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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up and COVID-19 focused Infection Control survey with onsite visits on 09/17/20 and 09/25/20, desk review on 09/17/20 to 09/18/20, 09/21/20 to 09/25/20, 09/28/20 to 09/30/20 and telephone exit on 10/01/20.	{D 000}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure physician's orders were implemented for 1 of 6 sampled residents (Resident #4) related to an order for weekly blood pressures (BP). The findings are: Review of Resident #4's current FL2 dated 02/14/20 revealed diagnoses included diabetes mellitus type II and schizophrenic disorder.	D 276		

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-An order to check the resident's BP weekly.

Review of Resident #4's record revealed there was no documentation of weekly BP checks.

Interview with Resident #3's Primary Care Provider (PCP) on 09/29/20 at 12:05pm revealed:
-She ordered weekly BP checks for Resident #4 because she wanted to monitor the resident's BP.
-She did not know the facility no longer checked Resident #4's BP weekly.
-She did not give an order to discontinue Resident #4's weekly BP checks and she expected facility staff to continue to check the resident's BP weekly.
-When she visited with Resident #4, she checked her BP, but she wanted the BP checked between her visits with the resident.

Interview with a personal care aide (PCA) on 09/29/20 at 1:33pm revealed:
-She checked residents' BP.
-The medication aide made her aware if a resident had BP checks to be done.
-She had not been told to check Resident #4's BP.

Interview with a medication aide (MA) on 09/25/20 at 4:43pm revealed:
-Resident #4's BP had not be checked because it was not documented on the MARs.
-She had worked at the facility since June 2020, and was never made aware Resident #4 had an order to check his BP weekly.

Interview with the Administrator on 10/01/20 at 10:43am revealed:
-When an order for weekly BP was received, the order would be put on the MARs.
-Resident #4's PCP looked at the MARs and

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D 276	Continued From page 2 checked the physician's order sheet, if she wanted Resident #4's BP to be checked weekly she should have made staff aware. -She had worked at the facility since June 2020 and did not know when or if staff obtained Resident #4's BP weekly. Based on observations, record reviews and interviews it was determined Resident #4 was not interviewable.	D 276		
{D 338}	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE A2 VIOLATION The Type A2 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic and practicing recommended infection prevention and control practices to reduce the risk of transmission and infection as related to staff appropriately wearing personal protective	{D 338}		

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{D 338}	Continued From page 3	{D 338}		

equipment (PPE), sanitizing the self-screening kiosk utilized by visitors and staff before and after usage, no signage posted reminding staff how to appropriately wear face coverings, and staff not maintaining a social distance of 6 feet from residents when not appropriately wearing PPE.

The findings are:

Review of the Center for Disease Control (CDC) guideline for the prevention and spread of the Coronavirus (COVID-19) disease in long-term care facilities revealed personnel should always wear a face mask while in the facility.

According to the state of North Carolina Executive Order #147 all workers in Long-Term Care (LTC) Facilities, including adult care homes must wear face coverings while in the facility, and those face coverings must be surgical masks as long as surgical mask supplies are available.

Review of the CDC guidelines for use of facemasks revealed COVID-19 is transmitted through droplet, therefore the mouth and nose are to be completely covered when wearing a facemask to prevent contamination and transmission of COVID-19.

Observation upon entrance to the facility on 09/17/20 at 11:28am revealed:
-The facility had a COVID-19 self-screening kiosk.
-The COVID-19 self-screening kiosk was located at least 20 feet inside the front door of the facility.
-The kiosk contained a wall mounted electronic tablet, hand sanitizer, sanitation wipes, disposable gloves, disposable masks and tissues.
-A visitor who was not wearing a mask entered

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the facility and checked in at the self-screening kiosk located in the hallway, at least 20 feet inside the facility.
-A resident who was not wearing a mask walked past the unmasked visitor as he was self-screening at the kiosk and was unable to socially distance, due to the width of the hallway.
-The visitor was provided a disposable mask by the facility staff.
-The kiosk was not sanitized by staff prior to the visitor using the kiosk nor after the visitor used the kiosk.

Interview with the Business Office Manager (BOM) on 09/27/20 at 11:25am revealed:
-The COVID-19 kiosk was set up for staff and visitors to self screen and sign in to the facility.
-The kiosk was cleaned by staff after each use of the kiosk.

Observation of the hallway on third floor at various times on 09/17/20 between 11:50am and 2:20pm revealed:
-At 11:57am, a housekeeper was standing at the elevator preparing to mop.
-The housekeeper was wearing a cloth face covering that only covered her mouth.
-At, 2:09pm the housekeeper was going into two residents' rooms to clean the room and the residents were present in the rooms and were not wearing a mask.
-The housekeeper had on cloth face covering.
-The cloth face covering had two ear loops and was affixed to the housekeeper's ears, but the cloth face covering was under the housekeeper's chin leaving her mouth and nose uncovered.

Interview with the housekeeper on 09/17/20 at 11:59am revealed:
-She knew her face covering needed to cover her

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nose and mouth when worn.
-Staff had been told they could wear a surgical mask or cloth face covering.
-She preferred to wear her own cloth face covering.
-She usually wore her cloth face covering to cover her nose and mouth when she was in a resident's room cleaning.
-She sometimes pulled her cloth face covering down when she was in the hallways.

Observation of the nurses' desk on the third floor on 09/17/20 at 12:04pm revealed:
-There was a MA seated at the desk and a PCA was standing at the side of the desk and they were less than 6 feet apart.
-Both the MA and the PCA were wearing a cloth face covering.
-The PCA who was standing was wearing her face covering below her nose and mouth and later pulled it up to cover her nose and her mouth.

Interview with the PCA on 09/17/20 at 12:21pm revealed:
-Staff "usually" wore a mask or cloth face covering when interacting with each other and residents.
-She did not have her face covering above her nose and mouth because she had just gotten off break and had been drinking a drink.

Interview with the MA on 09/17/20 at 12:21pm revealed:
-She did not realize the PCA did not have her mask on when she was standing at the desk talking to her.
-The facility gave her cloth face coverings to wear and she was wearing one of them with the facility name on it.
-She was not told she needed to wear a surgical

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mask, but the facility did provide surgical masks if staff wanted them.

Observation of the hallway on the 3rd floor on 09/25/20 at 1:38pm revealed:
-The housekeeper was in the hallway was wearing a cloth face covering below her nose.
-She was coming out of a resident's room, but it was not observed whether the resident was present in the room.

Interview with housekeeper on 09/25/20 at 1:39pm revealed:
-Her cloth face covering kept falling down below her nose, but she liked to wear the cloth face covering better than the surgical mask because the surgical masks broke her face out a little.
-The Administrator told staff that surgical masks were better than cloth face covering, but staff were given the option of wearing either surgical masks or cloth face coverings.
-Surgical facemasks were available for staff upon entrance to the facility at the screening station on the first floor.
-She also had a stack of 20 to 25 surgical facemasks on her cleaning cart.

Observation on of the 4th floor at 09/17/20 at 11:55am revealed:
-There was no signage in the hallway to remind residents to wear masks, cover coughs, practice frequent handwashing or social distancing.
-A staff member who was exiting the elevator, wore a cloth face covering which was down below her nose.

Observation on 09/17/20 at 12:32pm revealed:
-A staff was in the hallway wearing a cloth face covering pulled down below her nose.
-A resident was also in the hallway.

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{D 338}	Continued From page 7 Observation of the facility hallway on 09/17/20 at 1:50pm revealed: -There were 2 staff observed in the hallway. -Both staff wore cloth face coverings. -One staff wore the cloth face covering below her nose. -There were 2 residents in the hallway. Interview with a resident on 09/17/20 at 2:05pm revealed: -Facility staff provided him with a mask when he went outside earlier today to smoke. -He had not been provided a mask by the facility until today. -He did not usually wear a mask inside the facility. -He had not been told to wear a mask inside the facility until today. Interview with the Administrator on 09/17/20 at 4:30pm revealed: -About a month ago, the facility was sent 5,000 cloth face coverings. -The facility staff provided the cloth face coverings to the residents at that time. Observation of 2 staff on the 4th floor on 09/25/20 at 1:30pm revealed: -There were 2 staff wearing cloth face coverings. -One of the staff wore the cloth face covering below the nose. Interview with a housekeeper on 09/25/20 at 1:40pm revealed: -The facility provided the cloth face covering she wore. -She wore the cloth face covering while she worked at the facility. -She washed the cloth face covering at least twice a week, either by hand in the sink or in the	{D 338}		

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{D 338}	Continued From page 8 washing machine. Interview with a Personal Care Aide (PCA) on 09/25/20 at 1:45pm revealed: -The cloth face covering he wore was provided by the facility. -He washed the cloth face covering every night in the washing machine, along with his other laundry. -No one at the facility had advised him to wear the disposable face mask instead of the cloth face covering. Interview with a second staff on 09/25/20 at 1:48pm revealed: -The facility did not provide the cloth face covering she wore. -She bought the face covering herself. -The facility gave her some disposable face masks, but she forgot them today. -Today she wore the cloth face covering she had in her work locker. Interview with a second PCA on 09/25/20 at 4:40pm revealed: -The facility did not provide the cloth face covering she wore. -She bought her face covering herself. -The facility gave her some disposable face masks, but she preferred the designs on the cloth face coverings. Observation of the PCA during the interview at 4:40pm on 09/25/20 revealed: -The PCA wore a cloth face covering. -The face covering kept dropping below her nose as she spoke. -The staff pulled her mask back in to place at least 15 times during the interview, repeatedly touching the outside of the face covering.	{D 338}		

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{D 338}	Continued From page 9 Observation of the PPE supply on the third floor on 09/17/20 at 12:07pm revealed: -There was a 50-count box of facemasks on the counter at the nurses' desk. -There was a 50-count box of facemasks in the storage room along with 16 boxes of gloves, 5 containers of 75-count disinfecting wipes, and 5 gowns. Observation of the facility's PPE storage area on 09/25/20 at 1:58pm revealed there were more than 500 surgical face mask were available. Interview with the Administrator on 09/25/20 at 5:25pm revealed: -She had training with staff last week regarding the appropriate use and wearing of PPE. -She also talked with staff regarding surgical mask. -She had asthma and still wore her surgical mask and if staff had difficulty wearing a facemask they should let her know. Observation of a personal care aide (PCA) on the third floor on 09/25/20 at 2:20pm revealed: -The PCA was observed going into residents rooms with residents present in the room. -The PCA had menu sheets in her hand and was talking with residents obtaining their meal selection. -The PCA was wearing a cloth face covering. -The cloth face covering only covered the top of the PCA's lips, and her nose was uncovered. Interview with the PCA on 09/25/20 at 2:30pm revealed: -She often interacted with residents wearing her cloth face covering. -When interacting with the residents she did not	{D 338}		

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have her nose covered.
-She had asthma and did not pull the cloth face covering over her nose.
-No one at the facility had told her that she needed to cover her nose.
-No one at the facility had said anything to her about going into residents' rooms with her nose uncovered.
-No one at the facility had offered her a surgical face mask.
-She had not told the Administrator that she had asthma and did not cover her nose.

Interview with the Administrator on 09/17/20 at 4:38pm revealed:
-Staff at the facility provided direct care to the residents through personal care services and medication administration.
-The staff were told to wear face coverings.
-She was aware CDC and NC DHHS had made recommendations for staff to wear surgical face mask.
-She considered the recommendation not be a requirement and she elected to allow facility staff to wear their own cloth face coverings.
-In July, 2020 (unable to recall exact date), she had an updated COVID-19 training with facility staff related to the proper way to wear PPE, covering the mouth and nose.
-She did not observe staff to ensure they covered their mouth and nose when wearing face coverings.

Interview with a nurse from the local health department on 09/24/25 at 12:40pm revealed:
-They provided PPE and assistance to long-term care facilities related to keeping residents safe during the pandemic.
-If an assisted living facility staff called for suggestions related to the type of PPE that staff

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{D 338}	Continued From page 11 should wear, then she would tell them to follow the guidelines set by the regulatory agency. -No one at the named facility had contacted their agency inquiring about the type of PPE that staff should be wearing. _____ The facility failed to adhere to the Centers for Disease Control (CDC) and North Carolina Division of Health and Human Services (NC DHHS) guidelines for COVID-19 to include recommendations for use of personal protective equipment (PPE) for staff. The facility's failure to ensure staff wear face masks correctly during the global pandemic of COVID-19, failure to sanitize the self-screening kiosk utilized by visitors and staff before and after each useage and signage posted reminding users to sanitize, staff maintaining a social distance of 6 feet from residents when not appropriately wearing PPE was detrimental to the health, safety and welfare of residents and constitutes a Type B violation. _____ A plan of protection was provided by the facility in accordance with G.S. 131D-37 on September 17, 2020 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 15, 2020.	{D 338}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours	D 344		

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of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medication orders were clarified with the prescribing practitioner for 1 of 6 sampled residents (#6) related to the frequency of a hypertensive medication.

The findings are:

Review of Resident #6's current FL2 dated 02/14/20 revealed there were no diagnoses documented on the FL2:
-There was an order for Entresto 24-26mg twice daily (used to treat elevated blood pressure).

Review of Resident #6's physician's orders revealed:
-A physician' order dated 07/04/20 with a noted correction by the Primary Care Provider (PCP) that Entresto 24-26mg should be one tablet administered once daily.
-An electronically signed order by the PCP dated 07/29/20 for Entresto 24-26mg once daily.
-An electronically signed order by the PCP dated 08/14/20 for Entresto 24-26mg once daily.
-A physician's order dated 08/18/20 for Entresto 24-26mg twice daily.
-An electronically signed order by the PCP dated 08/26/20 for Entresto 24-26mg once daily.

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Review of Resident #6's August 2020 MAR revealed:
-There was an entry for Entresto 24-26mg twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation Entresto 24-26mg administered 56 times from 08/01/20 through 08/31/20.

Review of Resident #6's September 2020 MAR revealed:
-There was an entry for Entresto 24-26mg twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation Entresto 24-26mg was administered 57 times from 09/01/20 through 09/29/20.

Observation on 09/25/20 at 2:50pm of Resident #6's medications on hand at the facility revealed Entresto 24-26mg twice daily was available for administration.

Telephone interview with Resident #6's PCP on 09/29/20 at 12:58pm revealed:
-Resident #6 had a diagnosis of high blood pressure.
-She ordered Entresto 24-26mg once daily to aid in reducing the resident's high blood pressure.
-On the 07/04/20 physician's order, she noticed the order for Entresto 24-26mg was twice daily.
-She changed the order noting the medication should be administered once daily.
-She expected facility staff to notify the pharmacy and ensure Entresto 24-26mg was administered once daily as ordered.
-After each visit at the facility she followed-up with electronically signed orders that listed current medications.
-She expected facility staff to review the

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medication list and if they had questions to clarify the orders with her.
-The facility staff should have contacted her regarding the Entresto prior to administering the medication.
-She did not know the August 2020 physician's order changed Entresto 24-26mg back to twice.
-Prior to her scheduled visit day, she had asked on many occasions that facility staff faxed to her the MARs of residents that she was scheduled to see.
-She wanted the MARs prior to her visit, so that her assistant could review the medications on the MAR with orders in her records to ensure current medications were administered.
-The facility had never complied with her request and faxed the MARs prior to her visit.

Interview with Resident #6 on 09/25/20 at 2:40pm revealed:
-He had heart disease but was unsure about high blood pressure.
-He did not know if he was ordered a medication for high blood pressure.
-He did not know what medications were administered by facility staff.

Interview with a representative from the facility's contracted pharmacy on 09/30/20 at 3:38pm revealed:
-In July 2020, the pharmacy received a notification from Resident #6's PCP that Entresto 24-26mg should be administered once daily.
-The note was not dated, so the pharmacy did not change the medication on the MAR.
-On 08/18/20, the facility faxed a physician's order for Entresto 24-26mg twice daily.
-The pharmacy had no way of knowing the PCP did not want the order for Entresto to be twice daily.

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D 344	Continued From page 15 -If the order for Entresto 24-26mg had been changed to once daily the facility could have administered the medication using what they had on hand, and then changed the MAR to read once daily. -The facility should have clarified the order with Resident #6's PCP prior to faxing the order to the pharmacy. -There were 60 tablets of Entresto 24-26mg dispensed on 09/12/20 with instructions to administer the medication twice daily. -There were 42 tablets dispensed on 08/28/20 with instructions to administer the medication twice daily. Interview with the MA on 09/29/20 at 2:41pm revealed: -Resident #6 had been administered Entresto 24-26mg twice daily for several months. -She did not recall a time when Entresto 24-26mg once daily was administered to Resident #6. -When orders were received, the previous RCD was responsible for faxing orders to the pharmacy. -The previous RCD was also responsible for letting the MA know to add or change a medication on the MAR. -If orders needed to be clarified with the PCP the previous RCD was responsible for contacting the PCP to clarify orders. Interview with the Administrator on 09/25/20 at 2:17pm revealed: -The previous RCD had worked at the facility for barely 90 days. -The previous RCD had been responsible for auditing the medication cart audits. -The previous RCD was supposed to check medications listed on the MARs with current orders to identify discrepancies.	D 344		

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D 344	Continued From page 16 -If the previous RCD found discrepancies, she was to contact the resident's PCP to clarify the orders. -Ultimately, the previous RCD was responsible for ensuring the medication was documented correctly on the MAR. Interview with a Medication Aide (MA) on 09/25/20 at 3:47pm revealed: -The previous RCD had been responsible for ensuring medication orders and changes in medication orders were on the MAR and available for medication administration, but now the Administrator was responsible. -The Administrator was responsible for reviewing the residents' orders and compared them to the Medication Administration Record (MAR). Telephone interview with the previous RCD on 09/29/20 at 3:56pm revealed: -When she worked at the facility, her responsibilities included auditing the MARs and the medication cart. -Most times after a visit the facilty's PCP waited a couple of days, and then would email orders to the Administrator's computer. -The Administrator would print off and review the orders. -Because she was new and still learning the facility's process, after reviewing the orders the Administrator sorted the orders and told her what to do with the orders.	D 344		
{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,	{D 358}		

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{D 358}	Continued From page 17 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: FOLLOW-UP TO A TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Non-compliance continues. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 5 of 6 sampled residents (Residents #1, #3, #4, #5 and #6) including a sleep aide medication, a medication used for mood/sleep disorder, a potassium supplement (#5); an immunomodular agent, an anti-inflammatory, a muscle relaxant, and a pain medication (#1); an anti-hypertensive medication and a laxative (#3); a laxative, a long acting insulin, and a short acting insulin (#6), a topical skin protection cream, a long acting insulin, a short acting insulin and an anti-hypertensive medication (#4). The findings are: Review of the facility's Medication Policy effective 07/17/20 revealed: -Request refills when the bubble card is in the blue area of the card. -Medications should not run completely out so no doses are missed. -Medication aides are to fill out the refill sheet and fax the refill sheet to the pharmacy and document	{D 358}		

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the date and time it was faxed.
-Call the pharmacy to verify they received the fax and document who you spoke to and when they estimate delivery then place in the RCD in box in the med room.
-Staff were to check the medication room for supplies before you assume that there are none.
-All blood sugar testing must be done as ordered and documented on the MAR.
-All blood sugar readings results must be documented on the MAR with initials.
-Insulin given must be documented with the amount and the site you administered.
-Sliding scale must be documented with the reading and units of insulin administered.
-If no insulin administered put a 0 on the MAR with initials.
-The RCD was responsible for ensuring a weekly check of the MARs for accuracy and reporting results to the Executive Director.

1. Review of Resident #1's current FL2 dated 09/15/20 revealed diagnoses included constipation, anemia, elevated white blood cells, Vitamin D deficiency, hypernatremia, hypertension, pain, chronic obstructive pulmonary disease, gastroesophageal reflux disease, kidney failure, tachycardia, and anxiolytic dependence.

Review of Resident #1's rheumatologist office visit summary dated 05/07/2020 revealed:
-Resident #1's primary diagnosis was rheumatoid arthritis involving multiple sites.
-Diagnoses also included multilevel degenerative disc disease, and primary osteoarthritis involving multiple joints.

a. Review of Resident #1's current FL2 dated 09/15/20 revealed an order for hydroxychloroquine 200mg 1 tablet daily (used to

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{D 358}	Continued From page 19 treat rheumatoid arthritis). Review of Resident #1's physician's orders dated 07/04/20 revealed there was no order for hydroxychloroquine. Review of Resident #1's Medication Administration Record (MAR) for August and September 2020 revealed there was no entry for hydroxychloroquine 200mg take 1 tablet daily. Observation of Resident #1's medications on hand on 09/17/20 at 5:57pm revealed: -There was a bubble pack of hydroxychloroquine 200mg 1 tablet daily. -There were 15 tablets of hydroxychloroquine dispensed on 09/03/20 and there were 14 tablets remaining. Resident #1's progress notes were requested on 09/17/20 and 09/21/20, but not provided prior to exit on 10/01/20. Interview with Resident #1 on 09/25/20 at 1:58pm revealed: -She saw her rheumatologist every 3 months for her rheumatoid arthritis. -The rheumatologist told her she needed to continue to take hydroxychloroquine for rheumatoid arthritis. -She thought hydroxychloroquine was administered to her daily. -She experienced pain daily, mainly in her back. Telephone interview with a representative from the pharmacy on 09/18/20 at 10:57am revealed: -There was an active order for hydroxychloroquine 200mg 1 tablet daily. -Hydroxychloroquine had been dispensed to the facility in a quantity of 30 tablets on 05/23/20 and	{D 358}		

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a quantity of 15 tablets on 09/03/20 and was set up as a cycle filled medication on 09/03/20.
-The facility had not requested hydroxychloroquine from the pharmacy between 05/23/20 and 09/03/20.

Interview with a medication aide (MA) on 09/25/20 at 3:27pm revealed:
-Resident #1's hydroxychloroquine was in the medication cart, but it was not on the MAR.
-She did not administer hydroxychloroquine to Resident #1 because it was not on the MAR and she did not know whether she should administer or not.
-She had not asked anyone about whether the medication should have been administered or not.
-She had not contacted Resident #1's rheumatologist or Primary Care Provider (PCP) about whether hydroxychloroquine should have been administered or not.

A second interview with the Medication Aide (MA) on 09/25/20 at 3:47pm revealed:
-The previous RCD had been responsible for ensuring medication orders were on the MAR for medication administration, but now the Administrator was responsible.
-The Administrator was responsible for reviewing the residents' orders and comparing them to the MAR.
-There had been 1 tablet administered, but she did not know which MA administered the tablet or when.

Telephone interview with a nurse from Resident #1's rheumatologist's office on 09/28/20 at 3:59pm revealed:
-Resident #1 was seen by the rheumatologist on 05/07/20 and 08/27/20.

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{D 358}	Continued From page 21 -Resident #1 was prescribed hydroxychloroquine for rheumatoid arthritis. -On 05/07/20 and 08/27/20, the rheumatologist documented Resident #1 was to continue taking hydroxychloroquine 200mg 1 tablet daily. -The rheumatologist was not aware Resident #1 had been administered hydroxychloroquine only once in September 2020. -The rheumatologist expected Resident #1's hydroxychloroquine to be administered as ordered. A second telephone interview with a nurse from Resident #1's rheumatologist's office on 09/29/20 at 2:04pm revealed: -Resident #1 had an order for hydroxychloroquine 200mg 1 tablet daily. -Resident #1's rheumatologist did not know hydroxychloroquine was not being administered as ordered. -If hydroxychloroquine was not administered for rheumatoid arthritis as ordered, her rheumatoid arthritis could flare up and could be harmful causing joint damage as well as organ damage. Telephone interview with the Administrator on 09/30/20 at 1:11pm revealed: -She did not know Resident #1 had hydroxychloroquine in the medication cart with a quantity of 15 tablets dispensed to the facility on 09/03/20 and only 1 tablet had been administered. -She did not know hydroxychloroquine was not on the MAR to document administration. -She expected Resident #1's medications to be administered as ordered by the physician. Refer to interview with the Administrator on 09/25/20 at 2:17pm.	{D 358}		

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{D 358}	Continued From page 22 Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. b. Review of Resident #1's current FL2 dated 09/15/20 revealed an order for Miralax 17 grams in 6 ounces of fluid daily as needed (used to treat constipation). Review of Resident #1's physician's orders dated 07/04/20 revealed an order for Miralax mix 17 grams in 6 ounces of fluid daily as needed (used to treat constipation). Review of Resident #1's Medication Administration Record for August 2020 revealed: -There was an entry for Miralax mix 17 grams in 6 ounces of fluid daily as needed. -Miralax was documented as administered once a day 5 times from 08/20/20 to 08/31/20. -Miralax was documented as administered twice a day 4 times from 08/20/20 to 08/31/20. -Miralax was documented as administered three times a day on 08/26/20. -There was a total of 16 doses documented as administered to Resident #1 from 08/20/20 through 08/31/20 there should have only been up to 11 doses administered. Review of Resident #1's Medication Administration Record for September 2020 revealed: -There was an entry for Miralax mix 17 grams in 6 ounces of fluid daily as needed. -Miralax was documented as administered once a day 10 times from 09/01/20 to 09/17/20. -Miralax was documented as administered twice a day on 09/11/20.	{D 358}		

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{D 358}	Continued From page 23 -There was a total of 12 doses documented as administered to Resident #1 in September 2020. Resident #1's progress notes were requested on 09/17/20 and 09/21/20, but not provided prior to exit on 10/01/20. Observation of Resident #1's medications on hand on 09/17/20 at 5:57pm revealed Miralax was not available for administration. Interview with Resident #1 on 09/25/20 at 1:58pm revealed: -She needed Miralax almost daily due to constipation. -She had a dose of Miralax on the evening of 09/24/20 and on the morning of 09/25/20. -She had not had Miralax for a few weeks prior to the morning of 09/25/20. -She had asked for Miralax daily up until 09/24/20 and was told by Medication Aides (MA) there was no Miralax for her and they could not borrow Miralax from other residents. Telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am revealed: -Resident #1 had an order for Miralax mix 17 grams in 6 ounces of fluid daily as needed. -Miralax was dispensed by the pharmacy for a 30 day supply on 07/25/20, 08/26/20, and 09/19/20. -Staff had to request refills for Miralax. Telephone interview with a MA on 09/30/20 at 2:08pm revealed: -Resident #1 was out of Miralax for a few days in September 2020. -She called the pharmacy, but she did not remember what she was told by the pharmacy. -Resident #1 had asked for Miralax during the	{D 358}		

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time that it was not in the facility.
-Resident #1's order for Miralax was as needed.
-She had administered a second dose of Miralax to Resident #1 in August because she thought "daily as needed" meant that Resident #1 could have Miralax as many times as she needed it when she was constipated.
-Most of the time, Resident #1 was administered Miralax twice a day in the morning and in the evenings because that's when she asked for it.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 09/29/20 at 12:51pm revealed:
-Resident #1 had an order for Miralax 1 scoop daily as needed.
-She did not know there were times when Resident #1 was being administered Miralax more than once daily.
-She expected the facility to let her know if Resident #1 needed Miralax more than once daily.
-"Daily as needed" meant up to 1 time a day.
-There were no outcomes for administration of Miralax more than one time a day.
-She knew the facility was out of Miralax in September because Resident #1 let her know and she contacted the pharmacy herself.
-She expected staff to administer Miralax to Resident #1 as ordered.

Telephone interview with the Administrator on 09/30/20 at 1:11pm revealed:
-She did not know Miralax was not available on the medication cart on 09/17/20.
-She did not know MAs had administered more that 17grams of Miralax daily to Resident #1 in August and September 2020.
-She expected Resident #1's medications to be administered as ordered.

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{D 358}	Continued From page 25 Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. c. Review of Resident #1's current FL2 dated 09/15/20 revealed an order for Humira 40mg/0.4ML inject 1 pen every 14 days (used to treat rheumatoid arthritis). Review of Resident #1's physician's orders dated 07/04/20 revealed there was no order for Humira. Review of Resident #1's rheumatologist office visit summary dated 05/07/2020 revealed: -Resident #1's primary diagnosis was rheumatoid arthritis involving multiple sites. -Diagnoses also included multilevel degenerative disc disease, and primary osteoarthritis involving multiple joints. Review of Resident #1's physician's orders dated 02/18/20 revealed an order for Humira pen injection 40mg/0.4ML inject 1 pen (40 mg dose) under the skin every 14 days. Review of Resident #1's Medication Administration Record (MAR) for August and September 2020 revealed there was no entry for Humira. Review of Home Health (HH) notes for Resident #1 revealed Resident #1 was administered a Humira injection on 07/23/20, 08/07/20, and 09/01/20.	{D 358}		

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{D 358}	Continued From page 26 Resident #1's progress notes were requested on 09/17/20 and 09/21/20, but not provided prior to exit on 10/01/20. Observation of Resident #1's medications on hand on 09/17/20 at 5:57pm revealed Humira was not available for administration. Telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am revealed: -There was an order for Humira 40mg/0.4ML inject 1 pen every 14 days. -The pharmacy dispensed Humira 2 pens at a time on 07/17/20, 08/05/20, and 09/18/20. Interview with Resident #1 on 09/25/20 at 1:58pm revealed: -She was administered Humira every two weeks by a HH nurse for her rheumatoid arthritis. -She thought her last injection was given on 09/18/20. -The HH nurse was at the facility last Wednesday on 09/16/20, to administered Humira, but Humira was not available in the facility. -The HH nurse had to come back on 09/18/20 (she thought) to administer the medication. Interview with a MA on 09/25/20 at 3:47pm revealed: -She did not know Humira was being administered by a HH nurse. -Humira was not on the MAR ans she had never requested a refill from the pharmacy. Telephone interview with the HH nurse on 09/28/20 at 10:38am revealed: -Resident #1 had an order for Humira 40mg/0.4ML inject subcutaneously every 2	{D 358}		

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{D 358}	Continued From page 27 weeks. -Resident #1's order for Humira was written for 2 injections at a time. -When the HH nurse went to administer the second injection, she would take the empty Humira bag with the prescription label to the MA or the previous Resident Care Director (RCD) and ask that they reorder the Humira for the next injection in two weeks. -Sometimes when the HH nurse came out to administer Humira, the medication was not there. -In the last 4 months, there were 2 or 3 times when the medication was not available in the facility when it was needed to administer on the 14th day. -She followed up with the previous RCD or the MA on duty when Humira was not available in the facility. Telephone interview with a nurse from Resident #1's rheumatologist's office on 09/29/20 at 2:04pm revealed: -Resident #1 had an order for Humira 40mg/0.4ML inject 40mg every 14 days. -The rheumatologist did not know Humira had been administered beyond 14 days, but there was no real effect Resident #1 with the medication being administered after the 14th day. -The rheumatologist expected for Humira to be administered as ordered. Telephone interview with Resident #1's Primary Care Provider (PCP) on 09/29/202 at 12:51pm revealed: -Resident #1's Humira was being managed by her rheumatologist, but she was the one who wrote the order for HH to administer the medication. -She did not know Humira was not always available in the facility to administer to Resident	{D 358}		

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{D 358}	Continued From page 28	{D 358}		

#1 every 14 days.
-She did not know who was responsible for making sure Humira was available in the facility.
-She expected for Resident #1's medications to be administered as ordered by the physician.

Telephone interview with Administrator on 09/30/20 at 1:11pm revealed:
-She knew Resident #1 was to be administered Humira every 2 weeks by the HH nurse.
-Resident #1's HH nurse came to her the last time she was in the facility to let her know Humira was not available and needed to be ordered and she made sure Humira was ordered.
-She thought the HH nurse for Resident #1 called the facility to inform when she would be making a visit and the Humira was ordered at that time.
-The previous RCD was responsible for making sure Humira was available in the facility for HH to administer.
-She expected Humira to be available in the facility and administered as ordered by the physician.

Refer to interview with the Administrator on 09/25/20 at 2:17pm.

Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm.

Refer to interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm.

d. Review of Resident #1's current FL2 date 09/15/20 revealed:
-There was an order for tramadol 1 tablet four times daily (used for moderate pain).
-There was no dosage documented.

Review of resident #1's physician's orders dated

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{D 358}	Continued From page 29 08/18/20 revealed an order for tramadol 50mg 1 tablet 4 times daily. Review of Resident #1's physician's orders dated 07/04/20 revealed an order for tramadol 50mg 1 tablet 4 times daily. Review of Resident #1's Medication Administration Record (MAR) for August 2020 revealed: -There was an entry for tramadol 50mg 1 tablet 4 times daily and scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was no documentation tramadol was administered for 8 of 124 opportunities. -Medication aide (MA) initials were documented and circled 8 times from 08/24/20 to 08/30/20 with documentation on the back of the MAR of "waiting on pharmacy," "waiting on pharmacy, contacted," and "called pharmacy, medication should be here tonight." Review of Resident #1's Medication Administration Record (MAR) for September 2020 revealed: -There was an entry for tramadol 50mg 1 tablet 4 times daily and scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was no documentation tramadol was administered for 13 of 66 opportunities. -There was 1 blank space on 09/17/20 at 8:00am with no documentation on the back of the MAR indicating why tramadol was not administered. -MA initials were documented and circled 12 times from 09/05/20 to 09/07/20 with documentation on the back of the MAR of "pharmacy" and "waiting on PCP to sign new order". -There were 9 times when there was no documentation on the back of the MAR indicating	{D 358}		

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{D 358}	Continued From page 30 why tramadol was not administered. Resident #1's progress notes were requested on 09/17/20 and 09/21/20, but not provided prior to exit on 10/01/20. Observation of Resident #1's medications on hand on 09/17/20 at 5:57pm revealed: -Tramadol 50mg 1 tablet 6 hours as needed was available on the medication cart. -Twenty tablets of tramadol were dispensed to the facility on 09/07/20 and there was 1 tablet remaining. Interview with Resident #1 on 09/25/20 at 1:58pm revealed: -She was administered tramadol 4 times a day and she did not have any tramadol as needed. -She was not administered tramadol for about a week in August 2020. -"They told me they were waiting on the pharmacy." -She was administered tramadol for her pain and she had pain daily, mainly in her back. Telephone interview with a representative with the contracted pharmacy on 09/18/20 at 10:57am revealed: -Resident #1 had an order for tramadol 50mg 1 tablet 4 times a day. -There were 120 tablets of tramadol 50mg dispensed to the facility on 07/14/20 and 20 tablets were dispensed to the facility on 08/12/20, 08/13/20, 08/24/20, 08/30/20, and 09/07/20. -There had been an additional 20 tablets of tramadol 50mg dispensed on the facility on 09/07/20 and 09/17/20. -She was not sure why medications were dispensed with a 5-day supply and thought it may have been due to insurance.	{D 358}		

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{D 358}	Continued From page 31 -The facility had to contact the pharmacy to request a refill for tramadol. Interview with a MA on 09/25/20 at 2:25pm revealed: -Resident #1 had an order for tramadol 50mg 1 tablet 4 times a daily. -Resident #1 did not have any as needed orders for tramadol that she was aware of. -She did not pay attention to the label on the medication bubble pack for tramadol, but she administered the medication according to the MAR, 1 tablet 4 times daily. -There was an entry on the MAR for tramadol 50mg 1 tablet 4 times a day, but not for tramadol 50mg every 6 hours as needed. Interview with a second MA on 09/25/20 at 3:27pm revealed: -Resident #1 was administered tramadol 50mg 4 times daily. -Resident #1 had been out of medication for a few days in September 2020. -She did not know why it took 3 days to get the medication in the facility from the pharmacy. -Medications were usually reordered from the pharmacy when medications were administered down to the blue line on the medication bubble pack. -There was about a week of medication left when the medication got down to the blue line. -She was not sure when controlled substances were reordered, because the previous Resident Care Director (RCD) "usually" ordered the controlled substances. -She had not contacted the pharmacy regarding tramadol 50mg. Telephone interview with Resident #1's Primary Care Provider (PCP) on 09/29/20 at 12:51pm	{D 358}		

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{D 358}	Continued From page 32 revealed she expected Resident #1's medications to be administered as ordered. Telephone interview with the Administrator on 09/30/20 at 1:11pm revealed: -She knew Resident #1 had a physician's order for tramadol. -She was made aware Tramadol 50mg 1 tablet 4 times a day had been documented as not administered in September 2020 on 09/25/20. -Tramadol was documented as not administered because it had not been sent out by the pharmacy. -The pharmacy and PCP should have been contacted on the third day the medication was not administered, but the pharmacy sent the medication out to the facility on the third day in September 2020. -The previous RCD was responsible for following up with the pharmacy and the physician. -She expected Resident #1's medication to be administered as ordered by the physician. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. e. Review of Resident #1's current FL2 dated 09/15/20 revealed an order for prednisone 5mg 1 tablet daily (used to treat arthritis). Review of Resident #1's physician's orders dated 08/18/20 revealed an order for prednisone 5mg 1 tablet daily.	{D 358}		

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{D 358}	Continued From page 33 Review of a Refill Authorization Request dated 07/16/20 revealed there was a verbal order taken from Resident #1's Primary Care Provider (PCP) on 07/16/20 for prednisone 5 mg 1 tablet daily with a quantity of 30 tablets and 11 refills. Review of Resident #1's Medication Administration Record (MAR) for August 2020 revealed: -There was an entry for prednisone 5mg 1 tablet daily to be administered at 8:00am. -There was no documentation prednisone 5mg was administered for 4 of 11 opportunities on from 08/20/20 through 08/23/20. -There was documentation prednisone 5mg was administered from 08/24/20 through 08/31/20. -There was documentation on the back of the MAR why prednisone was not administered from 08/20/20 through 08/23/20. Review of Resident #1's MAR for September 2020 revealed: -There was a handwritten entry for prednisone 5mg 1 tablet daily to be administered at 8:00am. -There was documentation prednisone 5mg was administered daily from 09/01/20 through 09/16/2. Resident #1's progress notes were requested on 09/17/20 and 09/21/20, but not provided prior to exit on 10/01/20. Observation of Resident #1's medications on hand on 09/17/20 at 5:57pm revealed: -There were 3 bubble packs of Prednisone 5mg 1 table daily available on the medication cart. -There was a bubble pack of prednisone 5mg dispensed to the facility on 08/14/20 with a quantity of 30 tablets and there were 14 tablets remaining. -There was a second bubble pack of prednisone	{D 358}		

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{D 358}	Continued From page 34 5mg dispensed to the facility on 09/04/20 with a quantity of 15 with 8 tablets remaining. -There was a third bubble pack of prednisone 5mg dispensed to the facility on 09/15/20 with a quantity of 30 and there were 29 tablets remaining. Interview with Resident #1 on 09/25/20 at 1:58pm revealed: -The facility had been out of prednisone in August 2020 and she asked MAs what was going on with the medication. -MAs told her that prednisone was not available in the facility, but they did not tell her why. -She did not think the MAs were currently administering prednisone to her. Telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am revealed: -There was a current order for prednisone 5mg 1 tablet daily dated 07/23/20. -Prednisone 5mg was dispensed to the facility on 07/23/20 with a quantity of 30 tablets. -Prednisone 5mg was dispensed to the facility on 08/14/20 with a quantity of 30 tablets. -Prednisone 5mg was dispensed to the facility on 09/04/20 with a quantity of 15 tablets. -Prednisone 5mg was dispensed to the facility on 09/15/20 with a quantity of 30 tablets -The facility should have had prednisone available in August 2020 because the prednisone was filled on 07/23/20 with 30 tablets and on 08/14/20 with 30 tablets. Interview with a medication aide (MA) on 09/25/20 at 3:47pm revealed: -Resident #1 had an order for prednisone 5mg 1 tablet daily. -She had circled her initials on the MAR in August	{D 358}		

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{D 358}	Continued From page 35 2020 indicating prednisone 5mg had not been administered. -She thought prednisone 5mg had not been available in the facility days because they were waiting on the pharmacy to deliver it. -If a medication was not in the medication cart, MAs were to look in the overstock and if the medication was not in overstock, MAs were to contact the pharmacy to reorder. -She had not contacted the pharmacist, Resident #1's rheumatologist, or her PCP regarding prednisone 5mg. -The previous RCD had been responsible for contacting physician's regarding medications and MAs were responsible for contacting the pharmacy. Telephone interview with a nurse from Resident #1's rheumatologist's office on 09/28/20 at 3:59pm revealed: -Resident #1 was seen by the rheumatologist on 05/07/20 and on 08/27/20. -Resident #1's prednisone was decreased from 10mg to 5mg on 05/07/20. -There were no additional orders for prednisone after 05/07/20. A second telephone interview with a nurse from Resident #1's rheumatologist's office on 09/29/20 at 3:59pm revealed: -There was no documentation in the rheumatologist's notes Resident #1 was on prednisone during the 08/27/20 visit. -After speaking to the rheumatologist, he stated Resident #1 was not on prednisone and did not need to be on prednisone. A third telephone interview with a nurse from Resident #1's rheumatologist's office on 10/01/20 at 11:24am revealed:	{D 358}		

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{D 358}	Continued From page 36 -Resident #1 was not taking prednisone at the time of visit on 08/27/20. -Prednisone was not necessary because Resident #1's rheumatoid arthritis was controlled with her other medications. -Long term use of prednisone could cause issues with bone loss. -If there had not been any other orders for prednisone after 05/07/20. Telephone interview with Resident #1's Primary Care Provider (PCP) on 09/29/20 at 12:03pm. -Resident #1 was on prednisone 5mg 1 tablet daily. -Resident #1's rheumatologist managed her prednisone, but she had refilled the medication. -She was thinking Resident #1's rheumatologist "backed off" of prednisone, but she was not sure. -Sometimes Resident #1 went to her rheumatologist and orders were changed, but not communicated with the facility. -She did not know if the facility contacted the rheumatologist about prednisone. -She did not know Resident #1 did not get her medication from 08/20/20 through 08/23/20 and she did not know medication had been documented as administered from 08/24/20 through 09/16/20. -She expected Resident #1's medication to be administered as ordered. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm.	{D 358}		

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{D 358}	Continued From page 37 2. Review of Resident #5's current FL-2 dated 02/14/20 revealed diagnoses included cardiomyopathy, anxiety disorder, combined systolic and diastolic heart failure and COPD (chronic obstructive pulmonary disease). a. Review of Resident #5's physician orders dated 08/18/20 revealed there was an order for Trazodone 150mg one tablet at bedtime for mood/sleep. Review of Resident #5's mental health progress note dated 08/13/20 revealed: -There was clinical indication for a gradual dose reduction (GDR) of psychiatric medication. -Trazodone 150mg was discontinued. -There was an order to start Trazodone 100mg at bedtime. Review of Resident #5's mental health progress note dated 08/24/20 revealed: -Trazodone 100mg was discontinued. -There was an order to start Trazodone 50mg at bedtime. Review of Resident #5's mental health progress note dated 09/10/20 revealed: -The Trazodone GDR ordered last visit had not been implemented and would be reordered. -There was an order to discontinue Trazodone 100mg and to start Trazodone 50mg. Review of Resident #5's August 2020 medication administration record (MAR) revealed: -There was a printed entry for Trazodone 150mg, one tablet at bedtime for mood/sleep. -The printed entry for Trazadone 150mg was documented as administered from 08/01/20 to 08/13/20 with an undated "DC" hand-written on	{D 358}		

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{D 358}	Continued From page 38 the remainder of the entry. Further review of Resident #5's August 2020 MAR revealed: -There was an undated handwritten entry for Trazodone 100mg at bedtime and was documented as administered 8/21/20, and 08/22/20. -The Trazodone 100mg had a box drawn around the dates from 08/01/20 to 08/14/20 and two large "X"s filled the box. -The Trazodone 100mg had circled initials, indicating not administered, on 08/20/20 and from 08/23/20 to 08/25/20. -The Trazodone 100mg entry was marked as "D/C 8/26". -On 08/20/20 there was documentation the pharmacy was called, and the medication was to arrive that night. -On 08/24/20 there was documentation Trazodone 100mg was not administered due to "waiting on pharmacy". -There was no documentation why Trazodone 100mg was not administered on 08/23/20. -There was no documentation why Trazodone was not administered 08/25/20. Continued review of Resident #5's August 2020 MAR revealed: -There was a handwritten entry for Trazodone 50mg take one at bedtime and was dated 08/26/20. -The Trazodone 50mg had a box drawn around the dates from 08/01/20 to 08/26/20 and three large "X"s filled the box. -There was no documentation Trazodone 50mg was administered on 08/26/20, 08/27/20 and 08/28/20. -The Trazodone 50mg was documented as administered from 08/29/20 to 08/31/20.	{D 358}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 39 Review of Resident #5's September 2020 MAR revealed: -There was a printed entry for Trazodone 100mg, one tablet at bedtime. -The printed entry for Trazodone 100mg was marked as "D/C" on 09/14/20. -Trazodone 100mg was documented as administered on 09/01/20, 09/04/20 and from 09/07/20 to 09/13/29. -There was no documentation Trazodone 100mg was administered on 09/02/20, 09/03/20, 09/05/20, and 09/06/20 with no documentation why Trazodone 100mg was not administered. Continued review of Resident #5's September 2020 MAR further revealed: -There was an undated handwritten entry for Trazodone 50mg at bedtime. -The dates from 09/01/20 to 09/14/20 had a box drawn around them with two large "X"s filling the box. -Trazodone 50mg was documented as administered on 09/15/20 and 09/16/20. -There was no documentation Trazodone 50mg was administered on 09/14/20 with no documentation why Trazodone 50mg was not administered. Observation of medication on hand for Resident #5 on 09/17/20 at 5:57pm revealed: -Trazodone 50mg was dispensed on 08/24/20 with a quantity of 25 tablets. -There were 2 tablets available for administration. Telephone interview with a medication aide (MA) on 09/29/20 at 2:46pm revealed: -A circle around initials on the MAR indicated the medication was not administered. -The reason the medication was not administered	{D 358}		

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{D 358}	Continued From page 40 should be noted on the back of the MAR. -The Resident Care Director (RCD) was responsible to update the MAR with medication changes. -The RCD was responsible to verify the MARs were accurate at the beginning of each month. Telephone interview with a representative from the contracted pharmacy on 09/29/20 at 12:17pm revealed Trazodone 50mg was first dispensed on 08/24/20 with a quantity of 25 tablets. Telephone interview with Resident #5's mental health nurse practitioner on 09/30/20 at 3:01pm revealed: -Gradual dose reductions were recommended for Trazodone instead of just stopping the medication. -Missing the dose for a single day would not have been life threatening and the resident may have felt different. -He was not notified Resident #5 had missed doses from 08/23/20 to 08/28/20. -He struggled to get information from the facility and now reviewed the MAR when he visited the facility to see what medications had been administered. -He did not look at the dosage of Trazodone available in the medication cart. -He thought they may have copied the 100mg dose of Trazodone over to the September MAR instead of the 50mg dose. -Resident #5 not receiving the Trazodone from 08/23/20 to 08/28/30 constituted an abrupt stop of the medication and if he had been aware of it, he would not have restarted the medication. -Outcomes of an abrupt stop of Trazodone may have included withdrawal symptoms including mood and gastric changes.	{D 358}		

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{D 358}	Continued From page 41 Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to the telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. b. Review of Resident #5's mental health progress note dated 08/13/20 revealed there was an order to start Ambien 2.5mg at bedtime. (Ambien is a medication used to treat insomia). Review of Resident #5's mental health progress note dated 08/24/20 revealed Ambien 2.5mg was discontinued and Ambien 5mg at bedtime was started. Review of Resident #5's August 2020 MAR revealed: -There was an undated handwritten entry for Ambien 2.5mg at bedtime. -The dates from 08/01/20 to 08/13/20 had a box drawn around them with a large "X" filling the box. -The entry for Ambien 2.5mg was marked as "D/C 8/26". -Ambien 2.5mg was documented as administered from 08/14/20 to 08/23/20 and on 08/25/20. -The Ambien entry initials were circled indicating not administered on 08/24/20. -On 08/24/20 there was documentation Ambien 2.5mg was not administered due to "waiting on pharmacy". Continued review of Resident #5's August 2020 MAR revealed: -There was a handwritten entry dated 08/26/20 for Ambien 5mg at bedtime.	{D 358}		

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{D 358}	Continued From page 42 -The dates from 08/01/20 to 08/26/20 had a box drawn around them with two large "X"s filling the box. -Ambien 5mg was documented as administered from 08/27/20 to 08/31/20 -There was no documentation Ambien was administered on 08/26/20. Review of the Resident #5's September 2020 MAR revealed: -A printed entry for Zolpidem 5mg (For: Ambien), give one-half tablet daily at bedtime. -Handwritten below the printed order was "give 2 (2.5mg) to =5mg". -The Ambien, which had two conflicting doses after the handwritten entry was added, was documented as administered between 09/01/20 and 09/16/20. Review of the Controlled Substance Count Sheet (CSCS) for Ambien 5mg, partial tablet, dispensed on 08/13/20 revealed: -Thirty doses were received on 08/14/20. -No doses were signed out on 08/24/20 and 08/26/20. -Two tablets (5mg) were signed out on 08/28/20, 09/02/20, 09/03/20, 09/05/20, 09/06/20, and from 09/08/20 to 09/11/20. -A single dose of 2.5mg was signed out on 08/25/20 and 08/29/20. Review of the CSCS for Ambien 5mg, dispensed on 08/24/20, revealed: -Thirty tablets were received on 08/25/20. -Ambien 5mg was signed out on 09/09/20, along with two 2.5mg (5mg) tablets. Observation of medication on hand for Resident #5 on 09/17/20 at 5:57pm revealed: -There was one bubble pack of Ambien 5mg	{D 358}		

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{D 358}	Continued From page 43 dispensed on 08/24/20 with a quantity of 30 tablets. -There were 18 tablets available for administration. Telephone interview with Resident #5's mental health nurse practitioner on 09/30/20 at 3:01pm revealed: -Facility staff did not contact him regarding missed doses of Ambien or a double dose being given. -The Ambien order on the September 2020 MAR had two conflicting entries and was confusing. -He expected staff to clarify any conflicting information with him. -The outcome of Resident #5 getting a lower than the prescribed dose of Ambien could be she did not sleep well at night. -The outcome of Resident #5 getting a double dose of Ambien did not exceed the unsafe limit and she may have been drowsier the next day. -He expected staff to administer medications as ordered. Telephone interview with a representative from the facility's contracted pharmacy on 09/28/20 at 2:30pm revealed: -Ambien 2.5mg was started on 08/13/20 and 30 half-tablets were dispensed on that day. -The order was increased to 5mg on 08/24/20 and thirty 5mg tablets were last dispensed on 08/24/20. -The facility would have had 2.5mg tablets left on hand when the order was increased to 5mg. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm.	{D 358}		

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{D 358}	Continued From page 44 Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. c. Review of Resident #5's physician's order dated 08/18/20 revealed an order for potassium chloride micro tab, 20meq ER (extended release) daily. (Potassium is a medication used to treat low potassium levels). Review of Resident #5's August 2020 medication administration record (MAR) revealed: -The potassium chloride was documented as administered from 08/01/20 to 09/01/20. -Documentation of administration for potassium chloride was handwritten in the margin of the MAR as administered on 09/01/20 after 08/31/20. Review of Resident #5's September 2020 MAR revealed no entry for potassium chloride. Telephone interview with a representative from the facility's contracted pharmacy on 09/30/20 at 3:55pm revealed: -The original order for potassium was a verbal order given by Resident #5's primary care provider (PCP) to the pharmacist on 07/16/20. -The order had eleven refills and they were sent automatically to the facility. -The last dispensed date was 09/10/20 and thirty tablets were dispensed. -She did not have a discontinue order for potassium. -The facility was responsible to print the MAR each month. -The facility could make changes to the MARs and she would not be able to see them. -She did not know why potassium was not on the September 2020 MAR.	{D 358}		

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{D 358}	Continued From page 45 Telephone interview with a medication aide (MA) on 09/29/20 at 2:46pm revealed: -Potassium was not on Resident #5's September 2020 MAR. -Potassium was not in the medication cart. -There was a bubble pack of potassium for Resident #5 in the overstock room. -The dispensed date on the bubble pack was 09/10/20. -The Resident Care Director (RCD) was responsible for updating the MAR. -The RCD was responsible for printing the MARs for the upcoming month. -The RCD was responsible to make sure the new month's MAR was accurate. -The facility did not currently have an RCD. -The Administrator was performing the duties of the RCD. Telephone interview with Resident #5's primary care provider (PCP) on 10/01/20 at 8:30am revealed: -She did not discontinue the potassium. -The RCD was responsible to make sure the MARs were accurate. -Possible outcomes of Resident #5 not receiving potassium could be a low potassium level that could cause heart arrhythmias and weakness. Telephone interview with the Administrator on 09/29/20 at 4:59pm revealed: -The previous Resident Care Director (RCD) was responsible to make sure the MARs were accurate. -The RCD was supposed to sign the bottom of the new months MAR after she reviewed it for accuracy. -The MAR was not signed by the RCD.	{D 358}		

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{D 358}	Continued From page 46 Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. 3. Review of Resident #3's current FL2 dated 02/14/20 revealed diagnoses included abnormalities of gait, osteoporosis, vascular dementia, and hypertension. a. Review of Resident #3's current FL2 dated 02/14/20 revealed a medication order for carvedilol 12.5mg twice daily (used to treat high blood pressure). Review of Resident #3's subsequent physician orders revealed: -An order for carvedilol 12.5mg twice daily dated 07/04/20. -An order for carvedilol 12.5mg twice daily dated 08/18/20. Review of Resident #3's August 2020 Medication Administration Record (MAR) revealed: -There was an entry for carvedilol 12.5mg twice daily, scheduled for 8:00am and 8:00pm. -Carvedilol 12.5mg was documented as administered twice daily from 08/20/20 through 08/25/20. -There was documentation Resident #3 was hospitalized from 08/25/20 through 08/31/20. Review of Resident #3's September 2020 MAR revealed: -There was no entry for carvedilol 12.5mg.	{D 358}		

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{D 358}	Continued From page 47 -There was no documentation carvedilol 12.5mg was administered as ordered for the month of September 2020. -There was documentation Resident #3 was hospitalized from 09/01/20 through 09/03/20. Observation of medication on hand for Resident #3 on 09/17/20 at 4:00pm revealed: -The bubble pack of carvedilol 12.5mg was dispensed on 07/22/20 with a quantity of 60 tablets. -There were 26 tablets available for administration. Telephone interview with a representative from the contracted pharmacy on 09/29/20 at 1:00pm revealed: -The pharmacy had a current order for the carvedilol 12.5mg twice daily dated 08/18/20. -The carvedilol 12.5mg was dispensed with a quantity of 60 tablets on 07/22/20. -The carvedilol 12.5mg was dispensed with a quantity of 60 tablets on 06/17/20. -The pharmacy did not have a discontinue order for the carvedilol 12.5mg. -The facility had not requested a refill for the carvedilol 12.5mg for Resident #3 since the 60 tablets were dispensed on 07/22/20. Telephone interview with Resident #3's primary care provider (PCP) on 09/29/20 at 12:10pm revealed: -Resident #3 had a current order for carvedilol 12.5mg twice daily. -The carvedilol 12.5mg had not been discontinued for Resident #3. -Resident #3 should be receiving carvedilol 12.5mg twice daily. -She had the expectation facility staff administer medication as it was ordered by the provider.	{D 358}		

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{D 358}	Continued From page 48 Interview with a medication aide (MA) on 09/17/20 at 3:40pm revealed: -He did not know why the carvedilol 12.5mg was not on the September MAR. -He did not know if the carvedilol 12.5mg had been discontinued. -The previous Resident Care Director (RCD) was responsible for making changes to medication orders to the MARs. -The previous RCD was responsible for the monthly comparison from the old MARs to the new MARs. -He did not know who was responsible now for making changes to the medication orders on the MARs or for completing the monthly comparison from the old MARs to the new MARs. Interview with Resident #3 on 09/17/20 at 4:00pm revealed: -She did not know what medications she was prescribed. -She depended on the facility to provide medications as ordered by the PCP. Interview with the Administrator on 09/17/20 at 4:30 pm revealed: -The facility printed the MARs on a monthly basis. -The previous RCD was responsible for comparing the old MARs to the newly printed MARs, before the MARs were used by the MAs. -The pharmacy entered the medication orders into the MARs and made any changes as needed to the MARs. -The MARs often had errors and that was one reason the previous RCD had to check the MARs monthly. -She did not know why the carvedilol 12.5mg was not on the September MAR for Resident #3. -The facility was transitioning to a new pharmacy	{D 358}		

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{D 358}	Continued From page 49 on 10/01/20. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. b. Review of Resident #3's current FL2 dated 02/14/20 revealed an order for Senna-S 8.6mg-50mg one tablet daily (used to treat constipation). Review of Resident #3's subsequent physician orders revealed: -An order for Senna-S 8.6mg-50mg one tablet daily dated 07/04/20. -An order for Senna-S 8.6mg-50mg one tablet daily dated 08/18/20. Review of Resident #3's August 2020 Medication Administration Record (MAR) revealed: -There was an entry for Senna-S 8.6mg-50mg one tablet daily scheduled for administration at 8:00am. -Senna-S 8.6mg-50mg was documented as administered from 08/20/20 through 08/24/20. -There was documentation Resident #3 was hospitalized from 08/25/20 through 08/31/20. Review of Resident #3's September 2020 MAR revealed: -There was an entry for Senna-S 8.6mg-50mg one tablet daily scheduled for administration at 8:00am. -There was documentation Resident #3 was	{D 358}		

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hospitalized from 09/01/20 through 09/03/20.
-Senna-S 8.6mg-50mg was documented as administered on 09/04/20.
-There was no documentation of administration of Senna-S 8.6mg-50mg on 09/05/20.
-Senna-S 8.6mg-50mg had circled initials, indicating not administered from 09/06/20 through 09/11/20.
-There was no documentation of administration of Senna-S 8.6 mg-50mg on 09/12/20.
-Senna-S 8.6mg-50mg had circled initials, indicating not administered 09/13/20 and 09/14/20.
-The space for administration documentation for Senna-S 8.6mg-50mg was blank on 09/15/20.
-Senna-S 8.6mg-50mg had circled initials, indicating not administered 09/16/20 and 09/17/20.
-Senna-S 8.6mg-50mg was documented as "waiting on pharmacy" on the back of the MAR on 09/06/20, 09/08/20 and 09/11/20.
-None of the other dates from 09/05/20 through 09/19/20 had documentation to support either the blank space or circled initials.

Observation of Resident #3's medication on hand for on 09/17/20 at 4:00pm revealed there was no Senna-S 8.6mg-50mg available for administration.

Telephone interview with a representative from the contracted pharmacy on 09/29/20 at 1:00pm revealed:
-The pharmacy had an order for Senna-S 8.6mg-50mg daily dated 02/18/20.
-Senna-S 8.6mg-50mg was dispensed on 05/20/20 for a quantity of 30 tablets.
-Senna-S 8.6mg-50mg was dispensed on 06/17/20 for a quantity of 30 tablets.
-The pharmacy had an order for Senna-S

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8.6mg-50mg daily dated 08/18/20.
-The pharmacy received another order for Senna-S 8.6mg-50mg 2 tablets twice daily as needed (prn) on 09/07/20.
-Senna-S 8.6mg-50mg was dispensed on 09/18/20 for a quantity of 120 tablets.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/29/20 at 12:10pm revealed:
-Senna-S 8.6mg-50mg daily was the current order until the order changed to Senna-S 8.6mg-50mg twice daily as needed (prn) on 09/07/20.
-Resident #3 should have received the medication daily, until the order changed on 09/07/20.
-She expected facility staff to administer medication as it was ordered by the provider.

Interview with medication aide (MA) on 09/17/20 at 3:40pm revealed:
-Resident #3 was ordered Senna-S 8.6mg-50mg daily.
-There was no Senna-S 8.6mg-50mg available for administration for Resident #3.
-He had reported that Resident #3 needed Senna-S 8.6mg - 50mg several times to the previous Resident Care Director (RCD).
-He did not know the exact dates he had reported the need for refill for the Senna-S 8.6mg - 50mg to the previous RCD.
-He had been told by the previous RCD that MAs should not contact the pharmacy when refills were needed, that too many requests to the pharmacy could lead to miscommunication.
-The previous RCD was responsible for notifying the pharmacy when refills were needed.
-He did not know who was responsible now for contacting the pharmacy when refills of

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{D 358}	Continued From page 52 medication were needed. Interview with the Administrator on 09/17/20 at 4:30 pm revealed: -The facility printed the MARs on a monthly basis. -The previous Resident Care Director (RCD) was responsible for comparing the old MARs to the newly printed MARs, before the MARs are used by the MAs. -The pharmacy entered the medication orders into the MARs and made any changes as needed to the MARs. -The MARs often had errors, that was one reason the RCD had to check the MARs monthly. -The facility was transitioning to a new pharmacy on 10/01/20. -The facility had begun the process to locate a new RCD. Interview on 09/17/20 at 4:00pm with Resident #3 revealed: -She denied increased constipation. -She did not know what medications she was prescribed by the PCP. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. 4. Review of Resident #6's current FL2 dated 02/14/20 revealed there were no diagnoses listed on the FL2. a. Review of Resident #6's current FL2 dated	{D 358}		

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{D 358}	Continued From page 53 02/14/20 revealed an order for gavilax powder (polyethylene glycol 3350) 17gm in liquid daily (a laxative used to stimulate bowel movements). Review of Resident #6's physician's orders revealed the following medication orders: -An electronically signed order by the Primary Care Provider (PCP) dated 08/14/20 for gavilax powder 17gm in liquid daily. -A physician order sheet dated 08/18/20 for gavilax powder 17gm in liquid daily. -An electronically signed order by the PCP dated 08/26/20 for gavilax powder 17gm in liquid daily. Review of Resident #6's August 2020 MAR revealed: -There was an entry for gavilax powder 17gm in liquid daily was scheduled for administration at 8:00am. -There was documentation gavilax powder 17gm was administered daily 31 times from 08/01/20 through 08/31/20. Review of Resident #6's September 2020 MAR revealed: -There was an entry for gavilax powder 17gm in liquid daily was scheduled for administration at 8:00am. -There was documentation gavilax powder 17gm was administered daily 28 times from 09/01/20 through 09/29/20. Observation of Resident #6's medications on hand at the facility on 09/25/20 at 2:50pm revealed gavilax powder 17gm was not available for administration. Interview with Resident #6 on 09/25/20 at 2:40pm revealed: -He was administered medications daily, but he	{D 358}		

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did not know the names of the medications administered.
-He did not recall getting a medication that was a liquid or a medication that resembled water.

Telephone interview with a representative from the facility's contracted pharmacy on 09/30/20 at 3:38pm revealed:
-The pharmacy had a current order dated 08/18/20 for gavilax powder 17gm once daily.
-The gavilax powder was not automatically refilled and only dispensed when facility staff called to request a refill.
-The last time gavilax powder was requested to be refilled was on 06/11/20, and a 30-day supply was dispensed.
-There were no problems that prevented dispensing the gavilax powder, facility staff just needed to call and request the medication.
-As of today's, date (09/30/20), no one at the facility had called to request a refill of gavilax powder since 06/11/20.

Telephone interview with a first shift medication aide (MA) on 09/30/20 at 4:16pm revealed:
-Resident #6 had not been administered gavilax powder in months.
-She knew the medication was on the MAR, but not available for administration.
-When a medication needed to be refilled, she could order the medication herself or complete a refill request form for the RCD to refill the medication.
-She did not recall if she had completed a refill request for Resident #6's gavilax powder.
-She was also unable to recall if she had requested the medication to be refilled.
-The facility's policy was that if a medication was not available for administration the next day following a refill request, she had to contact the

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pharmacy.
-If the medication was unavailable the second day she was to inform the RCD.
-If the medication was unavailable the third day the RCD was to let the Administrator know.
-There should be documentation on the MAR or in Resident #6's record why the gavilax powder was not available.
-She was unable to recall the last time Resident #6 was administered gavilax powder.
-She had not documentation that she had followed the facility's protocol and notified the RCD that Resident #6's gavilax powder needed to be refilled.

Telephone interview with Resident #6's PCP on 10/01/20 at 8:29am revealed:
-She did not know Resident #6 was not administered gavilax powder daily.
-Gavilax powder was ordered because Resident #6 currently had orders for psychotropic medications that sometimes caused constipation.
-The facility staff should not stop a medication without consulting her first.
-If a medication was not available the facility staff should let her know, then she could determine if the resident needed the medication or switch to another medication.

Refer to interview with the Administrator on 09/25/20 at 2:17pm.

Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm.

Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm.

b. Resident of Resident #6's current FL2 dated

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{D 358}	Continued From page 56 02/14/20 revealed an order for Lantus 24 units subcutaneously at bedtime (a long acting insulin used to treat elevated blood sugar values). Review of Resident #6's a physician's order sheet dated and signed by the PCP on 08/18/20 with orders for Lantus 30 units subcutaneously twice daily at 6:30am and 4:30pm. Review of Resident #6's August 2020 Medication Administration Record (MAR) revealed: -There was an entry for Lantus insulin inject 30 units twice daily scheduled for administration at 8:00am and 8:00pm from 08/20/20 through 08/31/20. -Lantus insulin was not documented as administered on 4 of 22 opportunities at 8:00am on 08/22/20, and 08/31/20; and at 8:00pm on 08/25/20 and 08/26/20 with no explanation for why the medication was not administered. Review of Resident #6's September 2020 MAR revealed: -There was an entry for Lantus insulin inject 30 units twice daily scheduled for administration at 6:30am and 4:30pm from 09/01/20 through 09/15/20. -Lantus insulin inject 30 units was not documented as administered on 6 of 31 opportunities from 09/01/20 to 09/16/20 with no explanation for why the medication was not administered. -There was documentation Resident #6 refused Lantus 12 times at 6:30am from 09/04/20 to 09/16/20. -There was an entry for Lantus insulin inject 36 units twice daily scheduled for administration at 9:00am and 9:00pm from 09/16/20 through 09/29/20. -Lantus insulin was not documented as	{D 358}		

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administered on 3 of 26 opportunities at 9:00am on 09/26/20; and at 9:00pm on 09/16/20 and 09/29/20.
-There was documentation Resident #6 refused Lantus 36 units 3 times from 09/16/20 through 09/29/20.

Observation of Resident #6's medication on hand at the facility on 09/25/20 at 2:50pm revealed Lantus was available for administration.

Telephone interview with a first shift medication aide (MA) on 09/29/20 at 2:41pm revealed:
-Resident #6 had many changes with his Lantus insulin.
-The Lantus was ordered to be administered twice daily.
-The previous RCD was supposed to review the MARs to identify holes in the MAR or medications not administered.
-If Lantus was not administered there should be documentation on the MAR why the medication was not administered.
-If there was no documentation why Lantus was not administered, then there was no way to verify the medication was administered.

Telephone interview with a second shift MA on 09/29/20 at 09/29/20 at 4:59pm revealed:
-When she administered Resident #6's Lantus, she was to document on the MAR showing the medication had been administered.
-If the MAs worked they looked for holes on the MAR from the previous MA, they were supposed to leave a note and make the MA aware.
-The MA was supposed to follow-up and documented why the medication was not administered.
-If she did not document on the MAR, it was possible the medication was not administered.

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{D 358}	Continued From page 58 -The facility's system, when medications were not administered was to circle her initials, and then document on the back of the MAR why the medication was not administered. Telephone interview with the Primary Care Provider (PCP) on 09/29/20 at 12:05pm revealed: -Resident #6 had uncontrolled diabetes. -She ordered Lantus twice daily to help control the resident's high blood sugar levels. -She expected facility staff to administer Resident #6's medications as ordered. -She expected to be informed if a resident was not getting medications as ordered. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. c. Review of Resident #6's current FL2 dated 02/14/20 revealed an order for Finger Stick Blood Sugar (FSBS) before meals and Novolog (fast acting insulin used to treat elevated blood sugar values) 20 units for FSBS over 250 and an additional 10 units for FSBS over 450. Review of Resident #6's physician's orders revealed a physician's order sheet signed and dated 08/18/20 by the Primary Care Provider (PCP) with an order for Novolog 14 units for FSBS over 250 and an additional 10 units for FSBS over 450 for a total of 24 units. Review of Resident #6's August 2020 MAR	{D 358}		

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{D 358}	Continued From page 59 revealed: -There was an entry for Novolog insulin inject 14 units subcutaneously for FSBS over 250 and additional 10 units for FSBS over 450 for a total of 24 units. -Novolog insulin was not documented as administered on 3 of 13 opportunities from 08/20/20 to 08/31/20. -Novolog insulin was not documented as administered 3 times at 7:30am on 08/23/20 and at 11:30am on 08/20, and at 4:30pm on 08/31/20 with no explanation for why the medication was not administered. -Resident #6's FSBS ranged between 140 to 454 from 08/20/20 through 08/31/20. Review of Resident #6's September 2020 MAR revealed: -There was an entry for Novolog insulin inject 14 units subcutaneously for FSBS over 250 and additional 10 units for FSBS over 450 for a total of 24 units. -Novolog insulin was not documented as administered on 13 of 39 opportunities from 09/01/20 through 09/29/20 with no explanation for why the medication was not administered. -Lantus was documented as administered instead of Novolog for 2 opportunities as follows: -On 09/22/20 at 4:30pm, FSBS was 310 and Lantus 14 units was documented as administered, but Novolog 14 units should have been administered. -On 09/25/20 at 4:30pm, FSBS 331 and Lantus 14 units was documented as administered, but Novolog 14 units should have been administered. -There was documentation Resident #6 refused Novolog 11 times from 09/01/20 to 09/29/20. -Resident #6's FSBS ranged between 168 to 501 from 09/01/20 to 09/29/20.	{D 358}		

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{D 358}	Continued From page 60 Interview with Resident #6 on 09/25/20 at 2:40pm revealed: -Some days facility staff checked his FSBS twice daily. -Depending on the staff working, some days his FSBS was not checked at all. -Sometimes staff administered insulin after they checked his FSBS, but he did not know the name of the insulin or how much insulin was administered. Telephone interview with a MA on at 09/29/20 at 4:59pm revealed: -When she administered Resident #6's Novolog, she was to document on the MAR showing the medication had been administered. -She worked on 09/11/20 but could not recall if she administered Resident #6's Novolog or not. -If she did not administer the medication as ordered she was supposed to circle her initials and document why the medication was not administered. -She did not know what happen and why she did not document. -Without documentation she could not be certain that she administered the medication. Telephone interview with Resident #6's Primary Care Provider on 09/29/20 at 12:05pm revealed: -Resident #6 had uncontrolled diabetes and she ordered a Novolog as needed (PRN). -Resident #6 should be administered 14 units of Novolog for FSBS over 250 and additional 10 units for FSBS over 450. -She expected facility staff to administer Resident #6's Novolog PRN as needed based on the FSBS results. -She expected facility staff to inform her if a resident did not get medications as ordered.	{D 358}		

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{D 358}	Continued From page 61 Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. 5. Review of Resident #4's current FL2 dated 02/14/20 revealed diagnoses included type II diabetes mellitus and schizophrenic disorder. a. Review of Resident #4's current FL2 dated 02/14/20 revealed calazime skin protect cream was not on the FL2. Review of Resident #4's physician's orders revealed: -A physician's order sheet dated 08/18/20 with an order for calazime skin protect cream - apply topically to buttocks twice daily (a topical skin protection cream). -An order dated 09/07/20 for calazime paste apply to buttocks twice daily. Review of Resident #4's August 2020 MAR record revealed: -There was an entry for calazime skin protect cream - apply topically to buttocks twice daily for diaper dermatitis scheduled for 7:00am to 3:00pm and 3:00pm to 11:00pm. -Calazime skin protection cream was not applied 8 of 22 opportunities from 08/20/20 to 08/31/20 with no explanation why the medication was not applied. -There was documentation Resident #6 refused calazime paste 11 times from 08/20/20 to 08/31/20.	{D 358}		

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{D 358}	Continued From page 62 Review of Resident #4's September 2020 MAR record revealed: -There was an entry for calazime skin protect cream - apply topically to buttocks twice daily for diaper dermatitis scheduled for 7:00am to 3:00pm and 3:00pm to 11:00pm. -Calazime skin protection cream was not applied 24 of 34 opportunities from 09/01/20 to 09/17/20 with no explanation why the medication was not applied. -There was documentation Resident #6 refused calazime paste 10 times from 09/01/20 to 09/17/20. Observation of Resident #4's medications on hand on 09/17/20 at 4:50pm revealed there were four containers of calazime protect cream available for application. Telephone interview with Resident #4's PCP on 09/29/20 at 12:05pm revealed: -Resident #4 was semi-ambulatory and used a wheelchair to get around. -Resident #4 sat most of the day in her wheelchair and was often saturated. -The moisture caused redness and skin break down on the resident's buttocks. -She ordered the barrier cream to help protect Resident #4's buttocks and prevent skin breakdown. -The calazime was ordered twice daily, some refusals were okay, but if the medication was not applied several days in a row she wanted to be notified. -Facility staff should not stop applying the medication without first talking with her. Telephone interview with a MA on 09/29/20 at 4:59pm revealed:	{D 358}		

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{D 358}	Continued From page 63 -The barrier cream was not applied to Resident #4. -She thought the cream was discontinued. -She was unable to recall the last time calazime was applied to Resident #4's buttocks. Based on observation interviews and records reviews it was determined that Resident #4 was not interviewable. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. b. Review of Resident #4's current FL2 dated 02/14/20 revealed an order for Lantus 44 units twice daily (a long acting insulin used to treat elevated blood sugar values). Review of physician's orders in Resident #4's record revealed: -An order dated 08/18/20 for Lantus 28 units subcutaneously at 6:30am and 6:30pm. -An order dated 09/01/20 for Lantus 30 units subcutaneously twice daily. -An order dated 09/07/20 for Lantus 30 units twice daily. Review of Resident #4's August 2020 Medication Administration Record (MAR) revealed: -There was an entry for Lantus insulin inject 28 units twice daily scheduled for administration at 6:30am and 6:30pm. -Lantus insulin was not documented as	{D 358}		

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{D 358}	Continued From page 64 administered 3 of 22 opportunities from 08/20/20 through 08/31/20 with no explanation for why the medication was not administered. Review of Resident #4's September 2020 MAR revealed: -There was an entry for Lantus insulin inject 28 units twice daily scheduled for administration at 6:30am and 6:30pm. -Lantus insulin 28 units were not documented as administered for 3 of 6 opportunities 09/01/20 to 09/03/20 with no explanation for why the medication was not administered. -There was an entry for Lantus insulin inject 30 units twice daily scheduled for administration at 6:30am and 6:30pm. -Lantus 30 units were not documented as administered for 2 of 28 opportunities from 09/03/20 to 09/17/20 with no explanation for why the medication was not administered. Observation of Resident #4's medications on hand on 09/17/20 at 4:50pm revealed Lantus was available for administration. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm.c. Review of Resident #4's current FL2 dated 02/14/20 revealed an order for FSBS twice daily before breakfast and supper and Novolog 10 units for FSBS greater than 250, give additional 8 units for FSBS over 400 (a short acting insulin used to treat elevated blood sugars).	{D 358}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 65 Review of Resident #4's physician's orders revealed: -A physician's order dated 08/18/20 for Novolog 16 units twice daily for FSBS over 250, give an additional 4 units for FSBS over 400 for a total of 20 units. -An order dated 09/07/20 for Novolog 16 units twice daily for FSBS over 250, give an additional 4 units for FSBS over 400 for a total of 20 units. Review of Resident #4's August 2020 MAR record revealed: -There was an entry for FSBS twice daily scheduled for 6:30am and 4:30pm. -There was an entry for Novolog insulin inject 16 units subcutaneously twice for FSBS over than 250, give additional 4 units for FSBS over 400. -Novolog insulin was documented as administered incorrectly for 5 of 16 opportunities from 08/21/20 through 08/31/20 as follows: -On 08/22/20 at 4:30pm, FSBS was 200, Novolog 4 units was documented as administered, but Novolog 0 units should have been administered. -On 08/24/20 at 4:30pm, FSBS was 493, Novolog 16 units was documented as administered, but Novolog 20 units should have been administered. -On 08/29/20 at 6:30am, FSBS was 285, Novolog 0 units was documented as administered, but Novolog 16 units should have been administered. -On 08/30/20 at 6:30am, FSBS was 411, Novolog 16 units was documented as administered, but Novolog 20 units should have been administered. -On 08/30/20 at 4:30pm, FSBS was 268, Novolog 20 units was documented as administered, but Novolog 16 units should have been administered. -Resident #4's FSBS ranged between 149 to 493 from 08/21/20 to 08/31/20. Review of Resident #4's September 2020 MAR	{D 358}		

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{D 358}	Continued From page 66 record revealed: -There was an entry for FSBS twice daily scheduled at 6:30am and 4:30pm. -There was an entry for Novolog insulin inject 16 units subcutaneously twice for FSBS over than 250, give additional 4 units for FSBS over 400. -Novolog insulin was not documented as administered or documented incorrectly for 4 of 20 opportunities from 09/01/20 to 09/17/20 as follows: -On 09/01/20 at 6:30am, there was no documentation. -On 09/01/20 at 4:30pm, FSBS was 464, Lantus 20 units was documented as administered, but Novolog 20 units should have been administered. -On 09/07/20 at 6:30am, FSBS was 233, Lantus 16 units was documented as administered, but Novolog 0 units should have been administered. -On 09/14/20 at 4:30pm, FSBS was 420, Lantus 0 units was documented as administered, but Novolog 20 units should have been administered. -Resident #4's FSBS ranged between 120 to 567 from 09/01/20 to 09/17/20. Observation of Resident #4's medications on hand on 09/17/20 at 4:50pm revealed Novolog was available for administration. Telephone interview with a medication aide (MA) on 09/29/20 at 2:37pm revealed: -When she checked Resident #4's FSBS she would document the units of insulin administered. -If there were no units documented on the MAR, then the resident did not get the insulin. -The facility's policy was if a medication was not administered, then staff had to document the reason why. Telephone interview with Resident #4's PCP on 09/29/20 at 12:29pm revealed:	{D 358}		

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{D 358}	Continued From page 67 -Resident #4 had diagnoses of diabetes mellitus. -She ordered insulin to help decrease the resident's elevated blood sugars. -She did not know that Resident #4's insulin was not administered as ordered. -She expected facility staff to administer medications as ordered. -Resident #4 was compliant with receiving her medications, so there should be no reason why the resident did not get her insulin. Based on observation interviews and records reviews it was determined that Resident #4 was not interviewable. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. d. Review of Resident #4's current FL2 dated 02/14/20 revealed an order for Metoprolol 50mg one and one-half tablet (75mg) twice daily (used to treat elevated blood pressure). Review of Resident #4's physician's orders revealed: -A physician's order dated 08/18/20 with an order for Metoprolol 50mg one and one-half tablet (75mg) twice daily. -An order dated 09/07/20 for Metoprolol 50mg one and one-half tablet (75mg) twice daily. Review of Resident #4's September 2020 Medication Administration Record (MAR)	{D 358}		

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{D 358}	Continued From page 68	{D 358}		

revealed:
-There was an entry for Metoprolol 50mg one and one-half tablet (75mg) twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation Metoprolol 50mg was not administered for 5 of 33 opportunities on 09/15/20 at 8:00am and 8:00pm, on 09/16/20 at 8:00am and 8:00pm and on 09/17/20 at 8:00am.
-There were two entries on the back of the MAR on 09/15/20 at 8:00pm and on 09/16/20 at 8:00am "waiting on pharmacy."

Observation on 09/17/20 at 4:50pm of Resident #4's medications on hand at the facility revealed Metoprolol 50mg was not available for administration.

Interview with the MA on 09/17/20 at 4:58pm revealed:
-Resident #4 had been out of Metoprolol 50mg for the last two nights that he worked (09/16/20 and 09/17/20).
-The RCD was responsible for reordering medication.
-He did not know if the RCD had re-ordered Resident #4's Metoprolol.
-Metoprolol was bubble packed and automatically refilled.

Telephone interview with Resident #4's PCP on 09/28/20 at 12:49pm revealed:
-Resident #4 had a history of hypertension and she ordered Metoprolol 75mg twice daily.
-She did not know Resident #4 was out of Metoprolol.
-She expected the facility to have medications available for administration, so the resident did not miss doses of the medication.

Telephone interview with a representative from

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{D 358}	Continued From page 69	{D 358}		

the facility's contracted pharmacy on 09/28/20 at 2:44pm revealed:
-Resident #4's Metoprolol was on a cycle fill.
-The medication was filled every 28 days per cycle.
-Resident #4 should not run out of the Metoprolol.
-When new cycle medications were received, facility staff were taking all medication cards out before the medication was finished and sending the medication back to the pharmacy.
-Sending the medication back to the pharmacy created a shortage, and it was an expense for the resident.
-This issue had been discussed with the facility numerous times and it was suggested that staff used all the medications before starting a new medication card.
-It was also noticed that sometimes staff administering the medications failed to check the facility storage area for medications, and they let the medication run out and then request a refill.
-This created several days a resident was without a medication because they must provide documentation showing the medication was dispensed and should be at the facility.

Based on observation, interviews and record review it was determined that Resident #4 was not interviewable.

Refer to interview with the Administrator on 09/25/20 at 2:17pm.

Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm.

Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm.

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{D 358}	Continued From page 70 Interview with the Administrator on 09/25/20 at 2:17pm revealed: -The previous RCD had worked at the facility for barely 90 days and she quit on 09/17/20. -The previous RCD was responsible for auditing the medication cart audits. -The previous RCD was supposed to check medications listed on the MARs with current orders to identify discrepancies. -The previous RCD never told her that she was unable to follow the facility's protocol for auditing MARs, she thought the system was in place and being followed. -She expected medications to be available for administration unless there were extenuating circumstances. -She did not know the previous RCD and MA were not following the facility's protocol for refilling and following up on medications that were not available for administration. -The medication aide was to reorder a medication before the medication ran out. -Most residents' medications were dispensed in bubble packaged cards. -The bubble packaged medication card had a designated point that specified when to reorder the medication. -The MAs could order medications for refill or they could complete a medication refill form. -If the MA completed the medication refill form, the form was given the RCD. -The previous RCD was supposed to send the refill request to the pharmacy either by fax, telephone call or through the pharmacy online system. -If the medication was unavailable on the next day for administration, then the MA on duty was to call the pharmacy and document why the medication was not available on the back of the MAR.	{D 358}		

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{D 358}	Continued From page 71 -If the medication was still not available on the second day the MA was to notify the RCD and document on the back of the MAR. -The RCD was to contact the pharmacy and document the reason why the medication was not available. -If the medication was not available the third day the RCD was to notify the Administrator and document on the back of the MAR. -There was a back-up pharmacy used by the main pharmacy, but it was only used for antibiotics, because the pharmacy was open 24/7 and they delivered to the facility twice daily. -A resident should never be more than three days without a medication. -She had provided training in July 2020 to staff regarding facility's policy related to refills and following up with the pharmacy regarding unavailable medications. -When new, changed or discontinued orders were received from health care providers, it was mainly, the RCD's responsibility to fax the orders to the pharmacy. -The RCD was supposed to transcribe the order on the MAR. -If the RCD was busy, she could instruct the MA to fax the order to the pharmacy and update the MAR. -Ultimately, the RCD was responsible for ensuring the medication was documented correctly on the MAR. -Medication carts were audited weekly. -The RCD was supposed to assign a third shift MA to weekly audit the medications on the medication cart and compare the medications with the MARs to ensure medications and MARs matched. -If discrepancies were identified the MA was to document the issues found and give the documentation to the RCD.	{D 358}		

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{D 358}	Continued From page 72 -The RCD was supposed to bring any noted concerns with the MA to her. -She had not seen any documentation related to discrepancies that resulted from the medication cart and MARs audit, therefore she thought there were no issues with medications being unavailable. Interview with a MA on 09/25/20 at 3:47pm revealed: -The previous RCD had been responsible for ensuring medication orders and changes in medication orders were on the MARs and available for medication administration, but now the Administrator was responsible as of 09/17/20. -The Administrator was responsible for reviewing the residents' orders and compared them to the Medication Administration Record (MAR). -If a medication was not administered due to the medication not being in the facility, the MA should contact the pharmacy and the resident's physician. -Any medication not administered and any contacts with the pharmacy and physicians should have been documented in the residents' records. -Medication errors occurred when any of the "6 rights" were not followed: "right resident, right route, right time, right dosage, right documentation, and right medication." -The person who found the error should have notified Administrator and the physician. -Third shift MA were responsible for completing medication cart audits when cycle filled medication were delivered to the facility. -The last medication cart audit was completed in September when the cycle filled medications were delivered, but she did not know if the audit was documented. -During a medication cart audit, the MA should	{D 358}		

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{D 358}	Continued From page 73 make sure the medications on the medication cart match what is on the MAR. Telephone interview with the previous RCD on 09/29/20 at 3:56pm revealed: -When she worked at the facility, her responsibilities included auditing the MARs and the medication cart. -She rotated the audit each week so that at least twice per month she looked at MARs and the medication cart. -When she did the medication cart audit, she checked the medications on the cart and compared with the MARs to make sure medications were available for administration. -If the medications were not available, she checked to see why. -If there was an insurance problem and the medication was not available, she contacted the pharmacy to see if another medication was available that would be covered by the insurance. -She also notified the resident's PCP. -She also re-ordered medications based on the "refill order sheet" that she received from the MA. -She was having a problem with the MAs letting her know when medications needed to be refilled. -If the MA did not give her a refill order sheet, she had no way of knowing what medications were unavailable for administration. -One problem with medications not being administered was the MAs often did not check the medication room for overstock medications, instead they documented on the MAR "waiting on the pharmacy." -This issue had been addressed and several MAs were wrote-up for not administering medications. _____ The facility failed to ensure medications were administered as ordered by the licensed prescribing provider for 5 of 6 sampled residents	{D 358}		

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{D 358}	Continued From page 74 (#1, #3, #4, #5 and #6) which resulted in a resident experiencing continued pain due to not receiving two medications for rheumatoid arthritis and not receiving a medication for pain (#1); a hypertensive resident not receiving a blood pressure medication twice daily for the month of September 2020 which could result in elevated blood pressures and increaed risk for stroke (#3); a resident with elevated blood sugars not receiving a short acting and a long acting insulin which could result in nerve and organ damage and not receiving 5 doses of a high blood pressure medication which could result in elevated blood pressures and increased risk of stroke (#4); a schizophrenic resident not receiving a medication used to treat mood/sleep disorder which could result in the confusion and behavior disorder, and not receiving a medication used to treat low potassium which could result in cardiac arrhythmia (#5); and a resident with elevated blood sugars not receiving a long acting and a short acting insulin which could result in nerve and organ damage (#6). The facility's failure to administer medications as ordered placed the residents at substantial risk of physical harm and neglect which constitutes an Unabated Type A2 Violation. _____ The facility provided a plan of protection on 09/17/20 in accordance with G.S. 131D-34 for this violation.	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:	{D 367}		

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{D 367}	Continued From page 75 (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Medication Administration Records (MARs) were accurate for 4 of 6 sampled residents (#1, #4, #5, and #6) related to correctly entering, scheduling, and documenting administration of medications according to physician's orders, including documenting the administration as needed medications, medications not administered, documenting administration of medications. The findings are:	{D 367}		

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{D 367}	Continued From page 76 Review of the facility's medication policy revealed: -All blood sugar testing must be done as ordered and documented on the MAR. -All blood sugar readings results must be documented on the MAR with initials. -Insulin given must be documented with the amount and the site you administered. -Sliding scale must be documented with the reading and units of insulin administered. -If no insulin administered put a 0 on the MAR with initials. -The RCD was responsible for ensuring a weekly check of the MARs for accuracy and reporting results to the Executive Director. -All medications are documented on the MAR including administered, refused or not. -Circled initials must indicate if the medication was not given, an explanation on the back of the MAR. -PRN medications document explanation on the back of the MAR why the medication was given, reason and 2 hours note if the medication worked. -Unavailable medications - do not just document "waiting on pharmacy or not available." Give explanation of what has been done. 1st day - waiting on pharmacy to deliver, call the pharmacy, 2nd day waiting on pharmacy, inform the RCD, on 3rd day waiting on pharmacy in the Administrator. "Should not wait more than 3 days for a medication." 1. Review of Resident #1's current FL2 dated 09/15/20 revealed diagnoses included constipation, anemia, elevated white blood cells, Vitamin D deficiency, hypernatremia, hypertension, pain, chronic obstructive pulmonary disease, gastroesophageal reflux disease, kidney failure, tachycardia, and anxiolytic dependence.	{D 367}		

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{D 367}	Continued From page 77 Review of Resident #1's rheumatologist office visit summary dated 05/07/2020 revealed: -Resident #1's primary diagnosis was rheumatoid arthritis involving multiple sites. -Diagnoses also included multilevel degenerative disc disease, and primary osteoarthritis involving multiple joints. -Resident #1 was to continue taking Humira Pen 40mg injection, inject 1 pen under the skin every 14 days for rheumatoid arthritis. a. Review of Resident #1's current FL2 dated 09/15/20 revealed an order for Humira 40/0.4 ML 1 pen every 14 days (used to treat arthritis). Review of Resident #1's physician's orders dated 07/04/20 revealed there was no order for Humira. Review of Resident #1's physician's orders dated 02/18/20 revealed an order for Humira pen injection 40mg/0.4ML inject 1 pen (40 mg dose) under the skin every 14 days. Review of Resident #1's Medication Administration Record (MAR) for August and September 2020 revealed there was no entry for Humira 40mg/04ML inject 1 pen every 14 days. Review of Resident #1's Home Health (HH) notes revealed Resident #1 was administered a Humira injection on 07/23/20, 08/07/20, 08/18/20, and 09/01/20. Interview with Resident #1 on 09/25/20 at 1:58pm revealed: -She was administered Humira every two weeks by a HH nurse for her rheumatoid arthritis. -She thought her last injection was given on 09/18/20.	{D 367}		

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{D 367}	Continued From page 78 Telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am revealed: -There was an order for Humira 40mg/0.4ML inject 1 pen every 14 days. -The pharmacy dispensed Humira 2 pens on 07/17/20, 08/05/20, and 09/18/20. Interview with a medication aide (MA) on 09/25/20 at 3:47pm revealed: -She did not know Humira injections were administered to Resident #1 by the HH nurse because Humira was not on the MAR. -Resident #1's Humira injections should have been on the MAR and documented as administered by the HH nurse. -The previous Resident Care Director (RCD) would have been responsible for placing Humira on the MAR for documentation. Telephone interview with the HH nurse on 09/28/20 at 10:38am revealed: -Resident #1 had a physician's order for Humira 40mg/0.4ML administer subcutaneously every 2 weeks. -Humira was administered on 08/04/20, 08/18/20, 09/01/20, and 09/19/20. -She documented an entry in the HH notebook, but she did not document on the MAR in August or September 2020. -Humira used to be on the MAR and she would document it was administered by writing in her initials the location of the injection site on the MAR. Telephone interview with the Administrator on 09/25/20 at 3:44pm revealed: -She knew Resident #1 received HH services for Humira injections.	{D 367}		

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{D 367}	Continued From page 79 -The Humira injections should be on the MAR. -She did not know Resident #1's Humira injections were not on her August and September 2020 MARs. -The previous RCD was responsible for ensuring Humira was entered on the MAR. Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. b. Review of Resident #1's FL2 dated 09/15/20 revealed there was not an order for Flexeril (used short-term to treat muscle spasms). Review of Resident #1's physician's orders dated 08/27/20 revealed an order for Flexeril 10mg 1 tablet 3 times daily as needed for up to 10 days. Review of Resident #1's Medication Administration Record (MAR) for August 2020 revealed there was not an entry for Flexeril 10mg 1 tablet 3 times daily as need for up to 10 days. Review of Resident #1's MAR for September 2020 revealed: -There was an entry written on the MAR for Flexeril 10 mg take 1 tablet 3 times a day as needed for spasms. -The entry for Flexeril did not include the limited	{D 367}		

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{D 367}	Continued From page 80	{D 367}		

time of 10 days.
-Twenty three of 30 tablets of Flexeril were administered from 09/04/20 through 09/17/20 (13 days).
-One tablet of Flexeril was documented as administered on 09/04/20, 09/05/20, 09/08/20, 09/12/20, 09/13/20, 09/15/20, and 09/17/20.
-Two tablets of Flexeril were documented as administered on 09/06/20, 09/09/20, 09/10/20, and 09/11/20.
-Three tablets of Flexeril were documented as administered on 09/07/20, 09/14/20, and 09/16/20.
- There was no documentation on the back of the MAR indicating the reason Flexeril as needed was given and the results for 9 doses from 09/06/20 to 09/17/20.
-Flexeril 1 tablet 3 times a day as needed was discontinued on the MAR on 09/22/20.

Observation of the medication cart on 09/17/20 at 5:57pm revealed:
-Flexeril 10mg 1 tablet 3 times daily or up to 10 days was on the medication cart.
-Thirty tablets of Flexeril had been dispensed to the facility on 08/27/20 and there was 1 tablet remaining.

Interview with Resident #1 on 09/25/20 at 1:58pm revealed:
-She had an order for Flexeril as needed which stopped last week.
-She started taking Flexeril again on 08/24/20 at 8:00am, 2:00pm, and 8:00pm.

Telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am revealed:
-There was an order for Flexeril 10mg 1 tablet 3 times daily as needed for up to 10 days.

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{D 367}	Continued From page 81 -Thirty tablets of Flexeril were dispensed to the facility on 08/27/20. Telephone interview with a medication aide (MA) on 09/30/20 at 3:27pm revealed: -She administered Flexeril to Resident #1, but she did not remember seeing the dosage on the MAR. -She administered Flexeril to Resident #1 on 09/17/20, but she did not know Flexeril should have been discontinued 09/14/20. -She normally compared the MAR to the medication bubble pack, but she did not catch that Flexeril was only supposed to be administered for up to 10 days. Telephone interview with the Administrator on 09/25/20 at 3:44pm revealed she did not know Flexeril had been documented on the MAR as administered for 14 days. Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. c. Review of Resident #1's FL2 dated 09/15/20 revealed there was not an order for Ibuprofen (used to treat minor pain). Review of Resident #1's physician's orders dated	{D 367}		

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{D 367}	Continued From page 82 08/25/20 revealed an order for Ibuprofen 800mg 1 tablet every 8 hours for 7 days. Review of Resident #1's Medication Administration Record (MAR) for August 2020 revealed there was not an entry for ibuprofen 800mg 1 table every 9 hours for 7 days. Review of Resident #1's MAR for September 2020 revealed: -There was an entry for ibuprofen 800mg 1 tablet every 8 hours for 7 days and scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Ibuprofen 800 mg was documented as administered 7 days for 21 of 21 times at 8:00pm on 08/03/20; 8:00am 2:00pm, and 8:00pm on 09/04/20 through 09/09/20; and at 2:00pm and 8:00pm on 09/10/20. -There was also documentation ibuprofen was administered on 09/14/20 at 8:00am and 2:00pm and on 09/16/20 at 8:00am and 2:00pm. -There was documentation ibuprofen was not administered on 09/15/20 due to waiting on the pharmacy. Observation of the medication cart on 09/17/20 at 5:57pm revealed there was no Ibuprofen on the medication cart. Interview with Resident #1 on 09/25/20 at 1:58pm revealed she remembered taking ibuprofen for about a week because she popped something in her back. Interview with a medication aide (MA) on 09/25/20 at 3:27pm revealed: -Resident #1 had an order for Ibuprofen 800mg 1 tablet every 8 hours for 7 days. -She did not know why ibuprofen was documented as administered beyond 7 days.	{D 367}		

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{D 367}	Continued From page 83 Telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am revealed: -There was an order for Ibuprofen 800mg 1 tablet every 8 hours for 7 days. -Twenty-one tablets of Ibuprofen were dispensed to the facility on 08/27/20. Telephone interview with the Administrator on 09/30/20 at 1:11pm revealed she did not know Ibuprofen had been documented as administered on the MAR for 9 days. Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. 2. Review of Resident #5's current FL-2 dated 02/14/20 revealed diagnoses included cardiomyopathy, anxiety disorder, combined systolic and diastolic heart failure and COPD (chronic obstructive pulmonary disease). a. Review of Resident #5's mental health progress note dated 08/24/20 revealed: -Trazodone 100mg was discontinued. -There was an order to start Trazodone 50mg at bedtime (used to treat anxiety and sleep problems).	{D 367}		

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{D 367}	Continued From page 84 Review of Resident #5's mental health progress note dated 09/10/20 revealed: -The Trazodone gradual dose reduction (GDR) ordered last visit had not been implemented and would be reordered. -There was an order to discontinue Trazodone 100mg and to start Trazodone 50mg. Review of Resident #5's August 2020 medication administration record (MAR) revealed: -There was an undated, handwritten entry for Trazodone 100mg. -Trazodone 100mg was first documented as administered on 08/15/20. -The Trazodone 100mg entry was marked with a "DC" date of 08/26/20. -There was a handwritten entry for Trazodone 50mg take one at bedtime and was dated 08/26/20. -Trazodone 50mg was documented as administered from 08/29/20 to 08/31/20. Review of Resident #5's September 2020 MAR revealed: -There was a printed entry for Trazodone 100mg, one tablet at bedtime. -The printed entry for Trazodone 100mg was documented as administered on 09/01/20, 09/04/20 and from 09/07/20 to 09/13/29. Continued review of Resident #5's September 2020 MAR further revealed: -Trazodone 100mg was discontinued on 09/14/20. -There was an undated, handwritten entry for Trazodone 50mg, one at bedtime. -Trazodone 50mg was first documented as administered on 09/15/20.	{D 367}		

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{D 367}	Continued From page 85 Observation of medication on hand for Resident #5 on 09/17/20 at 5:57pm revealed: -The bubble pack of Trazodone 50mg was dispensed on 08/24/20 with a quantity of 25 tablets. -There were 2 tablets available for administration. Telephone interview with a medication aide (MA) on 09/29/20 at 2:46pm revealed the previous Resident Care Director (RCD) was responsible to verify the MARs were accurate at the beginning of each month. Telephone interview with a representative from the facility's contracted pharmacy on 09/29/20 at 12:17pm revealed: -Trazodone 50mg was first dispensed on 08/24/20 with a quantity of 25 tablets. -On 09/10/20, thirty tablets were dispensed to the facility. Telephone interview with the Administrator on 09/29/20 at 4:59pm revealed: -The previous RCD was responsible to make sure the MARs were accurate. -The previous RCD was supposed to sign the bottom of the upcoming new month's MAR to show it had been reviewed and was accurate but had not done that. Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm.	{D 367}		

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{D 367}	Continued From page 86 Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. b. Review of Resident #5's physician's orders dated 08/18/20 revealed an order for potassium chloride micro tab 20meq ER (extended release) daily (used to treat low potassium levels). Review of Resident #5's August 2020 medication administration record (MAR) revealed an entry for potassium chloride micro tablet ER, 20mEq one tablet daily . Review of Resident #5's September 2020 MAR revealed no entry for potassium chloride. Telephone interview with a representative from the facility's contracted pharmacy on 09/30/20 at 3:55pm revealed: -The original order for potassium was a verbal order given by Resident #5's primary care provider (PCP) on 07/16/20. -She did not have a discontinue order for this medication. -The facility printed the MARs for the upcoming month. -The facility could make changes to the MARs and she would not be able to see them. -She did not know why potassium was not on the September 2020 MAR. Telephone interview with a medication aide (MA) on 09/29/20 at 2:46pm revealed: -Potassium was not on Resident #5's September 2020 MAR. -The previous Resident Care Director (RCD) was responsible for printing the MARs for the upcoming month. -The previous RCD was responsible to make	{D 367}		

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{D 367}	Continued From page 87	{D 367}		

sure the new month's MAR was accurate.
-The facility did not currently have a RCD.
-The Administrator was performing the duties of the RCD.
-He would contact the Administrator for clarification since potassium was not on the MAR.

Telephone interview with the Administrator on 09/29/20 at 4:59pm revealed:
-The previous RCD was responsible to make sure the MARs were accurate.
-The previous RCD was supposed to sign the bottom of the new month's MAR after she reviewed it for accuracy.
-The September 2020 MAR was not signed by the RCD.

Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am.

Refer to interview with the Administrator on 09/25/20 at 2:17pm.

Refer to interview with a Medication Aide (MA) on 09/25/20 at 3:47pm.

Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm.

3. Review of Resident #6's current FL2 dated 02/14/20 revealed there were no diagnoses listed.

a. Review of Resident #6's current FL2- dated 02/14/20 revealed an order for gavilax powder (polyethylene glycol 3350) (a laxative used to stimulate bowel movements) 17gm in liquid daily.

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{D 367}	Continued From page 88 Review of Resident #6's physician's orders revealed: -An electronically signed order by the Primary Care Provider (PCP) dated 08/14/20 for gavilax powder 17gm in liquid daily. -An order dated 08/18/20 for gavilax powder 17gm in liquid daily. -An electronically signed order by the PCP dated 08/26/20 for gavilax powder 17gm in liquid daily. Review of Resident #6's August 2020 MAR revealed: -There was an entry for gavilax powder 17gm in liquid daily was scheduled for administration at 8:00am. -There was documentation gavilax powder 17gm was administered daily 31 times from 08/01/20 through 08/31/20. Review of Resident #6's September 2020 MAR revealed: -There was an entry for gavilax powder 17gm in liquid daily was scheduled for administration at 8:00am. -There was documentation gavilax powder 17gm was administered daily 28 times from 09/01/20 through 09/29/20. Observation of Resident #6's medications on hand at the facility on 09/25/20 at 2:50pm revealed gavilax powder 17gm was not available for administration. Interview with Resident #6 on 09/25/20 at 2:40pm revealed: -He was administered medications daily, but he did not know the names of the medications administered. -He did not recall getting a medication that was a liquid or that resembled water.	{D 367}		

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{D 367}	Continued From page 89 Telephone interview with the pharmacy director at the facility's contracted pharmacy on 09/30/20 at 3:38pm revealed: -The last time gavilax powder was requested to be refilled was on 06/11/20, and a 30-day supply was dispensed. -As of today's, date (09/30/20), no one at the facility had called to request a refill of gavilax powder since 06/11/20. Telephone interview with a first shift medication aide (MA) on 09/30/20 at 4:16pm revealed: -Resident #6 had not been administered gavilax powder in months. -She was aware the medication was on the MAR, but not available for administration. -She should have circled her initials and wrote on the back of the MAR the medication was not available. -She had no explanation why she documented on the MAR that she administered gavilax when it was not available for administration. Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. b. Review of Resident #6's current FL2 dated 02/14/20 revealed an order for Finger Stick Blood	{D 367}		

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{D 367}	Continued From page 90 Sugar (FSBS) before meals and Novolog (fast acting insulin used to treat elevated blood sugar values) 20 units for FSBS over 250 and an additional 10 units for FSBS over 450. Review of Resident #6's physician's orders dated 08/18/20 revealed an order for Novolog 14 units for FSBS over 250 and an additional 10 units for FSBS over 450 for a total of 24 units. Review of Resident #6's August 2020 MAR revealed: -There was an entry for Novolog insulin inject 14 units subcutaneously for FSBS over 250 and additional 10 units for FSBS over 450 for a total of 24 units. -There was no documentation for the units of Novolog insulin administered for FSBS over 250 for 11 of 31 opportunities from 08/21/20 through 08/31/20, no FSBS over 450. Review of Resident #6's September 2020 MAR revealed: -There was an entry for Novolog insulin inject 14 units subcutaneously for FSBS over 250 and additional 10 units for FSBS over 450 for a total of 24 units. -There was no documentation for the units of Novolog insulin administered for FSBS over 250 for 36 of 53 opportunities and for 1 of 4 opportunities over 450 from 09/01/20 through 09/29/20. Telephone interview with a medication aide (MA) on at 09/29/20 at 4:59pm revealed: -Resident #6's FSBS were checked three times daily, if the resident did not refuse. -The resident's FSBS result and the units of insulin administered were to be documented on the back of the MAR.	{D 367}		

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{D 367}	Continued From page 91 -The facility had provided training of MAR documentation, but she noticed that not all staff documented the units of insulin administered to Resident #6. Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on 09/25/20 at 3:47pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. 4. Review of Resident #4's current FL2 dated 02/14/20 revealed: -Diagnoses included diabetes mellitus Type 2 and schizophrenic disorder. -There was an order for FSBS twice daily before breakfast and supper and Novolog 10 units for FSBS greater than 250, give additional 8 units for FSBS over 400. Review of Resident #4's physician's orders revealed: -There was an order dated 08/18/20 for Novolog 16 units twice daily for FSBS over 250, give an additional 4 units for FSBS over 400 for a total of 20 units. -There was an order dated 09/07/20 for Novolog 16 units twice daily for FSBS over 250, give an additional 4 units for FSBS over 400 for a total of 20 units. Review of Resident #4's August 2020 MAR	{D 367}		

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	HAL034150	A. BUILDING: _____ B. WING _____	R 10/01/2020

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{D 367}	Continued From page 92 revealed: -There was an entry for Novolog insulin inject 16 units subcutaneously for FSBS over 250 and additional 4 units for FSBS over 400 for a total of 20 units. -There was no documentation for the units of Novolog insulin administered for FSBS over 250 for 3 of 9 opportunities and 6 of 8 opportunities for FSBS over 400 from 08/21/20 through 08/31/20. Review of Resident #4's September 2020 MAR revealed: -There was an entry for Novolog insulin inject 16 units subcutaneously for FSBS over 250 and additional 4 units for FSBS over 400 for a total of 20 units. -There was no documentation for the units of Novolog insulin administered for FSBS over 250 for 6 of 13 opportunities and for 2 of 6 opportunities over 450 from 09/01/20 through 09/17/20. Telephone interview with a medication aide (MA) on 09/29/20 at 2:37pm revealed: -When Resident #4's FSBS were checked, the FSBS and the units of insulin administered were to be documented on the MAR. -She had no explanation why she did not document the units of insulin administered Resident. #4. Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to interview with a medication aide (MA) on	{D 367}		

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{D 367}	Continued From page 93 09/25/20 at 3:47pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. _____ Telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am revealed: -Medication orders were faxed from the facility or the physician's office to the pharmacy. -Once received at the pharmacy, the orders went to the pharmacist who entered the order in the Medication Administration Record (MAR) system. -The pharmacist checked to make sure orders were complete and then sent the orders to pharmacy medical records. -MARs were sent to the facility on the 22nd or 23rd of each month for the next month. -If there were new medication orders or changes in medication orders, the facility was responsible for writing in those orders on the MAR received from the pharmacy and sending a copy back to the pharmacy. Interview with the Administrator on 09/25/20 at 2:17pm revealed: -The previous Resident Care Director (RCD) was responsible for auditing the medication administration records (MARs) every two weeks. -When the previous RCD reviewed the MARs, she was supposed look for holes, incorrect orders, check to see if staff circled initials and documented why, checked to ensure as needed (PRN) were properly document with results. -She met weekly with the previous RCD to identify problems with MAs following the facility's protocol. -The previous RCD never told her that she was unable to follow the facility's protocol for auditing	{D 367}		

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{D 367}	Continued From page 94 MARs, she thought the system was in place and being followed. -Ultimately, the previous RCD was responsible for ensuring the medication was documented correctly on the MAR. -The previous RCD audited the medication cart weekly to ensure medications were available. -The previous RCD was supposed to assign a third shift MA to weekly audit the medications on the medication cart and compare the medications with the MARs to ensure medications and MARs matched. -If discrepancies were identified the MA was to document the issues found and give the documentation to the previous RCD. -The previous RCD was supposed to bring identified problems she noticed being done by the MA to her for review. -She had not seen any documentation related to discrepancies that resulted from the medication cart and MARs audit, therefore she thought there were no issues with medications being unavailable. Interview with a medication aide (MA) on 09/25/20 at 3:47pm revealed: -She used to give new medication orders and changes in orders to previous RCD, but now she gave them to the Administrator. -The Administrator checked the MARs for accuracy, but she did not know how often. -The Administrator reviewed the residents' orders and compared them to the MAR. -A complete order on the MAR included the medication name, dosage, strength, and how many times the medication should be given. -If MA initials were circled on the MAR, it meant the medication was not given or the resident refused the medication and the reason the medication was not given should have been	{D 367}		

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{D 367}	Continued From page 95 documented on the back of the MAR. -If there was a blank space on the MAR, no one knew whether the medication was administered or not. -If as needed medication were administered, MAs should document the reason and effectiveness on the back of the resident's MAR. Telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:56pm revealed: -When she worked at the facility, her responsibilities included auditing the MARs and the medication cart. -She rotated the audit each week so that at least twice per month she looked at MARs and the medication cart. -When she did the MAR audit, she "flipped" through the MARs on the four medication carts to see if staff circled initials, and to make sure staff documented why medications were not administered. -When she completed a medication cart audit, she checked the medications on the cart and compared them to the medications on the MARs to make sure medications were available for administration.	{D 367}		
{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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure residents were	{D914}		

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{D914}	Continued From page 96	{D914}		

free of neglect as related to resident rights and medication administration.

The findings are:

1. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic and practicing recommended infection prevention and control practices to reduce the risk of transmission and infection as related to staff appropriately wearing personal protective equipment (PPE), sanitizing the self-screening kiosk utilized by visitors and staff before and after usage, no signage posted reminding staff how to appropriately wear face coverings, and staff not maintaining a social distance of 6 feet from residents when not appropriately wearing PPE. [Refer to Tag D338 10A NCAC 13F .0909 Residents' Right (Type B Violation)].

2. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 5 of 6 sampled residents (Residents #1, #3, #4, #5 and #6) including a sleep aide medication, a medication used for mood/sleep disorder, a potassium supplement (#5); an immunomodular agent, an anti-inflammatory, a muscle relaxant, and a pain medication (#1); an anti-hypertensive medication and a laxative (#3); a laxative, a long acting insulin, and a short acting insulin (#6), a topical skin protection cream, a long acting insulin, a short acting insulin and an anti-hypertensive medication (#4). [Refer to tag 0358 10A NCAC

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{D914}	Continued From page 97 13F .1004(a) Medication Administration (Unabated Type A2 Violation)].	{D914}		
{D9999}	Final Observation	{D9999}		