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
	HAL034110	A. BUILDING: _____ B. WING _____	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/PHILLIPS VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(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 and follow-up survey on November 23, 2021 through November 24, 2021.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 3 sampled residents (#2) with a physician's order for a medication used to treat muscle spasticity. The findings are: Review of Resident #2's current FL2 dated 02/26/21 revealed diagnoses included schizophrenia and hypothyroidism. a. Review of Resident #2's physician's orders dated 08/11/21 revealed there was an order to administer tizanidine 2mg, a medication used to treat muscle spasticity, three times a day for 1 week. Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed: -There was no entry for tizanidine 2mg administer	D 276		

Karen M. Polce Reviewed and Acknowledged February 28, 2022

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D 276	Continued From page 1 three times daily for one week. -There was no documentation tizanidine was administered three times daily for one week, from 08/11/21 to 08/18/21. Interview with the Supervisor in Charge (SIC) on 11/23/21 at 1:40pm revealed: -She did not review the resident's medication orders. -The business office manager (BOM) recieved all new orders. -She could only administer what was on the eMAR. Interview with the facilty contracted pharmacy on 11/23/21 at 1:37pm revealed: -The facility faxed physician orders and treatments for the residents to the pharmacy. -The pharmacy staff entered the orders on the eMAR. -The order was not active until the facility approved the order entry. -The pharmacist had no record of tinazidine 2mg three times a day for one week dated 08/11/21. Interview with the business office manager (BOM) on 11/23/21 at 2:45pm revealed: -She received all new orders from the facility contracted physician when she completed her weekly rounds with the residents or by fax. -She would fax new orders to the pharmacy, and the pharmacy staff would enter the orders on the eMARS. -She kept the orders at her deak until she reviewed the orders on the eMAR for accuracy and the medication was sent to the facility and placed on the medication cart. -She then approved the orders and the entry was visible on the eMAR for the MAs to administer the medication.	D 276	Facility protocol will be that all orders received will be followed by office manager and then given to villa supervisor. All orders will be checked to assure they are on the quick mar system and a paper copy	

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D 276	Continued From page 2 -Once an order had been approved, she did not review the eMARs for accuracy. -She did not recall the order for tinazidine 2mg three times a day for one week. -She did not know why the order had not been entered on the eMAR or verified by the staff. Interview with the Executive Director (ED) on 11/23/21 at 4:15pm revealed: -The BOM sends the medication and treatment orders to the pharmacy to be entered on the eMAR. -The BOM reviewed the eMAR entries for accuracy, comparing the entry to the physician's order and ensured the medication had arrived to the facility before approving the order. -The facility contracted pharmacist also reviewed the eMARs for accuracy, but she was unsure as to their process or procedure. -She did not know Resident #2's tinazidine three times daily for one week was not entered on the eMAR or implemented by the staff. Interview Resident #2's primary care physician on 11/23/21 at 3:40pm revealed she had not prescribed the tinazidine 2mg for muscle spasms, but it had not be reported to her that she was experiencing break through muscle spasms. Attempted telephone interview with Resident #2's responsible party on 11/23/21 at 11:10am was unsuccessful.	D 276	is available for the med. tech that is administering meds. 11-27-21 Admin. Medication orders are checked daily.	
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,	D 358		

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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 ensure medications were administered as ordered by the prescribing physician for 1 of 3 sampled residents (#2), related to a medication to treat muscle spasicity; and medications that were not available for administration for 2 of 3 residents (#2 and #3) for an as needed (prn) medication for muscle spasticity (#2), and prn medications for chest pains and breathing treatments (#3).

1. Review of Resident #2's current FL2 dated 02/26/21 revealed diagnoses included schizophrenia and hypothyroidism.

a. Review of Resident #2's physician's order dated 08/11/21 revealed there was an order for buspirone 5mg, a medication used to treat anxiety, three times a day.

Review of a Resident #2's subsequent physician's order dated 08/18/21 revealed an order for buspirone 5mg twice daily.

Review of Resident #2's August 2021 and September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for buspirone 5mg twice daily, to be administered at 8:00am and 8:00pm.
-There was documentation buspirone was administered twice daily from 08/19/21 through 09/30/21.

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D 358	Continued From page 4 Review of Resident #2's October 2021 eMAR revealed: -There was an entry for buspirone 5mg three times daily, to be administered at 8:00am, 1:00pm and 8:00pm. -There was documentation buspirone was administered three times daily from 10/01/21 through 10/31/21. Review of Resident #2's November 2021 eMAR from 11/01/21 through 11/23/21 revealed: -There was an entry for buspirone 5mg three times daily, to be administered at 8:00am, 1:00pm and 8:00pm. -There was documentation buspirone was administered three times daily from 11/01/21 through 11/06/21 and 11/12/21 through 11/23/21. -There was documentation Resident #2 was out of the facility from 11/07/21 through 11/11/21, at 8:00am, 1:00pm and 8:00pm. Observation of Resident #2's medications available for administration on 11/23/21 at 3:15pm revealed there was a blister pack of buspirone 5mg tablets with a medication label that read administer three times daily at 8:00am, 1:00pm and 8:00pm. Interview with Resident #2 on 11/23/21 at 4:00pm revealed: -She was not sure how often her buspirone was administered. -She would get anxious at times and knew the buspirone helped with her anxiety. Interview with the Supervisor in Charge (SIC) on 11/23/21 at 1:40pm revealed: -She administered medications to all the residents during her 12 hour shift.	D 358		

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D 358	Continued From page 5 -She relied on the entries on the eMAR and the bubble pack to administer the correct medication and dosage. -She did not review the medication orders with the eMAR entries. -She did not know the buspirone had been ordered for twice a day on 08/18/21, not three times daily. -She had been administering buspirone 5mg three times daily. Interview with the facilty contracted pharmacy on 11/23/21 at 1:37pm revealed: -The facility faxed physician orders and treatments for the residents to the pharmacy. -The pharmacy staff entered the orders on the eMAR and the facility reviewed and approved the order entry. -The facility faxed a physician order on 09/30/21 for buspirone 5mg three times daily at 8:00am, 1:00pm and 8:00pm. -The order was dated 08/11/21, and was treated as a new order and entered onto the eMAR on 09/30/21. -Medications were sent to the facility in multidose packaging. Interview with the business office manager (BOM) on 11/23/21 at 2:45pm revealed: -She received all new orders from the facility contracted physician when she completed her weekly rounds with the residents or by fax. -She would fax new orders to the pharmacy, and the pharmacy staff would enter the orders on the eMARs. -She kept the original orders on her desk until their entry onto the eMAR, and reviewed the orders for accuracy. -When the medication arrived at the facility, she approved the order and the entry was visible on	D 358		

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the eMAR for the SICs to administer.
-Once an order had been approved, she did not review the eMARs again for accuracy.
-Buspirone 5mg to be administered twice daily was sent to the pharmacy and was on the September eMARS accurately.
-She did not know why the order had been re-entered in October as buspirone 5mg three times daily.

Interview with the Executive Director (ED) on 11/23/21 at 4:15pm revealed:
-The BOM sends the medication and treatment orders to the pharmacy to be entered on the eMAR.
-The BOM reviewed the eMAR entries for accuracy, comparing the entry to the physician's order and when the medication had arrived at the facility she approved the order.
-The facility contracted pharmacist also reviewed the eMAR for accuracy, but she was unsure as to their process or procedure.
-She did not know Resident #2's current buspirone order was not on the eMAR.

Interview Resident #2's primary care physician on 11/23/21 at 3:40pm revealed:
-She had not prescribed buspirone 5mg to the resident.
-It had been prescribed by the mental health provider.

Attempted telephone interview with the MHP on 11/24/21 at 12:07pm was unsuccessful.

b. Review of Resident #2's physician orders dated 02/26/21 revealed an order for tizanidine 2mg, one tablet every 8 hours for muscle spasms as needed (prn).

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D 358	Continued From page 7 Review of Resident #2's September 2021, October 2021 and November 2021 electronic medication administration records (eMARs) revealed: -There were entries for tizanidine 2mg to be administered every 8 hours for muscle spasms prn. -There was no documentation tizanidine 2mg was administered prn during September 2021, October 2021 or November 2021. Observation of Resident #2's medications available for administration on 11/23/21 at 1:55pm revealed there were no tizanidine 2mg tablets in the facility. Interview with Resident #2 on 11/23/21 at 2:15pm revealed: -She would get muscle spasms in her lower legs at times. -She would report the times her legs were in spasm to the SIC. -She was not sure if she received medication when these spasms occurred. Interview with the Supervisor in Charge (SIC) 11/23/21 at 1:40pm revealed: -She did not know Resident #2 did not have tizanidine 2mg tablets in the facility. -She did not remember Resident #2 requesting tizanidine for muscle spasms. Telephone interview with the pharmacy on 11/23/21 at 1:37 pm revealed: -Most of the facility's medications were sent in multidose packaging. -PRN medications were sent in blister packs. -The last blister pack of thirty tablets of tinazadine 2mg prn was sent on 06/16/21.	D 358	all meds. for residents are to be ordered and in stock and available wether scheduled or PRN. BOM will verify all meds. 11-27-21 GS	

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D 358	Continued From page 8 Interview with the business office manager (BOM) on 11/24/21 at 2:45pm revealed: -The pharmacy delivers the resident's scheduled medications in a multi dose package every other week. -Medications that were not scheduled were ordered as needed by the facility staff. -She removed all unused multidose medications and packaging from the medication cart before the next pharmacy delivery. -The SICs placed the new multidose packaging on the medication carts. -The pharmacy completed an audit of the medications every quarter and reviewed the residents' diagnoses, cross referenced orders and looked for duplicate orders and medications in the facility for the orders on the eMARs. -The SIC responsible for that medication cart was also responsible for ensuring the medications were available for administration. -The SICs could order refill medications from the pharmacy as needed. -She did not know Resident #2's tinazadine 2mg prn was not available for administration. Interview with the Executive Director (ED) on 11/23/21 at 4:15pm revealed: -The eMAR software was a new system set up in June of 2021. -Prior to June 2021 the facility was using paper MARs. -The multidose packaging from the pharmacy has also been a recent change. -The staff were still learning the process and it has been a learning curve for them. -The BOM and the SICs could order medications for the residents through the pharmacy if needed. -The BOM reviewed the medications that arrived in multidose packaging from the pharmacy every other week.	D 358		

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D 358	Continued From page 9 -She ensured the medications were accurate according to the current eMAR. -She removed the previous multidose packaging from the cart and delivered the current medication to the SICs to place on the medication cart. -The SICs should be aware of diminishing inventory of all other medications and treatments and contact the pharmacy for refills. -She did not know Resident #2's tinazadine 2mg prn was not available for administration. Attempted telephone interview with Resident #2's responsible party on 11/23/21 at 11:10am was unsuccessful. 2. Review of Resident #3's FL2 dated 01/22/21 revealed diagnoses included coronary artery disease, peripheral vascular disease and anticoagulation. a. Review of Resident #3's physician orders dated 01/22/21 revealed an order for nitroglycerin 0.4mg tablet, administer sublingually every 5 minutes, three times, as needed for chest pain. Review of Resident #3's electronic medication administration record (eMARs) for September 2021, October 2021 and November 2021 revealed: -There was an entry for nitroglycerin 0.4mg tablet, administer sublingually every 5 minutes, three times, as needed for chest pain. -There was no documentation nitroglycerin 0.4mg tablet had been administered. Interview with Resident #3 on 11/23/21 at 3:20pm revealed she did not remember having any chest pains.	D 358		

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D 358	Continued From page 10 Observation of Resident #3's medications available for administration on 11/23/21 at 1:55pm revealed there were no nitroglycerin 0.4mg tablets in the facility. Interview with the Supervisor in Charge (SIC) 11/23/21 at 1:40pm revealed: -She thought the nitro glycerin tablet had expired. -She thought the BOM would order a refill for the medication. -She would contact the pharmacy and request a refill on the nitroglycerin tablets. Interview with the primary care physician (PCP) on 11/23/21 at 3:40pm revealed she did not prescribe the nitroglycerin tablet for this resident and did not have documentation of a cardiac event or complaints of chest pains in her notes. Interview with the business office manager (BOM) on 11/24/21 at 2:45pm revealed she did not know Resident #3 did not have nitroglycerin 0.4mg available for administration. Interview with the Executive Director (ED) 11/23/21 at 4:15pm revealed she did not know Resident #3 did not have nitroglycerin 0.4mg available for administration. b. Review of Resident #3's physician orders dated 01/22/21 revealed an order for ipratropium albuterol 0.83% nebulizer treatment, 1 vial every 4 hours as needed for wheezing. Review of Resident #3's electronic medication administration record (eMARs) for September 2021, October 2021 and November 2021 revealed: -There was an entry for ipratropium albuterol 0.83% nebulizer treatment, 1 vial every 4 hours	D 358		

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D 358	Continued From page 11 as needed for wheezing. -There was no documentation ipratropium albuterol 0.83% nebulizer treatment, 1 vial every 4 hours as needed for wheezing had been administered Interview with Resident #3 on 11/23/21 at 3:20pm revealed she did not remember experiencing any wheezing lately. Observation of Resident #3's medications available for administration on 11/23/21 at 1:55pm revealed there were no ipratropium albuterol vials in the facility. Interview with the SIC 11/23/21 at 1:40pm revealed: -Scheduled medication are highlighted on the desktop of the eMAR screen at the times of administration. -PRN's are not highlighted and do not show up during a medication pass unless the resident requested the medication. -She does not perform audits of the PRN's and did not know Resident #3 was missing ipratropium albuterol 0.83% vials for nebulizer treatments. -She does not remember the resident requesting a nebulizer treatment. -She had not observed the resident wheezing. Interview with the primary care physician (PCP) on 11/23/21 at 3:40pm revealed she had not observed the resident to be in respiratory distress nor had the facility reported she was wheezing. Interview with the business office manager (BOM) on 11/24/21 at 2:45pm revealed she did not know Resident #3 did not have ipratropium albuterol	D 358		

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D 358	Continued From page 12 vials for nebulization every 4 hours as needed for wheezing. Interview with the Executive Director on 11/23/21 at 4:15pm revealed she did not know Resident #3 did not have ipratropium albuterol vials for nebulizing treatment in the facility. c. Review of Resident #3's physician orders dated 01/22/21 revealed an order for albuterol HFA 108mcg inhale 2 puffs three times a day as needed for shortness of breath. Review of Resident #3's electronic medication administration record (eMARs) for September 2021, October 2021 and November 2021 revealed: -There was an entry for albuterol HFA 108mcg inhale 2 puffs three times a day as needed for shortness of breath. -There was no documentation albuterol HFA 108mcg had been administered. Interview with Resident #3 11/23/21 at 3:20pm revealed: -She did not remember experiencing any shortness of breath recently. -She did experience shortness of breath when she had pneumonia earlier in the year. Observation of Resident #3's medications available for administration on 11/23/21 at 1:55pm revealed there was no albuterol HFA 108mcg in the facility. Interview with the primary care physician (PCP) on 11/23/21 at 3:40pm revealed she had no reports from the facility the resident was experiencing shortness of breath.	D 358		

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D 358	Continued From page 13 Interview with the SIC 11/23/21 at 1:40pm revealed: -She does not recall Resident #3 experiencing shortness of breath since she had pneumonia in the spring of this year. -She did not know the albuterol HFA 108mcg for shortness of breath was not available for administration. Interview with the business office manager (BOM) on 11/24/21 at 2:45pm revealed she did not know Resident #3 did not have albuterol HFA three times a day for shortness of breath was not available for administration. Interview with the Executive Director on 11/23/21 at 4:15pm revealed she did not know Resident #3 did not have albuterol HFA on the medication cart, available for administration if needed. Attempted telephone interview with Resident #3's responsible party on 11/23/21 at 11:57am was unsuccessful.	D 358		