STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TRUEWOOD BY MERRILL, NEW BERN	2701 AMHURST BOULEVARD NEW BERN, NC 28562

(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 on September 29-30, 2021 and October 1, 2021.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide assistance with single incontinence brief care, repositioning, and elevating lower extremities for 1 of 5 sampled residents (#3) who needed assistance and was found wearing two incontinence briefs, had deep redness to the buttocks, posterior thighs and groin and increased swelling of the lower extremities. The findings are: Review of Resident #3's current FL-2 dated 03/31/21 revealed: -Diagnoses included chronic obstructive pulmonary disease, rheumatoid arthritis, urinary frequency, Alzheimer's disease and triennial neuralgia. -Bathing and dressing assistance were required. Review of Resident #3's current care plan dated	D 269		

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D 269	Continued From page 1 10/21/21 revealed: -She had limited ambulation ability and range of motion in her upper extremities. -She had occasional bowel and daily bladder incontinence. -She was always disoriented and had significant memory loss. -She required limited assistance with ambulation, bathing and dressing. -She required supervision with transfers and limited assistance with ambulation. Review of a hospice nurse visit note for Resident #3 dated 07/19/21 revealed: -The resident's legs were in the dependent position and had redness and swelling. -Instructions to elevate her legs as much as possible. Observations of Resident #3 in her room on 09/29/21 from 9:56am to 10:00am revealed: -She was sitting in a recliner with a bedside table over her lap. -She was slouched down in the recliner with more than half her thigh over the edge of chair seat. -Her legs were in a dependent position with her feet flat on the floor, a large amount of swelling to both legs from the knee to the toes and redness to the right lower leg. -A personal care aide (PCA) entered the room, removed the disposable breakfast plate from the bedside table and left the room immediately after discarding the plate in the trash basket. Observations of Resident #3 on 09/29/21 at 3:16pm revealed: -She was sitting in a recliner slouched down with a pillow behind her back. -Her feet wear in a dependent position, flat on the floor with a large amount of swelling from her	D 269		

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knee to her toes and redness to her right lower leg.

Interview with a PCA on 09/29/21 at 3:16pm revealed:
-She had just finished assisting Resident #3 with a shower.
-The swelling in her lower legs would come and go and tended to increase when she was up and moving around.

Observations of Resident #3 on 09/30/21 at 7:42am revealed:
-She was sitting in the recliner with her feet elevated on the footrest.
-There was significant decrease in the amount of swelling to her legs from her knees to her toes.

Telephone interview with Resident #3's hospice nurse on 09/30/21 at 8:35am revealed:
-Redness and swelling to Resident #3's lower extremities was a chronic issue.
-The swelling was managed by elevating her legs when she in the sitting position.
-She was able to communicate at times.
-She had increased episodes of incontinence recently (no date) and needed staff assistance to use the bathroom.

Observations of Resident #3 on 09/30/21 from 10:04am through 10:20am revealed:
-At 10:04am, she was sitting in the recliner with her feet flat on the floor and an increase in the swelling to her lower extremities.
-At 10:11am, the PCA used the electronic controls on the recliner to lift the resident to near standing position.
-The PCA assisted her to fully stand by placing her arm under the resident's right arm.
-Once she was standing, the PCA faced her and

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held both hands while she prompted the resident to take each step.
-The resident took one step at a time with difficulty and saying "ooh" and "ouch."
-In the bathroom, the PCA assisted with pulling down the resident's pants and brief.
-She was wearing a pull up style incontinence brief with a tape closure brief lining the inside of pull up brief.
-She had deep red areas on her buttocks resembling a seat, both posterior thighs down to the mid-thigh area and both sides of her groin.
-She grimaced and moaned when the PCA used a wipe to clean her peri-genital area and gluteal fold.
-The tape closure brief was moderately wet, and the resident urinated in the toilet.

Interview with a second PCA assigned to Resident #3 on 09/30/21 at 10:04am and 10:11am revealed:
-Staff normally elevated Resident #3's feet when she sat in the recliner.
-She did not know why her feet were not elevated at that time.
-She did not know Resident #3 was wearing two incontinence briefs.
-She did not know who had put two incontinence briefs on her.
-She had not seen the redness on the resident's skin before.
-That was the first time she had taken her to the bathroom since starting the shift at 7:00am.
-Normally the staff who assisted the resident to get up and dressed also took her to the bathroom.
-She normally did not take her to the bathroom until after breakfast and the next time would have been after lunch.
-Staff were responsible for checking for

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incontinence and/or assisting residents to the bathroom every two hours.

Interview with the Lead medication aide (MA) on 09/30/21 at 10:21am revealed:
-The swelling to her lower legs was a chronic issue.
-Redness on her buttocks, thighs and groin was not abnormal because Resident #3 had hospice aides that came in and bathed her.
-If there was anything abnormal, they would have notified the hospice nurse.
-Staff were not supposed to put two incontinence briefs on a resident.
-Staff were expected to use one brief and check the resident every two hours for incontinence.
-Resident #3 sat in her recliner all day; sometimes she cooperated with staff and walked to the bathroom with them.
-Neither facility staff nor hospice staff had reported the redness to her buttocks, thighs and groin.

Interview with the first PCA on 09/30/21 at 10:34am revealed she did not notice any redness to Resident #3's buttocks, thighs and groin when she showered her on 09/29/21.

Second interview with the MA/Supervisor on 09/30/21 at 11:49am revealed:
-She did not have a set schedule of checking the skin of residents with incontinence and decreased mobility.
-For Resident #3 specifically, she was under hospice care and hospice aide bathed her three times a week.
-The hospice aide would have checked her skin for any redness, bruises or marks.
-Facility PCAs were usually good about reporting any new bruises or marks found on residents.

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D 269	Continued From page 5 Second telephone interview with Resident #3's hospice nurse on 10/01/21 at 9:55am revealed: -No one had reported issues related to deep redness on her buttocks, posterior thighs and groin prior to 09/30/21. -He had placed an order for a barrier cream the evening of 09/30/21 after speaking with the Resident Care Director (RCD). -Her increased incontinence was mostly at night. -She had been able to reposition herself in the chair. -He had not seen Resident #3 ambulate. -Most of the information about her ambulatory status came from the hospice aides. -He relied on hospice aides and facility staff to report any changes in skin condition. -He typically completed a skin assessment if he knew there was a problem like a wound. -If a resident was using barrier cream, he would check their skin weekly. -He did not instruct staff to use two incontinence briefs because it was not hospice policy. Telephone interview with Resident #3's primary care provider (PCP) on 09/30/21 at 2:09pm revealed: -She had not seen Resident #3 at the facility. -She was the covering provider for the facility because the previous provider was no longer with the medical office. -The medical office was the PCP for Resident #3. -The facility last contacted the PCP on 09/07/21 reporting weight gain. -The previous provider followed up on the reported weight gain documenting the resident had chronic edema and redness of her lower legs. -There was no notation in the medical office's for Resident #3 of any contact since 09/07/21	D 269		

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including notification of redness to her bottom, thighs and groin.
-Typically, facility staff would report skin concerns like redness to the hospice nurse.
-If the hospice nurse then needed orders, then the hospice nurse would contact the PCP.

Telephone interview with Resident #3's hospice provider on 10/01/21 at 10:41am revealed:
-She did not know Resident #3 had deep red areas on her buttocks, posterior thighs and groin.
-At minimum, she expected staff to notify the hospice nurse for follow up.
-She never advised using two incontinence briefs.
-Using two briefs was not as breathable and added to moisture against the skin and risk of dermatitis.

Interview with the Resident Care Director (RCD) on 09/30/21 at 10:35am revealed:
-Resident #3 had significant dementia symptoms and would cry when wiped from being scared or anxious.
-Staff usually reported skin redness to the hospice nurse.
-Staff were not supposed to use two incontinence briefs on residents.
-Staff were expected to provide incontinence care every two hours and as needed if the resident was noticed to be soiled in between.
-Staff were able to tell when Resident #3 was soiled by her behavior when she got up and walked to the nursing station.
-Resident #3 was able to get up and walk on her own.
-The last time was three days ago (09/27/21) when she walked to the nursing station by herself.
-She did not spend all day and night in her recliner.
-Staff attempted to assist Resident #3 to get up,

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change her position and to bed at night.
-Resident #3 did not have current orders for a skin barrier cream or ointment for the redness.

Second interview with the RCD on 09/30/21 at 11:35am revealed:
-Redness could indicate sitting for too long.
-Resident #3 was not always cooperative with getting up out of the chair.
-Double briefs were not used because you did not want urine just sitting on the skin because it could lead to skin breakdown.
-She had not yet seen the redness on Resident #3's skin.

Third interview with the RCD on 09/30/21 at 11:59am revealed the MA/Supervisor competed quarterly skin checks for residents and as needed when a PCA reported a concern found with a resident shower.

Interview with the Administrator on 09/30/21 at 4:15pm revealed:
-Staff were expected to report a change in condition such as redness of the buttocks, thighs and groin to the DRC so she could assess, stage the wound and follow up with the resident's PCP.
-If a resident was a heavy wetter or on a diuretic, it was permissible to use two incontinence briefs if the PCP was aware.
-PCP notification should be documented in the care notes.
-Staff were not permitted to use two incontinence briefs to decrease the frequency of incontinence care.
-Staff were expected to provide incontinence care and/or assist residents to the bathroom every two hours.
-Redness on buttocks, posterior thighs and the groin area were concerning for discomfort and

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D 269	Continued From page 8 pain for the resident. -If the redness was found by hospice staff then they should have reported it to facility staff. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. Attempted telephone interview on 10/01/21 at 9:55am with hospice aide who provided bathing assistance to Resident #3 on 09/28/21 and 09/30/21 was unsuccessful.	D 269		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents (#8) observed during the medication pass including errors with two topical creams and medication for anxiety and agitation; and for 1 of 5 residents sampled (#5) for record review including errors with receiving the wrong dose of two medications for high blood pressure, continuing to receive two other medications for high blood pressure after	D 358		

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they were discontinued, receiving a medication for acid reflex at the wrong frequency, and not receiving a medication for constipation as ordered.

The findings are:

1. The medication error rate was 9% as evidenced by the observation of 3 errors out of 33 opportunities during the 8:00am and 9:00am medication passes on 09/30/21.

Review of Resident #8's current FL-2 dated 04/08/21 revealed diagnoses included cognitive decline, depression, diabetes mellitus II, mild malnutrition, and transient ischemia attack (temporary blockage of blood flow to the brain).

a. Review of Resident #8's mental health provider (MHP) visit note dated 07/13/21 revealed an order to start Lorazepam 0.5mg take 1 tablet twice a day as needed (prn) for acute anxiety / agitation. (Lorazepam is a controlled substance used for anxiety and agitation.)

Review of Resident #8's MHP visit note dated 08/03/21 revealed:
-There was an order to start Lorazepam 0.5mg 1 tablet daily in the morning.
-There was an order to continue Lorazepam 0.5mg every 12 hours prn as currently prescribed.

Review of Resident #8's MHP visit note dated 08/20/21 revealed:
-There was an order to discontinue Lorazepam 0.5mg every morning.
-There was an order to continue Lorazepam 0.5mg every 12 hours as currently prescribed.
-The order to continue Lorazepam every 12 hours did not specify prn or scheduled.

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D 358	Continued From page 10 Review of Resident #8's hospital discharge instructions dated 08/25/21, 08/28/21, and 08/29/21 revealed the resident was seen in the emergency room on those dates for falls with one injury documented of bruising around the right eye. Review of Resident #8's hospital discharge instructions dated 09/29/21 revealed: -The list of medications included Lorazepam 0.5mg every 12 hours. -The discharge instructions were not signed by a prescribing practitioner. -There were no signed orders on the discharge instructions. Review of Resident #8's physician's orders revealed no documentation of clarification for Lorazepam. Observation of the 9:00am medication pass on 09/30/21 revealed: -Resident #8 was awake, calm, and sitting in her recliner. -The Lead medication aide (MA) prepared and administered 10 oral medications to Resident #8 at 8:54am. -The Lead MA prepared and applied a topical cream to the resident at 8:59am. -The Lead MA went back to the medication cart and looked at the September 2021 electronic medication administration record (eMAR) on the computer screen several times scrolling through the resident's list of medications. Interview with the Lead MA on 09/30/21 at 9:02am revealed: -She needed to check the resident's record because she usually administered Lorazepam to	D 358		

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the resident every morning but she did not see it on the eMAR.
-Sometimes the pharmacy "messed up things" and a medication did not always show up on the eMAR.

Observation on 09/30/21 at 9:06am revealed:
-The Lead MA asked the Resident Care Director (RCD) to come to the medication cart with Resident #8's record.
-The RCD told the Lead MA the Lorazepam was listed on a recent hospital form when the resident returned to the facility and she needed to verify with the primary care provider (PCP) the information listed on the hospital forms.

Observation of the Lead MA on 09/30/21 revealed she administered one Lorazepam 0.5mg tablet to Resident #8 at 9:09am but there was no signed order for the resident to receive a scheduled dose of Lorazepam.

Interview with the Lead MA on 09/30/21 at 9:10am revealed:
-She administered the Lorazepam because she thought the order should have been on the eMAR.
-She would document the administration of the Lorazepam on a paper MAR when she finished the medication pass.

Observation of Resident #8's medications on hand on 09/30/21 at 12:08pm revealed:
-There was a supply of Lorazepam 0.5mg tablets dispensed on 08/17/21 with 9 of 30 tablets remaining with instructions to take 1 tablet every morning.
-There was a second supply of Lorazepam 0.5mg dispensed on 08/25/21 with 60 of 60 tablets remaining with instructions to take 1 tablet every

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D 358	Continued From page 12 12 hours prn for acute anxiety / agitation. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/01/21 at 11:43am revealed: -The pharmacy dispensed 30 Lorazepam 0.5mg tablets on 07/13/21 and 60 Lorazepam 0.5mg tablets on 08/25/21 with instructions to administer prn. -The pharmacy dispensed 30 Lorazepam 0.5mg tablets on 08/17/21 with instructions to administer scheduled daily in the morning. -The pharmacy received a discontinue order for Lorazepam 0.5mg every morning on 08/20/21 from the resident's MHP and that order was discontinued from the eMAR system. Review of Resident #8's controlled drug records (CDRs) for Lorazepam for 07/13/21 - 10/01/21 revealed: -There was a CDR for Lorazepam dated 07/13/21 with 30 tablets received with instructions to take 1 tablet every 12 hours prn for acute anxiety / agitation. -There were 2 once daily doses documented as administered at 8:00am on 08/24/21 and 08/25/21, after the order to discontinue the scheduled morning dose on 08/20/21. -There was a second CDR for Lorazepam dated 08/17/21 with 30 tablets received with instructions to take 1 tablet every morning. -The first dose was documented as administered at 8:00am (no date noted) and the last dose documented was on 10/01/21 at 8:00am, leaving a balance of 8 tablets. -There were 22 scheduled morning (8:00am) doses of Lorazepam documented as administered from 09/11/21 - 10/01/21, after the order to discontinue the scheduled morning dose on 08/20/21.	D 358		

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D 358	Continued From page 13 -There was a total of 24 scheduled morning (8:00am) doses of Lorazepam 0.5mg documented as administered from 08/24/21 - 10/01/21, after the order to discontinue the scheduled morning dose on 08/20/21. -There was a third CDR log for Lorazepam dated 08/25/21 with 60 tablets received with instructions to take 1 tablet every 12 hours prn for acute anxiety / agitation but no doses were documented as administered on this CDR. Review of Resident #8's August 2021 eMAR revealed: -There was an entry for Lorazepam 0.5mg take 1 tablet every 12 hours prn for acute anxiety / agitation and it was documented as administered on 7 occasions from 08/01/21 - 08/31/21. -There was a second entry for Lorazepam 0.5mg take 1 tablet every morning scheduled at 9:00am and it was documented as administered daily at 9:00am from 08/04/21 - 08/20/21. -The scheduled Lorazepam was documented as discontinued and not administered from 08/21/21 - 08/31/21. Review of Resident #8's September 2021 eMAR revealed: -There was an entry for Lorazepam 0.5mg take 1 tablet every 12 hours prn for acute anxiety / agitation and it was documented as administered on 2 occasions from 09/01/21 - 09/30/21. -There was no other entry for Lorazepam on the eMAR. Review of Resident #8's October 2021 eMAR on 10/01/21 revealed: -There was an entry for Lorazepam 0.5mg take 1 tablet every 12 hours prn for acute anxiety / agitation. -There was no other entries for Lorazepam.	D 358		

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D 358	Continued From page 14 -There was no Lorazepam documented as administered on the eMAR for 10/01/21 but there was 1 dose documented as administered on the CDR. Review of Resident #8's paper MAR dated 09/30/21 revealed: -There was a handwritten entry for Lorazepam 0.5mg take 1 tablet every morning scheduled for 8:00am. -The MA documented administration of Lorazepam 0.5mg on 09/30/21 at 9:10am. Interview with the RCD on 09/30/21 at 1:37pm revealed: -When a resident returned from a hospitalization, she would send a copy of the resident's most recent physician's order sheet to the resident's PCP. -She would then schedule a virtual visit between she and the PCP and she would go over the hospital discharge instructions with the PCP. -She would either scan the hospital discharge instructions or verbally tell the PCP. -She usually sent the hospital discharge instructions to the pharmacy but the discharge instructions were not usually signed by a provider. -She usually administered medications according to the unsigned hospital discharge instructions until she got clarification from the PCP. -The exception was for any controlled substances because the pharmacy needed a hard copy of a prescription to dispense those medications. -The MAs would continue to administer any controlled substances according to the eMAR until a new prescription was obtained. -She had not clarified Resident #8's unsigned medication list from the hospital discharge instructions dated 09/29/21 with the PCP yet. -She sent an email to the PCP today (09/30/21)	D 358		

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about the Lorazepam but she would also check with the resident's MHP since the MHP originally prescribed the Lorazepam.

Second interview with the RCD on 10/01/21 at 1:39pm revealed:
-The MA on duty was responsible for removing any discontinued medications from the medication cart at the time the discontinue order was received.
-Resident #8's scheduled Lorazepam supply should have been removed from the medication cart when it was discontinued on 08/20/21.
-If a medication was not listed on the eMAR, the MAs should not administer it.
-If the MAs had a question about a medication no longer being on the eMAR, the MAs should check with her or one of the Lead MAs when they first noticed a problem.

Interview with the Administrator on 09/30/21 at 4:15pm revealed:
-The RCD was responsible for clarification of medication orders.
-The RCD should clarify any incomplete or unclear orders at the time the order was received.
-The MAs should report any discrepancies to the RCD or if the RCD was not available, the MAs could contact the pharmacy.
-She was not aware Resident #8 continued to receive scheduled Lorazepam after the order was discontinued.
-She expected the MAs to administer medications as ordered.

Telephone interview with Resident #8's PCP on 09/30/21 at 2:14pm revealed:
-She was contacted today, 09/30/21, about the resident's Lorazepam order.
-She was waiting for a response from the

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resident's MHP.
-In the meanwhile, she was planning to write a new order for Lorazepam 0.5mg twice a day prn for agitation and for the facility to stop administering any scheduled Lorazepam
-The facility continuing to administer the Lorazepam on a scheduled basis instead of prn as ordered, could lead to increased sedation and increased risk of falls for the resident.

Telephone interview with Resident #8's MHP on 10/01/21 at 12:36pm revealed:
-Resident #8 had been agitated and fighting staff so she started Seroquel (an antipsychotic) on 08/20/21 and discontinued the scheduled Lorazepam the same day because the Lorazepam was not working.
-She discontinued the Lorazepam on 08/20/21 when she started the Seroquel because she did not want to double dose the resident with two medications because it could cause increased sedation and an increased risk for falls.
-The MAs should not have administered Lorazepam daily in the morning after it was discontinued on 08/20/21.
-She was not aware of the resident being sedated but the resident did have a history of falls.
-When she saw the resident on 09/23/21, the resident was not sedated and the September 2021 eMAR showed 2 doses of prn Lorazepam had been administered.
-She was not aware the resident continued to receive the scheduled Lorazepam because it was not documented on the eMAR.

Based on observations, interviews, and record reviews, it was determined Resident #8 was not interviewable.

b. Review of Resident #8's current FL-2 dated

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D 358	Continued From page 17 04/08/21 revealed: -There was an order for Eucerin Cream use twice daily. (Eucerin Cream is an emollient cream used to moisturize dry skin.) -There was an order for Triamcinolone Cream mix with Eucerin Cream apply twice daily. (Triamcinolone Cream is a topical steroid used to treat skin conditions such as itching, dryness, and redness.) Review of Resident #8's physician's order dated 04/27/21 revealed: -The facility requested clarification for the site of Eucerin Cream because the order stated to apply twice daily but no site was confirmed. -There was a clarification order for Eucerin Cream apply twice daily as needed to dry skin on arms and legs. -There was no clarification for the Triamcinolone Cream to indicate the strength, where to apply the cream, or how much of each cream to mix together. Observation of the medication pass on 09/30/21 at 8:59am revealed: -The Lead medication aide (MA) used a small plastic spoon to scoop some Triamcinolone Cream 0.1% from Resident #8's 1-pound container on hand. -The Lead MA put the spoonful of Triamcinolone Cream 0.1% Cream into a small clear plastic medication cup. -The Lead MA donned gloves and pulled off the resident's socks and shoes. -The Lead MA applied the Triamcinolone Cream to the top of the resident's feet and shins on both legs. -The Lead MA did not apply any Triamcinolone Cream to the bottom of the resident's feet or the back of her legs.	D 358		

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-The Lead MA did not apply Triamcinolone Cream to any other parts of the resident's body.
-The Lead MA did not attempt to mix the Triamcinolone Cream with the resident's Eucerin Cream on hand in the medication cart as ordered.

Review of Resident #8's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Triamcinolone Cream 0.1% mix with Eucerin Cream and apply twice a day scheduled for 9:00am and 9:00pm.
-Triamcinolone Cream was documented as administered from 09/14/21 - 09/30/21 except on 09/28/21 at 9:00pm when the resident was out of the facility.
-There was an entry for Eucerin Cream apply to dry skin on arms/legs twice a day as needed but none was documented as administered from 09/01/21 - 09/30/21.

Observation of Resident #8's medications on hand on 09/30/21 at 12:12pm revealed:
-There was a 1-pound container of Triamcinolone Cream 0.1% dispensed on 06/01/21 with instructions to mix with Eucerin Cream and apply twice a day.
-The container was over ¾ full of Triamcinolone Cream.
-There was a 1-pound container of Eucerin Cream dispensed on 04/29/21 with instructions to apply to dry skin on arms/legs twice a day as needed.
-The container was approximately ¾ full of Eucerin Cream.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/01/21 at 11:43am revealed:
-The pharmacy dispensed a 1-pound container of

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D 358	Continued From page 19 Triamcinolone Cream 0.1% each on 04/20/21 and 06/01/21 with instructions to mix with Eucerin Cream and apply twice a day. -The pharmacy dispensed a 1-pound container of Eucerin Cream once on 04/29/21 with instructions to apply to arms/legs twice a day as needed. Interview with the Lead MA on 09/30/21 at 11:58am revealed: -She usually applied the Triamcinolone Cream to Resident #8's feet and lower legs and she thought the cream was for dry skin. -She had not noticed the instructions on the eMAR or medication label were to mix the Triamcinolone Cream with the Eucerin Cream. -She was not sure how much of each cream to mix together because the instructions were unclear. -She applied the Triamcinolone Cream to the resident's feet and lower legs because that was where she thought the resident had dry skin. -She had not noticed the instructions did not indicate where the cream should be applied. -If a medication order needed to be clarified, the Lead MAs, the MAs, or the Resident Care Director (RCD) were responsible for contacting the primary care provider (PCP) for clarification. Interview with the RCD on 09/30/21 at 1:37pm revealed: -She was not aware Resident #8's order for Triamcinolone Cream was to mix it with Eucerin Cream or that the order did not include where the cream should be applied. -The Lead MAs or the MAs could contact the PCP for clarification for any incomplete or unclear orders or they should notify her. -The Lead MAs were responsible for doing quarterly medication cart audits, including reviewing orders and the eMARs.	D 358		

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-If there was a discrepancy found during the audits, the MAs were supposed to notify her.
-She expected the MAs to administer medications as ordered.

Interview with the Administrator on 09/30/21 at 4:15pm revealed:
-The RCD was responsible for clarification of medication orders.
-The RCD should clarify any incomplete or unclear orders at the time the order was received.
-The MAs should report any discrepancies to the RCD or if the RCD was not available, the MAs could contact the pharmacy.
-She was not aware Resident #8's order for Triamcinolone Cream mixed with Eucerin cream needed clarification.

Telephone interview with Resident #8's PCP revealed:
-She was contacted today, 09/30/21, to clarify the order for Triamcinolone Cream and Eucerin Cream.
-She expected the Triamcinolone Cream and Eucerin Cream to be administered as ordered or contact her for clarification if there were questions.
-The Triamcinolone Cream and Eucerin Cream should be applied to the resident's hands and feet and it was usually used for dry skin.

Based on observations, interviews, and record reviews, it was determined Resident #8 was not interviewable.

2. Review of Resident #5's current FL-2 dated 03/23/21 revealed diagnoses included orthostatic syncope, hypotension, arthritis and tachycardia.

Interview with Resident #5 on 09/29/21 at

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D 358	Continued From page 21 10:32am revealed: -She recently experienced a fall out of bed; she did not remember what happened or when it was. -She got a cut from the fall and staff were changing the dressing every so often. -She felt like she could not bounce back from the fall and did not have any energy. -She had seen her physician since the fall happened. Interview with Resident #5 on 10/01/21 at 11:17am revealed: -When she went to the hospital on 09/12/21, she felt terrible. -She did not have specific symptoms other than feeling awful. -She kind of felt like that currently. a. Review of Physician Order Reviews for Resident #5 signed by the primary care provider (PCP) on 08/17/21 and 09/20/21 revealed an order for Miralax 1 capful (17gm) daily. (Miralax is used to treat constipation) Observations of medications available for administration for Resident #5 on 10/01/21 at 11:27am revealed: -A 17.9-ounce manufacturer's bottle (30 capfuls) with a pharmacy label for Miralax and instructions for one capful (17gm) daily. -One bottle was dispensed on 06/01/21 and was nearly full. Interview with the Lead medication aide (MA) on 10/01/21 at 11:27am revealed: -Resident #5 was supposed to be on Miralax every day. -She did not have an explanation for how the bottle dispensed 06/01/21 was nearly full.	D 358		

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D 358	Continued From page 22 Review of Resident #5's June 2021 electronic medication administration record (eMAR) revealed: -An entry for Miralax 1 capful (17gm) daily at 9:00am. -Documentation a dose was administered daily 06/01/21 through 06/30/21. Review of Resident #5's July 2021 eMARs revealed: -An entry for Miralax 1 capful (17gm) daily at 9:00am. -Documentation a dose was administered daily 07/01/21 through 07/31/21. Review of Resident #5's August 2021 eMARs revealed: -An entry for Miralax 1 capful (17gm) daily at 9:00am. -Documentation a dose was administered daily 08/01/21 through 08/31/21. Review of Resident #5's September 2021 eMARs revealed: -An entry for Miralax 1 capful (17gm) daily at 9:00am. -Documentation a dose was administered daily 09/01/21 through 09/13/21 and 09/19/21 through 09/30/21. -Documentation doses were held 09/14/21 through 09/18/21. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/01/21 at 11:51am revealed: -The current order for Miralax was for 17 grams daily dated 03/24/21 for Resident #5. -Miralax was dispensed for Resident #5 on 03/21/21, 04/27/21 and 06/01/21.	D 358		

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D 358	Continued From page 23 Interview with Resident #5 on 10/01/21 at 1:06pm revealed: -She had a bowel movement on 09/30/21. -She did not take Miralax. -She did get Miralax when she was in the hospital and got along okay with it. Interview with the Resident Care Director (RCD) (Administrator present) on 10/01/21 at 1:37pm revealed MAs were expected to check medications against eMAR, administer according to the order and observe the resident take the medication. b. Review of Resident #5's primary care provider (PCP) progress note dated 09/20/21 revealed: -Resident #5 was seen for follow up after hospitalization for chest pain and elevated blood pressure. -Her metoprolol was increased at discharge from the hospital. (Metoprolol is used to treat hypertension, chest pain and heart failure.) -She now felt fatigued with lightheadedness. Review of a Physician Order Review for Resident #5 signed by the primary care provider (PCP) on 08/17/21 revealed an order for metoprolol 12.5mg twice daily. Review of the medication discharge report dated 09/13/21 for Resident #5 revealed there was no licensed provider's signature or electronic signature on the list of new medications which included metoprolol 25mg twice daily. Review of a Physician Order Review for Resident #5 signed by the PCP on 09/20/21 revealed an order to change metoprolol from 25mg twice daily to 12.5mg twice daily.	D 358		

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D 358	Continued From page 24 Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/01/21 at 11:51am revealed: -The current order for metoprolol was 25mg one half tablet (12.5mg) twice daily dated 09/20/21 for Resident #5. -Metoprolol 25mg was listed on the medication discharge report dated 09/13/21. Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed: -An entry for metoprolol 25mg one half tablet (12.5mg) twice daily at 9:00am and 9:00pm. -Documentation doses were administered from 09/20/21 at 9:00pm through 09/30/21 at 9:00pm. Observations of medications available for administration for Resident #5 on 10/01/21 at 11:27am revealed: -A bubble pack with a pharmacy label for metoprolol 25mg tablets and instructions for one tablet daily. -Fifty-six whole tablets were dispensed on 09/16/21 with 6 whole tablets remaining. Observations of medications on hand for Resident #5 on 10/01/21 at 4:46pm revealed: -A second bubble pack with a pharmacy label for metoprolol 25mg tablets and instructions for one tablet twice daily. -Fifty-six tablets were dispensed on 09/16/21 with 26 tablets remaining. Interview with the Lead medication aide (MA) on 10/01/21 at 11:27am revealed: -Resident #5 was getting one half of a 25mg tablet for 12.5mg, then the order was changed to one whole tablet of 25mg after she returned from the hospital (09/13/21).	D 358		

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-She administered the metoprolol 25mg tablet that morning (10/01/21).
-The resident was receiving metoprolol 25mg twice daily because that was what was in the medication cart for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/01/21 at 12:42pm revealed the pharmacy dispensed 28 whole tablets of metoprolol halved for 56 metoprolol 12.5mg doses on 09/15/21.

Interview with the Lead MA on 10/01/21 at 12:58pm revealed:
-She found a new bubble pack of metoprolol 25mg tablets halved to make 12.5mg, for Resident #5 in the overstock drawer at the bottom of the medication cart.
-She did not know how MAs were documenting administering metoprolol 12.5mg twice daily on the eMAR when the bubble pack contained a different dosage.

Telephone interview with Resident #5's PCP on 10/01/21 at 2:45pm revealed:
-Metoprolol was prescribed for her heart.
-He would be concerned if she had been taking 25mg twice daily instead of 12.5mg twice daily for an exceedingly low heart rate (below 60) .
-An increased dose of metoprolol may have contributed to her falls.

Based on interviews with staff, observations of medications on hand and review of orders, metoprolol 25mg was administered twice daily for 10 days (09/20/21 through 10/01/21) after being decreased to 12.5mg twice daily by the PCP (09/20/21).

Refer to interview with the Lead medication aide

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TRUEWOOD BY MERRILL, NEW BERN	2701 AMHURST BOULEVARD NEW BERN, NC 28562

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D 358	Continued From page 26 (MA) on 10/01/21 at 12:58pm. Refer to observation of Resident #5 on 10/01/21 at 1:03pm. Refer to interview with Resident #5 on 10/01/21 at 1:06pm. Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/01/21 at 2:45pm. Refer to interview with the Resident Care Director (RCD) on 10/01/21 at 3:20pm. Refer to interview with the Resident Care Director (RCD) (Administrator present) on 10/01/21 at 1:37pm. c. Review of Resident #5's primary care provider (PCP) progress note dated 09/20/21 revealed Resident #5's losartan was increased at discharge from the hospital. (Losartan is used to treat hypertension and an enlarged heart.) Review of Resident #5's PCP progress note dated 09/30/21 revealed: -Resident #5 continued to have significant hypotension. -She had not been taking losartan 25mg twice daily. -She felt dizzy. Review of a Physician Order Review for Resident #5 signed by the primary care provider (PCP) on 09/20/21 revealed an order to change losartan from 50mg daily to 25mg twice daily. Review of Resident #5's September 2021 electronic medication administration record	D 358		

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D 358	Continued From page 27 (eMAR) revealed: -An entry for losartan 25mg twice daily at 9:00am and 9:00pm. -Documentation doses were administered from 9:00pm on 09/20/21 through 9:00pm 09/30/21. Observations of medications on hand for Resident #5 on 10/01/21 at 11:27am revealed: -A bubble pack with a pharmacy label for losartan 50mg tablets and instructions for one tablet daily. -Twenty-eight tablets were dispensed on 09/16/21 with 10 tablets remaining. Interview with the Lead medication aide (MA) on 10/01/21 at 11:27am revealed: -Resident #5 was on losartan 50mg daily since returning from the hospital (09/13/21). -She administered the losartan 50mg tablet that morning (10/01/21). -The resident was receiving losartan 50mg daily because that was what was in the medication cart for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/01/21 at 11:51am revealed: -The current order for losartan was 25mg twice daily dated 09/20/21 for Resident #5. -The pharmacy dispensed 28 tablets of Losartan 25mg on 09/20/21. -Losartan 50mg daily was listed on the medication discharge report dated 09/13/21. Interview with the Lead MA on 10/01/21 at 12:58pm revealed: -She found a new bubble pack of losartan 25mg twice daily for Resident #5 in the overstock drawer at the bottom of the medication cart. -She did not know how MAs were documenting administering losartan 25mg twice daily on the	D 358		

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eMAR when the bubble pack contained a different dosage.

Telephone interview with Resident #5's PCP on 10/01/21 at 2:45pm revealed:
-Losartan was also prescribed for Resident #5's heart.
-He wrote an order to discontinue losartan 25mg twice daily because her blood pressure (BP) was low.

Based on interviews with staff, observations of medications on hand and review of orders, losartan 50mg was administered daily for 10 days (09/20/21 through 10/01/21) after being changed to 25mg twice daily by the PCP (09/20/21).

Refer to interview with the Lead medication aide (MA) on 10/01/21 at 12:58pm.

Refer to observation of Resident #5 on 10/01/21 at 1:03pm.

Refer to interview with Resident #5 on 10/01/21 at 1:06pm.

Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/01/21 at 2:45pm.

Refer to interview with the Resident Care Director (RCD) on 10/01/21 at 3:20pm.

Refer to interview with the Resident Care Director (RCD) (Administrator present) on 10/01/21 at 1:37pm.

d. Review of Resident #5's PCP progress note dated 09/30/21 revealed he had discontinued triamterene-hydrochlorothiazide.

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D 358	Continued From page 29 (Triamterene-hydrochlorothiazide is used to treat hypertension and fluid retention.) Review of the medication discharge report dated 09/13/21 for Resident #5 revealed there was no licensed provider's signature or electronic signature on the list of new medications which included triamterene-hydrochlorothiazide 37.5-25mg daily. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/01/21 at 11:51am revealed: -The last order for triamterene-hydrochlorothiazide was for 37.5-25mg daily dated 09/13/21. -Triamterene-hydrochlorothiazide 37.5-25mg daily was listed on the medication discharge report dated 09/13/21. Telephone interview with Resident #5's primary care provider (PCP) on 10/01/21 at 2:45pm revealed he discontinued the triamterene-hydrochlorothiazide before seeing the resident the week of 09/27/21. Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed: -An entry for triamterene-hydrochlorothiazide 37.5-25mg daily at 9:00am. -Documentation one dose was administered on 09/15/21. -Documentation the order was discontinued on 09/17/21. Observations of medications on hand for Resident #5 on 10/01/21 at 11:27am revealed: -A bubble pack with a pharmacy label for triamterene-hydrochlorothiazide 37.5-25mg	D 358		

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tablets and instructions for one tablet daily.
-Twenty-eight tablets were dispensed on 09/16/21 with 13 tablets remaining and 15 doses removed.

Interview with the Lead medication aide (MA) on 10/01/21 at 11:27am revealed:
-Resident #5 was still receiving the triamterene-hydrochlorothiazide 37.5-25mg daily.
-She had administered the triamterene-hydrochlorothiazide that morning (10/01/21).
-The resident was receiving triamterene-hydrochlorothiazide 37.5-25mg daily because that was what was in the medication cart for administration.

Interview with the Resident Care Director (RCD) (Administrator present) on 10/01/21 at 1:37pm revealed:
-She had been in the process of getting clarification for the triamterene-hydrochlorothiazide because it was not on Resident #5's original medication list prior to hospitalization on 09/13/21.
-The triamterene-hydrochlorothiazide was discontinued on 09/20/21 and she was not supposed to continue taking the medication.

Based on interviews with staff and PCP and observations of medications on hand, triamterene-hydrochlorothiazide 37.5-25mg was administered daily from 09/20/21 through 10/01/21 after being discontinued by the PCP on 09/17/21.

Refer to interview with the Lead medication aide (MA) on 10/01/21 at 12:58pm.

Refer to observation of Resident #5 on 10/01/21 at 1:03pm.

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D 358	Continued From page 31 Refer to interview with Resident #5 on 10/01/21 at 1:06pm. Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/01/21 at 2:45pm. Refer to interview with the Resident Care Director (RCD) on 10/01/21 at 3:20pm. Refer to interview with the Resident Care Director (RCD) (Administrator present) on 10/01/21 at 1:37pm. e. Review of a Physician Order Review for Resident #5 signed by the primary care provider (PCP) on 09/20/21 revealed an order to discontinue amlodipine 5mg daily. (Amlodipine is used to treat hypertension.) Review of Resident #5's PCP progress note dated 09/30/21 revealed he had discontinued amlodipine. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/01/21 at 4:50pm revealed: -Amlodipine 5mg daily was ordered to start on 09/13/21 and discontinued on 09/21/21 for Resident #5. -Amlodipine 5mg was listed on the medication discharge report dated 09/13/21. Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed: -An entry for amlodipine 5mg daily at 9:00am. -Documentation doses were administered daily from 09/17/21 through 09/21/21.	D 358		

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D 358	Continued From page 32 -Documentation the order was discontinued on 09/23/21. Observations of medications on hand for Resident #5 on 10/01/21 at 4:46pm revealed: -A bubble pack with a pharmacy label for amlodipine 5mg tablets and instructions for one tablet daily at bedtime. -Twenty-eight tablets were dispensed on 09/16/21 with 14 tablets remaining. Based on observations of medications on hand and review of orders and eMARs, amlodipine was administered daily from 09/20/21 through 10/01/21 after being discontinued by the PCP on 09/20/21. Refer to interview with the Lead medication aide (MA) on 10/01/21 at 12:58pm. Refer to observation of Resident #5 on 10/01/21 at 1:03pm. Refer to interview with Resident #5 on 10/01/21 at 1:06pm. Refer to telephone interview with Resident #5's primary care provider (PCP) on 10/01/21 at 2:45pm. Refer to interview with the Resident Care Director (RCD) on 10/01/21 at 3:20pm. Refer to interview with the Resident Care Director (RCD) (Administrator present) on 10/01/21 at 1:37pm. _____ Interview with the Lead medication aide (MA) on 10/01/21 at 12:58pm revealed: -She checked the eMAR against the bubble pack	D 358		

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for each medication she administered.
-Resident #5 had a lot of medication order changes since she was hospitalized 09/13/21.
-When the new medications ordered came into the facility staff must have just put them in the overstock drawer.
-She had not stocked the cart for two weeks which was before the changed orders for Resident #5.
-She had not yet checked the resident's blood pressure (BP) since identifying the error.
-Normally the resident would let staff know if she was feeling dizzy and staff would administer an as needed medication.

Observation of Resident #5 on 10/01/21 at 1:03pm revealed:
-She was seated in a recliner next to her bed.
-The MA used an electronic wrist cuff to check her BP.
-The BP result was 112/52 and her heart rate was 56.

Interview with Resident #5 on 10/01/21 at 1:06pm revealed she did not have symptoms she was aware of for low BP.

Telephone interview with Resident #5's primary care provider (PCP) on 10/01/21 at 2:45pm revealed:
-He saw her twice the week of 09/27/21.
-First for a fall out of bed on Monday night (09/27/21) resulting in hip and leg pain and again on 09/30/21.
-Her BP was low at 104/60 when she was seen in the office on 09/30/21.
-He wrote the BP result and concerns on a physician's visit sheet brought in with the resident by a family member.
-All the information and orders should be

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available for review at the facility.
-He was concerned about Resident #5's blood pressure being low at her office visits which was why he changed and discontinued medications.

Interview with the Resident Care Director (RCD) on 10/01/21 at 3:20pm revealed:
-She did not have a physician's visit form for Resident #5 for 09/30/21.
-She was unable to contact the family member who took her to the PCP's office.

Interview with the Resident Care Director (RCD) (Administrator present) on 10/01/21 at 1:37pm revealed:
-The changed medication orders should have been documented in the 24 hour communication log by the MA on duty when the orders were received.
-The MA on duty when the new medications arrived was responsible for reviewing the 24 hour communication log and replacing the old medications with the new medications.
-Medications were delivered at 11:00pm.
-MAs were responsible for faxing new PCP orders to the pharmacy and placing the order in the bucket to be filed in the resident's chart.
-The MA on duty when new orders were received, removed the medications from the medication cart.
-Because medications were pulled from the medication cart the MA on duty when the medications arrived knew medications were discontinued and to check for new medications.
-The pharmacy entered the order on the eMAR and either she or one of the MA/Supervisors approved the order.
-For Resident #5, the discontinued medications were not pulled from the medication cart.
-MAs were expected to check medications

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D 358	Continued From page 35 against eMAR, administer according to the order and observe the resident take the medication. -If a medication was no longer on the eMAR and/or discontinued, the MA should not give the medication without clarification from the MA/Supervisor or RCD. _____ The facility failed to administer medications as ordered to Resident #8 who received 24 scheduled doses of a controlled substance for anxiety and agitation from 08/24/21 - 10/01/21 after the order was discontinued on 08/20/21, putting the resident at risk for increased sedation and falls, including falls on 08/25/21, 08/28/21, and 08/29/21. Resident #5 received the wrong dose of two blood pressure medications and continued to receive two other blood pressure medications after they were discontinued, causing the resident to have blood pressures as low as 104/60 and the resident had a fall that the primary care provider indicated could have been related to having low blood pressure. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-21 on 10/01/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 15, 2021.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 367		

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D 367	Continued From page 36 (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication administration records were accurate related to the documentation of the administration of Lorazepam, a controlled substance for anxiety and agitation, for 2 of 6 sampled residents (#3, #8). The findings are: 1. Review of Resident #8's current FL-2 dated 04/08/21 revealed diagnoses included cognitive decline, depression, diabetes mellitus II, mild malnutrition, and transient ischemia attack (temporary blockage of blood flow to the brain). Review of Resident #8's mental health provider	D 367		

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(MHP) visit note dated 07/13/21 revealed an order to start Lorazepam 0.5mg take 1 tablet twice a day as needed (prn) for acute anxiety / agitation. (Lorazepam is a controlled substance used for anxiety and agitation.)

Review of Resident #8's MHP visit note dated 08/03/21 revealed:
-There was an order to start Lorazepam 0.5mg 1 tablet daily in the morning.
-There was an order to continue Lorazepam 0.5mg every 12 hours prn as currently prescribed.

Review of Resident #8's MHP visit note dated 08/20/21 revealed:
-There was an order to discontinue Lorazepam 0.5mg every morning.
-There was an order to continue Lorazepam 0.5mg every 12 hours as currently prescribed.

Observation of Resident #8's medications on hand on 09/30/21 at 12:08pm revealed:
-There was a supply of Lorazepam 0.5mg tablets dispensed on 08/17/21 with 9 of 30 tablets remaining with instructions to take 1 tablet every morning.
-There was a supply of Lorazepam 0.5mg tablets dispensed on 08/25/21 with 60 of 60 tablets remaining with instructions to take 1 tablet every 12 hours prn for acute anxiety / agitation.

Review of Resident #8's controlled drug records (CDRs) for Lorazepam for 07/13/21 - 10/01/21 revealed:
-There was a CDR for Lorazepam dated 07/13/21 with 30 tablets received with instructions to take 1 tablet every 12 hours prn for acute anxiety / agitation.
-The first dose was documented as administered on 07/14/21 at 9:00am and the last dose was

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documented as administered on 09/26/21 at 12:30am, leaving a balance of zero.
-There were 2 once daily doses documented as administered at 8:00am on 08/24/21 and 08/25/21, after the order to discontinue the scheduled dose on 08/20/21.
-There were 5 prn doses of Lorazepam documented on this CDR from 09/12/21 - 09/26/21.
-There was a second CDR for Lorazepam dated 08/17/21 with 30 tablets received with instructions to take 1 tablet every morning.
-The first dose was documented as administered at 8:00am (no date noted) and the last dose documented on the CDR was on 10/01/21 at 8:00am, leaving a balance of 8 tablets.
-There were 22 scheduled morning (8:00am) doses of Lorazepam documented as administered from 09/11/21 - 10/01/21, after the order to discontinue the scheduled morning dose on 08/20/21.
-There were a total of 24 scheduled morning (8:00am) doses of Lorazepam 0.5mg documented as administered from 08/24/21 - 10/01/21, after the order to discontinue the scheduled morning dose on 08/20/21.
-There was a third CDR log for Lorazepam dated 08/25/21 with 60 tablets received with instructions to take 1 tablet every 12 hours prn for acute anxiety / agitation.
-There were no doses of Lorazepam documented as administered on this log.
-There was a total of 11 doses of Lorazepam documented as administered in August 2021.
-There was a total of 26 doses of Lorazepam documented as administered in September 2021.
-There was one dose of Lorazepam documented as administered for 10/01/21.

Review of Resident #8's August 2021 electronic

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TRUEWOOD BY MERRILL, NEW BERN	2701 AMHURST BOULEVARD NEW BERN, NC 28562

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medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet every 12 hours prn for acute anxiety / agitation and it was documented as administered on 7 occasions from 08/01/21 - 08/31/21.
-There was a second entry for Lorazepam 0.5mg take 1 tablet every morning scheduled at 9:00am and it was documented as administered daily at 9:00am from 08/04/21 - 08/20/21.
-The scheduled Lorazepam was documented as discontinued and not administered from 08/21/21 - 08/31/21.
-Lorazepam was documented as administered 24 times on the August 2021 eMAR but only 11 times on the CDR.
-The eMAR was not accurate and did not match the CDR for the administration of Lorazepam.

Review of Resident #8's September 2021 eMAR revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet every 12 hours prn for acute anxiety / agitation and it was documented as administered on 2 occasions from 09/01/21 - 09/30/21.
-There was no other entry for Lorazepam on the eMAR.
-Lorazepam was documented as administered 2 times on the September 2021 eMAR but it was documented as administered 26 times on the CDR.
-The eMAR was not accurate and did not match the CDR for the administration of Lorazepam.

Review of Resident #8's October 2021 eMAR on 10/01/21 revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet every 12 hours prn for acute anxiety / agitation.
-There was no other entries for Lorazepam.

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D 367	Continued From page 40 -There was no Lorazepam documented as administered on the eMAR for 10/01/21 but there was 1 dose documented as administered on the CDR. -The eMAR was not accurate and did not match the CDR for the administration of Lorazepam. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/01/21 at 11:43am revealed: -The pharmacy dispensed 30 Lorazepam 0.5mg tablets on 07/13/21 and 60 Lorazepam 0.5mg tablets on 08/25/21 with instructions to administer prn. -The pharmacy dispensed 30 Lorazepam 0.5mg tablets on 08/17/21 with instructions to administered scheduled daily in the morning. -The pharmacy received a discontinue order for scheduled Lorazepam on 08/20/21 from the MHP and the order was discontinued from the eMAR. Interviews with a Lead medication aide (MA) on 09/30/21 at 9:02am and 9:10am revealed: -The pharmacy sometimes "messed up things" and Resident #8's scheduled morning dose of Lorazepam medication did not always show up on the eMAR. -She continued to administer the Lorazepam because she thought the order should have been on the eMAR. -She was not aware the order for scheduled Lorazepam had been discontinued on 08/20/21. Interview with the Resident Care Director (RCD) on 09/30/21 at 1:37pm revealed: -The Lead MAs were responsible for doing quarterly medication cart audits, including reviewing orders and the eMARs. -If there was a discrepancy found during the audits, the MAs were supposed to notify her.	D 367		

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D 367	Continued From page 41 -MAs were supposed to document the administration of any medications administered on the eMAR, including controlled substances. -The administration of controlled substances on the eMARs should match the documentation on the CDR. Interview with the Administrator on 09/30/21 at 4:15pm revealed: -The MAs should document the administration of controlled substances on the CDR and the eMAR. -She was not aware Resident #8's Lorazepam documentation on the eMAR was inaccurate and did not match the CDR. Telephone interview with Resident #8's MHP on 10/01/21 at 12:36pm revealed: -Resident #8 had been agitation and fighting staff so she started Seroquel (an antipsychotic) on 08/20/21 and discontinued the scheduled Lorazepam the same day because the Lorazepam was not working. -She discontinued the Lorazepam on 08/20/21 when she started the Seroquel because she did not want to double dose the resident with two medications because it could cause increased sedation and an increased risk for falls. -When she saw the resident on 09/23/21, the resident was not sedated and the September eMAR showed 2 doses of prn Lorazepam had been administered. -She was not aware the resident continued to receive the scheduled Lorazepam because it was not documented on the eMAR. -It was important for the eMAR to reflect what medications the resident was receiving because she used the eMAR documentation to determine if changes were needed with a resident's medications.	D 367		

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D 367	Continued From page 42 Based on observations, interviews, and record reviews, it was determined Resident #8 was not interviewable. 2. Review of Resident #3's current FL-2 dated 03/31/21 revealed diagnoses included chronic obstructive pulmonary disease, rheumatoid arthritis, urinary frequency, Alzheimer's disease and trigeminal neuralgia. Review of a prescription order dated 06/30/21 for Resident #3 revealed an order for Lorazepam (2mg/ml) 0.5ml every 4 hours as needed for agitation. Observation of medications on hand for Resident #3 on 09/30/21 at 10:29am revealed: -A manufacturers bottle containing 30ml lorazepam 2mg/ml stored in plastic bag with a faded pharmacy label. -Along the vertical edge of the label were ml markings for 6ml to 22ml. -The level of the liquid in the bottle was at 22ml. Review of a controlled drug record (CDR) for Resident #3 revealed: -A pharmacy label dated 06/30/21 with instructions for lorazepam 0.5ml every 4 hours as needed (PRN). -Documentation 30ml was dispensed. -Documentation doses were administered on 07/03/21 at 12:00pm, 07/05/21 at 11:00am, 07/19/21 at 11:00am, 07/25/21 at 11:26am, 09/03/21 at 12:00pm, 09/15/21 at 9:52pm, 09/18/21 at 12:00pm and 09/26/21 at 10:00am. Review of Resident #3's July 2021 electronic medication administration record (eMAR) revealed:	D 367		

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D 367	Continued From page 43 -An entry for lorazepam 0.5ml every 4 hours PRN for agitation. -Documentation a dose was administered on 07/25/21 at 11:27am. -No documentation of doses administered on 07/03/21 at 12:00pm, 07/05/21 at 11:00am and 07/19/21 at 11:00am, Review of Resident #3's August 2021 eMAR revealed: -An entry for lorazepam 0.5ml every 4 hours PRN for agitation. -No doses documented as administered. Review of Resident #3's September 2021 eMAR revealed: -An entry for lorazepam 0.5ml every 4 hours PRN for agitation. -Documentation a dose was administered on 09/03/21 at 11:53am. -No documentation of doses administered on 09/15/21 at 9:52pm, 09/18/21 at 12:00pm and 09/26/21 at 10:00am. Interview with a medication aide (MA) on 10/01/21 at 11:05am revealed: -Resident #3's lorazepam was a PRN medication he forgot to sign off administering on the eMAR on 07/03/21, 07/19/21 and 09/26/21. -He just knew the order was for 0.5ml and that was what he administered. -He used a syringe with a 0.5ml marking to measure and then emptied the syringe in a plastic medication cup. Interview with the Administrator on 09/30/21 at 4:15pm revealed MAs were expected to document administration of controlled drugs on the CDR and the eMAR.	D 367		

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D 367	Continued From page 44 Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the medication pass on 09/30/21 by 1 of 2 medication aides observed who failed to wash or sanitize his hands prior to preparing and after administering a nasal spray and multiple oral medications to residents and after adjusting his face mask with his ungloved hands. The findings are: The facility's written medication administration infection control policy was requested on 09/30/21 at 2:48pm and 10/01/21 at 10:27am but not received. Review of the facility's general infection control policies and procedures revealed: -Infection control procedures and universal precautions would be employed at the facility to ensure the provision of safe, sanitary, and	D 371		

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comfortable environment for residents.
-All staff would be trained on and would utilize proper handwashing and hand hygiene that meets professional health care standards.
-Staff must wash their hands including after any contaminated contact, before and after assisting a resident that required contact with skin or soiled items, and before handling medications.
-All staff would be provided orientation in-service education upon hire and at least annually on the control of infections in a health care setting.

Observation of a medication aide (MA) administering medications on the 200 hall on 09/30/21 from 7:15am - 8:30am revealed:
-There was a large bottle of hand sanitizer on top of the medication cart.
-The MA prepared medications and took them into a resident's room at 7:46am.
-The MA knocked on the resident's bathroom door with his ungloved hand.
-The resident came out of the bathroom but refused to take the medications until after breakfast.
-The MA left the room, returned to the medication cart and sat the cup of medications on top of the medication cart.
-The MA did not sanitize or wash his hands prior to preparing the medications or after returning to the medication cart and he was not wearing gloves.
-The MA then pushed the medication cart near a second resident's room and prepared oral medications for the second resident.
-The MA touched and repositioned his face mask with his ungloved hand while preparing medications for the second resident.
-The MA administered medications to the second resident at 7:56am.
-The MA did not sanitize or wash his hands prior

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to preparing, after adjusting his face mask, or after administering medications to the second resident and he was not wearing gloves.
-The MA pushed the medication cart near a third resident's room and prepared oral medications for the third resident.
-At 8:15am, the MA went into the third resident's room and administered the oral medications then came back into the hallway to the medication cart.
-The MA did not sanitize or wash his hands prior to preparing the medications or after returning to the medication cart and he was not wearing gloves.
-The MA returned to the first resident's room and checked the resident's blood pressure and pulse touching the resident's skin while applying the cuff.
-The MA administered the first resident's nasal spray at 8:20am.
-The MA administered the first resident's oral medications at 8:25am from the cup that had been sitting uncovered on the medication cart since 7:46am.
-The MA did not sanitize or wash his hands prior to or after checking the resident's blood pressure or prior to or after administering the nasal spray and oral medications to the first resident.
-The MA was not wearing gloves.
-The MA returned to the medication cart at 8:26am and pushed the medication cart down the hall near a fourth resident's room.
-The MA started preparing medications for a fourth resident and entered the resident's room and entered the resident's room at 8:30am.
-The MA did not sanitize or wash his hands prior to preparing the fourth resident's medications and he was not wearing gloves.

Interview with the MA on the 200 hall on 09/30/21

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D 371	Continued From page 47 at 12:22pm revealed: -The facility's policy was for the MAs to sanitize their hands between each resident when administering medications. -He forgot to sanitize his hands during the medication pass that morning (09/30/21) because he was nervous. Interview with the Resident Care Director (RCD) on 09/30/21 at 1:37pm revealed: -Hand sanitizer was always available on the medication carts for the MAs to use. -The facility's policy was for the MAs to sanitize their hands before administering medications to each resident. -After 10 uses of hand sanitizer, the MAs should wash their hands with soap and water or sooner if their hands were visibly soiled. -She was concerned about the MA not sanitizing his hands during the medication pass that morning (09/30/21) because of lack of infection control during the COVID-19 pandemic and flu season. Interview with the Administrator on 09/30/21 at 4:15pm revealed: -The facility's policy was to sanitize hands between each resident and after the 10th use of hand sanitizer, the MAs should wash their hands with soap and water for 30 seconds or they should wash with soap and water sooner if their hands were visibly soiled. -It was not safe for the MA or the residents when the MA did not sanitize his hands during the medication pass because of the COVID-19 pandemic. -The MAs had been trained on the infection control and hand hygiene and she expected the MAs to use hand hygiene when administering medications.	D 371		

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D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications left on top of a medication cart were locked when not under the direct physical supervision of a medication aide observed during the 8:00am medication pass on 09/30/21. The findings are: Review of the facility's medication storage policies and procedures revealed: -Medications administered by the facility should be stored in a locked area accessible only by authorized facility staff. -Medications must be kept in a safe and locked space that is not accessible to persons other than those authorized to handle medications. -Medications must be secured at all times. Observation of a medication aide (MA) administering medications on the 200 hall on 09/30/21 from 7:15am - 8:25am revealed: -The MA prepared 10 oral medications and Flonase Nasal Spray (for seasonal allergies) and took them into a resident's room at 7:46am for administration. -The resident refused to take the medications	D 378		

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until after breakfast.
-The MA left the room, returned to the medication cart and sat the cup of medications on top of the medication cart.
-Oral medications in the cup included Prilosec 20mg (for acid reflux), Aggrenox 25/200mg (a blood thinner used to prevent strokes), Coreg 6.25mg (lowers blood pressure), Colace 100mg (stool softener), Ferrous Sulfate 325mg (for iron-deficiency anemia), Imdur 30mg (prevents chest pains and lowers blood pressure), Lasix 20mg (diuretic for swelling), Potassium Chloride ER 20mEq (potassium supplement), Senna Plus 8.6/50mg (for constipation), and Vitamin B12 ER 1000mcg (a vitamin supplement).
-The MA placed the Flonase Nasal Spray back into the top drawer of the medication cart.
-The MA then pushed the medication cart down the hallway near a second resident's room and prepared oral medications for the second resident.
-The MA locked the medication cart and went into the second resident's room and administered medications to the resident at 7:56am, leaving the uncovered plastic cup with 10 oral medications belonging to the first resident on top of the medication cart unattended.
-The top of the medication cart where the cup with medications was located could not be seen from inside the second resident's room.
-A resident in the hallway walked by the medication cart with the unsecured cup with oral medications at 7:59am, while the MA was still in the second resident's room.
-At 8:00am, the Resident Care Director (RCD) walked by the medication cart, looked at the cup with oral medications, and stood by the medication cart.
-The MA came out of the second resident's room and back to the medication cart at 8:01am and

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the RCD walked away and down the hall.
-The RCD did not question the MA about the unsecured medications in the plastic medication cup on top of the cart.
The MA left the medication cup with pills on top of the cart and pushed the medication cart down the hall near a third resident's room and prepared oral medications for the third resident.
-At 8:15am, the MA locked the medication cart and went into the third resident's room to administer medications.
-The MA left the cup with the first resident's 10 oral medications on top of the medication cart unsecured and unattended.
-The top of the medication cart where the cup with medications was located could not be seen from inside the third resident's room.
-At 8:16am, 2 residents walked down the hallway past the medication cart with the unsecured medication on top of the cart.
-There was no staff in view of the medication cart.
-At 8:17am, another resident walked down the hallway past the medication cart with the unsecured medication on top of the cart.
-At 8:17am, one of the two residents who walked by the medication cart at 8:16am walked back by the medication cart again.
-At 8:18am, the MA came out of the third resident's room and walked back to the medication cart.
-The medications for the first resident on the medication pass observed were still on top of the medication cart.
-At 8:19am, the MA returned to the first residents and administered the nasal spray at 8:20am and the oral medications at 8:25am.

Interview with the MA on the 200 hall on 09/30/21 at 7:49am revealed:
-The first resident did not usually refuse his

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medications, so he was not sure what to do.
-He asked the Lead MA and she told him to try to administer the medications again in a few minutes.

Second interview with the MA on the 200 hall on 09/30/21 at 12:22pm revealed:
-He left the pills in the medication cup unlocked and unattended on top of the medication cart that morning (09/30/21) during the morning medication pass because he forgot to lock them up due to being nervous.
-There were "some" (could not state how many) residents in the facility and the medications should have been locked in the medication cart so residents did not have access to them.

Interview with the Resident Care Director (RCD) on 09/30/21 at 1:37pm revealed:
-The facility's policy was medications should not be left unlocked and unattended unless under the direct supervision of the MA.
-The MA should have disposed of the medications that were left on top of the medication cart.
-The MA should have went back after the resident ate, prepared the medications again and offered the medications again.
-She was not sure if the facility's policy allowed the MAs to label and locked the medications in the medication cart until the resident finished eating but she would check the policy.
-The medication should not be left on top of the medication cart unattended because another resident with dementia could take the medications.
-There were 5 or 6 residents in the facility with confusion that had to be prompted and redirected by staff.
-If another resident took those medications, it

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TRUEWOOD BY MERRILL, NEW BERN	2701 AMHURST BOULEVARD NEW BERN, NC 28562

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could cause a drop in the resident's blood pressure since there were medications used to treat high blood pressure in the cup.
-It could also cause an allergic reaction if a resident had an allergy to one of those medications.
-She saw the cup with medications had been left unattended on the medication cart in the hallway when she walked by the medication cart that morning (09/30/21).
-She stopped and stood at the cart until the MA came out of a resident's room and went back to the cart.
-She did not intervene or question the MA at that time because she did not want to interrupt the medication pass during the survey.
-She discussed it with the MA after he finished administering the morning medications that day (09/30/21).

Interview with the Administrator on 09/30/21 at 4:15pm revealed:
-The MA should have wrapped the resident's medication cup with pills with plastic wrap and locked them in the medication cart until the resident finished eating.
-If that was a recurring problem, the PCP should have been contacted to change the scheduled times for the resident's morning medications.
-She was concerned that the medications were left unlocked and unattended on the medication cart because other residents had access to the medications.
-She would have expected the RCD to question the MA when the RCD noticed the medications had been left unattended on top of the medication cart.

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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 an accurate accounting of controlled drugs such as lorazepam and tramadol for 2 of 5 sampled residents (#3 and #5). The findings are: 1. Review of Resident #3's current FL-2 dated 03/31/21 revealed diagnoses included chronic obstructive pulmonary disease, rheumatoid arthritis, urinary frequency, Alzheimer's disease and trigeminal neuralgia. Review of a prescription order dated 06/30/21 for Resident #3 revealed an order for Lorazepam (2mg/ml) 0.5ml every 4 hours as needed (PRN) for agitation. Observation of medications available for administration for Resident #3 on 09/30/21 at 10:29am revealed: -A manufacturers bottle containing 30ml lorazepam 2mg/ml stored in plastic bag with a faded pharmacy label. -Along the vertical edge of the label were ml	D 392		

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markings for 6ml to 22ml.
-The level of the liquid in the bottle was at 22ml.

Review of Resident #3's July 2021 electronic medication administration record (eMAR) revealed:
-An entry for lorazepam 0.5ml every 4 hours PRN for agitation.
-Documentation a dose was administered on 07/25/21 at 11:27am.

Review of Resident #3's August 2021 eMAR revealed:
-An entry for lorazepam 0.5ml every 4 hours PRN for agitation.
-No doses documented as administered.

Review of Resident #3's September 2021 eMAR revealed:
-An entry for lorazepam 0.5ml every 4 hours PRN for agitation.
-Documentation a dose was administered on 09/03/21 at 11:53am.

Review of a controlled drug record (CDR) for Resident #3 revealed:
-A pharmacy label dated 06/30/21 with instructions for lorazepam 0.5ml every 4 hours PRN.
-Documentation 30ml was dispensed.
-Documentation doses were administered on 07/03/21 at 12:00pm, 07/05/21 at 11:00am, 07/19/21 at 11:00am, 07/25/21 at 11:26am, 09/03/21 at 12:00pm, 09/15/21 at 9:52pm, 09/18/21 at 12:00pm and 09/26/21 at 10:00am.
-Documentation a total of 4ml were removed.
-No documentation of the amount remaining.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/30/21 at

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D 392	Continued From page 55 11:14am revealed: -Lorazepam 30ml was dispensed on 06/30/21 which was the first and only fill for Resident #3. -The instructions for the lorazepam was 0.5ml every four hours as needed so the bottle contained 60 doses. -The lorazepam was in a manufacturer's bottle with likely margin of error and some overfill, but there was no way for the pharmacy to know for sure for an unopened bottle. Interview with a medication aide (MA) on 10/01/21 at 11:05am revealed: -He did not know he was supposed to check and document how much was remaining in the liquid lorazepam bottle. -He just knew the order was for 0.5ml and that was what he administered. -He used a syringe with a 0.5ml marking to measure and then emptied the syringe in a plastic medication cup. -He did not know he was supposed to count the liquid lorazepam with the controlled drug count at shift change. -He was told when he was training as an MA to count the controlled drug pills on the medication cart. Interview with the MA/Supervisor on 09/30/21 at 11:49am revealed: -MAs were expected to count the liquid lorazepam by pouring the contents of the bottle into a plastic graduated medicine cup and measure the amount each shift. -She was not sure MAs were measuring and counting the amount of liquid lorazepam. Interview with the Resident Care Director (RCD) on 09/30/21 at 11:35am revealed: -The facility did not handle many liquid controlled	D 392		

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drugs.
-Sometimes what the bottle said was not necessarily what was in the bottle.
-MAs were not able to count the lorazepam every shift change, if there was no remaining amount documented on the controlled drug record (CDR).
-MAs administering Resident #3's lorazepam should have written the amount remaining on the CDR each time a dose was taken from the bottle.

Interview with the Administrator on 09/30/21 at 4:15pm revealed staff should document ml remaining in bottle after each dose was removed from the bottle.

Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.

Refer to interview with the medication aide (MA)/Supervisor on 09/30/21 at 11:49am.

Refer to interview with the Resident Care Director (RCD) on 09/30/21 at 11:35am.

Refer to second interview with the RCD on 09/30/21 at 11:59am.

Refer to interview with the Administrator on 09/30/21 at 4:15pm.

2. Review of Resident #5's current FL-2 dated 03/23/21 revealed:
-Diagnoses included orthostatic syncope, hypotension, arthritis and tachycardia.
-An order for tramadol 50mg daily. (Tramadol is used to treat pain.)

Review of Physician Order Reviews for Resident #5 signed by the primary care provider (PCP) on

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D 392	Continued From page 57 08/17/21 and 09/20/21 revealed an order for tramadol 50mg three times daily as needed. Review of Resident #5's May 2021 and June 2021 electronic medication administration records (eMARs) revealed: -No entry for tramadol 50mg on the May 2021 eMAR. -An entry for tramadol 50mg three times daily as needed on the June 2021 eMAR. -No doses were documented as administered. Review of Resident #5's July 2021 eMAR revealed: -An entry for tramadol 50mg three times daily as needed. -Documentation a dose was administered on 07/24/21 at 10:29am. Review of Resident #5's August 2021, September 2021 and October 2021 eMARs revealed: -Entries for tramadol 50mg three times daily as needed. -No doses were documented as administered. Upon request on 10/01/21, a controlled drug record (CDR) for tramadol 50mg dispensed on 05/24/21 for Resident #5 was not available for review. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/01/21 at 11:51am revealed: -The current order for tramadol was 50mg four times daily as needed dated 09/30/21 for Resident #5. -The pharmacy dispensed 120 tramadol 50mg tablets on 09/30/21. -Prior to 09/30/21, tramadol was ordered for 50mg three times daily as needed dated	D 392		

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D 392	Continued From page 58 05/24/21. -The pharmacy dispensed 30 tramadol tablets on 05/24/21 for Resident #5. -There was no tramadol dispensed from the pharmacy between 05/24/21 and 09/30/21. Interview with Resident #5 on 10/01/21 at 1:06pm revealed: -She received a dose of tramadol the morning of 10/01/21 for lower back pain from her fall earlier in the week (09/27/21). -Prior to 10/01/21, she did not have a prescription for tramadol for a long time. -She could not remember when she last took tramadol before 10/01/21. Interview with the Resident Care Director (RCD) on 10/01/21 at 3:20pm revealed she was unable to find a CDR for the tramadol dispensed on 05/24/21 for Resident #5. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/01/21 at 4:50pm revealed there was no record of return for any of the 30 tablets of tramadol dispensed 05/24/21 for Resident #5. Refer to interview with the medication aide (MA)/Supervisor on 09/30/21 at 11:49am. Refer to interview with the Resident Care Director (RCD) on 09/30/21 at 11:35am. Refer to second interview with the RCD on 09/30/21 at 11:59am. Refer to interview with the Administrator on 09/30/21 at 4:15pm. _____ Interview with the medication aide	D 392		

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D 392	Continued From page 59 (MA)/Supervisor on 09/30/21 at 11:49am revealed: -MAs counted each change of shift; the outgoing MA checked the book with the controlled drug records (CDRs) on the medication cart and the oncoming MA checked the controlled drug bubble packs. -Both MAs signed the Controlled Medication Shift to Shift Count Sheet when the count was completed. -There was a comment section on the count sheet for MAs to document deliveries, returns and errors. -She had not been able to keep up reviewing CDRs for accuracy. Interview with the Resident Care Director (RCD) on 09/30/21 at 11:35am revealed medication aides (MAs) counted controlled drugs at every shift change. Second interview with the RCD on 09/30/21 at 11:59am revealed: -The MA/Supervisor did the monitoring for medications and controlled drugs. -The MA/Supervisor was responsible for completing cart audits and checking CDRs. Interview with the Administrator on 09/30/21 at 4:15pm revealed: -Outgoing and oncoming MAs were expected to count all controlled drugs every shift. -It was important to verify the controlled drug count because the oncoming MA took responsibility for the accuracy of the count. -MAs were expected to report errors and omissions in the controlled drug count to the DRC. -MAs were expected to document administration of controlled drugs on the CDR and the eMAR.	D 392		

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D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. 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 medication administration, adult care home infection prevention requirements, and adult care home medication aides training and competency evaluation requirements. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents (#8) observed during the medication pass including errors with two topical creams and medication for anxiety and agitation; and for 1 of 5 residents sampled (#5) for record review including errors with receiving the wrong dose of two medications for high blood pressure, continuing to receive two other medications for high blood pressure after they were discontinued, receiving a medication for acid reflex at the wrong frequency, and not receiving a medication for constipation as ordered. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		

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D912	Continued From page 61 2. Based on observations, interviews, and record reviews, the facility failed to provide mandatory, annual state approved infection prevention training for 3 of 3 medication aides (A, B, C) sampled that had been employed for more than one year, including Staff C who did not perform hand hygiene during the 8:00am medication pass observed on 09/30/21. [Refer to Tag 934, G.S. 131D-4.5B(a) Adult Care Home Infection Prevention Requirements (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 staff sampled (A, B, C) who administered medications had completed the medication administration clinical skills validation checklist prior to administering medications (A, B, C) and had completed the state-approved 5-hour and 10-hour medication aide training courses as required (A, B, C). [Refer to Tag 935, G.S. 131D-4.5B(b) Adult Care Home Medication Aides Training and Competency Evaluation Requirements (Type B Violation)].	D912		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount	D934		

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D934	Continued From page 62 determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide mandatory, annual state approved infection prevention training for 3 of 3 medication aides (A, B, C) sampled that had been employed for more than one year, including Staff C who did not perform hand hygiene during the 8:00am medication pass observed on 09/30/21. The findings are: 1. Review of Staff C's personnel record revealed: -Staff C was hired as a personal care aide (PCA) on 10/04/18. -There was no hire date as a medication aide (MA) but there was a job description for MA dated 06/04/20. -Staff C had passed the written MA exam on 10/31/18. -There was documentation the annual state approved infection control training was completed on 01/10/19 and 08/08/19. -There was no documentation the annual state infection control training had been completed since 08/08/19. Observation of the medication pass on the 200 hall on 09/30/21 from 7:15am - 8:30am revealed: -Staff C was administering medications to residents on the 200 hall. -There was a large bottle of hand sanitizer on top	D934		

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D934	Continued From page 63 of the medication cart. -Staff C prepared and administered oral medications to 4 residents without sanitizing or washing his hands before or after preparing and administering the medications. -Staff C did not perform hand hygiene prior to or after administering a nasal spray to a resident and he was not wearing gloves. -Staff C came in contact with the skin of a resident while checking the resident's blood pressure and continued to prepare and administer medications without performing hand hygiene or wearing gloves. -Staff C touched and repositioned his face mask with his ungloved hand while preparing medications for a resident and he continued to prepare and administer the medications without performing hand hygiene. Telephone interview with Staff C on 10/01/21 at 3:37pm revealed: -He had worked at the facility for 3 ½ years. -He started working as a PCA but then started administering medications about 2 ½ years ago. -He remembered doing infection control training with the Resident Care Director (RCD) sometime during the start of the COVID-19 pandemic (could not recall date). -He was not sure if he had completed the annual state infection control training course. Refer to interview with the Administrator on 10/01/21 at 3:46pm. Refer to interview with the Resident Care Director (RCD) on 10/01/21 at 4:36pm. 2. Review of Staff A's personnel record revealed: -Staff A was hired as a medication aide (MA) on 02/18/18.	D934		

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D934	Continued From page 64 -There was documentation the annual state approved infection control training was completed on 01/10/19 and 08/08/19. -There was no documentation the annual state infection control training had been completed since 08/08/19. Interview with Staff A on 10/01/21 at 3:30pm revealed: -She started working at the facility on 02/14/18 as a MA. -She had some infection control training since starting at the facility but she did not know if it was the annual state approved infection control training course. Refer to interview with the Administrator on 10/01/21 at 3:46pm. Refer to interview with the Resident Care Director (RCD) on 10/01/21 at 4:36pm. 3. Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on 03/28/19. -There was documentation the annual state approved infection control training was completed on 07/16/19 and 08/08/19. -There was no documentation the annual state infection control training had been completed since 08/08/19. Interview with Staff B on 10/01/21 at 3:18pm revealed: -She was hired as a MA in March 2019. -She was not sure if she had completed the annual state infection control training course. Refer to interview with the Administrator on 10/01/21 at 3:46pm.	D934		

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D934	Continued From page 65 Refer to interview with the Resident Care Director (RCD) on 10/01/21 at 4:36pm. _____ Interview with the Administrator on 10/01/21 at 3:46pm revealed: -The Business Office Manager (BOM) was responsible for the personnel files but the BOM position had been vacant for 2 days. -She audited the personnel files quarterly but she did not check for MA qualifications including annual state infection control training because she "assumed" it was in the personnel files and had been done. -The facility's Resident Care Director (RCD) was a registered nurse (RN) and the RCD was responsible for completing the annual state infection control training course with staff. -She was not aware the state infection control training course had not been completed annually. -The facility staff had other infection control training through the corporate computer training system. -She could not locate any state infection control training since 08/08/19. Interview with the RCD on 10/01/21 at 4:36pm revealed: -She had completed the state infection control training course for staff in August 2019. -She was not aware the state infection control training course was required to be done annually. -She had not done the state infection control training course for any staff since August 2019. _____ The facility failed to ensure Staff A, B, and C completed the mandatory state approved infection control training course. Staff C failed to perform hand hygiene while administering medications to 4 residents during the 8:00am	D934		

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D934	Continued From page 66 medication pass on 09/30/21. Staff C failed to perform hand hygiene prior to and after administering oral medications, a nasal spray, and after touching and readjusting his face mask. The failure of the facility to provide the state approved infection control training course annually was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-21 on 10/01/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 15, 2021.	D934		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if	D935		

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D935	Continued From page 67	D935		

applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.
(3) Within 60 days from the date of hire, the individual must have completed the following:
a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:
1. The key principles of medication administration.
2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 staff sampled (A, B, C) who administered medications had completed the medication administration clinical skills validation checklist prior to administering medications (A, B, C) and had completed the state-approved 5-hour and 10-hour medication aide training courses as required (A, B, C).

The findings are:

1. Review of Staff A's personnel record revealed:
-Staff A was hired as a medication aide (MA) on

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D935	Continued From page 68 02/18/18. -There was no Medication Administration Clinical Skills Validation Checklist for Staff A. -There was no 5, 10, or 15-hour MA training courses completed for Staff A. -Staff A completed the MA written exam on 05/02/17. Review of residents' August 2021 - October 2021 electronic medication administration records (eMARs) on 10/01/21 revealed: -Staff A administered medications on 2 of 31 days from 08/01/21 - 08/31/21 including 08/12/21 and 08/23/21. -Staff A administered medications on 5 of 30 days from 09/01/21 - 09/30/21 including 09/07/21, 09/13/21, 09/15/21, 09/20/21, and 09/30/21. -Staff A made an error by documenting administration of Lorazepam (a controlled substance for anxiety and agitation) for a resident on 09/15/21 after the medication had been discontinued on 08/20/21 and was no longer on the eMAR. Observation of the 9:00am medication pass on 09/30/21 revealed: -Staff A made 3 medication errors with one resident during the medication pass. -Staff A did not administer the resident's Triamcinolone Cream (for irritated skin conditions) and Eucerin Cream (for dry skin) as ordered. -Staff A administered Lorazepam after the order had been discontinued and was not on the current eMAR. Interview with Staff A on 10/01/21 at 3:30pm revealed: -She started working at the facility on 02/14/18 as a MA.	D935		

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D935	Continued From page 69 -She had not completed the 5, 10, or 15-hour MA training courses since working at this facility. -She thought the former nurse for the facility had completed a medication checklist but she was not sure. -She passed the written MA exam (could not recall date). Refer to interview with the Administrator on 10/01/21 at 3:46pm. Refer to interview with the Resident Care Director (RCD) on 10/01/21 at 4:36pm. 2. Review of Staff C's personnel record revealed: -Staff C was hired as a personal care aide (PCA) on 10/04/18. -There was no hire date as a medication aide (MA) but there was a job description for MA dated 06/04/20. -There was no Medication Administration Clinical Skills Validation Checklist for Staff C. -There was no 5, 10, or 15-hour MA training courses completed for Staff C. -Staff C had passed the written MA exam on 10/31/18. Review of residents' August 2021 - October 2021 electronic medication administration records (eMARs) on 10/01/21 revealed: -Staff C administered medications on 15 of 31 days from 08/01/21 - 08/31/21 including 08/01/21, 08/04/21, 08/05/21, 08/06/21, 08/09/21, 08/10/21, 08/11/21, 08/13/21, 08/14/21, 08/15/21, 08/18/21, 08/19/21, 08/24/21, 08/28/21, and 08/30/21. -Staff C administered medications on 11 of 30 days from 09/01/21 - 09/30/21 including 09/02/21, 09/07/21, 09/09/21, 09/11/21, 09/12/21, 09/15/21, 09/16/21, 09/25/21, 09/26/21, 09/27/21, and 09/30/21.	D935		

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D935	Continued From page 70 -Staff C administered medications on 10/01/21. -Staff C made an error by documenting administration of Lorazepam (a controlled substance for anxiety and agitation) for a resident on 09/27/21 after the medication had been discontinued on 08/20/21 and was no longer on the eMAR. Observation of the medication pass on the 200 hall on 09/30/21 from 7:15am - 8:30am revealed: -Staff C administered medications to 4 residents without performing hand hygiene. -Staff C left 10 oral medications in a cup on top of the medication cart unsecured and unattended multiple times during the medication pass. Telephone interview with Staff C on 10/01/21 at 3:37pm revealed: -He had worked at the facility for 3 ½ years. -He started working as a PCA but then started administering medications about 2 ½ years ago. -He thought the RCD had completed a Medication Administration Clinical Skills Validation Checklist with him about 2 ½ years ago but he could not recall for sure. -He did not complete the 5, 10, or 15-hour MA training course and he was not aware he needed to complete the courses. -He passed the written MA exam (could not recall date). -He had not worked as a MA anywhere prior to working as a MA at this facility for 2 ½ years. Refer to interview with the Administrator on 10/01/21 at 3:46pm. Refer to interview with the Resident Care Director (RCD) on 10/01/21 at 4:36pm. 3. Review of Staff B's personnel record revealed:	D935		

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D935	Continued From page 71 -Staff B was hired as a medication aide (MA) on 03/28/19. -There was no Medication Administration Clinical Skills Validation Checklist for Staff B. -Staff B had a MA Verification form signed by the Administrator on 08/20/19. -There was only one 24-month period documented with date of qualified work at 08/15/19. -There was no documentation of verification of working as a qualified MA for the 24 months prior to 10/01/13 or the subsequent 24 months after that. -There was no 5, 10, or 15-hour MA training courses completed for Staff B. -Staff B passed the MA written exam on 11/10/03. Review of residents' August 2021 - October 2021 electronic medication administration records (eMARs) on 10/01/21 revealed: -Staff B administered medications on 16 of 31 days from 08/01/21 - 08/31/21 including 08/01/21, 08/03/21, 08/05/21, 08/10/21, 08/11/21, 08/12/21, 08/14/21, 08/15/21, 08/17/21, 08/18/21, 08/20/21, 08/24/21, 08/26/21, 08/28/21, 08/29/21, and 08/31/21. -Staff B administered medications on 17 of 30 days from 09/01/21 - 09/30/21 including 09/01/21, 09/03/21, 09/07/21, 09/08/21, 09/09/21, 09/11/21, 09/12/21, 09/14/21, 09/15/21, 09/17/21, 09/21/21, 09/22/21, 09/23/21, 09/25/21, 09/26/21, 09/28/21, and 09/30/21. Interview with Staff B on 10/01/21 at 3:18pm revealed: -She was hired as a MA in March 2019. -She had been a MA at nursing homes and other assisted living facilities since 2003. -She did not recall completing a Medication Administration Clinical Skills Validation Checklist	D935		

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D935	Continued From page 72 but she had passed the written exam. -She had not completed the 5, 10, or 15-hour MA training courses and she was not aware she needed to take the courses. Interview with the Administrator on 10/01/21 at 3:46pm revealed: -She filled out Staff B's MA Verification form and faxed it to Staff B's former employer. -She did not receive a response from the former employer, so she just filed the MA Verification form in the personnel record. -She thought her signature was sufficient for verification if she did not get a response from the former employer. -She did not have Staff B complete the 5, 10, or 15 hours state approved MA training course since Staff B stated she had previously worked as a MA. Refer to interview with the Administrator on 10/01/21 at 3:46pm. Refer to interview with the Resident Care Director (RCD) on 10/01/21 at 4:36pm. _____ Interview with the Administrator on 10/01/21 at 3:46pm revealed: -The Business Office Manager (BOM) was responsible for the personnel files but the BOM position had been vacant for 2 days. -The facility had a change of ownership in 2020 and she thought the former owners may have taken some information from the personnel records with them. -She audited the personnel files quarterly but she did not check for MA qualifications because she "assumed" it was in the personnel files and had been done. -She "assumed" the MA's had completed all of	D935		

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D935	Continued From page 73 the required training. -The MAs should have completed the Medication Administration Clinical Skills Validation Checklist prior to administering medications. -The facility's Resident Care Director (RCD) was a registered nurse (RN) and the RCD was responsible for completing the Medication Administration Clinical Skill Validation Checklists for MAs. Interview with the RCD on 10/01/21 at 4:36pm revealed: -She usually completed the Medication Administration Clinical Skills Validation Checklist for the MAs. -The BOM would notify her of any newly hired MAs and she would complete the checklist and she gave it to the Administrator to sign off. -Staff A, B, and C were hired prior to her starting the position as RCD so she would not have completed the MA Clinical Skills Validation Checklist for Staff A, B, and C. -She was not responsible for auditing personnel records and she was not aware Staff A, B, and C did not have the MA Clinical Skills Validation Checklist on file. -She did not complete any 5, 10, or 15-hour MA training courses with the MAs because she thought if a MA had passed medications for over a year, they did not need to take the courses. _____ The facility failed to ensure 3 of 3 medication aides (MAs) sampled met the qualifications to administer medications to residents. Staff A, B, and C did not have Medication Administration Clinical Skills Validation Checklists which are required prior to the administration of any medications. Staff A, B, and C did not complete the 5, 10, or 15-hour MA training courses as required. Staff A was observed making 3	D935		

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D935	Continued From page 74 medication errors for one resident during the 9:00am medication pass on 09/30/21. Staff C was observed failing to use hand hygiene and failing to secure medications on top of the medication cart during the 8:00am medication pass on 09/30/21. Both Staff A and Staff C administered a controlled substance to a resident after it had been discontinued and removed from the electronic medication administration record. The facility's failure to assure MAs met training requirements prior to the administration of medications resulted in increased risk for medication errors and was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-21 on 10/01/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 15, 2021.	D935		