed:
-There was an entry for scheduled Diazepam 5mg three times daily 8:00am, 12:00pm, and 8:00pm.
-Diazepam was documented administered three times daily from 11/01/21-11/09/21 at 8:00am, 12:00pm, and 8:00pm.

Observation of Resident #4's medications on hand on 11/10/21 at 9:38am revealed there was no Diazepam available for administration.

Interview with Resident #4 on 11/09/21 at 9:03am revealed she was unsure what medications she

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D 358	Continued From page 18 received from the facility. Interview with a medication aide (MA) on 11/10/21 at 7:39am revealed: -She was unsure why Resident #4's Diazepam order changed from as needed to scheduled. -She did not think there had been a new order to administer Resident #4's Diazepam to scheduled, but that was the Resident Care Coordinator's (RCC) responsibility and she would know for sure. -When MAs administered medications, they were to pull the medication, compare it to the eMAR for accuracy, then administer the medication if everything was correct. -If a medication was incorrect or a medication was unavailable, the MAs were supposed to call the pharmacy to clarify the issue and ask management for help. -She administered Resident #4's last Diazepam earlier that morning and had already disposed of the medication label and was unsure if the label was for scheduled or as needed. -She could not remember if Resident #4's Diazepam medication label matched her eMAR that morning. Interview with a pharmacist from the facility's contracted pharmacy on 11/10/21 at 12:02pm revealed: -The most recent order on file for Resident #4's Diazepam was 5mg three times daily as needed on 10/06/21. -Resident #4 should be receiving Diazepam as needed, not scheduled, and that was how the order was entered by the pharmacy that transferred over to the facility's eMARs for approval. -She was not sure why Resident #4's Diazepam was scheduled on her eMAR, but the facility may	D 358		

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have changed the order during the approval process.
-When orders were entered by the pharmacy, it was one-way communication to the facility to be approved or clarified and she was unable to view resident eMARs.
-The facility was able to deny an order and have the pharmacy clarify it, or the facility had the ability to fix or edit an order themselves.
-The last time Resident #4 had an order for scheduled Diazepam was on 03/17/21.

Interview with the Resident Care Coordinator (RCC) on 11/10/21 at 3:06pm revealed:
-When an order was received for a resident, it was faxed to the pharmacy and the pharmacy would enter the order onto the eMAR.
-The facility then compared the original order to the order entered by the pharmacy prior to approving the order so the medication could be placed on the cart for administration.
-After reviewing pharmacy records, she accidentally approved an order for Resident #4's scheduled Diazepam from April 2021 instead of the as needed order for Diazepam on 10/06/21.
-She should have caught the error when comparing the original order to the order she approved but she must have missed it.

Attempted telephone interview with Resident #5's family member on 11/10/21 at 9:28am was unsuccessful.

Attempted telephone interview with Resident #5's PCP on 11/10/21 at 12:00pm and 2:39pm was unsuccessful.

Attempted telephone interview with the Administrator on 11/10/21 at 12:30pm and 4:30pm was unsuccessful.

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D 358	Continued From page 20 3. Review of Resident #4's current FL-2 revealed an order for Clotrimazole 1% cream, apply topically to affected areas three times per day as needed for redness and itching (Clotrimazole is an antifungal medication). Interview with Resident #4 on 11/09/21 at 9:03am revealed: -She always had itchy skin. -She was unsure if the shingles were resolved, or what other medications or treatments she had received for the shingles and itchy skin. Review of Resident #4's September 2021 electronic medication administration record revealed: -There was an entry for Clotrimazole 1% cream, apply topically to affected areas three times per day as needed for redness and itching. -The Clotrimazole 1% cream was documented as not administered from 09/01/21-09/30/21. Review of Resident #4's October 2021 electronic medication administration record revealed: -There was an entry for Clotrimazole 1% cream, apply topically to affected areas three times per day as needed for redness and itching. -The Clotrimazole 1% cream was documented as not administered from 10/01/21-10/31/21. Review of Resident #4's November 2021 electronic medication administration record revealed: -There was an entry for Clotrimazole 1% cream, apply topically to affected areas three times per day as needed for redness and itching. -The Clotrimazole 1% cream was documented not administered from 11/01/21-11/09/21.	D 358		

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D 358	Continued From page 21 Observation of Resident #4's medications on hand on 11/10/21 at 9:38am revealed there was no Clotrimazole cream available for administration. Interview with the medication aide (MA) on 11/10/21 at 9:49am revealed: -Cart audits were supposed to be done weekly by the 3rd shift MAs, then given to the Resident Care Coordinator (RCC). -If a medication was unavailable, the MAs were supposed to re-order the medication and then follow up with the pharmacy until it arrived at the facility. -She was unsure why Resident #4 did not have any Clotrimazole cream available for administration. -Resident #4 had never asked her to use the Clotrimazole cream and kept a different cream for itching at her bedside with a self-administration order. Interview with a pharmacist from the facility's contracted pharmacy on 11/10/21 at 12:02pm revealed: -The pharmacy began serving the facility in March 2021 and it was assumed resident's as needed medications were on hand from the previous pharmacy at that time unless the facility requested them to be filled. -The Clotrimazole cream had never been filled by the pharmacy for Resident #4 because the facility had never requested it. Interview with the RCC on 11/10/21 at 3:06pm revealed: -Medications should be available and on hand for residents as ordered. -Cart audits were supposed to be done weekly by the lead MA.	D 358		

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-It was her responsibility to review the cart audits and follow up and anything noted.
-The cart audits had not been done recently and the last audit on file was from June 2021.
-Resident #4 should have Clotrimazole cream on hand because it was still an active order.
-She was not aware that Resident #4 did not have any Clotrimazole, but any MA was responsible to order it for her directly from the eMAR system if it was unavailable.
-If medication cart audits had been done as expected, it would have been identified that the cream was unavailable for Resident #4 and she could have reviewed the order and re-ordered the medication.

Attempted telephone interview with Resident #5's family member on 11/10/21 at 9:28am was unsuccessful.

Attempted telephone interview with Resident #5's PCP on 11/10/21 at 12:00pm and 2:39pm was unsuccessful.

Attempted telephone interview with the Administrator on 11/10/21 at 12:30pm and 4:30pm was unsuccessful.

4. Review of Resident #4's current FL-2 revealed an order for Trolamine Salicylate pain relief cream 10%, apply topically to the affected area on right hip four times daily as needed for joint pain (Trolamine Salicylate is a medication used to treat joint pain).

Interview with Resident #4 on 11/09/21 at 9:03am revealed she was unsure what medications or creams she received from the facility.

Review of Resident #4's September 2021

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electronic medication administration record revealed:
-There was an entry for Trolamine Salicylate pain relief cream 10%, apply topically to the affected area on right hip four times daily as needed for joint pain.
-The Trolamine Salicylate pain relief cream was documented as not administered from 09/01/21-09/30/21.

Review of Resident #4's October 2021 electronic medication administration record revealed:
-There was an entry for Trolamine Salicylate pain relief cream 10%, apply topically to the affected area on right hip four times daily as needed for joint pain.
-The Trolamine Salicylate pain relief cream was documented as not administered from 10/01/21-10/31/21.

Review of Resident #4's November 2021 electronic medication administration record revealed:
-There was an entry for Trolamine Salicylate pain relief cream 10%, apply topically to the affected area on right hip four times daily as needed for joint pain.
-The Trolamine Salicylate pain relief cream was documented as not administered from 11/01/21-11/09/21.

Observation of Resident #4's medications on hand on 11/10/21 at 9:38am revealed there was no Trolamine Salicylate cream available for administration.

Interview with the medication aide (MA) on 11/10/21 at 9:49am revealed:
-Cart audits were supposed to be done weekly by the 3rd shift MAs, then given to the Resident

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Care Coordinator (RCC).
-If a medication was unavailable, the MAs were supposed to re-order the medication and then follow up with the pharmacy until it arrived at the facility.
-She was unsure why Resident #4 did not have any Trolamine Salicylate cream available for administration.
-Resident #4 had never asked her to use the Trolamine Salicylate cream.

Interview with a pharmacist from the facility's contracted pharmacy on 11/10/21 at 12:02pm revealed:
-The pharmacy began serving the facility in March 2021 and it was assumed resident's as needed medications were on hand from the previous pharmacy at that time unless the facility requested them to be filled.
-The Trolamine Salicylate cream had never been filled by the pharmacy for Resident #4 because the facility had never requested it.

Interview with the RCC on 11/10/21 at 3:06pm revealed:
-Medications should be available and on hand for residents as ordered.
-Cart audits were supposed to be done weekly by the lead MA.
-It was her responsibility to review the cart audits and follow up and anything noted.
-The cart audits had not been done recently and the last audit on file was from June 2021.
-Resident #4 should have Trolamine Salicylate cream on hand because it was still an active order.
-She was not aware that Resident #4 did not have any Trolamine Salicylate cream, but any MA was responsible to order it for her directly from the eMAR if it was unavailable.

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D 358	Continued From page 25 -If medication cart audits had been done as expected, it would have been identified that the cream was unavailable for Resident #4 and she could have reviewed the order and re-ordered the medication. Attempted telephone interview with Resident #5's family member on 11/10/21 at 9:28am was unsuccessful. Attempted telephone interview with Resident #5's PCP on 11/10/21 at 12:00pm and 2:39pm was unsuccessful. Attempted telephone interview with the Administrator on 11/10/21 at 12:30pm and 4:30pm was unsuccessful.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the medication pass on 11/10/21 by 1 of 2 medication aides observed who failed to wash or sanitize her hands prior to preparing and after administering multiple oral medications. The findings are:	D 371		

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THE GARDENS OF PAMLICO	22 MAGNOLIA WAY GRANTSBORO, NC 28529

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D 371	Continued From page 26 Review of the facility's hand hygiene policy and procedure revealed: -Staff were expected to sanitize hands with alcohol-based sanitizers before and after resident care. -Staff were expected to sanitize hands before administering medications or at any other appropriate time. -Using a hand sanitizer was not a substitute for washing hands with soap and water when hands were visibly soiled. Review of the facility's medication administration policy revealed: -The person administering medications should adhere to good hand hygiene before beginning a medication pass, before handling any medication, and after coming into direct contact with a resident. -Staff were expected to use hand sanitizer between handwashing with soap and water, when returning to the medication cart or preparation area, and at regular intervals during a medication pass such as after leaving each resident room; assuming handwashing was not indicated. -Sanitization was not a substitute for proper handwashing and washing should be done it there was any question of having soiled hands. Observation of a medication aide (MA) administering medications on the 300 and 400 halls on 11/10/21 from 7:54am to 8:20am revealed: -There were two large bottles of hand sanitizer in the medication preparation area. -The MA performed hand hygiene, prepped oral medications for a resident, dropped several of the pills, picked the pills up off the floor with one gloved hand and one ungloved hand and placed	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL069002	A. BUILDING: _____ B. WING _____	11/10/2021

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D 371	Continued From page 27	D 371		

them back into the medication cup with the clean pills.
-The MA wasted all the medication she prepared for the first resident, removed her glove, prepared the same medications again, then covered, labeled and locked the medications into the cart until the resident was finished eating breakfast with ungloved hands.
-The MA did not perform hand hygiene after touching the floor in between prepping the medications for the first resident.
-The MA then prepared a second resident's oral medication, knocked on the resident's door, entered the room, administered the medications to the second resident at 8:01am, threw away the medication cup the resident placed to her mouth with ungloved hands, then returned to the medication preparation area.
-The MA did not sanitize her hands after leaving the resident's room and prior to returning to the medication preparation area and she was not wearing gloves.
-The MA then prepared a third resident's medications, knocked and entered the resident's room, assisted the resident to sit up in bed, and administered her medications at 8:09am.
-The MA did not sanitize her hands prior to prepping the third resident's medications, after entering the resident room, touching the resident, after administering the medications, or before returning to the medication preparation area.
-The MA then pulled the first resident's medications that were locked in the cart, entered the first resident's room, and administered her medications at 8:13am.
-The MA did not sanitize her hands before pulling or administering the first resident's medications, after leaving the resident's room, or prior to returning to the medication preparation area.

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D 371	Continued From page 28 Interview with the MA on 11/10/21 at 9:49am revealed: -Facility staff were expected to wash their hands as often as possible. -At minimum, staff were required to sanitize their hands after interaction with every three residents. -It was not necessary to sanitize or wash after every resident unless staff performed something like a finger stick blood sugar, or their hands were visible soiled. Interview with the Resident Care Coordinator on 11/10/21 at 4:34pm revealed the facility policy was that staff were expected to perform hand hygiene either with hand sanitizer or handwashing before and after every resident interaction. Interview with the facility nurse on 11/10/21 at 4:34pm revealed the facility policy was that staff were expected to perform hand hygiene either with hand sanitizer or handwashing before and after every resident interaction. Attempted interview with the Administrator on 11/10/21 at 12:30pm and 4:30pm was unsuccessful.	D 371		