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	HAL077010	A. BUILDING: _____ B. WING _____	07/12/2023

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HAMLET HOUSE	632 FREEMAN MILL ROAD HAMLET, NC 28345

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D 000	Initial Comments The Adult Care Licensure Section and the Richmond County Department of Social Services conducted an annual survey on July 11 and 12, 2023.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the 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 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to follow up with the primary care provider (PCP) on a failed endocrinology referral and 16 pound weight gain over 2 months for of 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's current FL-2 dated 02/07/23 revealed diagnoses included dementia with behaviors, schizoaffective disorder, major depressive disorder, anxiety, hypertension, heart disease, sleep disorder, obesity, folic acid and vitamin D deficiencies and type II diabetes mellitus. a. Review of Resident #3's physician's order dated 03/07/23 revealed an order for an endocrinology referral. Review of Resident #3's primary care provider (PCP) visit note dated 03/08/23 revealed: -Laboratory results revealed a glucose level of 464 (normal 70-100) and a hemoglobin A1c of 15.7 (normal 4.8 - 5.6). (A hemoglobin A1c	D 273	Hamlet House shall ensure referral and follow-up to meet the routine and acute health care needs of residents. Area Clinical Director (ACD) in-serviced staff on the importance of obtaining accurate weights, as well as when to report weight gains and losses to the PCP. 7/21/23 Resident Care Coordinator (RCC) will monitor order processing system daily to ensure appropriate and accurate use, as well as ensuring that all orders are processed correctly including referrals. 8/26/23 RCC will review electronic Facility documentation to review for follow up from the previous day including vital signs, weights, progress notes, and any incidents of concern. This will be reviewed with the Executive Director (ED) to ensure notifications and documentation has occurred appropriately. 8/26/23 RCC will complete a minimum of 2 chart audits per week to ensure there have been no missed new orders or	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Cassie Beard, ED TITLE Executive Director (X6) DATE 8-23-23
Type text here

Reviewed and acknowledged 5 September 2023 Bynithia Washington

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D 273	Continued From page 1 measures the average blood sugar level for the previous 3 months.) -Insulin and blood sugar checks were being refused by Resident #3. -The resident requested insulin be discontinued. -The resident was being referred to endocrinology for further recommendations. Review of Resident #3's electronic progress note dated 04/04/23 revealed: -The Resident Care Coordinator (RCC) documented contacting the endocrinologist's office on 04/04/23. -The endocrinologist's office declined to schedule the resident for an appointment because he had refused insulin. -The endocrinologist's office could not see the resident for oral medication management. Review of Resident #3's PCP visit notes dated 03/21/23, 03/28/23, 04/04/23, 06/06/23 and 07/03/23 revealed there was no documentation regarding the endocrinology referral for the resident. Interview with the Resident Care Coordinator (RCC) on 07/12/23 at 4:16pm revealed: -She received referral orders from the primary care provider (PCP). -She was responsible for faxing referral requests and scheduling the appointment. -Resident #3 did not refuse to see the endocrinologist, the endocrinologist refused to see the resident because he refused blood sugar checks and insulin. -She documented a note in Resident #3's electronic progress notes on 04/04/23 about the conversation. -She did not document notifying the PCP the endocrinologist refused to see the resident	D 273	referrals. Chart audits will be verified by the ED for compliance.	

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because she forgot.
-She notified the PCP verbally but did not remember when.

Telephone interview with the Senior Access Coordinator at the endocrinologist's office on 07/12/23 at 3:01pm revealed:
-She was responsible for scheduling referral appointments.
-She did not see that a referral was sent or faxed from the facility for Resident #3.
-There was no documentation in the resident's chart of a conversation with staff at the facility regarding the need for an appointment and refusal of blood sugar checks and insulin.

Interview with the Administrator on 07/12/23 at 5:20pm revealed she was not aware of issues and follow up surrounding Resident #3's endocrinology referral.

b. Review of Resident #3's current FL-2 dated 02/07/23 revealed an order to obtain a monthly vital signs (unspecified).

Review of Resident #3's May 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for monthly vital signs which included temperature, pulse, respirations, blood pressure and weight.
-The weight documented was 206 pounds on 05/05/23.

Review of Resident #3's June 2023 eMAR revealed:
-There was an entry for monthly vital signs which included temperature, pulse, respirations, blood pressure and weight.
-The weight documented was 216 pounds on

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06/05/23.

Review of Resident #3's July 2023 eMAR revealed:
-There was an entry for monthly vital signs which included temperature, pulse, respirations, blood pressure and weight.
-The weight documented was 222.5 pounds on 07/05/23.

Observation of Resident #3 on 07/12/23 at 5:15pm revealed:
-He walked to the wheelchair accessible scale independently.
-The scaled was set at 0.0 pounds prior to the resident stepping onto the scale.
-The weight result was 225.5 pounds.

Review of Resident #3's PCP visit notes dated 06/06/23 revealed:
-There were discrepancies in weights recorded for Resident #3.
-His weight went from 240 to 106 to 216 pounds over the last 4 months.

Review of Resident #3's PCP visit notes dated 07/03/23 revealed there was no documentation of a weight change, gain or loss reported for Resident #3.

Interview with Resident #3 on 07/12/23 at 5:15pm revealed:
-He normally liked to weigh around 180 pounds.
-He liked to eat snack cakes every now and then.

Interview with the Resident Care Coordinator (RCC) on 07/12/23 at 4:16pm revealed:
-Medication aides (MAs) were responsible for obtaining resident weights and documenting the result in the resident's electronic record.

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-MAs were responsible for reporting changes in the resident's weight to her.
-She was responsible for reviewing the monthly weight report every month.
-She had not reviewed the weight report for July 2023.
-She had not reported Resident #3's weight gain from May to July 2023 to his primary care provider (PCP).

Interview with the Administrator on 07/12/23 at 5:20pm revealed:
-Weights were done by MAs and documented on the eMAR.
-She was still learning the clinical process of monitoring and reporting weight changes.
-MAs and the RCC were responsible for notifying the PCP with all resident concerns and documenting an electronic progress note in the resident's record.

Interview with the Area Clinical Director (ACD) on 07/12/23 at 5:12pm revealed:
-She was at the facility weekly.
-She was responsible for observing medication passes, completing licensed health professional support (LHPS) assessment and evaluations, and completed clinical competency skills checks for staff.
-She reviewed resident weights with LHPS assessments.
-She routinely left the weight reviews for the PCP to sign off and followed up with staff after each LHPS assessment.

Review of Resident #3's LHPS assessment and evaluation dated 07/11/23 revealed:
-There was a check mark next to no LHPS tasks identified.
-There was a narrative note documented under

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D 273	Continued From page 5 the section for changes and follow up recommended to meet the resident's needs. -The narrative documented the resident had an endocrinology consult but they refused him because he refused finger stick blood sugar checks. -The resident's PCP was notified and had been adjusting his diabetic medications. -The LHPS evaluation was completed on 07/11/23 and there was no documentation of when the PCP was notified. -There was no documentation of Resident #3's weight. Attempted interview with Resident #3's Primary Care Provider on 07/12/23 at 2:15pm was unsuccessful.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a clean and sanitary environment including for 1 sampled resident (#3) who had mental health illnesses requiring an alternative approach to standard cleaning schedules but was avoided by housekeeping staff. The findings are: Review of Resident #3's current FL-2 dated 02/07/23 revealed diagnoses included dementia	D 338	Hamlet House shall ensure that the rights of all Residents guaranteed under the Declaration of Residents' Rights, are maintained and may be exercised without hindrance. Resident #3 was evaluated by the provider for assistance with an appropriate plan of care. 7/25/23 ED educated all staff on the importance of providing proper personal care and supervision to ensure their needs are being met, as well as reporting to RCC/ED when a Resident's condition inhibits proper care, supervision, cleaning of their space, etc; mainly referring to clinical condition and/or behaviors. 7/21/23	

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D 338	Continued From page 6 with behaviors, schizoaffective disorder, major depressive disorder, anxiety, hypertension, heart disease, sleep disorder, obesity, folic acid and vitamin D deficiencies and type II diabetes mellitus. Observations of Resident #3's room on 07/11/23 at 8:53am revealed: -The hallway exit door near the resident's room had spider webs with a dead fly on the push bar handle. -There was an accumulation of dust and small dead insects on the windowsill next to the exit door. -There was an accumulation of dirt and grime at the edges and corners of the floor at the end of the hall near Resident #3's room. -The floor in the resident's room had an accumulation of dirt, spills covered in dirt and debris and a heavy accumulation of dirt and grime around the edges, at the corners and behind the entrance door. -The baseboard was loose and cracked around the corner of the wall next to the closet. -There were black scuff marks and black and brown drip marks from approximately 3 feet high down to the floor on the walls not blocked by furniture. -There was an overbed table with a heavy accumulation of dirt and debris on the bottom frame and floor underneath. -The top of table had a large amount of white granules resembling salt or sugar, brown stains and snack food wrappers. -There was a heavy accumulation of dust on the cover of the wall mounted air conditioning unit. -There was a piece of painted wood and a single drawer under the resident's bed. -The linoleum flooring was torn with raised and curled edge across the entrance into the shared	D 338	ED re-inserviced staff on Resident Rights. ED re-educated Housekeeping staff member on the responsibilities of completing the daily checklist as provided to ensure a clean and sanitary environment for the Residents. ED will make facility rounds no less than twice daily to ensure the facility is clean, sanitary, and without foul odors. Any concerns noted will be addressed promptly with the housekeeping team.	7/21/23 7/13/23 8/26/23

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bathroom.
-There was a heavy build up of dirt and grime on floor exposed from the missing linoleum.
-There were black and brown stains on the floor next to the tub.
-There was soap scum and grime on an area cut down on the side of the tub and covered with dry wall that was deteriorating.
-There were brown stains with accumulated dirt and grime on the floor and baseboards on the sides and behind the toilet and under the sink.
-There was an accumulation of white drip marks and spots on both mirrors in the bathroom.

Observations of Resident #3's room on 07/12/23 at 8:12am revealed:
-The dirt and grime behind the entrance door had been cleaned but there was still debris as if mopped but not swept.
-The wall next to the bathroom door had been cleaned.
-There was a reduction in the accumulation of dirt and grime on the bathroom floor but it was not clean.
-The room was otherwise unchanged from observations on 07/11/23.

Interview with Resident #3 on 07/12/23 at 12:00pm revealed:
-He was okay with the housekeeping staff coming into his room to clean.
-He did not want to move rooms.
-The bathroom floor could be replaced in 30 minutes like the floor done in another room on the hall.

Interview with a housekeeper on 07/11/23 at 8:57am revealed:
-He was one of two housekeepers and worked daily Monday through Friday.

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-He was responsible for mopping the bathroom floors, sweeping the floors, dusting, and wiping sticky surfaces in resident rooms.
-He also replaced toilet paper and paper towels in resident bathrooms.
-Resident #3 had mood swings and did not like females going in his room.
-Resident #3 allowed him to go in his room and clean.
-He mopped the floor in the resident's room on 07/10/23.
-The current condition of the room did not happen overnight.
-He had been cleaning Resident #3's room little by little; it was a slow process.

Telephone interview with Resident #3's mental health provider (MHP) on 07/14/23 at 2:05pm revealed:
-She was previously notified Resident #3 had verbal outbursts, anxiety and threw things from his room.
-She was not previously aware Resident #3 would not allow staff into his room to clean.
-Resident #3's room was always a mess and dirty when she saw him at the facility.
-She primarily prescribed medications to manage the resident's behaviors and anxiety.
-She would have instructed staff to clean the resident's room when he was at lunch.
-Resident #3 typically ate lunch in the dining room and stayed in the dining room for approximately 20 minutes.
-She had prescribed lorazepam as needed on 04/21/23 for agitation.
-Staff could administer it to calm him down if he became agitated about having his room cleaned.
-Staff had not been administering the lorazepam.
-Staff should administer the lorazepam when needed.

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D 338	Continued From page 9 Interview with the Resident Care Coordinator (RCC) on 07/12/23 at 12:10pm revealed: -Resident #3's behaviors including not allowing staff to clean his room had been reported his MHP. -Staff did the best they could to work around Resident #3 to provide care including cleaning his room. Interview with the Administrator on 07/11/23 at 1:10pm revealed: -It was difficult to manage the clutter in Resident #3's room because he collected things from other residents who left the facility. -She was told today (07/11/23) that Resident #3 only allowed the male housekeeper in his room to clean. -The male housekeeper did not fully grasp the expected standards of cleaning. -The lack of cleaning at that end of the hall and Resident #3's room was due to the male housekeeper being assigned to that hall. -She was responsible for supervising housekeeping staff. -She was going to have to monitor the cleaning of Resident #3's room and that hall more often. -She was aware of the torn linoleum on the bathroom floor in Resident #3's room. -She was waiting for corporate funds to replace floors. -Moving the resident to an unoccupied room with an intact floor was an option. Attempted interview with Resident #3's Primary Care Provider on 07/12/23 at 2:15pm was unsuccessful.	D 338		

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D 358	Continued From page 10	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#7) observed during the medication pass and 1 of 5 residents for record review including errors with antihypertensive medications. The findings are: The medication error rate was 10% as evidenced by the observation of 3 errors out of 37 opportunities during the 8:00am medication passes on 07/11/23 and 07/12/23. 1. Review of Resident #7's current FL-2 dated 02/22/23 revealed: -Diagnoses included essential hypertension. -There was an order for Chlorthalidone 25mg take 1 tablet by mouth every morning. Review of Resident #7's primary care provider (PCP) order report dated 08/11/22 revealed: -The reasons for the visit were hypertension,	D 358	Hamlet House shall ensure that the preparation and administration of medications and treatments by staff are according to Providers' orders, which are maintained in the Resident's record, the facility's policies and procedures, and the rules in Section .1004(a). ACD in-serviced RCC and Med Techs on: the importance of obtaining accurate weights, as well as the importance of reporting significant gains and losses; notifying the provider of vital signs outside of parameters; dating meds when opened to ensure meds are not used past their "dispose after" date; proper medication disposal; cart audits; documentation; the importance of completing 3 checks before administering meds; and promptly removing discontinued meds from the cart as appropriate. 7/21/23 Med Techs will complete MAR to cart audits per facility schedule to ensure availability and accuracy of medications on medication carts. The audits will be reviewed by the RCC and ED upon completion for compliance, and to ensure accurate and adequate medications are on hand at all times. 7/31/23 RCC will complete cart audits weekly for overall QA of the medication carts to ensure the cart is stocked with appropriate and accurate medications. 8/26/23	

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D 358	Continued From page 11 headache, and medication. -Adverse drug reaction to isosorbide caused the resident to have headaches. -There were orders to to start Chlorthalidone 25 mg every morning. Observation of the 8:00am medication pass on 07/12/23 revealed the medication aide (MA) did not administer Chlorthalidone 25mg (a diuretic that helps prevent your body from absorbing too much salt, which can cause fluid retention in people with congestive heart failure, cirrhosis of the liver, or kidney disorders, or edema caused by taking steroids and used to treat high blood pressure) as ordered. Observation of the prepackaged medications for Resident #7 on 07/12/23 at 7:17am revealed did not include Chlorthalidone 25mg. Review of Resident #7's primary care provider (PCP) order report dated 06/26/23 revealed there was an order for Chlorthalidone 25mg take 1 tablet every morning. Review of Resident #7's May 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Chlorthalidone 25mg take 1 tablet every morning. -There was documentation that Chlorthalidone 25mg had been administered every morning from 05/01/23-05/31/23. Review of Resident #7's June 2023 eMAR revealed: -There was an entry for Chlorthalidone 25mg take 1 tablet every morning. -There was documentation that Chlorthalidone 25mg had been administered every morning from	D 358	RCC will complete a minimum of 2 chart audits weekly to ensure that all orders have been processed properly to allow for accurate medication administration. Completed chart audits will be reviewed by the ED for compliance. RCC will pull Medication Compliance Reports daily to ensure medications are administered per MD orders. Reports will be reviewed with the ED during management meeting daily for compliance. Any noted areas of concern will have follow-up as appropriate, including MD notifications, clarifications, and any interventions needed. ACD will perform random med pass observations at a minimum of 2 observations per month. Observations will be reviewed with the Med Tech for educational feedback, the RCC, and the ED who will then file in the employee's education folder.	8/26/23 8/26/23 8/26/23

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D 358	Continued From page 12 06/01/23-06/30/23. Review of Resident #7's July 2023 (07/01/23-07/12/23) eMAR revealed: -There was an entry for Chlorthalidone 25mg take 1 tablet every morning. -There was documentation that Chlorthalidone 25mg had been administered every morning from 07/01/23-07/12/23. Interview with the medication aide (MA) on 07/12/23 at 11:07am revealed: -She did not review the medications in the package with the medications listed on the eMAR, which was one of the checks MAs were supposed to complete when administering medications. -She did not know that the Chlorthalidone was not in the package. -Resident #7 used a different pharmacy than the pharmacy that the facility had contracted to fill the resident's prescriptions and his packages would not scan on the computer. Telephone interview with a pharmacist from Resident #7's pharmacy on 07/12/23 at 11:55am revealed: -They had been Resident #7's pharmacy provider prior to his admission to the facility. -They had never received any orders for Resident #7 for Chlorthalidone and therefore did not fill the medication. -They packaged Resident #7's medications in multidose package strips for the facility to administer to him. -The packages did not contain Chlorthalidone. -The multidose packs were labeled with Resident #7's name, date, and time to be administered. -Each medication that was in the pack, the amount, the dosage, along with all the prescribing	D 358		

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	HAL077010	A. BUILDING: _____ B. WING _____	07/12/2023

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information was also included on the label.

Review of the document for the last blood pressure reading reported to the PCP was dated 02/03/23 at 3:13pm with a blood pressure reading of 181/112.

Review of Resident #7's blood pressure readings for 06/01/23 -06/30/23 revealed a blood pressure reading that ranged from 118/56 - 178/102.

Review of Resident #7's blood pressure readings for 07/01/23 -07/12/23 revealed a blood pressure reading that ranged from 138/61 - 176/108.

Telephone interview with Resident #7's PCP on 07/12/23 at 9:03am revealed:
-The Chlorthalidone had been ordered back on 08/11/22, to replace the HCTZ due to the resident's uncontrolled high blood pressure.
-The facility staff who had accompanied Resident #7 to his appointment was given the PCP's order report for their records of the office visit along with a "hard" copy of the prescription for the Chlorthalidone 25mg to take to the pharmacy to get the medication filled when they left the PCP's office on 08/11/22.
-She had expected the orders that were given to be followed.
-Chlorthalidone was better than the HCTZ in providing better blood pressure control.
-She was not aware that Resident #7 had never received the Chlorthalidone that had been ordered for his blood pressure on 08/11/22.
-Resident #7 was on several different medications for his blood pressure since it was so hard to control.
-Resident #7's blood pressure continued to be uncontrolled, which put him at risk for a heart attack or stroke, possibly heart failure, along with

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ongoing damage to his kidneys and if the kidneys become damaged, it could lead to dialysis or death.

Refer to interview with the Resident Care Coordinator (RCC) on 07/12/23 at 9:00am and 12:10pm.

Refer to interview with the Area Clinical Director on 07/12/23 at 12:15pm.

2. Review of Resident #7's current FL-2 dated 02/22/23 revealed there was no order for isosorbide 60mg.

Review of Resident #7's primary care provider (PCP) order report dated 08/11/22 revealed:
-The reasons for the visit were hypertension, headache, and medication.
-Adverse drug reaction to isosorbide caused the resident to have headaches.
-There were orders to discontinue isosorbide mononitrate.

Review of Resident #7's primary care provider (PCP) order report dated 06/26/23 revealed there was no order for isosorbide 60mg.

Observation of the 8:00am medication pass on 07/12/23 revealed the medication aide (MA) administered isosorbide 60 mg (used to prevent chest pain by enlarging the coronary arteries).

Observation of the prepackaged medications for Resident #7 on 07/12/23 at 7:17am revealed the packages contained 1 Isosorbide 60mg.

Review of Resident #7's July 2023 (07/01/23-07/12/23) electronic medication administration record (eMAR) revealed there was

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D 358	Continued From page 15 no entry for isosorbide 60mg. Interview with the medication aide (MA) on 07/12/23 at 11:07am revealed she was not aware the isosorbide had been discontinued. Telephone interview with a pharmacist from Resident #7's pharmacy on 07/12/23 at 11:55am revealed: -They had been Resident #7's pharmacy provider prior to his admission to the facility. -They had never received any orders for Resident #7 to discontinue isosorbide 60mg and continued to fill the medication. -They packaged Resident #7's medications in multidose package strips for the facility to administer to him. -The packages contained Isosorbide 60mg. Telephone interview with Resident #7's PCP on 07/12/23 at 9:03am revealed: -She was not aware that Resident #7 had continued to receive the isosorbide which was ordered to be discontinued on 08/11/22. -Resident #7 was on several different medications for his blood pressure since it was so hard to control. -Resident #7's blood pressure continued to be uncontrolled, which put him at risk for a heart attack or stroke, possibly heart failure, along with ongoing damage to his kidneys and if the kidneys become damaged, it could lead to dialysis or death. -Her office would contact the facility to get Resident #7 in to be seen as soon as possible to be assessed and have blood work done to determine if there had been any changes or damage done by remaining on the and isosorbide.	D 358		

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D 358	Continued From page 16 Refer to interview with the Resident Care Coordinator (RCC) on 07/12/23 at 9:00am and 12:10pm. Refer to interview with the Area Clinical Director on 07/12/23 at 12:15pm. 3. Review of Resident #7's current FL-2 dated 02/22/23 revealed there was no order for HCTZ 25mg. Review of Resident #7's primary care provider (PCP) order report dated 06/26/23 revealed there was an order for HCTZ 25mg take 1 tablet every day. Review of Resident #7's May 2023 electronic medication administration record (eMAR) revealed: -There was an entry for HCTZ 25mg take 1 tablet every day. -There was documentation that HCTZ had been administered every day from 05/01/23-05/31/23. Review of Resident #7's June 2023 electronic medication administration record eMAR revealed: -There was an entry for HCTZ 25mg take 1 tablet every day. -There was documentation that HCTZ had been administered every day from 06/01/23-06/30/23. Observation of the prepackaged medications for Resident #7 on 07/12/23 at 7:17am revealed the packages contained 1 HCTZ 25mg. Interview with the medication aide (MA) on 07/12/23 at 11:07am revealed she was not aware that the HCTZ had been discontinued. Telephone interview with a pharmacist from	D 358		

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D 358	Continued From page 17 Resident #7's pharmacy on 07/12/23 at 11:55am revealed: -They had been Resident #7's pharmacy provider prior to his admission to the facility. -They had never received any orders for Resident #7 to discontinue HCTZ 25mg and continued to fill the medication. -They packaged Resident #7's medications in multidose package strips for the facility to administer to him. -The packages contained HCTZ 25mg. Telephone interview with Resident #7's PCP on 07/12/23 at 9:03am revealed: -Another medication had been ordered back on 08/11/22, to replace the HCTZ due to the resident's uncontrolled high blood pressure. -She was not aware that Resident #7 had continued to receive the HCTZ that were ordered to be discontinued on 08/11/22. -Chlorthalidone was better than the HCTZ in providing better blood pressure control. -Her office would contact the facility to get Resident #7 in to be seen as soon as possible to be assessed and have blood work done to determine if there had been any changes or damage done by remaining on the HCTZ. Refer to interviews with the Resident Care Coordinator (RCC) on 07/12/23 at 9:00am and 12:10pm. Refer to interview with the Area Clinical Director on 07/12/23 at 12:15pm. _____ Interviews with the Resident Care Coordinator (RCC) on 07/12/23 at 9:00am and 12:10pm revealed: -Resident #7 used his own pharmacy; he did not use the facility contracted pharmacy.	D 358		

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-Resident #7's pharmacy did not accept faxed prescriptions.
-The PCP would have to electronically prescribe (escribed) the prescription for the resident or provide the resident a written prescription to take to the pharmacy to have the medication filled.
-She was not sure what had happened to the orders from Resident #7's PCP visit on 08/11/22.
-The MAs were expected to go through the 6 rights when administering medications which were the right resident, the right medication, the right time, the right dosage, the right route, and the right documentation after administering.
-When administering the medication, the MAs should go through the list of medications when they took them out of the drawer and compared it to what was listed on the eMAR.
-She had not observed the MAs administering medications.
-She had not kept a record of her cart audits that she had done but would start.

Interview with the Area Clinical Director on 07/12/23 at 12:15pm revealed:
-It was the standard of the facility to ensure medication orders were processed and implemented based on physician/provider orders.
-Medication cart audits were completed to ensure medications were in the community and were available for administration.
-The MA was responsible to check each medication that was ordered was in the medication cart.
-The MAs would sign and date the residents' PCP orders and would document if there no discrepancies or if discrepancies were identified.
-These audits remained in the book for the her to review.
-She was not sure the last time a medication audit had been done; the last ones in the book

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D 358	Continued From page 19 were dated April 2023. -There were none found for Resident #7. -The medication orders should be verified by the MAs prior to administration. Based on observations, record review, and interviews, it was determined Resident #7 was not interviewable. _____ The facility failed to administer medications as ordered for 1 of 3 sampled residents (#7) which included errors for 3 medications for hypertension which resulted in Resident #7 receiving HCTZ 25mg and isosorbide 60mg which had been discontinued 08/11/22 by his PCP and not receiveing Chlorthalidone 25mg which increased the resident's risk for headaches, continued elevated blood pressures, possible heart and kidney damage, strokes, or heart attacks. This failure was detrimental to the health and welfare of Resident #7 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-21 on 07/12/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 26, 2023.	D 358		