

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2022
NAME OF PROVIDER OR SUPPLIER DUNMORE PLANTATION		STREET ADDRESS, CITY, STATE, ZIP CODE 515 W. KAPP STREET DOBSON, NC 27017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from May 18, 2022 to May 20, 2022.	D 000		
D 311	10A NCAC 13F .0904(f)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (1) Sufficient staff shall be available for individual feeding assistance as needed. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure there was sufficient staff available to provide feeding assistance for 4 of 5 sampled residents (#1, #8, #10 and #11) resulting in staff feeding two residents at the same time. The findings are: Observation of the lunch meal on 05/19/22 from 12:24pm to 12:48pm revealed: -The residents from the Memory Care Unit (MCU) ate in the main dining room after the Assisted Living (AL) residents ate. -There were three staff from the MCU in the dining room with the residents. -There were round tables in the dining room; most tables had four residents seated at them. -Two of the tables had four residents and one personal care aide (PCA) seated at them. -Two of the PCAs were seated between two residents each. -Each PCA was feeding two residents; one on each side.	D 311	Additional staff available during meal service. Trained & checked off by LHPS nurse for individual feeding assistance as needed. Informed additional staff assigned to feeding assistance of meal times and duties. Dietary Aides informed of regulations, duties, trained & checked off by LHPS nurse for feeding techniques/assistance with returned demonstration.	05/24/2022 06/16/2022

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Shannon Hardy
STATE FORM

Administrator in Charge

06/29/2022

6899

S09V11

If continuation sheet 1 of 48

Reviewed and acknowledged on 07/01/22

Janet Thornburg JT

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D 311	Continued From page 1 -One PCA sat between Resident #1 and Resident #11. -A second PCA sat between Resident #8 and Resident #10. 1. Review of Resident #1's current FL-2 dated 12/16/21 revealed: -Diagnoses included vascular dementia, altered mental status and gastroesophageal reflux disease (GERD). -Resident #1 was ordered pureed diet and thickened liquids. Review of a signed physicians order for Resident #1 dated 03/07/22 revealed an order for nectar thickened liquids. Review of Resident #1's current care plan dated 03/10/22 revealed: -Resident #1 required extensive assistance with eating. -Resident #1 required a wheelchair and a lap buddy. Review of visitation note from Resident #1's primary care provider (PCP) dated 02/11/22 revealed Resident #1 was not speaking. Observation of the lunch meal on 05/19/22 from 12:24pm to 12:48pm revealed: -Resident #1 was seated at on side of a PCA and another resident was on the other side of the PCA. -Each resident had a plate of food in front of them. -The PCA wore gloves and alternated feeding Resident #1 and the other resident. -The PCA alternated offering beverages to each resident after each resident took a couple of bites of food.	D 311		

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D 311	Continued From page 2 -The second resident left the dining room before finishing her meal. -Resident #1 ate approximately 50 percent of her meal. Refer to the telephone interview with the Licensed Health Care Skills (LHPS) Nurse on 05/19/22 at 4:13pm. Refer to interview with a PCA on 05/19/22 at 12:53pm. Refer to interview with a medication aide (MA) on 05/19/22 at 3:00pm. Refer to interview with the Memory Care Coordinator (MCC) on 05/19/22 at 3:18pm revealed: Refer to the interview with the Administrator in Charge (AIC) on 05/19/22 at 3:31pm. Based on observations, record reviews and interviews it was determined Resident #1 was not interviewable. 2. Review of Resident #8's current FL-2 dated 11/16/21 revealed: -Diagnoses included Alzheimer's dementia and type two diabetes. -Resident #8 was ordered a pureed diet and thin liquids served in coffee cups. Review of #8's current care plan dated 07/05/21 revealed she required limited assistance with eating. Review of a physician's visit report dated 10/13/20 revealed Resident #8 was feeding herself the year before but could not continue to	D 311		

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D 311	Continued From page 3 feed herself. Observation of the lunch meal on 05/19/22 from 12:24pm to 12:48pm revealed: -Resident #8 sat next to a personal care aide (PCA) the PCA had another resident on the opposite side. -The PCA assisted Resident #8 with eating by feeding her bites of food and encouraging her to drink her beverages. -Resident #8 picked up her spoon and took bites herself and the PCA fed her bites of food as well. -The PCA was feeding another resident on her other side in between feeding and encouraging Resident #8 to eat. -Resident #8 ate approximately 50 percent of her meal. Refer to the telephone interview with the Licensed Health Care Skills (LHPS) Nurse on 05/19/22 at 4:13pm. Refer to interview with a PCA on 05/19/22 at 12:53pm. Refer to interview with a medication aide (MA) on 05/19/22 at 3:00pm. Refer to interview with the Memory Care Coordinator (MCC) on 05/19/22 at 3:18pm revealed: Refer to the interview with the Administrator in Charge (AIC) on 05/19/22 at 3:31pm. Based on observations, record reviews and interviews it was determined Resident #8 was not interviewable. 3. Review of Resident #10's current FL-2 dated	D 311		

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D 311	Continued From page 4 09/22/21 revealed: -Diagnoses included dementia, Parkinson's disease and a history of pneumonia. -Resident #10 was ordered a pureed diet and nectar thickened liquids. Review of Resident #10's current care plan dated 09/22/21 revealed she required total assistance with eating. Review of Resident #10's Licensed Health Care Skills (LHPS) report dated 04/06/22 revealed she needed to be fed by staff with meals and snacks. Observation of the lunch meal on 05/19/22 from 12:24pm to 12:48pm revealed: -Resident #10 sat beside a personal care aide (PCA); there was another resident on the other side of the PCA. -The PCA fed Resident #10 bites of her meal; the PCA also prompted and fed the resident on the other side of her in between feeding Resident #10 bites of her food. -Resident #10 waited for the PCA to feed her bites of food while the PCA prompted and fed the other resident. -The PCA assisted Resident #10 with her beverages in between bites of food. -The PCA turned her head away from Resident #10 as she assisted and prompted the other resident. -Resident #10 ate approximately 80 percent of her meal. Refer to the telephone interview with the LHPS Nurse on 05/19/22 at 4:13pm. Refer to interview with a PCA on 05/19/22 at 12:53pm.	D 311		

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D 311	Continued From page 5 Refer to interview with a medication aide (MA) on 05/19/22 at 3:00pm. Refer to interview with the Memory Care Coordinator (MCC) on 05/19/22 at 3:18pm revealed: Refer to the interview with the Administrator in Charge (AIC) on 05/19/22 at 3:31pm. Based on observations, record reviews and interviews it was determined Resident #10 was not interviewable. 4. Review of Resident #11's current FL-2 dated 07/06/21 revealed: -Diagnoses included dementia, type two diabetes and Parkinson's disease. -Resident #11 was ordered a pureed diet. Review of Resident #11's Licensed Health Care Skills (LHPS) report dated 03/11/22 revealed she needed prompting and assistance from staff with eating. Observation of the lunch meal on 05/19/22 from 12:24pm to 12:48pm revealed: -Resident #11 was seated beside a personal care aide (PCA). -The PCA was feeding a resident on one side and Resident #11 was on the other. -The PCA would turn her head to the second resident while Resident #11 chewed her food. -Resident #11 picked up her spoon several times but did not appear to know what to do with it. -Resident #1 was prompted to drink her beverages by the PCA; the PCA would then turn her head while Resident #11 drank her beverage. -Resident #11 got up left the table around 11:32pm; she ate less than 50 percent of her	D 311		

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D 311	Continued From page 6 meal. Refer to the telephone interview with the LHPS Nurse on 05/19/22 at 4:13pm. Refer to interview with a PCA on 05/19/22 at 12:53pm. Refer to interview with a medication aide (MA) on 05/19/22 at 3:00pm. Refer to interview with the Memory Care Coordinator (MCC) on 05/19/22 at 3:18pm revealed: Refer to the interview with the Administrator in Charge (AIC) on 05/19/22 at 3:31pm. Based on observations, record reviews and interviews it was determined Resident #11 was not interviewable. Telephone interview with the Licensed Health Care Skills (LHPS) Nurse on 05/19/22 at 4:13pm revealed: -She did not train staff on feeding techniques; all skills training should have been complete prior to her doing the skills check off list. -She trained staff on how a pureed meal should look and how a thickened beverage should look. -She had staff demonstrate feeding techniques one on one with each other. -She checked staff for competency and then checked them off on the skills check list. -If staff were unable to demonstrate feeding skills, she would refer them back to the facility for more training. -She did not know if the facility fed or assisted more than one resident at a time with feeding.	D 311		

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D 311	Continued From page 7 Interview with a personal care aide (PCA) on 05/19/22 at 12:53pm revealed: -The PCAs were not assigned to feed certain residents; they just sat with the resident and began to assist them with eating. -Sometimes she fed two residents at a time. -She fed one resident at a time a couple of times a week, but most times she fed two residents at a time. -She was trained by a medication aide (MA) on feeding techniques. -She observed the MA feed residents and then she was observed feeding a resident by the MA. -It was the same training for feeding two residents as it was to feed two residents except, she was trained to alternate between residents when feeding two residents at the same time. Interview with a medication aide (MA) on 05/19/22 at 3:00pm revealed: -She was trained on feeding techniques upon hire by a PCA who had worked at the facility for a number of years. -She had been trained to feed two residents at a time by the PCA. -There were four residents who had orders for feeding assistance and one resident who needed prompting when eating and sometimes needed to be fed. -There were only three staff from the Memory Care Unit (MCU) available in the dining room to assist the residents with eating, so two residents had to be fed at the same time. -It took about the same time to feed two residents as it did one. -Staff had been feeding two residents at a time since she started working at the facility two years ago. -No one had told her not to feed two residents at the same time.	D 311		

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D 311	Continued From page 8 -She trained PCAs to feed residents and she trained them the same way she was trained. Interview with the Memory Care Coordinator (MCC) on 05/19/22 at 3:18pm revealed: -The PCAs and MAs were trained on feeding assistance and feeding techniques during their orientation. -She conducted the orientation for the MCU. -The staff were trained to feed two residents at a time by sitting in between the two residents. -Staff were trained not to feed the same residents with the same hand but to use a different hand for each resident when feeding two residents at the same time. -There were four residents on the MCU with orders for feeding assistance. -There was a fifth resident that could feed herself but just needed to be encouraged and prompted to eat because she would just sit or lay her head on the table. -She was not aware residents should have been individually fed or individually assisted with feeding. Interview with the Administrator in Charge (AIC) on 05/19/22 at 3:31pm revealed: -The staff received basic skills training from the MCC at their new hire orientation training. -The LHPS nurse did the feeding techniques training and competency and then validated the skills after the training. -The residents who were assisted with feeding or were fed during meals were at risk of aspiration or could not feed themselves. -Feeding or assisting two residents at a time was not permitted because it was not sanitary and chewing and swallowing could not be observed. -Any residents that required feeding assistance were to be fed one on one in the dining room	D 311		

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D 344	Continued From page 10 multiple falls, and seizures. The findings are: Review of Resident #3's FL-2 dated 03/18/22 revealed: -Diagnoses included seizures, hypothyroidism, right leg lymphedema, ventriculoperitoneal shunt; a device that drains excess cerebrospinal fluid (VPS), mild mental retardation, history of hydrocephalus, gastro-esophageal reflux disease (GERD) and acute kidney infection (AKI). -He was intermittently disoriented. -He was semi-ambulatory with the assistance of a rollator. -He was incontinent of bowels and bladder at times. -He had a history of seizures. -There was an order for levothyroxine (Levothyroxine was used to treat an underactive thyroid gland) 88mcg daily. Review of Resident #3's physician's order dated 05/01/21 revealed: -There was an order to discontinue levothyroxine 112mcg. -There was an order to administer levothyroxine 100mcg daily. Review of Resident #3's laboratory results dated 05/11/21 revealed his thyroid stimulating hormone (TSH) level was 0.151; the normal range was 0.450 - 5.330. Review of Resident #3's laboratory results dated 07/02/21 revealed his TSH level was 0.726. Review of Resident #3's laboratory results dated 12/17/21 revealed his TSH level was 0.407.	D 344		

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D 344	Continued From page 11 Review of Resident #3's physician's order dated 12/19/21 revealed: -There was an order to discontinue levothyroxine 100mcg. -There was an order to administer levothyroxine 88mcg daily. Review of Resident #3's FL-2 dated 01/25/22 revealed: -Diagnoses included seizures, VPS, mild mental retardation, hypothyroidism, GERD, history of hydrocephalus and AKI. -There was no order for levothyroxine 88mcg daily. -He was ambulatory with assistance of rollator. Review of Resident #3's January 2022 medication administration recorded (MAR) revealed: -There was an entry for levothyroxine 88mcg daily to be administered at 6:00am. -There was documentation levothyroxine 88mcg was administered daily from 01/01/22 to 01/31/22. Review of Resident #3's February 2022 MAR revealed: -There was an entry for levothyroxine 88mcg daily to be administered at 6:00am. -There was documentation levothyroxine was administered daily from 02/01/22 to 02/28/22. Review of Resident #3's laboratory results dated 02/01/22 revealed his TSH level was 1.759. Review of Resident #3's March 2022 MAR revealed: -There was a handwritten entry on 03/15/22 for levothyroxine 88mcg daily to be administered at 6:00am.	D 344		

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D 344	Continued From page 12 -There was documentation that levothyroxine was administered daily from 03/16/22 to 03/31/22. -There was no documentation that levothyroxine was administered daily from 03/01/22 to 03/15/22. Review of Resident #3's April 2022 MAR revealed: -There was an entry for levothyroxine 88mcg daily to be administered at 6:00am. -There was documentation that levothyroxine was administered daily from 04/01/22 to 04/30/22. Review of Resident #3's May 2022 MAR revealed: -There was an entry for levothyroxine 88mcg daily to be administered at 6:00am. -There was documentation that levothyroxine was administered daily from 05/01/22 to 05/18/22. Observation of Resident #3's medications on hand on 05/18/22 revealed: -There was a medication cassette dispensed on 05/03/22 with 9 tablets of levothyroxine 88mcg. -The medication cassette contained 2 of 9 levothyroxine tablets. Telephone interview with a representative for the facility's contracted pharmacy on 05/18/22 at 4:05pm revealed: -The pharmacy accepted the physician signed FL-2s as current orders. -The pharmacy received Resident #3's FL-2 dated 01/25/22 by fax on 01/26/22. -Levothyroxine 88mcg was not listed on the FL-2 dated 01/25/22. -The pharmacy assumed the levothyroxine was discontinued since it was not listed on the FL-2 dated 01/25/22. -The pharmacy discontinued levothyroxine on	D 344		

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D 344	Continued From page 13 Resident #3's profile. -Resident #3 had been on levothyroxine 88mcg in January 2022. -Levothyroxine was entered on the February 2022 MAR since the MARS for February 2022 were printed before the FL-2 dated 01/25/22 arrived in the pharmacy. -The pharmacy dispensed 14 tablets of levothyroxine 88mcg on 01/11/22 and 01/25/22. -The pharmacy did not dispense levothyroxine in February 2022. -The pharmacy was not contacted by the facility staff to inquire about levothyroxine not being dispensed in February 2022. -There was an order from Resident #3's (Primary Care Provider) PCP for levothyroxine 88mcg daily dated 03/15/22. -The pharmacy dispensed 14 levothyroxine 88mcg on 03/15/22, 03/22/22, 04/05/22, 04/19/22, 05/03/22, and 05/17/22. -The pharmacy did not contact the facility to verify levothyroxine was discontinued; they assumed the medication was discontinued since it was not on the FL-2 dated 01/25/22. Review of the facility's contracted pharmacy's packing slips revealed: -The facility received 14 tablets of levothyroxine 88mcg on 01/11/22, 01/25/22 and 03/22/22. -The facility did not receive levothyroxine 88mcg on 02/08/22, 02/22/22 and 03/08/22. Review of Resident #3's incident report dated 03/07/22 revealed: -He had fallen while walking through a doorway; no injuries were noted. -He was placed on 30-minute checks for 24 hours. Review of Resident #3's fall risk assessment	D 344		

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D 344	Continued From page 14 dated 03/07/22 revealed: -He was alert and oriented times three. -He had 1-2 falls in the past three months. -He was ambulatory with the assistance of a rollator. -He was incontinent of bowel and bladder at times. -He had a balance problem when standing and walking. -He had a change in gait when walking through a doorway. -He had no predisposing disease such as seizures. -His total score for a falls risk was 15. (a score of 10 or more indicated high risk for falls.) Review of Resident #3's incident report dated 03/09/22 revealed: -He was observed lying on the floor; no injuries were noted. -He was placed on 30 minutes checks for 24 hours. Review of Resident #3's fall risk assessment dated 03/09/22 revealed: -He was intermittently confused. -He had 1-2 falls in the past three months. -He was ambulatory with the assistance of a rollator. -He was incontinent of bowels and bladder at times. -He had a balance problem when standing and walking. -He had a change in gait when walking through a doorway. -He had no predisposing disease such as seizures. -His total score for falls risk was 15. Review of Resident #3's incident report dated	D 344		

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NAME OF PROVIDER OR SUPPLIER DUNMORE PLANTATION		STREET ADDRESS, CITY, STATE, ZIP CODE 515 W. KAPP STREET DOBSON, NC 27017		
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D 344	Continued From page 15 03/10/22 revealed: -Resident #3 had fallen while walking in the bathroom. -Resident #3 hit his head causing an abrasion. -Resident #3 was sent to the Emergency Department (ED) for an evaluation. Review of the Emergency Medical Services (EMS) report dated 03/10/22 revealed: -EMS arrived at the facility at 8:16am on 03/10/22. -Upon arrival Resident #3 was in bed, alert and oriented. -Resident #3 was noted to have a laceration to his head. -Staff verbalized Resident #3 had experienced multiple falls over the past 2 - 3 days. Review of the ED report for Resident #3 dated 03/11/22 revealed: -Resident #3 was seen for a laceration of the scalp that required staples. -Staples were to be removed in 7 to 10 days. -Resident #3 was discharged back to the facility. Review of Resident #3's fall risk assessment dated 03/11/22 revealed: -He was intermittently confused. -He had 3 or more falls in the past three months. -He was ambulatory with the assistance of a rollator. -He was incontinent of bowels and bladder at times. -He had a balance problem when standing and walking. -He had a change in gait when walking through a doorway. -He was jerking or unstable when making turns. -He had no predisposing disease such as seizures.	D 344		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2022
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D 344	Continued From page 16 -His total score for falls risk was 22. (a score of 10 or more indicates high risk for falls.) Review of Resident #3's progress note dated 03/11/22 revealed: -He had a fall on 03/10/22 causing a head laceration. -The PCP ordered labs to be drawn on 03/12/22 and to schedule a neurology appointment. Review of labs drawn on 03/12/22 revealed: -There were no significant findings noted. -There was no indication that blood was drawn for a TSH level. Review of Resident #3's progress note dated 03/13/22 revealed: -He was confused the morning of 03/13/22. -He had a seizure that lasted about 4 minutes. -EMS was called, and he was transported to the local hospital. Review of Resident #3's EMS report dated 03/13/22 at 8:10am revealed: -He was received lying on his side in his bed. -Staff verbalized Resident #3 had not been "acting right" for the past several weeks; he had a seizure earlier this morning that lasted less than 5 minutes. -He was alert, oriented, and in no distress; he was transferred to the ED. Interview with a medication aide (MA) on 05/20/22 at 8:20am revealed: -Resident #3 was transported to the ED on the morning of 03/13/22; he was jerking, his eyes rolled back, he became disoriented and incontinent of urine. -She went to the hospital to pick Resident #3 up to transport back to the facility.	D 344		

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D 344	Continued From page 17 -Resident #3 became limp, started shaking and rolled his eyes back when he was being placed in the vehicle. -The ED staff returned him to the ED. -After reassessing, Resident #3 was discharged back to the facility. -Resident #3 was found seated on the floor against the bed on 03/13/22 after returning from the ED. -Resident #3 was alert and talkative; he verbalized he had a seizure. -She and a personal care aide (PCA) assisted Resident #3 from the floor to the bed. -Resident #3 began shaking, rolled his eyes back and became unresponsive again; he was unresponsive for about 1 to 2 minutes. -The MA telephoned the PCP on call and was instructed to transfer Resident #3 to a larger medical center. -EMS was called, and he was transported. Interview with a PCA on 05/20/22 at 8:15am revealed: -She assisted the MA in helping get Resident #3 off the floor and onto his bed on 03/13/22. -Resident #3 was not talking at first, but after a few minutes, he became alert and started talking. -The MA called EMS to transport Resident #3 to the hospital. Review of Resident #3's hospital ED report dated 03/13/22 revealed: -EMS reported he had a seizure that lasted about 4 minutes the morning of 03/13/22. -He complained of not feeling well. -He was alert and in no acute distress. -He was oriented to self, where he lived, and the month of the year; his speech was clear and he followed commands. -He was discharged back to the facility; during	D 344		

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D 344	Continued From page 18 transport from the waiting room to the car, he had a brief seizure. -He was returned to the ED and re-evaluated where he was given ativan (used to treat continuous seizures) and observed. -He was discharged back to the facility once he was back to baseline. Review of Resident #3's second progress note dated 03/13/22 revealed: -He returned from the morning ED visit on 03/13/22. -He was non-ambulatory, incontinent of urine, and disoriented. -He had a total of three seizures on the morning of 03/13/22. -The on-call physician requested Resident #3 be sent to a larger medical center. Review of Resident #3's private medical transport report dated 03/13/22 revealed: -Medical transport arrived at the facility at 2:14pm. -Staff reported Resident #3 was not himself and had 3 previous seizures today. -He fell to the floor as the transport team entered his room with a seizure. -He was placed on his side while on the floor. -The county EMS was notified for transport to the hospital ED; the private medical transport could not transport Resident #3 due to resident status. Review of Resident #3's EMS report dated 03/13/22 revealed: -EMS arrived at the facility at 2:38pm. -Resident #3 was alert and oriented times three. -Staff reported Resident #3 had four seizures this morning. -His PCP wanted him transferred to a larger medical center.	D 344			

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D 344	Continued From page 19 Review of Resident #3's ED neurology report dated 03/13/22 revealed: -Resident #3 was evaluated because of increased seizures. -Facility staff reported Resident #3 had increased confusion and increased seizure frequency over the past three weeks. -On 03/13/22, Resident #3 was assisted into bed, had seizure-like activity, and fell. -Resident #3 stated he did not feel well and was tired. -Resident #3 was admitted to the hospital for further evaluation. Review of Resident #3's neurology hospital course summary report dated 03/14/22 revealed: -He had a history of congenital hydrocephalus, bilateral VPS placement, and hypothyroidism. -He had an increase in seizure frequency and falls over the past month; both had worsened over the past week. -He was administered Keppra (used to treat seizures) and Vimpat (used to treat tonic-clonic seizures) on arrival to the ED. -He had undetectable free T4 and a TSH of 130; normal range free T4 was .06-1.3NG/DL and normal range for TSH was 0.450 - 5.330UIU/ML -The Neurologist was concerned that the seizures were caused by untreated hypothyroidism. -He was previously treated for hypothyroidism with levothyroxine, but the medication was stopped several months ago. -The facility described increased fatigue since levothyroxine was stopped. -The facility reported he began having falls and seizures shortly after stopping his levothyroxine. -Treatment for hypothyroidism of levothyroxine 88mcg was resumed.	D 344		

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D 344	Continued From page 20 Review of Resident #3's Endocrinology Consultant note dated 03/14/22 revealed: -He was alert and oriented to time, place, and person. -He had been on levothyroxine for acquired primary hypothyroidism for several years. -His levothyroxine was discontinued over a month ago for unknown reasons. -Review of his free T4 was <0.6; normal range was 0.6 - 1.3. Review of Resident #3's hospital discharge summary dated 03/15/22 revealed: -Resident #3 was admitted to the hospital on 03/13/22 for seizures and increased falls; the resident was discharged from the hospital to the facility on 03/15/22. -The discharge diagnoses were breakthrough seizures and hypothyroidism. -Resident #3 presented with increased seizure activity described as full body stiffening and eye deviation, increased somnolence, and increased falls with unsteadiness for several months; before this incident; he had been seizure free for several years. -Routine lab findings revealed an abnormal TSH on 03/13/22 of 130.45 and an abnormal free T4 on 03/14/22 of <0.6. -Facility staff reported that Resident #3's levothyroxine was discontinued several months ago but was unclear why levothyroxine was discontinued. -Endocrinology was consulted and Resident #3 was restarted on levothyroxine 88mcg daily. -The etiology of the increased falls and increased somnolence was likely untreated hypothyroidism; this could also play a role in Resident #3's breakthrough seizures. -Resident #3 did not have any seizures during hospital stay.	D 344		

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D 344	Continued From page 21 -Resident #3 was to follow up with his PCP on 03/18/22. Review of Resident #3's laboratory results drawn on 04/29/22 revealed: -Resident #3's TSH level was 4.67. -Resident #3's free T4 level was <0.6. (normal range was 0.6-1.3 NG/DL) Interview with Resident #3 on 05/18/22 at 3:43pm revealed: -He did not know what medications he was administered. -He did not know why he was administered the medications. -He had several falls "a while back." -He went to the ED to get staples in his head recently. -He had a seizure and had to go to the hospital for a few days. -He had not had a seizure since he returned from the hospital. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/19/22 at 10:53am revealed: -Levothyroxine was used as replacement therapy when the thyroid did not produce enough TSH. -As people age, their thyroid could stop producing TSH. -A person's metabolism could slow down, they could have an increase in fatigue, become constipated, and have a sensitivity to cold. Interview with Resident #3's PCP on 05/19/22 at 11:58am revealed -Resident #3's TSH was normal the first of February 2022. -Resident #3's TSH was greater than 130 when he was in the hospital on 03/15/22.	D 344		

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D 344	Continued From page 22 -She was not aware the levothyroxine was not on the FL-2 she signed on 01/25/22. -She was not contacted by the pharmacy to see if the medication was discontinued. -She was not contacted by the facility staff to see why the medication was not on the FL-2 dated 01/25/22. -Elevated TSH levels could cause elevated blood pressure, constipation, dry skin and the inability to concentrate. -She expected the pharmacy or facility staff to notify her if they noticed a discrepancy. Interview with the RCC on 05/18/22 at 3:15pm revealed: -The staff reported Resident #3 was found on the floor on 03/13/22 having seizure-like activity. Resident #3 was transported to the ED where he was admitted to the hospital. -She received a call from the hospital requesting if Resident #3 was taking medication for hypothyroidism; Resident #3's TSH level was low. -She reported Resident #3 was taking levothyroxine 88mcg daily. -She re-checked the FL-2 dated 1/25/22 and realized levothyroxine was not listed as a current medication. -She telephoned the pharmacy to see if they had an active order for levothyroxine for Resident #3; the pharmacy did not have an active order for levothyroxine. -She telephoned the PCP and informed her that the levothyroxine was not listed on the FL-2 dated 01/25/22; she did not know how long Resident #3 had been without the levothyroxine. -When a FL-2 was received from a PCP office, she would review and fax the FL-2 to the pharmacy. -She did not remember the date the FL-2 was faxed to the pharmacy.	D 344	Reviewed rule area and current facility policy & procedures with appropriate staff. Revised Facility "Medication Observation" form, reviewed/trained appropriate staff, RCC and UCC conducted Med Admin observation with current Med Aides by 06/30/2022 & per facility policy & procedure. Add Facility Admin & Admin in Charge conducted observation, oversight and training of Medication Trade out process, which medications, prescriptions, non-prescription & treatments were received, reviewed against current MAR's & orders. Proper clarifications completed prior to placement on secure medication carts for administration. Periodic trade out observations will be conducted per facility policy & procedure.	06/30/2022 06/02/2022

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D 344	Continued From page 23 -The pharmacy accepted signed FL-2s as orders. -The pharmacy did not contact the facility regarding the levothyroxine, why it was not on the FL-2 or requested a discontinue order. Review of the request form faxed to Resident #3's PCP revealed: -The request form was completed by the Resident Care Coordinator (RCC) on 03/15/22. -The reason for the request was Resident #3's levothyroxine 88mcg was not listed on the FL-2 dated 01/25/22. -The FL-2 dated 01/25/22 was faxed to the facility's contracted pharmacy; the pharmacy discontinued levothyroxine since it was not listed on the FL-2 as a current medication. Review of the returned request form for Resident #3 dated 03/15/22 revealed the PCP ordered for levothyroxine 88mcg daily to be resumed. Interview with the RCC on 05/19/22 at 9:02am revealed: -The pharmacy sent the MARs for the upcoming month the last week of the current month. -She would compare the MARs for the upcoming month with the current MARs. -She would look for inaccuracies on the MARs. -She did not notice the levothyroxine 88mcg was not on the March 2022 MAR. Interview with the RCC on 05/19/22 at 10:40am revealed: -She would compare the FL-2 with the MAR; she did not compare the FL-2 dated 01/25/22 with the MAR. -She would notify the PCP when she noticed something different on the MAR; she would call the PCP and resolve the issue the same day.	D 344		

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D 344	Continued From page 24 Interview with the Administrator on 05/19/22 at 2:23pm revealed: -She expected the RCC to compare the new FL-2 against the MARs. -The RCC should clarify orders when there was a discrepancy. -The pharmacy would place a 15 tablets of levothyroxine 88mcg in the medication cassette; it would be administered if needed. -The pharmacy would send two weeks of levothyroxine 88mcg at a time plus 1 extra. Based on interviews, record reviews and review of Resident #3's MARs it was revealed: -Levothyroxine 88mcg was not listed on the FL-2 dated 01/25/22. -The FL-2 was received by the pharmacy on 01/26/22. -The pharmacy dispensed 14 tablets levothyroxine on 01/25/22. -The pharmacy did not dispense any levothyroxine in February 2022 through 03/14/22. -There was no levothyroxine available for administration to from 02/12/22 to 03/15/22. -Resident #3 had multiple falls, one fall causing a laceration to his head requiring staples between 03/07/22 to 03/13/22. -He had multiple seizures requiring ED visits with one hospitalization between 03/07/22 to 03/13/22. The facility failed to ensure clarification of thyroid medication orders for 1 of 5 residents sampled (#3), who had been receiving levothyroxine for hypothyroidism for years, resulting in levothyroxine being omitted from the FL-2 dated 01/25/22 and Resident #3 not receiving levothyroxine for 30 days from 02/11/22 to 03/13/22. Resident #3 had an increase in seizure activity, falls, and disorientation during this period of time resulting in a fall that required staples to a	D 344	Reviewed rule area and current facility policy & procedures with appropriate staff. Revised Facility "Medication Observation" form, reviewed/trained appropriate staff, RCC and UCC conducted Med Admin observation with current Med Aides by 06/30/2022 & per facility policy & procedure. Facility Admin & Admin in Charge conducted observation, oversight and training of Medication Trade out process, which medications, prescriptions, non-prescription & treatments were received, reviewed against current MAR's & orders. Proper clarifications completed prior to placement on secure medication carts for administration. Periodic trade out observations will be conducted per facility policy & procedure.	06/30/2022 06/02/2022

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STATE FORM

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D 358	Continued From page 26 review including errors with administering sliding scale insulin (SSI). The findings are: 1. Review of Resident #2's current FL2 dated 07/10/21 revealed: -Diagnoses included Alzheimer's dementia and diabetes. -There was an order to check fingerstick blood sugars (FSBS) twice a day and as needed for symptoms of hypoglycemia or hyperglycemia. -There was an order for Novolin R (a rapid acting insulin used to lower blood sugar levels) 100 units per milliliter (100u/ml) twice a day for sliding scale insulin (SSI) coverage with sliding scale for blood sugars (BS): 180-200= 4 units, 201-240=6 units, 241-280= 8 units, 281-300= 10 units, 301-320= 12 units, 321-360= 14 units, 361-400= 16 units. Call physician (MD) if BS over 400. Review of Resident #2's signed physician's orders dated 04/20/22 revealed: - There was an order to check fingerstick blood sugars (FSBS) twice a day and as needed for symptoms of hypoglycemia or hyperglycemia. -There was an order for Novolin R insulin 100u/ml use for coverage inject subcutaneously per sliding scale twice daily: 180-200= 4 units, 201-240=6 units, 241-280= 8 units, 281-300= 10 units, 301-320= 12 units, 321-360= 14 units, 361-400= 16 units. Call physician (MD) if BS over 400. Review of Resident #2's Resident Register revealed an admission date of 04/02/20. Review of Resident #2's laboratory test results revealed there was a hemoglobin A1C (used to test the blood sugar level over an extended	D 358		

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D 358	Continued From page 27 period of time) value of 5.8 documented on 07/30/21. (According to the American Diabetic Association a hemoglobin A1C of 5.7 to 6.4 is normal for adults). Review of Resident #2's May 2022 MAR revealed: -There was an entry for FSBS twice a day scheduled at 8:00am and 8:00pm. -There was documentation FSBS were obtained twice a day at 8:00am and 8:00pm from 05/01/22 to 05/17/22. -There was an entry Novolin R insulin 100u/ml use for coverage inject subcutaneously per sliding scale twice daily: 180-200= 4 units, 201-240=6 units, 241-280= 8 units, 281-300= 10 units, 301-320= 12 units, 321-360= 14 units, 361-400= 16 units. Call physician (MD) if BS over 400 scheduled for administration at 8:00am and 8:00pm daily. -The 8:00pm FSBS values obtained ranged from 188 to 318 with SSI coverage documented for 17 of 17 opportunities where Novolin R was administered correctly per Resident #2's SSI parameters. -The 8:00am FSBS values obtained ranged from 90 to 244 with no SSI coverage documented and 3 opportunities when Novolog R insulin should have been administered per Resident #2's SSI parameters as follows: -On 05/01/22 at 8:00am, FSBS value documented was 193 with no SSI documented and Resident #2 should have received 4 units of Novolin R (FSBS was 286 at 8:00pm on 05/01/22). -On 05/07/22 at 8:00am, FSBS value documented was 244 with no SSI documented and Resident #2 should have received 8 units of Novolin R (FSBS was 237 at 8:00pm on 05/07/22).	D 358		

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NAME OF PROVIDER OR SUPPLIER DUNMORE PLANTATION		STREET ADDRESS, CITY, STATE, ZIP CODE 515 W. KAPP STREET DOBSON, NC 27017		
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D 358	Continued From page 28 -On 05/17/22 at 8:00am, FSBS value documented was 190 with no SSI documented and Resident #2 should have received 4 units of Novolin R (FSBS was 259 at 8:00pm on 05/17/22). Observation of medication on hand for administration for Resident #2 on 05/18/22 at 4:10pm revealed there was a partial vial of Novolin R 100u/ml dispensed on 02/21/22. Interview with first shift medication aide (MA) on 05/18/22 at 3:35pm revealed: -The morning MAs routinely worked from 5:00am to 5:00pm, except on Tuesdays and some weekend days. -She administered medications according to the medications listed on the MAR routinely. -She routinely obtained Resident #2's FSBS around 7:30am to 8:00am on the days she worked. -Resident #2 had not routinely needed SSI coverage with Novolin R insulin except on 05/01/22, 05/07/22 and 05/17/22. -Resident #2 received a long acting insulin (Levemir) at 8:00am daily. -She did not think Resident #2 needed both the long acting insulin and Novolin R insulin at 8:00am. -She held the SSI dose of Novolin R insulin on 05/01/22, 05/07/22 and 05/17/22. -She had not informed and facility staff, including the MCC, that she had not administered Novolin R insulin to Resident #2 per her SSI parameters. Interview with the Memory Care Coordinator (MCC) on 05/19/22 at 11:03am revealed: -She was responsible to review the MARs for auditing medication administration. -She audited the MARs for refused medications	D 358		

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D 358	Continued From page 29 or missed medication documentation (blank spaces left on the MAR). -She had not audited Resident #2's May 2022 MAR for FSBS and insulin administration. -She did not know Resident #2's Novolin R insulin was not administered as ordered at 8:00am on 05/01/22, 05/07/22 and 05/17/22. -The MA should have administered Novolin R insulin to Resident #2 according to the resident's SSI parameters. -The MA had received training on administration of insulins including the different types of insulin within the last year (she was not sure of the exact date). Telephone interview with the nurse at Resident #2's primary care provider's (PCP) office on 05/19/22 at 3:20pm revealed: -Resident #2 should be administered Novolin R insulin per the SSI parameters as ordered. -The long acting insulin should be administered daily as well. -Not receiving the Novolin R insulin could result in elevated FSBS values and uncontrolled diabetes increasing the risk for damage to kidneys and eyes. Interview with the Administrator-in-Charge (AIC) on 05/19/22 at 3:17pm revealed: -The MCC was responsible to ensure medications were administered as ordered. -The MCC should contact the PCP for order changes that might be needed to ensure residents were administered medications properly. -The MAs were responsible to inform the MCC if a medication was not administered at the scheduled time. Based on observations, interviews, and record	D 358		

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D 358	Continued From page 30 reviews, it was determined Resident #2 was not interviewable. 2. The medication error rate was 6% as evidenced by the observation of 2 errors out of 31 opportunities during the 8:00am medication pass on 05/19/22. a. Review of Resident #7's current FL2 dated 08/31/21 revealed: -Diagnoses included Alzheimer's and anxiety disorder. -There was an order for Tylenol 500mg (used to treat mild pain) 2 tablets every 8 hours. Review of Resident #7's signed physician's orders dated 04/19/22 revealed acetaminophen 500mg take 2 tablets every 8 hours was ordered. Observation of the medication pass for Resident #7 on 05/19/22 at 7:49am revealed: -Resident #7 was seated in the Memory Care Unit (MCU) sitting area, along with all the other residents waiting to be escorted to the dining room area. -At 7:49am, the morning medication aide (MA) prepared 8 oral medications for administration to Resident #7. -Tylenol (acetaminophen is generic) 500mg two tablets was prepared using a partially full facility stock bottle of acetaminophen 500mg stored in the bottom right drawer of the medication cart and included in the medications for administration for Resident #7. -At 7:53am, Resident #7 was administered all medications, including 2 tablets of acetaminophen 500mg. -The MA documented administration of medications, including acetaminophen 500mg, on the resident's medication administration record	D 358		

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D 358	Continued From page 31 (MAR). Review of Resident #7's May 2022 MAR revealed: -There was an entry for acetaminophen 500mg take 2 tablets every 8 hours and scheduled for administration at 5:00am, 1:00pm, and 9:00pm. -Acetaminophen 500mg take 2 tablets every 8 hours was documented as administered daily at 5:00am from 05/01/22 to 05/19/22 and at 1:00pm and 9:00pm daily from 05/01/22 to 05/18/22. -The MA who administered Resident #7's medications during the 8:00am medication pass on 05/19/22 documented administration of acetaminophen 500mg (2 tablets) 14 out of 19 opportunities scheduled at 5:00am on the May 2022 MAR. -The MA who administered Resident #7's medications during the 8:00am medication pass on 05/19/22 documented administration of acetaminophen 500mg (2 tablets) 13 out of 18 opportunities scheduled at 2:00pm on the May 2022 MAR from 05/01/22 to 05/18/22. Interview with the MA who administered Resident #7's medications during the 8:00am medication pass on 05/19/22 at 11:00am revealed: -The morning MAs routinely worked from 5:00am to 5:00pm, except on Tuesdays. -She administered medications according to the medications listed on the MAR. -The facility's policy was to administer medications starting one hour before up to one hour after the time scheduled on the MAR. -She did not routinely wake Resident #7 up at 5:00am to administer acetaminophen 500mg tablets because the resident would not go back to sleep. -She administered all of Resident #7's morning medications at the same time in the sitting area	D 358		

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D 358	Continued From page 32 before breakfast when she worked. -She routinely administered the next dose scheduled for 1:00pm close to 1:00pm. -She had not discussed Resident #7's acetaminophen 500mg being administered routinely more than 2 hours after the scheduled 5:00am dose and less than 8 hours prior to the next dose was scheduled. Interview with the Memory Care Coordinator (MCC) on 05/19/22 at 11:03am revealed: -She was responsible to review the MARs for auditing medication administration. -She audited the MARs for refused medications or missed medication documentation (blank spaces left on the MAR). -Some medications were routinely scheduled in the early morning like thyroid medications and medications to treat GERD. -The facility's staff could change the hours (time) of administration but not the every 8 hours interval without a physician's order. -She was not sure if the facility's staff or the contracted pharmacy's staff had scheduled Resident #7's acetaminophen 500mg at 5:00am. Interview with the Administrator-in-Charge (AIC) on 05/19/22 at 3:17pm revealed: -The MCC was responsible to ensure medications were administered as ordered. -The MCC should contact the PCP for order changes that might be needed to ensure residents were administered medications properly. The MAs were responsible to inform the MCC if a medication was not administered at the scheduled time. Attempted telephone interview with Resident #7's primary care provider's (PCP) office on 05/19/22	D 358		

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D 358	Continued From page 33 at 10:50am was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #7 was not interviewable. b. Review of Resident #6's current FL-2 dated 07/07/21 revealed: -Diagnoses included Alzheimer's disease unspecified, dementia with behavior disturbances and history of major depressive disorder. -There was an order for ibuprofen (used to treat mild pain) 400mg three (3) times a day. Review of Resident #6's signed physician's orders dated 04/19/22 revealed there was an order for ibuprofen 400mg one tablet every 8 hours scheduled. Observation of the 8:00am medication pass for Resident #6 on 05/19/22 revealed: -At 7:59am, the morning medication aide (MA) prepared 10 oral medications for administration to Resident #6. -The MA removed one ibuprofen 400mg from the cassette for 14 tablets dispensed leaving one tablet in the morning cassette. -At 8:04am, the MA administered Resident #6's prepared medications. Review of Resident #6's May 2022 medication administration record (MAR) revealed: -There was an entry for ibuprofen 400mg one tablet every 8 hours scheduled for administration at 6:00am, 2:00pm and 10:00pm daily. -Ibuprofen 400mg one tablet every 8 hours was documented as administered daily at 6:00am from 05/01/22 to 05/19/22 and at 1:00pm and 9:00pm daily from 05/01/22 to 05/18/22. -The MA who administered Resident #7's	D 358		

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D 358	Continued From page 34 medications during the 8:00am medication pass on 05/19/22 documented administration of ibuprofen 400mg 14 out of 19 opportunities scheduled at 6:00am on the May 2022 MAR. -The MA who administered Resident #7's medications during the 8:00am medication pass on 05/19/22 documented administration of ibuprofen 400mg 13 out of 18 opportunities scheduled at 2:00pm on the May 2022 MAR from 05/01/22 to 05/18/22. Interview with the MA who administered Resident #6's medications during the 8:00am medication pass on 05/19/22 at 11:00am revealed: -The morning MAs routinely worked from 5:00am to 5:00pm, except on Tuesdays. -She administered medications according to the medications listed on the MAR. -The facility's policy was to administer medications starting one hour before up to one hour after the time scheduled on the MAR. -She administered residents' medication about the same time every morning and pretty much in the same order as today. -She did not routinely wake Resident #6 up at 6:00am to administer ibuprofen 400mg tablets because the resident would not go back to sleep. -She administered all of Resident #6's morning medications at the same time in the Memory Care Unit (MCU) sitting area before breakfast when worked. -She routinely administered the next dose scheduled for 2:00pm close to 2:00pm. -She had not discussed Resident #6's ibuprofen 400mg being administered routinely more than 2 hours after the scheduled 6:00am dose and less than 8 hours prior to the next dose as ordered. Interview with the Memory Care Coordinator (MCC) on 05/19/22 at 11:03am revealed:	D 358		

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D 358	Continued From page 35 -She was responsible to review the MARs for auditing medication administration. -She audited the MARs for refused medications or missed medication documentation (blank spaces left on the MAR). -The facility's staff could change the hours (time) of administration but not the every 8 hours interval without a physician's order. -She was not sure if the facility's staff or the contracted pharmacy's staff scheduled Resident #6's ibuprofen 400mg at 6:00am. Interview with the Administrator-in-Charge (AIC) on 05/19/22 at 3:17pm revealed: -The MCC was responsible to ensure medications were administered as ordered. -The MCC should contact the PCP for order changes that might be needed to ensure residents were administered medications properly. The MAs were responsible to inform the MCC if a medication was not administered at the scheduled time. Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable. Attempted telephone interview with Resident #6's PCP on 05/19/22 at 10:25am was unsuccessful.	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;	D 367		

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D 367	Continued From page 36 (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 observation, interview, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#3) including inaccurate documentation of a thyroid medication. The findings are: Review of Resident #3's FL-2 dated 1/25/22 revealed: -Diagnoses of seizures, VP shunt, mild mental retardation, hypothyroidism and history of hydrocephalus. -There was no order for levothyroxine. Review of Resident #3's January 2022 MAR revealed: -There was an entry for levothyroxine 88mcg daily to be administered at 6:00am. -There was documentation that levothyroxine was administered daily from 01/01/22 to 01/31/22.	D 367	Reviewed rule area and current facility policy & procedures with appropriate staff. Revised Facility "Medication Observation" form, reviewed/trained appropriate staff, RCC and UCC conducted Med Admin observation with current Med Aides by 06/30/2022 & per facility policy & procedure. Facility Admin & Admin in Charge conducted observation, oversight and training of Medication Trade out process, which medications, prescriptions, non-prescription & treatments were received, reviewed against current MAR's & orders. Proper clarifications completed prior to placement on secure medication carts for administration. Periodic trade out observations will be conducted per facility policy & procedure. Corrected action measures cross referenced per 10A NCAC 13F .1002(a) Medication Orders on page 10	06/30/2022 06/02/2022 05/20/2022 and 06/09/2022

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D 367	Continued From page 37 Review of Resident #3's February 2022 MAR revealed: -There was an entry for levothyroxine 88mcg daily to be administered at 6:00am. -There was documentation that levothyroxine was administered daily from 02/01/22 to 02/28/22. Telephone interview with a representative for the facility's contracted pharmacy on 05/18/22 at 4:05pm revealed: -The pharmacy received a FL-2 dated 01/25/22 for Resident #3 on 01/26/22. -The pharmacy discontinued Resident #3's levothyroxine 88mcg because it was not listed on the signed FL-2 dated 01/25/22. -The pharmacy dispensed 14 levothyroxine 88mcg tablets on 01/11/22 and 01/25/22. -The pharmacy did not dispense levothyroxine in February 2022. Based on MAR documentation, medications dispensed and medications on hand between January 2022 and February 2022 revealed there would have been no levothyroxine 88mcg available to be administered between 02/11/22 - 02/28/22. Telephone interview with a medication aide (MA) on 05/19/22 at 11:10am revealed: -She compared the medication with the MAR, placed the medication in a souffle cup, administered the medication and signed the MAR. -She thought the levothyroxine was on the cart for administration for the month of February 2022. -She called the pharmacy when she noticed the levothyroxine was not electronically entered on the March 2022 MAR and was informed that levothyroxine 88mcg was not on the FL-2 dated	D 367		

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D 367	Continued From page 38 01/26/22 and had been discontinued. Interview with the Resident Care Coordinator (RCC) on 05/18/22 at 3:15pm revealed: -The pharmacy sent the MARs for the upcoming month the last week of the current month. -She would compare the MARS for the upcoming month with the current MARs. -She would look for inaccuracies on the MARs. Interview with the RCC on 05/19/22 at 10:40am revealed: -The MAs should check the MAR with the medication three times before administering the medication. -If the medication was not on the medication cart, the MAs should notify her that the medication was not on the medication cart. -She would contact the pharmacy to see why the medication was not in the facility. -She completed a medication cart audit every 14 days or more frequently. -She had not noticed the levothyroxine was not on the medication cart. -She would compare new FL-2s with the MAR; she did not compare Resident #3's FL-2 dated 01/25/22 with the MAR. -She would notify the PCP when she noticed something different on the MAR; she would call the PCP and resolve the issue the same day. Interview with the Administrator on 05/19/22 at 2:23pm revealed: -She did not understand why the MAs did not report that there was no levothyroxine available for administration. -She would expect the MAs to notify the RCC when medications were not available.	D 367		

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D 392	Continued From page 39	D 392		
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 observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record, related to controlled substances count sheet (CSCS) that accurately reconciled the receipt, administration, and disposition of a controlled medication was maintained for 1 of 3 sampled residents related to pain medication (#3). The findings are: Review of Resident #5's current FL2 dated 10/25/21 revealed: -Diagnoses included altered mental status, schizophrenia, and osteoarthritis. -The resident was semi-ambulatory and used a wheelchair. -There was an order for oxycodone IR (immediate release) 5mg one every 6 hours as needed for pain. (Oxycodone is a Schedule II narcotic used to treat moderate to severe pain). Review of Resident #5's signed physician's orders dated 04/19/21 revealed oxycodone IR 5mg one every 6 hours as needed for pain was ordered.	D 392	Conducted oversight & observation of Medication Trade out with RCC & UCC. Reviewed facility & pharmacy medication policy & procedures with appropriate staff to assure proper CSCS documentation of administration and disposition of controlled medication is maintained in an accurate, readily retrievable form. Including numbering the controlled substance count sheet that corresponds to the Medication cassette or bubble pack. Administration, RCC & UCC will conduct review and observation of returned demonstration of Med Aides documenting administered controlled medications on the CSCS, MAR's including effectiveness & times.	07/10/2022

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NAME OF PROVIDER OR SUPPLIER DUNMORE PLANTATION		STREET ADDRESS, CITY, STATE, ZIP CODE 515 W. KAPP STREET DOBSON, NC 27017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 40 Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/20/22 at 9:50am revealed: -The pharmacy sent controlled substance count sheets (CSCS) with all controlled substances dispensed by the pharmacy. -The CSCS was used to maintain a decreasing inventory tracking as the medication was signed out and along with the facility's medication administration record was used as a readily retrievable record of receipt, administration, and disposition of the controlled substance. -The pharmacy records documented Resident #5 was dispensed oxycodone IR 5mg tablets with instructions for one every 6 hours as needed for pain as follows: -On 02/25/22, oxycodone IR 5mg tablets was dispensed for a quantity of 30 tablets. -On 03/16/22, oxycodone IR 5mg tablets was dispensed for a quantity of 30 tablets. -On 03/30/22, oxycodone IR 5mg tablets was dispensed for a quantity of 30 tablets. -On 04/15/22, oxycodone IR 5mg tablets was dispensed for a quantity of 30 tablets. -On 05/05/22, oxycodone IR 5mg tablets was dispensed for a quantity of 30 tablets. Review of Resident #5's March 2022 medication administration record (MAR) revealed: -There was an entry for oxycodone IR 5mg tablets with instructions for one every 6 hours as needed for pain with no scheduled time of administration. -Oxycodone IR 5mg was documented as administered 42 of 58 opportunities for administration. Review of Resident #5's CSCS for oxycodone IR 5mg tablets with instructions for one every 6	D 392		

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D 392	Continued From page 41 hours as needed for pain was dispensed for a quantity of 30 tablets on 02/25/22 compared to Resident #5's March 2022 MAR revealed: -There was a beginning balance of 28 oxycodone IR 5mg tablets documented on the CSCS on 03/01/22. -From 03/01/22 to 03/16/22 at 2:00pm, there was documentation 28 oxycodone IR 5mg tablets were signed out on the CSCS. -From 03/01/22 03/16/22 at 2:00pm, there were 7 doses of oxycodone IR 5mg signed out on the CSCS that were not documented as administered on Resident #5's MAR or documented for administration and effectiveness. -Examples of doses of oxycodone IR 5mg signed out on the CSCS as administered but not documented as administered, including effectiveness, for 30 tablets dispensed on 02/25/22 included: -On 03/01/22 at 8:00pm, oxycodone IR 5mg was signed out on the CSCS but not documented as administered on the March 2022 MAR. -On 03/08/22 at 8:00pm, oxycodone IR 5mg was signed out on the CSCS but not documented as administered on the March 2022 MAR. -On 03/05/22 at 3:00pm, oxycodone IR 5mg was signed out on the CSCS but not documented as administered on the March 2022 MAR. -On 03/14/22 at 2:00pm, oxycodone IR 5mg was signed out on the CSCS but not documented as administered on the March 2022 MAR. Review of Resident #5's CSCS for oxycodone IR 5mg tablets with instructions for one every 6 hours as needed for pain was dispensed for a quantity of 30 tablets on 03/16/22 compared to Resident #5's March 2022 MAR revealed: -From 03/16/22 at 8:00pm to 03/31/22 at 8:00pm, there was documentation 30 oxycodone IR 5mg tablets were signed out on the CSCS with 7	D 392		

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D 392	Continued From page 42 doses of oxycodone IR 5mg signed out on the CSCS that were not documented as administered on Resident #5's MAR or documented for administration and effectiveness. -Examples of doses of oxycodone IR 5mg signed out on the CSCS as administered but not documented as administered, including effectiveness, for 30 tablets dispensed on 03/16/22 included: -On 03/18/22 at 2:00pm, oxycodone IR 5mg was signed out on the CSCS but not documented as administered on the March 2022 MAR. -On 03/20/22 at 2:00pm, oxycodone IR 5mg was signed out on the CSCS but not documented as administered on the March 2022 MAR. -On 03/27/22 at 8:00pm, oxycodone IR 5mg was signed out on the CSCS but not documented as administered on the March 2022 MAR. -On 03/29/22 at 10:00am, oxycodone IR 5mg was signed out on the CSCS but not documented as administered on the March 2022 MAR. Review of Resident #5's April 2022 MAR revealed: -There was an entry for oxycodone IR 5mg tablets with instructions for one every 6 hours as needed for pain with no scheduled time of administration. -Oxycodone IR 5mg was documented as administered 45 of 52 opportunities for administration. Review of Resident #5's CSCS for oxycodone IR 5mg tablets with instructions for one every 6 hours as needed for pain was dispensed for a quantity of 30 tablets on 03/30/22 compared to Resident #5's April 2022 MAR revealed: -From 04/01/22 at 2:00pm to 04/16/22 at 4:00pm, there was documentation 30 oxycodone IR 5mg tablets were signed out on the CSCS with 7	D 392		

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D 392	Continued From page 43 doses of oxycodone IR 5mg signed out on the CSCS that were not documented as administered on Resident #5's MAR or documented for administration and effectiveness. -Examples of doses of oxycodone IR 5mg signed out on the CSCS as administered but not documented as administered, including effectiveness, for 30 tablets dispensed on 03/30/22 included: -On 04/01/22 at 2:00pm, oxycodone IR 5mg was signed out on the CSCS but not documented as administered on the April 2022 MAR. -On 04/03/22 at 2:00pm, oxycodone IR 5mg was signed out on the CSCS but not documented as administered on the April 2022 MAR. -On 04/07/22 at 8:00am, oxycodone IR 5mg was signed out on the CSCS but not documented as administered on the April 2022 MAR. -On 04/11/22 at 2:00pm, oxycodone IR 5mg was signed out on the CSCS but not documented as administered on the April 2022 MAR. Review of Resident #5's CSCS for oxycodone IR 5mg tablets dispensed for a quantity of 30 tablets on 04/15/22 compared to Resident #5's April 2022 MAR revealed 22 oxycodone IR 5mg were signed out on the CSCS and documented as administered on the MAR from 04/16/22 at 10:30pm to 4/30/22 at 3:00pm. Review of Resident #5's May 2022 MAR revealed: -There was an entry for oxycodone IR 5mg tablets with instructions for one every 6 hours as needed for pain with no scheduled time of administration. -Oxycodone IR 5mg was documented as administered 21 of 21 opportunities for administration from 05/01/22 to 05/18/22.	D 392		

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D 392	Continued From page 44 Review of Resident #5's CSCS for oxycodone IR 5mg tablets dispensed for a quantity of 30 tablets on 04/15/22 compared to Resident #5's May 2022 MAR revealed 8 oxycodone IR 5mg were signed out on the CSCS and documented as administered on the MAR from 05/01/22 at 8:00am to 05/04/22 at 8:00pm accounting for all the tablets. Review of Resident #5's CSCS for oxycodone IR 5mg tablets dispensed for a quantity of 30 tablets on 05/05/22 compared to Resident #5's May 2022 MAR revealed 16 oxycodone IR 5mg were signed out on the CSCS and documented as administered on the MAR from 05/05/22 at 8:00pm to 05/19/22 at 8:00pm leaving a balance of 14 oxycodone IR 5mg on the CSCS. Observation of oxycodone IR 5mg on hand for administration for Resident #5 on 05/20/22 revealed there were 14 tablets remaining on a bingo card dispensed on 05/05/22 matching the count remaining on the CSCS. Review of Resident #5 CSCS for oxycodone IR 5mg compared to the resident's MARs revealed there were 21 out of 136 doses not accurately for the administration that included signing out on the CSCS and documenting on the resident's MAR. Interview with the Resident Care Coordinator (RCC) on 05/20/22 at 10:30am revealed: -The facility policy was for the medication aides (MAs) to sign controlled medication out on the corresponding CSCS at the time the medications were prepared for administration. -The MA was supposed to document the administration of the controlled medication on the resident's MAR after observing the resident swallow the medication to complete the	D 392		

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D 392	Continued From page 45 documentation for administration of a controlled substance. -Medications that were administered as needed (PRN) were to have the effectiveness documented after one hour as part of the MAR documentation. -There had been staffing issues in March 2022 and April 2022 which resulted in staff turnover during that time. -MA staff were working extra shifts and extended hours which could have contributed to incomplete accounting for the oxycodone IR 5mg on the CSCS and the MARs. -The RCC conducted audits of the resident's CSCS and MARs for accuracy looking for holes (blank documentation), missed medications as time allowed. -She was staffing as a MA during the March 2022 and April 2022 staffing shortages and did not complete CSCS audits during the time. -She did not know Resident #5 had 21 oxycodone IR 5mg not properly accounted for in March 2022 and April 2022. -Oxycodone IR 5mg not documented at 2:00pm for Resident #5 could have been because the MA was assisting with distributing snacks, signed out and administered Resident #5's medication and did not go back and document on the MAR. -The MAs that signed out most of Resident #5's oxycodone IR 5mg was no longer working at the facility. Interview with Administrator-in-Charge (AIC) on 05/20/22 at 10:45am revealed: -The RCC was responsible to ensure medications were administered as ordered and the MAs completed documentation on the residents' MARs. -MA staff were trained to document administration of controlled medications on the CSCS and on	D 392		

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D 392	Continued From page 46 the MAR for accurate accounting of the controlled medications and frequently reminded of proper documentation. -The MAs were to supposed to document as trained for the administration of controlled medications. Interview with Resident #5 on 05/20/22 at 11:00am revealed: -She asked for her pain medication (oxycodone IR 5mg) 2 times a day most days. -She needed the medication in the morning, and in the evening before bedtime. -Sometimes she asked for her pain medication around 2:00pm. -She did not recall a time when she asked for her pain medication that she did not receive the medication.	D 392		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication orders. The findings are:	D914	Refer to corrective active measures and complete dates listed on pages #10 and #36	

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D914	Continued From page 47 Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 residents sampled (#3) who had been ordered a thyroid medication and the medication was discontinued resulting in the resident missing doses of the medication, having multiple falls, and seizures. [Refer to Tag D0344, 10A NCAC 13F .1002(a) Medication Orders (Type A2 Violation).]	D914		