STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081005	A. BUILDING: _____ B. WING _____	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS SENIOR CITIZENS HOME	1881 BIG ISLAND ROAD RUTHERFORDTON, NC 28139

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 06-08-22.	D 000		
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; (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, interviews and record reviews the facility failed to ensure accurate documentation on the Medication Administration Record (MAR) for 1 of 3 sampled residents (Resident #3) related to a medication to treat depression and a shampoo to treat psoriasis. The findings are:	D 367	(A) Medication Aides for each cart will check documentation for all medication that where/are to be given as well as all shampoos, creams + lotions etc. 6/14/22 (B) Resident care director RCD & RCDA Resident care director Assistant will check MARS weekly for any possible errors/deletions 6/14/22 (C) RCD + RCDA will check old versus new MARS for any errors +/or deletions 6/14/22 (D) Medication Aides will check each shift to make sure all necessary medication, creams, lotions, shampoos, etc are in stock 6/14/22 (E) RCD + RCDA will then recheck daily that all necessary medication, creams, lotions, shampoo, etc are in stock 6/14/22	

Reviewed and acknowledged LSB 06-22-2022

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D 367	Continued From page 1 1. Review of Resident #3's current FL2 dated 03/22/22 revealed: -Diagnoses included mental retardation, depression and psoriasis. -There was an order for seroquel (used to treat depression) 100mg each evening. Review of Resident #3's April 2022 MAR revealed: -There was an entry for seroquel 100mg at 8pm. -There was no documentation seroquel 100mg was administered from 04/01/22 through 04/30/22. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/08/22 at 1:16pm revealed: -Resident #3's Seroquel 100mg was delivered to the facility every 2 weeks as part of a routine cycle fill. -Fourteen seroquel 100 mg tablets, in cassettes, were delivered to the facility on 03/31/22, 04/14/22 and 04/28/22. -Medications were delivered in cassettes and when new deliveries were made, previously delivered cassettes that had been used were collected and returned to the pharmacy. -There was no record any of Resident #3's seroquel 100mg tablets were returned to the pharmacy. Observation of Resident #3's medications on hand on 06/08/22 at 1:05pm revealed there was a medication cassette containing seroquel 100mg tablets. Interview with the Resident Care Coordinator (RCC) on 06/08/22 at 2:00pm revealed: -Medications were delivered from the pharmacy every 2 weeks.	D 367	(F) Verbal orders will be transcribed immediately + copies will be placed not only in to Sign box for PCP [redacted] but in Resident Chart + Resident MAR (G) Said Verbal Orders will also be monitored by RCC + RCDA multiple times weekly for Sig, transcription, the Δ or D/C was completed. (H) is includes in (G) RCC + RCDA will check O/D versus new MARs for any changes, verbal orders, deletions or misalignment of printing Admin times (I) Wizard Shampoo has since been D/C	6/14/22 6/14/22 6/14/22 6/21/22

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D 367	Continued From page 2 -Second shift Medication Aides (MAs) were responsible for removing empty medication cassettes and putting the newly delivered medication cassettes into the medication cart. -All empty cassettes were returned to the pharmacy and someone from the pharmacy would call the facility if a medication was still in a cassette. -She was responsible for conducting monthly MAR audits. -She must have missed the error when she conducted the April 2022 audit. Interview with a MA on 06/08/22 at 2:51pm revealed: -She worked in the evening and was responsible for administering Resident #3's seroquel. -She always administered Resident #3's seroquel and did not know why she did not document the administration on the April 2022 MAR. -Second shift was responsible for putting all newly delivered medications into the medication cart every 2 weeks. -She did not ever remember a time that Resident #3's seroquel was not delivered from the pharmacy. -The RCC was responsible for conducting monthly MAR audits. -The RCC brought any administration discrepancies to her attention when they were discovered on the MAR audit. -She did not know how she, the RCC and the other 2nd shift MA all missed the discrepancy when the April 2022 MAR audit was conducted. Interview with the Administrator on 06/08/22 at 2:00pm revealed: -The RCC was responsible for conducting monthly MAR audits. -He was unaware of any documentation errors on	D 367	Key RCD - Resident Care Director RCDA - Resident Care Director Assistant A - Change D/C - discontinued MAR - Medication Administration Record PCP - primary care Provider [redacted]	6/14/22

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D 367	Continued From page 3 Resident #3's April 2022 MAR. -All MAs were trained to document on the MAR when medications were administered. 2. Review of Resident #3's current FL2 dated 03/22/22 revealed: -Diagnoses included mental retardation, depression and psoriasis. -There was an order for Nizoral 2% shampoo to be used to wash scalp twice a week. Review of Resident #3's April 2022 MAR revealed: -There was an entry for Nizoral 2% shampoo (used to treat psoriasis) to be used to wash scalp twice a week. -Nizoral 2% shampoo was documented as administered on 04/01/22, 04/05/22, 04/08/22, 04/12/22, 04/15/22, 04/19/22, 04/22/22, 04/26/22 and 04/29/22. Review of Resident #3's May 2022 MAR revealed: -There was an entry for Nizoral 2% shampoo to be used to wash scalp twice a week. -Nizoral 2% shampoo was documented as administered on 05/03/22, 05/06/22, 05/10/22, 05/13/22, 05/17/22, 05/20/22, 05/24/22 and 05/27/22 Review of Resident #3's June 2022 MAR revealed: -There was an entry for Nizoral 2% shampoo to be used to wash scalp twice a week. -Nizoral 2% shampoo was documented as administered on 06/03/22 and 06/07/22. Observation of Resident #3's medications on hand on 06/08/22 at 1:05pm revealed Nizoral 2% shampoo was not available.	D 367	In Sweation all Aspects of Medication Administration for dispensing, Orders, documentation, Supply etc. will be more closely monitored by all Med Aides per shift... RCD, RCDA, ... per shift, daily, weekly, bi-weekly, + monthly in order that no such errors occur again. Administration	6/22/22

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D 367	Continued From page 4 Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/08/22 at 1:16pm revealed: -A bottle of Nizoral 2% shampoo was last delivered to the facility in March 2020. -A request to refill Nizoral 2% shampoo was received from the facility earlier today (06/08/22). Interview with the Resident Care Coordinator (RCC) on 06/08/22 at 2:00pm revealed: -Resident #3 had her hair washed 2 times a week in the morning. -Staff at the facility had not used the Nizoral 2% shampoo for many months because they discovered regular shampoo and vinegar worked better to control Resident #3's psoriasis. -The Primary Care Provider (PCP) was aware the Nizoral 2% shampoo was not being used. -She should have had the PCP change the order from Nizoral 2% shampoo to shampoo with vinegar. -She did not know why she continued to document administration of Nizoral 2% shampoo when she knew it was not being used. Interview with the Administrator on 06/08/22 at 2:00pm revealed: -Nizoral 2% shampoo was not being used to wash Resident #3's hair. -The PCP was aware Resident #3's hair was being washed with vinegar and regular shampoo. -He thought the facilty received an order to discontinue the Nizoral 2% shampoo. -Staff should not have continued to document the use of Nizoral 2% shampoo. Telephone interview with Resident #3's PCP on 06/08/22 at 2:27pm revealed: -Resident #3 had psoriasis and needed special	D 367		

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D 367	Continued From page 5 treatment to keep her scalp clear. -She was aware the facility was washing Resident #3's hair with vinegar and regular shampoo because that treatment worked best. -She remembered giving the facility a verbal order in late 2020 to discontinue using the Nizoral 2% shampoo. -She did not remember signing the verbal order the next time she came to the facility and did not know why the order was not transcribed.	D 367		