Recieved via email 02/06/23

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PRINTED: 01/27/2023
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034085	A. BUILDING: _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY ELMS	3750 HARPER ROAD CLEMMONS, NC 27012

(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 January 11, 2023, January 12, 2023 and January 13, 2023.	D 000	MEASURES TO CORRECT DEFICIENT PRACTICE The facility nurse will be educated on AL regulations regarding LHPS requirements. The current staff files will be 100% audited for completed LHPS forms. MEASURES TO PREVENT REOCCURRENCES The facility system will initiate with all new hires to include training and completion of LHPS on day 2 of orientation. A list of all newly hired staff will be audited monthly x 6 months and then quarterly x 4 months to ensure compliance. The facility will bring the findings of audits to quarterly QA meetings. The facility RN will be responsible for LHPS requirements compliance. The audit of current employees will be completed by 2/10/23. Audits will be conducted monthly x 6 months, then quarterly x 3 months, then as needed if no further compliance issues are noted.	01/31/2023
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a licensed health professional support (LHPS) competency validation had been completed for tasks including ambulation using assistive devices that requires physical assistance and transferring	D 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diata Berthe-Albert | TITLE: Administrator | (X6) DATE: 02/06/2023

Reviewed and acknowledged 02/07/23

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D 161	Continued From page 1 semi-ambulatory residents for 2 of 6 staff sampled (Staff A and E). The findings are: 1. Review of Staff A's, personal care aide, personnel record revealed: -She was hired on 11/28/22 as a personal care aide (PCA). -There was no documentation LHPS competency validation for Staff A had been completed. Interview with Staff A, PCA, on 01/13/23 at 2:35pm revealed: -She worked with another PCA for training when she started working at the facility. -She was not evaluated by the facility Nurse or any nursing staff for assisting residents with tasks. -She assisted residents with transferring from wheelchairs to the bed. -She assisted residents with ambulating with walkers (reminded residents to use walkers, and helped residents position to their walkers). Observation on 01/13/23 at 2:25pm revealed Staff A assisted a resident with ambulating by propelling her in the wheelchair in the hallway. Refer to the interview with the facility Nurse on 01/13/23 at 3:22pm. Refer to the interview with the Administrator on 01/13/23 at 3:50pm. 2. Review of Staff E's, personal care aide (PCA) personnel record revealed: -She was hired on 07/26/22. -There was no documentation a LHPS competency validation for Staff A had been	D 161		

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D 161	Continued From page 2 completed. -She started working as a medication aide (MA) in October 2022. Interview with Staff E on 01/13/23 at 2:40pm revealed: -She worked with another PCA for training when she started working at the facility. -She did not remember if she had been evaluated by a nurse for assisting residents with tasks. -She assisted residents with transferring from wheelchairs to the bed and assisted residents with ambulating with walkers. Refer to the interview with the facility Nurse on 01/13/23 at 3:22pm. Refer to the interview with the Administrator on 01/13/23 at 3:50pm. Interview with the facility Nurse on 01/13/23 at 3:22pm revealed: -The Nurse was responsible to ensure new staff were LHPS competency validated upon hire. -She started working in the facility in late November 2022. -She did not receive orientation training from the previous facility Nurse when she was hired. -She used a facility form to evaluate the PCA's knowledge for performing task, but did not document LHPS competency validation on the state approved LHPS competency validation form. Interview with the Administrator on 01/13/23 at 3:50pm: -The previous Administrator was a nurse and had completed most of the LHPS competency validations herself. -The current facility Nurse was not trained by the	D 161		

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D 161	Continued From page 3 previous Administrator for staff competency validation requirements. -The current facility Nurse was hired around the same time as newer employees and may not have known to ensure LHPS competency validations were completed.	D 161		01/31/2023
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (#1) related to refusing application of anti-embolism (TED) hose. The findings are: Review of the facility's General Guidelines for Medication Administration revealed if dose of regularly scheduled medication (or treatment) is withheld, or refused it should be documented or noted on the electronic medication administration record (eMAR) with an explanatory note and the primary care provider notified for 3 days of consecutive missed doses (or treatments). Review of Resident #2's FL2 dated 05/11/22 revealed diagnoses included peripheral neuropathy, decompensated hepatic cirrhosis, and hypokalemia. Review of Resident #2's electronically signed physicians' orders dated 09/22/22, 10/18/22,	D 273	MEASURES TO CORRECT DEFICIENT PRACTICE The facility will do a 100% audit all medical records for refusals/omissions of TED hose. The physician will be notified of any deficiencies found. MEASURES TO PREVENT RECURRENCE 100% education of med techs on the requirement for physician notification for any medication or treatment (TED hose) not given due to refusal or unavailability. All med techs will be expected to report refusals/omissions on 24hr report sheet. Health Care Coordinator and Memory Care Coordinator to review 24hr report sheets for patterns of refusal/omission that need to be reported to MD. Diata Berthé-Albert 02/06/2023	

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D 273	Continued From page 4 11/10/22, 12/04/22, and 12/30/22 revealed was an order to apply TED hose knee high daily to both lower extremities daily for edema. Review of Resident #2's physician's progress notes for encounters on 11/18/22 and 11/29/22 revealed slight edema of the feet was documented. Review of Resident #2's November 2022 eMAR revealed: -There was an entry for apply TED hose knee high to both lower extremities(BLE) 2 times a day for edema scheduled for apply (on) at 8:00am and off (remove) at 7:00pm. -There was documentation Resident #2 refused TED hose application on 11 or 30 days in November 2022. -The dates documented for refused application were 11/02/22, 11/03/22, 11/07/22, 11/08/22, 11/10/22, 11/14/22, 11/16/22, 11/11/22, 1123/22, 11/24/22, and 11/28/22. Review of Resident #2's December 2022 eMAR revealed: -There was an entry for apply TED hose knee high to BLE 2 times a day for edema scheduled for apply (on) at 8:00am and off (remove) at 7:00pm. -There was documentation Resident #2 refused TED hose application on 16 or 31 days in December 2022. -Example of the dates documented for refused application for December 2022 included 12/02/22, 12/05/22 to 12/07/22, 12/14/22 to 12/16/22, and 12/19/22 to 12/22/22. Review of Resident #2's January 2023 eMAR revealed: -There was an entry for apply TED hose knee	D 273	The five medication records will be audited for patterns of refusals or omission of TED hose. Audits will occur weekly x 3 months and monthly x 3 months as needed if no further compliance issues are noted. The facility will bring the findings of audits to quarterly QA meetings. The Health Care Coordinator and Memory Care Coordinator will carry out this compliance. The facility will complete an audit of all medical records for refusal/omission of TED hose, and physician notification will be completed by 2/10. Five medication records will be audited for patterns of refusals or omission of TED hose and physician notification. Audits will occur weekly x 3 months, then monthly x 3 months, then as needed if no further compliance issues are noted. Diata Berke-Albert 02/06/2023	01/31/2023

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D 273	Continued From page 5 high to BLE 2 times a day for edema scheduled for apply (on) at 8:00am and off (remove) at 7:00pm. -There was documentation Resident #2 refused TED hose application on 8 or 12 days from January 01, 2023 to 01/12/23. -Example of the dates documented for refused application for January 2023 included 01/01/23, 01/02/23, 01/06/23 to 01/09/23, 01/11/23, and 01/12/23. Interview with the Resident Services Coordinator (RSC) on 01/13/23 at 10:30am revealed: -The residents' TED hose were routinely applied by PCAs in the early morning. -The MA was responsible to document the resident was wearing TED hose on the eMAR. -The lead MA supervisor was assigned the responsibility to ensure residents with orders for TED were added to the task list. -Resident #2's TED hose application was not listed on the assignment sheet. -There was a PCA assignment sheet listing the residents who had orders for TED hose or other task placed at the nursing station on each hall. -The PCA was supposed to use the assignment sheet and the residents' assigned to the PCA to ensure LHPS task were completed. -The RSC would be responsible to ensure the PCP was notified for residents' refusing medications or treatments. -She did not currently have a system in place to audit for notifying the PCP of medication refusals or treatment refusals. Telephone interview with Resident #2's primary care provider (PCP) on 01/13/23 at 11:17am revealed: -There was no documentation the facility had contacted her office or the PCP regarding	D 273		

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D 273	Continued From page 6 Resident #2 refusing to wear TED hose. -She had documentation that Resident #2 did not have TED hose on when she saw the resident on 3 encounters from 10/01/22 to 01/13/23. -Resident #2 had a small amount of bilateral ankle edema when she saw her. -The facility should have notified her of Resident #2 refusing to wear TED hose. -She could have been monitoring more closely for edema and possibly discontinued the TED hose for non-compliance or not needed. Interview with the RSC and Medical Record Specialist (MRS) on 01/13/23 at 3:10pm revealed: -The MAs had been trained and instructed to notify residents' PCPs for refusing medications or treatments 3 times in a row. -The MAs were supposed to notify the PCP by telephone, or by faxing a facility form for refusals to the PCP. -A copy of the faxed form was supposed to be placed in the residents' electronic record for documentation of the PCP notification. -There was no documentation for notification that Resident #2 was refusing TED hose application. Interview with the Administrator on 01/13/23 at 3:39pm revealed: -The TED hose were supposed to be applied by the PCAs or the MA and application documented on the residents' eMAR. -If a resident was refusing TED hose, the PCP should be notified and the notification documented in the electronic progress notes. -The nursing staff and lead MAs were responsible to ensure the refusal of medications or treatments was documented and followed up on.	D 273		

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D 358	Continued From page 7	D 358	MEASURES TO CORRECT DEFICIENT PRACTICE	01/31/2023
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by the physician for 2 of 7 residents (#1 and #4) including a cholesterol medication (#1), and an anti-hypertensive medication (#4). The findings are: 1. Review of Resident #1's current FL2 dated 05/05/22 revealed: -Diagnoses included syncope and collapse, paroxysmal atrial fibrillation, venous insufficiency, atherosclerotic heart disease of native coronary artery without angina pectoris, and mild cognitive impairment. -There were physician's orders attached to the FL2 which included an order for pravastatin sodium 40mg (used to treat high blood pressure) 1 tablet daily at bedtime. Review of Resident #1's electronic Medication Administration Record (eMAR) for November 2022 revealed: -There was an entry for pravastatin sodium 40mg	D 358	The facility will 100% audit medication administration records to identify omissions of medications due to unavailability. MEASURES TO PREVENT RECURRENCE Med techs will be 100% educated on the requirement for physician notification for any medication or treatment not given due to refusal or unavailability. All med techs are expected to report refusals/omissions on 24hr report sheet. Health Care Coordinator and Memory Care Coordinator to review 24hr report sheets for patterns of refusal/omission that need to be reported to MD. The med techs will be 100% educated on requesting and ensuring medication refills from the pharmacy. Staff will be educated on the importance of parameters for medications being followed. The facility will do five random audits of medication administration records for medications omitted due to unavailability and parameters being met before administration of medication. Audits will occur weekly x 3 months, monthly x 3 months, then as needed if no further compliance issues are noted.	

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D 358	Continued From page 8 1 tablet daily scheduled for administration at 7:00pm. -Pravastatin sodium was documented as administered for 28 of 30 opportunities. -There was documentation pravastatin sodium was not administered on 11/04/22 due to resident refused and on 11/05/22 due to waiting on pharmacy. Review of Resident #1's eMAR for December 2022 revealed: -There was an entry for pravastatin sodium 40mg 1 tablet daily scheduled for administration at 7:00pm. -Pravastatin sodium was documented as administered for 19 of 31 opportunities. -There was documentation pravastatin sodium was not administered on 12/23/22 due to needed to be ordered, on 12/24/22 due to waiting for pharmacy, on 12/26/22 due to waiting on pharmacy, on 12/27/22 due to waiting on pharmacy, on 12/28/22 due to waiting on medication to arrive from pharmacy, on 12/30/22 due to medicine not in building, and on 12/31/22 due to waiting on medication to arrive from the pharmacy. Review of Resident #1's January 2023 eMAR from 01/01/23 through 01/10/23 revealed: -There was an entry for pravastatin sodium 40mg 1 tablet daily scheduled for administration at 7:00pm. -Pravastatin Sodium was documented as administered for 6 of 10 opportunities. -There was documentation pravastatin sodium was not administered on 01/09/23 due to waiting on pharmacy. Observation of Resident #1's medications available for administration on 01/12/23 at	D 358	Monthly audits by the pharmacist for patterns of omissions/refusals as well as compliance with parameters. The facility will bring the findings of audits to quarterly QA meetings. The Health Care Coordinator, Memory Care Coordinator, and Medical Records staff will be responsible for this compliance. Initial audits for compliance with physician notification of omissions/refusals will be completed by 2/10/2023. Random audits of 5 MARs will be completed weekly x 3 months, then monthly x 3 months as needed if no further compliance issues are noted. Diana Berth-Albert	01/31/2023 02/06/2023

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D 358	Continued From page 9 1:12pm revealed pravastatin sodium was not available for administration. Interview with a medication aide (MA) on 01/12/23 at 1:28pm revealed: -She did not remember if Resident #1 was out of pravastatin sodium in November or December 2022. -She thought she administered pravastatin sodium to Resident #1 on 01/11/23. A second interview with the MA on 01/12/23 at 1:38pm revealed: -She pulled the refill sticker located at the black dot on the medication bubble pack when there was 1 week of medication remaining. -She faxed the refill sticker to the pharmacy and made a copy of the fax to file in the refill book. -If a medication was not on the medication cart, MAs were to check the medication room to see if it was there. -If the medication was not in the medication room, MAs were to call the pharmacy. -She did not notice if Resident #1 was out of pravastatin sodium when she administered medication to her on 01/11/23. -She did not call the pharmacy on 01/11/23 to reorder pravastatin sodium. Interview with a pharmacy technician at the facility's contracted on 01/12/23 at 11:07am revealed: -Resident #1 had an order for pravastatin sodium 40mg 1 tablet daily at bedtime. -Pravastatin sodium was dispensed on 11/07/23 with a quantity of 30 tablets and there had not been any dispenses since 11/07/23. -The facility sent a request for refills when needed. -There was no documentation of a request for a	D 358		

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D 358	Continued From page 10 refill for pravastatin sodium and there was no documentation of any insurance issues. Interview with the Resident Services Coordinator (RSC) on 01/12/23 at 1:55pm revealed: -MAs should have reordered medication when the medication was down to the black sticker on the medication bubble pack where there were about 7 doses of medication remaining. -She did not know pravastatin sodium was not available for administration. -If the medication was not in the facility, a MA should have contacted the pharmacy. -She would have expected the MA to come to her if the MA had trouble getting the medication from the pharmacy or if the MA noticed the medication was not in the facility for multiple days. Interview with Resident #1's primary care provider (PCP) on 01/13/22 at 11:22am revealed: -Resident #1 had an order for pravastatin sodium to treat high cholesterol. -She did not know Resident #1 did not have pravastatin sodium available for administration. -Possible outcomes of Resident #1 not being administered pravastatin sodium were elevated lipid panels, increased cholesterol, and increased risk for heart attack or stroke. Interview with the Administrator on 01/13/23 at 3:37pm revealed: -Medications should have been reordered medication within a week of the medication running out. -If a medication was not in the facility for an extended time or there was difficulty getting the medication from the pharmacy and the MA should have informed the supervisor on duty or the RSC for follow-up. -She did not know Resident #1's pravastatin	D 358		

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D 358	Continued From page 11 sodium was not available on the medication cart for administration on 01/12/23. -She expected MAs to administer medication as ordered. 2. Review of Resident #4's current FL-2 dated 11/07/22 revealed: -Diagnoses included hypertension, atrial fibrillation, and dementia. -There was a medication order for metoprolol 50mg (used to treat high blood pressure) one tablet two times a day. Hold for systolic blood pressure (SBP) less than 100. Hold for pulse (P) less than 55. Review of Resident #4's November 2022 electronic medication administration record (eMAR) 11/07/22-11/30/22 revealed: -There was an entry for metoprolol 50mg one tablet two times a day. Hold if SBP less than 100, hold if P less than 55, scheduled for 7:00am and 7:00pm. Including entries for blood pressure (BP) and pulse (P) at 7:00am and 7:00pm. -Metoprolol 50mg was documented as administered on 11/15/22 for P-50, 11/18/22 for P-47, 11/23/22 for P-53, 11/26/22 for P-49, 11/27/22 for P-52, and 11/29/22 for P-53 at 7:00am and 11/07/22 for P-50, 11/08/22 for P-53, 11/09/22 for P-43, 11/10/22 for P-46, 11/11/22 for P-48, 11/12/22 for P-52, 11/13/22 for P-49, 11/18/22 for P-50, 11/24/22 for P-48, 11/25/22 for P-46, 11/28/22 for P-46 and 11/30/22 for P-53 at 7:00pm. -There were 18 opportunities when Resident #4's P met the parameter to hold metoprolol 50mg and it was documented as administered. Review of Resident #4's December 2022 eMAR 12/01/22-12/31/22 revealed: -There was an entry for metoprolol 50mg one	D 358		

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D 358	Continued From page 12 tablet two times a day. Hold if SBP less than 100, hold if P less than 55, scheduled for 7:00am and 7:00pm. Including entries for blood pressure (BP) and pulse (P) at 7:00am and 7:00pm. -Metoprolol 50mg was documented as administered on 12/07/22 for P-54 at 7:00am and 12/13/22 for SBP-95 for 7:00pm, 12/01/22 for P-49, 12/03/22 for P-51, 12/07/22 for P-51, 12/15/22 for P-50, 12/20/22 for P-54, 12/22/22 for P-54, and 12/27/22 for P-50 at 7:00pm. -There were 9 opportunities when Resident #4's SBP or P met the parameter to hold metoprolol 50mg and it was documented as administered. Review of Resident #4's January 2023 eMAR 01/01/22-01/12/22 revealed: -There was an entry for metoprolol 50mg one tablet two times a day. Hold if SBP less than 100, hold if P less than 55, scheduled for 7:00am and 7:00pm. Including entries for blood pressure (BP) and pulse (P) at 7:00am and 7:00pm. -Metoprolol 50mg was documented asadministered on 1/04/22 for P-51, 01/07/23 for P-49, 01/08/23 for P-53 and 01/11/23 for P-54 at 7:00am, and 01/05/23 for P-52, 01/06/23 for P-50, 01/07/23 for P-53, 01/09/23 for P 52 at 7:00pm. -There were 8 opportunities when Resident #4's SBP or P met the parameter to hold metoprolol 50mg and it was documented as administered. Observation of Resident #4's medications on hand on 01/12/23 at 4:05pm revealed: -There was one bubble packet of metoprolol 50mg labeled give one tablet two times a day. Hold if SBP less than 100, hold if P less than 55. -The bubble packet was dispensed on 12/29/22 with 48 of 60 tablets remaining. Interview with a medication aide (MA) on	D 358		

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D 358	Continued From page 13 01/12/23 at 4:00pm revealed: -Resident #4 had blood pressure and pulse parameters to hold her metoprolol for top BP less than 100 and P less than 55. -Resident #4 had her blood pressure taken on day and evening shift because she had multiple blood pressure medication. -When staff had to enter her BP and P before they documented administration of Resident #4's metoprolol in the eMAR. Interview with a second MA on 01/12/23 at 4:10pm revealed: -She did not know Resident #4 had BP and P parameters to hold her metoprolol. -Resident #4 had her blood pressure taken on day and evening shift because she had multiple blood pressure medication. -She would enter the Resident #4's blood pressure, but was unsure when she was to hold her BP medication. -She did not remember ever holding her metoprolol. Interview with a third MA on 01/13/23 at 9:15am revealed: -She did not know Resident #4 had BP and P parameters to hold her metoprolol. -Resident #4 had her blood pressure taken on day and evening shift. -She was not sure if there was an entry to check the resident's BP and P. -The MA had taken her blood pressure on day shif,t but did not remember ever holding her metoprolol. Interview with a fourth MA on 01/13/23 at 9:20am revealed: -Resident #4 had blood pressure parameters to hold her metoprolol.	D 358		

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D 358	Continued From page 14 -Resident #4 had her blood pressure taken on day and evening shift and she had multiple scheduled blood pressure medications. -She had to enter Resident #4's BP and P to document administration of her metoprolol. -She could not remember any time she held Resident #4's metoprolol. Interview with the Memory Care Coordinator (MCC) on 01/27/22 at 9:35am revealed: -There was no set audit system or frequency for eMARs. -She would randomly audit the medication carts for medication bubble pack instructions to match the eMAR, but she did not recheck for accuracy of documentation according to BP and P parameters. -Resident #4 had BP and P parameters to hold her metoprolol on day and evening shift. -She expected the MAs to hold Resident #4's metoprolol if her BP and P met the parameters. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10:10am revealed: - Resident #4 had an order for metoprolol 50mg give one tablet two times a day, hold for systolic blood pressure (SBP) less than 100 or pulse (P) less than 55. -Metoprolol 50mg tablets were dispensed 10/21/22, 11/28/22 and 12/28/22 for 60 tablets on each date. Telephone interview with Resident #4's primary care provider (PCP) on 01/13/23 at 11:40am revealed: -Resident #4 had an order for metoprolol 50mg twice a day and hold for SBP than 100 or P less than 55. -She looked at BP and P readings on a printout	D 358		

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D 358	Continued From page 15 and did not look at eMARs when she visited residents and did not know that staff had administered Resident #4's metoprolol when it should have been held. -Resident #4 had high blood pressure and had several medications scheduled for that reason and an order to check her blood pressure two times a day. -She did not recall Resident #4's BP or P readings, but she noted them in her visit notes. -She expected staff to hold Resident #4's when parameters were met as ordered. -If Resident #4 received her metoprolol when she had a low BP or P, she could become hypotensive and be at risk for falls due to orthostatic hypotension. -She did not think Resident #4 had any negative effects from not holding her metoprolol on the occasions her SBP and P were documented below parameters. Interview with the Administrator on 01/13/23 at 3:30 pm revealed: -The MA, Supervisor should be auditing medication carts weekly checking for expired medications and comparing medication labels to eMARs. -No one checked for parameters being met on any medication between quarterly pharmacy reviews. -She did not know if the eMAR system guided MAs to enter vital signs before administering BP medication. -She expected the MAs to hold BP medication as ordered when parameters were met.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration	D 366		

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D 366	Continued From page 16 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a medication aide (MA) observed a resident taking their medication for 1 of 7 sampled residents (#1). The findings are: Review of Resident #1's current FL2 dated 05/05/23 revealed: -Diagnoses included syncope and collapse, paroxysmal atrial fibrillation, venous insufficiency, atherosclerotic heart disease of native coronary artery without angina pectoris, and mild cognitive impairment. -There were physician's orders attached to the FL2 which included an order for Diovan HCT (used to treat hypertension) 160-12.5mg 1 tablet daily. -There was an order for Docusate Sodium (used to treat constipation) 100mg 2 tablets daily. -There was an order for Ferrous Sulfate (used to treat iron deficiency) 325mg 1 tablet daily. -There was an order for FiberCon 625mg (used to treat prophylaxis) 2 tablets daily. -There was an order for Mucinex ER (used to treat congestion) 600mg 1 tablet daily. -There was an order for Bentyl (used to treat spasms) 10mg 1 capsule twice daily.	D 366	MEASURES TO CORRECT DEFICIENT PRACTICE Med techs will be 100% educated to monitor residents as they take their medication. Med techs will also be educated that medicine cannot be left unattended. MEASURES TO PREVENT RECURRENCE Five opportunities of med tech compliance to be audited weekly x 3 months, then monthly x 3 months, then as needed if no further issues with compliance are noted. The facility will bring findings of audits will be brought to quarterly QA meetings. Health Care Coordinator, Memory Care Coordinator, and Supervisor In Charge will be the responsible party for ensuring compliance. The facility will complete the education of all staff by 2/10/23. Audits will be completed weekly x 3 months, then monthly x 3 months, then as needed if no further issues with compliance are noted. Diata Belfie-Albert 02/06/2023	01/31/2023

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D 366	Continued From page 17 -There was an order for Calcium-Vitamin D (used to treat hypocalcemia) 600-400mg-unit 1 tablet twice daily. -There was an order for Eliquis (used to treat atrial fibrillation) 5mg 1 tablet twice daily. -There was an order for metoprolol tartrate (used to treat hypertension) 50mg 1 tablet twice daily. -There was an order for Protonix DR (used to treat gastroesophageal reflux disease) 40mg 1 tablet twice daily. Review of Resident #1's electronic medication administration record (eMAR) for 01/01/23 through 01/11/23 revealed: -There was an entry for Diovan HCT 160-12.5mg 1 tablet daily scheduled for administration at 7:00am. -There was an entry for Docusate Sodium 100mg 2 tablets daily scheduled for administration at 7:00am. -There was an entry for Ferrous Sulfate 325mg 1 tablet daily scheduled for administration at 7:00am. -There was an entry for FiberCon 625mg 2 tablets daily scheduled for administration at 7:00am. -There was an entry for Mucinex ER 600mg 1 tablet daily scheduled for administration at 7:00am. -There was an entry for Bentyl 10mg 1 capsule twice daily at 8:00pm, but there was no morning administration time listed. -There was an entry for Calcium-Vitamin D 600-400mg-unit 1 tablet twice daily scheduled for administration at 8:00am and 7:00pm. -There was an entry for Eliquis 5mg 1 tablet twice daily scheduled for administration at 8:00am and 7:00pm. -There was an entry for Metoprolol Tartrate 50mg 1 tablet twice daily scheduled for administration at	D 366		

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D 366	Continued From page 18 8:00am. -There was an entry for Protonix DR 40mg 1 tablet twice daily scheduled for administration at 8:00am. Observation of Resident #1's room during the initial tour of the facility on 01/11/23 at 9:05 am revealed: -Resident #1 was sitting in her wheelchair near her bed. -There was a medication cup containing medication sitting on her bed on top of paper towels. -There was no staff present in Resident #1's room. -Resident #1 poured the medication onto the paper towels and there were 12 tablets. Interview with Resident #1 on 01/11/23 at 9:06am revealed: -A medication aide (MA) gave her the cup of medication about an hour ago. -She stopped by the medication cart when she left the dining room after breakfast. -The MA gave her the cup of medication and she told the MA she was going back to her room because she had to use the restroom. -She thought there were about 17 tablets in the medication cup. -She could not identify any of the medication except for a small pink tablet which was for her heart. -She always poured her tablets out on a paper towel to separate them and took the larger tablets first. -It took her a while to take her medication because she sometimes had a hard time getting them down. -The MAs wanted her to stand at the nurse's station to take her medication, but she did not like	D 366		

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D 366	Continued From page 19 to. -Sometimes, the MAs brought medication to her in her room and left it with her to take without watching her take it. Observation of Resident #1's room on 01/11/23 at 9:18am revealed Resident #1 was sitting in her room by her bed and the cup of medication was still on her bed. Observation of Resident #1's room on 01/11/23 at 9:44am revealed: -The door was opened to Resident #1's room. -Resident #1 was in the private bathroom in her room. -The cup of medication was on Resident #1's bed unattended and visible to anyone who passed by the room. Observation of Resident #1's room on 01/11/23 at 9:47am revealed: -The MA took the medication cup from Resident #1's bed and left the room. -The MA returned with a beverage and the medication cup, poured the medication onto the paper towel, and separated the larger tablets from the smaller tablets. -The MA watched Resident #1 take the medications that were in the medication cup. Interview with the MA on 01/11/23 at 9:53am revealed: -She administered medication to Resident #1 this morning, 01/11/23, but she did not watch Resident #1 take her medication. -Resident #1 usually sat outside the nurse's station, but this morning she stated she had to go use the restroom and carried the medication with her. -She meant to go back and check on her, but she	D 366		

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D 366	Continued From page 20 forgot. -She usually watched Resident #1 take her medication. Interview with the Resident Services Coordinator (RSC) on 01/12/23 at 1:55pm revealed: -The MA told her on yesterday, 01/11/23, that she had not watched Resident #1 take her medication. -She told the MA that "she knew better than that." -She expected all MAs to watch all Residents take their medications to make sure they swallow. Interview with the Administrator on 01/13/23 at 3:37pm revealed: -She did not know the MA had administered medication to Resident #1 and did not watch her take them. -She expected MAs to watch residents take medication before administering medication to the next resident.	D 366		01/31/2023
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure action was taken in response to a medication review and documented that the prescribing practitioner had	D 406	MEASURES TO CORRECT DEFICIENT PRACTICE The facility will reconcile the past three months of pharmacy recommendations to ensure all requests were signed by the physician and orders entered as needed. The 100% audit of PRN medications with the parameter to ensure orders are in place for compliance.	

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D 406	Continued From page 21 been informed of the findings for 2 of 7 sampled residents related to incorrect orders for an anti-hypertensive medication (#4) and a vitamin supplement (#1) . The findings are: 1. Review of Resident #4 current FL-2 dated 11/07/22 revealed: -Diagnoses included hypertension, atrial fibrillation, and dementia. -There was an order for clonidine (a medication used to treat high blood pressure) 0.1 mg tablet daily as needed (prn). Give for diastolic blood pressure (DBP) greater than 180 or systolic blood pressure (SBP) greater than 100; then check blood pressure BP in one hour-Call provider if still above 180/100. Review of Resident #4's previous primary care provider (PCP) orders revealed there was an order dated 11/17/20 for clonidine 0.1mg tablet daily as needed for SBP greater than 180 or DBP greater than 100. Review of Resident #4's pharmacy review dated 12/19/22 revealed there was a recommendation from the pharmacist to correct clonidine as needed order directions from "give if DBP greater than 180 or SBP greater than 100" to give if SBP greater than 180 or DBP greater than 100". Review of Resident #4's December 2022 eMAR revealed: -There was an entry for clonidine 0.1mg tablet take one tablet daily as needed, Give if DBP greater than 180 or SBP greater than 100. -There was no documentation of administration of clonidine 0.1mg from 12/19/22 to 12/31/22. -There was an entry to record BP daily,	D 406	MEASURES TO PREVENT RECURRENCE Health Care Coordinators will be educated on how pharmacy recommendations must be completed and reconciled within ten days of receipt. Medical Records will audit compliance by completing a 2nd check of reconciliation to ensure all pharmacy recommendations were completed and entered into the medical record. Audits will be conducted monthly x 6 months, then quarterly x 3 months, then as needed if no further issues with compliance are noted. The facility will educate Med techs on watching orders for vital signs/weights for instructions to give PRN medications. All orders for PRN medications with parameters related to vital signs/weights will have corresponding orders attached to the vital sign orders to alert the med tech of the PRN medication. The facility will bring the findings of audits to quarterly QA meetings. The responsible party to ensure compliance are: Health Care Coordinator, Memory Care Coordinator, and Medical Records staff	01/31/2023

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D 406	Continued From page 22 scheduled for 7:00am to 7:00pm. -Resident #4 had 10 of 20 opportunities when her systolic blood pressure met the parameter for administration of clonidine 0.1mg as needed and it was not documented as administered. Review of Resident #4's January 2023 eMAR revealed: -There was an entry for clonidine 0.1mg tablet take one tablet daily as needed, Give if DBP greater than 180 or SBP greater than 100. -There was no documentation of administration of clonidine 0.1mg from 01/01/23 to 01/12/23. -There was an entry to record BP daily, scheduled for 7:00am to 7:00pm. -Resident #4 had 10 of 34 opportunities when her systolic blood pressure met the parameter for administration of clonidine 0.1mg as needed and it was not documented as administered. Observation of Resident #4's medications on the medication cart on 01/12/23 at 4:05pm revealed: -There was one bubble packet clonidine 0.1mg tablets that contained 30 of 30 tablets dispensed on 12/21/22. -The bubble packet label read clonidine 0.1 mg tablet daily as needed. Give for diastolic blood pressure (DBP) greater than 180 or systolic blood pressure (SBP) greater than 100. Then check blood pressure (BP) in one hour-Call provider if still above 180/100. Interview with a medication aide (MA) on 01/12/23 at 4:00pm revealed: -The Resident Services Coordinator (RSC), Memory Care Coordinator (MCC) and Medical Records Specialist (MRS) input all orders by PCP when the facility changed computer programs in September 2022, including eMARs. -Resident #4 had BP parameters as to when to	D 406	The facility will complete the reconciliation of the past three months of pharmacy recommendations by 2/10/23. The audit of PRN orders with parameters will be completed by 2/10/23. Audits will be completed monthly x 6 months, then quarterly x 3 months, then as needed if no further issues with compliance are noted. Diana Berke-Albert 02/06/2023	01/31/2023

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D 406	Continued From page 23 administer her as needed clonidine, but she did not pay attention to the SBP and DBP wording change. -Resident #4 had BP taken on day and evening shift because she had multiple BP medication. -When staff checked a resident's BP, they would have to check the list of as needed medication for BP parameters to administer. -The MA had not administered the as needed dose of clonidine to Resident #4 because she was never above the parameters according to the instructions. Interview with a second medication aide (MA) on 01/12/23 at 4:10pm revealed: -The RSC or MCC input all orders by PCP in the resident's eMARs. -She did not know Resident #4 had BP parameters as to when to administer her as needed clonidine, and she did not pay attention to the SBP and DBP wording. -Resident #4 had her BP taken on day and evening shift because she had multiple BP medication. -She would enter the Resident #4's BP reading, but was unsure when she was to be administered an as needed medication. -The MA had taken her BP on evening shift, but had not administered the as needed dose of clonidine to Resident #4. Interview with a third medication aide (MA) on 01/13/23 at 9:15am revealed: -She thought the MCC input all orders by PCP in the resident's eMARs. -She did not know Resident #4 had BP parameters as to when to administer her as needed clonidine, and she did not pay attention to the SBP and DBP wording. -Resident #4 had her BP taken on day and	D 406		

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D 406	Continued From page 24 evening shift. -She was not sure if there was an entry to check a resident's BP that prompted her to check the list of as needed medication. -The MA had taken her BP on day shift, but had not administered the as needed dose of clonidine to Resident #4. Interview with a fourth medication aide (MA) on 01/13/23 at 9:20am revealed: -The RSC, MCC and MRS input all orders by PCP when the facility changed computer programs in September 2022, including eMARs. -Resident #4 had BP parameters as to when to administer her as needed clonidine, but she did not realize the SBP and DBP numbers were reversed in the instructions in the new eMAR program. -Resident #4 had her BP taken on day and evening shift and she had multiple scheduled BP medications. -When she entered a resident's BP reading, she knew to click on the as needed medication for administration instructions for BP parameters. -She had not administered the as needed dose of clonidine to Resident #4 because she was never above the parameters according to the instructions. Interview with the MCC on 01/27/22 at 9:35am revealed: -The facility changed computer systems for eMARs in September 2022. -She the RSC and MRS were responsible to enter all the resident's orders into the new eMAR system. -The MRS then rechecked all the orders that had been entered in the eMAR. -The pharmacy audited the medication carts and residents' medication orders.	D 406		

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D 406	Continued From page 25 -The RSC received an email for all pharmacy medication reviews and gave them to the PCP. -The MCC or RSC would give resident's pharmacy review to the PCP and ensure the recommendations were followed. -There was no set audit system or frequency for eMARs and medication carts. -She would randomly audit the medication carts for medication bubble pack instructions to match the eMAR, but she did not recheck for accuracy of the order wording from the old eMAR system to the new eMAR system. -Resident #4 had clonidine for set parameters and had her blood pressure checked on day and evening shift. Interview with Medical Records Specialist (MRS) on 01/13/23 at 9:55am revealed: -The facility changed computer eMAR systems in September 2022. -She and the RSC and MCC were responsible to input all the resident's orders in the new eMAR, pharmacy did not enter orders in the facility eMAR. -Resident #4's as needed clonidine order was entered by the RSC, according to the time stamp, on 09/02/22 at 1:12pm. -She did not review every resident's eMAR orders because there were too many to review within a short period or time when the facility changed computer systems. -The facility's consult pharmacist reviewed eMARs shortly after the facility went live with the new eMAR. -She was not sure of the consult pharmacist's process, but any discrepancies would have been listed as a recommendation on the pharmacist's review for each resident. -The RSC received all pharmacist's reviews and gave them to the PCP for order changes or	D 406		

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D 406	Continued From page 26 comments. Interview with the RSC on 01/13/23 at 10:33am revealed: -She printed all residents' pharmacy reviews from the contracted Pharmacist Consultant and gave them to the PCP for review. -She did not remember reading and giving the PCP Resident #4's pharmacy review dated 12/19/22 that had a recommendation to correct the wording on her clonidine 0.1mg as needed order. -She did not remember entering Resident #4's orders into the eMAR specifically, but she did help the MRS and MCC enter orders into the new eMAR system in September 2022. -If the time stamp showed she entered the order for Resident #4's clonidine, then she was the one who entered the order. -She must have transposed the SBP and DBP readings when typing in the order on the eMAR system. -The consult pharmacist, MRS, MCC and herself also reviewed eMARs just after the new eMAR system went live in September 2022 and they all had missed the wording change in Resident #4's clonidine order. Telephone interview with Resident #4's PCP on 01/13/23 at 11:40am revealed: -Resident #4 had an as needed order for clonidine 0.1mg for SBP greater than 180 and DBP greater than 100. -The RSC would leave pharmacy reviews for the residents on her desk for her to review for order changes or comments. -She did not remember seeing Resident #4's pharmacy review dated 12/19/22 that recommended correcting the wording on her clonidine order.	D 406		

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D 406	Continued From page 27 -If she had seen the order, she would have signed and dated and made comments for corrections. -She expected to see all resident's pharmacy reviews so that she could make the appropriate changes in the recommendations. -She looked at BP readings on a printout and did not look at eMARs when she visited residents and did not know that her order had been entered incorrectly on the eMAR. Telephone interview with the facility's contracted Pharmacist Consultant on 01/13/23 at 2:00pm revealed: -She completed quarterly medication reviews for the Memory Care Unit at the facility in December 2022. -She found the discrepancy in Resident #4's clonidine order in December 2022, but had missed it herself in her September 2022 review just after the facility changed to their new eMAR system. -The RSC and the Administrator received her electronic mail containing the resident's pharmacy reviews to provide to the PCP on the PCP's next visit. -She expected all of her reviews and recommendations to be considered by the resident's PCP. Interview with the Administrator on 01/13/23 at 3:30 pm revealed: -She and the RSC received the Pharmacy Consultant's email with the Quarterly Medication Review recommendation. -She or the RSC would clarify any discrepancies with the PCP and a pharmacist at the facilty's contracted pharmacy. -She did not remember seeing Resident #4's December 2022 pharmacy review that	D 406		

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D 406	Continued From page 28 recommended to correct the wording of her clonidine parameters. -The facility changed computer systems in September 2022 and the MRS, RCC and MCC had to reenter all of the resident's orders into the new eMAR. -The MA, supervisor should be auditing medication carts weekly checking for expired medications and comparing medication labels to eMARs. -No one checked for parameters being met on any medication between Quarterly Medication Reviews. -She did not know if the eMAR system guided MAs to use a as needed medication in response to a vital sign. 2. Review of Resident #1's current FL2 dated 05/05/22 revealed physician's orders attached to the FL2 which included an order for Vitamin D3 50,000 units (used to treat low Vitamin D3 levels) 1 capsule once a week. Review of the Pharmacist Consultant's Note to Attending Physician/Prescriber for Resident #1 dated 11/28/22 revealed: -Resident #1 received Vitamin D3 50,000 units once weekly. -Resident #1's Vitamin D level on 11/02/22 was noted as 68 (normal reference rage is 20 mg/L or above). -The Pharmacist Consultant suggested reducing Vitamin D frequency. -The suggestion was to discontinue Vitamin D3 50,000 units once weekly; start Vitamin D3 50,000 units once monthly. -Resident #1's primary care provider (PCP) circled "start Vitamin D3 50,000 units once monthly and documented "good." -The PCP signed the order on 12/20/22.	D 406		

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D 406	Continued From page 29 Review of Resident #1's electronic Medication Administration Record (eMAR) for November 2022, December 2022, and January 2023 revealed: -There was an entry for Vitamin D3 50,000 units 1 capsule one time a day every Monday. -There was documentation Vitamin D3 was administered every Monday in November 2022 and December 2022, and from 01/01/23 through 01/09/23. -There was not an entry for Vitamin D3 50,000 units 1 capsule once a month. Observation of Resident #1's medications available for administration on 01/12/23 at 1:12pm revealed Vitamin D3 50, 000 units 1 capsule once a month was not available. Interview with the facility's contracted Pharmacist Consultant on 01/12/23 at 4:26pm. -She completed Quarterly Medication Reviews for residents of the facility. -Resident #1 had an order for Vitamin D3 50,000 units once weekly. -She reviewed Resident #1's medication and Vitamin D level. -Resident #1's Vitamin D level was 68 which was within range, so she made the recommendation to reduce the dosage from 50,000 units once weekly to 50,000 units once monthly. Interview with a representative for the facility's contracted pharmacy on 01/13/23 at 9:55am revealed: -Resident #1 had an order for Vitamin D3 50,000 units once a week. -The pharmacy had not received an order for Vitamin D3 50,000 units once a month.	D 406		

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D 406	Continued From page 30 Interview with the facility's Medical Records Specialist (MRS) on 01/13/23 at 10:37am revealed: -The Resident Services Coordinator (RSC) was responsible for reviewing the medication reviews and following up with any orders. -She assisted the RSC sometimes with reviewing and following up with orders from medication reviews. -She did not see the physician's order to decrease the frequency of Vitamin D3 to once a month as recommended by the facility's contracted pharmacist. Interview with the RSC on 01/13/23 at 10:44pm revealed: -She was responsible for following up with pharmacy recommendations. -She put all pharmacy recommendations in a folder for the facility primary care provider (PCP) to review and sign. -Once Resident #1's PCP signed the order to start Vitamin D3 50,000 units once monthly, it should have been sent to the pharmacy by a MA, herself, or the Medical Records Specialist. -She did not remember seeing the order to start Vitamin D3 50,000 units once monthly. -The order was in a pile of documents that needed to be scanned in to the computer system. Interview with Resident #1's PCP on 01/13/23 at 11:22am revealed: -She did not know Resident #1's order for Vitamin D3 50,000 units once monthly was not started. -Resident #1's order for Vitamin D3 50. 000 units monthly, as recommended by the pharmacy, should have been sent to the pharmacy for administration once monthly. -It may have been an oversight by staff.	D 406		

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D 406	Continued From page 31 Interview with the Administrator on 01/13/23 at 3:37pm revealed: -The pharmacist emailed any recommendations for residents' medications to her and the RSC and they reviewed them. -The recommendations were provided to the PCP for review when she visited the facility. -If the PCP was in agreement with the pharmacist's recommendations and it required a change in medications, the signed recommendation form was sent to the pharmacy. -Whichever MA was working on the medication cart when the recommendation was received would have been responsible for sending the signed recommendation form to the pharmacy. -She expected the signed recommendation form, decreasing Vitamin D3 from once weekly to once monthly, to be sent to the pharmacy on 12/20/22 when it was signed by the PCP.	D 406		