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FORM APPROVED

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
	HAL080014	A. BUILDING: _____ B. WING _____	R 04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SALISBURY	2201 STATESVILLE BOULEVARD SALISBURY, NC 28147

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 04/21/22 to 04/22/22.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#3) had completed tuberculosis (TB) testing in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #3's current FL2 dated 03/07/22 revealed diagnoses included major depression, severe sepsis, acute kidney failure, obstructive sleep apnea, hypercalcemia, and muscle weakness. Review of Resident #3's Resident Register revealed an admission date of 05/24/19. Review of Resident #4's record revealed there	D 234	All residents will have 1st step TB placed upon admission and/or Quantiferon Blood test results upon admission. HWD/ Resident Care Coordinator will confirm the test prior to admission or administer the PPD at the community upon admission. 2nd Step PPD will be placed and read 14-21 days after 1st step as required. HWD/RCC will monitor and track for compliance.	5/19/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana Seeley | TITLE: Executive Director | (X6) DATE: 6/3/2022

Reviewed and acknowledged 06/03/22. SG.

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D 234	Continued From page 1 was no documentation of a TB skin test. There was a chest X-ray with notation there was no active TB. Interview with Resident #3 on 04/21/22 at 3:21pm revealed: -She moved into the facility from home. -She had not received a TB skin test since she moved into the facility. -She had never tested positive for TB in the past. Interview with the Administrator on 04/21/22 at 1:09am revealed: -The Health and Wellness nurse was responsible to ensure residents admitted to the facility completed 2 TB skin tests and the TB tests were administered and read. -When Resident #3 was admitted to the facility in 2019, there was a shortage of the TB test serum. -The nurse in charge at the time had the resident do a chest X-ray to rule out active TB. -After the TB serum became available, she did not think she had to do the 2 TB skin tests on Resident #3.	D 234		
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 follow-up with a health care provider for 1 of 5 sampled residents (Residents #3) related to a referral to psychiatrist for depression and referral to a	D 273	Resident #3 was seen by the Psychiatrist on 4/25/22. All physician referral orders will be followed in a timely manner and will be tracked for timely completion using the new order tracking form. HWD/RCC will track all physician orders to ensure that they have been followed in a timely manner.	5/19/2022

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D 273	Continued From page 2 vascular specialist for vascular disease of the foot and legs (#3). The findings are: Review of Resident #3's current FL2 dated 03/07/22 revealed diagnoses included major depression disorder, severe sepsis, acute kidney failure, obstructive sleep apnea, hypercalcemia, and muscle weakness. a. Review of Resident #3's physician's orders revealed: -There was an order dated 02/24/22 for psychiatrist, diagnosis was depression. -There was an order dated 02/25/22 for Home Health (HH) nurse consult for depression. -There was an order dated 03/29/22 for psychiatry referral. Review of Resident #3's record revealed there was no documentation of a psychiatrist visit. There was no documentation of a HH nurse consult. Interview with Resident #3 on 04/21/21 at 9:41am revealed: -In February, the PCP referred her to a psychiatrist. -As of today's, date (04/21/22), she still had not seen a psychiatrist and no one had told her why. -She had some depression related to her health issues. -She wanted to see a psychiatrist for treatment and possible medication. -The facility was supposed to schedule the appointment for her. Interview with the Resident Care Coordinator (RCC) on 04/21/22 at 3:53pm revealed:	D 273		

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D 273	Continued From page 3 -She was aware that Resident #3 was ordered a psychiatrist referral. -She thought the HH nurse did a psychiatry evaluation of Resident #3. -She was not sure which HH nurse and she was not sure where the paperwork for the evaluation was located. -The facility's corporate office was supposed to handle scheduling the referral for the psychiatrist. -She had reached out to the corporate person that was responsible for handling scheduling the appointment several times. -She thought the reason it was taking so long to get the psychiatrist referral was that someone no longer worked at the corporation. Telephone interview with the Corporate person responsible for scheduling the psychiatrist referral on 04/21/22 at 4:47pm revealed: -The corporation had an in-house psychiatry service. -The corporation did not have a psychiatry nurse to do the evaluation of Resident #3. -The plan was for someone from the corporation in-house psychiatry to assess Resident #3, but before they could do the evaluation another the HH agency started performing physical therapy for the resident. -The corporation in-house service could not be done because the resident's insurance will not pay for two agencies. -She thought the HH agency that was doing the physical therapy was going to do psychiatry services. -She had not contacted the HH agency and she was not sure if they offered psychiatry services. -She was not sure who was responsible for ensuring Resident #3 psychiatry services were completed as ordered.	D 273		

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D 273	Continued From page 4 Telephone interview with Resident #3's PCP on 04/21/22 at 2:57pm revealed: -She had written several orders for Resident #3 to see a psychiatrist. -If the facility was unable to make the referral appointment as ordered then they should have contacted him so he could make other arrangements or refer the resident to another agency. -Resident #3 had major depression due to her illness and decline. -He wanted the resident to see a psychiatrist to be evaluated for treatment and/or medications. Telephone interview with a representative from the HH agency that offered Resident #3 physical therapy on 04/22/22 at 2:00pm revealed: -The agency did not offer psychiatric services. -If the facility had called to inquire about psychiatry services, they would have been informed the agency does offer those type of services. Interview with the Administrator on 04/21/22 at 4:10pm revealed: -The Health and Wellness nurse was usually responsible for handling referral appointments. -The facility's Health and Wellness nurse was out from February 2022 through April 2022 for surgery. -The RCC would have been responsible for scheduling Resident #3's referral appointments. -The RCC should have scheduled Resident #3's referral appointment. -The referral for psychiatry was missed. -She would schedule an appointment for Resident #3 to see a psychiatrist as soon as possible. b. Review of Resident #3's PCP orders revealed	D 273		

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D 273	Continued From page 5 an order dated 03/29/22, "referral to vascular places." Review of Resident #3's record revealed there was no documentation that an appointment had been scheduled or documentation Resident #3 had been seen by a vascular specialist. Interview with Resident #3 on 04/21/22 at 9:43am revealed: -She frequently had lower extremity swelling with pain. -She also had a sore on one of her ankles. -Home Health wrapped her legs once weekly because they sometimes leaked fluid. -She did not know that she had been referred to vascular specialist. -No one at the facility had mentioned anything to her about seeing a vascular specialist. Interview with the RCC on 04/21/22 at 3:53pm revealed: -She did not schedule Resident #3 an appointment with the vascular specialist because sometimes Resident #3 schedule her own appointments. -Also, she thought maybe the resident's PCP had scheduled the appointment because she thought the referral note read "referral to vascular placed," meaning someone else had already made the appointment. -She did not contact the resident's PCP or resident to ensure that an appointment had already been made. Telephone interview with Resident #3's PCP on 04/21/22 at 2:57pm revealed: -Resident #3 had chronic venous stasis that caused edema in her lower extremities. -The resident had a healing wound on the side of	D 273		

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D 273	Continued From page 6 her ankle that was caused by the disease. -He wanted Resident #3 to see the vascular specialist to determine treatment of the disease. -If the facility was not sure if they needed to make the appointment for the vascular specialist then they should have contacted his office to clarify the order.	D 273		
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 orders were implemented and documented for 1 of 5 sampled residents (#3) related to the application and removal of compression stockings. The findings are: Review of Resident #3's current FL2 dated 03/07/22 revealed diagnoses included major depression disorder, severe sepsis, acute kidney failure, obstructive sleep apnea, hypercalcemia, and muscle weakness. Review of Resident #3's physician's order dated 03/02/22 revealed an order for compression stockings - apply in the morning and remove at bedtime.	D 276	HWD will provide inservice training on compression hose/stockings to all associates responsible for the adminitration and documentation of administration of the compression hose/stockings. HWD will also provide training regarding the difference between compression hose/stockings and tubi grip. This training will include proper identification, application, removal, and documentation. HWD/RCC will perform weekly audits X 4weeks to ensure compliance. Documentation of training and audits will be maintained.	5/24/2022

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D 276	Continued From page 7 Review of Resident #3's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for compression stockings - apply in the morning and remove at bedtime scheduled for application at 6:30am and removal at 8:00pm. -There was documentation that compression stockings were applied daily at 6:30am from 03/03/22 through 03/31/22. -There was documentation that compression stockings were removed daily at 8:00pm from 03/03/22 through 03/31/22. Review of Resident #3's April 2022 (eMAR) revealed: -There was an entry for compression stockings - apply in the morning and remove at bedtime scheduled for application at 6:30am and removal at 8:00pm. -There was documentation that compression stockings were applied daily at 6:30am from 04/01/22 through 04/21/22. -There was documentation that compression stockings were removed daily at 8:00pm from 04/01/22 through 04/20/22. Observation of Resident #3 on 04/21/22 at 9:43am revealed the resident was not wearing compression stockings but was wearing tubigrip hose (provide static compression for strains, sprains and swelling). Observation of Resident #3 on 04/22/22 from 12:30pm through 3:10pm revealed the resident's legs were bare and she was not wearing compression stockings or tubigrip hose. Interview with Resident #3 on 04/21/22 at 9:43am	D 276		

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D 276	Continued From page 8 and on 04/22/21 at 3:10pm revealed: -She did not wear compression stockings. -She had never worn compression stockings since she was admitted to the facility. -Two weeks ago, her family ordered her the tubigrip hose. -She had worn the tubigrip stockings for two weeks but had never worn compression stockings. -The past two weeks staff put the tubigrip hose on her and took them off at night. -Some nights they did not take them off. -This morning, she asked the personal care aide (PCA) to help her put the tubigrip hose on, but the PCA told her that she was busy and would come back. -The PCA did not come back to put the hose on her. Telephone interview with Resident #3's Primary Care Provider (PCP) on 04/21/22 at 2:57pm revealed: -The compression stockings were ordered due to the resident's chronic venous stasis causing edema leg weeping. -If the resident was not wearing the compression stockings, he wanted to be notified so the resident's condition did not get out of hand and beyond treatment. -He expected orders to be implemented as ordered. Telephone interview with the nurse at the Home Health agency on 04/22/22 at 2:08pm revealed: -Resident #3 became a patient of the agency on 03/24/22. -When the resident became their patient, she was not wearing compression stockings. -She obtained an order for tubigrip hose to help with the resident's edema.	D 276		

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D 276	Continued From page 9 Interview with the Resident Care Coordinator (RCC) on 04/22/22 at 10:40am revealed: -Resident #3 was not wearing tubigrip hose, but she was wearing compression stockings. -She had seen the resident with the compression stockings on. Interview with the RCC on 04/22/22 at 3:12pm revealed: -She thought the pharmacy had sent Resident #3 compression stockings. -She just found out today from Resident #3 that she had never worn compression stockings since she moved into the facility. -She thought the stockings that Resident #3 was currently wearing were compression stockings, she did not know they were tubigrip hose. -She would ensure training was obtained for the medication aides (MA) to make them aware of the differences between compression stockings versus tubigrip hose. Interview with the second shift MA on 04/22/21 at 4:34pm revealed: -Resident #3 had been wearing tubigrip hose for about two weeks. -The electronic medication administration record (eMAR) documented compression stockings, but that was not what the resident was wearing. -She told the third shift MA to let the day shift MA know so she could inform the RCC or the nurse. -Prior to two weeks ago, she had not seen Resident #3's compression stockings. -She thought the resident was taking them off. Interview with the Administrator on 04/22/22 at 4:04pm revealed: -Resident #3 was not wearing compression stockings as ordered.	D 276		

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D 276	Continued From page 10 -She expected treatment orders for compression stockings to be implemented as ordered.	D 276		
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater;	D 278	HWD will complete LHPS within 30 days after identification of a new task. HWD will maintain a compliance tracker to assure all LHPS are completed timely. HWD will review the compliance tracker weekly with Executive Director to ensure that the tracker is maintained.	5/18/2022

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D 278	Continued From page 11 (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21	D 278		

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D 278	Continued From page 12 NCAC 36. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed within 30 days after the identification of a new task for 1 of 5 sampled residents (Resident #3) for the identified task of compression stockings (TED hose). The findings are: Review of Resident #3's current FL2 dated 03/07/22 revealed diagnoses included major depression disorder, severe sepsis, acute kidney failure, obstructive sleep apnea, hypercalcemia, and muscle weakness. Review of Resident #3's physician's order dated 03/02/22 revealed an order for compression stockings - apply in the morning and remove at bedtime. Review of Resident #3's medical record revealed there was a licensed health professional support (LHPS) evaluation dated 01/05/22. There was not another LHPS after the 01/05/22 evaluation. Interview with Resident #3 on 04/22/22 at 3:10pm revealed: -She had not worn compression stockings since she moved into the facility. -Two weeks ago, the Home Health nurse told her she could get tubigrip hose. -Her family member ordered the tubigrip hose and she cut them to fit her legs.	D 278		

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D 278	Continued From page 13 -Facility staff put the tubigrip hose on and took them off. Interview with the Health and Wellness nurse on 04/22/22 at 11:03am revealed: -She had not completed an LHPS for Resident #3 because she was out of work from February 2022 through early April 2022. -Today, (04/22/22), she observed Resident #3 was wearing tubigrip hose and not compression stockings. -She had not provided training to the MAs to know the difference between the compression stockings and the tubigrip hose. -She was not aware the MAs were documenting the application and removal the tubigrip hose as compression stockings. Interview with the second shift medication aide (MA) on 04/22/21 at 4:34pm revealed: -Resident #3 had been wearing tubigrip hose for about two weeks. -The electronic medication administration record (eMAR) documented compression stockings, but that was not what the resident was wearing. -She told the third shift MA to let the day shift MA know so she could inform the RCC or the nurse. -Prior to two weeks ago, she had not seen Resident #3's compression stockings. -She thought the resident was taking them off. -She initialed the eMAR documenting the compression stockings were off. Interview with the Administrator on 04/22/22 at 4:04pm revealed: -The Health and Wellness nurse was out of work from February 2022 to April 2022 and recently returned to work. -There was a corporate nurse filling in as the facility nurse.	D 278		

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D 278	Continued From page 14 -She was sure the corporate nurse did not complete LHPS for residents.	D 278		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#4) related to a laxative. The findings are: Review of Resident #4's current FL2 dated 10/25/21 revealed: -Diagnoses included chronic kidney disease, heart failure, hypertension, anxiety and depression. -There was an order for miralax 17grams 1 packet in liquid daily (used to treat constipation). Review of Resident #4's physician's orders revealed: -There was an order dated 02/02/21 for miralax powder 17grams, 1 scoop one time daily for constipation. -There was a physician's order sheet dated 12/22/21 for miralax powder 17grams, 1 scoop	D 358	HWD/RCC will provide inservice training on the proper med ordering and medication receipt procedure to all staff responsible for ordering and receiving medications. HWD/RCC will perform weekly cart audits X 4 weeks to ensure that all medications have been received and are available for administration. Cart audits will be performed monthly thereafter. A cart audit was performed by HWD/RCC and all current medication orders have been received and are available for administration.	5/24/2002 5/24/2022

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D 358	Continued From page 15 one time daily for constipation. Review of Resident #4's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for miralax 17grams once daily scheduled for administration at 8:00am. -There was documentation miralax powder was administered as ordered at 8:00am from 02/01/22 through 02/28/22. Review of Resident #4's March 2022 eMAR revealed: -There was an entry for miralax 17grams once daily scheduled for administration at 8:00am. -There was documentation miralax powder was administered as ordered at 8:00am from 03/01/22 through 03/31/22. Review of Resident #4's April 2022 eMAR revealed: -There was an entry for miralax 17grams once daily scheduled for administration at 8:00am. -There was documentation miralax powder was administered as ordered at 8:00am from 04/01/22 through 04/22/22. Observation of Resident #4's medications on hand at the facility on 04/22/22 at 3:28pm revealed miralax was not available for administration. Interview with Resident #4 on 04/21/22 at 9:50am revealed: -She did not know about her medications administered. -Today, (04/21/22), she had an upset stomach. -She often had an upset stomach. -When her stomach was upset the medication aide (MA) gave her ginger ale to drink.	D 358		

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D 358	Continued From page 16 -The ginger ale sometimes helped because she was filled up with gas. Interview with Resident #4 on 04/22/22 at 2:29pm revealed: -She sometimes had constipation but did not think it was daily. -She did not know if she was ordered miralax and did not know the last time the medication was administered. -She did not recall if she got a liquid medication to drink every day. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 04/22/22 at 4:17pm revealed: -The pharmacy last filled and dispensed miralax 17grams on 10/27/21. -The medication was not automatically dispensed and the facility had to call and request a refill. -One container, if used daily should have lasted 45 days if administered daily as ordered. Telephone interview with Resident #4's power of attorney (POA) on 04/22/22 at 4:27pm revealed: -All resident #4's medications should be provided by the facility. -The resident's family paid the facility to administer all the resident's medications. -Resident #4 should not run out of a medication. Telephone interview with Resident #4's Primary Care Provider (PCP) from a returned phone call on 04/22/22 at 4:48pm revealed: -She was not made aware that Resident #4 was not administered miralax once daily as ordered. -She wanted to be notified if the resident missed dosages of a medication ordered daily. -It was possible not getting the miralax daily was correlated to the resident's continual complaint of	D 358		

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D 358	Continued From page 17 an upset stomach. Interview with the Administrator on 04/22/22 at 4:30pm revealed: -Medications were not supposed to run out. -Medications should be reordered before the last dosage was administered. -The Resident Care Coordinator (RCC) was supposed to do a medication cart audits. -She did not know how frequent the RCC did the cart audits. Telephone interview with the RCC on 04/22/22 at 4:35pm revealed: -She was doing medication cart audits a little bit at a time. -With the nurse being out she was not able to do a full medication cart audit. -She had assigned the third shift to do audits, but was not sure if the audits were completed because there was no documentation to show the audits were done.	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	HWD will provide staff inservice on proper documentation of medication administration in point click care. The training will include ordering, obtaining, administering, and recording the administration of medications. HWD/RCC will complete cart audits weekly X4 weeks, then monthly Thereafter to ensure that medication being documented as administered are being administered properly.	5/24/2022

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D 367	Continued From page 18 (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 electronic medication administration records were accurate for 1 of 5 sampled residents (Resident #4) related to inaccurate documentation of a laxative. The findings are: Review of Resident #4's current FL2 dated 10/25/21 revealed: -Diagnoses included chronic kidney disease, heart failure, hypertension, anxiety and depression. -There was an order for miralax 17grams 1 packet in liquid daily (used to treat constipation). Review of Resident #4's physician's orders revealed: -There was an order dated 02/02/21 for miralax powder 17grams, 1 scoop one time daily for constipation. -There was a physician's order sheet dated 12/22/21 for miralax powder 17grams, 1 scoop one time daily for constipation. Review of Resident #4's February 2022 electronic medication administration record (eMAR) revealed:	D 367	Type text here	

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D 367	Continued From page 19 -There was an entry for miralax 17grams once daily scheduled for administration at 8:00am. -There was documentation miralax powder was administered as ordered at 8:00am from 02/01/22 through 02/28/22. Review of Resident #4's March 2022 eMAR revealed: -There was an entry for miralax 17grams once daily scheduled for administration at 8:00am. -There was documentation miralax powder was administered as ordered at 8:00am from 03/01/22 through 03/31/22. Review of Resident #4's April 2022 eMAR revealed: -There was an entry for miralax 17grams once daily scheduled for administration at 8:00am. -There was documentation miralax powder was administered as ordered at 8:00am from 04/01/22 through 04/22/22. Observation of Resident #4's medications on hand at the facility on 04/22/22 at 3:28pm revealed miralax was not available for administration. Interview with Resident #4 on 04/21/22 at 9:50am revealed: -She did not know about her medications administered. -Today, (04/21/22), she had an upset stomach. -She often had an upset stomach. -When her stomach was upset the medication aide (MA) gave her ginger ale to drink. -The ginger ale sometimes helped because she was filled up with gas. Interview with Resident #4 on 04/22/22 at 2:29pm revealed:	D 367		

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D 367	Continued From page 20 -She sometimes had constipation but did not think it was daily. -She did not know if she was ordered miralax and did not know the last time the medication was administered. -She did not recall if she got a liquid medication to drink every day. Interview with the Administrator on 04/22/22 at 4:30pm revealed: -If medication were not on the medication cart, the MAs should not document they administered the medication. -Each resident should have their own medication and they should not be borrowed. -She expected medications to be administered as ordered. Telephone interview with the RCC on 04/22/22 at 4:35pm revealed she was unable to explain why she documented the administration of a medication that was not available. The first shift MA was not available for interview on 04/22/22.	D 367		
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.	D 392		

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D 392	Continued From page 21 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances for 1 of 5 sampled residents (#2) who had orders for an anxiolytic and narcotic pain reliever. The findings are: a. Review of Resident #2's current FL2 dated 09/20/21 revealed there was an order for alprazolam 1mg (a controlled drug used to treat anxiety), take 1 tablet every 8 hours as needed for anxiety. Review of Resident #2's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for alprazolam 1mg give one tablet every 8 hours as needed for anxiety. -There was documentation that alprazolam 1mg was administered 27 times from 02/01/22 through 02/28/22. Review of Resident #2's March 2022 eMAR revealed: -There was an entry for alprazolam 1mg give one tablet every 8 hours as needed for anxiety. -There was documentation that alprazolam 1mg was administered 26 times from 03/01/22 through 03/31/22. Review of Resident #2's April 2022 eMAR revealed: -There was an entry for alprazolam 1mg give one tablet every 8 hours as needed for anxiety. -There was documentation that alprazolam 1mg was administered 18 times from 04/01/22 through	D 392	Type text here Communitiy implemented New Hard bound Controlled Substance log books. This page is used to record the receipt of the controlled substances for multiple residents, listing the residents name, physician prescriber, medication (dose,form,strength), the RX#, page numbers where this individual medication is recorded in the book, start date, and the signature of the Med Tech/HWD/ RCC responsible for the drug when removed from the count. HWD/RCC/Med Techs who have the responsibility to handle controlled substances have been inserviced by the HWD on proper procedures for receiving controlled substances, counting controlled sustances between shifts, and reporting any discrepancies in the narc count to the ED immediately. HWD/RCC will audit new hard bound books weekly to ensure that narcotic counts are correct.	5/27/2022

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D 392	Continued From page 22 04/21/22. Review of Resident #2's controlled substance count sheet (CSCS) for alprazolam revealed: -The starting quantity of alprazolam 1mg tablets dispensed from the pharmacy 09/28/21 was 270 tablets. -There were five CSCS pages documenting administration dates and times. -The count on the first page started on 09/28/21 with 270 tablets and ended on 10/17/21 with 241 tablets. -The count on the second page started on 11/14/21 with 203 tablets and ended on 12/17/21 with 172 tablets. -The count on the third page started on 02/12/22 with 92 tablets and ended on 03/22/22 with 55 tablets. -The count on the fourth page started on 03/23/22 with 55 tablets and ended on 03/31/22 with 47 tablets. -The count on the fifth page started on 04/02/22 with 47 tablets and ended on 04/21/22 with 26 tablets. Observation of medication on hand on 04/21/22 at 4:25pm revealed: -There was one bottle of alprazolam 1mg tablets for Resident #2. -The bottle was dated 09/27/21 with a dispensed quantity of 270 tablets. -There were 26 tablets remaining in the bottle. Telephone interview with a representative from Resident #2's pharmacy on 04/22/22 at 11:30am revealed: -Alprazolam 1mg tablets were dispensed for Resident #2 on 09/28/21 with a quantity of 270 tablets; the medication was delivered to the facility and not picked up from the pharmacy by	D 392	Community will partner with Moose Pharmacy to ensure the all medication deliveries are accounted for and received by either a Med Tech, HWD, or RCC. Moose Pharmacy understands that medications are to only be given to those individuals and not dropped of to whoever answers the door.	5/27/2022

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D 392	Continued From page 23 facility staff, the resident or her family. -Alprazolam 1mg tablets were dispensed for Resident #2 on 04/08/22 with a quantity of 90 tablets; the medication was delivered to the facility and not picked up from the pharmacy by facility staff, the resident or her family. -When pharmacy staff delivered medication to the facility, they handed the medication off to whichever staff person was at the front door. The driver from the pharmacy would then write the resident's initials on their paperwork indicating that resident's medications were delivered to staff at the facility. They did not have facility staff sign for the medication at delivery. -They had not received any alprazolam sent back to the pharmacy from the facility for Resident #2. Interview with the Resident Care Coordinator (RCC) on 04/22/22 at 10:10am revealed: -She did not know where the CSCS were for Resident #2 to account for alprazolam 1mg tablets counting down from 241 tablets to 203 tablets, or counting down from 172 to 92 tablets. -Resident #2's pharmacy dropped her medications off at the front desk rather than delivering them in a locked tote like their contracted pharmacy did, so it was hard to keep track of Resident #2's prescriptions sometimes. -Resident #2 had gone back and forth with being able to self-administer her medications and having staff administer her medications so it was possible that a medication aide (MA) could have received a package of medication for Resident #2 and gave it to the resident rather than placing it in the medication cart. -MAs on third shift were responsible for completing medication cart audits but she did not know when they had last completed an audit. -She was unaware of medication ever being returned to the pharmacy for Resident #2.	D 392		

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D 392	Continued From page 24 Interview with the Administrator on 04/22/22 at 3:20pm revealed: -She did not know where the CSCS were for Resident #2 to account for alprazolam 1mg tablets to account for tablets 241 to 203, or account for 172 tablets to 92 tablets. -Staff had tried to locate the alprazolam that had been delivered on 04/08/22 but did not find the medication. -The pharmacy was supposed to have a clinical staff person at the facility sign to accept controlled substances. -She expected staff to keep a clear record of all Resident #2's controlled substances that were received from the pharmacy or dispensed to the resident. Second interview with the RCC on 04/22/22 at 3:30pm revealed: -She did not go through the medication cart to ensure the number of tablets she was writing down on the CSCS matched the number of tablets on hand in the medication cart when transcribing information from the old CSCS to the new CSCS. -She had not thought to verify the count with the tablets in the medication cart because at every shift change the MAs counted controlled substances together. Interview with Resident #2 on 04/22/22 at 3:40pm revealed: -She had never received or signed for medications from her pharmacy at the facility's front door while they were being dropped off. -She did not keep medication in her room aside from her inhaler which she was allowed to have at her bedside.	D 392		

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D 392	Continued From page 25 Interview with a MA on 04/22/22 at 4:50pm revealed: -Resident #2's pharmacy delivered her medications at the facility's front entrance or her family member would pick up Resident #2's medications and give them to the resident to give to the MAs to place on the medication cart. -She had not returned any of Resident #2's medications to the pharmacy. -She was unaware of other staff returning any of Resident #2's medications to the pharmacy. -The MAs counted controlled substances at every shift change and the count had never been off during her shift. Review of the facility's Medication & Treatments Controlled Substances Count policy dated 4/2022 revealed: -It was facility policy for an on-coming MA and an out-going MA to count each controlled substance and verify the amount of controlled substances remaining against the amount listed on the CSCS. -The community should document on the audit form every shift and verify that all numbered pages were present in the hard bound Narcotic Log Book. -If there was a discrepancy in the count, MAs should immediately notify the nurse, ED or designee. -The completed CSCS should be filed in a secure administrative file. -The CSCS should be retained for a minimum of 2 years unless otherwise directed by the ED. Attempted telephone interview with Resident #2's primary care provider (PCP) on 04/22/22 at 10:30am was not successful. Attempted telephone interview with Resident #2	D 392		

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D 392	Continued From page 26 power of attorney (POA) on 04/22/22 at 12:15pm was not successful. b. Review of Resident #2's current FL2 dated 09/20/21 revealed there was an order for hydrocodone-acetaminophen 5-325mg (a Schedule II narcotic pain reliever) take one tablet every 8 hours as needed for pain. Review of Resident #2's February 2022 eMAR revealed: -There was an entry for hydrocodone-acetaminophen 5-325mg tablets, take one tablet every 8 hours as needed for pain. -Hydrocodone-acetaminophen was administered 5 times from 02/01/22 through 02/28/22. Review of Resident #2's March 2022 eMAR revealed: -There was an entry for hydrocodone-acetaminophen 5-325mg tablets, take one tablet every 8 hours as needed for pain. -Hydrocodone-acetaminophen was administered 3 times from 03/01/22 through 03/31/22. Review of Resident #2's April 2022 eMAR revealed: -There was an entry for hydrocodone-acetaminophen 5-325mg tablets, take one tablet every 8 hours as needed for pain. -Hydrocodone-acetaminophen was administered 2 times from 04/01/22 through 04/21/22. Review of Resident #2's CSCS for hydrocodone-acetaminophen 5-325mg revealed: -There were four CSCS pages documenting administration dates and times. -The count on the first page started on 11/14/21 with 21 tablets and ended on 03/03/22 with 3 tablets.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080014	A. BUILDING: _____ B. WING _____	R 04/22/2022

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D 392	Continued From page 27 -The count on the second page started on 04/14/22 with 3 tablets and ended on 04/17/22 with 1 tablet. -The count on the third page started on 01/08/22 with 60 tablets and ended on 03/06/22 with 54 tablets. -The count on the fourth page started with 60 tablets and had 60 tablets remaining. Observation of medication on hand on 04/21/22 at 4:25pm revealed: -Resident #2 had three medication cards with hydrocodone-acetaminophen 5-325mg tablets. -The first card was dated 10/06/21 and of 21 total tablets dispensed there was one tablet remaining. -The second two cards were dated 02/11/22 and each had 30 tablets remaining for a total of 60 tablets that were dispensed. Telephone interview with a representative from Resident #2's pharmacy on 04/22/22 at 11:30am revealed: -They had dispensed and delivered hydrocodone-acetaminophen 5-325mg tablets to the facility for Resident #2 on 01/05/22 for 60 tablets, and on 02/15/22 for 60 tablets. -When pharmacy staff delivered medication to the facility, they handed the medication off to whichever staff person was at the front door. -The driver from the pharmacy would then write the resident's initials on their paperwork indicating that resident's medications were delivered to staff at the facility and they did not have facility staff sign for the medication at delivery. -The pharmacy had not received any hydrocodone-acetaminophen sent back to the pharmacy from the facility for Resident #2. Telephone interview with a representative from the facility's contracted pharmacy on 04/22/22 at	D 392		

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D 392	Continued From page 28 9:35am revealed they had dispensed hydrocodone-acetaminophen 5-325mg tablets for Resident #2 on 10/06/21 for 21 tablets. Interview with the Resident Care Coordinator (RCC) on 04/22/22 at 10:10am revealed: -She did not know where the remaining 54 tablets of hydrocodone-acetaminophen were from the CSCS for Resident #2 that started on 01/08/22. -Resident #2 had gone back and forth with being able to self-administer her medications and having staff administer her medications so it was possible that a MA could have given Resident #2 that medication to keep in her room. -MAs on third shift were responsible for completing medication cart audits but she did not know when they had last completed an audit. -She was unaware of medication ever being returned to the pharmacy for Resident #2. Interview with the Administrator on 04/22/22 at 3:20pm revealed: -She did not know where the remaining 54 tablets of hydrocodone-acetaminophen were for Resident #2. -Staff had tried to locate the hydrocodone-acetaminophen that had been delivered on 01/05/22 but did not find the medication. -She expected staff to keep a clear record of all Resident #2's controlled substances that were received from the pharmacy or dispensed to the resident. Second interview with the RCC on 04/22/22 at 3:30pm revealed: -They had just gotten a new book to keep record of CSCS in at the beginning of April 2022. -She and the regional nurse had transcribed the information from the previous CSCS into the new	D 392		

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D 392	Continued From page 29 book, ensuring the counts on the new sheets picked up where the counts on the previous sheets left off. -They did not go through the medication cart to ensure the number of tablets they were writing down on the CSCS matched the number of tablets on hand in the medication cart. -She had not thought to verify the count with the tablets in the medication cart because at every shift change the MAs counted controlled substances together. Interview with Resident #2 on 04/22/22 at 3:40pm revealed: -She did not keep medication in her room aside from her inhaler which she was allowed to have at her bedside. -She rarely needed to take medication for pain so she would not have mistakenly taken them or needed to keep them in her room. Interview with a MA on 04/22/22 at 4:50pm revealed: -She had not returned any of Resident #2's medications to the pharmacy. -She was unaware of other staff returning any of Resident #2's medications to the pharmacy. -The MAs counted controlled substances at every shift change and the count had never been off during her shift. Review of the facility's Medication & Treatments Controlled Substances Count policy dated 4/2022 revealed: -It was facility policy for an on-coming MA and an out-going MA to count each controlled substance and verify the amount of controlled substances remaining against the amount listed on the CSCS. -The community should document on the audit	D 392		

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D 392	Continued From page 30 form every shift and verify that all numbered pages were present in the hard bound Narcotic Log Book. -If there was a discrepancy in the count, MAs should immediately notify the nurse, ED or designee. -The completed CSCS should be filed in a secure administrative file. -The CSCS should be retained for a minimum of 2 years unless otherwise directed by the ED. Attempted telephone interview with Resident #2's primary care provider (PCP) on 04/22/22 at 10:30am was not successful. Attempted telephone interview with Resident #2's power of attorney (POA) on 04/22/22 at 12:15pm was not successful.	D 392		