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
	HAL051024	A. BUILDING: _____ B. WING _____	R 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SMITHFIELD	830 BERKSHIRE ROAD SMITHFIELD, NC 27577

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on June 14, 2022 - June 15, 2022.	D 000		
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, interviews, and record reviews, the facility failed to ensure referral and follow up for 1 of 3 sampled residents (#3) who was supposed to attend a follow up appointment with an orthopedic provider after sustaining an injury from a fall and notifying the primary care provider (PCP) of blood pressures and weight loss outside of ordered parameters. The findings are: Interview with the Health and Wellness Director (HWD) on 06/14/22 at 8:55am revealed: -The Administrator was on leave and would not be able to be present that week. -She was covering for the facility as the Administrator and was in charge at that time. Review of Resident #3's current FL-2 dated 12/22/21 revealed: -The resident was admitted to the special care unit (SCU) from a skilled nursing facility. -Diagnoses included dementia, Parkinson's disease, hypertension, and anxiety. -The resident was constantly disoriented and semi-ambulatory.	D 273		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrew Wheeler III — TITLE: Administrator — (X6) DATE: 7/15/2022

Reviewed and Acknowledged RNR 07/18/2022

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Review of Resident #3's current care plan dated 04/08/22 revealed:
-The resident required supervision with ambulation, transferring, and eating requiring prompts and cues at times.
-The resident was at high risk for falls, had a kneecap fracture, and was forgetful requiring reminders.
-There were instructions to obtain the resident's blood pressure daily.
-There were instructions to consider orthostatic hypotension for the resident. (A condition in which the blood pressure suddenly drops when standing up quickly causing dizziness and risk of injury.)
-It was documented that both family and caregivers were responsible to take the resident to her appointments.

Based on observations, interviews, and record reviews, it was determined that Resident #3 was not able to be interviewed.

1. Observation of Resident #3 on 06/14/22 at 8:26am revealed:
-The resident was in a wheelchair in her room with a private aide.
-The resident had a knee brace on her right knee.

Interview with Resident #3's private aide on 06/14/22 at 8:26am revealed:
-The resident wore a brace on her right knee because she had a history of several falls.
-The resident fell a couple of months ago and fractured her kneecap requiring the brace.

Review of Resident #3's urgent care visit note dated 03/15/22 revealed:
-The resident was seen for right knee pain after a fall.

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D 273	Continued From page 2 -Her knee was swollen, and x-rays showed a transverse and longitudinal fracture of the right kneecap. -She was prescribed a knee brace, and cool compressions and Tylenol for comfort. -She was to follow-up with an orthopedic provider in 10-14 days for re-imaging and reevaluation. Review of Resident #3's current physician orders dated 03/22/22 revealed there was an order to apply the resident's knee brace every morning prior to ambulating or transferring and to remove the brace prior to bedtime. Review of Resident #3's record revealed there was no documentation the resident was seen 10-14 days after her knee injury by the orthopedic provider. Review of Resident #3's progress notes revealed there was no documentation that the resident had an appointment on 04/04/22 or that the PCP was made aware that she missed her appointment on 04/04/22. Interview with Resident #3's orthopedic provider's scheduler on 06/15/22 at 8:42am revealed: -Resident #3 was seen for an urgent care visit on 03/15/22 after a fall to be assessed for injury. -She was to follow up with the orthopedic provider on 04/04/22 but did not attend the appointment and it was noted she was a "no call, no show". Interview with Resident #3's family member on 06/15/22 at 9:49am revealed: -He was very involved in Resident #3's care and normally took the resident to and from her doctor appointments as needed. -He had not realized Resident #3 missed her orthopedic appointment scheduled for 04/04/22.	D 273		

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D 273	Continued From page 3 -He thought Resident #3 was to have followed up with the orthopedic provider in 10-14 weeks, not 10-14 days. -If he had known the resident had an appointment on 04/04/22, he would have taken her to the appointment. Interview with a medication aide (MA) on 06/15/22 at 9:23am revealed: -Resident #3's family or private aide usually took her to her doctor's appointment when they were scheduled. -When the resident would come back to the facility, the MAs were responsible to review the discharge paperwork for any orders or follow-up appointments and enter them into the computer tracker system in the resident's record. -The MAs would then write the appointment in the transporter's appointment book, so they knew to take the resident if the family or private aide was unavailable. -It was the HWD's responsibility to go behind the MA to ensure they did not miss any orders or appointments the resident may need. -She was not sure why or how Resident #3 missed her follow up appointment to the orthopedist. -It was important for Resident #3 to attend the follow up appointment to the orthopedist for guidance of care, to ensure her injury was healing, and to ensure she did not have any complications with the injury. Interview with the HWD on 06/15/22 at 8:25am revealed: -The process for order implementation was for the MAs to obtain paperwork regarding a resident's appointment and need for follow up, review it, and enter any orders or follow-up appointments into the computer under the	D 273		

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resident's record in a tracker that would remind everyone what needed to be done.
-Another MA was to go behind the MA that entered any orders and information and verify accuracy.
-There was no process in place at that time to do chart audits because they had been understaffed and did not have time to do them.

Interview with the HWD on 06/15/22 at 11:58am revealed:
-She was not aware that Resident #3 had missed her follow up appointment with the orthopedic provider on 04/04/22 and was unsure how it was overlooked.
-It was important for Resident #3 to have followed up with the orthopedic provider so they could guide her care in wearing the knee brace, mobility restrictions, and treatment.
-Resident #3's family member normally took Resident #3 to her appointments, but the MAs were responsible to read resident discharge paperwork and notate appointments for follow-up in the tracker and progress notes located in the resident record.
-If the appointment had been documented in the tracker, it would have triggered someone in the facility to investigate the appointment and ensure Resident #3 attended as ordered.

Interview with the facility's contracted PCP on 06/15/22 at 11:07am revealed:
-She was not aware that Resident #3 had not followed up with the orthopedic provider as ordered and expected.
-She was under the impression that Resident #3's care and treatment for her injury from her fall was being guided by the orthopedic provider.
-She was relying on the orthopedic provider's orders to guide when the resident could try to

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resume weight-bearing activity and discontinue the use of her knee brace.
-It was important for Resident #3 to have followed up with the orthopedic provider as ordered to ensure the injury was healing properly and implement further intervention as necessary.
-She expected the facility to ensure Resident #3 attended her follow up appointment with the orthopedic provider on time as ordered.

Interview with Resident #3's orthopedic provider's nurse on 06/15/22 at 2:06pm revealed:
-Resident #3 was seen on 03/15/22 by the urgent care doctor and was expected to follow up with the orthopedic doctor on 04/04/22 but did not show up for the appointment.
-The resident had sustained two fractures on her kneecap that crossed over each other and it was a significant injury.
-It was important for Resident #3 to have followed up as ordered so the orthopedist could assess her, possibly do more imaging based on the injury report in her record, and to monitor how the resident was healing.
-Without proper follow up care, Resident #3 was at risk for complications from the injury that included increased risk of further falls, deep vein thrombosis (blood clots that can travel through the body and cause severe injury or stroke), and sepsis (as severe and possibly life-threatening infection).

2. Review of Resident #3's current physician orders dated 03/22/22 revealed there was an order to check blood pressures daily and notify the PCP of any systolic blood pressure (SBP) greater than 160 or less than 90.

Review of Resident #3's April 2022 electronic medication administration record (eMAR)

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D 273	Continued From page 6 revealed: -There was an entry to obtain blood pressures daily and notify the PCP of any systolic blood pressure (SBP) greater than 160 or less than 90. -The resident's blood pressure was documented daily as ordered. -On 04/27/22, it was documented that the resident's blood pressure was documented as 168/90, with the SBP greater than 160. Review of Resident #3's May 2022 eMAR revealed: -There was an entry to obtain blood pressures daily and notify the PCP of any systolic blood pressure (SBP) greater than 160 or less than 90. -The resident's blood pressure was documented daily as ordered. -On 05/04/22, it was documented that the resident's blood pressure 161/92, with the SBP greater than 160. Review of Resident #3's progress notes revealed there was no documentation that the provider was made aware of the blood pressure values outside of ordered parameters. Interview with a medication aide (MA) on 06/15/22 at 9:23am revealed: -The MA was responsible to obtain resident's blood pressures and document them in the eMAR. -The MA was responsible to assess the value of the blood pressure to see if it was outside ordered parameters. -If the blood pressure was outside of ordered parameters, the MA was responsible to notify the resident's PCP via phone call, fax, or tell the HWD so she could notify the PCP, then document the notification in the resident progress notes.	D 273		

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D 273	Continued From page 7 -If the MA did not notify the PCP via phone call or fax, the PCP would review the values when she next assessed the resident at the facility. -It was important to follow orders as written and report blood pressures outside of parameters because high blood pressures could cause adverse health outcomes and the PCP wrote the order for a reason. -She was not sure why Resident #3's blood pressures outside of parameters were not reported to the PCP as ordered. Interview with the HWD on 06/14/22 at 4:25pm revealed she or the MAs did not report values outside of ordered to parameters to Resident #3's PCP via call or fax because the PCP came each week to see the resident and would review the information at that time. Interview with the HWD on 06/15/22 at 11:58am revealed: -She was not aware Resident #3 had blood pressures that were outside parameter that were not reported to the PCP as ordered. -She expected the MAs to follow the order to notify the PCP of values outside of parameters as ordered. -It was important to follow orders accurately to provide care to residents safely for their health and well-being. Interview with the facility's contracted PCP on 06/15/22 at 11:07am revealed: -She was not notified of Resident #3's blood pressures that were outside of parameters on 04/27/22 or on 05/04/22. -The order to notify her of Resident #3's blood pressures outside of parameters was put in place to monitor the resident for high blood pressures which could be signs of complications.	D 273		

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D 273	Continued From page 8 -If she had been aware the resident had blood pressures outside of parameters, she would have wanted to assess the resident and might have adjusted some of the resident's medications. 3. Review of Resident #3's current physician orders dated 03/22/22 revealed there was an order to check weight weekly and notify the PCP of any weight loss of 3 or more pounds. Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry to obtain weekly weights and notify the PCP of any weight loss of 3 or more pounds. -The resident's weight was documented weekly as ordered. -On 04/20/22, the resident's weight was documented as 109.4 pounds. -On 04/27/22, the resident's weight was documented as 102 pounds, which was a 7 pound weight loss from the week before. Review of Resident #3's progress notes revealed there was no documentation that the provider was made aware of the blood pressure values outside of ordered parameters. Interview with a medication aide (MA) on 06/15/22 at 9:23am revealed: -The MA or the PCA were responsible to obtain resident weights and the MA was responsible to document them in the eMAR. -The MA was responsible to assess the value of the weight to see if it was outside ordered parameters. -If the weight was outside of ordered parameters, the MA was responsible to notify the resident's PCP via phone call, fax, or tell the HWD so she	D 273		

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could notify the PCP, then document the notification in the resident progress notes.
-If the MA did not notify the PCP via phone call or fax, the PCP would review the values when she next assessed the resident at the facility.
-It was important to follow orders as written and weights outside of parameters because the Resident #3 was not a good eater, weight loss could cause adverse health outcomes, and the PCP wrote the order for a reason.
-She was not sure why Resident #3's weight outside of parameters were not reported to the PCP as ordered.

Interview with the HWD on 06/14/22 at 4:25pm revealed she or the MAs did not report values outside of ordered to parameters to Resident #3's PCP via call or fax because the PCP came each week to see the resident and would review the information at that time.

Interview with the HWD on 06/15/22 at 11:58am revealed:
-She was not aware Resident #3 had a weight loss that was outside parameter and was not reported to the PCP as ordered.
-She expected the MAs to follow the order to notify the PCP of values outside of parameters as ordered.
-It was important to follow orders accurately to provide care to residents safely for their health and well-being.

Interview with the facility's contracted PCP on 06/15/22 at 11:07am revealed:
-The facility did not notify her of Resident #3's 7-pound weight loss that was documented on 04/27/22.
-The order to notify her of Resident #3's weight loss parameters were put into place because she

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D 273	Continued From page 10 was monitoring the resident's nutritional status to try and prevent malnutrition and weight loss was also an indication the resident's dementia may be progressing. -She expected the facility to notify her of weight loss outside of ordered parameters as instructed as soon as possible so she could guide the resident's care.	D 273		
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 3 sampled residents (#3) in which medications were not available on the medication cart for administration. The findings are: Interview with the Health and Wellness Director (HWD) on 06/14/22 at 8:55am revealed: -The Administrator was on leave and would not be able to be present that week. -She was covering for the facility as the Administrator and was in charge at that time.	D 358		

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D 358	Continued From page 11 Review of the facility's medication error policy dated December 2017 revealed: -Medication aides (MAs) were expected to administer medications per the 7 rights (right medication, route, refuse, documentation, person, dose, and time). -MAs were expected to document medication administration accurately on the resident's electronic medication administration record (eMAR). -MA's were expected to report medication errors to the nurse, executive director (ED), or other designee and to the primary care provider (PCP) immediately, then document it in the resident's progress notes and complete an incident report. Review of Resident #3's current FL-2 dated 12/22/21 revealed: -The resident was admitted to the special care unit (SCU) from a skilled nursing facility. -Diagnoses included dementia, Parkinson's disease, hypertension, and anxiety. -The resident was constantly disoriented and semi-ambulatory. Review of Resident #3's current care plan dated 04/08/22 revealed: -It was documented that the facility would order and coordinate medications between the family, healthcare providers, and the pharmacy. -The facility would provide assistance with the administration of medications. Review of the facility's medication availability policy dated December 2017 revealed the facility was responsible to order all medications for residents that had an active order from the resident's preferred pharmacy to ensure to no interruption of medication administration took place.	D 358		

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D 358	Continued From page 12 Based on observations, interviews, and record reviews, it was determined that Resident #3 was not able to be interviewed. Review of Resident #3's current physician orders dated 03/22/22 revealed there was an order for Lipitor 10mg (a medications used to lower cholesterol) take one tablet at bedtime. Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Lipitor 10mg take one tablet at bedtime. -The Lipitor was documented as administered from 04/01/22-04/30/22. Review of Resident #3's May 2022 eMAR revealed: -There was an entry for Lipitor 10mg take one tablet at bedtime. -The Lipitor was documented as administered from 05/01/22-05/31/22 except on 05/20/22 and 05/21/22 when it was documented as spit out. Review of Resident #3's June 2022 eMAR revealed: -There was an entry for Lipitor 10mg take one tablet at bedtime. -The Lipitor was documented as administered from 06/01/22-06/13/22. Observation of Resident #3's medications on hand on 06/15/22 at 9:23am revealed there was no Lipitor available on hand for administration to the resident. Interview with a pharmacist at the Resident #3's pharmacy on 06/15/22 at 9:45am revealed the	D 358		

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D 358	Continued From page 13 pharmacy never filled Lipitor for the resident. Interview with a pharmacist at the facility's contracted pharmacy provider on 06/15/22 at 9:59am revealed: -Resident #3's Lipitor was last filled on 03/25/22 with a 30-day supply; it would have run out on 04/18/22. -The pharmacy had not received a request or order to refill the Lipitor until that day, 06/15/22. -The facility was responsible to refill resident medications as needed prior to running out. -It was important for Resident #3 to receive her Lipitor as ordered because the medication was used to help reduce cholesterol levels and her primary care provider (PCP) ordered the medication for a reason. Review of Resident #3's progress notes revealed there was no documentation that the provider was made aware that the resident had run out of Lipitor or that it was documented as administered when not available. Interview with Resident #3's family member on 06/15/22 at 9:49am revealed: -He was not aware of the resident missing or running out of any medication. -He relied on the facility to ensure the resident had her medications on hand and available to be administered to her as ordered. Interview with a mediation aide (MA) on 06/15/22 at 9:23am revealed: -There was no process in placed for MAs to do cart audits to ensure all medications were available to the residents as ordered. -She was no sure why Resident #3's Lipitor and Lomotil were not available on the cart to be administered as ordered.	D 358		

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	HAL051024	A. BUILDING: _____ B. WING _____	R 06/15/2022

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D 358	Continued From page 14 -MAs were responsible to order medications when a resident ran out; the Lipitor was never given on her shift and she did not know the resident ran out and the Lomotil was an as needed medication that the resident had not needed recently. -MAs were responsible to administered medications as ordered and accurately document administration of medications the resident's eMAR. Interview with the HWD on 06/15/22 at 11:58am and 12:40pm revealed: -She was not aware that Resident #3 did not have medications on hand to be administered to her accurately as ordered. -It was the MA's responsibility to request a refill from the pharmacy for any medications residents that were needed on each shift. -If MAs were having trouble refilling a medication, they were responsible to report the issue to her so she could remediate the situation. -She expected MAs to administer and document medications accurately as ordered following the rights to safe medication administration per their training. -It was important for residents to receive their prescribed medications by their PCP and other providers to treat medical conditions and health needs. -The MAs were responsible to audit the medication carts once monthly comparing the resident's medications on hand to their orders and the eMAR. -It was her responsibility to review the audits to ensure everything was accurate behind the MAs, but she could not find an audit for Resident #3 and was not sure how it was missed. Interview with the facility's contracted PCP on	D 358		

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D 358	Continued From page 15 06/15/22 at 11:07am revealed: -She was not aware that Resident #3 was not receiving her Lipitor as ordered. -The Lipitor was ordered for Resident #3 to reduce her cholesterol. -She expected the facility to administer the Lipitor to Resident #3 accurately order and notify her if the resident did not receive the medication as ordered. -She ordered medications for Resident #3 to treat the resident based on her diagnoses. -She expected the facility to have a process in place to ensure resident medications were available to be administered as ordered or as needed and to not run out of medications. -She expected medications to be administered accurately as ordered and to notify her if there were any issues as soon as possible.	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; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,	D 367		

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D 367	Continued From page 16 (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 medication documentation on the electronic medication administration record (eMAR) for 1 of 3 sampled residents (#3) in which medications were not available on the medication cart for administration but had been documented as administered on the resident's eMAR. The findings are: Interview with the Health and Wellness Director (HWD) on 06/14/22 at 8:55am revealed: -The Administrator was on leave and would not be able to be present that week. -She was covering for the facility as the Administrator and was in charge at that time. Review of the facility's medication error policy dated December 2017 revealed: -Medication aides (MAs) were expected to administer medications per the 7 rights (right medication, route, refuse, documentation, person, dose, and time). -MAs were expected to document medication administration accurately on the resident's electronic medication administration record (eMAR). -MA's were expected to report medication errors to the nurse, executive director (ED), or other designee and to the primary care provider (PCP) immediately, then document it in the resident's progress notes and complete an incident report.	D 367		

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D 367	Continued From page 17 Review of Resident #3's current FL-2 dated 12/22/21 revealed: -The resident was admitted to the special care unit (SCU) from a skilled nursing facility. -Diagnoses included dementia, Parkinson's disease, hypertension, and anxiety. -The resident was constantly disoriented and semi-ambulatory. Review of Resident #3's current physician orders dated 03/22/22 revealed there was an order for Lipitor 10mg take one tablet at bedtime. Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Lipitor 10mg take one tablet at bedtime. -The Lipitor was documented as administered from 04/01/22-04/30/22. Review of Resident #3's May 2022 eMAR revealed: -There was an entry for Lipitor 10mg take one tablet at bedtime. -The Lipitor was documented as administered from 05/01/22-05/31/22 except on 05/20/22 and 05/21/22 when it was documented as spit out. Review of Resident #3's June 2022 eMAR revealed: -There was an entry for Lipitor 10mg take one tablet at bedtime. -The Lipitor was documented as administered from 06/01/22-06/13/22. Observation of Resident #3's medications on hand on 06/15/22 at 9:23am revealed there was no Lipitor available on hand for administration to	D 367		

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D 367	Continued From page 18 the resident. Interview with a pharmacist at the Resident #3's pharmacy on 06/15/22 at 9:45am revealed the pharmacy never filled Lipitor for the resident. Interview with a pharmacist at the facility's contracted pharmacy provider on 06/15/22 at 9:59am revealed: -Resident #3's Lipitor was last filled on 03/25/22 with a 30-day supply; it would have run out on 04/18/22. -The pharmacy had not received a request or order to refill the Lipitor until that day, 06/15/22. -The facility was responsible to refill resident medications as needed prior to running out. -It was important for Resident #3 to receive her Lipitor as ordered because the medication was used to help reduce cholesterol levels and her PCP ordered the medication for a reason. Review of Resident #3's progress notes revealed there was no documentation that the provider was made aware that the resident had run out of Lipitor or that it was documented as administered when not available. Interview with a mediation aide (MA) on 06/15/22 at 9:23am revealed there was no process in placed for MAs to do cart audits to ensure all medications were available to the residents as ordered. Interview with the HWD on 06/15/22 at 11:58am and 12:40pm revealed: -She was not aware that Resident #3 did not have medications on hand to be administered to her accurately as ordered. -She expected MAs to administer and document medications accurately as ordered following the	D 367		

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D 367	Continued From page 19 rights to safe medication administration per their training. -It was her responsibility to review the audits to ensure everything was accurate behind the MAs, but she could not find an audit for Resident #3 and was not sure how it was missed. Interview with the facility's contracted PCP on 06/15/22 at 11:07am revealed: -She ordered medications for Resident #3 to treat the resident based on her diagnoses. -She expected medications to be administered and documented on the eMAR accurately as ordered. -She expected the facility to notify her if there were any issues as soon as possible. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not able to be interviewed.	D 367		

Brookdale Smithfield HAL 051024 6/15/2022 01AK11

This Plan of Correction is not to be construed as an admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.

. 10A NCAC 13F .0902(b) Health Care

Review of current residents' records for referral / follow-up to health care needs, including weight gain, weight loss, laboratory tests and xrays, that require involvement of outside services will be conducted once by the clinical staff. Further review will occur with each new tracking order.

Notification or contact with physicians or other health care providers concerning the needs that are unmet will be documented in the residents' records by the HWD or Designee.

Training on New Order Tracking Forms will be conducted by the HWD/Designee. Training on reporting change of condition will be conducted by the HWD/Designee.

Contacts and/or visits, with a prescribing practitioner, or other licensed health professional, will be documented in residents' records.

The HWD or designee will review the new tracking orders on a daily basis and document interventions and exceptions in the residents' records.

New tracking orders will be maintained for 30 days.

The Executive Director will notify family members that the community is to be provided with appointment information, new orders and other information from appointments when they take the resident to the appointment.

Associate transporting the resident will report following all provider visits, appointment changes or cancellations for each occurrence and ensure that orders are provided to the HWD/Designee. The HWD/ED will document visits, changes and cancellations and assure follow up as needed.

The Executive Director will review a sample of resident records and new order tracking forms on a weekly basis to assure referral and follow-up for health care needs are met for four weeks and then monthly for six months and then randomly ongoing.

The date of correction for this violation will not exceed July 27, 2022.

10A NCAC 13F .1004(a) Medication Administration

Medication Aides will be retrained in company policy and procedure for preparation and administration of medications including but not limited to unavailable medications.

The HWD or designee will generate and review a missed medication administration report daily.

Medications noted to not be administered due to unavailability will be followed up within 12 hours.

The HWC (Health and Wellness Coordinator) or designee will monitor medication carts on a weekly basis to verify medications are available times six weeks and then monthly midway the batch cycle.

The date of correction for this standard deficiency will not exceed July 27, 2022

10A NCAC 13F .1004(j) Medication Administration

The HWD (Health and Wellness Director) will complete training with Medication Aides in the area of Medication Administration Basics to include but not limited to: documentation, review of routes of medication and treatments/ dosages of medication and treatments.

The HWD/RCC (Resident Care Coordinator) /Designee will review resident eMars and current medication orders for accuracy. These will be compared to the medication labels. Physicians will be contacted for clarification as needed.

The HWD/Licensed RCC will observe medication aides administering medications on a weekly basis x 4 weeks and then monthly and maintain documentation of the observation for 90 days.

The ED (Executive Director) will review the observation forms monthly for three months and then quarterly as needed.

The date of correction for this standard deficiency will not exceed July 27, 2022.