DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-036-034**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: **10/27/2022**

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Court of Cherryville	**401 West Academy St. Cherryville, NC, 28021**

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D 0000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 10/25/22 through 10/27/22.	D 0000	**"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law."**	
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 evidenced by: Based on observations, record review and interviews, the facility failed to administer medication as ordered for 1 of 5 sampled residents (#5) who had orders for an anticonvulsant medication, an antipsychotic medication, a sedative, and eye drops. The findings are: Review of Resident #5's current FL2 dated 09/29/22 revealed diagnoses included type 2 diabetes, obstructive sleep apnea, high blood pressure, congestive heart failure and chronic renal failure. a. Review of Resident #5's signed physician's orders	D 358	10A NCAC 13F .1004 (a) Medication Administration The Executive Director and Resident Care Coordinator will review the process for Medication Administration requirements with the Medication Aides to ensure proper medication administration requirements are met and understood by all necessary core staff members who would be responsible for proper medication administration. The Executive Director and Resident Care Coordinator will review Medication Administration reports through stand up meetings to ensure compliance with the process is maintained. If any areas are found to be out of practice Executive Director will immediately take action and retrain Resident care coordinator on the rule area and determine any training needs for the facility Medications Aides. Resident Care Coordinator and Lead SIC will ensure compliance with weekly cart audits to determine when medications are not being administered and are awaiting for pharmacy and or prescription refill orders from the providers. Medication aides will be retrained on documenting attempts with the pharmacy and or PCP to resolve any medications that are not on site. RCC will be responsible for maintaining oversight and accountability for proper documentation and follow up notifications to the pharmacy and/or PCP.	12/15/2022

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

Tiffany Crumpton, Executive Director 11/25/22

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D 358	dated 08/01/22 revealed an order for divalproex (an anticonvulsant medication used to treat seizures, bipolar disorder or migraines) 125mg take 2 capsules (250mg total) every night at bedtime. Review of Resident #5's September 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for divalproex 125mg, take 2 capsules scheduled nightly at 9:00pm. -There was documentation divalproex was not administered from 09/12/22 through 09/17/22, and from 09/24/22 through 09/30/22; the reason documented was waiting on prescription or the medication was not on the medication cart. Observation of medication on hand for Resident #5 on 10/27/22 at 10:50am revealed: -There was one almost-full bottle for divalproex 125mg capsules with a dispensed date of 07/01/22, a dispensed quantity of 90 capsules, and one refill remaining. -There was one full medication bottle for divalproex 125mg capsules with a dispensed date of 08/29/22, and a dispensed quantity of 90 capsules with 5 refills remaining. Interview with a medication aide (MA)/lead supervisor (LS) on 10/26/22 at 4:00pm revealed: -She had documented Resident #5's divalproex as not administered due to waiting on prescription to come from the pharmacy three times in September 2022. -She should have notified Resident #5's primary care provider (PCP) after one missed doses of medication, but at the time she had not thought to. -Resident #5 used a different primary care provider	D 358		

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D 358	(PCP) and a different pharmacy than the rest of the residents and sometimes it was difficult to get in contact with either the PCP or the pharmacy. Interview with Resident #5 on 10/27/22 at 9:05am revealed: -In September 2022, he remembered missing doses of divalproex, but he did not know why. -He did not remember feeling any different around the time when he had missed doses of divalproex. Interview with a second MA on 10/27/22 at 10:30am revealed: -She had documented Resident #5's divalproex as not administered due to waiting on the prescription to come from the pharmacy one time in September 2022. -She did not remember Resident #5 being out of divalproex because it was a nighttime medication and she usually worked day shift. -She had not requested a refill of the medication because she figured one of the other MAs already had. -Resident #5's pharmacy mailed his medications to the facility. -When Resident #5's medications arrived at the facility they were supposed to be placed in the medication cart, but they could have been placed in the overstock medication cart instead. -The MAs were supposed to check the overstock medication cart before requesting a refill from the pharmacy and before documenting a medication as not administered due to it not being available. -Since Resident #5 had two bottles full of divalproex with dispensed dates from July and August 2022, which was prior to him missing doses in September 2022, she thought the bottles were probably in the overstock	D 358		

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D 358	medication cart and nobody had thought to check for them there. Interview with the Resident Care Coordinator (RCC) on 10/27/22 at 11:15am revealed: -The MAs were expected to send a refill request to Resident #5's pharmacy 7-10 days before his medication ran out so there would be no gaps in his medication administration. -She had been doing audits of the eMAR, but she was only auditing missed doses of medication that had no documentation on the eMAR (holes or blank spaces in the eMAR). -She did not know if anyone had been doing eMAR audits before she started. -The Regional Nurse came to the facility in August or early September 2022 to do an in-service with the MAs about medications not being administered due to MAs not requesting the refill prior to medications running out. -She did not know Resident #5 missed 13 doses of divalproex in September 2022. -She expected the MAs to let her know if a medication ran out so that she could either look for the medication in the overstock medication cart, work with the pharmacy on getting a refill sent right away, or let the PCP know that the resident would miss a dose. Interview with a third MA on 10/27/22 at 1:20pm revealed: -Resident #5's pharmacy mailed his medication to the facility. -The medications were usually placed into the medication cart upon arrival to the facility. -Resident #5 probably had one bottle of divalproex	D 358		

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D 358	already in the medication cart at the time, so his new refill bottles were probably placed in the overstock medication cart and when he ran out nobody thought to check the overstock of medications. Interview with the Executive Director (ED) on 10/27/22 at 12:35pm revealed: -The MAs were expected to request refills of medications 7-10 days prior to the medication running out. -The MAs had to refill Resident #5's medications by calling the pharmacy on his behalf. -It was the responsibility of the RCC to complete audits of the eMAR so that she knew if medications were not being administered. Attempted telephone interview with Resident #5's PCP on 10/27/22 at 12:25pm was unsuccessful. Attempted telephone interview with a representative from Resident #5's pharmacy on 10/27/22 at 12:30pm was unsuccessful. b. Review of Resident #5's signed physician's orders dated 08/01/22 revealed an order for olanzapine (an antipsychotic medication used to treat various mental disorders) 10mg, take one-half tablet (5mg total) at bedtime. Review of Resident #5's August 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for olanzapine 10mg take one-half tablet nightly scheduled at 9:00pm. -Olanzapine was not documented as administered 12 times from 08/13/22 through 08/27/22 with the reason	D 358		

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D 358	documented as waiting on prescription. Review of Resident #5's September 2022 eMAR revealed: -There was an entry for olanzapine 10mg take one-half tablet nightly scheduled at 9:00pm. -Olanzapine was not documented as administered 13 times from 09/15/22 through 09/30/22 with the reason documented as waiting on prescription. Observation of medication on hand for Resident #5 on 10/27/22 at 10:50am revealed: -There was one medication bottle for olanzapine 10mg tablets with a dispensed date of 08/13/22 and a dispensed quantity of 15 full tablets. -There were 15 half-tablets remaining in the medication bottle. Interview with a medication aide (MA)/lead supervisor (LS) on 10/26/22 at 4:00pm revealed: -She was not aware Resident #5 missed 25 doses of olanzapine between August and September 2022. -The MAs were all responsible for requesting medication refills 7-10 days prior to the medication running out. -The RCC was responsible for completing audits of the eMARs weekly, but she did not know if the audits had been getting done. Interview with Resident #5 on 10/27/22 at 9:05am revealed: -He was not familiar with his prescription for olanzapine or what he would be taking it for. -He did not notice any new symptoms or changes in the way he felt between August and September 2022.	D 358		

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D 358	Interview with a second MA on 10/27/22 at 10:30am revealed: -The MAs were supposed to reorder medications when the medication was down to 10 doses remaining. -She had documented Resident #5's olanzapine as not administered two times in August 2022 and three times in September 2022. -She could not remember if she had initiated a refill request or not for Resident #5's olanzapine. -She did not remember checking to see if Resident #5 had olanzapine in the overstock medication cart. -She had not noticed Resident #5 having any change in behavior in the last three months. Interview with the Resident Care Coordinator (RCC) on 10/27/22 at 11:15am revealed: -The MAs were expected to send a refill request to Resident #5's pharmacy 7-10 days before his medication ran out so there would be no gaps in his medication administration. -She had been doing audits of the eMAR and she was only auditing doses of medication that were due and had no documentation. -She did not know if anyone had been doing eMAR audits before she started. -The Regional Nurse came to the facility in August or early September 2022 to do an in-service with the MAs about medications not being administered due to MAs not requesting the refill prior to medications running out. -She did not know Resident #5 missed 25 doses of olanzapine between August and September 2022. -She had not noticed any change in behavior to Resident #5 in the last three months. -She expected the MAs to let her know if a medication ran out so that she could try and find the medication in	D 358		

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D 358	the overstock medication cart, work with the pharmacy on getting a refill sent right away, or let the PCP know that the resident would miss a dose. Interview with a third MA on 10/27/22 at 11:45am revealed: -She had documented Resident #5's olanzapine as not administered one time because they were waiting on his pharmacy to deliver the medication. -It was hard to get in touch with Resident #5's pharmacy so sometimes his refills were delivered late. -She could not remember if she checked the overstock medication cart for Resident #5's olanzapine. Interview with the Executive Director on 10/27/22 at 12:35pm revealed: -She was not aware that Resident #5 had missed 25 doses of olanzapine between August and September 2022. -The MAs were expected to request refills of medications 7-10 days prior to the medication running out. -The MAs had to refill Resident #5's medications by calling the pharmacy on his behalf. -If a medication had run out and the resident missed three doses, the MA was responsible for notifying the RCC so that the RCC could contact the PCP office regarding the missed doses and request a new prescription order be sent to the pharmacy. -It was the responsibility of the RCC to complete audits of the eMAR so that she knew if medications were not being administered. Attempted telephone interview with Resident #5's PCP on 10/27/22 at 12:25pm was unsuccessful.	D 358		

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D 358	Attempted telephone interview with a representative from Resident #5's pharmacy on 10/27/22 at 12:30pm was unsuccessful. c. Review of Resident #5's signed Physician's Orders dated 08/01/22 revealed there was an order for trazodone 100mg take one-half tablet (50mg) at bedtime for mood/sleep. Review of Resident #5's August 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for trazodone 100mg take one-half tablet at bedtime scheduled at 9:00pm. -There was documentation trazodone was not administered 21 days between 08/01/22 and 08/31/22. -The documented reason for not administering trazodone was waiting on prescription from the pharmacy. Review of Resident #5's September 2022 eMAR revealed: -There was an entry for trazodone 100mg take one-half tablet at bedtime scheduled at 9:00pm. -There was documentation trazodone was not administered 11 days between 09/01/22 and 09/19/22. -The documented reason for not administering trazodone was waiting on prescription from the pharmacy. Review of Resident #5's Progress Notes revealed: -On 09/01/22 at 12:49pm, the medication aide (MA)/lead supervisor (LS) documented she had requested a refill of trazodone for Resident #5. -On 09/01/22 at 4:08pm, the MA/LSIC documented she contacted Resident #5's pharmacy and "he had to get a	D 358		

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D 358	new order for trazodone and they sent me to the provider and she sent it to the doctor to expedite it over here today." Observation of medication on hand for Resident #5 on 10/27/22 at 10:50am revealed: -There was one medication bottle for trazodone 100mg tablets with a dispensed date of 09/16/22 and a dispensed quantity of 15 full tablets, with 4 refills remaining on the order. -There were two full tablets remaining in the bottle. Interview with a MA/LS on 10/26/22 at 4:00pm revealed: -The MAs were all responsible for requesting medication refills 7-10 days prior to the medication running out. -The RCC was responsible for completing audits of the eMARs weekly, but she did not know if the audits had been getting done. -0On ,9/01/22 was the first day she had worked on the medication cart when Resident #5 did not have trazodone to administer so she requested a refill. -She thought a refill had been delivered the following day. Interview with Resident #5 on 10/27/22 at 9:05am revealed: -He remembered not having trazodone off and on throughout August and September 2022. -He had not minded going without the trazadone because sometimes it upset his stomach. -He did not sleep well without the trazodone, so he had been taking it that month, October 2022. Interview with a second MA on 10/27/22 at 11:15am	D 358		

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D 358	revealed: -She was not aware that Resident #5 had missed doses of trazodone or that he had mentioned it giving him stomach upset and nightmares. -The MA who first documented Resident #5's trazodone as not administered due to not having the medication would have been responsible for notifying her that the medication was not on the medication cart, so that she could contact the pharmacy or primary care provider (PCP) right away. -The MAs were responsible for reordering medications prior to the medication running out. Interview with the Executive Director on 10/27/22 at 12:35pm revealed: -The MAs were expected to request refills of medications 7-10 days prior to the medication running out. -The MAs had to refill Resident #5's medications by calling the pharmacy on his behalf. -It was the responsibility of the RCC to complete audits of the eMAR so that she knew if medications were not being administered. -She did not know Resident #5 missed 32 doses of trazodone between August and September 2022. Attempted telephone interview with Resident #5's PCP on 10/27/22 at 12:25pm was unsuccessful. Attempted telephone interview with a representative from Resident #5's pharmacy on 10/27/22 at 12:30pm was unsuccessful. d. Review of Resident #5's signed Physician's Orders dated 08/01/22 revealed there was an order for artificial tears (polyvinyl alcohol) 1.4% eye drop	D 358		

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D 358	solution, instill 1 drop in affected eye four times a day (used to treat eye dryness). Review of Resident #5's September 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for artificial tears 1.4% solution, instill 1 drop in affected eye four times a day, scheduled at 9:00am, 1:00pm, 5:00pm and 9:00pm. -Artificial tears were not documented as administered 53 times from 09/01/22 through 09/20/22. -The reason documented for not administering artificial tears 15 times was that Resident #5 refused, and 38 times was waiting on medication to come from the pharmacy or "other." Observation of medication on hand for Resident #5 on 10/27/22 at 10:50am revealed there were no artificial tears on the medication cart for Resident #5. Interview with a medication aide (MA)/ lead supervisor in charge (LSIC) on 10/26/22 at 4:00pm revealed: -She thought she had requested a refill of Resident #5's artificial tear solution around 09/12/22. -If a refill of a medication was requested the pharmacy usually delivered it that same evening. -The MAs were all responsible for requesting medication refills 7-10 days prior to the medication running out. Interview with Resident #5 on 10/27/22 at 9:05am revealed: -He did not remember missing doses of his artificial tears, but he also was not sure how often they were ordered. -Sometimes his eyes were itchy but he had no other symptoms.	D 358		

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D 358	Interview with a second MA on 10/27/22 at 10:30am revealed: -She remembered Resident #5's artificial tears being unavailable for a while, and she thought it had been discontinued. -She had documented Resident #5's artificial tears as not administered due to waiting on prescription from the pharmacy 15 times, and as resident refused 11 times in September 2022. -She did not think that she had ever told the Resident Care Coordinator (RCC) or the Executive Director (ED) about Resident #5 refusing the artificial tears or not having any available on the medication cart for administration, because she thought a different MA already had. -The eMAR at the time did not allow the MAs to see if a medication refill request had been sent or not. -During September 2022, if she wanted to see if a refill request had been sent for a medication, she would need to look in the "sent faxes" folder on the computer, which she did usually once a shift. -Resident #5 had a supply of artificial tears within the last day because she had administered them and she had not noticed if they were running low at the time. Interview with the RCC on 10/27/22 at 11:15am revealed: -She was not aware that Resident #5 had gone without artificial tears 53 times in September 2022 or that there were not any artificial tears on the medication cart for Resident #5 that day, 10/27/22. -If the artificial tears had been documented as administered that morning, the MA would have used the last dose. -She did not know if more artificial tears had been	D 358		

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D 358	ordered for Resident #5. Interview with the ED on 10/27/22 at 12:30pm revealed: -The MAs were responsible for notifying either herself or the RCC if a medication had been refused or not administered three or more consecutive doses. -She did not know Resident #5 missed 53 doses of artificial tears in September 2022. -The RCC was able to pull reports from the eMAR system that would alert her if medications had not been administered. -She did not know how often the RCC had been pulling those reports or completing audits of the eMAR. Attempted telephone interview with Resident #5's PCP on 10/27/22 at 12:25pm was unsuccessful. Attempted telephone interview with a representative from Resident #5's pharmacy on 10/27/22 at 12:30pm was unsuccessful. 10A NCAC 13F .1002(a) Medication Orders	D 358	**"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law."** 10A NCAC 13F .1002 (a) Medication Orders The Executive Director and Resident Care Coordinator will review the process for Medication Order requirements with the Medication Aides to ensure understanding of facility need to notify PCP in regards to medication and or treatment orders received requiring verification and clarification. The Resident Care Coordinator will audit/review medication administration reports daily and if any new medication orders are found for needed clarification/ verification the facility will ensure this has been completed and if it has not RCC/LSIC will then ensure the findings have been reported to the PCP and the order has then been verified or clarified and documented in the resident's chart. Resident Care Coordinator and Lead SIC will ensure facility completion of weekly cart audits are completed and reviewed for compliance. This will allow the facility to determine if there are pending needs for verification or clarification by the resident's provider for any medication orders. RCC will notify ED of any obstacles or trainings needed that would inhibit their ability to ensure compliance with the process is maintained among the facilities Med Aides and determine any further training staff needs necessary for the facility staff that are responsible for the clarification and verification of orders for medications and treatments. RCC /LSIC will be responsible for maintaining oversight and accountability for proper documentation and follow up on notifications to the pharmacy and/or PCP. If found to be in compliance Medication aides will be retrained on documentation and follow up.	12/15/2022
D 344	10A NCAC 13F .1002 MEDICATION ORDERS (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.	D 344		

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D 344	This Rule is not evidenced by: Based on observations, record review and interviews, the facility failed to ensure contact with a resident's physician for clarification of a treatment order for 1 of 5 sampled residents (#1) who had an order for a topical ointment. The findings are: Review of Resident #1's current FL2 dated 02/22/22 revealed: -Diagnoses included type 2 diabetes, chronic kidney disease stage 3, congestive heart failure and venous insufficiency. -There was an order for Eucerin calming itch-relief (menthol-colloidal oatmeal) 0.1% lotion, apply three times daily. Review of Resident #1's physician order dated 03/18/22 revealed an order to discontinue Eucerin calming itch-relief lotion. Review of Resident #1's signed Physician's Order sheet dated 07/18/22 revealed there was an order for Eucerin calming itch-relief (menthol colloidal oatmeal) 0.1% topical lotion, apply three times daily. Review of Resident #1's August 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Eucerin calming itch-relief (menthol-colloidal oatmeal) 0.1% lotion, apply to entire skin three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was documentation Eucerin was not applied 38 out of 93 opportunities from 08/01/22 to 08/31/22 due to Resident #1 already having a supply in her room.	D 344		

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D 344	Review of Resident #1's September 2022 eMAR revealed: -There was an entry for Eucerin calming itch-relief (menthol-colloidal oatmeal) 0.1% lotion, apply to entire skin three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was documentation Eucerin was not applied 36 out of 90 opportunities from 09/01/22 through 09/30/22 due to Resident #1 either refusing it, or documentation that the medication was discontinued. Review of Resident #1's October 2022 eMAR revealed: -There was an entry for Eucerin calming itch-relief (menthol-colloidal oatmeal) 0.1% lotion, apply to entire skin three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was documentation Eucerin was not applied 19 out of 73 opportunities from 10/01/22 through 10/25/22 due to "don't use anymore," discontinued, or resident refusing. Observation of medication on hand for Resident #1 on 10/25/22 at 4:00pm revealed there was no Eucerin 0.1% lotion available for application. Telephone interview with a representative from the facility's current contracted pharmacy on 10/26/22 at 10:10am revealed: -They had served the facility since the beginning of October 2022. -They had an order for Eucerin 0.1% lotion on file for Resident #1 but a refill had not been requested from the facility, so they had not yet dispensed that medication for Resident #1. Telephone interview with a representative from Resident #1's primary care provider's (PCP) office on 10/26/22 at 11:00am revealed:	D 344		

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D 344	-There was not an active order on file for Eucerin 0.1% lotion for Resident #1. -She was not able to see when the Eucerin order had been discontinued. Interview with Resident #1's home health nurse on 10/26/22 at 11:45am revealed: -He did not use or apply Eucerin to Resident #1. -He did not know Resident #1 had an order for Eucerin or why it would be ordered. Interview with Resident #1 on 10/26/22 at 3:30pm revealed: -She had an order for Eucerin one year ago, in August or September 2021, due to an itchy skin condition she had at the time. -She had not needed or used Eucerin in almost a year. -She had asked for the Eucerin order to be discontinued months ago so the medication aides (MA) would stop offering it to her three times a day. -The MAs had not offered her Eucerin lately because as far as she knew, one of them had removed it from the medication cart. Interview with a MA/lead supervisor (LS) on 10/26/22 at 4:00pm revealed: -Resident #1's order for Eucerin lotion had been discontinued one or two months prior. -The Resident Care Coordinator (RCC) and Executive Director (ED) shared the responsibility of updating the eMAR when medications were discontinued. -The RCC was responsible for completing audits of the eMARs weekly, but she did not know if the audits had been getting done. -She had not contacted Resident #1's PCP to ask if Resident #1's Eucerin was supposed to be an active order or not because she thought the RCC already had, and it usually took a while to hear back from the PCP's	D 344		

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D 344	office. Interview with a second MA on 10/27/22 at 10:30am revealed: -Resident #1's Eucerin order was discontinued months ago. -The RCC and ED were responsible for removing discontinued orders from the eMAR. -She had not asked the RCC or ED about Resident #1's Eucerin order, she had not thought to do so. Interview with the RCC on 10/27/22 at 11:15am revealed: -She was aware that Resident #1's Eucerin order was discontinued because Resident #1 told her, and when she asked the LSIC about it, the LSIC told her it had been discontinued for a while. -Either the ED or herself would have been responsible for clarifying if the order was to be discontinued with the PCP and then removing the order from the eMAR. -She had documented Resident #1's Eucerin as "discontinued" on the eMAR but was busy during the medication pass and forgot to come back to that order to ask the PCP if they should remove it from the eMAR. -She had just started doing eMAR audits in the last two weeks because the ED showed her how to run exception reports and see which medications were being documented as not administered. -She did not know if anyone had been doing audits of the eMAR prior to her starting. Interview with a third MA on 10/27/22 at 11:45am revealed: -She had documented Resident #1's Eucerin as administered in August because it had been on the medication cart and if it was on the eMAR she assumed it was a current order. -If the Eucerin order had been discontinued, the ED	D 344		

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D 344	would be responsible for removing it from the eMAR. -The MAs did not have access to discontinue orders from the eMAR. -After she saw that the Eucerin was documented as discontinued she had asked the ED several times to take Resident #1's Eucerin order off the eMAR but she never did. -Either the RCC or the ED would be responsible for contacting Resident #1's PCP's office to determine if the Eucerin order was active or not. Interview with the ED on 10/27/22 at 12:30pm revealed: -The RCC who had been employed at the facility back in March 2022 would have been responsible for removing Resident #1's Eucerin from the eMAR. -She was not aware Resident #1's Eucerin had been on the eMAR and that MAs were documenting it as not administered due to order being discontinued. -Resident #1 had told her at one point that she was not using the Eucerin cream routinely anymore but she was not aware it was supposed to have been discontinued. -She expected the MAs to notify the RCC after three consecutive refusals or doses not administered so that the RCC could call and clarify if the order should be active or discontinued with the PCP office. -The RCC was responsible for pulling reports from the eMAR that would alert her if a medication was not administered. Attempted telephone interview with a representative from the facility's previous contracted pharmacy on 10/27/22 at 11:45am was unsuccessful.	D 344		

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-036-034**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: **10/27/2022**

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Court of Cherryville	**401 West Academy St. Cherryville, NC, 28021**

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)	COMPLETE DATE
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 HEALTH CARE (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not evidenced by: Based on observations, record review and interviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (#1) related to medication refusal. The findings are: Review of the facility's Medication Administration policy dated September 2021 revealed: -Missed or refused medications were to be documented in the resident's electronic Medication Administration Record (eMAR) and the provider was to be notified and documented. -The medication aide (MA) and/or the Resident Care Coordinator (RCC) would notify the provider of missed/refused medications immediately after 3 consecutive refusals. -The RCC would evaluate the resident refusals and contact the physician and responsible party if the resident was continually refusing a medication and then document the communication on the Progress Note. Review of Resident #1's current FL2 dated 02/22/22 revealed: -Diagnoses included type 2 diabetes, chronic kidney	D 273	**"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law."** 10A NCAC 13F .0902(b) Health Care The Executive Director and Resident Care Coordinator will review the process for notification requirements with the Medication Aides to ensure proper notification requirements are met to the Primary Care Provider, as well as documentation within the resident's echart regarding the medication refusals and notification to the provider. The Resident Care Coordinator will review reports daily to include notifications of missed medications due to unavailable and refusals to ensure compliance with notification to the provider has been communicated. All necessary core staff members (Med Aides/SICs, RCC, ED) will be retrained on the process for ensuring any resident health care needs that arise are reported to the appropriate providers in a timely manner. Resident referral and follow up will be monitored by the Care Manager and ED of the Facility on a daily and weekly basis through stand up to correct any deficient areas of practice found.	12/15/2022

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

Tiffany Crumpton, Executive Director 11/25/22

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)	COMPLETE DATE
D 273	disease stage 3, congestive heart failure and venous insufficiency. -There was an order for fish oil 1000mg twice daily. Review of Resident #1's August 2022 eMAR revealed: -There was an entry for fish oil 1000mg scheduled twice daily at 8:00am and 8:00pm. -There was documentation on 08/30/22 that fish oil was not administered due to resident refusing because it was making her sick. Review of Resident #1's September 2022 eMAR revealed: -There was an entry for fish oil 1000mg scheduled twice daily at 8:00am and 8:00pm. -There was documentation fish oil was not administered 55 out of 60 opportunities from 09/01/22 through 09/30/22. -There was documentation the fish oil was not administered due to it making her sick 18 out of the 55 times, and the remaining 37 times it was documented as not administered due to resident refusing. Review of Resident #1's Progress Notes revealed: -On 08/30/22, there was a note documenting that Resident #1 had refused her bedtime dose of fish oil; Resident #1 had spoken with the Executive Director (ED) about the reason for her refusal and was told it was "okay" to refuse since she had not been feeling well after taking it. -On 09/03/22, there was a note documenting that Resident #1 had been refusing to take the fish oil supplement because it was making her sick. -There was no documentation the physician was notified of refusals and the medication was making her	D 273		

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D 273	sick. Telephone interview with a representative from the facility's current contracted pharmacy on 10/25/22 at 10:10am revealed: -They had started servicing the facility in October 2022. -They were dispensing fish oil for Resident #1 in the weekly bubble packs along with the rest of her medications. -They had not received any notice requesting a different type of fish oil to be dispensed. Telephone interview with a representative from Resident #1's primary care provider's (PCP) office on 10/26/22 at 11:00am revealed: -There were no notes documenting the facility had contacted their office regarding Resident #1 refusing fish oil or the medication was making her sick throughout September 2022. -If Resident #1 had been refusing a medication due to it making her feel sick, they would expect to receive an update so that the PCP could review and change the order. Interview with Resident #1 on 10/26/22 at 3:30pm revealed: -She did not take her fish oil supplement in September 2022 because the facility's previous pharmacy started sending a different type of fish oil than they had been sending previously. -The new variation of fish oil had been upsetting her stomach, so she refused to take it. -One of the staff, she could not remember who, had told her that they tried notifying her PCP, but it always took a long time to get in touch with them.	D 273		

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D 273	-She did not know if her PCP was ever contacted regarding the fish oil. -The new pharmacy had been dispensing a type of fish oil that was not upsetting to her stomach, so she had been taking her fish oil again in the month of October 2022. Interview with a MA/ lead supervisor (LS) on 10/26/22 at 4:00pm revealed: -She had notified Resident #1's PCP's office about the fish oil making her feel sick in the middle of September 2022 and requested the fish oil be changed to a different type of omega-3 supplement. -The pharmacy started sending a fish oil supplement that did not make Resident #1 feel sick when the pharmacy changed at the beginning of October 2022. -She did not know if Resident #1's PCP had changed the order or if the new pharmacy had a different type of fish oil than the previous pharmacy. Interview with a second MA on 10/27/22 at 10:30am revealed: -Resident #1 had refused to take fish oil in September 2022 because it had been making her sick. -She had told the ED about Resident #1's fish oil making her sick, and the ED told her she already knew because Resident #1 had told her. -She did not know if Resident #1's PCP had been notified about the refusals and the fish oil making her sick or not. -She had not contacted Resident #1's PCP because she figured the ED, the RCC, or the MA/LS already had. -She did not think Resident #1's PCP wrote a new order for fish oil, because the previous pharmacy had originally been dispensing omega-3 fish oil and in	D 273		

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D 273	September 2022, it changed to a generic fish oil. -The new pharmacy was dispensing the omega-3 fish oil which Resident #1 liked to take. Interview with the RCC on 10/27/22 at 11:15am revealed: -She was aware Resident #1's fish oil supplement was making her feel sick during September 2022. -She thought that one of the MAs had contacted Resident #1's PCP's office and the pharmacy to request a different type of fish oil to be dispensed. -The pharmacy sent an additional supply of fish oil for Resident #1, but it had been the same kind they dispensed previously that was upsetting Resident #1's stomach. -The MA should have documented her notifications to the PCP's office and the pharmacy in a Progress Note. Interview with a third MA on 10/27/22 at 11:45am revealed: -She was aware Resident #1's fish oil was making her sick in September 2022. -Resident #1 had requested a different type of fish oil. -She had contacted the pharmacy to request a different type of fish oil to be dispensed but was told she would need to send a new order because they were dispensing the variation that was covered by Resident #1's insurance. -Both herself and the RCC had called Resident #1's PCP's office but never spoke directly with anyone at the office or received a call back. -She did not think she remembered to document her call to Resident #1's PCP's office in a Progress Note. Interview with the ED on 10/27/22 at 12:30pm	D 273		

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D 273	revealed: -Resident #1 had told her in September 2022 that she wanted her fish oil supplement changed because it was making her feel sick, and she wanted to switch back to the fish oil the pharmacy had previously been dispensing. -Both she and the RCC had attempted to call Resident #1's PCP's office to get a different fish oil supplement order but had not been able to talk to the PCP. Attempted telephone interview with a representative from the facility's previous contracted pharmacy on 10/27/22 at 11:45am was unsuccessful.	D 273	**"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law."**	
D 126	10A NCAC 13F .0403(b) Qualifications of Medication Staff 10A NCAC 13F .0403 QUALIFICATIONS OF MEDICATION STAFF (b) Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration. This Rule is not evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) who administered medications had passed the written medication aide exam within 60 days of completing the medication clinical skills competency validation checklist. The findings are:	D 126	10A NCAC 13F .0403(b) Qualifications of Medication Staff The Executive Director will review the rule requirement for Qualifications of Medication Staff with the Business Office Coordinator and Resident Care Coordinator to ensure proper requirements are understood and process is in place to prevent non compliance. The Executive Director, Resident Care Coordinator will send MA to BOC once MA completes prior requirements and has officially been checked off by the ACD validating their skills to enroll and sign up for a medication aide test. BOC will then maintain record keeping of scheduled test and will follow up with registry once test has been completed. Any MA that does not pass the test prior to 60 days post skills check off date will immediately be removed from the schedule until proof of a passed NC medication aide test is available from the registry. BOC will complete an audit on all current MA to ensure facility is in compliance with rule area 10A NCAC 13F .0403.	12/15/2022

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D 126	Review of Staff C's personnel record revealed: -Staff C was hired on 02/22/22 as a personal care aide (PCA). -There was a certificate of completion dated 05/24/22 for the 15-hour state approved medication aide training for Staff C. -There was documentation of a medication clinical skills competency validation checklist completed for Staff C dated 05/24/22 (timeframe for taking the written medication aide exam ended on 07/24/22). -There was no documentation Staff C had successfully passed the written medication aide (MA) exam. Review of residents' medication administration records for August, September and October 2022 revealed Staff C documented administration of medications for 8 of 31 days in August 2022; for 7 of 30 days in September 2022; and for 18 of 26 days from 10/01/22 through 10/26/22. Telephone interview with Staff C on 10/26/22 at 6:23pm revealed: -She was hired on 02/22/22 as a PCA. -She started working as a MA in May 2022. -She had difficulties with signing up for the written MA exam and was previously unable to take the exam. -She had not passed the written MA exam. -She thought the Executive Director (ED) or Area Clinical Director had told her that she had to pass the written MA exam within 60 days of completing a medication clinical skills validation checklist, but she had forgotten. -She thought the Business Office Manager (BOM) was responsible to ensure that MAs passed the written MA exam within 60 days of completing a medication clinical skills validation checklist. -She knew she had to pass the written MA exam within	D 126		

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D 126	60 days of completing a medication clinical skills validation checklist, but she had forgotten before she was able to do so. Interview with the Resident Care Coordinator (RCC) on 10/27/22 at 9:48am revealed: -She was not aware Staff C had not passed the written MA exam within 60 days of completing the medication clinical skills validation checklist. -She was hired in early June 2022. -She did not know if anyone had told Staff C that she had to pass the written MA exam within 60 days of completing the medication clinical skills validation checklist because Staff C was already working when she was hired. -She was not sure who was responsible to ensure that MAs passed the written MA exam within 60 days of completing the medication clinical skills validation checklist. Interview with the Business Office Manager (BOM) on 10/27/22 at 9:57am revealed: -She was not aware that Staff C had not passed the written MA exam within 60 days of completing the medication clinical skills validation checklist. -She was hired in early May 2022. -She did not know if anyone had told Staff C that she had to pass the written MA exam within 60 days of completing the medication clinical skills validation checklist. -She thought that she and the Area Clinical Director were responsible to ensure that MAs passed the written MA exam within 60 days of completing the medication clinical skills validation checklist.	D 126		

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D 126	Interview with the Area Clinical Director 10/27/22 at 10:07am revealed: -She worked in multiple facilities and began her current role in July 2021. -She was not aware Staff C had not passed the written MA exam within 60 days of completing the medication clinical skills validation checklist. -She told Staff C after she validated Staff C's medication clinical skills that Staff C had to pass the written MA exam within 60 days of completing the validation or she had to come off the medication cart. -She informed Staff C of the website address for signing up for the written MA exam and told Staff C that she had to create an account on the website and pay 25 dollars to register. -The BOM and the ED were responsible to ensure that MAs passed the written MA exam within 60 days of completing the medication clinical skills validation checklist. Interview with the Executive Director (ED) on 10/27/22 at 10:18am revealed: -She was not aware Staff C had not passed the written MA exam within 60 days of completing the medication clinical skills validation checklist. -She thought Staff C had taken the written MA exam and she had asked Staff C to print her exam results in early October 2022 to be placed in Staff C's record on file. -She and the Area Clinical Director told Staff C that Staff C had to pass the written MA exam within 60 days of completing the medication clinical skills validation checklist. -She, the BOM and the Area Clinical Director were all responsible to ensure that MAs passed the written MA	D 126		

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-036-034**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: **10/27/2022**

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Court of Cherryville	**401 West Academy St. Cherryville, NC, 28021**

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D 126	exam within 60 days of completing the medication clinical skills validation checklist.	D 126		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

Tiffany Crumpton, Executive Director 11/25/22