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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on February 12, 2020 through February 14, 2020.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure cleaning products were stored in a locked area resulting in a hazardous liquid being unattended and accessible to residents who resided in the Special Care Unit (SCU). The findings are: Observation of two shower rooms in the facility on 02/12/20 at 9:01am revealed: -There was a shower room on the 100-hall and a second shower room located on the 200-hall. -The shower doors were not locked. -In each shower room , was a one-gallon container of a liquid green pot and pan detergent sitting on the floor beside the commode. -The label had a warning "safety reminder-before using this product make sure all employees read and understand the product label and safety data	D 056		

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D 056	Continued From page 1 sheet." Interview with a housekeeper on 02/12/20 at 9:18am revealed: -The container was always in the shower rooms; it was used in the commode when the commode stopped up. -The doors to the shower room were usually locked. -She thought the shower room was unlocked because the staff had assisted a resident with a shower and had taken the resident to their room and had not gone back to lock the shower room. Interview with a personal care aide on 02/12/20 at 9:23am revealed: -The shower room doors were always locked. -There were no residents who used the shower rooms independently. Observation of the hallway on 02/12/20 between 8:55am-10:00am revealed: -A female resident went into a male resident's room; staff told the resident it was not her room and walked her out into the hall where she began walking the halls. -A different female resident went into another resident's room and was told to "get out." -A male resident was pacing up and down the hall. -There was no visible staff in the hallway at various times during the observation. Observation of the shower rooms on 02/13/20 at 7:47am revealed: -Both shower rooms were unlocked and no staff was observed using the shower rooms. -The one-gallon containers of detergent were sitting on the floor beside the commodes.	D 056		

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Observation of the shower rooms on 02/13/20 at 7:58am revealed the shower rooms remained unlocked and unattended.

Observation of the SCU on 02/13/20 at 8:01am revealed:
-There were residents in the living room, private rooms, and walking in the hallway.
-The staff were in the living room, dining room, and in private rooms assisting residents.
-There was no staff directly observing the hallway near the shower rooms at the time the rooms were observed unlocked.

Confidential interview with staff revealed:
-There had been no showers given on 02/13/20, between 7:00am and 8:00am.
-The shower rooms were supposed to be locked.
-Third shift staff did not assist with resident showers.
-There were times the shower rooms were not locked.
-Staff was supposed to check the shower room doors when they made rounds to make sure the doors were locked.
-They had not checked the shower room doors today on 02/20/20.
-There were residents who wandered the hallways and went into other residents rooms.

Observation of the shower rooms on 02/13/20 at 8:10am revealed one shower room was locked and one shower room remained unlocked and unattended.

Observation of the shower rooms on 02/13/20 at 9:56am revealed both shower rooms were locked.

Interview with the Maintenance Director on

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D 056	Continued From page 3 02/13/20 at 11:36am revealed: -He ordered the green pot and pan detergent weekly; it should be stored in the kitchen and the maintenance room. -He had not noticed the containers in the shower rooms. Telephone interview with a third shift medication aide on 02/14/20 at 9:10am revealed: -She did not give residents showers on third shift. -Staff put dirty laundry and trash in the shower rooms. -Staff probably did not make sure the door was pulled tight behind them. Interview with the Executive Director on 02/13/20 at 10:01am revealed: -Shower rooms were supposed to be locked between residents' care. -If only one staff was providing care, they may not lock the door immediately. -After a shower, the resident was taken back to their room, and staff should go back and lock the door after the care was finished, but sometimes they were pulled to do other things and may have forgotten. -She checked the shower doors every morning; she had not checked the shower doors on 02/13/20. -She had found the doors unlocked in the past and had talked to staff about keeping the doors locked. -Third shift staff did not give resident showers, but they did take bins into the shower rooms every morning; the bins contained dirty clothing and trash. -There should not be any chemicals in the shower room. -She thought the containers were dish soap.	D 056		

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D 056	Continued From page 4 Interview with the Administrator on 02/13/20 at 10:08am revealed: -There should not be any chemicals stored in the shower rooms. -He was very concerned. -He took pride in keeping the shower rooms locked for the safety of the residents.	D 056		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that 29 chairs and 2 tables in the dining room were in good repair. The findings are: Observation of the dining room on 02/14/20 at 8:09am revealed: -There were 29 chairs in the dining room with scratches on the wood and peeling vinyl on the seat area. -There were 2 tables in the dining room with the sides were held together by duct tape. Interview with a dietary aide on 02/14/20 at 8:13am revealed: -The chairs in the dining room had been in disrepair for about 6 months. -There were tables that had duct tape on them because the sides were peeling.	D 076		

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-She did not know who put the duct tape on the tables or how long they had the duct tape on them.

Interview with the Maintenance Director on 02/14/20 at 8:37am revealed:
-He was responsible for fixing anything that was broken in the facility.
-If he was unable to fix something, he would be responsible for contracting the work out to an outside company.
-He was responsible for making sure the furnishings were in good repair.
-He was aware of the condition of the chairs and tables in the dining area.
-He put the duct tape on the side of the tables because the sides of the table were coming apart.
-He did not have the exact dates when he taped the tables.
-He was aware the dining room chairs were scratched, and the vinyl was peeling.
-He had worked on repairing a few chairs in the dining room in the past few months.
-He contacted an outside restaurant equipment and supply company to come assess the dining chairs and tables about 3 or 4 months ago.
-The company was supposed to call back him back after they found similar chairs and square tables, but he had not heard back.

Telephone interview with the owner of the restaurant equipment and supply company on 02/14/20 at 11:03am revealed:
-He sent a salesman to the facility 2 months ago at request of the Maintenance Director.
-The salesman advised the Maintenance Director would call him back once he decided on which equipment the facility wanted to purchase.
-The salesman had called the Maintenance Director 2 times at the facility in the past few

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D 076	Continued From page 6 months and left messages to receive a call back. -The salesman had not heard back from the Maintenance Director. Interview with the Administrator on 02/14/20 at 6:34pm revealed: -He supervised the Maintenance Director. -The dining room chairs and tables were in good repair. -The dining room chairs and tables were not in a condition that could harm residents. -The Maintenance Director had refurbished the chairs in the past few months. -He had worked with the corporate office for a over a year to get new dining room chairs and tables to get better chairs and tables. -The Vice President from corporate headquarters was expected to tour the facility on 02/28/20 to inspect the dining chairs and tables.	D 076		
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: TYPE A2 VIOLATION Based on observations, interviews, and record	D 273		

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reviews, the facility failed to ensure referrals were made for 2 of 2 sampled residents (#4, #5) who had orders for physical therapy and occupational therapy (#4) and orders for una boots to be applied by a Home Health nurse (#5).

The findings are:

1. Review of Resident #4's current FL-2 dated 11/13/19 revealed:
-Diagnoses included dementia, cerebrovascular disease, atrial fibrillation, hypertension, gastroesophageal reflux disease, and coronary artery disease.
-Resident #4 was semi-ambulatory.

Review of Resident #4's care plan dated 11/15/19 revealed Resident #4 required extensive assistance from staff with toileting, ambulation, and transfers.

Review of Resident #4's physician's visit summary dated 11/18/19 revealed:
-Resident #4 was a new patient for the primary care provider (PCP).
-Resident #4 had a history of frequent falls.
-Resident #4 had muscle weakness due to age and a sedentary lifestyle.
-The plan was to order physical (PT) and occupational (OT) therapy for muscle strengthening and transfer training.

Review of Resident #4's physician's visit summary dated 11/25/19 revealed:
-Resident #4 had a fall on 11/18/19 around 4:00pm; no injury was reported.
-There was an order for PT and OT completed on an initial visit last week.

Review of Resident #4's physician's visit

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summary dated 01/27/20 revealed:
-Resident #4 had a fall on 01/17/20.
-The resident had a second fall on 01/26/20.
-The plan was to order PT and OT for muscle reconditioning and fall risk reduction.

Review of Resident #4's physician's visit summary dated 02/10/20 revealed:
-Resident #4 had a fall on 02/09/20 in her bathroom.
-A bedside commode was ordered so Resident #4 could transfer safely to and from the toilet with reduced fall risk in the future.

Interview with the Executive Director (ED) on 02/13/20 at 9:0am revealed:
-Therapy notes were kept in residents' records.
-They used a named Home Health agency for all therapy needs.

Review of Resident #4's record revealed there were no notes from PT or OT.

Review of Resident #4's progress note dated 02/11/20 revealed:
-The Resident Care Coordinator (RCC) contacted Resident #4's family member to notify her Resident #4's insurance did not cover OT or PT and the daughter said they would "wait for now."
-The family member would take a bedside commode owned by Resident #4 to the facility.

Telephone interview with a representative of the named Home Health agency on 02/13/20 at 9:25am revealed:
-Resident #4 was not listed in their computer system.
-The agency's central intake was responsible for referrals and checking insurance coverage.

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Telephone interview with a representative in central intake for the named Home Health agency on 02/13/20 at 10:30am revealed:
-A referral was received for Resident #4 on 12/05/19.
-The referral was made "non-admit" because Resident #4's insurance coverage was not in-network.
-There was no other referral for Resident #4.
-There could be other agencies who were in-network for Resident #4's insurance.

Interview with Resident #4 on 02/13/20 at 10:57am revealed:
-She had two or three falls since she moved into the facility.
-Her falls were before she was in a wheelchair all the time; when she was more independent.
-She used the wheelchair all the time because she was afraid she was going to fall again.
-She would like to try physical therapy, so she could walk again.
-She would like to be able to walk but was afraid to try on her own.

Telephone interview with Resident #4's PCP on 02/13/20 at 10:10am revealed:
-If Resident #4 did not receive PT and OT as ordered Resident #4 was at risk of progressive physical deconditioning and increased risk of falls and injuries subsequent to those falls.
-He did not recall anyone notifying him that Resident #4 was not receiving PT or OT.
-He would expect the RCC to seek out a different Home Health agency to provide the services ordered.

Telephone interview with the RCC on 02/13/20 at 10:23am revealed:
-She was responsible for referrals for PT and OT

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made by the PCP.
-If the PCP was in the facility and wanted the referral to be made "right away" he would write a hard script.
-Usually, orders for PT and OT were on the PCP's encounter form, and she would process the referral from the encounter form.
-The first order for PT and OT for Resident #4 was when Resident #4 first moved into the facility; she did not recall when the referral was made but she "would have faxed it to the agency."
-The facility only used a named Home Health agency for PT and OT.
-The named Home Health agency took more insurance companies than any other company, so if the named company did not cover PT and OT for Resident #4, then no one would.
-She did not know if the named Home Health agency went to the facility and did an assessment of Resident #4 when the referral was made.
-She made the referral and the Home Health agency would contact Resident #4's family member.
-Resident #4 was more mobile in the beginning so therapy was probably not covered because Resident #4 did not need it.
-Resident #4's PCP "just redid the order" and a representative for the named Home Health agency called and said the PT and OT were not covered by the resident's insurance.

Telephone interview with Resident #4's family member on 02/13/20 at 10:44am revealed:
-She was concerned that Resident #4 had fallen "quite a bit."
-She chose to not have PT and OT see Resident #4 because the insurance did not cover the services.
-No one had offered a different agency to see if it was covered.

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D 273	Continued From page 11 Interview with the Area Wellness Director (AWD) on 02/13/20 at 11:32am revealed: -She knew the named Home Health agency was out of network for Resident #4. -She told the RCC to check other agencies. -"The RCC dropped the ball." -She expected the RCC to have called the PCP and asked for a discontinue order if there was no agency in-network. Interview with the RCC on 02/14/20 at 4:46pm revealed: -She did not call any other home health agency to see if Resident #4's insurance was in-network. -"They all pretty much have the same guidelines." -The named Home Health agency said they accepted most insurance. -She did not think to call Resident #4's insurance agency to see which home health agency they recommended. -She made the referral for PT and OT in January 2020, she did not recall the date. -She had received a call last week or the week before from the named Home Health agency that the insurance would not cover the PT and OT for Resident #4. -She did not notify Resident #4's PCP because Resident #4 was on the list for a follow-up appointment and she was going to tell the PCP at that time. Interview with the Executive Director on 02/14/20 at 6:30pm revealed: -She knew PT and OT had been ordered for Resident #4. -A representative from the named Home Health agency had called earlier this week (week of 02/10/20) to notify Resident #4 was not covered for therapy services.	D 273		

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-She would have expected the RCC to check with other agencies and notify the PCP if no other agency was available.

2. Review of Resident #5's current hospital FL-2 dated 01/24/20 revealed diagnoses included Alzheimer's disease, left hip fracture, Crohn's disease, and anemia.

Review of Resident #5's physician's order dated 07/01/19 revealed an order for compression stockings apply in the morning and remove at night. (compression stockings are used to treat venous insufficiency and severe leg swelling and help stop blood clots from forming.).

Review of Resident #5's care plan dated 12/18/19 revealed:
-Resident #5 required supervision from staff with ambulation and transfers.
-Resident #5 required limited assistance from staff with toileting, grooming, and dressing.
-Licensed Health Professional Support (LHPS) tasks included compression stockings.

Review of Resident #5's care plan dated 01/30/20 revealed:
-Resident #5 was totally dependent on staff for toileting, ambulation, transferring, bathing, and dressing.
-Resident #5 required extensive assistance from staff with grooming.
-LHPS tasks included compression stockings.

Review of Resident #5's LHPS Evaluations & Quarterly Reviews revealed:
-There was an LHPS quarterly review completed on 10/24/19 with the task of TED hose checked.
-Documentation revealed that Resident #5 used TED hose for lower leg swelling.

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D 273	Continued From page 13 -There was an LHPS evaluation completed on 01/18/20 with the task of TED hose checked. -Documentation revealed that Resident #5 used TED hose for lower leg swelling. Observation of Resident #5 on 02/12/20 at 8:59am revealed: -The resident was sitting in the day room in a wheelchair. -The resident was not wearing socks, shoes, or compression stockings. -The resident's left foot was discolored and had a large 2 inches by 2 inches fluid-filled area on the top of the foot approximately 2 inches by 2 inches. -The resident's right foot had a smaller 1inch by 1-inch fluid-filled area on the top of the foot. -Both feet were swollen. Observation of Resident #5 on 02/13/20 at 7:37am revealed: -The resident was sitting in the hall in a chair; her wheelchair was parked beside the chair. -The resident was not wearing socks, shoes, or compression stockings. -The resident's left lower pant leg was wet. Observation of Resident #5 on 02/13/20 at 4:10pm revealed: -The resident was sitting in a chair in the day room. -The resident had socks on both of her feet. -The resident's lower pant legs were both wet. -The resident was not wearing compression stockings. Observation of Resident #5 on 02/14/20 at 10:41am revealed: -The resident was sitting in her wheelchair in the day room.	D 273		

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-The resident had on a pair of calf-length socks.
-The left sock was wet, and the leg was swollen above and below the top of the sock.
-The right sock was rolled partially down around the resident's ankle and had a wet spot at the ankle.

Review of Resident #5's January 2020 electronic medication administration record (eMAR) revealed:
-There was an entry to apply compression stockings in the am and remove at bedtime with a scheduled time of 6:00am and 8:00pm.
-Resident #5's compression stockings were not documented as applied 9 times from 01/01/20-01/16/20; exceptions documented were "refused" and "would not put on the foot."
-Resident #5's compressions stockings were documented as applied 17 times from 01/04/20-01/19/20 and 01/25/20-01/31/20.
-Resident #5 was hospitalized for a fractured hip from 01/20/20-01/24/20.

Review of Resident #5's February 2020 eMAR revealed:
-There was an entry to apply compression stockings in the am and remove at bedtime with a scheduled time of 6:00am and 8:00pm.
-Resident #5's compression stockings were not documented as applied between 02/01/20-02/04/20 at 6:00am with an exception was documented as "too small."
-Resident #5's compressions stockings were documented as applied on 02/05/20 at 6:00am; an exception was documented at 8:00pm as "they were not put on the resident."
-Resident #5's compression stockings were not documented as applied on 02/06/20 at 6:00am; an exception was documented as "too small."
-Resident #5's compression stockings were not

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documented as applied on 02/07/20 at 6:00am; an exception was documented as "resident refused."
-Resident #5's compression stockings were not documented as applied on 02/08/20 at 6:00am; an exception was documented as "swelling."
-Resident #5's compression stockings were not documented as applied on 02/09/20-02/10/20 at 6:00am; an exception was documented as "legs wrapped/una boots."
-Resident #5's compression stockings were not documented as applied from 02/11/20-02/13/20; an exception was documented as "legs swelling/did not fit."
-Resident #5's compression stockings were documented as removed on 02/01/20-02/20, 02/04/20, 02/09/20, and 02/11/20 at 8:00pm.
-Resident #5's compression stockings were documented as not removed on 02/03/20, 02/05/20-02/08/20, 02/10/20/20, and 02/12/20 at 8:00pm; an exception was documented as "not applied."
-Resident #5's compression stockings were not documented as applied for 11 of 12 opportunities.

Review of Resident #5's physician's visit summary dated 01/27/20 revealed no edema in the lower extremities.

Review of Resident #5's hospital discharge summary dated 02/01/20 revealed:
-Resident #5 had been seen in the emergency department for leg swelling.
-Resident #5 complained of bilateral lower extremity swelling and bilateral leg pain.
-Resident #5 had 3+ pitting edema to bilateral lower extremities from the knee down.
-Resident #5 had some open wounds that were weeping.
-Resident #5's legs were wrapped with coban ace

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wraps.
-Resident #5 was referred to the wound care clinic.
-Resident #5 was diagnosed with venous insufficiency (a problem with the flow of blood from the veins of the legs back to the heart, it is sometimes caused by deep vein thrombosis).

Review of Resident #5's wound care discharge summary dated 02/03/20 revealed:
-Resident #5 had +3 pitting edema to the bilateral lower extremities and thin frail skin.
-Resident #5 was wearing compression stockings.
-An ointment was applied to an open area and the area was covered.
-Discharge orders included using the ointment as needed to open areas and cover; change every other day and as needed.
-Resident #5 was scheduled for a follow-up appointment in 2-weeks.

Review of Resident #5's physician's visit summary dated 02/03/20 revealed no edema in the lower extremities.

Review of Resident #5's Home Health nurse's note dated 02/05/20 revealed una boots were applied to Resident #5's lower legs.

Review of Resident #5's physician's visit summary dated 02/10/20 revealed:
-It was reported to him Resident #5's una boots were half off because Resident #5 attempted to remove the una boots.
-Resident #5 had 3+ edema in the feet secondary to increased compression from una boots being pushed down causing inadvertent constriction.
-He removed Resident #5's una boots due to increased constriction in the lower extremities.

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D 273	Continued From page 17 Telephone interview with Resident #5's primary care provider (PCP) on 02/13/19 at 12:30pm revealed: -He ordered Home Health to apply una boots to Resident #5's lower legs. (He did not recall the date). -He removed the una boots on 02/10/20 because Resident #5 was pulling them, causing more constriction. -The una boots should have been replaced by the Home Health Nurse. -He would have expected the Home Health Nurse to have replaced the una boots that he removed on 02/10/20. -He told the Resident Care Coordinator (RCC) to call Home Health. Interview with the RCC on 02/14/20 at 8:55am revealed Resident #5's PCP discontinued the una boots on 02/10/20. Telephone interview with a nurse with the facility's contracted Home Health provider on 02/14/20 at 9:30am revealed: -They had received an order to discontinue Resident #5's una boots -The order to discontinue Resident #5's una boots was signed by the PCP; they would not discontinue an order without the physician's signature. Second telephone interview with Resident #5's primary care provider (PCP) on 02/14/19 at 9:01am revealed he did not discontinue Resident #5's una boots Interview with a medication aide (MA) on 02/14/20 at 8:59 am revealed: -She did not know if Resident #5's compression	D 273		

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stockings were being applied.
-She had taken Resident #5's compression stockings off at night.
-Before Resident #5 had surgery she wore compression stockings.
-Resident #5's legs were so swollen "they were leaking."

Telephone interview with a nurse from the facility's contracted Home Health provider on 02/14/20 at 8:08am and 8:39am revealed:
-An order was received on 02/05/20 for una boots weekly and as needed (prn).
-Una boots and coban compression wraps were used to prevent swelling.
-If the una boots were off, the Home Health nurse would need to be called.
-There had been no calls documented that the una boots needed to be reapplied.
-They had received an order to discontinue Resident #5's una boots on 02/11/20.

Telephone interview with a third shift medication aide on 02/14/20 at 9:10am revealed:
-Resident #5's legs were weeping.
-Resident #5's compression stockings were applied but Resident #5 took them off.
-Resident #5's compression stockings were applied a couple of days ago at 5:45am and by 6:30am-6:45am the compression stockings were soaking wet.

Telephone interview with a second shift MA on 02/14/20 at 9:30am revealed Resident #5 could not wear her compression stockings because Resident #5's legs were so swollen and weeping.

Review of fax provided by the Home Health provider on 02/14/20 revealed:
-A telephone order was taken by the RCC on

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02/14/20 at 2:00pm to discontinue una boots due to the resident removing.
-It was documented to apply compression stockings in the am and off in the pm.
-It was signed by the RCC and co-signed by the Area Wellness Director.
-It was not signed by the PCP.

Third telephone call with Resident 5's PCP on 02/14/20 at 9:47am revealed:
-He had reviewed the faxed order to discontinue Resident #5's una boots.
-He thought it was a reasonable alternative to the una boot but did not recall having a discussion with the Home Health wound care nurse.
-He obviously had not signed the order.
-He looked through his text messages and did not have a message from staff regarding the order anytime during the week of 02/10/20.
-The RCC communicated with him with text messages.
-If it was not written down, he could not say it happened or not.
-He was in the facility until 5:00pm on 02/10/20 so it did not make sense that he did not sign the order.
-He did not believe he gave the order to discontinue Resident #5's una boots.
-He would have expected staff to notify him of their inability to carry out orders for Resident #5 and request advice on how to proceed.
-If staff were not able to carry out the order for compression stockings due to excessive swelling with weeping ulcerations and una boots were not feasible, he wanted Resident #5 sent to the hospital for acute management of the swelling and assessment for deep vein thrombosis (a blood clot that can break loose and cause a serious problem in the lung).
-Resident #5 could go into heart failure due to

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strain on her heart from the excessive fluid build-up in her legs.

Telephone interview with Resident #5's family member on 02/14/20 at 11:03am revealed:
-She thought Resident #5's legs needed to be elevated.
-A wheelchair was purchased for Resident #5 so her legs could be elevated.

Second interview with the RCC on 02/14/20 at 12:42pm revealed:
-When Resident #5 came home from the hospital, her legs were too swollen to use the compression stockings and she notified the PCP.
-The staff had been able to use the compression stockings at times.
-Resident #5 could remove the compression stockings on her own and that was why the PCP ordered the una boots.

Interview with the Area Wellness Director (AWD) on 02/14/20 at 1:01pm revealed:
-She and the RCC were together when they told Resident #5's PCP during his visit on 02/10/20 that it took "four of us" to apply Resident #5's una boots and Resident #5 then took the una boots off.
-The PCP told her and the RCC to discontinue the una boots.
-She asked the PCP for a discontinue order while the PCP was in the building.
-The RCC did not get the order signed because she was busy.

Interview with a MA on 02/14/20 at 4:13pm revealed:
-Resident #5 wore compression stockings before her fall and subsequent surgery.
-Resident #5's legs were swollen after surgery

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and the compression stockings did not fit.
-A physician put "casts" on Resident #5's legs last week and the PCP took them off because the swelling went down (beginning of this week) and they had been applying compression stockings since then.
-She did not know why Resident #5 had not been observed wearing compression stockings, "she took them off."

Interview with another MA on 02/14/20 at 4:13pm revealed a 3rd shift MA told her to not use Resident #5's compression stockings because her legs were swelling.

Telephone interview with Resident #5's Home Health nurse on 02/14/20 at 4:15pm revealed:
-She made a visit to see Resident #5 on 02/12/20.
-She knew there was an order to discontinue the una boots.
-Resident #5 had compression stockings on 02/12/20.
-The compression stockings had a small wet spot where one leg was weeping; the spot was smaller than an orange.
-She would have been concerned if she had seen both legs weeping and would have contacted the provider.
-Compression stockings would have not helped with the weeping, and something would need to be done.
-Resident #5's legs were swollen, but not alarming.
-Resident #5's leg had 1+ edema.

Third interview with the RCC on 02/14/20 at 4:46pm revealed:
-Resident #5 had an order for compression stockings.

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D 273	Continued From page 22 -Resident #5 would roll the compression stockings down to her ankles and was cutting off her circulation. -The PCP said to keep trying the compression stockings. -Resident #5 had an open area due to "non-compliance." -The Home Health nurse tried to use bandages on the area and compression stockings. -The Home Health nurse suggested trying una boots since they would be applied once a week versus compression stockings daily. -The PCP saw Resident #5 on 02/10/20 and reported he cut the una boots off Resident #5 because the boots were cutting off Resident #5's circulation because the una boots were pulled down to her ankles. -The PCP discontinued Resident #5's una boots. -She was with the PCP in her office when she discussed Resident #5's una boots; she did not recall any other staff with her at the time of the discussion. -She did a verbal order to discontinue the una boots because the PCP did not give her a prescription. -They started back trying to use compression stockings on Resident #5. -It was not uncommon for Resident #5's pants to be wet from the knees down. -She usually made rounds in the mornings and would put compression stockings on anyone who had refused during third shift. -She had assessed Resident #5's legs when the PCP sent the order to send Resident #5 to the hospital to be evaluated on 02/14/20; her legs were swollen and weeping, there was a change but not that significant. Interview with the Executive Director on 02/14/20 at 6:30pm revealed:	D 273		

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D 273	Continued From page 23 -Resident #5 had an order for compression stockings due to swelling. -The PCP wanted to try una boots on Resident #5 because he thought she could not remove them. -The RCC and the AWD spoke to the PCP about discontinuing the una boots and reinstating the compression stockings. -She was aware Resident #5's legs were weeping. -The orthopedic physician saw Resident #5 on 02/12/20. -The Home Health nurse was scheduled to see Resident #5 on 02/14/20 and reported she could not do anything with Resident #5's leg. -She would have expected the Home Health nurse to call the PCP to seek advice. Attempted interview with Resident #5 on 02/14/20 between 2:00pm-6:30pm was unsuccessful _____ The facility failed to ensure referral and follow up for two orders for physical and occupational therapy for a resident who had a history of falls, who did not receive therapy and subsequently had another fall resulting in the resident being wheelchair dependent because she was afraid to walk (#4); referral for una boots and use of compression stockings for Resident #5, who had a history of ongoing lower extremity edema, resulting in worsening edema and pain. This failure placed the residents at substantial risk of neglect and physical harm and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 02/14/20. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MACRH 15, 2020.	D 273		

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D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure foods were stored in a manner to prevent contamination related to food packages not being labeled or dated after opening and food stored uncovered in the freezer. The findings are: Observation of the pantry on 02/12/20 at 9:14am revealed there was a large white bin 50% full of a white powdery substance labeled flour that had a lid that did not cover the entire opening of the bin. Observation of the freezer on 02/12/20 at 9:16am revealed: -There was a 1-gallon container of chocolate ice cream on the bottom shelf of the freezer. -To the right of the 1-gallon container of ice cream on the same shelf was an unlabeled clear plastic bag of frozen fish; 1 piece of fish was sticking out through the opening of the bag. -The clear plastic bag of frozen fish did not indicate if it was in the original packaging. -In the freezer on the row above the 1-gallon container of ice cream was about 1-pound of frozen meat in a clear plastic that was not labeled with an opened date or a label that named the contents of the bag.	D 283		

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D 283	Continued From page 25 -The clear plastic bag of frozen meat did not indicate any labels that it was in the original packaging. Observation of the refrigerator on 02/12/20 at 9:18am revealed: -In the refrigerator on the bottom shelf was a box that had a bag of raw bacon in it with no opened date in its original packaging. -In the refrigerator on the bottom shelf on top of the box with the bag of raw bacon was a clear bag full of raw breakfast sausage with no opened date in its original packaging. Interview with the cook/dietary aide on 02/12/20 at 9:20am revealed: -It was the responsibility of each cook/dietary aide to go through the pantry, the freezer, and the refrigerator to make sure everything was clean and organized. -Every shift she worked she checked the pantry, freezer, and refrigerator to ensure items were covered and labeled. -She was aware the lid on the large white bin of the powdery substance labeled flour did not fit. -She did not know how long the lid had not fit the container. Interview with the Dietary Manager on 02/12/20 at 11:25am revealed: -She had 5 staff in the kitchen that were cross trained as cooks and dietary aides. -She had 1 staff that was only trained as a dietary aide. -She went through the pantry, the freezer, and the refrigerator every shift that she worked to make sure everything was clean and organized. -She expected all items in the kitchen to be labeled when they were opened and to be securely closed after opening.	D 283		

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D 283	Continued From page 26 -She had not known the large white bin labeled flour did not have a lid large enough to close the bin completely. -She had not known about the other items in the refrigerator and the freezer that were opened and not labeled. Interview with the Executive Director on 02/13/20 at 9:07am revealed: -She inspected the kitchen and pantry daily. -She last inspected the kitchen and pantry sometime during that week. -She did not know the large white bin labeled flour did not have a lid large enough to close the bin completely. -Her expectation was that opened items in the pantry to be covered and secured once opened, to be labeled with an opened date.	D 283		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents were provided with a non-disposable place setting, including a a knife	D 287		

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and non-disposable cup.

The findings are:

Observation of the dinner meal service in the dining room on 02/12/20 between 5:00pm-5:30pm revealed:
-There were 29 residents seated in the dining room.
-The meal consisted of a roast beef and cheddar cheese on 2 pieces of white bread with lettuce and tomato, pasta salad, and a chocolate chip cookie.
-There were 12 residents who were served milk in a disposable cup.
-There were 3 residents who were served a nutritional drink supplement in a disposable cup.
-No residents had a knife to cut their roast beef and cheddar cheese sandwich.

Observation of the breakfast meal service in the dining room on 02/13/20 between 7:27am-8:00am revealed:
-There were 24 residents seated in the dining room.
-There were 7 residents who were served milk in a disposable cup.
-There were 6 residents who were served a nutritional supplement in a disposable cup.

Attempted interview with Resident #2 on 02/13/20 at 10:30am was unsuccessful.

Observation of the kitchen on 02/13/20 at 7:58 am revealed:
-There were 29 clean 5-ounce non-disposable cups on the drying rack.
-No knives had been observed in the drying rack.

Interview with the Dietary Manager on 02/13/20 at

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D 287	Continued From page 28 8:51am revealed: -She had a total of 106 non-disposable cups to serve residents their drinks. -She had always served residents milk during meals in disposable cups. -The disposable cups were easy to dispose of because many of the residents did not like milk. Interview with the Business Office Manager on 02/13/20 at 9:12am revealed: -She observed the meal service everyday she worked. -The nutritional supplements and milk during had always been served in disposable cups. -There were no knives in the building to protect the residents from harming themselves or other residents. -She was not sure when the facility no longer gave knives to resident. -She was aware that had always been the policy to not give residents knives.	D 287		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and records reviews, the facility failed to have a matching therapeutic menu for 1of 1 sampled residents with a physician's order for a mechanical soft diet	D 296		

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(#2).

The findings are:

Review of Resident #2's current FL-2 dated 10/30/19 revealed:
-Diagnoses included Alzheimer's disease, essential hypertension, anxiety disorder, major depressive disorder, muscle weakness, anemia, chronic kidney disease, and chronic pain.
-The resident was constantly disoriented.
-There was an order for a mechanical soft diet.

Review of tthe facility's Week 1, Fall Winter 2016/2017" therapeutic diet spreadsheet revealed the lunch meal for a regular diet consisted of 3 oz boiled ham dinner, 4 oz potato wedge, 4 oz cabbage&carrots, and 1 home made biscuit.

Interview with the DM on 02/12/20 at 11:30am revealed:
-She placed 2 breaded chicken patties and 2 rolls in the food processor.
-She looked for the texture of the mechanical soft foods to not have any large chunks once it came out of the food processor.
-She blended the food and added a few tablespoons of water to the food, so it was not so thick.
-She blended 1 cup of steamed broccoli and 2 servings of cheese filled manicotti with cheese sauce to the blender.
-She blended the food and added a few tablespoons of water to the food, so it was not so thick.
-She placed Resident #2's food for the lunch meal.

Observation of the lunch meal service on 02/12/20 from 12:03pm-12:46pm revealed:

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D 296	Continued From page 30 -Resident #2 was served 1 cup of breaded chicken patty and a roll that was blended together, ½ cup of broccoli and cheese filled manicotti with white cheese sauce that was blended together, ½ cup of applesauce, juice and water. -Resident #2 ate 100% of the breaded chicken patty and roll, 100% of the broccoli and cheese filled manicotti, and 100% of the applesauce. -The consumed the lunch meal without difficulty. Interview with the Dietary Manager (DM) on 02/12/20 at 8:50am revealed a mechanical soft diet was a diet offered by the facility. Review of the facility's therapeutic menus revealed: -There was no menu for a mechanical soft diet (consisted of moist and soft foods that were easy to chew.. -The facility had a menu for a ground diet. A second interview with the DM on 02/12/20 at 11:25am revealed the cooks followed the regular menu plan when preparing meals for the residents on a mechanical soft diet. Review of the facility's "Week 1, Fall Winter 2016/2017" therapeutic diet spreadsheet revealed the dinner meal for a regular diet consisted of 3 oz hot roast beef and cheese ground, bulky bun, 2 slices of romaine lettuce/romaine lettuce, ½ ounce of ketchup/horseradish, 3 oz of pasta salad, and 4 oz apricots. Observation of the cook preparing the meal for the dinner service on 02/12/20 at 4:47pm revealed: -She put 2 cups of cooked pasta salad in the food processor along with a few teaspoons of water	D 296		

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and blended the food.
-She then put 4 pieces of white bread, 5 slices of sliced roast beef, ½ cup of shredded cheddar cheese, 2 slices of romaine lettuce, and 2 slices of tomato in the food processer along with a few teaspoons of water and blended the food.

Observation of the dinner meal service on 02/12/20 from 5:00pm-5:30pm revealed:
-Resident #2 was served a roast beef and cheese sandwich with a slice of lettuce and tomato on 2 pieces of white bread and 1 cup of pasta salad.
-Resident #2 began eating the bread.
-Resident #2 was served by the dietary aide.
-The Resident Care Coordinator took Resident #1's regular plate that was served and gave him a plate of the blended food prepared by the cook.
-Resident #2 was served 1 cup of the blended pasta salad, 1 cup of the blended white bread/roast beef/cheese/lettuce/tomato, and 1 chocolate chip cookie.
-The resident ate 100% of the blended pasta salad, 100% of the blended roast beef sandwich, and 100% of the cookie.
-The resident consumed all of the dinner meal without difficulty.

Based on observations it could not be determined if Resident #2 wa served the appropriate meal due to no mechanical soft menu available for staff guidance.

Attempted interview with Resident #2 on 02/13/20 at 10:30am was unsuccessful.

Interview with the cook on 02/12/20 at 4:47pm:
-She was trained 4 years ago when she started working at the facility.
-She always used the regular diet menu for guidance to prepare the mechanical soft diets.

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D 296	Continued From page 32 -She was not aware if the facility had a mechanical soft diet menu. Interview with the DM on 02/12/20 at 9:00am revealed: -There was a Dietician from corporate that sent the menu once a year. -She processes the regular menu items in a food processor to serve as mechanical soft. -She was trained to prepare mechanical soft diets in the food processor. Interview with the Business Office Manager on 02/13/20 at 9:10am revealed: -The facility did not have a mechanical soft diet menu. -The cooks had always used the regular menu and prepared the mechanical soft diet in the food processor. Interview with the Adminstrator on 02/13/20 at 9:15 am revealed: -He was told by Speech Therapist at a local Home Health agency that services residents in the facility several years ago that a mechanical soft diet had to go through a food processor. -He did not remember the exact name of the Speech Therapist that had told him that. -He would have the Dietician call the state worker to discuss the mechanical soft menu. Interview with a Speech Therapist at the local Home Health agency on 02/13/20 at 9:29am revealed: -Mechanical soft diets did not have to be processed in a food processor. -All items served for a mechanical soft diet had to be moist. -Mechanical soft diets do allow for canned fruit cocktail.	D 296		

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D 296	Continued From page 33 -Pasta salad did not need to be processed in a food processor because it was already soft. -Bread was okay to serve as long as it is not toasted and the crust was removed. -Residents on a mechanical soft diet should stay away from any hard crusted or breaded meats.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and records reviews, the facility failed to serve nutritional supplements for 1of 1 sampled residents (#2) with a physician's order for nutritional supplements. The findings are: Review of Resident #2's current FL-2 dated 10/30/19 revealed: -Diagnoses included Alzheimer's disease, essential hypertension, anxiety disorder, major depressive disorder, muscle weakness, anemia, chronic kidney disease, and chronic pain. -The resident was constantly disoriented. -There was an order for a mechanical soft diet and nutritional supplements. Review of a physicians diet order for Resident #2	D 310		

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dated 10/30/19 revealed an order for nutritional supplements served three times a day with meals.

Interview with the Dietary Manager on 02/12/20 at 9:50am revealed:
-There were several residents that received nutritional supplements.
-Resident #2 was not listed as one of the residents that received nutritional supplements.
-She had a diet order list on the inside of the kitchen door that listed each resident, the diet order, and if the resident received nutritional supplements.
-The dietary staff prepared the nutritional supplements and usually the MA passed them.

Review of the diet order list posted in the kitchen on 02/12/20 revealed Resident #2 diet order was mechanical soft diet and nutritional supplements three times a day.

Observation of the lunch meal service on 02/12/20 from 12:03pm-12:46pm revealed:
-Resident #2 was served water and juice.
-The resident did not receive a nutritional supplement.

Observation of the dinner meal service on 02/12/20 from 5:00pm-5:30pm revealed:
-Resident #2 was served water and tea.
-The resident did not receive a nutritional supplement.

Attempted interview with Resident #2 on 02/13/20 at 10:30am was unsuccessful.

Interview with Primary Care Physician (PCP) on 02/13/20 at 10:19am revealed:
-He was not aware that Resident #2 had not

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received his nutritional supplements.
-He was concerned that Resident #2's nutritional status had been compromised because he had not received his nutritional supplements.
-He was concerned Resident #2 weight had not been improved.

Interview with a medication aide (MA) on 02/13/20 at 11:18am revealed:
-The MA's were responsible for passing out the nutritional supplements to the residents that had an order to receive one.
-She went over every resident that received a nutritional supplement at snack and meal times, and Resident #2 was not one of them.
-The residents electronic medication administration record (eMAR) would have had an entry that said "snack".
-She reviewed Resident #2's February 2020 eMAR, and it did not have an entry for "snack".
-She had never given Resident #2 a nutritional supplement.
-She was not aware Resident #2 had been ordered nutritional supplements.
-The Resident Care Coordinator (RCC) and the Area Wellness Director (AWD) were responsible for putting orders in the eMAR.

Review of Resident #2's eMARs from December 2019 through February 2020 revealed no entry for "snack" or nutritional supplements.

Interview with the AWD on 02/13/20 at 11:33am revealed:
-The RCC was responsible for updating diet orders.
-She was not aware Resident #2 had an order for nutritional supplements.
-The RCC updated the diet orders for the MAs when they were received from the physician.

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D 310	Continued From page 36 -The Business Office Manager (BOM) then updated the diet order list for the dietary staff. -Resident #'2 nutritional suppplement order was missed by the AWD and BOM.	D 310		
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 A1 VIOLATION Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 1 of 6 residents (#5) observed during the medication pass, including errors with an anticoagulant, a mineral supplement, and a nasal spray, and for 5 of 6 sampled residents who were ordered an anti-seizure and a cholesterol-controlling medication (Resident #6), and an antibiotic, an anticoagulant, a blood pressure medication, a diabetes medication, and a vitamin supplement (Resident #3); a resident who was ordered a blood thinner and a diuretic (#4); and a resident who had an order for an anti-psychotic medication, a medication used to treat ulcers, Crohn's disease and ulcerative colitis, and multiple vitamin supplements; a resident who was ordered an antipsychotic and an anti-depressant	D 358		

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D 358	Continued From page 37 (#1); and a resident who had an order for a medication used to treat chest pain (#2). The findings are: 1. The medication error rate was 10% as evidenced by the observation of 3 errors out of 30 opportunities during the 7:00am medication pass on 02/13/20. Review of Resident #5's FL2 dated 01/24/20 revealed diagnoses included left hip fracture, Alzheimer's dementia, Crohn's disease, and anemia. a. Review of Resident #5's FL2 dated 01/24/20 revealed there was an order for Eliquis 2.5mg twice a day. (Eliquis is an anticoagulant used to prevent blood clot formation.) Review of Resident #5's eMAR for January 2020 revealed there was no entry for Eliquis 2.5mg twice a day. Review of Resident #5's electronic medication administration record (eMAR) for February 2020 revealed there was no entry for Eliquis 2.5mg twice a day. Observation on 02/12/20 at 3:39pm of Resident #5's medication on hand revealed there was no Eliquis 2.5mg available for administration. Interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am revealed: -The primary care provider (PCP) and the Resident Care Coordinator (RCC) completed the FL2. -The RCC entered the orders into the system and the pharmacy printed the eMAR.	D 358		

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D 358	Continued From page 38 -The RCC checked the orders to verify the accuracy of the eMAR. -Resident #5 was ordered Eliquis following hip surgery in January 2020. -The Eliquis tablet was specifically requested because the medication aide (MA) was not permitted to administer intramuscular (IM) injections. -The FL2 should have been faxed to the pharmacy. -She assumed the RCC faxed the order for Eliquis to the pharmacy. Telephone interview with Resident #5's PCP on 02/13/20 at 1:16pm revealed: -He had not been notified Resident #5 had not received Eliquis as ordered. -He was concerned because Resident #5 was ordered Eliquis to reduce the risk of a blood clot following her recent hip fracture. Interview with the RCC on 02/14/20 at 4:45pm revealed: -Resident #5's order was changed from an IM injection to Eliquis because the MA was not permitted to administer IM injections. -She faxed Resident #5's FL2 to the pharmacy. -She did not make sure the Eliquis was sent from the pharmacy. -When she called the pharmacy to check on the Eliquis order, she was told there was documentation someone from the facility had instructed the pharmacy not to send the Eliquis to the facility. -The pharmacy was delivering the Eliquis on 02/14/20. Refer to interview with the AWD on 02/13/20 at 11:33am.	D 358		

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D 358	Continued From page 39 Refer to telephone interview with the PCP on 02/13/20 at 4:27pm. Refer to interview with the RCC on 02/14/20 at 4:45pm. Refer to interview with the ED on 02/14/20 at 6:32pm. b. Review of Resident #5's FL2 dated 01/24/20 revealed an order for Klor-Con 20mEq 2 tabs (40mEq) daily. (Klor-Con is a potassium supplement.) Observation of the morning medication administration for Resident #5 on 02/13/20 at 7:09am revealed: -The Medication Aide (MA) removed two Klor-Con 20mEq tablets from the medication punch card and placed them in a small plastic cup with Resident #5's other tablets. -The label on the Klor-Con 20mEq medication punch card read "do not crush." -The MA crushed all the tablets, put them in applesauce, and administered them to Resident #5 with a spoon. Interview with the MA on 02/13/20 at 7:13am revealed: -Resident #5 had a hard time swallowing medication. -Resident #5's medications were regularly crushed. -She assumed the medication could be crushed. -She did not read the administration instructions on the label. -She followed the administration instructions that were in the computer. -She never noticed the "do not crush" instructions in the computer.	D 358		

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D 358	Continued From page 40 Review of Resident #5's electronic medication administration record (eMAR) for February 2020 revealed: -There was an entry for Klor-Con 20mEq ER take 2 tabs (40mEq) every day, do not crush. -Klor-Con 40mEq had been administered 13 of 13 opportunities. Interview with a representative from the facility's contracted pharmacy on 02/13/20 at 8:53am revealed: -Crushing Klor-Con could result in esophageal discomfort if the resident was not sitting up straight after administration of the medication. -An extended release medication was not meant to be crushed. -Crushing an extended release medication led to differing rates of absorption of the medication. -Liquid alternatives were available for residents unable to swallow pills. -Staff had not contacted the pharmacy about other options for Resident #5's Klor-Con. Interview with the Resident Care Coordinator (RCC) on 02/14/20 at 4:45pm revealed: -Resident #5 used to be able to swallow the Klor-Con tablets. -Extended release medications should not be crushed. Refer to interview with the AWD on 02/13/20 at 11:33am. Refer to telephone interview with the PCP on 02/13/20 at 4:27pm. Refer to interview with the RCC on 02/14/20 at 4:45pm.	D 358		

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Refer to interview with the Executive Director (ED) on 02/14/20 at 6:32pm.

c. Review of Resident #5's FL2 dated 01/24/20 revealed an order Atrovent two sprays each nostril three times a day. (Atrovent is used to relieve a runny nose.)

Review of Resident #5's physician order dated 10/28/19 revealed there was an order for Atrovent one spray in each nostril three times a day.

Review of Resident #5's electronic medication administration record (eMAR) for February 2020 revealed:
-There was an entry for Atrovent instill two sprays in each nostril three times a day.
-Atrovent was administered 35 out of 37 opportunities.

Observation of the morning medication administration for Resident #5 on 02/13/20 at 7:09am revealed:
-The Medication Aide (MA) removed Resident #5's Atrovent from a plastic bag labeled with directions to instill one spray in each nostril three times a day.
-The MA instilled one spray in each nostril while Resident #5 was sitting on a chair in the hallway.

Interview with a MA on 02/12/20 at 4:27pm revealed:
-The RCC or MA removed discontinued meds from the medication carts.
-The Resident Care Coordinator (RCC) checked the medication carts one or two times each week to be sure current medications were on the cart.

Interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am revealed:

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D 358	Continued From page 42 -She and the RCC audited the medication cart on Resident #5's hall on 02/10/20. -The medication cart audit included removing discontinued medications and making sure the medications in the cart matched the orders on the eMAR. Interview with a MA on 02/13/20 on 12:51pm revealed: -There was another bag in the medication cart containing Resident #5's Atrovent. -The label on the bag instructed to instill two drops into each nostril three times a day. -Resident #5's Atrovent order had changed and the previous bag should have been removed from the medication cart. -This morning, she had administered the Atrovent according to Resident #5's previous order. -The order in the computer system instructed to instill two drops in each nostril three times a day. -She read the instructions on the label and did not confirm it was the same as on the computer. Interview with the RCC on 02/14/20 at 4:45pm revealed: -She audited the medication carts every two months. -She and the AWD audited the cart on Resident #5's hall on 02/10/20. -She used the most recent orders when completing medication cart audits. -The audit included removing discontinued medications from the cart. Refer to interview with the AWD on 02/13/20 at 11:33am. Refer to telephone interview with the PCP on 02/13/20 at 4:27pm.	D 358		

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D 358	Continued From page 43 Refer to interview with the RCC on 02/14/20 at 4:45pm. Refer to interview with the Executive Director (ED) on 02/14/20 at 6:32pm. 2. Review of Resident #6's FL2 dated 02/03/20 revealed diagnoses included dementia, hypertension, and hyperlipidemia. a. Review of Resident #6's FL2 dated 02/03/20 revealed there was an order for levetiracetam solution 100mg/ml give 5ml twice a day. (Levetiracetam is an anti-seizure medication.) Review of Resident #6's physician order dated 10/28/19 revealed there was an order for levetiracetam solution 100mg/ml give 5ml twice a day. Review of the primary care provider's (PCP) progress note dated 01/27/20 revealed Resident #6 sustained a seizure on 01/18/20 and was not transported to the hospital. Review of Resident #6's eMAR for December 2019 revealed: -There was an entry for levetiracetam solution 100mg/ml take 5ml twice a day. -Levetiracetam solution 100mg/ml 5ml was administered 55 of 62 opportunities. Review of Resident #6's eMAR for January 2020 revealed: -There was an entry for levetiracetam solution 100mg/ml take 5ml twice a day. -There was documentation levetiracetam solution 100mg/ml 5ml was administered 55 of 62 opportunities.	D 358		

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D 358	Continued From page 44 Review of Resident #6's electronic medication administration record (eMAR) for February 2020 revealed: -There was an entry for levetiracetam solution 100mg/ml take 5ml twice a day. -There was documentation levetiracetam solution 100mg/ml 5ml was administered 22 of 25 opportunities. Observation on 02/13/20 at 4:20pm of Resident #6's medication available for administration revealed: -There was one opened bottle of levetiracetam solution 100mg/ml with ¾ remaining. -There was a label on the bottle with a pharmacy dispense date of 02/01/20. Telephone interview with a representative from the facility's contracted pharmacy on 02/13/20 at 4:04pm revealed: -The pharmacy dispensed a 30-day supply of levetiracetam solution 100mg/ml for Resident #6 on both 11/29/19 and 02/01/20. -The facility was not on a cycle fill. -The facility staff was supposed to contact the pharmacy to have the medication dispensed to the facility. -The pharmacy was not contacted by anyone from the facility to fill the levetiracetam in December 2019 or January 2020. -Resident #6 was at an increased risk for seizure if the levetiracetam was not administered. Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable. Telephone interview with Resident #6's primary care provider (PCP) on 02/13/20 at 4:27pm revealed:	D 358		

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-Not administering levetiracetam could lead to Resident #6 having a seizure.
-Missing one month of levetiracetam would give inaccurate lab results and would lead him to increase Resident #6's levetiracetam dose.
-Needlessly increasing Resident #6's levetiracetam dose could lead to levetiracetam toxicity.
-He was concerned that the lab results were not accurately reflecting Resident #6's levetiracetam level.
-Based on Resident #6's latest levetiracetam lab results (2mcg/mL), Resident #6 had no levetiracetam in her system.

Telephone interview with a MA on 02/14/20 at 10:07am revealed:
-She would have let the RCC know after five days if medication was not available for administration.
-Resident #6's levetiracetam was available for administration in January 2020.
-She did not know who reviewed the eMAR.

Interview with a second MA on 02/14/20 at 10:47am revealed she was certain Resident #6's levetiracetam was available for administration in January 2020.

Interview with the Executive Director (ED) on 02/14/20 at 6:32pm revealed:
-Resident #6's PCP had been informed of the lack of Resident #6's medication earlier today.
-The nurse consultant from the pharmacy informed her when medications were not on the cart.
-She was not informed by the nurse consultant from the pharmacy that Resident #6's levetiracetam was not on the medication cart.
-Resident #6's PCP had been informed of the lack of Resident #6's medication earlier today,

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D 358	Continued From page 46 02/14/20. Refer to interview with a MA on 02/12/20 at 1:43pm. Refer to interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm. Refer to interview with the AWD on 02/13/20 at 11:33am. Refer to telephone interview with the PCP on 02/13/20 at 12:30pm and 4:27pm. Refer to interview with the RCC on 02/14/20 at 4:45pm. Refer to interview with the Executive Director (ED) on 02/14/20 at 6:32pm. b. Review of Resident #6's FL2 dated 02/03/20 revealed there was an order for pravastatin 20mg at bedtime. (Pravastatin is used to treat high cholesterol.) Review of Resident #6's physician order dated 10/28/19 revealed there was an order for pravastatin 20mg take one tablet at bedtime. Review of Resident #6's eMAR for December 2019 revealed: -There was an entry for pravastatin 20mg take one tablet by mouth every evening. -Pravastatin 20mg had been administered 7 of 31 opportunities. Review of Resident #6's eMAR for January 2020 revealed: -There was an entry for pravastatin 20mg take	D 358		

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one tablet by mouth every evening.
-Pravastatin 20mg had been administered 3 of 31 opportunities.

Review of Resident #6's electronic medication administration record (eMAR) for February 2020 revealed:
-There was an entry for pravastatin 20mg take one tablet by mouth every evening.
-There was documentation pravastatin 20mg was administered 4 of 12 opportunities.

Telephone interview with a representative from the facility's contracted pharmacy on 02/14/20 at 9:43am revealed:
-The pharmacy dispensed a 30-day supply of pravastatin 20mg on 08/12/19.
-The facility was not on a cycle fill.
-The facility staff was supposed to contact the pharmacy to have the medication dispensed to the facility.
-There had not been any further communication from staff at the facility regarding dispensing pravastatin 20mg since August 2019.
-He did not recall any problems with delivering medication to the facility.

Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.

Interview with a MA on 02/14/20 at 10:07am revealed:
-She did not administer Resident #6's pravastatin in February 2020.
-The entries on the eMAR showing she administered the medication were errors caused by a "fast click" on the computer.
-Resident #6's pravastatin was not available for administration.

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D 358	Continued From page 48 Telephone interview with Resident #6's primary care provider (PCP) on 02/14/20 at 3:30pm revealed: -Resident #6 was at risk for elevated cholesterol levels and heart disease by not getting the pravastatin as ordered. -Resident #6's most recent lab values (LDL 162mg/dL) exceeded the higher risk limit for heart disease. -Resident #6's cholesterol levels would have likely been within normal limits if she had received the pravastatin as ordered. Interview with the Resident Care Coordinator (RCC) on 02/14/20 at 4:45pm revealed: -She and the PCP reviewed Resident #6's eMAR on 02/10/20. -They did not discuss Resident #6's pravastatin order when the PCP visited on 02/10/20. -She could not recall if the pravastatin was on the medication cart during her last audit or if she ordered it from the pharmacy. Interview with the Administrator on 02/14/20 at 6:32pm revealed: -The nurse consultant from the pharmacy had audited the carts "two days ago," on 02/10/20. -He was not notified about any medication needing to be ordered for any residents. Refer to interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am. Refer to telephone interview with the PCP on 02/13/20 at 4:27pm. Refer to interview with the RCC on 02/14/20 at 4:45pm.	D 358		

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D 358	Continued From page 49 Refer to interview with the Executive Director (ED) on 02/14/20 at 6:32pm. 3. Review of Resident #3's current FL2 dated 02/03/20 revealed diagnoses included dementia, shortness of breath on exertion, hypertension, and type 2 diabetes. Review of Resident #3's previous FL2 dated 12/12/19 revealed diagnoses included dementia, shortness of breath on exertion, hypertension, and type 2 diabetes. a. Review of Resident #3's current FL2 dated 02/03/20 revealed there was an order for lisinopril 40mg take one tablet daily. (Lisinopril is used to treat high blood pressure.) Review of Resident #3's previous FL2 dated 12/12/19 revealed there was an order for lisinopril 40mg take one tablet daily. Review of Resident #3's eMAR for December 2019 revealed: -There was an entry for lisinopril 40mg take one tablet daily scheduled at 8:00am. -Lisinopril 40mg was administered 27 of 31 opportunities. Review of Resident #3's eMAR for January 2020 revealed: -There was an entry for lisinopril 40mg take one tablet daily scheduled at 8:00am. -Lisinopril 40mg was not administered 13 of 31 opportunities. Review of Resident #3's electronic medication administration record (eMAR) for February 2020 revealed: -There was an entry for lisinopril 40mg take one	D 358		

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tablet daily scheduled at 8:00am.
-Lisinopril 40mg was not administered 3 of 12 opportunities.

Observation on 02/12/20 at 4:47pm of Resident #3's medication available for administration revealed there were 25 lisinopril 40mg tablets on hand with a pharmacy dispense date of 02/06/20.

Interview with a representative from the facility's contracted pharmacy on 02/12/20 at 5:09pm revealed:
-The facility staff contacted the pharmacy when medication refills were needed.
-The pharmacy dispensed 30 lisinopril 40mg tablets to the facility on 11/15/19 and 02/06/20.
-There were no refills requested by the facility for lisinopril 40mg for December 2019 or January 2020.

Interview with a MA on 02/14/20 at 8:52am revealed:
-She would let the Resident Care Coordinator (RCC) know on the third day if medication was not available for administration.
-The MA would notify the pharmacy by fax or phone if medications were not available for administration.
-She would not document administering a medication if it was not available.
-She did not know how Resident #3's lisinopril could have been given if the medication was not at the facility.

Interview with another MA on 02/14/20 at 10:47am revealed:
-If it was documented she gave the medication, she gave it.
-She could not remember notifying the pharmacy to refill the lisinopril.

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D 358	Continued From page 51 -The lisinopril was available for administration whenever she had documented she gave it. Telephone interview with Resident #3's primary care provider (PCP) on 02/13/20 at 11:35am revealed he was not notified Resident #3 had missed any doses of lisinopril. Refer to interview with a MA on 02/12/20 at 1:43pm. Refer to interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm. Refer to interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am. Refer to telephone interview with the PCP on 02/13/20 at 4:27pm. Refer to interview with the RCC on 02/14/20 at 4:45pm. Refer to interview with the Executive Director (ED) on 02/14/20 at 6:32pm. b. Review of Resident #3's current FL2 dated 02/03/20 revealed there was an order for Plavix 75mg take one tablet daily. (Plavix is prescribed to prevent blood clots.) Review of Resident #3's previous FL2 dated 12/12/19 revealed there was an order for Plavix 75mg take one tablet daily. Review of Resident #3's eMAR for December 2019 revealed: -There was an entry for Plavix 75mg take one tablet daily scheduled at 8:00am.	D 358		

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D 358	Continued From page 52 -Plavix 75mg was administered 27 of 31 opportunities. Review of Resident #3's eMAR for January 2020 revealed: -There was an entry for Plavix 75mg take one tablet daily scheduled at 8:00am. -Plavix 75mg was not administered 12 of 31 opportunities. Review of Resident #3's electronic medication administration record (eMAR) for February 2020 revealed: -There was an entry for Plavix 75mg take one tablet daily scheduled at 8:00am. -Plavix 75mg was not administered 3 of 12 opportunities. Observation on 02/12/20 at 4:47pm of Resident #3's medication available for administration revealed there were 25 Plavix 75mg tablets on hand with a pharmacy dispense date of 02/06/20. Interview with a representative from the facility's contracted pharmacy on 02/12/20 at 5:09pm revealed: -The facility staff contacted the pharmacy when medication refills were needed. -The pharmacy dispensed 30 Plavix 75mg tablets to the facility on 11/23/19 and 02/06/20. -There were no refills requested by the facility for Plavix 75mg for December 2019 or January 2020. Telephone interview with Resident #3's primary care provider (PCP) on 02/13/20 at 11:35am revealed he was not notified Resident #3 had missed any doses of Plavix. Interview with a MA on 02/14/20 at 8:52am revealed:	D 358		

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-She would let the Resident Care Coordinator (RCC) know on the third day if medication was not available for administration.
-The MA would notify the pharmacy by fax or phone if medications were not available for administration.
-She would not document giving a medication if it was not available for administration.
-She did not know how Resident #3's Plavix could have been given if the medication was not at the facility.

Interview with another MA on 02/14/20 at 10:47am revealed:
-If it was documented she gave the medication, she gave it.
-Resident #3's Plavix 75mg was in the extra medication drawer and was available for administration in January 2020.

Refer to interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am.

Refer to telephone interview with the PCP on 02/13/20 at 4:27pm.

Refer to interview with the RCC on 02/14/20 at 4:45pm.

Refer to interview with the ED on 02/14/20 at 6:32pm.

c. Review of Resident #3's previous FL2 dated 12/12/19 revealed there was an order for amoxicillin 500mg every eight hours for six days. (Amoxicillin is an antibiotic.)

Review of Resident #3's electronic medication administration record (eMAR) for December 2019 revealed:

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-There was an entry for amoxicillin 500mg take 1 capsule every 8 hours for six days scheduled for 8:00am and 4:00pm.
-There was documentation amoxicillin 500mg was administered at 8:00am from 12/14/19-12/20/19.
-There was documentation amoxicillin 500mg was administered at 4:00pm from 12/13/19-12/20/19.
-There was no documentation a third dose of amoxicillin 500mg was administered at any time in December 2019.

Interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am revealed:
-The Resident Care Coordinator (RCC) entered the orders into the system.
-The pharmacy printed the eMAR.
-The RCC verified the eMAR contained the current orders.
-She did not double-check the RCC's work.
-She did not see an entry for the third dose of amoxicillin 500mg on Resident #3's eMAR for December 2019.

Interview with the RCC on 02/14/20 at 4:45pm revealed:
-She was responsible for making sure the eMAR reflected the current orders.
-The third dose of amoxicillin 500mg was not on the eMAR.
-Resident #3 did not receive the amoxicillin 500mg as ordered.
-She did not "catch that" when she reviewed the eMAR.

Refer to interview with a MA on 02/12/20 at 1:43pm.

Refer to interview with a pharmacist from the

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facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm.

Refer to interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am.

Refer to telephone interview with the PCP on 02/13/20 at 4:27pm.

Refer to interview with the RCC on 02/14/20 at 4:45pm.

Refer to interview with the ED on 02/14/20 at 6:32pm.

d. Review of Resident #3's previous FL2 dated 12/12/19 revealed there was an order for glipizide 10mg twice a day. (Glipizide is used to treat diabetes.)

Review of Resident #3's physician orders revealed there was an order dated 01/07/20 to discontinue glipizide 10mg twice a day.

Review of Resident #3's electronic medication administration record (eMAR) for December 2019 revealed:
-There was an entry for glipizide 5mg take two tablets twice a day scheduled for 8:00am.
-Glipizide 5mg two tablets was administered at 8:00am from 12/01/19-12/08/19 and from 12/13/19-12/31/19.
-Glipizide 5mg two tablets was not administered from 12/09/19-12/12/19 because Resident #3 was hospitalized.
-There was no documentation a second dose of glipizide 5mg two tablets was administered at any time in December 2019.

Review of Resident #3's electronic medication

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administration record (eMAR) for January 2020 revealed:
-There was an entry for glipizide 5mg take two tablets twice a day scheduled for 8:00am.
-Glipizide 5mg two tablets was administered at 8:00am from 01/01/20-01/10/20.
-There was no documentation a second dose of glipizide 5mg two tablets was administered at any time in January 2020.

Interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am revealed:
-The Resident Care Coordinator (RCC) entered the orders into the system.
-The pharmacy printed the eMAR.
-The RCC verified the eMAR contained the current orders.
-She did not see an entry for the second dose of glipizide 5mg two tablets on Resident #3's eMARs for December 2019 and January 2020.

Interview with the RCC on 02/14/20 at 4:45pm revealed:
-She was responsible for making sure the eMAR reflected the current orders.
-The second dose of glipizide 5mg two tablets was not on the eMAR.
-Resident #3 did not receive the glipizide 5mg two tablets as ordered.
-She did not "catch that" when she reviewed the eMAR.

Refer to interview with a MA on 02/12/20 at 1:43pm.

Refer to interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm.

Refer to interview with the AWD on 02/13/20 at

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D 358	Continued From page 57 11:33am. Refer to telephone interview with the PCP on 02/13/20 at 4:27pm. Refer to interview with the RCC on 02/14/20 at 4:45pm. Refer to interview with the Executive Director (ED) on 02/14/20 at 6:32pm. e. Review of Resident #3's previous FL2 dated 12/12/19 revealed there was an order for Vitamin D3 2000 units take one capsule daily. Review of Resident #3's physician orders revealed there was an order to discontinue Vitamin D3 2000 units take one capsule daily signed and dated 02/03/20. Review of Resident #3's electronic medication administration record (eMAR) for December 2019 revealed: -There was an entry for Vitamin D3 2000 units take one tablet by mouth daily scheduled at 8:00am. -Vitamin D3 2000 units was administered 15 of 27 opportunities. Review of Resident #3's electronic medication administration record (eMAR) for January 2020 revealed: -There was an entry for Vitamin D3 2000 units take one tablet by mouth daily scheduled at 8:00am. -Vitamin D3 2000 units was administered 27 of 28 opportunities. Interview with a representative from the facility's contracted pharmacy on 02/12/20 at 5:09pm	D 358		

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revealed:
-The facility staff contacted the pharmacy when medication refills were needed.
-The pharmacy dispensed 30 Vitamin D3 2000 unit tablets to the facility on 09/30/19 and 12/23/19.

Interview with a MA on 02/14/20 at 8:52 revealed:
-She would let the Resident Care Coordinator (RCC) know on the third day if medication was not available for administration.
The MA would notify the pharmacy by fax or phone if medications were not available for administration.
-She would not document giving a medication if it was not available for administration.
Interview with another MA on 02/14/20 at 8:52am revealed she would not document giving a medication if it was not available for administration.

Interview with another MA on 02/14/20 at 10:47am revealed if it was documented she gave the medication, she gave it.

Telephone interview with Resident #3's primary care provider (PCP) on 02/13/20 at 11:35am revealed he was not notified Resident #3 had missed any doses of Vitamin D3.

Refer to interview with a MA on 02/12/20 at 1:43pm.

Refer to interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm.

Refer to interview with the AWD on 02/13/20 at 11:33am.

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D 358	Continued From page 59 Refer to telephone interview with the PCP on 02/13/20 at 4:27pm. Refer to interview with the RCC on 02/14/20 at 4:45pm. Refer to interview with the Executive Director (ED) on 02/14/20 at 6:32pm. 3. Review of Resident #4's current FL-2 dated 11/13/19 revealed diagnoses included dementia, cerebrovascular disease, atrial fibrillation, coronary artery disease, hypertension, gastroesophageal reflux disease, and hyperlipidemia. a. Review of Resident #4's physician's order dated 11/13/19 revealed an order for Warfarin 2.5mg on Thursdays and 5mg on all other days. Review of Resident #4's physician's order dated 11/18/19 revealed an order for Warfarin 2.5mg every day except Monday and Thursday, and 5mg on Monday and Thursday. (Warfarin is a blood thinner). Review of Resident #4's physician's order dated 12/03/19 revealed an order for Warfarin 2.5mg on Tuesday, Thursday, Saturday, and Sunday and 5mg on Monday, Wednesday, and Friday. Review of Resident #4's physician's order dated 12/12/19 revealed an order for Warfarin 2mg every day. Review of Resident #4's physician's order dated 12/30/19 revealed an order for Warfarin 3mg on Tuesday, Thursday, Saturday, and Sunday and	D 358		

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Warfarin 4mg on Monday, Wednesday, and Friday.

Review of Resident #4's INR lab work (INR is a lab value to determined effectiveness of Warfarin and is usually recommended to be between 2 and 3) results in the record revealed:
-Resident #4's INR was 1.64 (below therapeutic range) on 12/03/19.
-Resident #4's INR was 1.30 (below therapeutic range) on 12/06/19.
-Resident #4's INR was 1.11 (below therapeutic range) on 12/17/19.
-Resident #4's INR was 1.20 (below therapeutic range) on 12/24/19.
-Resident #4's INR was 1.16 (below therapeutic range) on 12/31/19.

Review of Resident #4's December 2019 Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Warfarin 2.5mg take one tablet every day except Monday and Thursday with a scheduled administration time of 8:00am; the entry had a start date of 11/16/19 and an end date of 12/03/19.
-There was documentation Warfarin 2.5mg was administered at 8:00am on 12/04/19.
-There was a second computer-generated entry for Warfarin 5mg take one tablet on Monday, Wednesday, and Friday with a schedule administration time of 6:00pm; the entry had a start date of 12/03/19 and an end date of 12/12/19.
-There was documentation Warfarin 5mg was administered at 6:00pm on 12/04/19.
-There was a third computer-generated entry for Warfarin 2.5mg take one tablet on Tuesday, Thursday, Saturday, and Sunday with a

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scheduled administration time of 6:00pm; the entry had a start date of 12/03/19 and an end date of 12/12/19.
-There was no documentation Warfarin was administered on 12/06/19-12/08/19; there was an exception documented as waiting on pharmacy.
-There was a fourth computer-generated entry for Warfarin 2mg take one tablet every day with a scheduled administration time of 8:00am; the entry had a start date of 12/12/19 and an end date of 12/19/19.
-There was no documentation Warfarin was administered on 12/12/19-12/13/19; there was an exception documented as waiting on the pharmacy.

Review of Resident #4's pharmacy dispensing records from 11/ 19-02/0 /20 revealed:
-Eight Warfarin 5mg were dispensed on 11/26/29.
-Sixteen Warfarin 2.5mg were dispensed on 12/03/19.
-Twelve Warfarin 5mg were dispensed on 12/03/19.
-Thirty Warfarin 2mg were dispensed on 12/12/19.
-Sixteen Warfarin 3mg were dispensed on 12/19/19.
-Twelve Warfarin 2mg were dispensed on 12/19/19.
-Three Warfarin 4mg were dispensed on 12/30/19.
-Seven Warfarin 4mg were dispensed on 01/07/20.
-Seven Warfarin 4mg were dispensed on 01/15/20.
-Thirty Warfarin 5mg were dispensed on 01/16/20.
-Fourteen Warfarin 6mg were dispensed on 01/27/20.
-Thirty Warfarin 5mg were dispensed on

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D 358	Continued From page 62 02/08/20. Review of Resident #4's physician's order dated 01/7/20 revealed an order to discontinue Warfarin 3mg on Tuesday, Thursday, Saturday, and Sunday and Warfarin 4mg on Monday, Wednesday, and Friday and begin Warfarin 4mg daily. Review of Resident #4's physician's order dated 01/16/20 revealed an order to discontinue Warfarin 4mg daily and begin Warfarin 5mg daily. Review of Resident #4's physician's order dated 01/27/20 revealed an order to discontinue Warfarin 5mg daily and begin Warfarin 6mg daily. Review of Resident #4's lab work results in the record revealed: -Resident #4's INR was 1.72 (below therapeutic range) on 01/07/20. -Resident #4's INR was 1.46 (below therapeutic range) on 01/15/20. -Resident #4's INR was 1.52 (below therapeutic range) on 01/22/20. -Resident #4's INR was 2.22 on 01/29/20. Review of Resident #4's January 2020 eMAR revealed: -There was a computer-generated entry for Warfarin 3mg take one tablet on Tuesday, Thursday, Saturday, and Sunday with a schedule administration time of 8:00am; the entry had a start date of 12/19/19 and an end date of 01/07/20. -There was documentation Warfarin 3mg was administered at 8:00am on 01/04/20. -There was a second computer-generated entry for Warfarin 3mg take one tablet on Tuesday, Thursday, Saturday, and Sunday with a schedule	D 358		

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administration time of 6:00pm; the entry had a start date of 12/19/19 and an end date of 01/07/20.
-There was documentation Warfarin 3mg was administered at 6:00pm on 01/04/20.
-There was a third computer-generated entry for Warfarin 5mg take one tablet every day with a scheduled administration time of 6:00pm; the entry had a start date of 01/16/20 and an end date of 01/27/20.
-There was no documentation Warfarin 5mg was administered on 01/17/20 or 01/19/20; there was an exception documented on 01/19/20 that Resident #4 refused.

Review of Resident #4's physician's telephone order dated 02/05/20 at 11:00am revealed an order to discontinue Warfarin on 02/05/19 and begin Warfarin 5mg on 02/08/20.

Review of Resident #4's February 2020 eMAR revealed:
-There was a computer-generated entry for Warfarin 6mg take one tablet daily at 6:00pm; the entry had a start date of 01/27/20 and an end date of 02/05/20.
-There was documentation Warfarin 6mg was administered at 6:00pm on 02/05/20.

Observation of Resident #4's medication on hand on 02/12/20 at 3:39pm revealed Warfarin 5mg was available to be administered.

Review of Resident #4's physician's visit summary dated 02/10/20 revealed:
-Resident #4's INR was "acutely high this week" at 4.09 on Warfarin 6mg.
-"I was notified when the results were made available on 02/05/20 and I instructed staff to stop Warfarin and on 02/08/20 start Warfarin on 5mg."

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D 358	Continued From page 64 -INR became supratherapeutic (high)following an increase in Warfarin 5mg to Warfarin 6mg. -Warfarin dose was held for three days in response and reinstated at 5mg. Telephone interview with Resident #4's primary care provider (PCP) on 02/12/20 at 4:3qpm revealed: -He was concerned Resident #4 was not receiving her Warfarin as ordered. -He had not been able to get Resident #4 to a therapeutic level and was having to adjust her Warfarin weekly. -Resident #4 had been supratherapeutic (high), so he was adjusting the Warfarin to get the INR to a therapeutic range. -Resident #4 not receiving Warfarin or receiving too much Warfarin was skewing the INR results. -Resident #4 should not have received a dose of Warfarin on 02/05/20. -If Resident #4 received a dose on 02/05/20 when her INR was already critically high, it would increase Resident #4's risk of bleeding and possible hemorrhage. Observation of Resident #4's hands, on 02/13/20 at 10:57am revealed the back of both hands had multiple areas of dark bruising. Interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am revealed if a telephone order was received at 11:00am (02/05/20) she would have expected to have been held at the scheduled administration time of 6:00pm. Interview with a medication aide (MA) on 02/13/20 at 1:43pm revealed: -She did not know why it was documented Resident #4 had missed doses of Warfarin because it was not available.	D 358		

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-When the medication was not available the MA should check the cart, if the sticker was still on the prescription card, it would be faxed to the pharmacy and if the sticker was missing the MA should check the logbook to see if the medication had been ordered.
-If the medication had been ordered, the MA should check on the status and let the Resident Care Coordinator (RCC) know the medication had not been received.
-After her medication pass, she always made a list of medications that needed to be reordered.

Interview with a MA on 02/13/20 at 5:50pm revealed:
-She did not recall why Warfarin was not available for Resident #4.
-The MAs were responsible for re-ordering medication.
-Resident #4's Warfarin changed a lot.

Interview with the RCC on 02/14/20 at 4:46pm revealed:
-She was not aware Resident #4 had missed doses of Warfarin because the medication was not in the facility.
-She did not know why Resident #4 received Warfarin when it should have been held, she thought it was because she did not fax it to the pharmacy until the end of the day and it did not get changed because the pharmacy had already closed.

Interview the with Executive Director on 02/14/20 at 6:30pm revealed:
-She was aware Resident #4 recently had a high INR.
-She was not aware Resident #4's Warfarin was not held as ordered.
-She was not aware Resident #4 had missed

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doses of Warfarin and had received double doses of Warfarin.

Refer to the interview with a MA on 02/12/20 at 1:43pm.

Refer to the interview with the AWD on 02/13/20 at 11:33am.

Refer to the interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm.

Refer to a telephone interview with the PCP on 02/13/20 at 12:30pm and 4:27pm.

Refer to the interview with the RCC on 02/14/20 at 4:45pm.

Refer to the interview with the ED on 02/14/20 at 6:32pm.

b. Review of Resident #4's physician's order dated 11/18/19 revealed an order for Furosemide 20mg daily. (Furosemide is a diuretic used to treat fluid retention (edema) and swelling caused by congestive heart failure, liver disease, kidney disease, and other medical conditions.).

Review of Resident #4's physician's order dated 01/13/20 revealed an order for Furosemide 40mg daily.

Review of Resident #4's December 2019 Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Furosemide 20mg to take one tablet every day with a scheduled administration time of 8:00am.
-There was documentation Furosemide was

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administered at 8:00am on 12/01/19-12/26/19.
-There was an exception documented on 12/27/19-12/31/19 Furosemide was not available, "waiting on pharmacy."

Review of Resident #4's January 2020 eMAR revealed:
-There was an exception documented on 01/01/20-01/08/20 Furosemide was not available, "waiting on pharmacy.".
-Furosemide 20mg was documented as administered on 01/09/20-01/13/20.
-There was a second computer-generated entry for Furosemide 40mg one tablet every day with a scheduled administration time of 8:00am with a start date of 01/14/20.
-Furosemide 40mg was documented as administered at 8:00am from 01/15/20-01/31/20.
-Furosemide was not documented as administered on 01/14/20; there was no exception documented.

Review of Resident #4's physician's visit summary dated 11/18/19 revealed:
-Resident #4 had swelling in both lower legs.
-Resident #4 was not currently being treated for edema.
-Resident #4 was started on Furosemide 20mg daily.
-Resident blood pressure (BP) on the visit was documented as 106/58.

Review of Resident #4's physician's visit summary dated 11/25/19 revealed:
-Resident #4's edema had not improved with Furosemide 20mg daily.
-Resident#4 was measured for TED hose [thromboembolism-deterrent hose used to aid in the treatment of edema (fluid retention) and DVT (deep vein thromboses, or blood clots)] and an

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order for TED hose on in the am and off in the pm was written.
-He did not want to increase Resident #4's Furosemide due to Resident #4's BP was already too low to safely increase the Furosemide any further.
-Resident BP on the visit was documented as 105/60.

Review of Resident #4's physician's visit summary dated 12/03/19 revealed:
-Resident #4 had no edema noted.
-Resident #4's TED hose were in place.
-Resident #4's BP on the visit was documented as 132/98.

Review of Resident #4's physician's visit summary dated 12/30/20 revealed:
-Resident #4's edema had improved.
-Resident #4 had TED hose in place and no edema noted.
-Resident #4's BP on the visit was documented as 106/63.

Review of Resident #4's physician's visit summary dated 01/13/20 revealed:
-Resident #4 had swelling in both lower legs noted with TED hose in place.
-Furosemide increased to 40mg daily as edema had worsened in the past two weeks.
-There was a concern for the exacerbation of congestive heart failure (CHF).
-Resident BP on the visit was documented as 135/76.
-CHF was added to the residents' diagnoses list.
-He felt exacerbation of CHF was imminent without intervention.

Review of Resident #4's physician's visit summary dated 01/27/20 revealed:

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-Resident #4's edema had improved in her lower extremities.
-Resident BP on the visit was documented as 140/78.

Observation of Resident #4's medication on hand on 02/12/20 at 3:39pm revealed Furosemide 20mg, take 2 tablets at bedtime, was available to be administered.

Telephone interview with Resident #4's PCP on 02/13/20 at 9:08am revealed:
-If Resident #4 went without Furosemide it could have caused an increase in her edema as opposed to exacerbation of CHF.
-He was concerned that the increase in Resident #4's Furosemide on 01/13/20 may have been unnecessary.
-Increasing Resident #4's Furosemide increased her risk of electrolyte depletion, dehydration, and acute kidney injury.

Interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am revealed she was not aware Resident #4 had missed 13 days of Furosemide.

Telephone interview with the Resident Care Coordinator (RCC) on 02/13/20 at 12:56pm revealed she did not recall anything specifically related to Resident #4's Furosemide.

Interview with a medication aide (MA) on 02/13/20 at 1:43pm revealed she recalled Resident #4 not having Furosemide on the cart, she did not recall when Resident #4 did not have Furosemide available to be administered.

Interview with the Resident Care Coordinator on 02/14/20 at 4:46pm revealed:

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D 358	Continued From page 70 -She was not aware Resident #4 had missed doses of Furosemide. -She was not aware Resident #4's PCP had increased the dosage of Furosemide after missed doses. Interview with the Executive Director on 02/14/20 at 6:30pm revealed: -She was not aware Resident #4 had missed doses of Furosemide. -She would have expected to have been notified. Refer to the interview with a MA on 02/12/20 at 1:43pm. Refer to the interview with the AWD on 02/13/20 at 11:33am. Refer to the interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm. Refer to a telephone interview with the PCP on 02/13/20 at 12:30pm and 4:27pm. Refer to the interview with the RCC on 02/14/20 at 4:45pm. Refer to the interview with the ED on 02/14/20 at 6:32pm. c. Review of Resident #4's physician's order dated 11/13/19 revealed an order for Atorvastatin 80mg daily. (Atorvastatin is used to treat high cholesterol and triglycerides levels. This may reduce the risk of angina, stroke, heart attack, and heart and blood vessel problems.). Review of Resident #4's December 2019 Medication Administration Record (eMAR)	D 358		

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revealed:
-There was a computer-generated entry for Atorvastatin 80mg to take one tablet every day with a scheduled administration time of 8:00pm.
-There was documentation Atorvastatin 80mg was administered at 8:00pm on 12/01/19-12/10/19.
-There was an exception documented on 12/11/19-12/18/19 Atorvastatin was not available, "waiting on pharmacy."
-There was documentation Atorvastatin was administered at 8:00pm on 12/19/19-12/23/19.
-There was an exception documented on 12/24/19-12/31/19 that Atorvastatin was not available, "waiting on pharmacy."

Review of Resident #4's January 2020 eMAR revealed:
-There was a computer-generated entry for Atorvastatin 80mg to take one tablet every day with a scheduled administration time of 8:00pm.
-Atorvastatin was not documented as administered from 01/01/20-01/31/20.
-There was an exception documented on 01/01/20-01/31/20 that Atorvastatin was not available, "waiting on pharmacy."

Review of Resident #4's February 2020 eMAR revealed:
-There was a computer-generated entry for Atorvastatin 80mg to take one tablet every day with a scheduled administration time of 8:00pm.
-Atorvastatin was not documented as administered from 02/01/20-02/11/20.
-There was an exception documented on 02/01/20-02/11/20 that Atorvastatin was not available, "waiting on pharmacy."

Observation of medication on hand on 02/12/20 at 3:39pm revealed Atorvastatin 80mg was not

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available to be administered.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/12/20 at 4:16pm revealed:
-They had never dispensed Atorvastatin for Resident #4.
-It was documented on 11/15/20 the order for Atorvastatin 80mg was to be "profiled" because Resident #4 had the medication on hand.
-They had the FL-2 dated 11/18/20 for Atorvastatin 80mg daily.
-There had been no request to have the Atorvastatin 80mg refilled.

Telephone interview with Resident #4's primary care provider (PCP) on 02/12/20 at 4:31pm revealed:
-Atorvastatin had been ordered for Resident #4 because of elevated cholesterol.
-He was not aware Resident #4 had not taken Atorvastatin since December 2019.
-He did routine lab work on 02/10/20 to include cholesterol levels but the results had not been returned.
-He was concerned three months ago Resident #4's cholesterol had been controlled but without Atorvastatin for over 60 days, her cholesterol levels may have gotten very high.

Interview with a medication aide (MA) on 02/12/20 at 5:15pm revealed:
-She had administered Atorvastatin to Resident #4.
-If she documented she administered Atorvastatin to Resident #4 the medication had to have been available.
-She would not document Atorvastatin had been administered if there was none available to be administered.

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D 358	Continued From page 73 -She thought maybe some had been delivered or maybe it had been misplaced in the medication cart. -She did not recall when Atorvastatin 80mg had been reordered for Resident #4. Interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am revealed: -She was not aware Resident #4 had missed doses of Atorvastatin since December 2019. -She would have expected the MA to have told the Resident Care Coordinator (RCC), notified the PCP. Telephone interview with the RCC on 02/13/20 at 12:56pm revealed: -She did not recall anything specific about Resident #4's Atorvastatin. -She had problems with medications being ordered but not delivered from the pharmacy. -She had audited the medication cart "a couple of weeks ago." -She did not recall if she had noted Resident #4's Atorvastatin was not on the medication cart. -If she did not see Atorvastatin on the medication cart for Resident #4 she would have reordered. Interview with the Executive Director on 02/14/20 at 6:30pm revealed: -She was not aware Resident #4's Atorvastatin was not available to be administered and had not received since December 2019. -She expected medication to be reordered and administered as ordered. Refer to the interview with a MA on 02/12/20 at 1:43pm. Refer to the interview with the AWD on 02/13/20 at 11:33am.	D 358		

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D 358	Continued From page 74 Refer to the interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm. Refer to a telephone interview with the PCP on 02/13/20 at 12:30pm and 4:27pm. Refer to the interview with the RCC on 02/14/20 at 4:45pm. Refer to the interview with the ED on 02/14/20 at 6:32pm. d. Review of Resident #4's physician's order dated 12/03/19 revealed an order for Vitamin D3 daily. (Vitamin D3 helps your body absorb calcium and phosphorus which is important for building and keeping strong bones). Review of Resident #4's December 2019 Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Vitamin D3 to take one tablet every day with a scheduled administration time of 8:00am. -There was documentation Vitamin D3 was administered at 8:00am on 12/05/19-12/31/19. -There were 27 doses of Vitamin D3 documented as administered out of 27 opportunities. Review of Resident #4's January 2020 eMAR revealed: -There was a computer-generated entry for Vitamin D3 to take one tablet every day with a scheduled administration time of 8:00am. -There was documentation Vitamin D3 was administered at 8:00am on 01/01/20-01/13/20 and 01/15/20-01/31/20. -Vitamin D3 was not documented as	D 358		

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administered on 01/14/20; there was no exception documented.
-There were 30 doses of Vitamin D3 documented as administered out of 31 opportunities.

Review of Resident #4's February 2020 eMAR revealed:
-There was a computer-generated entry for Vitamin D3 to take one tablet every day with a scheduled administration time of 8:00am.
-There was documentation Vitamin D3 was administered at 8:00am on 02/01/20-02/12/20.
-There were 12 doses of Vitamin D3 documented as administered out of 12 opportunities.

Observation of medications on hand on 02/12/20 at 2:39pm revealed:
-There was one blister pack of 30 Vitamin D3 with a dispense date of 12/03/19.
-Three tablets had been administered; there were 27 tablets available to be administered.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 02/13/20 at 8:19am revealed:
-Thirty tablets of Vitamin D3 had been dispensed on 12/03/19 for Resident #4.
-There were no other dispensing records for Vitamin D3 for Resident #4.

Telephone interview with Resident #4's PCP on 02/13/20 at 12:37pm revealed:
-Vitamin D3 was ordered for Resident #4 in response to Vitamin D level being below the therapeutic level.
-He was concerned Resident #4 had not received Vitamin D3 as ordered.
-Resident #4 was at risk of fracture if she had a fall, and her bone density would be affected.
-Vitamin D3 would have improved Resident #4's

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D 358	Continued From page 76 overall energy and alertness. Telephone interview with the Resident Care Coordinator (RCC) on 02/13/20 at 12:56pm revealed: -Resident #4 may have had a supply of Vitamin D3 from home; Resident #4's family could have brought over the counter (OTC) Vitamin D3 to the facility. -Vitamin D3 would not have been re-ordered since there were still tablets available to be administered. -If she thought Vitamin D3 had not been administered she would contact the PCP and have him do lab work to check Resident #4's Vitamin D level. Telephone interview with Resident #4's family member on 02/13/20 at 1:20pm revealed she had not brought any OTC medications or prescription medications into the facility for Resident #4. Interview with a medication aide (MA) on 02/13/20 at 1:43pm revealed: -She had never administered Vitamin D3 to Resident #4 out of a bottle. -She had administered Vitamin D3 to Resident #4 out of the punch card. -She did not know why only three tablets had been administered from the punch card. -If she documented Vitamin D3 had been administered when it had not, it was clicked off by accident. Interview with a second MA on 02/14/20 at 6:12pm revealed: -She did not know why Resident #4's Vitamin D3 punch card that was dispensed on 12/03/19 still had medication available to be administered. -If she documented, she had administered	D 358		

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Vitamin D3 when it was not administered, she may have hit the wrong button.
-She may have gotten Resident #4's Vitamin D3 mixed up with her other vitamins.

Refer to the interview with a MA on 02/12/20 at 1:43pm.

Refer to the interview with the AWD on 02/13/20 at 11:33am.

Refer to the interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm.

Refer to telephone interview with the PCP on 02/13/20 at 12:30pm and 4:27pm.

Refer to interview with the RCC on 02/14/20 at 4:45pm.

Refer to interview with the ED on 02/14/20 at 6:32pm.

4. Review of Resident #5's current hospital FL-2 dated 01/24/20 revealed diagnoses included Alzheimer's disease, left hip fracture, Crohn's disease, and anemia.

a. Review of Resident #5's FL-2 dated 01/24/20 revealed an order for Ferrous Sulfate 325mg daily. (Ferrous Sulfate is used to treat anemia.).

Review of Resident #5's previous FL-2 dated 06/27/19 revealed an order for Ferrous Sulfate 325mg daily.

Review of Resident #5's December 2019 Medication Administration Record (eMAR) revealed:

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D 358	Continued From page 78 -There was a computer-generated entry for Ferrous Sulfate 325mg take one tablet daily with a schedule administration time of 8:00pm. -There was no documentation Ferrous Sulfate was administered at 8:00pm on 12/01/19-12/31/19; there was an exception documented as not on the medication cart and waiting on the pharmacy. Review of Resident #5's January 2020 eMAR revealed: -There was a computer-generated entry for Ferrous Sulfate 325mg take one tablet daily with a schedule administration time of 8:00pm. -There was no documentation Ferrous Sulfate was administered at 8:00pm on 01/01/20-01/31/20; there was an exception documented as hospitalization (5 days) and waiting on the pharmacy. Review of Resident #5's February 2020 eMAR revealed: -There was a computer-generated entry for Ferrous Sulfate 325mg take one tablet daily with a schedule administration time of 8:00pm. -There was no documentation Ferrous Sulfate was administered at 8:00pm on 02/01/20-02/12/20; there was an exception documented as waiting on the pharmacy. Review of Resident #5's pharmacy dispensing records from 11/19-02/12/20 revealed Ferrous Sulfate had not been dispensed. Observation of Resident #5's medication on hand on 02/12/20 at 3:39pm revealed Ferrous Sulfate 325mg was not available to be administered. Review of Resident #5's hospital discharge summary dated 01/24/20 revealed:	D 358		

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-Resident #5 experienced anemia following surgery with a hemoglobin of 6.5 and was transfused with 2 units of PRBCs (packed red blood cells.).
-Resident #5's hemoglobin improved to 10.7.

Review of Resident #5's physician's summary dated 02/10/12 revealed Resident #5 had a history of B12 anemia.

Telephone interview with Resident #5's primary care provider (PCP) on 02/13/20 at 11:36am revealed:
-He ordered Ferrous Sulfate for Resident #5 to treat iron deficiency anemia.
-If Ferrous Sulfate was not administered as ordered Resident #5 was at risk for fatigue, confusion, agitation, difficulty breathing, dizziness, and chest pain.

Interview with the Resident Care Coordinator (RCC) on 02/14/20 at 4:46pm revealed:
-She did not recall anything specifically related to Resident #5's Ferrous Sulfate.
-She did not recall any problems with Resident #5's Ferrous Sulfate on the cart audit.

Attempted interview with Resident #5 on 02/14/20 between 2:00pm-6:30pm was unsuccessful.

Refer to the interview with a MA on 02/12/20 at 1:43pm.

Refer to the interview with the AWD on 02/13/20 at 11:33am.

Refer to the interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm.

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Refer to a telephone interview with the PCP on 02/13/20 at 12:30pm and 4:27pm.

Refer to the interview with the RCC on 02/14/20 at 4:45pm.

Refer to the interview with the ED on 02/14/20 at 6:32pm.

b. Review of Resident #5's physician's order dated 10/21/19 revealed an order to increase Valproic Acid 2.5 ml to 5ml twice daily. (Valproic Acid is used behaviors).

Review of Resident #5's November 2019 Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Valproic Acid 5ml twice daily with a schedule administration time of 8:00am and 8:00pm. There was documentation Valproic Acid 5ml was administered at 8:00am and 8:00pm on 11/01/19-11/30/19.

Review of Resident #5's December 2019 eMAR revealed:
-There was a computer-generated entry for Valproic Acid 5ml twice daily with a scheduled administration time of 8:00am and 8:00pm. There was documentation Valproic Acid 5ml was administered at 8:00am and 8:00pm on 12/01/19-12/11/19 and 12/14/19-12/31/19.
-There was an exception documented on 12/12/19 at 8:00pm and 12/13/19 at 8:00am that the resident refused.

Review of Resident #5's January 2020 eMAR revealed:
-There was a computer-generated entry for Valproic Acid 5ml twice daily with a schedule

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administration time of 8:00am and 8:00pm.
-There was documentation Valproic Acid 5ml was administered at 8:00am and 8:00pm on 01/01/20-01/20/20 and 01/25/20-01/31/20.
-There was an exception documented on 01/20/20-01/24/20 due to resident was in the hospital.

Review of Resident #5's February 2020 eMAR revealed:
-There was a computer-generated entry for Valproic Acid 5ml twice daily with a schedule administration time of 8:00am and 8:00pm.
-There was documentation Valproic Acid 5ml was administered at 8:00am and 8:00pm on 02/01/20-02/12/20.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 02/13/20 at 4:44pm revealed:
-Valproic Acid was dispensed on 09/23/20 for a 30-day supply.
-Valproic Acid was dispensed on 10/22/19 for a 47-day supply.
-There have been no requests to refill Valproic Acid since 10/22/19.

Observation of medication on hand on 02/12/20 at 3:39pm revealed:
-There was a bottle of Valproic Acid with a dispense date of 02/23/19; the bottle was ¾ full.
-There was a second bottle of Valproic Acid with a dispense date of 10/22/19; the bottle was ¾ full.

Review of Resident #5's care notes revealed:
-On 02/03/20, Resident #5 had been "a little aggressive and combative" during routine care.
-On 02/04/20 at 10:46am, Resident #5 was combative with staff during personal care; a second note at 8:52pm documented Resident #5

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was combative during personal care.
-On 02/05/20, the Resident Care Coordinator (RCC) called Resident #5's family member to discuss Resident #5's increased agitation and aggression, including kicking, hitting, digging, biting, and punch staff members.
-On 02/06/20 at 2:12pm, Resident #5 had been a little aggressive and combative.
-On 02/06/20 at 9:08pm, Resident #5 was still being combative with staff.
-On 02/07/20, Resident #5 was combative with staff during her personal care, including kicking at staff.
-On 02/09/20, Resident #5 was up most of the night, very agitated.
-On 02/11/20, Resident #5 was combative toward staff during personal care.

Review of Resident #5's incident reports dated 01/19/20 revealed:
-Resident #5 had an altercation with another resident.
-Resident #5 tried to pull another resident out of her room, the resident pulled her hand away, causing Resident #5 to lose her balance and fall.
-Resident #5 complained of pain in her left hip.
-Resident #5 was sent to the emergency department.

Review of Resident #5's physician's summary dated 01/24/20 revealed Resident #5 had a closed hip fracture and underwent a left hemiarthroplasty.

Review of Resident #5's physician summary on 01/27/20 revealed Haldol was increased due to persistent agitation.

Review of Resident #5's physician's summary on 02/10/20 revealed:

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D 358	Continued From page 83 -Staff reported Resident #5 continued to beat up staff members. -There had been no improvement with an increase in Haldol from 2mg to 4mg twice daily. -He was concerned Resident #5 was over-medicated and possibly suffering from psychomotor agitation secondary to polypharmacy. -He discontinued Resident #5's Sertraline, Donepezil, and Risperidone. Telephone interview with Resident #5's PCP on 02/14/20 at 11:54am revealed: -Valproic Acid was ordered to curtail Resident #5's aggressive behavior. -He was concerned the lack of use would cause persistent aggressive behavior. -It was possible Resident #5's behaviors were as bad as they were because Resident #5 had not received the treatments as ordered for her behavior. Interview with the RCC on 02/14/20 at 4:46pm revealed: -Resident #5 had behavior problems, causing difficulty with her care at times. -She was not aware Resident #5's Valproic Acid had not been administered as ordered. -She did not know why there was Valproic Acid on hand from 09/23/19 and 10/22/19 that should have been used by early December 2019. Attempted interview with Resident #5 on 02/14/20 between 2:00pm-6:30pm was unsuccessful. Refer to the interview with a MA on 02/12/20 at 1:43pm. Refer to the interview with the AWD on 02/13/20 at 11:33am.	D 358		

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D 358	Continued From page 84 Refer to the interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm. Refer to a telephone interview with the PCP on 02/13/20 at 12:30pm and 4:27pm. Refer to the interview with the RCC on 02/14/20 at 4:45pm. Refer to the interview with the ED on 02/14/20 at 6:32pm. c. Review of Resident #5's physician's order dated 01/24/20 revealed an order for a Multivitamin. (Multivitamin is a dietary supplement.). Review of Resident #5's previous FL-2 dated 06/27/19 revealed an order for Multivitamin daily. Review of Resident #5's December 2019 Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Multivitamin take one tablet daily with a scheduled administration time of 8:00pm. -There was no documentation a Multivitamin was administered at 8:00pm on 12/01/19-12/11/19; there was an exception documented as not on the medication cart and waiting on the pharmacy. Review of Resident #5's January 2020 eMAR revealed: -There was a computer-generated entry for Multivitamin take one tablet daily with a scheduled administration time of 8:00pm. -There was no documentation a Multivitamin was administered at 8:00pm on 01/01/20-01/31/20;	D 358		

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there was an exception documented as not on the medication cart, hospitalization (5 days) and waiting on the pharmacy.

Review of Resident #5's February 2020 eMAR revealed:
-There was a computer-generated entry for a Multivitamin take one tablet daily with a scheduled administration time of 8:00pm.
-There was no documentation Multivitamin was administered at 8:00pm on 02/01/20-02/12/20; there was an exception documented as waiting on the pharmacy.

Review of Resident #5's pharmacy dispensing records from 11/ 19-02/12/20 revealed a Multivitamin had not been dispensed.

Observation of Resident #5's medication on hand on 02/12/20 at 3:39pm revealed a Multivitamin was not available to be administered.

Telephone interview with Resident #4's primary care provider (PCP) on 02/13/20 at 11:36am revealed:
-He ordered a Multivitamin for Resident #4 to ensure healthy levels of vitamins and minerals to prevent any number of deficiencies.
-If a Multivitamin was not administered as ordered Resident #5 was at risk for exacerbation of malnutrition.

Interview with the Resident Care Coordinator (RCC) on 02/14/20 at 4:46pm revealed:
-She did not recall anything specifically related to Resident #5's Multivitamin.
-She did not recall any problems with Resident #5's Multivitamin on the cart audit.

Attempted interview with Resident #5 on 02/14/20

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D 358	Continued From page 86 between 2:00pm-6:30pm was unsuccessful. Refer to the interview with a MA on 02/12/20 at 1:43pm. Refer to the interview with the AWD on 02/13/20 at 11:33am. Refer to the interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm. Refer to a telephone interview with the PCP on 02/13/20 at 12:30pm and 4:27pm. Refer to the interview with the RCC on 02/14/20 at 4:45pm. Refer to the interview with the ED on 02/14/20 at 6:32pm. d. Review of Resident #5's physician's order dated 10/30/19 revealed an order for a Vitamin D3 2000u daily. (Vitamin D3 is a dietary supplement used to help your body absorb calcium and phosphorus which is important for building and keeping strong bones.). Review of Resident #5's December 2019 Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Vitamin D3 1000u take two tablets daily with a schedule administration time of 8:00pm. -There was documentation Vitamin D3 2000u was administered at 8:00pm on 12/01/19-12/12/19, 12/13/19-12/24/19, and 12/25/19-12/31/19. -There was an exception documented on 12/12/19 as resident refused and 12/24/19 as	D 358		

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D 358	Continued From page 87 resident out of the facility. Review of Resident #5's January 2020 eMAR revealed: -There was a computer-generated entry for Vitamin D3 1000u take two tablets daily with a schedule administration time of 8:00pm. -There was documentation Vitamin D3 was administered at 8:00pm on 01/01/20-01/09/20, 01/16/20-01/17/20. -There was an exception documented on 01/10/20-01/15/20, 01/18/20-01/31/20, as awaiting on pharmacy and resident in the hospital (5 days). Review of Resident #5's February 2020 eMAR revealed: -There was a computer-generated entry for Vitamin D3 1000u take two tablets daily with a schedule administration time of 8:00pm. -There was no documentation Vitamin D3 was administered at 8:00pm on 02/01/20-02/12/20; there was an exception documented on 02/01/12-02/12/20, as awaiting on pharmacy. Review of Resident #5's pharmacy dispensing records from 11/04/19-02/12/20 revealed Vitamin D3 had not been dispensed. Observation of medication on hand on 02/12/20 at 3:39pm revealed Vitamin D3 was not available to be administered. Review of Resident #5's physician's summary dated 02/10/12 revealed Resident #5 had a history of osteoporosis. Telephone interview with Resident #5's primary care provider (PCP) on 02/13/20 at 11:36am revealed:	D 358		

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D 358	Continued From page 88 -He ordered Vitamin D3 for Resident #5 to treat vitamin D deficiency. -If Vitamin D3 was not administered as ordered Resident #5 was at risk for bone loss, fractures and reduced absorption of calcium. Review of Resident #5's hospital discharge summary dated 01/24/20 revealed Resident #5 had a fall on 01/19/20 and was diagnosed with a closed-hip fracture, resulting in surgery. Attempted interview with Resident #5 on 02/14/20 between 2:00pm-6:30pm was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 02/14/20 at 4:46pm revealed: -She did not recall anything specifically related to Resident #5's Vitamin D3. -She did not recall any problems with Resident #5's Vitamin D3 on the cart audit. Refer to the interview with a MA on 02/12/20 at 1:43pm. Refer to the interview with the AWD on 02/13/20 at 11:33am. Refer to the interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm. Refer to a telephone interview with the PCP on 02/13/20 at 12:30pm and 4:27pm. Refer to the interview with the RCC on 02/14/20 at 4:45pm. Refer to the interview with the ED on 02/14/20 at 6:32pm.	D 358		

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e. Review of Resident #5's physician's order dated 11/18/19 revealed an order for a Vitamin B12. ((Vitamin B12 is a dietary supplement used Vitamin B12 also helps prevent a type of anemia called megaloblastic anemia that makes people tired and weak.).

Review of Resident #5's December 2019 Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Vitamin B-12 1000mcg take one tablet daily with a schedule administration time of 8:00pm.
-There was documentation Vitamin B-12 was administered at 8:00pm on 12/01/19-12/12/19, 12/13/19-12/24/19, and 12/25/19-12/31/19.
-There was an exception documented on 12/12/19 as the resident refused and 12/24/19 as resident out of the facility.

Review of Resident #5's January 2020 eMAR revealed:
-There was a computer-generated entry for Vitamin B-12 1000mcg take one tablet daily with a schedule administration time of 8:00pm.
-There was documentation Vitamin B-12 was administered at 8:00pm on 01/01/20-01/08/20, 01/11/20-01/17/20, 01/24/20-01/28/20, and 01/31/20.
-There was an exception documented on 01/09/20-01/10/20, 01/18/20, 01/20/20-01/24/20, 01/29/20-01/30/20, as awaiting on pharmacy and resident in the hospital (5 days).

Review of Resident #5's February 2020 eMAR revealed:
-There was a computer-generated entry for Vitamin B-12 1000mcg take one tablet daily with a schedule administration time of 8:00pm.
-There was documentation Vitamin B-12 was

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administered at 8:00pm on 02/01/20-02/06/20, and 02/08/20-02/12/20; there was an exception documented on 02/07/20, as awaiting on pharmacy.

Review of Resident #5's pharmacy dispensing records from 11/04/19-02/12/20 revealed:
-There were 30 tablets of Vitamin B-12 was dispensed on 12/26/20.
-There were no other dispensing records for Vitamin B-12.

Observation of medication on hand on 02/12/20 at 3:39pm revealed:
-There was a punch card of Vitamin B-12 with a dispense date of 12/26/20.
-There were 3 of 30 tablets of Vitamin B-12 available to be administered.

Review of Resident #5's physician's summary dated 02/10/12 revealed Resident #5 had a history of B12 anemia.

Telephone interview with Resident #4's primary care provider (PCP) on 02/13/20 at 11:36am revealed:
-He ordered Vitamin B-12 for Resident #4 to treat B-12 anemia.
-If Vitamin B-12 was not administered as ordered Resident #5 was at risk for fatigue, agitation, and exacerbation of cognitive dysfunction.

Attempted interview with Resident #5 on 02/14/20 between 2:00pm-6:30pm was unsuccessful; Resident #5 was sent to the hospital by her PCP.

Interview with the Resident Care Coordinator (RCC) on 02/14/20 at 4:46pm revealed:
-She did not recall anything specifically related to Resident #5's Vitamin B12.

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D 358	Continued From page 91 -She did not recall any problems with Resident #5's Vitamin B12 on the cart audit. Attempted interview with Resident #5 on 02/14/20 between 2:00pm-6:30pm was unsuccessful. Refer to the interview with a MA on 02/12/20 at 1:43pm. Refer to the interview with the AWD on 02/13/20 at 11:33am. Refer to the interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm. Refer to a telephone interview with the PCP on 02/13/20 at 12:30pm and 4:27pm. Refer to the interview with the RCC on 02/14/20 at 4:45pm. Refer to the interview with the ED on 02/14/20 at 6:32pm. f. Review of Resident #5's physician's order dated 01/02/20 revealed an order for Carafate 1gm four times a day, with meals and at bedtime. (Carafate is an antacid used to treat ulcers.). Review of Resident #5's previous FL-2 dated 06/27/19 revealed an order for Carafate 1gm four times daily. Review of Resident #5's November 2019 Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Carafate 1gm take one tablet four times daily with a schedule administration time of 6:00am,	D 358		

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11:00am, 4:00pm, and 8:00pm.
-There was documentation Carafate was administered 113 times out of 120 opportunities from 11/01/19-11/31/19.
-There was an exception documented on 11/04/19 at 12:00pm need refill; there were 3 other exceptions documented as "other."

Review of Resident #5's December 2019 eMAR revealed:
-There was a computer-generated entry for Carafate 1gm take one tablet four times daily with a schedule administration time of 6:00am, 11:00am, 4:00pm, and 8:00pm.
-There was documentation Carafate was administered 123 times out of 124 opportunities from 12/01/19-12/31/19.

Review of Resident #5's January 2020 eMAR revealed:
-There was a computer-generated entry for Carafate 1gm take one tablet four times daily with a schedule administration time of 6:00am, 11:00am, 4:00pm, and 8:00pm.
-There was documentation Carafate was administered 100 times out of 124 opportunities from 01/01/20-01/31/20.

Review of Resident #5's February 2020 eMAR revealed:
-There was a computer-generated entry for Carafate 1gm take one tablet four times daily with a schedule administration time of 6:00am, 11:00am, 4:00pm, and 8:00pm.
-There was documentation Carafate was administered 39 times out of 50 opportunities from 02/01/20-02/13/20.
-There were 10 exceptions documented as hospital 1 dose, 5 refusals, and 1 out of the facility.

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D 358	Continued From page 93 Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/13/20 at 4:44pm revealed: -A refill was requested on 11/19/20; there were 120 tablets dispensed. -A refill was requested on 12/06/19; there were 120 tablets dispensed. -A refill was requested on 12/31/19; there were 120 tablets dispensed. -A refill was requested on 01/27/20; there were 120 tablets dispensed. Observation of Resident #5's medication on hand on 02/12/20 at 3:39pm revealed: -There were 2 punch cards of Carafate 1gm with a dispense date of 12/06/19, each card had 30 tablets dispensed; there were 60 tablets available to be dispensed. -There were 3 punch cards of Carafate 1gm with a dispense date of 12/31/19, each card had 30 tablets dispensed; there were 73 Carafate available to be dispensed. -There were 4 punch cards of Carafate 1gm with a dispense date of 01/27/20, each card had 30 tablets dispensed; there were 120 tablets available to be dispensed. Based on observations and record reviews from 11/11/19-01/27/20, 480 Carafate 1gm was dispensed; Carafate 1gm was documented as administered 475 times and there were 253 Carafate 1gm available to be administered. Review of Resident #5's physician's summary dated 02/03/12 revealed: -Resident #5 had a history of a duodenal ulcer. -Resident #5's duodenal ulcer was being managed with Carafate.	D 358		

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D 358	Continued From page 94 Telephone interview with Resident #5's primary care provider (PCP) on 02/14/20 at 11:36am revealed: -Resident #5 was ordered Carafate to prevent recurrent duodenal ulcerations. -If Carafate was not administered as ordered Resident #5 was at risk for reoccurring ulcers, which would cause abdominal pain, bloating, bleeding, anorexia, nausea, weakness, and fatigue. Interview with the Resident Care Coordinator (RCC) on 02/14/20 at 4:46pm revealed: -She did not recall anything specifically related to Resident #5's Carafate. -She did not recall any problems with Resident #5's Carafate on the cart audit. Attempted interview with Resident #5 on 02/14/20 between 2:00pm-6:30pm was unsuccessful. Refer to the interview with a MA on 02/12/20 at 1:43pm. Refer to the interview with the AWD on 02/13/20 at 11:33am. Refer to the interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm. Refer to a telephone interview with the PCP on 02/13/20 at 12:30pm and 4:27pm. Refer to the interview with the RCC on 02/14/20 at 4:45pm. Refer to the interview with the ED on 02/14/20 at 6:32pm.	D 358		

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D 358	Continued From page 95 g. Review of Resident #5's physician's orders dated 01/24/20 revealed an order for Pentasa 500mg four times daily. (Pentasa is a Nonsteroidal anti-inflammatory drug that is used to treat and prevent flare-ups of ulcerative colitis.). Review of Resident #5's previous FL-2 dated 06/27/19 revealed an order for Pentasa 500mg four times daily. Review of Resident #5's November 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Pentasa 500mg four times daily with a scheduled administration time at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Pentasa 500mg was documented as administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 11/01/19-11/30/19; there were 2 exceptions documented as "other" and "out of facility" on 11/21/19 and 11/28/19. Review of Resident #5's December 2019 eMAR revealed: -There was an entry for Pentasa 500mg daily with a scheduled administration time at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Pentasa 500mg was documented as administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 12/01/19-12/31/19; there were 6 exceptions documented as "refused," "other," and "out of facility" on 12/13/19, 12/20/19, 12/24/19 (3 doses) and 12/25/19. Review of Resident #5's January 2020 eMAR revealed: -There was an entry for Pentasa 500mg daily with a scheduled administration time at 8:00am, 12:00pm, 4:00pm, and 8:00pm.	D 358		

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D 358	Continued From page 96 -Pentasa 500mg was documented as administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 01/01/20-01/19/20 and 01/25/20-01/31/20; there were 19 exceptions documented between 01/20/20-01/24/20 due to Resident #5 being in the hospital. Review of Resident #5's February 2019 eMAR revealed: -There was an entry for Pentasa 500mg daily with a scheduled administration time at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Pentasa 500mg was documented as administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 02/01/20-02/13/20; there were 5 exceptions documented as "refused," "hospital," on 02/01/20, 02/03/20, 02/06/20, 02/11/20, and 02/13/20. Observation of medication on hand on 02/12/20 at 3:39pm revealed: -There was a punch card for Pentasa 500mg that was dispensed on 11/12/19; 30 of 30 tablets were available to be administered. -There were two punch cards for Pentasa 500mg that were dispensed on 12/16/19; 31 of 60 tablets were available to be administered. -There were four-punch cards for Pentasa 500mg that were dispensed on 01/10/20; 120 of 120 tablets were available to be administered. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 02/13/20 at 4:44pm revealed: -Pentasa 500mg had been dispensed on 11/12/19 for 120 tablets. -Pentasa 500mg had been dispensed on 12/16/19 for 120 tablets. -Pentasa 500mg had been dispensed on 01/10/20 for 120 tablets.	D 358		

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Review of Resident #5's physician's summary dated 02/10/12 revealed Resident #5 had a Crohn's disease and was being treated with Pentasa for ulcerative colitis.

Interview with the Resident Care Coordinator (RCC) on 02/14/20 at 4:46pm revealed:
-She did not recall anything specifically related to Resident #5's Pentasa.
-She did not recall any problems with Resident #5's Pentasa on the cart audit.

Attempted interview with Resident #5 on 02/14/20 between 2:00pm-6:30pm was unsuccessful.

Attempted telephone interview with Resident #5's primary care provider (PCP) on 02/14/20 at 3:05pm was unsuccessful.

Refer to the interview with a MA on 02/12/20 at 1:43pm.

Refer to the interview with the AWD on 02/13/20 at 11:33am.

Refer to the interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm.

Refer to a telephone interview with the PCP on 02/13/20 at 12:30pm and 4:27pm.

Refer to the interview with the RCC on 02/14/20 at 4:45pm.

Refer to the interview with the ED on 02/14/20 at 6:32pm.

h. Review of Resident #5's physician's orders

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D 358	Continued From page 98 dated 01/24/20 revealed an order for Budesonide 3mg three times daily. [Budesonide is used to treat Crohn's disease, ulcerative colitis and chronic obstructive pulmonary disease (COPD).]. Review of Resident #5's previous FL-2 dated 06/27/19 revealed an order for Budesonide 3mg three times daily. Review of Resident #5's November 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Budesonide 3mg with a scheduled administration time at 8:00am, 2:00pm and 8:00pm. -Budesonide 3mg was documented as administered at 8:00am, 2:00pm, and 8:00pm from 11/01/19-11/30/19; there were 2 exceptions documented as out of the facility on 11/14/19 and 11/28/19 at 2:00pm. Review of Resident #5's December 2019 eMAR revealed: -There was an entry for Budesonide 3mg with a scheduled administration time at 8:00am, 2:00pm and 8:00pm. -Budesonide 3mg was documented as administered at 8:00am, 2:00pm, and 8:00pm from 12/01/19-12/31/19. Review of Resident #5's January 2020 eMAR revealed: -There was an entry for Budesonide 3mg with a scheduled administration time at 8:00am, 2:00pm and 8:00pm. -Budesonide 3mg was documented as administered at 8:00am, 2:00pm, and 8:00pm from 01/01/20-01/31/20; there were 15 exceptions documented between 01/20/20-01/24/20 due to Resident #5 being in	D 358		

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the hospital, out of the facility, or no reason documented.

Review of Resident #5's February 2019 eMAR revealed:
-There was an entry for Budesonide 3mg with a scheduled administration time at 8:00am, 2:00pm and 8:00pm.
-Budesonide 3mg was documented as administered at 8:00am, 2:00pm, and 8:00pm 02/01/19-02/13/19; there were 2 exceptions documented on 02/01/20 and 02/03/20.

Observation of Resident #5's medication on hand on 02/12/20 at 3:39pm revealed:
-There were two punch cards for Budesonide 3mg that were dispensed on 01/08/20; 55 of 60 tablets were available to be administered.
-There were three punch cards for Budesonide 3mg that were dispensed on 02/03/20; 90 of 90 tablets were available to be administered.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 02/13/20 at 4:44pm revealed:
-Budesonide 3mg had been dispensed on 11/22/19 for 90 tablets.
-Budesonide 3mg had been dispensed on 01/08/20 for 90 tablets.
-Budesonide 3mg had been dispensed on 02/02/20 for 90 tablets.

Telephone interview with Resident #5's primary care provider (PCP) on 02/13/20 at 11:36am revealed:
-Resident #5 was taking Budesonide for COPD.
-If Budesonide was not administered as ordered Resident #5 was at risk for a cough, hypoxia, increased sputum production, respiratory distress, weakness, and fatigue.

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D 358	Continued From page 100 Interview with the Resident Care Coordinator (RCC) on 02/14/20 at 4:46pm revealed: -She did not recall anything specifically related to Resident #5's Budesonide. -She did not recall any problems with Resident #5's Budesonide on the cart audit. Attempted interview with Resident #5 on 02/14/20 between 2:00pm-6:30pm was unsuccessful. Refer to the interview with a MA on 02/12/20 at 1:43pm. Refer to the interview with the AWD on 02/13/20 at 11:33am. Refer to the interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm. Refer to a telephone interview with the PCP on 02/13/20 at 12:30pm and 4:27pm. Refer to the interview with the RCC on 02/14/20 at 4:45pm. Refer to the interview with the ED on 02/14/20 at 6:32pm. 5. Review of Resident #1's current FL-2 dated 09/10/19 revealed diagnoses included dementia, advanced diabetes, degenerative joint disease chronic kidney disease, and hypertension. a. Review of the physician orders for Resident #1 dated 09/16/19 revealed a medication order for Quetiapine (used as an antipsychotic medicine) 25mg- 1 ½ tablets at bedtime.	D 358		

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Review of a subsequent physician's orders for Resident #1 dated 02/10/20 revealed a medication order to discontinue Quetiapine 25mg 1 ½ tablets.

Review of the October 2019 electronic medication administration records (eMARs) for resident #1 revealed:
-There was an entry for Quetiapine 25mg 1 ½ tablets at bedtime scheduled at 9:00pm.
-The was a circle around the staff initials for documenting administration for the Quetiapine from 10/20/19 through 10/31/19.
-There was an "information key" printed on the eMARs but it did not indicate what the circle meant.
-There was four pages of medication notes that directly correlated to the medication aides (MA) initials that had a circle around it.
-There was documentation of "waiting on pharmacy delivery" for 11 doses beginning on 10/20/19 through 10/31/19 at 9:00pm.

Review of the November 2019 eMARs for resident #1 revealed:
- There was an entry for Quetiapine 25mg 1 ½ tablets at bedtime scheduled at 9:00pm.
-There was a circle around the staff initials for documenting administration for the Quetiapine from 11/01/19 through 11/12/19 and from 11/14/19 through 11/30/19.
-The was documentation of "waiting on pharmacy delivery" for 29 doses beginning on 11/01/19 through 11/12/19 and from 11/14/19 through 11/30/19.

Review of the December 2019 eMARs for resident #1 revealed:
12/01/19 through 12/31/19.
-There was documentation of "waiting on

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pharmacy delivery" for 31 doses beginning on 12/01/19 through 12/31/19.

Review of the January 2020 eMARs for Resident #1 revealed:
- There was an entry for Quetiapine 25mg 1 ½ tablets at bedtime scheduled at 9:00pm.
-There was a circle around the staff initials for documenting administration for the Quetiapine from 01/01/20 through 01/31/20.
-There was documentation of "waiting on pharmacy delivery" for 31 doses beginning on 01/01/20 through 01/31/20.

Review of the February 2020 eMARs for Resident #1 revealed:
- There was an entry for Quetiapine 25mg 1 ½ tablets at bedtime scheduled at 9:00pm.
-There was a circle around the staff initials for documenting administration for the Quetiapine from 02/01/20 through 02/03/20 and 02/05/20 through 02/10/20.
-There was documentation of "waiting on pharmacy delivery" for 9 doses beginning on 02/01/20 through 02/03/20 through 02/10/20.

Telephone interview with a Pharmacist on 02/13/20 at 2:24pm from the contracted pharmacy provider for the facility revealed:
-Resident #1 Quetiapine 25mg 1 ½ tablets at bedtime was profiled in the system but had never been requested to be filled by the facility.
-On 09/16/19 the Executive Director (ED) called into the contracted pharmacy and revealed Resident #1's family would bring in the medication.
-He had not received any subsequent calls to fill the prescription for Quetiapine 25mg 1 ½ tablets at bedtime.

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Review of Resident #1's PCP signed visit report dated 12/09/19 revealed:
-The resident's family member was concerned that Resident #1's mood and increased agitation.
-The resident's family was concerned that on the last two visits Resident #1 was increasingly more agitated.

Review of Resident #1's facility progress notes from 12/2019 through 02/2020 revealed Resident #1 had more episodes of increased aggression, combativeness, and agitation.

Interview with Primary Care Provider (PCP) on 02/13/19 at 3:08pm revealed:
-It was imperative for staff to give care as directed so he could treat the residents properly.
-He was not aware that Resident #1 had missed 111 doses of Quetiapine 25mg tablets from October 2019 through February 2020.
-He was concerned the Quetiapine was not being given as ordered and could be a cause for mood and agitation in Resident #1.

Refer to interview with a medication aide on 02/12/20 at 1:43pm

Refer to the interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am.

Refer to the interview with the RCC on 02/14/20 at 4:45pm.

Refer to the interview with the ED on 02/14/20 at 6:32pm

b. Review of the physician orders for Resident #1 dated 11/01/19 revealed a medication order for Mirtazapine (used in treatment for depression) 7.5mg tablet one time a day at bedtime for 7

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days.

Review of a subsequent physician order for Resident #1 dated 11/01/19 revealed a medication order for Mirtazapine 15mg tablet one time a day at bedtime after completion of the 7 days of the Mirtazapine 7.5mg tablet one time a day at bedtime.

Review of the November 2019 electronic medication administration records (eMARs) for Resident #1 revealed:
-There was an entry for Mirtazapine 7.5mg tablet one time a day at bedtime for 7 days scheduled at 9:00pm.
-There were staff initials documenting administration of the Mirtazapine 7.5mg from 11/02/19 through 11/09/19.
-There was an entry for Mirtazapine 15mg tablet one time a day at bedtime scheduled at 9:00pm.
-There was a circle around the staff initials for documenting administration for the Mirtazapine 15mg on 11/12/19, 11/15/19 through 11/19/19, 11/21/19 through 11/27/19, and 11/29/19 through 11/30/19.
-There was an "information key" printed on the eMARs but it did not indicate what the circle meant.
-There was four pages of medication notes that directly correlated to the medication aides (MA) initials that had a circle around it.
-There was documentation of "waiting on pharmacy delivery" for 15 doses beginning on 11/12/19 through 11/30/19 at 9:00pm.

Review of the December 2019 eMARs for Resident #1 revealed:
-There was an entry for Mirtazapine 15mg tablet one time a day at bedtime scheduled at 9:00pm.
-There was a circle around the staff initials for

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documenting administration for the Mirtazapine 15mg on 12/01/19 through 12/20/19 and 12/27/19 through 12/31/19.
-The was three pages of medication notes that directly correlated to the MA initials that had a circle around it.
-There was documentation of "waiting on pharmacy" and "other not on cart" for 25 doses beginning on 12/01/19 through 12/31/19 at 9:00pm.

Review of the January 2020 eMARs for Resident #1 revealed:
-There was an entry for Mirtazapine 15mg tablet one time a day at bedtime scheduled at 9:00pm.
-There was a circle around the staff initials for documenting administration for the Mirtazapine 15mg on 01/01/20 through 01/31/20.
-There were five pages of medication notes that directly correlated to the MA initials that had a circle around it.
-There was documentation of "awaiting pharmacy deliver" and "other not on cart" for 31 doses beginning on 01/01/20 through 01/31/20 at 9:00pm.

Review of the February 2020 eMARs for Resident #1 revealed:
-There was an entry for Mirtazapine 15mg tablet one time a day at bedtime scheduled at 9:00pm.
-There was a circle around the staff initials for documenting administration for the Mirtazapine 15mg on 02/01/20 through 02/03/20 and 02/05/20 through 02/12/20 at 9:00pm.
-There were three pages of medication notes that directly correlated to the MA initials that had a circle around it.
-There was documentation of "awaiting pharmacy deliver" and "other not on cart" for 11 doses beginning on 02/01/20 through 02/12/20.

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Telephone interview with a Pharmacist on 02/13/20 at 2:24pm from the contracted pharmacy provider revealed:
-Resident #1's Mirtazapine 7.5mg tablet at bedtime for 7 days was filled and dispensed to the facility on 11/01/19.
-Resident #1's Mirtazapine 15mg tablet at bedtime was not filled and dispensed to the facility on 02/12/20.

Interview with the Primacy Care Provider (PCP) on 02/13/20 at 3:08pm revealed:
-He expected Resident #1 to get prescribed medication as ordered.
-He expected to be notified when medications were not received by Resident #1 or delivered from the pharmacy.
-It was imperative for staff to give care as directed so he could treat the residents properly.
-He was not aware Resident #1 had missed 82 doses of the Mirtazapine 15mg tablet at bedtime from 11/12/2019 through 02/12/2020.
-Mirtazapine 15mg not being given as prescribed would be the cause of increased episodes of aggression by Resident #1.

Attempted interview with Resident #1 on 02/13/20 at 3:15pm was unsuccessful.

Refer to interview with a medication aide on 02/12/20 at 1:43pm

Refer to the interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am.

Refer to the interview with the RCC on 02/14/20 at 4:45pm.

Refer to the interview with the ED on 02/14/20 at

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D 358	Continued From page 107 6:32pm 6. Review of Resident #2's current FL-2 dated 10/30/19 revealed diagnoses included Alzheimer's disease, essential hypertension, anxiety disorder, major depressive disorder, muscle weakness, anemia, chronic kidney disease, and chronic pain. Review of physician orders for Resident #1 dated 10/30/19 revealed a physician order for Nitroglycerin (used in treatment for chest pain) 0.4mg 1 tablet as needed for chest pain. Review of the December 2019 eMARs for Resident #1 revealed the resident did not receive any Nitroglycerin 0.4mg and it was not needed. Review of the January 2020 eMARs for Resident #1 revealed the resident did not receive any Nitroglycerin 0.4mg and it was not needed. Review of the February 2020 eMARs for Resident #1 revealed the resident did not receive any Nitroglycerin 0.4mg and it was not needed. Interview with a MA on 02/12/20 at 4:03pm revealed she could not find Resident #1's Nitroglycerin on the medication cart. Interview with the RCC on 02/12/20 at 5:49pm revealed: -Resident #1's Nitroglycerin 0.4mg was a medication that the resident had brought with him from his previous facility. -She had performed a cart audit and checked for expired medications on the medication cart on 02/10/20. -She had the found Resident #1's Nitroglycerin and it had expired.	D 358		

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-She sent the expired Nitroglycerin back to the pharmacy on 02/10/20.

Interview with a Pharmacist on 02/13/20 at 2:24pm from the contracted pharmacy provider for the facility revealed:
-The Nitroglycerin 0.4mg was ordered and dispensed on 11/19/19.
-The Pharmacist did not know when the medication would expire, it would be whatever date was on the medication itself.
-The last date the Nitroglycerin 0.4mg was ordered 02/12/20 and delivered to the facility on 02/12/20.
-He did not receive any expired Nitroglycerin 0.4mg from the facility.

Interview with the PCP on 02/13/20 at 10:19am revealed:
-He was not aware that Resident #1 did not have any Nitroglycerin on hand in the facility.
-He expected the facility to have it on hand in the event of acute chest pain with concern of acute coronary syndrome versus myocardial infarction.
-He expected the MA to notify the RCC or the pharmacy about medications that were needed.

Attempted interview with Resident #2 on 02/13/20 at 10:30am was unsuccessful.

Refer to interview with a medication aide on 02/12/20 at 1:43pm

Refer to the interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am.

Refer to the interview with the RCC on 02/14/20 at 4:45pm.

Refer to the interview with the ED on 02/14/20 at

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D 358	Continued From page 109 6:32pm _____ Interview with a medication aide (MA) on 02/12/20 at 1:43pm revealed: -If a medication was not available on the medication cart, she would let the RCC know, document "waiting on pharmacy" and would reorder the medication. -She would use the sticker off the medication card to reorder medication; if the medication card did not have a sticker, she would write the information on a piece of paper and fax it to the pharmacy. -If a resident refused a medication after three attempts, she would destroy the medication and notify the RCC and document the refusal on the residents MAR. -When she clicked on a resident name a list would "pop-up" and time the medication would be administered. -She reordered medications when there were "ten or so left on the card." -There was not a marker on the medication punch card to indicate when to refill a medication. -She would let the RCC know if a medication been ordered but was not available on the 2nd day. -At the end of her medication pass, she made a list of all medications that were not available and gave the list to the RCC. Interview with the Area Wellness Director (AWD) on 02/13/20 at 11:33am revealed: -The RCC audited the medication carts once a month. -The medication card audit included making sure the medication on the cart matched the order on the eMAR. -If a medication was not on the cart, the pharmacy would be notified by the RCC or the	D 358		

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MA.
-The MA was to inform the RCC of any concerns related to medications.
-The PCP was to be notified in 2-3 days if a resident had not received or had refused a medication.
-She did not review the RCC's work.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/20 at 8:19am and 4:04pm revealed:
-The facility was not on a cycle fill.
-The facility staff was supposed to contact the pharmacy to have the medication dispensed to the facility.
-If medication refills were ordered before 2:00pm it would be delivered the same day; medication refills ordered after 2:00pm would be delivered the following day.
-New prescription requests ordered before 5:00pm would be delivered the same day.

Telephone interview with the same PCP for all of the residents on 02/13/20 at 12:30pm and 4:27pm revealed:
-He expected all residents to get prescribed medication as ordered.
-He was concerned medications were not administered as ordered.
-He was concerned medications were not available to be administered.
-He expected to be notified when medications were not received by the residents or delivered from the pharmacy.
-He expected the MA to notify the RCC or the pharmacy about medications that were needed.
-It was imperative for staff to give care as directed so he could treat the residents properly.
-He was concerned he was treating resident issues and was getting zero to little response to

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treatments and had been "scratching his head about it."
-It was "very concerning" to him that residents were not receiving medications he had ordered.

Interview with the RCC on 02/14/20 at 4:45pm revealed:
-She supervised the MA.
-She was available to staff all day and all night.
-She was responsible for making sure the eMAR reflected the current orders.
-The MAs were instructed to request refills from the pharmacy when there were 7 or fewer doses of medication left.
-There had been difficulties with the pharmacy related to getting medication delivered to the facility.
-The MA was supposed to let her know if medication was ordered and was not delivered to the facility.
-She performed medication cart audits every two months.
-She had completed a cart audit on one of the medication carts on 02/10/20 and the other medication cart "about 2 weeks before that."
-The audits included making sure ordered medications were available on the cart.
-If she didn't see a medication on the cart, she ordered it.
-She did not keep a log of the findings of the cart audits.
-The quarterly review by the pharmacist was considered a back-up audit.

Interview with the ED on 02/14/20 at 6:32pm revealed:
-The ED would make sure if orders had been changed.
-She made sure new orders had been approved in the eMAR.

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D 358	Continued From page 112 -Two or three times each week, she made sure order approvals were done. -The pharmacy was responsible for putting medication orders in the eMAR. -She expected to be notified regarding missed medications. -She expected the pharmacy to be notified within 2-3 days of residents missing medication. -She was concerned that the staff was not documenting properly. -She oversaw the RCC's functions. -She had not looked at any exception reports in the eMAR system because she trusted it was being done. _____ The facility failed to ensure medications were administered as ordered for a resident (#5), who was prescribed an anticoagulant after a hip surgery and was at risk for blood and subsequently had 2 emergency department visits for leg swelling; a resident (#6), who had a seizure after not being administered her seizure medication a resident (#4), who missed 8 doses of the blood thinner when her INR level was subtherapeutic and received a dose of the blood thinner when it had been held by the PCP due to a critically high INR level putting the resident at risk for bleeding, and missed 13 doses of Furosemide which increased the resident's edema in her lower legs resulting in the PCP increasing the dosage unnecessarily putting her at risk of electrolyte depletion, dehydration, and acute kidney injury; a resident (#5), who had an increase in her agitation and a fall secondary to an altercation with another resident and was not administered an antipsychotic medication, an iron supplement for a resident (#5) with anemia and a supplement used to support bone health and had a diagnosis of osteoporosis and a fall on	D 358		

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D 358	Continued From page 113 01/19/20, resulting in a closed-hip fracture resulting in surgery; and a resident (#1), who missed 82 doses of a medication used to treat depression and 102 doses of an anti-psychotic, who was having increased agitation. The failure of the facility to assure medications were administered as ordered resulted in serious neglect to the residents (1, 4, 5, and 6), which constitutes a Type A1 Violation _____ The facility provided a Plan of Protection on 02/12/20 in accordance with G. S. 131D-34. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED March 13, 2020.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to infection control measures, health care, and medication aide training. The findings are: 1. Based on observations, interviews and record	D912		

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D912	Continued From page 114 reviews, the facility failed to ensure referrals were made for 2 of 2 sampled residents (#4, #5) who had orders for physical therapy and occupational therapy (#4) and orders for una boots to be applied by a Home Health nurse (#5). [Refer to Tag 273 10A NCAC 13F.0902(c) Referral and Follow-Up (Type A2 Violation)] 2. Based on observations, interviews and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention (CDC) guidelines to assure proper infection control procedures for the use of glucometers for 3 of 3 sampled diabetic residents (#1, #3, and #8) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. [Refer to Tag 932 10A NCAC 13F. G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements) (Type B Violation)] 3. Based on observations, interviews, and record reviews, the facility failed to assure 1 of 2 staff sampled (Staff B) who administered medications had passed the written medication aide exam within 60 days of hire. [Refer to Tag 935 10A NCAC 13F.G.S. 131D 4.5(B)(b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.) (Type B Violation)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

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D914	Continued From page 115 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 1 of 6 residents (#5) observed during the medication pass, including errors with an anticoagulant, a mineral supplement, and a nasal spray, and for 5 of 6 sampled residents who were ordered an anti-seizure and a cholesterol-controlling medication (Resident #6), and an antibiotic, an anticoagulant, a blood pressure medication, a diabetes medication, and a vitamin supplement (Resident #3); a resident who was ordered a blood thinner and a diuretic (#4); and a resident who had an order for an anti-psychotic medication, a medication used to treat ulcers, Crohn's disease and ulcerative colitis, and multiple vitamin supplements; a resident who was ordered an antipsychotic and an anti-depressant (#1); and a resident who had an order for a medication used to treat chest pain (#2). [Refer to Tag 358 10A NCAC 13F.1004(a) Medication Administration (Type A1 Violation)]	D914		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements	D932		

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D932	Continued From page 116 (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.	D932		

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D932	Continued From page 117	D932		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention (CDC) guidelines to assure proper infection control procedures for the use of glucometers for 3 of 3 sampled diabetic residents (#1, #3, and #8) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents.

The findings are:

Review of the Center for Disease Control and Prevention (CDC) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents.

Review of the facility's policy and procedures related to glucometers revealed:
-The policy was to ensure that proper precautions

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D932	Continued From page 118 were taken to avoid spreading contagious diseases and infection through the proper use, storage, and cleaning of glucometers. -Residents were required to have their own individual glucometer. -Glucometers were to be labeled with the resident's name. -Glucometers were not to be shared among residents. Observation of medication cart A on 02/14/20 at 10:57am revealed: -There was one glucometer on the cart. -There was a black fabric pouch with a resident's name on it. -There was a labeled glucometer (Brand A), test strips, a disposable lancet, and alcohol pads in the pouch. Observation of medication cart B on 02/14/20 at 11:52am revealed: -There were three glucometers on the cart. -There was a black fabric pouch with another resident's name on it. -There was a labeled glucometer (Brand B) in the pouch. -There was an unlabeled black fabric pouch. -There was an unlabeled glucometer (Brand C), a lancet pen device, and refill needles in the pouch. -There was an unlabeled glucometer (Brand C) in a drawer. Observation of a glucometer provided by the Resident Care Coordinator (RCC) on 02/14/20 at 1:38pm revealed: -There was a black fabric pouch with a third resident's name on it. -There was a labeled glucometer (Brand A) in the pouch.	D932		

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COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

(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
D932	Continued From page 119 Review of the manufacturer's user manual for Brand A glucometer revealed: -It was recommended the glucometer be used on one patient. -The glucometer was not to be shared. -The glucometer was not meant to be used on more than one resident. -All parts of the glucometer could carry bloodborne diseases after use, even after cleaning and disinfecting. -Contact with blood presented a potential infection risk. -Wash your hands thoroughly with soap and warm water after handling the glucometer, lancing device, or test strips, as contact with blood presents an infection risk. -Clean the glucometer after each use to remove blood or soil and disinfect to destroy infectious agents on the surface of the glucometer after each use. -Wipe meter with a clean, lint-free cloth dampened with 70% isopropyl alcohol. -The name of the recommended germicidal wipe was listed. Review of the manufacturer's user manual for Brand B glucometer revealed: -The glucometer was intended to be used by a single resident and not to be shared. -The glucometer was for one resident use only. -Do not share your meter with anyone. -Do not use on multiple residents. -All parts of the blood glucose monitoring system could carry bloodborne pathogens after use, even after cleaning and disinfecting. -Cleaning and disinfecting the meter destroyed most, but not necessarily all, bloodborne pathogens. -Wash your hands thoroughly with soap and warm water before and after handling the meter,	D932		

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D932	Continued From page 120	D932		

lancing device, lancets, or test strips, as contact with blood presented an infection risk.
-Clean and disinfect immediately after getting any blood on the meter or if the meter was dirty.
-Clean and disinfect the meter at least once a week.
-If the meter was being operated by a second person who provided testing assistance, the meter and lancet device should be disinfected prior to use by the second person.
-The name of the recommended germicidal wipe was listed.

Review of the manufacturer's user manual for Brand C glucometer revealed:
-The glucometer was intended to be used by a single resident and should not be shared.
-All parts of the glucometer were considered biohazardous and could potentially transmit infectious disease from bloodborne pathogens, even after the glucometer had been cleaned and disinfected.
-The meter should never be used by more than one resident due to the risk of infection from bloodborne pathogens.
-Do not use on multiple residents!
-Cleaning and disinfecting the glucometer destroyed most, but not necessarily all, bloodborne pathogens.
-If the meter was being operated by a second person who was providing testing assistance to the user, the glucometer should be cleaned and disinfected prior to use by the second person.
-Disinfect the glucometer before allowing anyone else to handle it.
-Wash hands thoroughly before and after handling the glucometer.
-Disinfecting removed most, but not all disease-causing and other types of bloodborne pathogens from the meter.

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D932	Continued From page 121 -The name of the recommended germicidal wipe was listed. 1. Review of Resident #3's current FL2 dated 02/03/20 revealed diagnoses included dementia, diabetes, shortness of breath on exertion, and high blood pressure. Review of Resident #3's physician orders revealed: -There was an order dated 10/28/19 for fingerstick blood sugar (FSBS) every morning. -There was an order dated 12/30/19 for FSBS on Monday, Wednesday, and Friday at 7:00am, and on Tuesday, Thursday, Saturday, and Sunday at 2:00pm. -There was an order dated 02/03/20 to discontinue the FSBS. Review of the memory for Resident #3's Brand A glucometer revealed there were no readings in the glucometer memory. Review of the memory for the unlabeled Brand C glucometer identified by the medication aide (MA) on 02/14/20 as being used for Resident #3 revealed: -The date on the glucometer was 02/15/20. -The time on the glucometer was 1:12am. -There were six readings recorded in the glucometer memory from 01/17/20-01/26/20. -There were two readings obtained within 31 minutes of each other on 01/17/20. -There were two readings obtained within 22 minutes of each other on 01/22/20. -There were two readings obtained within 2 minutes of each other on 01/26/20. -Three of the readings were documented on Resident #3's January 2020 FSBS log.	D932		

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D932	Continued From page 122 -None of the other three readings was documented on Resident #3's January 2020 FSBS log. Review of Resident #3's FSBS log for November 2019 revealed: -FSBS were scheduled daily at 6:00am. -There were 24 results documented on the log. -The results documented on Resident #3's FSBS log for November 2019 were not in Brand A glucometer's memory or Brand C glucometer's memory. -The FSBS result for Resident #3 documented for 11/10/19 was recorded in the memory of the glucometer indicated to be used on another resident; the other resident's FSBS was not obtained on 11/10/19. Review of Resident #3's FSBS log for December 2019 revealed: -FSBS were scheduled daily at 6:00am. -There were 20 entries documented on the log ranging from 97-215. -The results documented on Resident #3's FSBS log for December 2019 were not recorded in Brand A glucometer's memory or Brand C glucometer's memory. Review of Resident #3's FSBS log for January 2020 revealed: -FSBS were scheduled at 7:00am on Monday, Wednesday, and Friday, and at 2:00pm on Tuesday, Thursday, Saturday, and Sunday. -There were 24 results documented on the log ranging from 127-353. -Three of the FSBS results documented for January 2020 were recorded in Brand C glucometer's memory. -Twenty-one of the FSBS results documented for January 2020 were not recorded in Brand A	D932		

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glucometer's memory or Brand C glucometer's memory.

Based on observations, record reviews and interviews, it was determined Resident #3 was not interviewable.

Interview with a medication aide (MA) on 02/14/20 at 12:00pm revealed she used the unlabeled Brand C glucometer for Resident #3 and another resident.

Interview with another MA on 02/14/20 at 12:50pm revealed she used an unlabeled glucometer on Resident #3 and another resident.

Interviews with the Resident Care Coordinator (RCC) on 02/14/20 at 1:38pm and 3:15pm revealed:
-There was another glucometer (Brand A) that belonged to Resident #3, and was removed from the medication cart when Resident #3's FSBS order was discontinued earlier in the month.
-She was not sure if the memory had been cleared on Resident #3's Brand A glucometer.

Interview with the Executive Director (ED) on 02/14/20 at 6:32pm revealed:
-She did not know Resident #3's glucometer had been changed.
-There were no readings in Resident #3's Brand A glucometer because the memory card had been removed.

Telephone interview with a representative from the manufacturer for Brand A glucometer on 02/21/20 at 9:59am revealed:
-If there were no results in the memory, it meant the glucometer had never been used.
-It was not possible to erase or remove FSBS

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results from the memory system.
-The memory would remain intact even if the battery was dead or removed.

Refer to interviews with a MA on 02/14/20 at 1:58pm and 2:38pm.

Refer to interviews with another MA on 02/14/20 at 12:50pm and 2:36pm.

Refer to interviews with the RCC on 02/14/20 at 1:38pm and 3:15pm.

Refer to interview with the ED on 02/14/20 at 6:32pm.

2. Review of Resident #1's current FL2 dated 09/10/19 revealed diagnoses included advanced dementia, diabetes, and chronic kidney disease.

Review of Resident #1's physician orders revealed an order dated 10/21/19 for fingerstick blood sugar (FSBS) on Monday, Wednesday, and Friday at 7:00am and Tuesday, Thursday, Saturday, and Sunday at 2:00pm.

Observation of a finger stick blood sugar (FSBS) check for Resident #1 on 02/13/20 at 2:05pm revealed:
-The medication aide (MA) cleaned her hands with hand sanitizer that was on the medication cart and put on gloves.
-The MA retrieved a Brand A glucometer from a black fabric pouch with Resident #1's name on it.
-The glucometer was labeled with Resident #1's name.
-The MA went into Resident #1's room and placed a test strip into the glucometer.
-The MA swabbed Resident #1's left middle finger with an alcohol pad and used a disposable lancet

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to obtain a blood sample.
-The MA placed a drop of blood on the test strip that was in the glucometer.
-The result of the FSBS was 182.
-The MA discarded the test strip and lancet into the biohazard container.
-The MA cleaned the glucometer with an alcohol pad and placed it into the pouch.
-The MA discarded the gloves, documented the FSBS results, and returned the glucometer to the drawer.
-The MA cleaned her hands with hand sanitizer.

Review of the memory for Resident #1's Brand A glucometer on 02/14/20 revealed:
-The date on the glucometer reflected the current date of 02/14/20.
-The time on the glucometer reflected 12:21pm.
-There were 24 readings recorded in the memory from 11/03/19-11/30/19.
-There was one reading recorded in the memory from 11/10/19 that was documented on the November 2019 FSBS log for another resident.
-There were three readings obtained within 55 minutes of each other on 11/29/19.
-There were four readings recorded in the memory from 12/11/19-12/17/19.
-None of the four readings in the memory from 12/11/19-12/17/19 was documented on Resident #1's December 2019 FSBS log.
-There was one reading in the memory from 12/17/19 that was documented on the December 2019 FSBS log for another resident.
-There were three readings obtained within 14 minutes of each other on 12/17/19.
-There were no readings recorded in the memory for the month of January 2020.
-There were two readings recorded in the memory from 02/12/20-02/13/20.
-There was one reading recorded in the memory

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D932	Continued From page 126 from 02/12/20-02/13/20 that was not documented on Resident #1's February 2020 FSBS log. Review of Resident #1's FSBS log for November 2019 revealed: -FSBS were scheduled at 7:00am on Monday, Wednesday, and Friday, and at 2:00pm on Tuesday, Thursday, Saturday, and Sunday. -There were seven results documented on the log ranging from 119-200. -For example, Resident #1's blood sugar was 119 on 11/01/19. -There was no reading in Resident #1's Brand A glucometer's memory for 11/01/19. Review of Resident #1's FSBS log for December 2019 revealed: -FSBS were scheduled at 7:00am on Monday, Wednesday, and Friday, and at 2:00pm on Tuesday, Thursday, Saturday, and Sunday. -There were 26 results documented on the log ranging from 118-223. -One entry matched the readings recorded in Resident #1's Brand A glucometer's memory for December 2019. -For example, Resident #1's blood sugar was 210 on 12/24/19. -There was no reading in Resident #1's Brand A glucometer's memory for 12/24/19. Review of Resident #1's FSBS log for January 2020 revealed: -FSBS were scheduled at 7:00am on Monday, Wednesday, and Friday, and at 2:00pm on Tuesday, Thursday, Saturday, and Sunday. -There were 25 results documented on the log ranging from 97-245. -For example, Resident #1's blood sugar was 238 on 01/16/20. -The results documented on Resident #1's FSBS	D932		

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log for January 2020 were not recorded in Brand A glucometer's memory.

Review of Resident #1's FSBS log for February 2020 revealed:
-FSBS were scheduled at 7:00am on Monday, Wednesday, and Friday, and at 2:00pm on Tuesday, Thursday, Saturday, and Sunday.
-There were nine results documented on the log.
-One entry matched the readings recorded in Brand A glucometer's memory for February 2020.
-For example, Resident #1's blood sugar was 186 on 02/11/20.
-There was no reading in Resident #1's Brand A glucometer's memory for 02/11/20.

Based on observations, record reviews and interviews, it was determined Resident #1 was not interviewable.

Refer to interviews with a medication aide (MA) on 02/14/20 at 1:58pm and 2:38pm.

Refer to interviews with another MA on 02/14/20 at 12:50pm and 2:36pm.

Refer to interviews with the Resident Care Coordinator (RCC) on 02/14/20 at 1:38pm and 3:15pm.

Refer to interview with the Executive Director (ED) on 02/14/20 at 6:32pm.

3. Review of Resident #8's current FL2 dated 10/22/19 revealed:
-Diagnoses included dementia with behavioral disturbance, diabetes, and chronic back pain.
-There was an order for fingerstick blood sugar (FSBS) twice a day at 8:00am and 9:00pm.

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D932	Continued From page 128 Review of the memory for the unlabeled Brand C glucometer identified as being used for Resident #8 on 02/14/20 revealed: -The date on the glucometer was 02/15/20. -The time on the glucometer was 1:12am. -There were six readings recorded in the glucometer memory from 01/17/20-01/26/20. -The readings ranged from 101-304. -There were two readings obtained within 31 minutes of each other on 01/17/20. -There were two readings obtained within 22 minutes of each other on 01/22/20. -There were two readings obtained within 2 minutes of each other on 01/26/20 -Three of the readings were recorded on the January 2020 FSBS log of another resident. -None of the readings were documented on Resident #8's FSBS log for January 2020 or February 2020. Review of Resident #8's FSBS log for December 2019 revealed: -FSBS were scheduled twice each day at 9:00am and 9:00pm. -There were eleven results documented on the log ranging from 115-125. -The results documented on Resident #8's FSBS log for December 2019 were not recorded in Brand C glucometer's memory. Review of Resident #8's FSBS log for January 2020 revealed: -FSBS were scheduled twice each day at 9:00am and 9:00pm. -There were five results documented on the log ranging from 120-130. -The results documented on Resident #8's FSBS log for January 2020 were not recorded in Brand C glucometer's memory.	D932		

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D932	Continued From page 129 Review of Resident #8's FSBS log for February 2020 revealed: -FSBS were scheduled twice each day at 9:00am and 9:00pm. -There was one result, 120, documented on the log. -The result documented on Resident #8's FSBS log for February 2020 was not recorded in Brand C glucometer's memory. Interview with a medication aide (MA) on 02/14/20 at 12:00pm revealed she used an unlabeled Brand C glucometer for Resident #8 and another resident. Interview with another MA on 02/14/20 at 12:50pm revealed she used an unlabeled glucometer on Resident #8 and another resident. Refer to interviews with a MA on 02/14/20 at 1:58pm and 2:38pm. Refer to interviews with another MA on 02/14/20 at 12:50pm and 2:36pm. Refer to interviews with the Resident Care Coordinator (RCC) on 02/14/20 at 1:38pm and 3:15pm. Refer to interview with the Executive Director (ED) on 02/14/20 at 6:32pm. _____ Interviews with a MA on 02/14/20 at 1:58pm and 2:38pm revealed: -No one talked to her about not sharing glucometers. -Lancets and insulin pens were not shared among residents. -None of the residents had a bloodborne pathogen disease.	D932		

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D932	Continued From page 130 Interviews with another MA on 02/14/20 at 12:50pm and 2:36pm revealed: -Glucometers were not supposed to be shared. -She did not tell anyone in management there were residents without glucometers. -She did not tell anyone she was sharing glucometers between residents. -She knew she was not supposed to share glucometers. -Lancets and insulin pens were not shared among residents. -None of the residents had a bloodborne pathogen disease. Interviews with the Resident Care Coordinator (RCC) on 02/14/20 at 1:38pm and 3:15pm revealed: -Staff were not sharing glucometers between residents. -Glucometers were not supposed to be shared between residents. -No one had ever talked with her about sharing glucometers between residents. -She never suspected there was any sharing of glucometers between residents. -She had no explanation for the staff sharing glucometers between residents. Interview with the Executive Director (ED) on 02/14/20 at 6:32pm revealed: -Residents who needed glucometers were to have their own device. -She did not want the residents to be placed at risk. -She had no idea glucometers were being shared between residents. _____ The failure of the facility to implement infection control procedures consistent with the Centers for	D932		

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D932	Continued From page 131 Disease Control and Prevention (CDC) guidelines resulted in staff sharing glucometers for 3 of 3 sampled diabetic residents, placing residents at risk for bloodborne pathogen diseases. This failure was detrimental to the health, safety, and welfare of the residents, and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/14/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 30, 2020.	D932		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding	D935		

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D935	Continued From page 132 exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 1 of 2 staff sampled (Staff B) who administered medications had passed the written medication aide exam within 60 days of hire. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a personal care aide on	D935		

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	HAL096049	A. BUILDING: _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D935	Continued From page 133 11/22/18. -Staff B's position changed, and she was hired as a medication aide (MA) on 02/06/19. -Staff B completed the 5-hour training course on 01/24/19. -Staff B completed the 10-hour training course on 01/28/19. -Staff B completed the medication skills checklist on 05/01/19 and 11/07/19. -There was no documentation of Staff B passing the written MA exam (due within 60 days of hire as a MA on 02/06/19). Review of the residents' April 2019- February 2020 electronic medication administrator records (eMARS) revealed: -Staff B documented administration of medications beyond the 60-day timeframe ending on 04/06/19. -Staff B documented administration of medications on 05/17/19, 05/18/19, 05/26/19, and 05/27/19. -Staff B documented administration of medications on 06/05/19, 06/06/19, 06/08/19, 06/09/19. 06/10/19, 06/13/19, 06/14/19, 06/18/19, 06/19/19, 06/21/19, 06/22/19, 06/24/19, 06/27/19, and 06/28/19. -Staff B documented administration of medications on 08/01/19, 08/04/19, 08/05/19, 08/07/19, 08/08/19, 08/10/19, 08/12/19, 08/17/19, 08/18/19, 08/20/19, 08/22/19, 08/24/19, 08/25/19, 08/26/19, and 08/30/19. -Staff B documented administration of medications on 10/05/19, 10/06/19, 10/08/19, 10/14/19, 10/19/19, 10/20/19, 10/24/19, 10/28/19, and 10/30/19. -Staff B documented administration of medications on 12/01/19, 12/03/19, 12/05/19, 12/09/19, 12/10/19, 12/11/19, 12/14/19, 12/15/19, 12/20/19, 12/23/19, 12/27/19, 12/28/19, 12/29/19,	D935		

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D935	Continued From page 134	D935		

and 12/31/19.
Staff B documented administration of medications on 01/03/20, 01/06/20, 01/11/20, 01/12/20, 01/16/20, 01/20/20, 01/22/20, 01/30/20, and 01/31/20.
Staff B documented administration of medications on 02/03/20, 02/06/19, 02/08/20, 02/09/20 and 02/14/20.

Observation of the 7:00am medication pass on 02/13/20 revealed:
-Staff B removed two Klor-Con 20mEq tablets from the medication punch card and placed them in a small plastic cup with Resident #5's other tablets.
-The label on the Klor-Con 20mEq medication punch card read "do not crush."
-Staff B crushed all the tablets, put them in applesauce, and administered them to Resident #5 with a spoon.

Interview with Staff B on 02/13/20 at 7:13am revealed:
-Resident #5 had a hard time swallowing medication.
-Resident #5's medications were regularly crushed.
-She assumed the medication could be crushed.
-She did not read the administration instructions on the label.
-She followed the administration instructions that were in the computer.
-She never noticed the "do not crush" instructions in the computer.

Telephone interview with the primary care provider (PCP) on 02/13/20 at 4:27pm revealed:
-He expected all residents to get prescribed medication as ordered.
-He expected to be notified when medications

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D935	Continued From page 135	D935		

were not received by the residents or delivered from the pharmacy.
-He expected the MA to notify the RCC or the pharmacy about medications that were needed.
-It was imperative for staff to give care as directed so he could treat the residents properly.

Interview with Staff B on 02/14/20 at 10:22am revealed:
-She had been working as a MA at the facility for the about 7 months.
-She did not remember the exact date she had started as a MA.
-She had taken the written MA exam 3 times and she had failed each time.
-She did not remember the dates she had taken the written MA exam.
-She is going to retake the exam again March 2020, she did not know the exact date.
-When she failed the exam the Resident Care Coordinator (RCC) would take her off the medication cart for 3 or 4 days to observe other MA's work on the medication cart.
-After 3 or 4 days she would complete a medication skills checklist with the RCC before
-She had started passing medication alone since September 2019, but she was not sure that was correct date.
-She was training a new MA on 02/14/20 to start working the medication cart.

Interview with the Executive Director (ED) on 02/14/20 at 10:11am revealed:
-Staff B started working on the medication cart February 2019.
-She was aware that Staff B had not passed the written MA exam.
-She was not aware of the rule that MA's must pass the written MA exam within 60 days of hire as a MA.

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D935	Continued From page 136 -Staff B had continued to administer medications even though she had not passed the exam. -She did not know the exact date that Staff B had started to pass medications alone. -She thought that MA's could pass medications 60 days after the MA completed the medication skills checklist. Interview with the RCC on 02/14/20 at 6:17pm revealed: -She supervised the MA. -The ED, the Administrator, and the Area Wellness Coordinator were her supervisors. -She was aware that Staff B had not passed the written MA exam. -She was not aware of the rule that MA's must pass the written MA exam within 60 days of hire as a MA. -Staff B had continued to administer medications even though she had not passed the exam. -She thought that MA's could pass medications 60 days after the MA completed the medication skills checklist. -She completed the medication skills checklist with the MA's. _____ The facility failed to assure 1 of 2 sampled medication aides, who were administering medications to residents in the facility, passed the written medication aide exam in the required timeframe. Staff B was observed during the morning medication pass on 02/13/20 and made 3 errors out of 30 medications administered. The facilities failure to have qualified medication aides administering medications was detrimental to the health, safety, and welfare of the residents, which constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/14/20 for	D935		

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D935	Continued From page 137 this violation. CORRECTION DATE THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 20, 2020.	D935		