STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039016	A. BUILDING: _____ B. WING _____	R 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 and follow up survey on August 1, 2023 to August 3, 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 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care to 1 of 5 sampled residents (#5), who needed their toenails trimmed. The findings are: Review of Resident #5's current FL-2 dated 10/12/22 revealed diagnoses included schizoaffective disorder, depression, cerebral palsy, and obstructive sleep apnea. Observation of Resident #5's toenails on 08/01/23 at 8:55am revealed: -The first toenail on the left foot was broken and jagged, with ½ of the toenail approximately one-half inch long with tannish crustation under the toenail. -The second toenail on the left foot was broken and jagged, approximately ½ inch long, with tannish crustation on and under the toenail. -The third toenail on the left foot was broken with	D 270	Granville House staff shall provide supervision of Residents according to each Resident's assessed needs, care plan and current symptoms. Care Managers in-serviced staff on completing shower sheets when providing personal care to reflect the condition of the resident's skin and nails. Staff also educated on the importance of providing nail care to maintain nails short, neat, and clean. Staff to report toenails of diabetic residents that need care. Diabetic Residents, or Residents with podiatry needs will be able to obtain services at a minimum of quarterly or as needed. Foot Care will be coordinated by the Care Managers .	8/14/23 9/17/23

Reviewed and Acknowledged 09/18/23

Janet Thornburg

Jessica Eaton BRAMWELL 9/14/23

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D 270	Continued From page 1 tannish crustation on and under the toenail. -The fourth and fifth toenail on the left foot was approximately ¾ inch long with tannish crustation on and under the toenail. -The first toenail on the right foot was broken and jagged, approximately ½ inch long, with tannish crustation on and under the toenail. -The second toenail on the right foot was broken, approximately ¾ inch long, with tannish crustation on and under the toenail. -The third and fourth toenail on the right foot was approximately ¾ inch long, with tannish crustation on and under the toenail. -The fifth toenail on the right foot was approximately 1 inch long with tannish crustation on and under the toenail. Interview with Resident #5 on 08/01/23 at 8:55am revealed: -His toenails needed to be cut. -He had not had his toenails cut in several months. -He caught his broken toenails on his socks and bedding. -He had scratched himself "every once in a while." -He had not told anyone his toenails needed to be cut. Interview with Resident #5 on 08/02/23 at 1:42pm revealed: -The Podiatrist came to the facility a few times a year. -The Podiatrist came about 2 months ago and cut his toenails. -He asked someone yesterday, 08/01/23, to cut his toenails; he could not remember who he spoke with. -He was told someone would trim his toenails but did not say when his toenails would be trimmed.	D 270		

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D 270	Continued From page 2 -He was told there were a few personal care aids (PCA) who would cut toenails. Interview with Resident #5 on 08/03/23 at 12:51pm revealed his toenails had not been cut. Interview with a personal care aide (PCA) on 08/03/23 at 10:55am revealed: -Nail care was part of the personal care services provided by the facility staff. -She had not noticed Resident #5's toenails being jagged and long. -Resident #5 always wore socks. -Resident #5 was independent with his care. -Resident #5 had not asked her to trim his toenails. -Anyone could cut Resident #5's toenails, but he would need to ask to have them trimmed. -If she had noticed Resident #5 toenails needed to be trimmed, she would have trimmed them. Interview with a PCA on 08/03/23 at 11:03am revealed: -She had provided personal care assistance to Resident #5. -She assisted Resident #5 with combing his hair and cleaning his fingernails. -She had not cleaned or trimmed Resident #5's toenails. -She could trim toenails for any resident who was not a diabetic. -Resident #5 had not asked for his toenails to be trimmed. -Resident #5 was independent with his shower so she had not noticed his toenails. Interview with a medication aide (MA) on 08/03/23 at 3:11pm revealed: -The PCAs trimmed the resident's toenails. -She did not know if Resident #5 had asked	D 270		

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D 270	Continued From page 3 anyone to trim his toenails. -Resident #5 had not asked her to trim his toenails. -She had not seen Resident #5's toenails and did not know they needed trimming. Interview with the Resident Care Coordinator (RCC) on 08/03/23 at 12:18pm revealed: -The PCA should be checking to see if the resident's nails need cleaning, trimming, or filing. -The PCAs were expected to perform a skin assessment on the resident's shower days, even if the residents were independent with showers. -PCAs and MAs could trim nails for any resident who was not a diabetic. -Resident #5 had not asked her to clip his toenails. -The Podiatrist came every 6 months to trim nails for every resident that wanted or needed their nails trimmed. -In between the Podiatrist visits, the PCAs and MAs should be trimming the nails of the residents who were not diabetics. Interview with the Administrator on 08/03/23 at 2:05pm revealed: -The PCAs and MAs should perform skin assessments daily, including the resident's toenails. -The PCAs and MAs could trim the toenails of any resident who was not a diabetic. -She expected the skin assessments to be completed daily, and toenails trimmed when needed or requested by the residents.	D 270		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 4 (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 2 of 5 sampled residents for record review including errors with a sliding scale insulin (#1); and a medication for sleep and gastric reflux (#5). The findings are: 1. Review of Resident #1's current FL-2 dated 03/15/23 revealed diagnoses included type 2 diabetes, dementia, and Alzheimer's disease. Review of Resident #1's physician order dated 03/15/23 revealed: -There was an order to check fingerstick blood sugar (FSBS) three times daily before meals. -There was an order for insulin aspart (a rapid-acting insulin used to control FSBS) inject sliding scale insulin (SSI) three times a day before meals as follows: 2 units for FSBS reading of 201-250; 4 units for FSBS reading of 251-300; 6 units for FSBS reading of 301-350; 8 units for FSBS reading of 350-400; and 10 units for FSBS reading greater than 400. Review of Resident #1's May 2023 electronic medication administration record (eMAR)	D 358	Granville House shall ensure that the preparation and administration of medications and treatments by staff are according to Provider orders, which are maintained in the Resident's record; the facility's policies and procedures; and the rules of section .1004(a). Regional Director of Operations (RDO)/ Care Managers held Med Tech meeting to ensure there was focus on 6 Rights of Med Admin, Diabetic Care, the importance of having ordered medications on hand, and ensuring all medications are being administered per pysician orders and signed for after watching the Resident take the medication. Med Techs will complete cart audits per facility schedule to account for medications on hand in the facility, available for Resident administration. Care Managers will follow-up on completed cart audits for compliance. Care Managers will complete weekly QA cart audit to monitor for compliance of the medication cart. This will include ensuring items are dated upon opening as appropriate, no expired meds on cart, and meds are given appropriately. Results will be reviewed with the ED for any needed follow-up.	8/14/23 8/24/23 9/17/23 9/17/23

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D 358	Continued From page 5 revealed: -There was an entry to check FSBS three times daily before meals. -There was documentation Resident #1's FSBS reading was greater than 200 thirty-five times, requiring SSI to be administered. -There was an entry for insulin aspart SSI as follows 2 units for FSBS reading of 201-250; 4 units for FSBS reading of 251-300; 6 units for FSBS reading of 301-350; 8 units for FSBS reading of 350-400; and 10 units for FSBS reading greater than 400. -There was no documentation insulin aspart SSI was administered 15 of 35 times Resident #1's FSBS readings greater than 200. -Insulin aspart SSI should have been administered for FSBS readings greater than 200 as follow: 2units for a FSBS reading of 215 at 5:30pm on 05/01/23; 2units for a FSBS readings of 203 at 5:30pm on 05/13/23; 2units for a FSBS reading of 223 on 05/14/23 at 7:30am; 2units for a FSBS readings of 227 at 5:30pm on 05/14/23; 2units for a FSBS reading of 204 at 7:30am on 05/16/23; 4units for a FSBS reading of 291 at 5:30pm on 05/17/23; 2units for a FSBS reading of 227 at 11:30am on 05/19/23; 4units for a FSBS reading of 265 at 7:30am on 05/21/23; 2units for a FSBS reading of 205 at 7:30am on 05/24/23; 2units for a FSBS reading of 213 at 11:30am on 05/24/23; 2units for a FSBS reading of 215 at 11:30am on 05/25/23; 4units for a FSBS reading of 257 at 5:30pm on 05/26/23; 2units for a FSBS reading of 204 at 11:30am on 05/27/23; 2units for a FSBS reading of 243 at 11:30am on 05/28/23; and 2units for a FSBS reading of 211 at 7:30am on 05/30/23. Review of Resident #1's June 2023 eMAR revealed: -There was an entry to check FSBS three times	D 358	Care Managers will print EMAR compliance reports daily to review for accurate and compliant medication administration. Report will be reviewed in management meeting daily with the Executive Director. Any noted concerns will have prompt follow up at that time.	9/17/23

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D 358	Continued From page 6 daily before meals. -There was documentation Resident #1's FSBS reading was greater than 200 thirty-four times requiring SSI to be administered. -There was an entry for insulin aspart SSI as follows 2 units for FSBS reading of 201-250; 4 units for FSBS reading of 251-300; 6 units for FSBS reading of 301-350; 8 units for FSBS reading of 350-400; and 10 units for FSBS reading greater than 400. -There was no documentation insulin aspart SSI was administered 22 of 34 times Resident #1's FSBS was greater than 200. Insulin aspart SSI should have been administered for FSBS readings greater than 200 as follow: 4units for a FSBS reading of 264 at 5:30pm on 06/02/23; 4units for a FSBS reading of 273 at 7:30am on 06/03/23; 2units for a FSBS reading of 239 at 5:30pm on 06/03/23; 2units for a FSBS reading of 220 at 7:30am on 06/04/23; 6units for a FSBS reading of 340 at 5:30pm on 06/04/23; 2units for a FSBS reading of 227 at 11:30am on 06/07/23; 6units for a FSBS reading of 342 at 11:30am on 06/10/23; 2units for a FSBS reading of 213 at 5:30pm on 06/11/23; 2units for a FSBS reading of 207 at 11:30am on 06/12/23; 2units for a FSBS reading of 204 at 5:30pm on 06/14/23; 4units for a FSBS reading of 266 at 5:30pm on 06/20/23; 4units for a FSBS reading of 340 at 7:30am on 06/21/23; 2units for a FSBS reading of 233 at 11:30am on 06/21/23; 2units for a FSBS reading of 214 at 5:30pm on 06/21/23; 4units for a FSBS reading of 280 at 7:30am on 06/22/23; 6units for a FSBS reading of 361 at 7:30am on 06/24/23; 6units for a FSBS reading of 301 at 7:30am on 06/26/23; 6units for a FSBS reading of 326 at 11:30am on 06/26/23; 2units for a FSBS reading of 237 at 11:30am on 06/27/23; 6units for a FSBS reading of 383 at 5:30pm on 06/27/23; 6units for a FSBS reading of 360 at 7:30pm on	D 358		

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D 358	Continued From page 7 06/28/23; and 6units for a FSBS reading of 348 at 7:30am on 06/29/23. Review of Resident #1's July 2023 eMAR revealed: -There was an entry to check FSBS three times daily before meals. -There was documentation Resident #1's FSBS reading was greater than 200 thirty-one times requiring SSI to be administered. -There was an entry for insulin aspart SSI as follows 2 units for FSBS reading of 201-250; 4 units for FSBS reading of 251-300; 6 units for FSBS reading of 301-350; 8 units for FSBS reading of 350-400; and 10 units for FSBS reading greater than 400. -There was no documentation insulin aspart SSI was administered 20 of 31 times Resident #1's FSBS was greater than 200. Insulin aspart SSI should have been administered for FSBS readings greater than 200 as follow: 2units for a FSBS reading of 227 at 7:30am on 07/02/23; 6units for a FSBS reading of 301 at 11:30am on 07/02/23; 2units for a FSBS reading of 216 at 5:30pm on 07/02/23; 6units for a FSBS reading of 307 at 11:30am on 07/03/23; 2units for a FSBS reading of 214 at 11:30am on 07/04/23; 2units for a FSBS reading of 221 at 7:30am on 07/05/23; 2units for a FSBS reading of 210 at 5:30pm on 07/07/23; 2units for a FSBS reading of 228 at 5:30pm on 07/09/23; 2units for a FSBS reading of 206 at 11:30am on 07/13/23; 4units for a FSBS reading of 265 at 5:30pm on 07/15/23; 2units for a FSBS reading of 224 at 5:30pm on 07/17/23; 6units for a FSBS reading of 340 at 5:30pm on 07/18/23; 2units for a FSBS reading of 246 at 7:30am on 07/19/23; 2units for a FSBS reading of 207 at 5:30pm on 07/19/23; 2 units for a FSBS reading of 211 at 5:30pm on 07/11/23; 2units for a FSBS reading of 233 at 11:30am on	D 358		

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D 358	Continued From page 8 07/27/23; 6units for a FSBS reading of 302 at 5:30pm on 07/27/23; 2units for a FSBS reading of 207 at 5:30pm on 07/29/23; 4units for a FSBS reading of 276 at 11:30am on 07/31/23; and 8units for a FSBS reading of 385 at 5:30pm on 07/31/23. Observation of Resident #1's medications on hand on 08/01/23 at 2:32pm revealed: -There was one unopened insulin aspart pen in the refrigerator in the medication room dispensed on 06/27/23. -There was one opened insulin aspart pen containing 25units on the medication cart dispensed on 06/27/23. Interview with the Pharmacist at Resident #1's local pharmacy on 08/02/23 at 11:12am revealed: -The pharmacy had an order for insulin aspart sliding scale three times a day for FSBS readings greater than 200 as follows: 2 units for FSBS reading of 201-250; 4 units for FSBS reading of 251-300; 6 units for FSBS reading of 301-350; 8 units for FSBS reading of 350-400; and 10 units for FSBS reading greater than 400. -The Pharmacy dispensed one box containing 5 pens of insulin aspart on 04/10/23, 05/18/23, and 06/27/23. Interview with Resident #1 on 08/02/23 at 1:45pm revealed: -He was a diabetic. -The facility staff checked his blood sugar several times a day and administered insulin. -Some days he received more injections than other days. -He did not know how much insulin he was administered each day. Interview with a MA on 08/02/23 at 4:20pm	D 358		

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D 358	Continued From page 9 revealed: -She had checked FSBS readings and administered medications to Resident #1. -She had not administered SSI to Resident #1. -She did not know Resident #1 had an order for SSI for FSBS greater than 200. -The SSI entry did not appear on the eMAR to be administered. Interview with a second MA on 08/03/23 at 3:11pm revealed: -Resident #1 had a scheduled order for 14units of insulin aspart before meals. -Resident #1 did not have an order for SSI. -She did not know Resident #5 had an order for SSI. -The SSI order did not "pop-up" on the computer screen to be administered. -She had not administered SSI to Resident #1 based on his FSBS readings; she had only administered the scheduled insulin. Interview with Resident #1's PCP (Primary Care Provider) on 08/02/23 at 10:35am revealed: -Resident #1's insulin was managed by his Endocrinologist. -The last A1C (The hemoglobin A1C measures the average level of blood sugar over the previous 3 months) for Resident #1 was 7.6 The normal A1C level is below 5.7%). obtained in November 2022. Interview with the Resident Care Coordinator (RCC) on 08/02/23 at 2:45pm revealed: -She knew Resident #1 had an order for SSI. -She was "pretty sure" the MAs were administering SSI to Resident #1 when FSBS readings were greater than 200. -The MAs were not documenting when they administered the insulin to Resident #1 when the	D 358		

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D 358	Continued From page 10 FSBS readings was greater than 200. -She did not realize there were MAs who did not know Resident #1 had a SSI order for FSBS readings greater than 200. -She did not realize the SSI order did not "pop-up" for the MAs to administer the SSI. Interview with the Administrator on 08/03/23 at 12:24pm revealed: -The MAs should administer Resident #1's insulin as ordered. -Resident #1 could have even higher FSBS readings if his insulin was not administered as ordered. Attempted telephone interview with Resident #1's Endocrinologist on 08/02/23 at 11:37am was unsuccessful. Refer to the interview with the Administrator on 08/02/23 at 10:25am. 2. Review of Resident #5's current FL-2 dated 10/12/22 revealed diagnoses included gastritis without bleeding and obstructive sleep apnea. a. Review of Resident #5's physician order dated 03/01/23 revealed there was an order for pantoprazole 40mg (used for heartburn and reduce acid in the stomach) daily. Review of Resident #5 physician order dated 05/03/23 revealed: -There was an order to discontinue pantoprazole 40mg daily. -There was an order to start pantoprazole 40mg twice daily hold starting on 05/17/23. Review of Resident #5's May 2023 electronic medications administration record (eMAR)	D 358		

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D 358	Continued From page 11 revealed: -There was an entry for pantoprazole 40mg daily with a scheduled administration time at 9:00am. -There was documentation pantoprazole 40mg was administered daily on 05/01/23 and 05/03/23. -There was no documentation pantoprazole was administered on 05/02/23 and there was no exception documented. -There was documentation pantoprazole was administered twice daily from 05/04/23 to 05/16/23 at 8:00am and 8:00pm. -There was an entry for pantoprazole 40mg twice daily, hold starting 05/17/23. -There was documentation pantoprazole was held from 05/17/23 to 05/31/23. Review of Resident #5's June 2023 eMAR revealed: -There was an entry for pantoprazole 40mg twice daily, hold starting 05/17/23. -There was documentation pantoprazole was held from 06/01/23 to 06/30/23. Review of Resident #5's July 2023 eMAR revealed: -There was an entry for pantoprazole 40mg twice daily, hold starting 05/17/23. -There was documentation pantoprazole was held from 07/01/23 to 07/31/23. Observation of Resident #5's medications on hand date 08/01/23 at 4:02pm revealed: -There was one multi-dose pack on the medication cart for Resident #5. -There was an entry on the multi-dose pack that read "pantoprazole 40 mg twice daily, hold starting 05/17/23. -There were no labels on the multi-dose pack to indicate the pantoprazole was on hold. -There was a description of pantoprazole 40mg	D 358		

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	HAL039016	A. BUILDING: _____ B. WING _____	R 08/03/2023

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D 358	Continued From page 12 that read "pantoprazole was yellow, oblong with number 152 on the tablet". -There was a pantoprazole tablet located in the multi-dose pack for 8:00am each morning and 8:00pm each night. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 08/03/23 at 9:08am revealed: -The pharmacy had an order for pantoprazole 40mg twice daily dated 05/03/23. -The pharmacy had an order to hold pantoprazole 40mg twice daily starting 05/17/23. -Pantoprazole was placed in the multi-dose pack twice a day, even though it was on hold. -She did not know what the facility's policy or procedure was to remove a medication from the multi-dose pack when a medication was placed on hold. -Pantoprazole 40mg had been placed in the multi-dose pack twice daily since 05/03/23. Interview with Resident #5 on 08/03/23 at 12:51pm and 4:19pm revealed: -He took pantoprazole 40mg every day because he had gastric reflux. -He was still taking pantoprazole every day. -He did not think the pantoprazole was on hold. -He had problems for 2 years with gastric reflux. -Resident #5 has not had any nausea, vomiting, or bloody stools. Interview with a medication aide (MA) on 08/03/23 at 9:51am revealed: -When a medication was placed in the multi-dose pack by the pharmacy and then an order to hold the medication was obtained, the MA should remove the medication and dispose of the medication in the drug buster. -The Resident Care Coordinator (RCC) would	D 358		

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D 358	Continued From page 13 place a sticker on the multi-dose pack to make the MA aware of a change in an order. Interview with a second MA on 08/03/23 at 12:53pm revealed: -She had administered medications to Resident #5. -Resident #5's pantoprazole was on hold. -The RCC removed the pantoprazole from the multi-dose pack since it was on hold. -The MAs were not allowed to remove and dispose of medications from the multi-dose pack. -She did not realize the pantoprazole medication was still in the multi-dose pack; she thought the RCC removed the pantoprazole from the multi-dose pack. -If the pantoprazole was in the multi-dose pack, she administered it to Resident #5. -Resident #5 had not complained of indigestion or heartburn. Interview with a third MA on 08/03/23 at 3:11pm revealed: -Resident #5's pantoprazole was on hold. -The medication showed up on the eMAR to be administered, but it is on hold. -She would click "on hold" instead of administering the medication. -She did not remove the pantoprazole from the multi-dose pack, the RCC and Memory Care Manager (MCM) were responsible for removing all medications from the multi-dose pack that were not to be administered. -She administered all medications that were in Resident #5's multi-dose pack to him. -Resident #5 had not complained of any indigestion to her. Interview with Resident #1's PCP (Primary Care Provider) on 08/03/23 at 3:25pm revealed:	D 358		

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D 358	Continued From page 14 -Resident #5's pantoprazole 40mg was placed on hold due to a gastrointestinal bleed. -Resident #5 had an appointment with the Gastroenterologist in mid-June; he was to follow up with the Gastroenterologist about whether to continue the pantoprazole or to discontinue the medication. -She did not know the medication continued to be on hold. -She did not know the medication was being placed in the multi-dose pack by the pharmacy, and that the MAs were not removing the medication from the multi-dose pack but administering the medication to Resident #5. -The facility staff needed to contact the Gastroenterologist to see if he wanted to continue or discontinue the pantoprazole. Interview with the MCM on 08/03/23 at 4:15pm revealed: -She had received the multi-dose packs for the next 4 weeks from the pharmacy. -She pulled Resident #5's multi-dose pack to start the next day. -She identified pantoprazole in the 8:00am dose pack and the 8:00pm dose pack. -She did not remove the pantoprazole from the multi-dose pack, the MAs would remove the pantoprazole when they administered Resident #5's medication. Interview with the RCC on 08/03/23 at 11:34am and 4:19am revealed: -Resident #5's pantoprazole was placed on hold on 05/17/23. -When a medication was placed on hold, the MAs would remove the medication from the multi-dose pack and discard of the medication. -She did not know the MAs were not removing the medication from the multi-dose pack while	D 358		

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D 358	Continued From page 15 pantoprazole was on hold. -Resident #5 had not complained of any blood in his stools. -MAs were expected to hold medications as ordered. -The MAs were responsible for removing medications on hold from the multi-dose pack and placing the medication in the drug buster. -She did not know why the MAs thought they could not remove an "on hold" medication from the multi-dose pack and dispose of it. -She could not remove the medication prior to placing the multi-dose pack on the medication cart because the multi-dose pack cannot be resealed. Interview with the Administrator on 08/03/23 at 12:24pm revealed: -Medications should be removed from the multi-dose pack prior to be placing on the medication cart if the medication had been placed on hold. -She thought the RCC or MCM removed medications from the multi-dose pack that were on hold. -The MAs should read the order on the eMAR and see the pantoprazole was on hold. -The MAs should see the pantoprazole was in the multi-dose pack when they compared the medications to the eMAR, and they should have notified the RCC or the MCM. Attempted telephone interview with Resident #5's Gastroenterologist on 08/02/23 at 4:07pm was unsuccessful. Refer to the interview with the Administrator on 08/02/23 at 10:25am. b. Review of Resident #5's physician order dated	D 358		

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D 358	Continued From page 16 04/15/23 revealed there was an order for melatonin 3mg (used for sleep) take 2 tablets (6mg) at bedtime. Review of Resident #5's physician order dated 06/06/23 revealed: -There was an order to discontinue melatonin 3mg, 2 tablets at bedtime. -There was an order for melatonin 3mg, 3 tablets at bedtime. Review of Resident #5's electronic progress note dated 06/06/23 revealed: -The Resident Care Coordinator (RCC) received an order to discontinue melatonin 3mg, 2 tablets at bedtime. -Start melatonin 3mg, 3 tablets at bedtime for insomnia. Review of Resident #5's electronic progress note dated 06/07/23 revealed the new order received on 06/06/23 was faxed to the pharmacy by the Memory Care Manager (MCM). Review of Resident #5's June 2023 electronic medication administration record (eMAR) revealed: -There was an entry for melatonin 3mg, 2 tablets (6mg) at bedtime with a scheduled administration time of 9:00pm. -There was documentation two 3mg tablets of melatonin were administered at bedtime from 06/01/23 to 06/30/23. Review of Resident #5's July 2023 eMAR revealed: -There was an entry for melatonin 3mg, 2 tablets (6mg) at bedtime with as scheduled administration time of 9:00pm. -There was documentation two 3mg tablets of	D 358		

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D 358	Continued From page 17 melatonin were administered at bedtime from 07/01/23 to 07/13/23, 07/15/23 to 07/18/23, and 07/20/23 to 07/31/23. -There were exceptions documented on 07/14/23 and 07/19/23; the exception was resident unavailable. Observation of Resident #5's medications on hand on 08/01/23 at 4:03pm revealed: -Resident #5's medications were dispensed in weekly multi-dose packs. -Resident #5 had one multi-dose pack on the medication cart. -There were instructions on the multi-dose pack that read "melatonin 3mg 2 tablets (6mg) at bedtime. -There was a description of melatonin that read "melatonin was a plain, white, round tablet." -There were two 3mg tablets of melatonin in the dose pack to be administered at bedtime. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 08/03/23 at 9:08am revealed: -The pharmacy had an order for melatonin 3mg 2 tablets at bedtime dated 04/05/23. -The pharmacy did not receive an order for melatonin 3mg 3 tablets at bedtime dated 06/06/23. -The pharmacy received orders from the physician through electronic prescriptions or through fax from the facility. -Resident #5 used melatonin for sleep. Interview with Resident #5 on 08/03/23 at 12:51pm revealed: -He did not sleep all night; he would wake up 3 to 4 times a night. -He wore his CPAP every night and still would wake up 3 to 4 times each night.	D 358		

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D 358	Continued From page 18 -He took 3 tablets of melatonin each night for a total of 9mg each night. -The PCP increased his melatonin a couple of months ago, but it had not helped him sleep any better. Interview with a MA on 08/03/23 at 12:53pm revealed: -Resident #5 did not complain about not sleeping well. -She administered the melatonin as entered on the eMAR and packaged in the multi-dose pack. Interview with a second MA on 08/03/23 at 3:11pm revealed: -She administered melatonin 3mg 2 tablets to Resident #5 each night as entered on the eMAR. -She did not know Resident #5 had an order to increase his melatonin 3mg 3 tablets each night. -The RCC and MCM received the new orders, the MAs did not see them until they had been entered into the eMAR and approved by the RCC or MCM. -She would not have known a new order had been written. -He had not complained of difficulty sleeping. Interview with Resident #7's PCP (Primary Care Provider) on 08/03/23 at 3:25pm revealed: -The Mental Health (MH) Provider increased Resident #5's melatonin 3mg from 2 tablets to 3 tablets each night. -Resident #5 was complaining of difficulty sleeping. -Resident #5 could still have problems sleeping if the melatonin was not increased as ordered. Interview with the RCC on 08/03/23 at 11:34am revealed: -New medication orders were faxed to the	D 358		

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D 358	Continued From page 19 pharmacy by the RCC or the MA the same day the order was written. -The "Bucket List" was used to ensure follow through on all new medication orders. -Once the new medication order was scanned into the computer system, the order was placed in the yellow folder. -Once the order was entered into the eMAR, the order was placed in the orange folder. -Once the medication was delivered to the facility, the order on the eMAR could be approved, then the order was ready to be filed in the resident's record. -She did not know the melatonin order written on 06/06/23 was not received by the pharmacy when it was faxed. -She did not know how the order to change the melatonin dosage was filed before it was faxed to the pharmacy. Interview with the Administrator on 08/03/23 at 12:24pm revealed: -New medication orders were faxed to the pharmacy by the RCC or the Memory Care Manager (MCM). -The pharmacy would enter the order into the eMAR. -The entry would be approved by the RCC or MCM for the medication to be administered once the medication arrived in the facility. -The medication order should not be filed in the resident's record until the medication was in the facility. -The RCC and MCM needed to ensure all medication orders were faxed to the pharmacy. -Resident #5 could have an increase in insomnia. -She expected the staff to ensure new orders were faxed to the pharmacy. Refer to the interview with the Administrator on	D 358		

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D 358	Continued From page 20 08/02/23 at 10:25am. Interview with the Administrator on 08/02/23 at 10:25am revealed: -The MAs were expected to compare the medications with the eMAR when administering medications. -The MA should speak to the RCC or MCM if they have questions about a medication. -The MAs were expected to read the eMAR and compare with the medication three times to ensure they were administering the correct medication. The facility failed to administer insulin Aspart sliding scale insulin (SSI) for fingerstick blood sugar (FSBS) readings greater than 200, with ranges from 203-385, 57 times from 05/01/23 to 07/31/23 (#1); failed to hold a medication for gastric reflux as ordered and administer a medication for sleep as ordered and the resident continued to wake up multiple times during the night (#5). This failure was detrimental to the health and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 08/03/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED September 17, 2023.	D 358		