STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 000	Initial Comments The Adult Care Licensure Section completed an Annual Survey with onsite visit dates of 01/13/22, 01/14/22 and a desk review on 01/18/22 and 01/19/22 and a telephone exit on 01/20/22.	D 000		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Sufficient staff, space and equipment shall be provided for safe and sanitary food storage, preparation and service. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure mealtime table service included a non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage container. The findings are: Review of the North Carolina Department of Health and Human Services (NCDHHS) Statewide waivers of certain licensing requirements for Adult Care Homes due to Novel Coronavirus Disease 2019 revealed: - The waiver allowances issued on April 24, 2020 expired effective 12/03/21. -The notice was emailed to all facilities on 12/03/21. - Rule 10A NCAC 13F .0904(b)(2) (Disposable Place Settings) was no longer waived. Observation of a resident's beverage during initial tour on 01/13/22 at 9:30am revealed she was	D 286		

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drinking a beverage out of a disposable cup.

Interview with a resident on 01/13/22 at 10:15am revealed:
-She moved to the facility about 8 months ago.
-Since she moved to the facility food and beverages were always served in disposable containers due to COVID-19 protocol.
-She did not like her food being served in disposable containers.
-She started taking her meals in the independent living dining room about a month ago because she was served food and beverages on non-disposable dishes.

Interview with a Medication Aide (MA) on 01/13/22 at 11:42 revealed:
-When the COVID-19 pandemic started, the facility began using disposable plates, cups and silverware.
-She did not know why the assisted living unit was still serving meals using disposable containers and flatware since the independent living section of the facility stopped using disposable several months ago.

Observation of the lunch meal service in the assisted living unit on 01/13/22 at 12:01 revealed:
-The food was served in fold-over, take-out disposable containers.
-The cold beverages were served in plastic disposable cups.
-The coffee was served in insulated disposable cups.
-The knives, forks and spoons were disposable.

Observation of the breakfast meal service on 01/14/22 at 8:33am and the lunch meal service at 12:15pm revealed all meals were served in fold-over, take-out disposable container, with

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D 286	Continued From page 2 disposable silverware and beverage containers. Interview with the food service director on 01/13/22 at 1:45pm revealed: -When COVID-19 started almost 2 years ago the facility transitioned to all disposable plates, silverware and cups. -He was told last spring by the previous Administrator that he needed to continue to use disposables until he was told otherwise. -He was not aware of any new guidance. Interview with the Administrator on 01/14/22 at 11:16am revealed: -Management did not communicate COVID-19 waivers and changes, but rather left it up to her to keep up with the changes. -She remembered receiving an e-mail on 12/03/21 from NCDHHS but she did not read it thoroughly so she did not know facilities could no longer use disposable dishes at meal times. -She was responsible for communicating any meal service changes to the food service director.	D 286		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure residents rights were maintained related to not resuming communal dining. The findings are:	D 338		

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D 338	Continued From page 3 Review of the North Carolina Department of Health and Human Services (NCDHHS) Statewide waivers for Adult Care Homes due to Novel Coronavirus Disease 2019 revealed: -The communal dining waiver issued on 04/24/20 expired effective 12/03/21. -The notice was emailed to all facilities on 12/03/21. Observation during the initial tour of the facility on 01/13/22 from 9:30 to 10:45am revealed: -Resident rooms had portable tables for residents to use to eat their meals. -At each dining room table was a plastic divider hanging from the ceiling, so residents seated at the table were separated from each other. Observation of the lunch meal service on 01/13/22 and breakfast meal service on 01/14/22 revealed all residents ate the meals in their room. Observation of the lunch meal service on 01/14/22 at 12:15pm revealed 2 of the 17 residents came to the dining room to eat. Interview with a resident on 01/13/22 at 10:15am revealed: -When she moved to the facility about 8 months ago, residents were asked before each meal if they wanted to eat in their room or come to the dining room due to COVID-19 social distancing protocol. -Most people ate in their room but occasionally residents went to the dining room. -She started going to the independent living dining room about a month ago because she wanted more social interactions and preferred that dining room to eating alone in her room.	D 338		

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Interview with a medication aide (MA) on 01/13/22 at 11:42am revealed:
-When the COVID-19 pandemic started communal dining was eliminated at the facility.
-Residents were given the option to eat in their room or go to the dining room that had been set up to provide social distancing.
-Plastic dividers were hung from the ceiling so residents were socially distanced if they chose to eat in the dining room.
-Most residents chose to eat in their room.
-Dietary staff stopped coming to the dining room to serve meals from the steam table.
-She did not know why the assisted living unit was still serving meals using disposable containers and flatware since the independent living section of the facility stopped using disposable several months ago.

Interview with the food service director on 01/13/22 at 1:45pm revealed:
-When COVID-19 started almost 2 years ago the facility stopped sending staff to the dining room.
-Most residents ate in their room, but a few did eat in the dining room and a few went to the independent living dining room for meals.
-He was not aware of any new guidance.

Interview with the Administrator on 01/14/22 at 11:16am revealed:
-Management did not communicate COVID-19 waivers and changes, but rather left it up to her to keep up with the changes.
-She remembered receiving an e-mail on 12/03/21 from NCDHHS but she did not read it thoroughly, so she did not know the communal dining waiver expired.
-She was responsible for communicating any meal service changes to the food service director.

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D 344	10A NCAC 13F .1002(a) Medication Orders	D 344		

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 record.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure all orders for prescription, nonprescription and treatments were maintained in the resident record for 1 of 5 residents related to orders faxed to the facility by the primary care provider (PCP) prior to admission (Resident #3).

The findings are:

Review of Resident #3's current FL2 dated 11/24/21 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD, history of small bowel obstruction, hypertension(HTN) and dementia.
Medications ordered included: magnesium citrate solution 148ml(used for in the am, acidophilus chewable one tablet daily, albuterol sulfate HFA,100/90 mcg 2 puffs four times daily, ascorbic

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acid 500mg tablet one in the afternoon, aspirin 81mg one tablet daily, breztin aresol 160-9-4.8mcg 2 puffs twice daily, buspirone HCL 5mg one tablet twice a day, Centrum silver one tablet daily, cholecalciferol 100 units one tablet daily, donepezil HCL 23mg one tablet at bedtime, fish oil 1000mg one capsule at bedtime.

Review of the Resident Register for Resident #3 revealed an admission date of 12/20/21.

Observations of medications on hand for Resident #3 on 01/13/22 at 3:05pm revealed:
-Acidophilus chewable one tablet daily was not available for administration.
-Ascorbic acid 500mg one tablet in the afternoon was not available for administration.
-Aspirin 81 mg one tablet daily was not available for administration.
-Cholecalciferol 1000 units one tablet daily was not available for administration.
-Fish Oil 1,000mg one capsule at bedtime was not available for administration.

Interview with a medication aide (MA) on 01/14/22 at 9:15am revealed Resident #3 did not have all ordered medications available and she let the Resident Care Director (RCD) know shortly after he was admitted.

Telephone interview with the pharmacist at the local retail pharmacy on 01/14/22 at 8:55am for Resident #3 revealed:
-The pharmacy had refill orders for buspirone HCL 5mg one tablet twice a day, fish oil 1000mg one capsule at bedtime that were on the eMAR but no one had asked for them to be filled.
-The pharmacy also had orders for Aricept 23mg on tablet daily, melatonin 5mg one tablet nightly as needed, extra strength Tylenol 500mg one

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tablet 4 times daily as needed for pain, prednisone one tablet twice daily and Tramadol 50mg one three times daily as needed.
-There was no documentation of the facility calling to request any medications or clarification of prescriptions for Resident #3.

Interview with the RCD on 01/14/22 at 10:05am revealed:
-She had not asked for any clarification orders from Resident #3's physician.
-She had not spoken with anyone at the retail pharmacy to see if Resident #3 had medications that had been ordered, filled or delivered.

Telephone interview with the nurse at the primary care physician's office for Resident #3 on 01/20/22 at 9:47am revealed:
-Resident #3 was a new patient to the physician.
-Resident #3 had a virtual visit on 12/15/21 and an office visit on 01/11/22.
-She faxed a complete medication list to the facility on 12/17/21 at 11:26am.
-The following medication orders were sent to the facility on 12/17/21 for Resident #3:
Magnesium oxide was discontinued on 12/17/21, memantine HCL 10 mg (treats dementia) one tablet daily, donepezil HCL23mg (treats cognition) one tablet nightly, Vitamin D3 25mcg (helps body absorb calcium) one tablet daily, Centrum Silver 50+ Men (multivitamin) one tablet daily, Aspirin EC 81mg (blood thinner) one tablet daily, ascorbic acid 500mg (repairs tissues) one tablet daily, buspirone HCL 5mg (treats anxiety) one tablet twice daily, acidophilus 1 mg chewable (Probiotic to treat digestive disorders) one tablet daily, Breztri Aerosphere 160-9-4.8mcg/act (control wheezing and shortness of breath caused by lung disease) 2 puffs twice daily, Vesicare 10mg (overactive bladder) one tablet

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D 344	Continued From page 8 daily, doxepin HCL 3mg (antidepressant and treats nerve pain) one tablet nightly, pravastatin sodium 10mg treats high cholesterol) one tablet daily, potassium chloride extended release (ER) 20meq (treats low amounts of potassium in the blood) one tablet daily, pantoprazole sodium 40mg (treats acid reflux) one tablet daily, Ocuvite Adult 50 + (eye nutrients) daily, Nifedipine ER 60mg ER 24 HR (treats high blood pressure) one tablet daily, myrbetriq 50 mg ER 24 HR (treats overactive bladder) one tablet daily, magnesium oxide (elemental) 400mg (mineral supplement) one tablet daily, Hydralazine HCL 25mg (treats high blood pressure) one tablet daily, Vitamin B 12 1000mcg ER (encourages red blood cell formation, produces energy) one tablet daily, fish oil 1000mg capsule (helps reduce triglycerides) one capsule daily, albuterol sulfate HFA 108mcg 1-2 puffs every 6 hours as needed for shortness of breath or wheezing, Tylenol extra strength 500mg 1-2 tablets every 8 hours as needed for pain, tramadol HCL 50mg one tablet twice daily as needed for generalized pain, proctofoam 1% one daily as needed for hemmoroids, miralax 17gm packet one daily as needed for constipation, mucinex twice daily as needed for cough, Movantik 25mg one daily as needed for constipation, Mometasone furonate 50MCG 1-2 sprays each nostril as needed for allergies, gas relief 125 max strength daily as needed for gas, melatonin 5mg one nightly as needed for insomnia (sleep), Lidocaine 4% cream apply as needed every 6 hours for pain and Imodium 2 mg capsule one daily as needed to treat diarrhea. the facility had requested any medication clarification orders from the physician. -The facility had not reached out to the physician about clarification orders for Resident #3's medications.	D 344		

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D 358	Continued From page 9	D 358		
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, record review and interviews the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (Resident #3) including medications used for the treatment of dementia, digestive disorders, cornary artery disease, cholesterol, a blood thinner, and vitamin supplements. The findings are: Review of the facility medication policy titled "Medication Administration" revealed medications are administered as prescribed in a safe and timely manner in accordance with good nursing principles and practices. Review of Resident #3's current FL2 dated 11/24/21 revealed: -Diagnoses included Chronic Obstructive Pulmonary Disease (COPD),coronary artery disease, history of small bowel obstruction, hypertension and dementia. -Medications included: acidophilus chewable one tablet twice daily, ascorbic acid 500mg tablet one in the afternoon, aspirin 81mg one tablet daily,	D 358		

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cholecalciferol 1000 units one tablet daily, and fish oil 1000mg one capsule at bedtime.

Review of the Resident Register for Resident #3 revealed an admission date of 12/20/21.

a. Review of Resident #3's physician's order dated 12/22/21 revealed an order for Namenda 10mg at bedtime.

Review of Resident #3's electronic Medication Administration Record (eMAR) for December 2021 revealed:
-There was an entry for Namenda 10mg one tablet at bedtime with an administration time of 8:00pm.
-There was documentation the Namenda was administered 3 out of 9 opportunities.

Refer to the interview with a medication aide (MA) on 01/13/22 at 3:03pm.

Refer to the interview with Resident #3's family member on 01/13/22 at 12:01pm.

Refer to the interview with the RCD on 01/14/22 at 10:05am.

Refer to the telephone interview with the pharmacist at the local retail pharmacy on 01/14/22 at 8:55am.

Refer to the interview with the Administrator on 01/14/22 at 10:40am.

Refer to the follow-up telephone interview with a family member for Resident #3 on 01/20/22 at 12:47pm.

Refer to the confidential interview with staff.

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D 358	Continued From page 11 b. Review of Resident #3's physician's order dated 11/24/21 revealed an order for aspirin 81mg daily. Review of Resident #3's electronic Medication Administration Record (eMAR) for December 2021 revealed: -There was an entry for aspirin 81mg daily with an administration time of 8:00am. -There was documentation the aspirin was not available for administration 7 out of 9 opportunities. Observation of Resident #3's medications on hand on 01/13/22 at 3:05pm revealed aspirin 81mg was not available for administration. Refer to the interview with a medication aide (MA) on 01/13/22 at 3:03pm. Refer to the interview with Resident #3's family member on 01/13/22 at 12:01pm. Refer to the interview with the RCD on 01/14/22 at 10:05am. Refer to the telephone interview with the pharmacist at the local retail pharmacy on 01/14/22 at 8:55am. Refer to the interview with the Administrator on 01/14/22 at 10:40am. Refer to the follow-up telephone interview with a family member for Resident #3 on 01/20/22 at 12:47pm. Refer to the confidential interview with staff.	D 358		

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c. Review of Resident #3's physician's order dated 11/24/21 revealed an order for cholecalciferol 1000 units daily.

Review of Resident #3's electronic Medication Administration Record (eMAR) for 01/01/22 - 01/13/22 revealed:
-There was an entry for cholecalciferol 1000 units daily with an administration time of 8:00am.
-There was documentation the cholecalciferol was not available for administration 9 out of 13 opportunities.

Observation of Resident #3's medications on hand on 01/13/22 at 3:05pm revealed cholecalciferol 1000 units was not available for administration.

Refer to the interview with a medication aide (MA) on 01/13/22 at 3:03pm.

Refer to the interview with Resident #3's family member on 01/13/22 at 12:01pm.

Refer to the interview with the RCD on 01/14/22 at 10:05am.

Refer to the telephone interview with the pharmacist at the local retail pharmacy on 01/14/22 at 8:55am.

Refer to the interview with the Administrator on 01/14/22 at 10:40am.

Refer to the follow-up telephone interview with a family member for Resident #3 on 01/20/22 at 12:47pm.

Refer to the confidential interview with staff.

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D 358	Continued From page 13 d. Review of Resident #3's physician's order dated 11/24/21 revealed an order for acidophilus chewable 1 tablet twice daily. Review of Resident #3's electronic Medication Administration Record (eMAR) for December 2021 revealed: -There was an entry for acidophilus chewable 1 tablet daily with an administration time of 8:00am and 8:00pm. -There was documentation the acidophilus was not available for administration 21 out of 23 opportunities. Review of Resident #3's medications on hand on 01/13/22 at 3:05pm revealed the acidophilus chewable was not available for administration. Refer to the interview with a medication aide (MA) on 01/13/22 at 3:03pm. Refer to the interview with Resident #3's family member on 01/13/22 at 12:01pm. Refer to the interview with the RCD on 01/14/22 at 10:05am. Refer to the telephone interview with the pharmacist at the local retail pharmacy on 01/14/22 at 8:55am. Refer to the interview with the Administrator on 01/14/22 at 10:40am. Refer to the follow-up telephone interview with a family member for Resident #3 on 01/20/22 at 12:47pm. Refer to the confidential interview with staff.	D 358		

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e. Review of Resident #3's physician's order dated 11/24/21 revealed an order for ascorbic acid 500mg 1 tablet in every afternoon.

Review of Resident #3's electronic Medication Administration Record (eMAR) for December 2021 revealed:
-There was an entry for ascorbic acid 500mg 1 tablet daily with an administration time of 4:00pm.
-There was documentation the ascorbic acid was not available for administration 2 out of 12 opportunities.

Review of Resident #3's eMAR for 01/01/22 - 01/13/22 revealed:
-There was an entry for ascorbic acid 500mg 1 tablet daily with an administration time of 4:00pm.
-There was documentation the ascorbic acid was not administered 8 out of 10 opportunities.

Review of Resident #3's medications on hand on 01/13/22 at 3:05pm revealed the ascorbic acid 500mg was not available for administration.

Refer to the interview with a medication aide (MA) on 01/13/22 at 3:03pm.

Refer to the interview with Resident #3's family member on 01/13/22 at 12:01pm.

Refer to the interview with the RCD on 01/14/22 at 10:05am.

Refer to the telephone interview with the pharmacist at the local retail pharmacy on 01/14/22 at 8:55am.

Refer to the interview with the Administrator on 01/14/22 at 10:40am.

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Refer to the follow-up telephone interview with a family member for Resident #3 on 01/20/22 at 12:47pm.

Refer to the confidential interview with staff.

f. Review of Resident #3's physician's order dated 11/24/21 revealed an order for fish oil 1000mg at bedtime.

Review of Resident #3's electronic Medication Administration Record (eMAR) for December 2021 revealed there was no entry for the fish oil.

Review of Resident #3's eMAR for 01/01/22 - 01/13/22 revealed there was no entry for the fish oil.

Review of Resident #3's medications on hand on 01/13/22 at 3:05pm revealed the fish oil was not available for administration.

Refer to the interview with a medication aide (MA) on 01/13/22 at 3:03pm.

Refer to the interview with Resident #3's family member on 01/13/22 at 12:01pm.

Refer to the interview with the RCD on 01/14/22 at 10:05am.

Refer to the telephone interview with the pharmacist at the local retail pharmacy on 01/14/22 at 8:55am.

Refer to the interview with the Administrator on 01/14/22 at 10:40am.

Refer to the follow-up telephone interview with a family member for Resident #3 on 01/20/22 at

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D 358	Continued From page 16 12:47pm. Refer to the confidential interview with staff. _____ Interview with a medication aide (MA) on 01/13/22 at 3:03pm revealed: -She did not have all the medications available for administration that had been ordered for Resident #3. -She had informed the Resident Care Director (RCD) shortly after Resident #3 was admitted that he did not have all of his medication available. -She had received the Namenda on 12/29/21 but the other medications were still not available. Confidential interview with staff revealed: -Resident #3 was admitted to the facility a few weeks ago and had very few medications. -Resident #3's had been missing his medications since his admission. -The DON was aware of Resident #3's medication issues but had not helped resolve the problem. Interview with Resident #3's family member on 01/13/22 at 12:01pm revealed: -Medications were missing and he did not understand why because he knew the pharmacy was delivering them. -He brought all of Resident #3's medications with him for admission but was told the medications from another state could not be used and he would need to obtain all new prescriptions. Interview with the RCD on 01/14/22 at 10:05am revealed: -She was responsible for sending the FL2 to the pharmacy to obtain the medications and she entered the medication list for all new residents. -She was also responsible for ensuring the	D 358		

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residents had the medications available after the physician had ordered new medications.
-She was not responsible for Resident #3's medication because Resident #3 did not use the facility contracted pharmacy but a local retail pharmacy.
-The family was responsible for getting all the medications for Resident #3 and ensuring the medications were available at the facility for administration.
-If Resident #3 had a change in orders then she expected the family to bring in the orders since the family took the resident to all of his appointment.
-When she happened to see the family in the facility she had asked them to bring in the missing medications.
-She had no documentation to show she had ever spoken with the family about the missing medications.
-She had not spoken with anyone at the local retail pharmacy, or the facility contracted pharmacy regaridng the medications for Resident #3.
-She was aware on 01/11/22 of the missing inhaler and had asked the MA to do a cart audit and to have the audit on all the residents completed the next day.
-She did "random" medication cart audits but did not have any documentation of any completed audits.
-She had no documentation of the medication cart audit she said was completed on 01/12/22.

Telephone interview with the pharmacist at the local retail pharmacy on 01/14/22 at 8:55am for Resident #3 revealed:
-They were a retail pharmacy and not a facility pharmacy, the facility or the family would have to request the prescription to be filled and then the

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family or the pharmacy could deliver it to the facility.
-The pharmacy had not received any orders for Acidophilus chewable one tablet daily, ascorbic acid 500mg one tablet in the afternoon, Aspirin 81 mg one tablet daily and cholecalciferol 1000 units one tablet daily to be filled by the pharmacy.
-There was no documentation of the facility calling to request any medications for Resident #3.

Interview with the Administrator on 01/14/22 at 10:40 revealed:
-She had been informed by the RCD Resident #3 was missing few medications.
-She thought the RCD was following up on the medications issue for Resident #3 from her conversation with her.
-The RCD is responsible to ensure all medications are in the facility and available for administration.
-It was the facility's responsibility to have the medications in the facility that the physician has ordered whether the family brings in the medication or does not.

Telephone interview with the nurse at the primary care physician's office for Resident #3 on 01/20/22 at 9:47am revealed a complete medication list was faxed on 12/17/21 to the facility.

Follow-up telephone interview with a family member for Resident #3 on 01/20/22 at 12:47pm revealed:
-The family did not recall any conversations with the RCD but had received a call about 2 weeks ago from a MA who explained the facility did not have many of the medications the physician had ordered for Resident #3.

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D 358	Continued From page 19 -The MA that had called a couple of weeks ago had requested the family to bring in the medications. -The family member informed the MA that they had brought in all the medications they had for Resident #3 and the pharmacy had sent the rest. -The family member asked the MA at that time if they had the right resident as they had brought medications in for Resident #3. -The family did not understand why the facility had waited so long to notify them if they did not have medications for Resident #3. -The family had not talked with anyone at the facility since that call about missing medications. -The family thought there must had been a mistake by the MA and the facility had called the wrong family as they had taken medications to the facility after they had been ordered and no one had talked with them since. -The family had no way of knowing when to get a refill on a medication as the facility had not called them and asked.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;	D 367		

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(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews the facility failed to ensure the accuracy of the electronic medication administration record (eMAR) for 3 of 3 sampled residents (Resident #1, Resident #2 and Resident #3).

The findings are:

Review of Resident #3's current FL2 dated 11/24/21 revealed:
-Diagnoses included chronic obstructive pulmonary disease, coronary artery disease, history of small bowel obstruction, hypertension and dementia.
Medications included: magnesium citrate solution 148 ml in the am, acidophilus chewable one tablet daily, albuterol sulfate HFA,100/90 mcg 2 puffs four times daily, ascorbic acid 500mg tablet one in the afternoon, aspirin 81mg one tablet daily, breztin aerosol 160-9-4. 8mcg 2 puffs twice daily, buspirone HCL 5mg one tablet twice a day, Centrum silver one tablet daily, cholecalciferol 100 units one tablet daily, donepezil HCL 23 mg one tablet at bedtime, fish oil 1000mg one capsule at bedtime.

Observations of medications available for administration for Resident #3 on 01/13/22 at

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3:05pm revealed:
-Acidophilus chewable one tablet daily was not available for administration.
-Ascorbic acid 500mg one tablet in the afternoon was not available for administration.
-Aspirin 81 mg one tablet daily was not available for administration.
-Cholecalciferol 1000 units one tablet daily was not available for administration.

Review of the eMAR for December 2021 for Resident #3 revealed:
-There was a generated entry for acidophilus chewable one tablet daily was documented as administered at 8:00am on 12/21/21 and 12/22/21.
-There was a generated entry for ascorbic acid 500mg one tablet in the afternoon with no documentation of administration on 12/21/21 and 12/24/21, and documentation of administration on 12/23/21, 12/25/21-12/31/21 at 4:00pm.
-There was a generated entry for-Aspirin 81 mg one tablet daily was documented as administered on 12/21/21 and 12/22/21.
-There was a generated entry for Cholecalciferol 1000 units one tablet daily was documented as administered on 12/21/21-12/31/21 at 8:00am.

Review of the eMAR for January 2022 for Resident #3 revealed:
-There was a generated entry for ascorbic acid 500mg one tablet in the afternoon was documented as administered on 01/01/22-01/10/22 as administered at 4:00pm.
-There was a generated entry for Cholecalciferol 1000 units one tablet daily was documented as administered on 01/01/22, 01/02/22, 01/04/22 and 01/05/22.

Interview with a medication aide (MA) on

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D 367	Continued From page 22 01/13/22 at 3:03pm revealed: -She was working on 12/21/21 and 12/22/21. -She did not have all the medications available for administration that had been ordered for Resident #3. -She had informed the Resident Care Director (RCD) shortly after Resident #3 was admitted that he did not have all of his medication available. -She had received the breztin aerosol on 01/12/22 but the other medications were still not available. -She must have made a mistake on the eMAR when she signed because she noted "medication not available" on the eMAR notes because she did not have the medication available to administer to Resident #3. Interview with the pharmacist at the local retail pharmacy on 01/14/22 at 8:55am for Resident #3 revealed: -They were a retail pharmacy and not a facility pharmacy, the facility or the family would have to request the prescription to be filled and then the family or the pharmacy could deliver it to the facility. -The pharmacy had not received any orders for Acidophilus chewable one tablet daily, ascorbic acid 500mg one tablet in the afternoon, Aspirin 81 mg one tablet daily and cholecalciferol 1000 units one tablet daily to be filled by the pharmacy. Interview with the RCD on 01/14/22 at 10:05am revealed: -She was not aware staff had documented medications were administered when they did not have the medications on hand. -She expected staff to make a note on the eMAR system that medications were not available and notify her immediately so she could follow up.	D 367		

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Interview with the Administrator on 01/14/22 at 10:40am revealed:
-She was not aware staff had documented medications were administered when they did not have the medications on hand.
-She expected staff to accurately document on the eMAR and if medications were not available document the medication was not there.
-The RCD was responsible to ensure the MA's were documenting appropriately.

2. Review of Resident #1 current FL2 dated 04/22/21 revealed:
-Diagnoses included blindness due to retinitis pigmentosa, obesity, congestive heart failure with edema, hypertension and gastroesophageal reflux disease.
-There was an order for Carafate (used to treat an ulcer) 1gm 4 times a day at 7:00am, 11:00am, 4:00pm and 8:00pm.
-There was an order for famotidine (used to treat gastroesophageal reflux disease) 40mg twice a day at 8:00am and 8:00pm.
-There was an order for atorvastatin calcium (used to treat elevated cholesterol) 40mg daily at 8:00pm.

Review of Resident #1's record revealed:
-There was an order dated 05/13/21 for Potassium chloride ER (used to treat hypertension) 20mEq at 8:00am and 8:00pm.
-There was an order dated 06/03/21 for acetaminophen ER (used to treat pain) 650mg three times a day at 8:00am, 2:00pm and 8:00pm.
-There was an order dated 06/15/21 for gabapentin (used to treat restless leg syndrome) 100mg twice a day at 8:00am and 8:00pm.

Review of Resident #1's December 2021

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electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Carafate 1gm 4 times a day at 7:00am, 11:00am, 4:00pm and 8:00pm.
-There was an entry for famotidine 40mg twice a day at 8:00am and 8:00pm.
-There was an entry for atorvastatin calcium 40mg daily at 8:00pm.
-There was an entry for potassium chloride ER 20mEq at 8:00am and 8:00pm.
-There was an entry for acetaminophen ER 650mg three times a day at 8:00am, 2:00pm and 8:00pm.
-There was an entry for gabapentin 100mg twice a day at 8:00am and 8:00pm.
-There was no documentation Carafate, famotidine, atorvastatin, potassium chloride ER, acetaminophen ER, or gabapentin were administered at 8:00pm on 12/07/21.

Interview with a medication aide (MA) on 01/13/22 at 3:15pm revealed:
-She was working on 12/07/21.
-She documented administration of 4:00pm medications.
-If medications were not documented as administered 8:00pm, the only reason she could think of was she forgot to document administration on the MAR.

Interview with the RCD on 01/14/22 at 10:05am revealed she expected staff to properly document in the eMAR system.

Interview with the Administrator on 01/14/22 at 10:40am revealed the RCD was responsible to ensure the MA's were documenting appropriately.

3. Review of Resident #2's current FL2 dated 08/10/21 revealed:

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-Diagnoses included diverticulitis, colitis, vesicointestinal fistula, chronic kidney disease and bladder cancer.
-There was an order for Spironolactone (used to treat heart failure) 25mg twice daily at 8:00am and 8:00pm.
-There was an order for carvedilol (used to treat heart failure) 12.5mg twice daily at 8:00am and 8:00pm.
-There was an order for lanthanum carbonate (used to treat hyperphosphatemia) 1000mg twice daily at 8:00am and 8:00pm.
-There was an order for amlodipine besylate (used to treat hypertension) 5mg twice daily at 8:00am and 8:00pm.

Review of Resident #2's record revealed:
-There was an order dated 09/01/21 for lorazepam (used to treat insomnia) 0.5mg daily at 8:00pm.
-There was an order dated 09/24/21 for Dialyvite (a vitamin supplement) 0.8mg daily at 8:00pm.

Review of Resident #2's December 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Spironolactone 25gm twice a day at 8:00am and 8:00pm.
-There was an entry for carvedilol 12.5mg twice a day at 8:00am and 8:00pm.
-There was an entry for lanthanum carbonate 1000mg twice a day at 8:00am and 8:00pm.
-There was an entry for amlodipine Besylate 5mg twice a day at 8:00am and 8:00pm.
-There was an entry for lorazepam 0.5mg at 8:00pm.
-There was an entry for Dialyvite 0.8mg at 8:00pm.
-There was no documentation Spironolactone, carvedilol, lanthanum carbonate, amlodipine

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D 367	Continued From page 26 Besylate, lorazepam or Dialyvite were administered at 8:00pm on 12/07/21. Interview with a medication aide (MA) on 01/13/22 at 3:15pm revealed: -She was working on 12/07/21. -She documented administration of 4:00pm medications. -If medications were not documented as administered at 8:00pm, the only reason she could think of was she forgot to document administration on the MAR. Interview with the RCD on 01/14/22 at 10:05am revealed she expected staff to properly document in the eMAR system. Interview with the Administrator on 01/14/22 at 10:40am revealed the RCD was responsible to ensure the MA's were documenting appropriately.	D 367		
D 410	10A NCAC 13F .1010(c) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure	D 410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011022	A. BUILDING: _____ B. WING _____	01/20/2022

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D 410	Continued From page 27	D 410		

pharmaceutical services were in place to meet the needs of a resident (Resident #3) who did not use the facility pharmacy for 1 of 1 sampled residents.

The findings are:

Review of the facility medication policy titled "Outside PharmacyServices" revealed:
-The residents represenative will have the responsibility of delivering the medications to the facility in a timely manner.
-In the event of emergency, or if a medication delivery is delayed or uncertain and these medications are not available to be administered as ordered by the physician, the authorized staff member may order up to a seven-day supply from the pharmacy, which will be billed to the residents account.

Review of Resident #3's current FL2 dated 11/24/21 revealed:
-Diagnoses included chronic obstructive pulmonary disease,cornary artery disease, history of small bowell obstruction, hypertension and dementia.
Medications included:magnesium citrate solution 148ml in the am, acidophilus chewable one tablet daily, albuterol sulfate HFA,100/90 mcg 2 puffs four times daily, asorbic acid 500mg tablet one in the afternoon, aspirin 81mg one tablet daily, breztin aresol 160-9-4.8mcg 2 puffs twice daily, buspirone HCL 5mg one tablet twice a day, centrum silver one tablet daily, cholecalciferol 100 units one tablet daily, donepezil HCL 23mg one tablet at bedtime, fish oil 1000mg one capsule at bedtime.

Review of the Resident Register for Resident #3 revealed an admission date of 12/20/21.

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D 410	Continued From page 28 Interview with a medication aide (MA) on 01/13/22 at 3:03pm revealed: -She did not have all the medications on hand for administration that had been ordered for Resident #3. -She informed the Resident Care Director (RCD) shortly after Resident #3 was admitted that he did not have all of his medication available. -She had received the breztin aresol on 01/12/22 but the other medications were still not available. Observations of medications on hand for administration for Resident #3 on 01/13/22 at 3:05pm revealed: -Acidophilus chewable one tablet daily was not available for administration. -Asorbic acid 500mg one tablet in the afternoon was not available for administration. -Aspirin 81 mg one tablet daily was not available for administration. -Cholecalciferol 1000 units one tablet daily was not available for administration. -Fish Oil 1,000mg one capsule at bedtime was not available for administration. Confidential interview with staff revealed: -Resident #3 was admitted to the facility a few weeks ago and had very few medications. -Resident #3's had been missing an inhaler since his admission. -The DON was aware of Resident #3's medication issues but had not helped resolve the problem. Interview with the RCD on 01/14/22 at 10:05am revealed: -She was responsible for sending the FL2 to the pharmacy and entering the medication list for all new residents.	D 410		

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D 410	Continued From page 29	D 410		

-She was also responsible for ensuring the residents had the medications available after the physician had ordered the medication.
-She was not responsible for Resident #3's medication as Resident #3 did not use the facility contracted pharmacy but a local retail pharmacy.
-She was not aware of any medication orders from Resident #3's primary care physician dated 12/17/21.
-The family was responsible for getting all the medications for Resident #3 and ensuring the medication were available at the facility for administration.
-When she happened to see the family in the facility she had asked them to bring in the missing medications.
-She had no documentation to show she had ever spoken with the family about the missing medications
-She had not spoken with anyone at the local retail pharmacy, or the facility contracted pharmacy regarding medications for Resident #3.
-She was not aware of the family bringing in medications.
-There was currently no system in place that assured the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis for Resident #3 or residents who chose not to use the facility contracted pharmacy.

Telephone interview with the pharmacist at the local retail pharmacy on 01/14/22 at 8:55am for Resident #3 revealed because they were a retail pharmacy and not a facility pharmacy, the facility or the family would have to request the prescription to be filled and then the family or the pharmacy could deliver it to the facility.
daily as needed.

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D 410	Continued From page 30 Telephone interview with a family member for Resident #3 on 01/20/22 at 12:47pm revealed: -The family did not recall any conversations with the RCD but had recieved a call about 2 weeks ago from a MA who explained the facility did not have many of the medications the physician had ordered for Resident #3. -The MA had requested the family to bring in the medications. -The family member informed the MA that they had brought in all the medications they had for Resident #3. -The family did not understand why the facility had waited so long to notify them if they did not have medications for Resident #3. -The family had not talked with anyone at the facility since that call. Interview with the Administrator on 01/14/22 at 10:40am revealed: -The RCD was responsible to ensure all medications were in the facility and available for administration. -The RCD was responsible to ensure there was a system in place to assure an accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis for Resident #3 or residents who chose not to use the facility contracted pharmacy. -It was the facility's responsibility to have the medications in the facility that the physician has ordered whether the family brings in the medication or does not.	D 410		