DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **ACH 081-008**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: **10/25/2022**

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Manor Rest Home	**390 Hardin Road Forest City, NC 28043**

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D 000	Initial Comments: The Adult Care Licensure Section and the Rutherford County Department of Social Services conducted an Annual and Follow-up survey on 10/22/25.			
D 368	10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to ensure the medication administration records (MAR) were accurate for 3 of 3 sampled residents (#1, #2, #3,) related to a medication used to prevent blood clots (#1), a medication used to			

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	treat asthma (#2) and a medication used to treat diabetes (#3). The findings are: 1. Review of Resident #1's current FL2 dated 02/24/22 revealed: -Diagnoses included history of stroke and COVID-19 pneumonia. -There was an order for aspirin (used to prevent blood clots) 81mg 1 tablet daily. Review of Resident #1's Nurse Practitioner's (NP) order dated 08/31/22 revealed: -Start apixaban (used to prevent blood clots) 2.5mg twice daily for 10 days. -Hold aspirin while taking apixaban. Review of Resident #1's September 2022 Medication Administration Record (MAR) revealed: -There was a computer-generated entry for aspirin 81mg 1 tablet daily scheduled at 8:00am. -The aspirin was documented as administered daily from 09/01/22 to 09/30/22 at 8:00am. -There was a hand-written entry for apixaban 2.5mg 1 tablet twice daily scheduled at 8:00am and 8:00pm. -The apixaban was documented as administered twice daily at 8:00am and 8:00pm from 09/01/22 to 09/10/22 at 8:00am. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/25/22 at 11:24am revealed: -On 08/31/22, they received an electronic order from Resident #1's NP. -There was an order to start apixaban 2.5mg 1 tablet twice daily. -There was an order to hold Resident #1's aspirin for 10			

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	days. -The pharmacy sent medication supplies to the facility every two weeks. -The pharmacy supplied Resident #1's aspirin in cartridges. -The pharmacy did not send aspirin 81mg tablets in Resident #1's medication cartridge for 09/01/22 to 09/10/22, because of the NP order to hold the aspirin. Interview with the Resident Care Coordinator (RCC) on 10/25/22 at 11:00am revealed: -She administered Resident #1's 8:00am medications from 09/01/22 to 09/10/22. -She did not administer aspirin to Resident #1 from 09/01/22 to 09/10/22, because the aspirin was ordered to be held. -She made a mistake in documentation on Resident #1's September 2022 MAR. -She forgot to circle her initials on the aspirin MAR entries to indicate the aspirin was not administered. 2. Review of Resident #2's current FL2 dated 08/02/22 revealed: -Diagnoses included diabetes, asthma and depression. -There was an order for Fluticasone Salmeterol inhaler 1 puff daily. Review of Resident #2's Nurse Practitioner's (NP) order dated 10/07/22 revealed Fluticasone Salmeterol inhaler 1 puff daily to be discontinued. Review of Resident #2's October 2022 Medication Administration Record (MAR) revealed: -There was a computer-generated entry for Fluticasone Salmeterol inhaler 1 puff daily scheduled at 8:00am. -The letters DC were handwritten in the entry for the Fluticasone Salmeterol inhaler after 10/17/22.			

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	Observation of the medication on hand for Resident #2 on 10/25/22 at 2:30pm revealed the was no Fluticasone Salmeterol inhaler on hand for administration. Interview with the Medication Aide (MA) on 10/25/22 at 2:35pm revealed: -Resident #2 was running out of the Fluticasone Salmeterol inhaler and she had called the pharmacy to get a refill. -The pharmacy asked for a clarification on the Fluticasone Salmeterol inhaler as there was no dosage. -During her conversation with the NP for Resident #2 the NP decided to discontinue the Fluticasone Salmeterol inhaler as Resident #2 already had a similar inhaler. -She usually writes on the MAR when a medication is discontinued at the time the order is being discontinued. -She was not sure why she had not written on the MAR on 10/07/22 the Fluticasone Salmeterol inhaler had been discontinued. -The RCC usually kept up with the changes to the MAR, but she had been out. -She had assisted the last two months with the MARs. Interview with the Resident Care Coordinator (RCC) on 10/25/22 at 2:42pm revealed: -She was aware the Fluticasone Salmeterol inhaler had been discontinued but she was not aware staff continued to document the Fluticasone Salmeterol inhaler was being administered after it was discontinued. - Staff should have stopped documenting on 10/07/22 when the Fluticasone Salmeterol inhaler was discontinued.			

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	Telephone interview with the facility's contracted pharmacy on 10/25/22 at 2:48pm revealed: -The Fluticasone Salmeterol inhaler 1 puff daily was originally ordered 04/21/22. -The NP for Resident #2 had written an order for the Fluticasone Salmeterol inhaler 1 puff daily to be discontinued on 10/07/22. Interview with the Administrator-in-Charge on 10/25/22 at 3:27pm revealed she thought it was just an oversite that staff continued to sign the MAR after the Fluticasone Salmeterol inhaler was discontinued on 10/07/22. 3.Review of Resident #3's FL2 Form dated 08/02/22 revealed: -Diagnosis included Diabetes. -A medication order for Humalog Kwik Pen 100u/Ml Inject Ml SS (Sliding Scale) before meals with a SS of 150 or below =0 units, 151-200=6 units, 201-250=8 units, 251-300=10 units, 301-350=12 units, 351-400=14 units. Review of Resident #3's Physician orders dated 8/02/22 revealed there were no orders for the Humalog Kwik Pen 100u/Ml Inject Ml SS before meals with a SS of 150 or below =0 units, 151-200=6 units, 201-250=8 units, 251-300=10 units, 301-350=12 units, 351-400=14 units to be discontinued. Review of Resident #3's Medication Administration Record (MAR) for October 2022 revealed: -There was a computer-generated entry for Humalog Kwik Pen 100u/Ml Inject Ml SS before meals, 150 or < =0 units, 151-200=6 units, 201-250=8 units, 251-300=10 units, 301-350=12 units, 351-400=14 units. -There was a handwritten "DC" beside the Humalog			

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	Interview with Resident Care Coordinator (RCC) on 10/25/2022 at 11:30am revealed: -Resident #3 is still on Humalog Kwik Pen 100u/Ml Inject Ml SS before meals with a SS of 150 or below =0 units, 151-200=6 units, 201-250=8 units, 251-300=10 units, 301-350=12 units, 351-400=14 units. -Resident #3 received three finger sticks a day for blood sugar check (before meals) to determine if he needs his sliding scale Humalog before meals. -A "D/C" had been handwritten on the wrong medication line of the MAR for October. -Resident #3's MARs were becoming long and difficult to read due to Pharmacy not removing discontinued medications before the next month on the MAR. Interview with Med Aide (MA) on 10/25/2022 at 12:00pm revealed: -Resident #3 was still on Humalog with SS insulin. -She had documented "DC" for the wrong medication on Resident #3's October 2022 MAR. -She had documented on Resident #3's weekly diabetes record Resident #3's finger sticks for blood sugar checks and how many units of Humalog based on the SS when administered. Interview with Administrator in Charge (AIC) on 10/25/2022 at 3:20pm revealed: -Resident #3 was on Humalog with sliding scale insulin. -She did not know the Humalog had been discontinued on the MAR.			

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