STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	R 12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE OF MAYODAN	6970 NC HWY 135 MAYODAN, NC 27027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey on December 29, 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: Based on observations, record reviews and interviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (#5) related to blood pressure monitoring with parameters. The findings are: Review of Resident #5's current FL2 dated 11/23/21 revealed: -Diagnoses included hypertension. -There was an order for daily blood pressure checks with parameters to notify the primary care provider (PCP) if blood pressure was over 150/80 or under 100/50. Review of Resident #5's October 2021 electronic treatment administration record (eTAR) revealed: -There was documentation that Resident #5 was in the hospital from 10/01/21 through 10/04/21, and her blood pressure was checked daily from 10/05/21 through 10/31/21 and ranged from 120/62 to 160/80. -Resident #5's blood pressure on 10/16/21 was documented as 160/80. -There was no documentation the PCP had been notified of the blood pressure reading outside of the ordered parameters.	{D 273}	Medication Aides were retrained on facility policies of notifying physician following blood pressure monitoring with parameters. RCC will review MARS weekly to ensure physicians are being notified of routine and acute health care needs of residents including when blood pressure monitoring is out of parameters. Administrator will audit MARS at least 5 randomly thereafter to ensure physician notification per facility policy.	1/3/2022-1/7/2022 1/7/2022 & Ongoing 2/1/2022 & Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy R. Petty — TITLE: Administrator — (X6) DATE: 1/25/2022

Reviewed and acknowledged 01/31/22 Catherine Prater

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{D 273}	Continued From page 1 Review of Resident #5's November 2021 eTAR revealed: -There was documentation blood pressure was checked daily from 11/01/21 through 11/30/21 and ranged from 116/64 to 165/86. -Resident #5's blood pressure on 11/20/21 was documented as 165/86. -There was no documentation the PCP had been notified of the blood pressure reading outside of the ordered parameters. Review of Resident #5's progress notes revealed: -There were no notes on 10/16/21 or 11/20/21 documenting physician notification was completed for blood pressures outside of the ordered parameters. Interview with Resident #5 on 12/29/21 at 3:07pm revealed: -Staff checked her blood pressure every day and most of the time would tell her what her blood pressure reading was. -Staff had never mentioned having to notify her PCP of an elevated blood pressure. -She was unaware of parameters for her blood pressure readings and did not recall having any high blood pressures. Interview with the Administrator on 12/29/21 at 2:00pm revealed: -She had been the staff who checked Resident #5's blood pressure on 10/16/21 and 11/20/21. -Both 10/16/21 and 11/20/21 were Saturdays, so she had likely came in to work those days to cover for a medication aide (MA) who had called out of work. -On Saturdays, staff notified the on-call doctor rather than the PCP; she could not remember if she notified the doctor of Resident #5's blood	{D 273}		

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{D 273}	Continued From page 2 pressure readings outside of the ordered parameters. -When the doctor on call was contacted from the facility, they would fax a note back to the facility afterwards documenting if there were any new orders. -She was unable to provide a fax documenting the notification had been completed. Telephone interview with Resident #5's PCP on 12/29/21 at 2:55pm revealed: -Since 10/16/21 and 11/20/21 were both Saturdays, the notification would have gone to an on-call doctor and the on-call doctor would have made a notation of the call in their documentation system. -She did not recall seeing any notation that Resident #5's blood pressure had been outside of the ordered parameters. -It was her expectation that staff notified the doctor as ordered for blood pressures that were above or below the specified parameters.	{D 273}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's	D 344		

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D 344	Continued From page 3 record. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure clarification of medication orders for 1 of 5 sampled residents (#5) who had orders for a bronchodilator, a stool softener, an antipsychotic medication, and a thyroid medication. The findings are: Review of Resident #5's current FL2 dated 11/23/21 revealed diagnoses included chronic obstructive pulmonary disease (COPD), intellectual disabilities, and major depressive disorder. Review of primary care provider (PCP) Progress Note for Resident #5 dated 05/28/21 revealed there was a diagnosis of hypothyroidism. a. Review of Resident #5's current FL2 dated 11/23/21 revealed there was an order for albuterol (a bronchodilator used to treat difficulty breathing and wheezing) 2.5mg/3mL inhale one vial via nebulizer four times per day. Review of Resident #5's PCP progress note dated 05/10/21 revealed there was an order for Resident #5 to take albuterol nebulizer three times per day. Review of Resident #5's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for albuterol 2.5mg/3mL nebulizer solution, inhale 1 vial via nebulizer three times a day at 8:00am, 2:00pm, and 8:00pm.	D 344	Medication Aides/RCC compared physician's orders to medication administration record to ensure residents receive medications as ordered. Physician will be contacted for any orders that need clarification. Medication Aides were retrained on expectation of clarifying orders with physician as needed and documentation of clarifications in the resident's chart. Medication Aides/RCC will document the clarification of orders in resident's chart once received from physician. Administrator will randomly audit resident's charts monthly to ensure any physician's orders needing clarification have been completed and documented as per facility policy.	1/3/2022-1/17/2022 1/3/2022-1/7/2022 1/17/2022 & Ongoing 2/1/2022 & Ongoing

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D 344	Continued From page 4 -There was documentation albuterol nebulizer was administered at 8:00am, 2:00pm and 8:00pm from 10/05/21 through 10/31/21, and documented as not administered from 10/01/21 through 10/04/21 due to hospitalization. Review of Resident #3's November 2021 eMAR revealed: -There was an entry for albuterol 2.5mg/3mL nebulizer solution, inhale 1 vial via nebulizer three times a day at 8:00am, 2:00pm, and 8:00pm. -There was documentation albuterol nebulizer was administered at 8:00am, 2:00pm and 8:00pm from 11/01/21 through 11/30/21. Review of Resident #5's December 2021 eMAR revealed: -There was an entry for albuterol 2.5mg/3mL nebulizer solution, inhale 1 vial via nebulizer three times a day at 8:00am, 2:00pm, and 8:00pm. -There was documentation albuterol nebulizer was administered at 8:00am, 2:00pm and 8:00pm from 12/01/21 through 8:00am on 12/29/21. Observation of medications on hand for Resident #5 on 12/29/21 at 2:30pm revealed there was a box of albuterol 2.5mg/3mL vials of nebulizer solution to use three times per day with a dispensed date of 12/20/21. Telephone interview with a representative from the facility's contracted pharmacy on 12/29/21 at 2:50pm revealed: -They had an order on file for Resident #5 for albuterol 2.5mg/3mL nebulizer solution, inhale 1 vial via nebulizer three times per day scheduled, and four times per day as needed for shortness of breath or wheezing. -They had last dispensed albuterol for Resident #5 on 12/20/21 for 270 vials which was a	D 344		

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D 344	Continued From page 5	D 344		

one-month supply.
-They did not have the most recent FL2 dated 11/23/21 on file.

Telephone interview with Resident #5's PCP on 12/29/21 at 2:55pm revealed:
-She thought the staff at the facility had probably transcribed the albuterol order incorrectly onto the current FL2 and she had not realized albuterol had been ordered to be administered four times per day instead of three times per day when she had signed it.
-It had been her assumption and expectation that the staff would have entered the correct and current medication orders onto the FL2 prior to having her sign it.
-There was no harm done to Resident #5 because she had been receiving the correct medication at the proper intervals, it was just that the FL2 contained an incorrect order.

Interview with Resident #5 on 12/29/21 at 3:07pm revealed:
-She received nebulizer treatments 4-8 times per day between the scheduled albuterol nebulizer treatments, her other scheduled nebulizer treatments and her "as needed" (PRN) nebulizer treatments.
-She did not know which nebulizer treatment was which when she was doing them.
-She did not think she had ever missed a nebulizer treatment, but she sometimes would refuse a treatment if she was busy doing something else.

Refer to interview with the Resident Care Coordinator (RCC) on 12/29/21 at 1:40pm.

Refer to interview with the Administrator on 12/29/21 at 2:00pm.

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D 344	Continued From page 6 b. Review of the Resident #5's current FL2 dated 11/23/21 revealed there was an order for docusate sodium (a stool softener used to treat constipation) 100mg take 1 capsule daily. Review of Resident #5's October 2021 eMAR revealed: -There was an entry for docusate sodium 100mg take 1 capsule twice a day at 8:00am and 8:00pm. -There was documentation docusate sodium had been administered twice daily at 8:00am and 8:00pm from 10/05/21 through 10/31/21, and documented as not administered from 10/01/21 though 10/04/21 due to hospitalization. Review of Resident #5's November 2021 eMAR revealed: -There was an entry for docusate sodium 100mg take 1 capsule twice a day at 8:00am and 8:00pm. -There was documentation docusate sodium had been administered twice daily at 8:00am and 8:00pm from 11/01/21 through 11/30/21. Review of Resident #5's December 2021 eMAR revealed: -There was an entry for docusate sodium 100mg take 1 capsule twice a day at 8:00am and 8:00pm. -There was documentation that docusate sodium had been administered twice daily at 8:00am and 8:00pm from 12/01/21 through 8:00am on 12/29/21. Review of Resident #5's primary care provider (PCP) progress note dated 05/28/21 revealed there was an order to increase docusate sodium to 100mg twice daily.	D 344		

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D 344	Continued From page 7 Observation of medication on hand for Resident #5 on 12/29/21 at 2:30pm revealed there was a medication card for docusate sodium 100mg take 1 capsule twice daily, with a dispensed date of 12/21/21. Telephone interview with a representative from the facility's contracted pharmacy on 12/29/21 at 2:50pm revealed: -They had an order on file for Resident #5 for docusate sodium 100mg twice daily. -The docusate order had changed from once daily to twice daily in May 2021. -They did not have the most recent FL2 dated 11/23/21 on file. Telephone interview with Resident #5's PCP on 12/29/21 at 2:55pm revealed: -She thought the staff at the facility had probably transcribed the docusate order incorrectly onto the current FL2 and she had not realized it was ordered once per day instead of two times per day when she had signed it. -It had been her assumption and expectation that the staff would have entered the correct and current medication orders onto the FL2 prior to having her sign it. -There was no harm done to Resident #5 because she had been receiving the correct medication at the proper intervals, it was just that the FL2 contained an incorrect order. Interview with Resident #5 on 12/29/21 3:07pm revealed she was not sure what her order for docusate sodium was or how often she had been receiving it. Refer to interview with the Resident Care Coordinator (RCC) on 12/29/21 at 1:40pm.	D 344		

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D 344	Continued From page 8 Refer to interview with the Administrator on 12/29/21 at 2:00pm. c. Review of Resident #5's current FL2 dated 11/23/21 revealed there was an order for risperidone 0.25mg (an antipsychotic used to treat mental/mood disorders) take 1 tablet daily. Review of Resident #5's October 2021 eMAR revealed: -There was an entry for risperidone 0.25mg take one tablet twice daily at 8:00am and 8:00pm. -There was documentation risperidone was administered twice daily at 8:00am and 8:00pm from 10/05/21 through 10/31/21, and documented as not administered from 10/01/21 through 10/04/21 due to hospitalization. Review of Resident #5's November 2021 eMAR revealed: -There was an entry for risperidone 0.25mg take one tablet twice daily at 8:00am and 8:00pm. -There was documentation risperidone was administered twice daily at 8:00am and 8:00pm from 11/01/21 through 11/30/21. Review of Resident #5's December 2021 eMAR revealed: -There was an entry for risperidone 0.25mg take one tablet twice daily at 8:00am and 8:00pm. -There was documentation risperidone was administered twice daily at 8:00am and 8:00pm from 12/01/21 through 8:00am on 12/29/21. Observation of medication on hand for Resident #5 on 12/29/21 at 2:30pm revealed there was a medication card for risperidone 0.25mg take one tablet twice daily with a dispensed date on 12/21/21.	D 344		

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D 344	Continued From page 9 Telephone interview with a representative from the facility's contracted pharmacy on 12/29/21 at 2:50pm revealed: -They had an order on file for Resident #5 for risperidone 0.25mg twice daily. -They did not have record of the risperidone order ever being once a day. -They did not have the most recent FL2 dated 11/23/21 on file. Telephone interview with Resident #5's PCP on 12/29/21 at 2:55pm revealed: -She thought the staff at the facility had probably transcribed the risperidone order incorrectly onto the current FL2 and she had not realized it was ordered for once per day instead of two times per day when she had signed it. -It had been her assumption and expectation that the staff would have entered the correct and current medication orders onto the FL2 prior to having her sign it. -There was no harm done to Resident #5 because she had been receiving the correct medication at the proper intervals, it was just that the FL2 contained an incorrect order. Interview with Resident #5 on 12/29/21 at 3:07pm revealed she did not know what her risperidone order was for or how often she was taking it. Refer to interview with the Resident Care Coordinator (RCC) on 12/29/21 at 1:40pm. Refer to interview with the Administrator on 12/29/21 at 2:00pm. d. Review of Resident #5's current FL2 dated 11/23/21 revealed there was an order for levothyroxine 50mcg (used to treat	D 344		

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D 344	Continued From page 10 hypothyroidism) daily. Review of physician order dated 06/11/21 revealed the PCP increased levothyroxine dose from 37.5mcg daily to 50mcg daily. Review of physician consultation report dated 11/04/21 revealed Resident #5's endocrinologist advised to continue taking levothyroxine 75mcg daily for treatment of hypothyroidism. Review of Resident #5's October 2021 eMAR revealed: -There was an entry for levothyroxine 50mcg once daily at 8:00am. -There was documentation levothyroxine was administered once daily at 8:00am from 10/05/21 through 10/31/21, and documented as not administered from 10/01/21 through 10/04/21 due to hospitalization. Review of Resident #5's November 2021 eMAR revealed: -There was an entry for levothyroxine 50mcg take one tablet daily at 8:00am. -There was documentation levothyroxine was administered daily at 8:00am from 11/01/21 through 11/30/21. Review of Resident #5's December 2021 eMAR revealed: -There was an entry for levothyroxine 50mcg take one tablet daily at 8:00am. -There was documentation levothyroxine was administered daily at 8:00am from 12/01/21 through 12/29/21. Observation of medication on hand for Resident #5 on 12/29/21 at 2:30pm revealed there was a medication card for levothyroxine 50mcg daily	D 344		

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D 344	Continued From page 11 with a dispensed date of 12/21/21. Telephone interview with a representative from the facility's contracted pharmacy on 12/29/21 at 2:50pm revealed: -They had an order on file for Resident #5 for levothyroxine 50mcg daily. -They did not have previous orders for Resident #5 to take levothyroxine 75mcg daily, but she had been dispensed 75mcg tablets with orders to take half of a tablet (37.5mcg) daily and the order was discontinued in June 2021. Interview with the Administrator on 12/29/21 at 2:00pm revealed: -She had reviewed Resident #5's endocrinology orders after her appointment on 11/04/21. -She had not noticed the dose discrepancy on the physician consultation report because it had not been written on the separate physician order form. Telephone interview with Resident #5's PCP on 12/29/21 at 2:55pm revealed: -She had not received a request for clarification of Resident #5's levothyroxine order, but she would expect the clarification to have been called to the endocrinologist. -The endocrinologist doses Resident #5's levothyroxine. Telephone interview with a representative from Resident #5's endocrinology office on 12/29/21 at 3:55pm revealed: -They had no record of the facility contacting their office for clarification of the levothyroxine order. -The endocrinologist had wanted Resident #5 to continue her current dose which was 50mcg daily, she had just written it down incorrectly at 75mcg.	D 344		

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D 344	Continued From page 12 -There was no harm done to Resident #5 as she had received the correct dose of levothyroxine. Refer to interview with the Resident Care Coordinator (RCC) on 12/29/21 at 1:40pm. Refer to interview with the Administrator on 12/29/21 at 2:00pm. Interview with the RCC on 12/29/21 at 1:40pm revealed: -It was her responsibility for completing audits on the residents' records to ensure the physician orders matched the eMAR and what the residents were receiving. -She had a schedule for completing record audits, but she had been out of work at least twice since she started her role as RCC and she could not remember when she had last done an audit on Resident #5's record. -She was responsible for preparing Resident #5's FL2 for the PCP to review and sign; she used the current eMAR and electronic treatment administration record (eTAR) and transcribed those orders onto the FL2. -She thought since the orders were different on the eMAR from the current FL2, the FL2 must not have been faxed to the pharmacy. -Whenever Resident #5 had a physician visit, she was responsible for reviewing the paperwork for any new orders and then faxing them to the pharmacy. -The pharmacy would enter a new order onto the eMAR as pending, then she or another supervisor would be responsible for reviewing the order for accuracy and then approving the order to make it active on the eMAR. -She thought that since the orders on the current FL2 dated 11/23/21 did not match the orders on	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	R 12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE OF MAYODAN	6970 NC HWY 135 MAYODAN, NC 27027

(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 344	Continued From page 13 the current eMAR, she or one of the other supervisors must have mistakenly used an older eMAR when transcribing the orders on to the FL2. Interview with the Administrator on 12/29/21 at 2:00pm revealed: -It was the RCC's responsibility for completing monthly audits on the residents' records. -The current RCC had been out of work a couple of times since November 2021 and the record audits had fallen behind schedule as they did not have any other available staff to complete the audits in her absence. -They did not keep a record of their audit completions. -She would sometimes helped the RCC prepare the FL2 forms for the PCP to sign and when she did, she transferred the medication orders from the current eMAR. -She did not copy orders over from previous FL2s when filling out the new FL2 forms. -She did not think she was the one who prepared Resident #5's most recent FL2 form and was not aware that the orders on the FL2 were not the current orders; she thought the current FL2 must have been transcribed from an older eMAR rather than the current eMAR. -It was her expectation that the RCC transcribed orders onto the FL2 correctly.	D 344		