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	HAL049016	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 03/02/22-03/03/22.	D 000		
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 record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to clarify medication and treatment orders with the primary care provider for 1 of 3 residents (Resident #3) related to a cream used to treat a variety of inflamed fungal skin infections and the application of a dressing to a pressure ulcer. The findings are: Review of Resident #3 current FL2 dated 10/18/21 revealed: -Diagnoses included diabetes and history of a stroke with swallowing difficulty. -Resident #3 was semi-ambulatory and used a wheelchair.	D 344		

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D 344	Continued From page 1 -An order for Lotrisone cream 45gm with instructions to apply topically to buttocks twice daily. Review of Resident #3 Physician's orders dated 02/18/22 revealed an order for home health to evaluate and treat a stage 2 pressure ulcer on Resident #3's right greater trochanter (hip). Review of Resident #3's February 2022 medication administration record (MAR) revealed: -An order for Lotrisone cream 45gm with instructions to apply topically to affected area and surrounding areas of skin twice daily, scheduled for 8:00am and 8:00pm. -Lotrisone cream 45gm was documented as administered twice a day from 02/01/22-02/28/22. -There was not an order to apply a dressing to his right hip. Review of Resident #3's March 2022 MAR revealed: -An order for Lotrisone cream 45gm with instructions to apply topically to affected area and surrounding areas of skin twice daily, scheduled for 8:00am and 8:00pm. -Lotrisone cream 45gm was documented as administered twice on 03/01/22 and on the morning of 03/02/22. -There was not an order to apply a dressing to his right hip. Review of Resident #3's home health progress notes revealed: -On 02/23/22 the Home Health Registered Nurse (HHRN) visited the facility to clean Resident #3's right hip pressure ulcer and apply a dressing. -On 02/25/22 the HHRN provided wound care to Resident #3's right hip pressure ulcer and documented she would be visiting the facility	D 344		

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twice a week for dressing changes.
-On 03/02/22 the HHRN provided wound care and documented the wound was not progressing.
-There was no documentation of an order allowing the facility to apply a new dressing to Resident #3's pressure ulcer or documentation that the HHRN instructed the MA on how to apply a new dressing.

Interview with the medication aide (MA) on 03/02/22 at 3:40pm revealed:
-The HHRN applied the first dressing to Resident #3's pressure ulcer the week of 02/21/22 and came twice a week to change the dressing.
-The HHRN left dressing supplies at the facility in case the dressing needed to be changed before she returned due to becoming wet or soiled.
-Resident #3 had a shower scheduled three times per week and after each shower the MA would apply Lotrisone cream to his pressure ulcer and apply a new dressing.
-Some weeks Resident #3 would receive more than three showers and she applied a fresh dressing as well as Lotrisone cream to the pressure ulcer after each shower.

Telephone interview with the HHRN on 03/02/22 at 4:20pm revealed:
-The MA was allowed to change Resident #3's dressing if it became wet, soiled or started to peel off.
-She did not apply Lotrisone cream to Resident #3's pressure ulcer before applying the dressing.
-She did not expect the MA to apply Lotrisone cream before replacing Resident #3's dressing.

Interview with the MA on 03/03/22 at 11:41am revealed:
-The HHRN did not train her on how to apply a new dressing on Resident #3's pressure ulcer but

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they did have a discussion about how to do it.
-She received training on how to change a dressing many years ago.
-She thought there was an order from the Primary Care Provider (PCP) that allowed the facility to apply a new dressing on Resident #3.
-The MA or the Resident Care Director (RCD) was responsible for obtaining order clarification from the PCP.
-She was not sure why the order for Resident #3's Lostrisone cream had not been clarified before today (03/03/22).

Telephone interview with the HHRN on 03/03/22 at 11:13am and 12:45pm revealed:
-The verbal order she gave the facility for Resident #3's wound care was to clean the affected area with normal saline then apply a Xeroform dressing and cover with a dry dressing.
-She expected the MA to write down the wound care order.
-She did not remember the first time she gave the order but had spoken with the MA several times about changing Resident #3's dressing.
-She verbally reviewed how to change Resident #3's dressing with the MA but did not provide any hands-on training.

Interview with the RCD on 03/03/22 at 12:05pm revealed:
-She thought the facility had a verbal order from the HHRN to apply a new dressing to Resident #3.
-Whoever was given the verbal order should have written it down and had it signed by the PCP.
-The MAs should not be applying a new dressing to Resident #3's pressure ulcer without an order.
-She or the MAs were responsible for obtaining order clarification from the PCP.
-Resident #3's order for Lotrisone cream should

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D 344	Continued From page 4 have been clarified the day home health was ordered to treat his pressure ulcer. Telephone interview with the Administrator on 03/03/22 at 1:10pm revealed: -She expected the facility to have an order to apply a new dressing to Resident #3's pressure ulcer. -All verbal orders should be documented and written on the MAR. -She would expect the MA to contact the PCP if an order was needed and if an order needed to be signed. -The MA was responsible for clarifying orders and they should be clarified as soon as a discrepancy is discovered. Based on interviews and record review it was determined that Resident #3 was uninterviewable. Attempted telephone interview with Resident #3's PCP was unsuccessful.	D 344		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on interviews, observations, and record reviews, the facility failed to ensure a readily	D 392		

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retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances for 2 of 8 residents sampled who received anti-anxiety medications (Resident #4 and #5).

Review of the facility's Medication Policies and Procedures dated 01/2020 revealed:
-Documentation of controlled substances will be maintained by the facility and will be available for review.
-The record of documentation will be kept in the resident's record under the Medication Administration Record (MAR) or controlled drug sign-out record.

1. Review of Resident #4's current FL2 dated 06/01/21 revealed:
-Diagnoses included traumatic brain injury (TBI), bi-polar disorder and behavior disorder.
-There was an order for lorazepam 0.5 mg (used to treat anxiety), one tablet three times daily.

Review of Resident #4's physician orders dated 11/19/21 revealed there was an order for lorazepam 0.5 mg, one tablet three times daily.

Review of Resident #4's Control Substance Count Sheet (CSCS) for lorazepam 0.5mg revealed:
-Lorazepam 0.5mg, 42 tablets were dispensed to the facility on 02/18/22.
-The medication was dispensed in three cassettes.
-Each cassette contained 14 individual boxes and each box contained one tablet.

Observation of a medication pass on 03/02/22 at 2:00pm for Resident #4 revealed:
-The medication aide (MA) removed one tablet of

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lorazepam 0.5mg from a cassette for Resident #4.
-There were 3 tablets remaining in the medication cassette.
-The MA signed the CSCS after she removed the medication from the cassette.
-The CSCS for Resident #4's lorazepam revealed there were 2 tablets remaining.

Interview with the MA on 03/02/22 at 2:00pm revealed:
-She was unsure why the number of remaining lorazepam 0.5mg tablets for Resident #4 did not match the remaining quantity on the CSCS.
-She thought it may have been signed out on the CSCS as removed from the cassette but was not.

Telephone interview with a pharmacist with the facilities contracted pharmacy on 03/03/22 at 11:39am revealed:
-Lorazepam 0.5mg, 42 tablets were delivered to the facility the evening of 02/17/22 for Resident #4.
-A CSCS for lorazepam was sent to the facility with the medication for the facility to account for administration of the controlled substance.
-Resident #4 could have increased anxiety or agitation if she missed doses of her lorazepam.

Based on observations, record reviews and interviews it was determined Resident #4 was not interviewable.

Refer to second interview with the MA on 03/03/22 at 10:00am.

Refer to interview with the Resident Care Director (RCD) on 03/03/22 at 11:15am.

Refer to telephone interview with the

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D 392	Continued From page 7 Administrator on 03/03/22 at 1:10pm. 2. Review of Resident #5's current FL2 dated 03/22/21 revealed: -Diagnoses included schizophrenia and Parkinson's Disease. -There was an order for alprazolam 0.25mg (used to treat anxiety), 1 tablet three times daily. Review of Resident #5's physician orders dated 11/19/21 revealed there was an order for alprazolam 0.25mg, one tablet three times daily. Review of Resident #5's Control Substance Count Sheet (CSCS) for alprazolam 0.25mg revealed: -Alprazolam 0.25mg, 42 tablets were dispensed to the facility on 02/18/22. -The medication was dispensed in three cassettes. -Each cassette contained 14 individual boxes and each box contained one tablet. Observation of a medication pass on 03/02/22 at 2:00pm for Resident #5 revealed: -The medication aide (MA) removed one tablet of alprazolam 0.25mg from a cassette for Resident #5. -There were 7 tablets remaining in the medication cassette. -The MA signed the CSCS after she removed the medication from the cassette. -The CSCS for Resident #5's alprazolam revealed there were 5 tablets remaining. Interview with the MA on 03/02/22 at 2:00pm revealed: -She did not know why the number of remaining alprazolam 0.25mg tablets for Resident #5 did not match the remaining quantity on the CSCS.	D 392		

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D 392	Continued From page 8 -She thought it may have been signed out on the CSCS as removed from the cassette but was not. Telephone interview with a pharmacist with the facilities contracted pharmacy on 03/03/22 at 11:39am revealed: -Alprazolam 0.25mg, 42 tablets were delivered to the facility the evening of 02/17/22 for Resident #5. -A CSCS for the alprazolam was sent to the facility with the medication for the facility to account for administration of the controlled substance. -Resident #5 could have increased anxiety or agitation if he missed doses of his alprazolam. Interview with Resident #5 on 03/03/22 at 12:35pm revealed the resident had always received all his medications and the staff gave them all to him. Refer to second interview with the MA on 03/03/22 at 10:00am. Refer to interview with the Resident Care Director (RCD) on 03/03/22 at 11:15am. Refer to telephone interview with the Administrator on 03/03/22 at 1:10pm. _____ A second interview with the MA on 03/03/22 at 10:00am revealed: -She often works both first and second shift. -Medications were not passed on third shift but if a resident needed a medication the Resident Care Director (RCD) lived nearby and she was a medication aide. -She either reviewed controlled substances on hand and the controlled substance count sheets (CSCS) with the previous MA or reviewed the	D 392		

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controlled substances when she started and ended her shift.
-If the count was off, she made the RCD aware and called the previous MA.
-She had not made the RCD aware the count was off for Resident #4 and #5.
-She did not know why she had not reported the count discrepancy to the RCD.

Interview with the RCD on 03/03/22 at 11:15am revealed:
-The MAs were trained to pull the medication from the cart, give the medication to the resident, watch the resident swallow the medication and then sign the CSCS and the medication administration record (MAR).
-If done correctly, there was no reason the CSCS should not be accurate.

Telephone interview with the Administrator on 03/03/22 at 1:10pm revealed:
-She expected the documentation on the CSCS to be accurate.
-She expected any discrepancies between the controlled substance count and the CSCS to be brought to the RCD's attention as soon as it was identified.