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THE BRADFORD VILLAGE OF KERNERSVILLE - WES	602 PINEY GROVE ROAD KERNERSVILLE, NC 27284

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey with onsite visits on October 7, 2020 and October 15, 2020 and a desk review on October 7-9, 2020, October 12-16, 2020 and October 19-23, 2020 with a telephone exit on October 23, 2020. The complaint investigation was initiated by the Forsyth County Department of Social Services on September 16, 2020.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the resident bathrooms, window sills, floors and shower chairs were kept clean and in good repair. The findings are: Review of the facility's Environmental Health Report dated 05/31/19 revealed: -The sanitation score for the facility was 96. -There were demerits assigned for floors. -The comments section indicated the floors in resident rooms #12, #22, and #30 needed	D 074		

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cleaning especially along the baseboards and behind the furniture.
-The general comments section of the report indicated the shower chairs needed cleaning on the underside portion of the chair, and the toilet needed cleaning in the front hallway restroom.

Telephone interview with the local county health inspector on 10/20/20 at 8:53am revealed:
-The last inspection of the facility occurred on 05/31/19.
-There were no routine inspections of assisted living facilities due to COVID-19 unless there was a request because of an issue.
-The inspection from 05/31/19 revealed floors were unkempt, shower chair needed cleaning on the underside of the chair, and the toilets need cleaning.

Observations of resident room #11 on 10/07/20 at 10:10am revealed:
-The residents were not in the room.
-There were broken crayons and food debris on the floor.
-There was a layer of dust on the window sill along with small pieces of debris.
-There were brownish stains along the edges of the floor behind the door and in the corners of the room.

Observation of resident room #12 on 10/07/20 at 10:12am revealed there were large areas of brownish stains on the floors in front of the bathroom door, two closet doors, behind the entrance door and inside of the closets.

Interview with a resident who resided in resident room #12 on 10/07/20 at 10:12am revealed:
-Those stains had always been on the floor.
-She did not know what caused the stains.

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D 074	Continued From page 2 Observation of resident room #5 on 10/07/20 at 10:15am revealed: -There small bits of debris on the floor throughout the room. -The windowsill was covered in dust and debris. Interview with a resident who resided in room #5 on 10/07/20 at 10:15am revealed: -Her room was cleaned by the evening shift housekeeper who cleaned the toilet and mopped the floor. -She did not know the last time the window sill was cleaned. Observation of resident room #6 on 10/07/20 at 10:16am revealed there was a thick layer of dust and a dead bug on the window sill. Interview with a resident who resided in resident room #6 on 10/07/20 at 10:40am revealed: -The maintenance supervisor was doing his best as the day shift housekeeper. -The maintenance supervisor emptied the trash, cleaned the toilet, and sometimes mopped the floor. -The evening shift housekeeper cleaned the common bathrooms. Observations of the common resident bathroom on the front hallway on 10/07/20 at 10:14am revealed: -The tile floor had brownish dirt and debris from the door to the toilet base. -There were bits of debris on the bottom of the tub. Observations of common resident bathroom on back hallway on 10/07/20 at 1:45pm revealed: -There were black stains along the edges of the	D 074		

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tiled shower base near the wall.
-There were small bits of debris and dirt on the floor around the toilet area.

Interview with a resident who resided in room #3 on 10/07/20 at 10:05 am revealed:
-Her room was cleaned by the housekeeper who was also the maintenance supervisor.
-The evening shift housekeeper did her laundry and the floors.
-The personal care aides (PCA) cleaned up the towel in the bathroom after she showered.

Observation of resident room #17 on 10/07/20 at 10:55 am revealed there was a thick layer of dust and a dead bug on the window sill.

Observation of resident room #18 on 10/07/20 at 11:00am revealed
-There were brownish stains on the floor in the corners of the room and in front of the closet door.
-There were black stains in the crevices of the corners of the floor.

Observation of resident room #19 on 10/07/20 at 11:02am revealed there were black stains in the corners of the floor.

Interview with a resident who resided in resident room #19 on 10/07/20 at 11:02am revealed:
-Her room was cleaned by the housekeeper, but not every day.
-She did not think the room was cleaned well.
-The floor was mopped when it was cleaned, but she did not know what caused the black stains in the corners.

Observation of resident room #22 on 10/07/20 at 11:09 am revealed there were brownish stains on

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the floor along the edge of the wall near the closet doors, underneath the windowsill and behind the entrance door.

Observation of resident room #27 on 10/07/20 at revealed there were black stains along the crevices where the wall and floor connected behind the door.

Observation of resident room #28 on 10/07/20 at revealed there were black stains along the crevices where the wall and floor were connected.

Observation of resident room #30 on 10/07/20 at 11:10 am revealed:
-There was debris under both beds.
-There was a thick layer of dust and a dead insect on the window sill.

Interview with the resident who resided in resident room #30 on 10/07/20 at 11:11am revealed:
-There was no housekeeper during the daytime, only in the evening.
-There was a daytime housekeeper about a month ago.
-The maintenance supervisor cleaned some during the day and the evening housekeeper emptied the trash.

Observation on 10/07/20 at 11:59am of the shared bathroom between residents' room #3 and room #4 revealed:
-There was a black intermingled with rust (brownish red) colored ring at the water line of the toilet bowl.
-The bottom of the toilet bowl had brown splattered stains in the center of the bowl and exit outlet of the bowl.
-There was a dark blackish gray build up on the

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floor extending one to three inches toward the center of the room around the lower door jams.
-There was a dark blackish gray build up on the floor extending toward the center of the room along the rubberized shoe molding that cover where the wall joined the floor.

Interview with a resident on 10/07/20 at 11:09am revealed:
-He had never seen anyone dust or wipe the windowsills.
-His adjoining bathroom was mopped sometimes by the evening shift housekeeper.

Telephone interview on 10/15/20 at 4:38 pm with a PCA revealed:
-There was a day shift housekeeper who left about a month ago.
-The maintenance supervisor cleaned some, but if staff saw that something needed to be cleaned then staff cleaned.
-The Executive Director purchased disposable floor dusters for staff to use on 10/07/20.
-She thought the floors were just mopped not scrubbed and this was the reason for stains on the floors.
-She saw small bits of debris or trash in the common bathrooms.
-The PCAs sanitized the common bathrooms after each use.
-The former day shift housekeeper was supposed to disinfect the common bathrooms.
-In the past she asked, the former housekeeper to disinfect the common bathrooms, but the former housekeeper never disinfected the common bathrooms.
-When she first came to work at the facility seven months ago, the facility was very clean.
-However, over time the facility began to become messy and the former housekeeper did not clean

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thoroughly.

Interview with a housekeeper on 10/15/20 at 2:00pm revealed:
-She started working on day shift on 10/07/20 and was trained by the evening shift housekeeper.
-She worked each day of the week except Thursdays.
-She was responsible for emptying trash cans, residents' laundry, vacuuming the lobby area, mopping the residents' rooms near the end of her shift, mopping and cleaning the sinks and toilets of the common bathrooms on the front and back hallway.
-She was told the PCAs were to clean the common bathrooms after residents were showered or bathed.
-She was told deep cleaning would be done monthly.
-She noticed the resident room floors were "nasty", so she began mopping daily without being told.
-She had not been told to dust and wipe window sills.
-There was no cleaning schedule and she made her own cleaning schedule.
-The only housekeepers were she and the evening shift housekeeper who were assigned to clean resident rooms for 55 residents and common areas.

Interview with the Maintenance Supervisor on 10/15/20 at 2:15pm revealed:
-He supervised the housekeepers.
-He had hired a new daytime housekeeper who started on day shift on 10/07/20.
-He knew about the brownish stains on the floor of some resident rooms.
-The floors were stripped and waxed a year ago.
-He planned to request for the floors to be

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stripped again, but had to request approval from the corporate office.
-The new daytime housekeeper was responsible for mopping the floors, vacuuming the front area after meals, but the PCAs were supposed to clean the common bathrooms after each use.
-The common bathrooms were cleaned daily by housekeeping.
-The window sills were supposed to be done monthly.
-Deep cleaning would resume because he had a day shift housekeeper now.
-Deep cleaning involved pulling the furniture out of each resident room and cleaning and mopping the areas behind the furniture.

Telephone interview with the Executive Director on 10/23/20 at 2:08pm revealed:
-The Maintenance Supervisor supervised housekeeping for the facility.
-She knew there were brownish stains on the floor of specific resident rooms.
-She asked the Maintenance Supervisor what caused the stains and he thought it was caused by wax not being properly buffed a year ago when the floors were stripped and waxed.
-She had hired several day shift housekeepers since becoming the ED in December 2019.
-She expected the resident rooms to be cleaned two times per week and deep cleaning once a week.
-She expected the common bathrooms to be cleaned after each use by staff and the housekeepers were expected to disinfect.
-The housekeepers were responsible for cleaning toilets and sinks throughout the facility.
-She thought the dust and dead insects on the window sill were in rooms of residents who refused housekeeping services.
-She had completed walk through of the facility in

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D 074	Continued From page 8 the past to ensure housekeeping was maintained throughout the facility. -She had not been able to do a walk through of the facility since May 2020 because she had worked as a medication aide frequently. -She and the Maintenance Supervisor were responsible for housekeeping.	D 074		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: Based on telephone interviews and record reviews, the facility failed to ensure at least one staff was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management for 4 of 42 shifts sampled for 14 days from 09/20/20 to 10/03/20.	D 167		

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D 167	Continued From page 9 The findings are: Review of the staff schedule for 09/20/20-10/03/20 revealed: -The first column of the schedule contained the names of the staff. -The second column of the schedule was labeled "CPR." -There was no data listed in the CPR column. 1. Review of Staff C, medication aide's (MA) personnel record revealed: -Staff C was hired on 02/03/20. -There was no documentation Staff C had completed training on cardio-pulmonary resuscitation (CPR) within the last 24 months. Review of staffing time cards dated 09/22/20 and 09/24/20 revealed: -Staff C worked 8 hours on first shift (7:00am-3:00pm) both days. -There was no staff who worked with Staff C on first shift who had current CPR training. Attempted telephone interview on 10/23/20 at 1:35pm with Staff C was unsuccessful. Attempted telephone interviews on 10/14/20 at 10:20am and 10/15/20 at 9:18am with the Registered Nurse (RN) from the facility's contracted pharmacy were unsuccessful. Attempted telephone interview on 10/23/20 at 10:25am with the previous Resident Care Coordinator (RCC) was unsuccessful. Attempted telephone interview on 10/23/20 at 10:35am with the Business Office Manager (BOM) was unsuccessful.	D 167		

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Refer to the telephone interview on 10/23/20 at 10:35am with the current RCC.

Refer to the telephone interview on 10/23/20 at 2:07pm with the Executive Director (ED).

2. Review of Staff D, former personal care aide's (PCA) personnel record revealed:
-Staff D was hired on 06/08/20.
-There was no documentation Staff D had completed training on cardio-pulmonary resuscitation (CPR) within the last 24 months.

Review of staffing time cards dated 09/22/20 and 10/03/20 revealed:
-Staff D worked 8 hours on first shift (7:00am-3:00pm) both days.
-There was no staff who worked with Staff D on first shift who had current CPR training.

Attempted telephone interview on 10/14/20 at 10:36am with Staff D was unsuccessful.

Attempted telephone interviews on 10/14/20 at 10:20am and 10/15/20 at 9:18am with the Registered Nurse (RN) from the facility's contracted pharmacy were unsuccessful.

Attempted telephone interview on 10/23/20 at 10:25am with the previous Resident Care Coordinator (RCC) was unsuccessful.

Attempted telephone interview on 10/23/20 at 10:35am with the Business Office Manager (BOM) was unsuccessful.

Refer to the telephone interview on 10/23/20 at 10:35am with the current RCC.

Refer to the telephone interview on 10/23/20 at

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D 167	Continued From page 11 2:07pm with the Executive Director (ED). 3. Review of Staff E, former personal care aide's (PCA) personnel record revealed: -Staff E was hired on 08/25/20. -There was no documentation Staff E had completed training on cardio-pulmonary resuscitation (CPR) within the last 24 months. Review of staffing time cards dated 09/24/20 revealed: -Staff E worked 8 hours on second shift (3:00pm-11:00pm). -There was no staff who worked with Staff E on second shift who had current CPR training. Telephone interview on 10/23/20 at 11:47am with Staff E revealed: -She worked at the facility as a PCA since August 2020. -She did not have CPR certification and she had not been told she needed to obtain CPR certification. Attempted telephone interviews on 10/14/20 at 10:20am and 10/15/20 at 9:18am with the Registered Nurse (RN) from the facility's contracted pharmacy were unsuccessful. Attempted telephone interview on 10/23/20 at 10:25am with the previous Resident Care Coordinator (RCC) was unsuccessful. Attempted telephone interview on 10/23/20 at 10:35am with the Business Office Manager (BOM) was unsuccessful. Refer to the telephone interview on 10/23/20 at 10:35am with the current RCC.	D 167		

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D 167	Continued From page 12 Refer to the telephone interview on 10/23/20 at 2:07pm with the Executive Director (ED). Review of five personnel records revealed: -Three of five staff (Staff C, D, and E) had no documentation of completing a course in cardio-pulmonary resuscitation (CPR) in the past 24 months. -Three of five staff (Staff C, D, and E) worked on shifts where there was no other CPR certified staff coverage during the sampled days in September 2020 and October 2020. Telephone interview on 10/12/20 at 3:28pm with the Executive Director (ED) revealed: -She was a CPR instructor. -Staff CPR renewals were done online. -There were three medication aides (MA) whose CPR training had expired. -A former personal care aide (PCA) had CPR training, but she did not have documentation of the training. -She would provide documentation of CPR training. Review of staffing time cards for 09/20/20-10/03/20 revealed: -The facility had three shifts: first shift was 7:00am-3:00pm, second shift was 3:00pm-11:00pm, and third shift was 11:00pm-7:00am. -There were no staff on each shift per day who had training on CPR and choking management for 4 of 42 shifts. _____ Telephone interview on 10/23/20 at 10:35am with the current Resident Care Coordinator (RCC) revealed: -She was not sure of the requirement, but she thought all staff should be required to be trained	D 167		

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on CPR.
-All staff members knew they were required to have training on CPR.
-The staff who had CPR training online in early October 2020 had completed in-person return demonstration last week.
-The Business Office Manager (BOM) and the Executive Director (ED) maintained the CPR training records of staff.

Telephone interviews on 10/12/20 at 3:28pm and 10/23/20 at 2:07pm with the Executive Director (ED) revealed:
-The facility was required to have one CPR certified staff on each shift.
-The Business Office Manager (BOM) kept track of CPR certifications.
-The BOM told staff when their CPR certification was expired.
-The previous BOM and previous Resident Care Coordinator (RCC) would schedule classes with the Registered Nurse (RN) from the facility's contracted pharmacy.
-Staff were aware they had to have current training on CPR.
-Last week she conducted return demonstration assessment for staff who had completed online training on CPR.
-There was a column on the staffing schedule to keep track of the expiration dates of staff CPR training.
-She was responsible for printing the schedule, and the Staffing Coordinator was responsible for reviewing the schedule for accuracy.
-She did not answer when asked how she ensured staff on the schedule had current training on CPR.
-The ED was ultimately responsible for ensuring staff on the schedule had current training on CPR.

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D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the health care needs were met for 3 of 11 sampled residents including failure to contact the primary care provider for refusal of medications, the resident's decline in health, inability to get out of bed and reposition herself due to weakness, crying due to pain, vomiting and altered mental status resulting in the resident's death (#11), notifying the primary care provider for not applying anti-thrombotic hose (#20), and notifying the primary care provider for a resident's weight gain (#7). The findings are: 1. Review of Resident #11's current FL-2 dated 08/03/20 revealed: -Diagnoses included seizures, dementia, schizophrenia, hypertension, anemia, gastroesophageal reflux disease, hyperlipidemia, osteoporosis, hip and back pain. -Resident #11 was intermittently disoriented. -Resident #11 was semi-ambulatory, incontinent with bladder, and required assistance with bathing, feeding, and dressing. a. Review of Resident #11's current care plan dated 06/07/20 revealed:	D 273		

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-The resident required supervision with eating; limited assistance with toileting, dressing, and grooming; extensive assistance with bathing.
-The resident was independent with ambulation and transfers.

Review of Resident #11's hospital discharge summary report dated 07/28/20 revealed:
-Diagnoses included seizure disorder, cognitive impairment, severe degenerative joint disease, hypertension, gastroesophageal reflux disease, diabetes type II with hyperglycemia.
-Resident #11 was admitted to the hospital for sepsis due to Escherichia coli (a bacterium that causes urinary tract infection) with encephalopathy (loss of brain functions due to toxins in the blood) without septic shock, acute cystitis without hematuria (urinary tract infection), seizure disorder, cognitive impairment, and type 2 diabetes mellitus.
-During the course the hospital visit Resident #11 was additionally treated for acute kidney injury, bipolar I disorder and cognitive impairment, type 2 diabetes mellitus, severe right hip osteoarthritis.
-Discharge instructions were to notify the physician for confusion or disorientation.

Review of Resident #11's progress notes revealed:
-On 08/05/20 first shift 7:00am to 3:00pm, Resident #11 was having problems and was urinating on herself.
-On 08/17/20 first/second shift 7:00am to 7:00pm, cuts were observed on Resident #11, she was not her normal self, the resident told staff the "cat did it."
-On 08/18/20 first shift 7:00am to 3:00pm, Resident #11 refused breakfast and did not eat lunch.
-On 08/18/20 second/third shift 3:00pm to

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D 273	Continued From page 16 7:00am, Resident #11 struggled with getting in bed and required repositioning every two hours. Resident #11 provided a minimal assist during repositioning. Resident #11 stayed in the bed on both shifts (second and third). -On 08/18/20 at 3:00am, the medication aide/supervisor (MA) went to reposition Resident #11 again. The resident refused to speak to the MA. The resident would not respond when asked about repositioning and if she wanted an as-needed medication. -On 08/18/20 first shift 7:00 am to 3:00pm, Resident #11 was not helping the "girls (personal care aides)" at all with changing her and they had to do everything. Review of Resident #11's Emergency Medical Service (EMS) report dated 08/25/20 revealed: -EMS was called to the facility on 08/25/20 regarding a resident with altered mental status. -Facility staff reported the resident experienced a mental decline compared to her normal. -The resident started to have snoring respirations. -The resident responded to painful stimuli. -The resident was slightly combative when EMS used painful stimuli to arouse her. -Resident #11's mental status was confused. -Resident #11's heart rate ranged between 51 to 66, respiration was 18 blood glucose was 69. Telephone interview on 10/21/20 at 3:55pm with the medical responder from EMS revealed: -Upon arrival at the facility on 08/25/20, after 1:00pm, facility staff reported Resident #11 was "not herself." -Staff informed that Resident #11 was "not with it and was not her normal self." -Resident #11 was slightly combative and she believed that was due to the resident's low blood sugar that was 69.	D 273		

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-She also noticed that Resident #11 had a low blood pressure and continued decrease in route to the hospital.
-In route to the hospital Resident #11 could not keep her eyes open very long. She would open her eyes look around and then close them again.
-The resident sometimes provided appropriate responses and sometimes not.
-An electrocardiogram showed an abnormal T-wave indicating bradycardia (slow heart rate).
-Upon arrival at the hospital Resident #11 was alive but had periods of slow lingering responses.

Telephone interview on 10/22/20 at 9:47am with emergency department physician revealed:
-When Resident #11 arrived at the emergency department on 08/25/20 the resident had altered mental status and was unable to complain about pain.
-Resident #11 was also hypotensive.
-The altered mental status and hypotension were signs of some type of infection.
-Initially, another physician assistant (PA) cared for Resident #11, then the resident started to show signs of going into cardiac arrest and he was called to assist.
-More than likely, the infection possibly caused Resident #11's decline, resulting in cardiogenic shock (when the heart suddenly can't pump enough blood to meet the body's needs, can be fatal if not treated immediately), which ultimately was related to the resident's death.
-Sometimes an infection was accompanied with a fever, but not every infection caused a fever.
-An infection if not treated in a timely manner could result in cardiogenic shock like it did for Resident #11.

A Review of Resident #11's primary care provider (PCP) office records from 10/22/19 to 10/20/20

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revealed there was no documentation the PCP had been notified regarding the resident's decline in health, becoming dependent on facility staff to provide total care and services, and Resident #11 being so weak that she was unable to get out of bed.

Telephone interview on 10/19/20 at 11:18am with Resident #11's responsible person revealed:
-Before COVID-19 she visited Resident #11 every day.
-Since COVID-19 she tried to talk with Resident #11 on the telephone daily.
-Generally, Resident #11 was independent but used a walker due to her leg and hip hurting.
-Towards the end, a few days before her death, Resident #11 was not eating.
-When she talked with facility staff she was told if Resident #11 did not start eating they would send her out to the hospital, but they never sent her out.
-She did not know if the staff contacted the resident's doctor.

Telephone interview on 10/19/20 at 2:06pm with the former Resident Care Coordinator (RCC) revealed:
-Resident #11 eventually got to the point where she could not stand up anymore.
-The day before Resident #11 passed away, the MA told her that Resident #11 was not doing good and needed to go out to the hospital.
-The MA told the Executive Director (ED) and the ED did not allow the MA to send Resident #11 out because she did not believe Resident #11 was sick enough to go to the hospital.
-For two days the MA expressed Resident #11 needed to go out to the hospital, but the ED said, "It's her baseline, that's just Resident #11."
-On 08/25/20, the MA asked the ED again about

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sending Resident #11 out to the hospital, initially, the ED said the same "that's Resident #11's baseline," she then told the MA to go ahead and send her out.
-She did not call Resident #11's PCP to inform of the resident's decline because the MA on duty should have called the doctor.

Telephone interview on 10/19/20 at 2:15pm with a former second shift MA revealed:
-She noticed that Resident #11 had started declining in health one week after she returned from the hospital on 07/28/20.
-Resident #11 went completely downhill to not getting out of bed and using the bathroom and urinating on herself.
-Resident #11 went from being completely independent to needing staff to do things for her.
-One to two weeks before Resident #11 passed away, she missed a doctor's appointment because she refused to get out of bed.
-She was not sure if Resident #11's PCP was made aware of the resident's decline.
-She told the third shift MA, the first shift MA, and the RCC about Resident #11's decline.
-If there was a concern the facility's protocol was to notify the supervisor, the supervisor reported to the RCC and ED.
-She knew the ED was aware of Resident #11's decline in health because one night when the ED was working on the floor as a PCA Resident #11 used the bathroom on herself and the ED helped to clean the resident up.
-Additionally, she also told the ED that Resident #11 had declined since she returned from the hospital and no longer got out of bed and was no longer "herself."

Telephone interview on 10/19/20 at 2:46pm with a former first shift MA/supervisor revealed:

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D 273	Continued From page 20 -Resident #11 had declined almost three weeks before her death. -On 08/20/20 Resident #11 had an appointment with a doctor (she did not know what doctor), when they got Resident #11 ready for the appointment the resident could not make the appointment because she was so weak and in pain, she could not walk. -On 08/24/20, the day before Resident #11's death, the resident did not eat breakfast and was giving the PCAs a hard time and urinating on herself. -Resident #11 vomited and complained of pain in her head. -She went to the RCC and told her that Resident #11 was not herself and needed to go out to the hospital. -The RCC told her to go and tell the ED. -She told the ED that Resident #11 was not herself and asked if she could send the resident to the hospital. -The ED said Resident #11 was at her baseline and that was how she acted. -The ED refused to allow her to send the resident out to the hospital. -She did not call the resident's doctor regarding the concerns that she had about Resident #11's current health. -On the morning of 08/25/20, Resident #11 was a little lethargic and weaker. -Resident #11 grabbed her arm saying, "Oh, Oh it hurts so bad", she did not know what was hurting Resident #11, but she thought the resident was talking about the pain in her hip and leg. -She went to the RCC again and told her that Resident #11 was worse than the day before, and she felt the resident really needed to go out to the hospital. -The RCC again told her to go and ask the ED about sending Resident #11 to the hospital.	D 273		

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D 273	Continued From page 21 -She asked the ED about sending Resident #11 to the hospital and the ED said Resident #11 was a "pill chaser," and the resident was not in that much pain. -Resident #11 was in pain, but her mental status and ability to do things for herself had changed and that was why she wanted to send the resident to the hospital. -She told the ED that she was going to send her out anyway, then the ED said go ahead, send her out. Telephone interview on 10/21/20 at 9:00pm with a MA revealed: -She was a MA and sometimes she worked on the floor as a PCA. -She noticed that Resident #11 had changed since she returned from the hospital on 07/28/20. -She was not working on the date that Resident #11 had died, but the day before her death she noticed the resident had declined a little more than usual. -Resident #11 also had migraine headaches a lot and sometimes had confusion, saying things that were not true. -She did not contact the resident's PCP but referred the information according to the facility's protocol to the RCC and the ED through the progress notes because during that time the ED worked a lot on the medication cart. -The ED and the RCC were to review and sign off on the progress notes before they put them in the residents' record, and she thought they would contact the resident's PCP with noted concerns. Telephone interview on 10/21/20 at 11:58am with a second shift MA revealed: -Prior to Resident #11's hospitalization on 07/28/20 the resident used to be independent and only needed staff assistance with showers.	D 273		

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D 273	Continued From page 22 -After 07/28/20 she noticed the resident started to decline and required more assistance from staff to do everything for her. -Two weeks before Resident #11's death the resident refused to get out of bed. -She did not contact Resident #11's PCP to report the resident's decline or to report the resident continually complained of pain even with the scheduled pain medication. -Because it had been reported to the RCC and ED as was the facility's protocol. Telephone interview on 10/21/20 at 12:58pm with the staffing coordinator revealed: -Weeks before Resident #11's death she noticed the resident had declined. -Resident #11 got to the point she stopped getting up or had difficulty getting up, then she started using the bathroom on herself in the bed. -One night it took three staff to put the resident in the bed and they had to reposition Resident #11 every two hours because she was unable to turn herself. -The whole week before Resident #11's death she did not act like her normal self. -On 08/24/20, the day before Resident #11's death, the resident was alert, but she felt the resident needed to be seen by the physician. -Resident #11 did not say much of anything, but she could tell the resident was not her normal baseline. -She really couldn't determine whether or not to send Resident #11 to the hospital or to contact the resident's PCP. She wanted the ED to make that decision. -On 08/25/20 the morning before Resident #11 went to the hospital, she observed the resident was slumped over and could not sit up. -Resident #11 was basically out of it and that caused her to slump over.	D 273		

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-She knew something was not right because the resident did not normally act that way.
-She did not contact the resident's PCP and was not aware if the MA contacted the resident's PCP.

Telephone interview on 10/21/20 at 2:34pm with first shift MA revealed:
-She thought Resident #11's health had declined because she would not get out of bed anymore.
-The resident would soil herself because she could not get up.
-A couple of weeks before Resident #11 died she went to the resident's room with two other staff and the resident was sitting on the edge of the bed.
-It took three of them to move Resident #11 over because she could not move herself over.
-Resident #11 stopped getting out of bed at least one week before her death.

Telephone interview on 10/22/20 at 8:45am with the nurse at Resident #11's PCP's office revealed:
-She talked with Resident #11's PCP and was informed the facility staff contacted the doctor one time and that was regarding a seizure on 07/16/20, which resulted in the resident being hospitalized.
-The PCP said no one at the facility contacted her to inform Resident #11 had declined in health, was not eating, was weak unable to walk and care for herself or that the resident's mental status had changed.
-The PCP said she wanted to be notified when the resident's baseline had changed.

Telephone interview on 10/22/20 at 8:45am with the nurse at Resident #11's PCP office revealed:
-She talked with Resident #11's PCP and was informed that no one at the facility had contacted

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the PCP to report Resident #11 was in so much pain that the resident was crying.
-No one at the facility contacted the PCP to informed the current pain medications were not helping to control the resident's pain.
-The PCP wanted to be notified when the resident's current medication was not effective and if the pain was bad enough for the resident to cry.

Telephone interview on 10/23/20 at 3:19pm with the Executive Director (ED) revealed:
-She expected staff to document on the computer when there was something different or they had to take more time than usual, or something was off about a resident.
-The staff identifying the change should notify the staffing coordinator and RCC of what was happening with the resident.
-They could document in the progress notes if they did not want to document in the computer.
-Staff were document in the supervisor (SIC) book, and it was reviewed by the RCC and signed off, by initiating the next step and what was done acknowledging it was reviewed and all had been taken care. This includes following-up with the resident's PCP if necessary.
-The RCC was supposed to assess the issue and ask related questions and then make recommendations, this included notifying the resident's PCP.
-If the RCC determined the PCP needed to be notified, then the MA or the RCC were to contact the resident's PCP.
-Anyone at the facility had the ability to contact the PCP at any time.
-The staff on any shift had the ability to contact the PCP, they had to first contact the RCC and let her know why they were contacting the PCP.
-If there was no documentation, she could not

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prove the PCP was notified.

Review of Resident #11's death certificate dated 08/25/20 revealed the cause of death was cardiogenic shock and acute coronary syndrome.

b. Review of Resident #11's current FL-2 dated 08/03/20 revealed:
-Diagnoses included osteoporosis and hip and back pain.
-Orders for medications used to treat pain included naproxen 250mg twice daily, oxycodone 5mg every six hours as needed for pain for 5 days, tylenol 500mg as needed for pain at bedtime and voltaren gel apply topically four times daily as needed for pain.

Review of Resident #11's hospital discharge summary report dated 07/28/20 revealed:
-Diagnoses included severe degenerative joint disease of the right hip.
-The physician noted Resident #11 had severe degenerative change at both hip joints with complete loss of joint space, sub-chonodral sclerosis (a painful bone spur related to osteoarthritis), cystic change and marginal spurring (bone spur of causing sharp pain when moving).
-There were instructions to notify the physician for increased or unrelieved pain, confusion or disorientation.

Review of Resident #11's August 2020 electronic Medication Administration Records (eMARs) revealed:
-There was documentation naproxen 250mg was administered twice daily from 08/01/20 through 08/24/20 and once on 08/25/20.
-There was documentation oxycodone 5mg was administered 17 times from 08/01/20 through

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THE BRADFORD VILLAGE OF KERNERSVILLE - WES	602 PINEY GROVE ROAD KERNERSVILLE, NC 27284

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08/15/20.
-There was no documentation tylenol was administered for pain from 08/01/20 through 08/25/20.
-There was no documentation voltaren gel was applied for pain from 08/01/20 through 08/25/20.

Review of Resident #11's progress notes revealed:
-On 08/01/20 first shift 7:00am to 3:00pm, Resident #11 still complained of pain, the resident said it was no better.
-On 08/03/20 first/second shift 7:00am to 7:00pm, Resident #11's leg gave out and the resident complained of pain.
-On 08/09/20 first/second shift 7:00am to 7:00pm, Resident #11's legs "went weak" on the way to shower and had to sit down twice.
-On 08/09/20 second shift 7:00pm to 11:00pm, Resident #11 was crying due to pain.
-On 08/09/20 third shift 11:00pm to 7:00am, Resident #11 was crying saying her right hip and leg were hurting.
-On 08/19/20 second shift 3:00pm to 11:00pm, Resident #11 was refusing to get out of bed due to increased pain in her hip and leg.

Telephone interview on 10/19/20 at 11:18am with Resident #11's responsible person revealed:
-Resident #11 mostly complained about headaches and hip/leg pain.
-Resident #11 was independent but always used a walker due to her leg and hip hurting.
-Resident #11 had great hip pain because she needed a total hip replacement.
-Prior to Resident #11's death she spoke with the resident briefly because she could not stay on the phone due to complaining about pain.
-Two weeks before Resident #11 passed away she complained that the pain had become

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unbearable.
-Some days Resident #11 called her crying because she was in pain.
-Resident #11 told her when she asked staff for pain medication, they would not give her the medication.
-When she asked staff why they would tell her it was not time for the medication.
-Since COVID-19 she did not see Resident #11 and she did not know the resident's medications.
-She asked staff to contact the resident's PCP to inform her that Resident #11 was continually in pain.
-She did not know if staff contacted the resident's PCP.
-Some days Resident #11 did not get her morning medications until hours after the medication was due.
-Once Resident #11 did not get her morning medications until noon.
-When she called and asked staff what was the problem and why Resident #11's medications were late, staff told her the resident had to wait.

Telephone interview on 10/19/20 at 2:15pm with a former second shift MA revealed:
-Some days Resident #11 did not eat because she complained about being in so much pain.
-A couple of weeks before her death Resident #11's complaint of pain "went through the roof."
-She did not contact the resident's PCP but made the RCC and ED aware so they could call the resident's PCP.
-She thought the RCC or ED made the resident's PCP aware of Resident #11's pain.

Telephone interview on 10/19/20 at 2:46pm with a former first shift MA/supervisor revealed:
-Resident #11 had a lot of pain in her hip because the bone was touching another bone causing

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friction.
-Resident #11's blood pressure was checked once monthly unless the resident was not feeling well.
-Three days prior to Resident #11's death she checked the resident's blood pressure and it was high (could not remember the results).
-She informed the ED that the resident's blood pressure was elevated, and she believed it was because Resident #11 was in so much pain.
-The ED often referred to Resident #11 as a "Pill chaser," and did not believe the resident was in pain as she expressed.
-The ED or the RCC were supposed to contact the resident's PCP, but they did not.
-She did not she contact Resident #11's PCP because she thought the ED or RCC called.

Telephone interview on 10/19/20 at 10:15pm with a third shift MA revealed:
-Resident #11 temporarily had oxycodone (a narcotic medication used to treat pain) as needed for pain.
- Resident #11 had nothing to take for pain after the oxycodone was finished.
-Resident #11 always complained about hip and leg pain.
-The night before Resident #11 passed away, the resident complained about leg pain.
-She told the resident that she did not have anything for pain, so she asked the resident if she wanted her rub her leg.
-A few weeks before Resident #11 died she complained the leg pain got "worse and worse."
-She believed Resident #11's pain was so bad because the resident had "bone-on-bone," because she needed hip surgery.
-Resident #11 went out to the hospital a couple of times for leg pains.
-She documented several times in supervisor's

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binder in the progress notes that Resident #11 complained about leg pain.
-She also knew that several staff documented the resident complained about leg pain.
-She did not contact the resident's PCP because she was on third shift and was not calling someone in the middle of the night.
-She wrote on the progress notes for the ED, RCC and first shift MA to review and contact the resident's PCP.
-The RCC and ED reviewed the binder and she thought they had notified the PCP that Resident #11 still had leg pain.

Telephone interview on 10/21/20 at 9:00pm with a MA revealed:
-She was a MA and sometimes she worked on the floor as a PCA.
-Resident #11 kept telling her that her hip was hurting her, and the resident could not get up out of bed anymore.
-Sometimes she documented that Resident #11 was still in a lot of pain.
-She referred the information to the RCC and the ED because during that time the ED worked a lot on the medication cart.
-She also wrote in the supervisor's binder and she documented on the progress notes that Resident #11 was still in pain.
-The ED and RCC reviewed and signed off on the progress note before they put them in the residents' record.
-The RCC or the ED also should have contacted the resident's PCP with concerns noted.

Telephone interview on 10/21/20 at 11:58am with a second shift MA revealed:
-She thought Resident #11's PCP knew about the resident's pain because the resident was prescribed oxycodone.

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-Each time Resident #11 was in pain the resident said her hip hurt really bad.
-When Resident #11 complained of pain she left a note for the MA on first shift to call the resident's PCP.
Telephone interview on 10/21/20 at 5:22pm with a former MA/supervisor revealed:
-She documented when Resident #11's pain in her legs was so bad the resident buckled over in pain and almost fell in the hallway.
-Another incident when Resident #11's pain was bad the resident was bouncing off one leg to the other attempting to relieve the pain.
-There was also an incident when she was taking Resident #11 to the shower and the resident had to sit down two times because her legs hurt so bad.
-She did not contact the resident's PCP when that happened.
-She did document in the supervisor's binder that the resident was in a lot of pain.
-The ED and RCC were supposed to review comments in the supervisor's binder and they made a check mark indicating they had reviewed comments.
-She thought the ED and RCC had notified the resident's PCP.

Telephone interview on 10/21/20 at 2:34pm with first shift MA revealed:
-After Resident #11 returned from the hospital on 07/28/20, she regularly complained about more pain even with the ordered medication.
-She thought Resident #11 had something for pain, but she was not sure what the medication was.
-She was supposed to contact the doctor if there was a problem with a resident.
-She was unable to remember if she contacted Resident #11's PCP about her having more pain.

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D 273	Continued From page 31 -If she had contacted the PCP there would be documentation in the progress notes. Telephone interview on 10/21/20 at 12:58pm with the staffing coordinator revealed: -She was the staffing coordinator but when the facility was short staff she worked with residents as a PCA. -When she worked with Resident #11 most times the resident complained about pain in her hip and knees. -Resident #11 had an appointment on 07/23/20 with the neurologist but the resident was in the hospital and the appointment was rescheduled for 08/20/20. -On 08/20/20 Resident #11 was unable to make it to the appointment because she could not walk. She called and rescheduled the appointment for September or October 2020 (unable to recall exact date or month). -Resident #11 could not walk because she was unable to move her hips and knees. -Resident #11 basically gave up due to the pain in her hips and knees. -Resident #11 was crying because she was in so much pain. -On an average Resident #11 complained about her legs and hip hurting every day. -The ED, RCC or MA were responsible for contacting the resident's doctor regarding the pain. Telephone interview on 10/23/20 at 3:54pm with the Executive Director (ED) revealed: -If Resident #11 was in pain the MA should have contacted the resident's PCP and notified the RCC. -Staff should have notified the PCP that Resident #11's pain was getting worse and the resident was having breakthrough pain.	D 273		

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-There should be documentation based on what the PCP said.
-She did not refer to Resident #11 as a "pill chaser" and did not refuse to send the resident out to the hospital.
-She did not know of staff that referred to Resident #11 as "pill chaser."
-She did not know of any staff that refused to send Resident #11 to the hospital to be assessed because they considered the resident a "pill chaser."

c. Review of Resident #11's current FL-2 dated 08/03/20 revealed medication orders included gavalix power mix 17grams in 8 ounces of liquid daily (a laxative used to treat occasional constipation).

Review of Resident #11's hospital discharge summary report dated 07/28/20 revealed an order for gavalix power mix 17grams in 8 ounces of liquid daily.

Review of Resident #11's August 2020 electronic Medication Administration Records (eMARs) revealed an entry for gavalix powder 17grams once daily scheduled for administration daily at 9:00am.
-There was documentation Resident #11 refused gavalix powder 17 of 25 opportunities from 08/01/20 to 08/25/20.
-There was no documentation Resident #11's PCP was notified regarding the 17 refusals.

Review of Resident #11's PCP's office records from 10/22/19 to 10/20/20 revealed there was no documentation the PCP had been notified the resident refused gavalix.

Telephone interview on 10/19/20 at 2:46pm with a

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previous MA/supervisor revealed:
-Resident #11 refused gavalix because the resident felt she did not have a problem going to the bathroom.
-It was the facility's policy to contact the PCP after three refusals.
-She did not contact the resident's PCP to let her know the resident refused the gavalix.
-The RCC was aware Resident #11 refused gavalix and she thought the RCC would contact the resident's PCP.

Telephone interview on 10/20/20 at 9:25am with a representative from the facility's contracted pharmacy revealed:
-Resident #11's gavalix 17gm daily was filled and dispensed on 07/28/20.
-The size sent was a two-week supply.
-The pharmacy did not provide automatic refill for medications dispensed to this facility.
-Each time a medication needed to be refilled the facility had to request a refill.
-The first time gavalix 17gm once was dispensed from the pharmacy was on 07/28/20.
-This medication was sent in a 14-day supply due to space, and the facility needed to request a refill of the medication.

Telephone interview on 10/22/20 at 8:45am with the nurse at Resident #11's PCP office revealed:
-No one at the facility called to make the PCP aware that Resident #11 refused gavalix.
-The PCP said she wanted to be notified if a medication was not working or not being used.

Telephone interview on 10/23/20 at 3:39pm with the Executive Director (ED) revealed:
-Staff did not make her aware that Resident #11 refused gavalix.
-The RCC was to go into the system every day to

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review what was going on with the medications.
-The RCC was able to run a report to filter out resident refusals and identify when medications were not administered.
-The facility had a form titled "1, 2, and 3" to notify the PCP regarding refusal of medications.
-The facility also had other forms that could be used to fax the PCP to notify when a resident refused medications.
-The policy says after three consecutive refusals the PCP should be notified.
-If there were any refusals of services the refusal should be noted in the supervisor's book.
-The MAs were able to document in the progress notes if they did not want to document in the computer.
-If the PCP needed to be notified depending on the issue the MA or the RCC were to contact the resident's PCP.
-Any staff on any shift had the ability to contact the PCP, they were to first contact the RCC and let her know why they were contacting the PCP.
-If there was no documentation, she could not prove the PCP was notified.

d. Review of Resident #11's current FL-2 dated 08/03/20 revealed medication orders for zaditor 0.025% instill 1 drop into affected eyes twice daily (used to soothe allergy irritants in the eye).

Review of Resident #11's August 2020 eMARs revealed:
-There was an entry for zaditor 0.025% eye drops scheduled for administration daily at 9:00am and 5:00pm.
-There was documentation Resident #11 refused zaditor 21 of 25 opportunities from 08/01/20 to 08/25/20.
-There was not documentation Resident #11's doctor was notified regarding the 21 refusals.

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D 273	Continued From page 35 Review of Resident #11's PCP office records from 10/22/19 to 10/20/20 revealed there was no documentation the PCP had been notified the resident refused zaditor eye drops. Telephone interview on 10/21/20 at 5:22pm with a previous MA/supervisor revealed: -Resident #11 did not like the eye drops and said the drops burned her eyes. -The RCC was supposed to get the eye drops discontinued. -She did not contact Resident #11's PCP to inform the resident refused the eye drops or that the eye drops burned the resident's eyes. Telephone interview on 10/19/20 at 2:16pm with a previous second shift MA revealed: -When she tried to administer Resident #11's eye drops, and the resident refused. -Each time Resident #11 refused the eye drops she left a note for first shift staff MA to notify the resident's PCP. -It was the facility's policy to contact the PCP after three refusals. -She did not check with the first shift MA see if she contacted the PCP. Telephone interview on 10/22/20 at 8:45am with the nurse at Resident #11's PCP office revealed: -No one at the facility called to make the PCP aware that Resident #11 refused zaditor eye drops. -The PCP said she wanted to be notified if a medication was not working or not being used. Telephone interview on 10/23/20 at 3:39pm with the Executive Director (ED) revealed: -She did not know Resident #11 refused her eye drops.	D 273		

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-After three consecutive refusals the MA should contact the resident's doctor.
-If the eye drops burned Resident #11 eyes, they should not have been administered.
-She expected staff to contact the PCP with concerns.
-Staff were also supposed to document in the supervisor's binder and daily the RCC was supposed to review the notes and follow-up to make sure proper measures were followed.

e. Review of Resident #11's current FL-2 dated 08/03/20 revealed medication orders for flonase 0.05% use 1 spray into each nostril once daily (used to treat nasal congestion).

Review of Resident #11's August 2020 eMARs revealed:
-There was an entry for fluticasone 0.05% 1 spray into each nostril once daily scheduled for administration at 9:00am.
-There was documentation Resident #11 refused fluticasone 3 out of 25 opportunities from 08/01/20 to 08/25/20.
-There was not documentation Resident #11's doctor was notified regarding the refusals.

Review of Resident #11's PCP office records from 10/22/19 to 10/20/20 revealed there was no documentation the PCP had been notified the resident refused fluticasone nasal spray.

Telephone interview on 10/21/20 at 5:22pm with a previous MA/supervisor revealed:
-Resident #11 refused the nasal spray and said she only needed the nasal spray when her allergies were bothering her.
-She did not contact the resident's PCP because it was the facility's policy to contact the doctor after three consecutive refusals.

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D 273	Continued From page 37 Telephone interview on 10/22/20 at 8:45am with the nurse at Resident #11's PCP office revealed: -No one at the facility called to make the PCP aware that Resident #11 refused the nasal spray. -The PCP wanted to be notified if a medication was not working or not being used. Telephone interview on 10/23/20 at 3:39pm with the Executive Director (ED) revealed: -Refusals should be reported to the resident's PCP after three consecutive refusals. -The facility had a form that was supposed to be completed and sent to the PCP informing the resident refused a medication. -The facility had a form for refusals of medications titled "1, 2, and 3." -All facility staff had to do was fill-in the resident's information and fax the form to the resident's PCP. The form made notifying the PCP a quick and easy process. -The RCC was also able to run a report to filter out resident refusals to see how often a medication was refused and the RCC could determine if the PCP should be notified. Review of the facility's medication refusal policy revealed medication refusals should be reported to the prescriber after three consecutive doses (or otherwise deemed appropriate by nursing) are refused. There must be documentation showing the prescriber was notified. 2. Review of Resident #20's FL-2 dated 08/20/20 revealed diagnoses included allergies, anxiety, depression, history of deep vein thrombosis, gastroesophageal reflux disease, insomnia, rectal prolapse, and onychomycosis. Review of Resident #20's physician's orders	D 273		

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dated 10/01/20 revealed there was an order for thrombo-embolic deterrent (TED) hose apply daily in the morning and remove every evening (used to treat fluid retention).

Review of Resident #20's electronic Medication Administration Record (eMAR) for October 2020 revealed there was no entry for TED hose.

Observation on 10/17/20 at 10:17am of Resident #20 revealed:
-Resident #20 was not wearing TED hose.
-Resident #20's right and left foot were extremely swollen and rounded on the top.
-There was indentation on both ankle areas where the top of Resident #20's socks rested.

Interview on 10/15/20 at 10:08am with Resident #20 revealed:
-The primary care provider (PCP) told her she needed to wear TED hose because her feet were swollen.
-She asked staff about the TED hose and was told the TED hose had not come in from the pharmacy.
-She did not remember when she asked staff about the TED hose.

Interview on 10/15/20 at 10:18am with the Resident Care Coordinator (RCC) revealed:
-She was responsible for reviewing and processing new physician's orders.
-She sent new physician's orders to the pharmacy and once the pharmacy entered the order on the eMAR, she reviewed the entry and accepted it if it was correct.
-TED hose would have been ordered from the pharmacy.
-She had not seen TED hose on Resident #20.
-She remembered measuring Resident #20 for

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TED hose and thought she faxed the measurements to the pharmacy in September 2020, but the fax machine did not provide a fax receipt.
-The TED hose had not been delivered from the pharmacy.
-She followed up with the pharmacy once, but she did not remember when.
-The medication aide (MA) working the shift was responsible for contacting the pharmacy to follow up on the order for TED hose.

Interview on 10/15/20 at 11:07am with a MA revealed she had not seen TED hose on Resident #20 and did not know if she was supposed to wear them

Interview on 10/15/20 at 11:19 with a second MA revealed:
-Resident #20 was supposed to wear TED hose, but she did not know if she did not or not.
-Resident #20 was already up and dressed for the day when she came in to work and she had not looked to see if Resident #20 was wearing her TED hose.
-She did not know TED hose were not on the eMAR and not available in the facility.
-The RCC and MAs were responsible for faxing orders to the pharmacy and following up on the orders if they were not delivered to the facility.

Telephone interview on 10/15/20 at 2:03pm with a representative from the facility contracted pharmacy revealed:
-She did not see an order for TED hose dated 10/01/20.
-The pharmacy may have been waiting on measurements.

Telephone interview on 10/16/20 at 1:46pm

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revealed with a second representative from the facility contracted pharmacy revealed:
-The pharmacy received a physician's order on 10/01/20 for TED hose apply in the morning and remove every evening. The order was dated 10/01/20.
-The pharmacy faxed a request back to the facility on 10/01/20 for Resident #20's measurements for TED hose.
-The pharmacy faxed a second request for measurements to the facility on 10/03/20.
-The pharmacy never received a response from the facility and therefore TED hose were never sent to the facility nor added to the eMAR.

Interview on 10/15/20 at 12:03pm with the PCP revealed:
-Resident #20 had an order for TED hose due to edema in her feet.
-She did not know Resident #20 did not have TED hose available in the facility.
-If Resident #20 did not wear TED hose as ordered, it could cause a delay in improvement of Resident #20's edema.
-She expected the facility to let her know if they were not able to get TED hose and she expected the facility to follow up with the pharmacy.

Interview on 10/15/20 at 4:40pm with the Executive Director (ED) revealed:
-MAs were responsible for faxing physician's orders to the pharmacy.
-The pharmacy entered the order on the eMAR and the RCC was responsible for verifying and accepting the order entered on the eMAR.
-If the medication/treatment was not in the facility on their shift, the MA was responsible for contacting the pharmacy to find out why it was not in the facility.
-The RCC was, overall, responsible for making

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sure medication and treatments such as TED hose had been delivered to the facility from the pharmacy.

Telephone interview on 10/16/20 at 3:53pm with the ED revealed:
-Resident #20 had swelling in her feel since she came to the facility, but she had not seen the swelling as bad as it was now.
-The MA Supervisor should have let the RCC know so she could have followed up with the pharmacy.
-She did not know about the 2 requests from the pharmacy for measurements for Resident #20's TED
hose.
-She did not know if the PCP had been notified Resident #20 did not have her TED hose.
-She expected the MA and the RCC to follow up with the pharmacy and Resident #20's PCP.

3. Review of Resident #7's current FL-2 dated 03/05/20 revealed:
-Diagnoses included heart failure, benign prostatic hypertrophy, diabetes mellitus type II and chronic kidney disease stage III.
-There was an order for weights three times per week, notify provider if weight gain was 3 pounds since last weight.

Review of Resident #7's physician orders revealed:
-There was an order dated 08/27/20 for weights three times weekly, notify provider if weight gain was more than 3 pounds since last weight check.
- There was an order dated 10/08/20 for weights three times weekly, notify provider if weight gain was more than 3 pounds since last weight check.

Review of Resident #7's physician notification

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forms revealed
-There was a form dated 03/12/20 completed by the Executive Director indicating Resident #7 had a weight change greater than 3 pounds between the dates of 03/10/20 and 03/12/20, but the dates of the weights did not correlate with the documentation on the March 2020 electronic Medication Administration Record (eMAR) for weight gain.
-The form dated 03/12/20 indicated Resident #7's weight was 270 pounds on 03/10/20 and 239 pounds on 03/12/20.
-There was a form dated 09/20/20 completed by the Executive Director indicating Resident #7 loss weight from 09/18/20 to 09/20/20.
-The form dated 09/20/20 indicated Resident #7's weight was 250 pounds on 09/18/20 and 237 pounds on 09/20/20.
-There were no other physician notification forms notifying the provider of Resident #7's weight gain.

Review of Resident #7's March 2020 eMAR revealed:
-There was an entry to check weight three times weekly and notify provider if weight gain was more than 3 pounds since last weight check, scheduled for 7:00 am to 2:59 pm.
-There was a weight of 239 pounds documented on 03/12/20 and a weight of 269 pounds documented on 03/14/20.
-There was no documentation on the eMAR indicating the provider was notified of the 30 pounds weight gain.

Review of Resident #7's April 2020 eMAR revealed:
-There was an entry to check weight three times weekly and notify provider if weight gain was more than 3 pounds since last weight check,

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scheduled for 7:00 am to 2:59 pm.
-There was a weight of 250 pounds documented on 04/17/20 and a weight of 255.8 pounds documented on 04/19/20.
-There was no documentation on the eMAR indicating the provider was notified of the 5 pounds weight gain.

Review of Resident #7's May 2020 eMAR revealed:
-There was an entry to check weight three times weekly and notify provider if weight gain was more than 3 pounds since last weight check, scheduled for 7:00 am to 2:59 pm.
-There was a weight of 257 pounds documented on 05/01/20 and a weight of 265 pounds documented on 05/03/20.
-There was no documentation on the eMAR indicating the provider was notified of the 8 pounds weight gain.

Review of Resident #7's June 2020 eMAR revealed:
-There was an entry to check weight three times weekly and notify provider if weight gain was more than 3 pounds since last weight check, scheduled for 7:00 am to 2:59 pm.
-There was a weight of 267 pounds documented on 06/26/20 and a weight of 270 pounds documented on 06/28/20.
-There was no documentation on the eMAR indicating the provider was notified of the 3 pounds weight gain.

Review of Resident #7's July 2020 eMAR revealed Resident #7 did not have any weight gain more than 3 pounds between the dates he was weighed.

Review of Resident #7's August 2020 eMAR

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revealed:
-There was an entry to check weight three times weekly and notify provider if weight gain was more than 3 pounds since last weight check, scheduled for 7:00 am to 2:59 pm.
-There was a weight of 238 pounds documented on 08/21/20 and a weight of 245 pounds documented on 08/23/20.
-There was a weight of 248 pounds documented on 08/25/20.
-There was no documentation on the eMAR indicating the provider was notified of the 7 pounds and 3 pounds weight gain.

Review of Resident #7's September 2020 eMAR revealed Resident #7 did not have any weight gain more than 3 pounds between the dates he was weighed.

Review of Resident #7's October 2020 eMAR revealed Resident #7 did not have any weight gain more than 3 pounds between the dates he was weighed.

Interview on 10/15/20 at 1:58pm with Resident #7 revealed:
-Staff weighed him but he did not know the last time.
-He did not know the last date he had a visit with the primary care provider (PCP).
-He felt fine and did not have any problems breathing.

Interview on 10/15/20 at 11:45 am with the facility contracted PCP revealed:
-She ordered weights three times weekly for Resident #7 due to his diagnosis of heart failure.
-She ordered weights three times weekly for all residents with heart failure and if their weights stabilized, she changed the frequency for weights

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to monthly.
-If she ordered notification for Resident #7's weight gain, she expected to be notified via the physician notification forms not via telephone.
-She visited the facility weekly and received the physician notification forms during her weekly Thursday visits.
-She did not recall specifically a physician notification form provided for Resident #7's weight gain, but this would have been the way she was notified.

Telephone interview with a personal care aide (PCA) on 10/16/20 at 1:20pm revealed:
-She assisted with the monthly weights for residents.
-The medication aides (MA) did the frequent weights that were in the computer system.
-She did not recall if she had noticed Resident #7 weighed three times a week.

Telephone interview on 10/20/20 at 10:17am with a MA revealed:
-When a resident's weight was ordered more frequently than monthly, the order appeared on the eMARs.
-She notified the Resident Care Coordinator (RCC), when there was a parameter indicated on the eMARs for weights, or blood pressures.
-She had never completed a physician notification form for Resident #7's weight.
-If the eMAR indicated the provider should be notified for Resident #7's weight gain, she told the former RCC.
-She did not recall telling the former RCC about a weight gain for Resident #7.

Telephone interview on 10/22/20 at 11:17am with another MA revealed:
-She weighed Resident #7 in the morning before

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breakfast.
-The facility had a digital scale and a chair scale.
-She used the chair scale for Resident #7.
-She used the physician notification forms to fax over to the PCP for notifications.
-She had not notified the PCP of Resident #7's weight gains.
-If she had to notify the PCP, she also told the former RCC so that the former RCC was aware.
-The MAs were responsible for informing the RCC of Resident #7's weight changes.

Telephone interview on 10/19/20 at 1:37pm with the former RCC revealed:
-Weights that were ordered more frequently than monthly were placed on the resident's eMARS by pharmacy.
-The MAs were responsible for obtaining these weights and documenting the weights on the eMAR.
-She found out during her time as the RCC that MAs would ask the resident their weights and document the weight reported by the resident instead of weighing the resident.
-She also discovered during her last 4 months at the facility that some MAs were weighing the resident once during the week and then documenting the same weight for the remainder of the week.
-She addressed these errors with the MAs.
-She expected the MAs to tell her if Resident #7's weight increased as ordered by the NP so that she could prepare the physician notification form.
-She either faxed the physician notification form to the NP or saved it for the NP to review on Thursdays in a binder.
-After the PCP reviewed the physician notification forms, she filed the form in the resident records.
-She did not recall completing a physician notification form for Resident #7's weight gain in

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D 273	Continued From page 47 March, April, May, June or August 2020. -She thought the MAs did not report the weight gains to her. -She was able to review weights by profile on the eMAR system but did not recall Resident #7's weight gains. -The MAs were responsible for reporting Resident #7's weight gains so that she could notify the provider. Telephone interview with the Executive Director on 10/22/20 at 12:57pm revealed: -MAs were responsible for obtaining weights and documenting weights on the eMAR. -Notifications about weight parameters were supposed to be faxed over to the NP by the MAs. -The MAs could document the information on two available forms to fax over to the NP, a physician order form or a physician notification form. -She knew that the former RCC made the NP aware of various notifications. -She expected the MAs to notify the NP by faxing the notification form. -She completed the two physician notification forms concerning Resident #7's weight dated 03/12/20 and 09/20/20 and she faxed them to the PCP. -She did not know why Resident #7 was weighed three times a week. -She expected the RCC to also review the eMARs periodically and monthly to ensure things were not missed. -The MAs were expected to notify the RCC about Resident #7's weights to ensure the NP was notified. -She thought the NP was aware of Resident #7's weights because of the weekly NP visits to the facility, but she could not say the NP was notified of all of Resident #7's weight gains. _____	D 273		

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D 273	Continued From page 48 The facility failed to ensure the health care needs were met for 3 of 11 sampled residents including failure to contact the primary care provider for refusal of medications, a resident crying due to pain, a resident's decline in health and inability to get out of bed and becoming totally dependent on facility staff for care needs, the delayed reporting symptoms of illness and not sending the resident to the hospital after she vomited and had altered mental status resulted in the resident's death shortly after arriving to the hospital (#11); a resident not wearing TED hose as ordered resulted in fluid retention and swollen extremities (#20); and a resident who had congestive heart failure whose PCP was not notified for weight gains greater than 3 pounds per physician's order (#7) The facility's failure resulted in serious physical harm and serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/15/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 22, 2020.	D 273		
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	D 276		

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D 276	Continued From page 49 Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure physician orders were implemented for 1 of 11 sampled residents related to a speech therapy consult for a bedside swallowing test (Resident #9). The findings are: Review of Resident #9's current FL-2 dated 10/14/20 revealed: -Diagnoses included dysphagia, dementia without behavioral disturbance, transient ischemic attack, altered mental status, syncope, and history of stroke. -There were no orders for a speech therapy to complete a bedside swallowing test. Review of Resident #9's physician orders revealed there was an order dated 10/01/20 for "speech therapy to do bedside swallowing test." Review of Resident #9's record revealed there was no documentation of a speech therapy evaluation. Interview on 10/15/20 at 10:17am with Resident #9 revealed: -He did not recall having any tests done in his room.	D 276		

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-His beverages were thickened, and he did not like it.
-He drank the beverages but had talked with his physician about his beverages.
-He choked once that he could recall prior to the thickened beverages.

Interview on 10/15/20 at 11:45am with the facility contracted Nurse Practitioner (NP) revealed:
-She gave orders to the Resident Care Coordinator (RCC) or the Executive Director (ED).
-She ordered a swallowing test for Resident #9 because he did not like thickened liquids.
-During one of Resident #9 hospitalizations in 2020, he had a swallowing test and his diet was changed to thickened liquids because he did not do well with the swallowing test.

Telephone interview on 10/19/20 at 4:00pm with a representative from a local home health/therapy agency revealed:
-There were no orders sent for a Speech Therapy consult and bedside swallowing test.
-There was an order for Resident #9 sent over by the local hospital for physical therapy and nursing education on disease process.
-The order could not be processed because another home health/therapy agency was already providing these same services.

Telephone interview on 10/19/20 at 4:05pm with a representative from Resident #9's local home health agency revealed:
-Resident #9 was receiving physical therapy services, and nursing education on his disease process.
-Services were started for Resident #9 on 10/16/20.
-The agency provided Speech Therapy, but there

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was no active order for Resident #9 to receive these services.
-The facility was able to order Speech Therapy for a bedside swallowing test by sending over the provider order or calling.

Telephone interview on 10/20/20 at 10:17am with a medication aide (MA) revealed:
-The MAs did not process orders for referrals and tests.
-The Resident Care Coordinator (RCC) handled all orders for tests or referrals.

Telephone interview on 10/19/20 at 1:37pm with the former RCC revealed:
-She used to be responsible for ensuring referrals and tests were completed for residents at the facility.
-The NP came to the facility on Thursdays and the NP gave her residents' orders prior to leaving.
-For referrals or tests, she made a copy of the order, highlighted what was needed, and gave a copy to the transportation coordinator to schedule an appointment for tests.
-The facility used two different home health or therapy agencies.
-Services were arranged with which ever agency the resident's insurance covered.

Telephone interview on 10/21/20 at 11:11am with the current RCC revealed:
-She was responsible for orders written by the NP.
-She began on 09/28/20 and she began her responsibilities as an RCC on the second week of October 2020.
-She or the ED would be responsible for ordering tests.
-She knew Resident #9 needed a swallowing test.
-She was told by a therapist on 10/20/20 that

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THE BRADFORD VILLAGE OF KERNERSVILLE - WES	602 PINEY GROVE ROAD KERNERSVILLE, NC 27284

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D 276	Continued From page 52 Resident #9's speech therapy consult for a bedside swallowing test was not processed or completed. -She thought the order was taken care of after speaking with the NP and the Executive Director last week on 10/15/20, but it the test had not been ordered for Resident #9. Telephone interview on 10/22/20 at 2:17pm with the ED revealed: -She knew Resident #9 had a speech therapy consult for a bedside swallowing test ordered. -She found out the week of 10/19/20 to 10/21/20 that Resident #9's speech therapy consult was not ordered with the local home health agency. -She did not know the date Resident #9's swallowing test would be completed but she had mentioned it in the hallway to one of the therapists. -She would have to ask the RCC or the transportation coordinator when the swallowing test was scheduled.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a therapeutic diet was	D 310		

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served as ordered for 1 of 6 sampled residents (Resident #17) with physician orders for a nutritional supplement.

The findings are:

Review of Resident #17's current FL2 dated 08/04/20 revealed:
-Diagnoses included Alzheimer's, dysphagia and cognitive communication deficit.
-A diet order for mechanically soft foods.

Review of Resident #17's physician order dated 08/13/20 revealed an order for a nutritional shake three times daily with meals.

Review of Resident #17's physician order dated 08/27/20 revealed an order for a nutritional shake three times daily with meals.

Review of Resident #17's physician order dated 09/10/20 revealed an order for weekly weights for 8 weeks, then monthly weights.

Review of Resident #17's August 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for a nutritional shake three times daily with meals.
-The entry for a nutritional shake three times daily with meals was discontinued on 08/06/20.
-There was no documentation of administration of a nutritional shake three times daily with meals from 08/01/20 through 08/31/20.
-There was no other entry for a nutritional shake three times daily with meals.

Review of Resident #17's September 2020 eMAR revealed:
-There was an entry for a nutritional shake 8

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ounces three times daily after meals dated 09/02/2020.
-The nutritional shake 8 ounces three times daily after meals was scheduled at 8:00am, 12:00pm, and 5:00pm.
-There was documentation of administration of the nutritional shake 8 ounces three times daily after meals from 09/02/20 through 09/30/20 except for 5:00pm on 09/23/20 and 5:00pm on 09/29/20 when documentation reflected Resident #17 refused.

Review of Resident #17's record revealed:
-The resident's weight on 09/10/20 was documented as 109 pounds.
-The resident's weight on 09/17/20 was documented as 108 pounds.
-The resident refused to have weight taken on 09/24/20.
-Resident #17 moved out of the facility on 10/01/20.

Telephone interview on 10/21/20 at 2:20pm with a medication aide (MA) revealed:
-Resident #17 had a provider's order for a nutritional shake three times a day after meals.
-She had provided shakes to Resident #17, but could not remember the specific dates.
-Resident #17 had a poor appetite, but usually drank the shakes with no problems.
-She did not know the entry for Resident #17's nutritional shakes was not printed on the August 2020 eMAR.
-Resident #7 probably got the nutritional shake three times daily in August 2020, even if there was no documentation on the eMAR.
-The orders were entered into the eMAR system by either the pharmacy or by the Resident Care Coordinator (RCC).
-The order dated 08/13/20 for Resident #17 to

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D 310	Continued From page 55 receive a nutritional shake three times daily with meals must have been overlooked. Telephone interview on 10/21/20 at 2:30pm with the Primary Care Provider (PCP) revealed: -Resident #17 had been in rehabilitation a few weeks earlier this summer and had new orders when she returned to the facility. -On 08/13/20, she ordered a nutritional shake three times daily after meals. -The PCP was not notified by facility staff Resident #17 had not received the nutritional shake from 08/13/20 through 09/02/20. -It was her expectation was for facility staff to provide nutritional shakes as ordered. Attempted interviews on 10/22/20 at 12:50pm, 10/22/20 at 2:45pm and on 10/23/20 at 8:15am with the RCC were unsuccessful. Telephone interview on 10/22/20 at 1:00pm with the Executive Director revealed: -When orders were received, the MA or RCC would fax the order to the pharmacy. -The order was entered into the eMAR system by the pharmacy staff. -The order was reviewed and approved by the MA. -The copy of the order was verified by the RCC the next day. -She did not know why the order dated 08/13/20 for Resident #17 for a nutritional shake three times daily was not started until 09/02/20. Observation on 10/22/20 at 1:00pm revealed Resident #17 was unavailable for interview.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders	D 344		

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D 344	Continued From page 56 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 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 contact with the prescribing physician for clarification of medication orders for 1 of 11 sampled residents (Resident #13) regarding an order for sliding scale Humalog insulin. The findings are: Review of Resident #13's current FL-2 dated 01/07/20 revealed: -Diagnoses included diabetes mellitus type II, hypertension, chronic pain, and neuropathy. -There was an order for check fingerstick blood sugar (FSBS) before meals and at bedtime. -There was an order for Humalog insulin 100 units per ml (used to lower elevated blood sugar values) sliding scale before meals: 150-200 = 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, greater than 401= 12 units. Review of Resident #13's signed physician's	D 344		

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orders dated 02/11/20 revealed:
-There was an order to check FSBS fasting before meals and at bedtime.
-There was an order for Humalog insulin 100 units per ml sliding scale before meals: 150-200 = 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, greater than 401= 12 units.

Review of Resident #13's physician's order dated 04/16/20 revealed there was an order for "New insulin sliding scale orders" Humalog before meals: 250-300=4 units, 301-350= 6 units, 351-400= 8 units, greater than 450= 10 units.

Review of Resident #13's progress notes and record revealed there was no clarification regarding the amount of insulin to be administered when the FSBS was 401-450.

Review of Resident #13's signed physician's orders dated 09/18/20 revealed:
-There was an order to check FSBS fasting before meals and at bedtime.
-There was an order for Humalog before meals: 250-300=4 units, 301-350= 6 units, 351-400= 8 units, greater than 450= 10 units.
-There was a second order for Humalog sliding scale based on FSBS with parameters as follows: 0-250 give 0 units, 250-300 give 4 units, 301-350 give 6 units, 351-400 give 8 units, and 400 plus give 10 units.

Telephone interview on 10/16/20 at 3:40pm with Resident #13's primary care physician (PCP) revealed he did not know the facility had 2 different orders for Humalog sliding scale insulin.

Review of Resident #13's August 2020 electronic Medication Administration Record (eMAR)

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revealed:
-There was an entry for check FSBS fasting before meals and at bedtime with scheduled times of 6:30am, 11:30am, 4:30pm, and 8:00pm.
-There 88 documented FSBS values.
-There were 3 FSBS values documented between 401 and 450.
-On 08/08/20 at 6:30am FSBS=418, on 08/28/20 at 11:30am FSBS=440, and on 08/29/20 at 4:30pm FSBS=401; with 10 units of Humalog insulin documented as administered for each.

Review of Resident #13's September 2020 eMAR revealed:
-There was an entry to check FSBS fasting before meals and at bedtime with scheduled times of 6:30am, 11:30am, 4:30pm, and 8:00pm.
-There were 100 documented FSBS values.
-There were 7 FSBS values documented between 401 and 450.
-On 09/07/20 at 6:30am FSBS=438, on 09/24/20 at 11:30am FSBS=449, on 09/25/20 at 11:30am FSBS=431, on 09/04/20 at 4:30pm FSBS=412, on 09/13/20 at 4:30pm FSBS=407, on 09/19/20 at 4:30pm FSBS=425, and on 09/23/20 at 4:30pm FSBS=446; with 10 units of Humalog insulin documented as administered for each.

Review of Resident #13's October 2020 eMAR revealed:
-There was an entry for check FSBS fasting before meals and at bedtime with scheduled times of 6:30am, 11:30am, 4:30pm, and 8:00pm.
-There 53 documented FSBS values documented from 10/01/20 to 10/15/20 with no values documented between 401 and 450.

Interview on 10/15/20 at 5:00pm with Resident #13 revealed he knew he received insulin based on the value of his fingerstick but did not know

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D 344	Continued From page 59 the sliding scale parameters. Telephone interview on 10/16/20 at 2:35 pm with a pharmacist at the contract pharmacy revealed: -The pharmacy received Resident #13's physician's order for "New insulin sliding scale orders" Humalog before meals: 250-300=4 units, 301-350= 6 units, 351-400= 8 units, greater than 450= 10 units on 05/07/20. -There was documentation pharmacy staff faxed Resident #13's PCP for clarification of the missing 401-450 sliding scale parameters on 05/08/20, 05/11/20, and 05/13/20 with a PCP response to continue the sliding scale as ordered. -The facility was responsible for clarifying orders if the orders were not clear or complete. -There was no documentation for information received from the facility for clarification. -The eMAR computer had an area for entering the medication orders and an area for entering a sliding scale calculator and the eMAR computer would populate an amount of sliding scale insulin to be administered based on the sliding scale parameters used to input information. -The pharmacy staff and the facility staff could change information in the eMAR and calculator for this facility. -Pharmacy records revealed a facility staff member made changes to the sliding scale calculator on 05/08/20. -The physician's order sheet generated from the medication orders in the eMAR system and included the sliding scale insulin scale information as a separate entry which was on the signed physician's orders dated 09/18/20. -The pharmacy had not received a copy of the signed physician's orders dated 09/18/20. Telephone interview on 10/16/20 at 3:15pm with Resident #13's PCP revealed:	D 344		

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D 344	Continued From page 60 -He did not know changes to Resident #13's sliding scale for Humalog on 04/16/20 were not complete. -The sliding scale values he routinely used were 400-450= 10 units and greater than 450 units give 12 units. -He could not locate documentation the facility or the pharmacy contacted him to clarify the order from 04/16/20 or the signed physician's order dated 09/18/20. -Medication clarifications could be sent by fax or messages left on the phone. Telephone interview on 10/19/20 at 1:14pm with the former Resident Care Coordinator (RCC) revealed: -She was the RCC for 4 months until leaving 09/08/20. -She was a medication aide (MA) as well as the RCC. -She was able to enter some medications orders (orders for medications to be given stat or standing orders) and make changes to times of administration. -She was responsible to check orders entered into the eMAR computer system and approve the orders for the MAs to start administering. -She was responsible for auditing resident's eMARs for accuracy of the medication orders. -She did not realize Resident #13's Humulin sliding scale order had no order for FSBS values 401-450 on the 04/16/20 order or that the sliding scale insulin calculator parameters did not match the 04/16/20 order.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 61 (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 8 of 9 sampled residents (Residents #1, #4, #5, #11, #13, #14, #16 and #20), related to a medication for bipolar disorder and a medication for gastroesophageal reflux disease (#1), a narcotic pain medication (#4, #5, and #13), an anti-epileptic medication to control seizures, an osteoarthritis gel medication as needed for arthritic pain, an as needed pain medication, a medication for low blood levels of B12, a medication for vitamin deficiency, and an antihistamine to prevent allergy symptoms (#11), an anti-anxiety medication (#14), a medication used to treat nightmares and a medication for anxiety (#16), and a medication used to treat fluid retention (#20). The findings are: 1. Review of Resident #11's current FL-2 dated 08/03/20 revealed: -Diagnoses included seizures, dementia, schizophrenia, hypertension, anemia, gastroesophageal reflux disease, hyperlipidemia, osteoporosis, hip and back pain.	D 358		

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D 358	Continued From page 62 -A medication order for Vimpat 200mg one tablet twice daily. a. Review of Resident #11's previous FL-2 dated 06/02/20 revealed a medication order for Vimpat 200mg one tablet twice daily. Review of Resident #11's hospital discharge summary report dated 07/28/20 revealed: -Diagnoses included seizure disorder, severe degenerative joint disease of the right hip, severe right hip osteoarthritis, cognitive impairment, bipolar disorder, mental retardation, hypertension, gastroesophageal reflux disease, diabetes type II with hyperglycemia. -There was an order for Vimpat 200mg one tablet twice daily (used to treat seizures). Review of Resident #11's progress notes revealed: -On 07/08/20 the medication aide/supervisor (MA) noted Resident #11 was running out of Vimpat. -The MA called the neurologist to get a refill and left a message. -The nurse called back, and informed Resident #11 needed an appointment. An appointment was scheduled for 07/23/20. -The MA noted the nurse was going to send enough Vimpat to last until 07/23/20. -On 07/09/20 the MA noted Resident #11 did not receive Vimpat from pharmacy. -The pharmacy said a verbal order was needed, the Resident Care Coordinator (RCC) noted the physician was sending the order. -On 07/10/20, Resident #11 was out of Vimpat, "still waiting on doctor and script." -The MA called the physician and was informed a verbal order was given to someone at the facility on 07/08/20.	D 358		

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D 358	Continued From page 63 Review of Resident #11's July 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Vimpat 200mg scheduled for administration twice daily at 9:00am and 5:00pm. -There was documentation Vimpat was not available for administration 12 of 36 opportunities (6 days) from 07/01/20 to 07/31/20. -On 07/09/20 at 7:42am, "needs hard script, will call doctor." -On 07/09/20 at 4:17pm, "waiting on medication to come in from pharmacy." -On 07/10/20 at 7:27pm, "medication ordered." -On 07/10/20 at 4:34pm, "waiting on medication to come in from pharmacy." -On 0711/20 at 5:12pm, "waiting on script." -There was documentation Vimpat was administered 07/15/20. -There was documentation Resident #11 was in the hospital 12 days from 07/16/20 through 07/28/20. Review of an Emergency Medical Service responders (EMS) report dated 07/10/20 revealed: -EMS responded to the facility due to Resident #11 having a seizure. -Resident #11 had a one-minute long seizure and had become non-verbal and not at her baseline following the seizure. -The EMS documented Resident #11 looked lethargic, had tremors in her right hand, and tremors in her tongue. -The EMS was unable to assess Resident #11 mental status due to her current condition. -The facility staff reported that Resident #11 had a seizure and was in a postictal state (the altered state of consciousness after an epileptic seizure).	D 358		

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D 358	Continued From page 64 -Resident #11 was assisted to the stretcher with a pivot stand. Review of a hospital discharge summary report dated 07/10/20 revealed: -Resident #11 was at the hospital because the facility reported the resident had a seizure that lasted one minute and had become non-verbal and not at her baseline following the seizure. -Resident #11 slowly became cognitive and eventually was able to respond. -After several tests Resident #11 was later discharged back to the facility. Review of an incident report dated 07/16/20 revealed: -Resident #11 was sitting at the dining room table when she started having a seizure. -Resident #11 was not responding when staff attempted to arouse her. Review of an EMS report dated 07/16/20 revealed: -Upon arrival Resident #11 appeared to be tired and stated, "she had not felt good in several days." -Resident #11's blood pressure was on the low end of normal. -Staff reported the resident was not as interactive and had periods of time when she would not talk. Review of hospital discharge summary report dated 07/16/20 revealed: -Resident #11 was sent to the emergency department due to having a seizure. -Due to the seizure and being septic with a urinary tract infection Resident #11 was discharged to another hospital on 07/18/20. Telephone interview on 10/19/20 at 11:18am with	D 358		

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D 358	Continued From page 65 Resident #11's responsible person revealed: -Resident #11 had a history of seizures, but lately they were coming more often. -When Resident #11 went to the hospital on 07/16/20, she was lethargic for 24 hours. -Prior to the hospital visit she did not know Resident #11 was out of her seizure medication (Vimpat). -Resident #11 was sent to another hospital for further treatment related to seizures and an infection. Telephone interview on 10/19/20 at 2:15pm with a former second shift MA revealed: -Resident #11 was out of her seizure medication because the pharmacy did not send the medication. -She did not request a refill of Vimpat but thought the RCC had requested a refill of the medication. -While out of the seizure medication Resident #11 was sent out to the hospital "a few times for seizures." -She sent the resident out in July 2020 and another time (unable to recall exact date). -When she documented "waiting on pharmacy, medication ordered" on the eMAR, it meant the medication was not available for administration because the pharmacy had not delivered the medication to the facility. -Medication refills could be requested electronically through the medication administration system. -The system would indicate if the requested medication was accepted by the pharmacy. -If the request was rejected, she had to contact the pharmacy for further information. -Medication refills should be requested at least five days before the medication was out in case the pharmacy rejected, and then there would be time to figure out the problem, so the resident	D 358		

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was not without medication.
-This, this did not always happen, and residents often missed doses of medication.

Telephone interview on 10/19/20 at 2:06pm with the former RCC revealed:
-Resident #11 was without Vimpat for one week or more.
-The MA was supposed to request a refill 5 days before the medication was out.
-She talked with the nurse at Resident #11's neurologists office (unable to recall the exact date) and was told they would give an order for Vimpat with four refills.
-The nurse also said Resident #11 needed to be seen by the neurologist.
-She did not consider the information given by the nurse to be a verbal order.
-She thought the nurse was going to call the pharmacy with an order.
-She did not contact the neurologist again, she thought the MAs were contacting the neurologist.
-The MAs should have documented when they contacted the neurologist.
-If there was no documentation, she could not say the neurologist was contacted.
-The evening when Resident #11 went to the hospital on 07/10/20 she was off duty, but she was aware the resident went to the hospital.
-She did not think to have the MA ask the hospital for a refill of the Vimpat.
-The MA should have continued to contact the neurologist more than once per day and made her and the Executive Director (ED) aware.
-The Vimpat was not delivered to the facility until 07/15/20, Resident #11 had another seizure on 07/16/20 and was out of the facility until 07/28/20.

Telephone interview on 10/19/20 at 2:46pm with a former first shift MA revealed:

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D 358	Continued From page 67 -She remembered when Resident #11 was out of Vimpat, because the pharmacy did not send the medication. -On 07/08/20, she gave the morning dose of Resident #11's Vimpat. -She noticed there was one tablet left, so she requested a refill of Vimpat, and it was rejected. -When a request for refill was rejected it was usually because a new order was needed. -She informed the RCC and called the pharmacy to clarify why the medication was rejected. -She called the neurologist on 07/08/20 and was told a new order would be provided with four refills, but Resident #11 had to see the neurologist or his assistant. -She gave the information to the RCC and the RCC was supposed to call the neurologist. -She did not think or realize the information given by the neurologist nurse was a verbal order for Vimpat. -She thought the neurologist was going to send an electronic prescription (eScript) to the pharmacy. -She called the pharmacy when the medication was not delivered the next day and found out they still needed an order for Vimpat. -She informed the RCC and did not follow-up again with Resident #11's neurologist again because she thought the RCC was calling. -On 07/14/20, she realized Resident #11 was still without Vimpat and she called the primary care provider to request the medication. -On 07/15/20, the pharmacy sent Vimpat; and on 07/16/20 Resident #11 went out to the hospital due to a seizure and was gone for 12 days. -A medication should be reordered before the medication was out, at least 5 days. -Some of the MAs waited until the last dose was administered, then ordered the medication. -If there was a problem getting the medication	D 358		

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refilled the resident was without the medication for several days until the problem was solved.
-A request for a medication refill was simple and could be ordered electronically on the medication administration system; the system would indicate if a refill had been requested.
-Some MAs would fax a refill request to the pharmacy, either way of requesting a refill was permissible.
-Her and the RCC used to audit the medication carts, but the Executive Director (ED) stopped them and she started doing the cart audits herself.
-She did not know how often the ED performed the audit.

Telephone interview on 10/20/20 at 9:04am with a representative from the facility's contracted pharmacy revealed:
-On 02/07/20, the neurologist gave a prescription for Vimpat with four refills.
-The last refill of Vimpat from the 02/07/20 order was on 06/08/20, and 60 tablets were dispensed.
-The pharmacy sent a request for a new prescription on 06/15/20 and again on 06/25/20.
-On 06/25/20, the neurologist sent a note back asking that someone call the office.
-On 06/25/20, the pharmacy notified the RCC that the provider had denied the refill and wanted to be called.
-On 07/08/20, at 11:00pm, a staff at the facility sent a paper refill request for Resident #11's Vimpat.
-On 07/09/20, she called the RCC and informed the neurologist denied a prescription for Vimpat and requested that someone call the neurologist office.
-On 07/15/20, at 1:00pm, the pharmacy called the neurologist and got a verbal order for Vimpat with four refills.

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D 358	Continued From page 69 -The medication was refilled with a 30-day supply and immediately dispensed to the facility 1:30pm on 07/15/20. -If the RCC had received a verbal order for Vimpat she would not have accepted it because Vimpat was a controlled medication and needed the verbal to come directly from the doctor or a hand-written prescription (eScript). Telephone interview on 10/21/20 at 5:04pm with the nurse at Resident #11's neurologist office revealed: -The last time Resident #11 was seen by the neurologist was last year on 02/07/19. -There was another appointment scheduled for 02/21/19 that was canceled by the facility. -A verbal prescription was given to the pharmacy on 02/07/20 with four refills. -On 06/25/20, the neurologist received a refill request from the pharmacy. -The pharmacy was notified the resident needed to be seen and to call the office, the refill was denied. -On 07/08/20, someone at the facility called and requested a refill of Vimpat. A verbal order for Vimpat was given and the staff was told that Resident #11 needed an appointment to be seen by the physician. -On 07/09/20, the RCC called and made an appointment for Resident #11 to be seen on 07/23/20. The resident was a no show for the appointment. -If the pharmacy did not accept the verbal order given, then facility staff should have called back to make the neurologist aware. -No one called the office regarding Resident #11's Vimpat until the pharmacy called on 07/15/20 and asked for a hard script for Vimpat. -According to the neurologist, Resident #11's seizure activity on between 07/10/20 and	D 358		

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D 358	Continued From page 70 07/16/20 could have possibly been related to the resident not getting Vimpat twice daily. Telephone interview on 10/21/20 at 10:09pm with a medication aide (MA) revealed: -The MA was responsible for medication administration. -The exception "physically unable to take" on the eMAR meant the medication was not at the facility. -She requested refills when there were five doses left because sometimes insurance would not pay for a medication if the refill was requested too soon. -She would peel the sticker off the medication blister pack and fax it to the pharmacy when a refill was needed. -Sometimes she called the pharmacy for a refill if a medication was not available; she also checked the back-up medication storage cart before she called the pharmacy. -She wrote notes on the board near the MA station so other staff would know when to order medication. -The MA or supervisor was responsible for notifying the Primary Care Provider (PCP) when a medication was not available for administration. -The MA or supervisor would fax the PCP or put a note under the RCC door regarding missed medication. -The PCP was supposed to be notified after two days if a medication was missed, depending on the medicine. -The RCC was responsible for auditing the medication carts and the eMARs; she did not know how often the audits were done by the RCC. -She audited the medication carts and eMARs weekly. -She compared the medication available to be	D 358		

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administered to the entries on the eMAR.
-Shift reports were kept in a purple binder at the MA station.
-Subsequent shifts would know if a medication had been requested from the pharmacy by reviewing the report.
-She routinely reported medications that were not available to the first shift supervisor since management was not in when she left after working third shift.

Telephone interview on 10/23/20 at 3:19pm with the Executive Director (ED) revealed:
-She was out of town from 07/03/20 through 07/13/20 and unaware that Resident #11 was out of Vimpat.
-When she returned the MA and RCC said they had contacted the neurologist's office regarding the Vimpat.
-She had documentation that the MA talked with the pharmacy on 07/09/20 regarding Resident #11's Vimpat and she had seen documentation the pharmacy needed a prescription.
-She was not sure what happened with Resident #11's Vimpat from 07/09/20 and 07/14/20.
-The RCC should have called the resident's neurologist continually until she got a prescription for the Vimpat.
-The MA was supposed to contact the pharmacy at least 5 days before the medication was out.
-Medications in bubble packed containers had the blue indication on the container instructing when to reorder the medication.
-When Resident #11 was sent out to the hospital on 07/10/20 for a seizure the staff should have asked the hospital to get a prescription for Vimpat.
-If the RCC was not on duty when the resident returned from the hospital the MA on duty should have contacted the hospital and asked for an

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order for Vimpat.
-Her expectation was that staff continued to work to get the medication in facility and that no resident went without their medication.

According to the manufacturer's instructions stopping Vimpat suddenly can cause serious problems. Stopping seizure medicine suddenly in a patient who has epilepsy can cause seizures that will not stop.

b. Review of hospital discharge summary report dated 07/28/20 revealed an order for voltaren gel (diclofenac sodium) 1% apply to affected area four times daily as needed (used to treat and relieve pain, swelling and joint stiffness).

Review of Resident #11's current FL-2 dated 08/03/20 revealed an order for voltaren gel 1% gel apply to affected area four times daily as needed.

Review of Resident #11's progress notes revealed:
-On 08/01/20 first shift 7:00am to 3:00pm, Resident #11 "still complained of pain," the resident said it was no better.
-On 08/03/20 first/second shift 7:00am to 7:00pm, Resident #11's leg gave out and the resident complained of pain.
-On 08/09/20 first/second shift 7:00am to 7:00pm, Resident #11 legs "went weak" on the way to shower and had to sit down twice.
-On 08/09/20 second shift 7:00pm to 11:00pm, Resident #11 was crying due to pain.
-On 08/09/20 third shift 11:00pm to 7:00am, Resident #11 was crying saying her right hip and leg were hurting.
-On 08/19/20 second shift 3:00pm to 11:00pm, Resident #11 was refusing to get out of bed due

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D 358	Continued From page 73 to increased pain in her hip and leg. Review of Resident #11's July 2020 eMARs revealed: -There was an entry for voltaren gel 1% four times daily scheduled as needed. -There was no documentation voltaren gel had been applied from 07/01/20 through 07/31/20. -There was documentation Resident #11 was in the hospital from 07/16/20 through 07/28/20. Review of Resident #11's August 2020 eMARs revealed: -There was an entry for voltaren gel 1% four times daily scheduled as needed. -There was no documentation voltaren gel had been applied from 08/01/20 through 08/25/20. Interview on 10/19/20 at 11:18am with Resident #11's responsible person revealed: -In August 2020, her conversations with Resident #11 were brief due to the resident complaining about pain. -Resident #11 complained about hip pain day and night. -Resident #11 was independent but used a walker because her leg and hip were hurting. -Resident #11 had great hip pain because she needed a total hip replacement. -Some days Resident #11 called her crying because she was in pain. -Resident #11 told her when she asked staff for pain medication, they would not give her the medication. -She called staff to ask why they would not give Resident #11 pain medication and they would tell her it was not time. -She did not know Resident #11's medications and did not know what she had for pain. -Two weeks before Resident #11 passed away on	D 358		

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D 358	Continued From page 74 08/25/20, she complained about the pain being unbearable. Telephone interview on 10/19/20 at 10:15pm with a third shift MA revealed: -The resident always complained about leg pain. -Resident #11 went out to the hospital a couple of times for leg pains. -She did not know that Resident #11 had voltaren gel to use for pain. -She had the ability to review Resident #11's eMARs and did not recall seeing voltaren gel for Resident #11. Telephone interview on 10/20/20 at 9:44am with a representative from the facility's contracted pharmacy revealed: -Voltaren gel was dispensed 07/28/20 in a 100gram tube. -If voltaren gel was applied as ordered up to four times daily to the hip or knees using a 2/3-inch diameter, the medication would last at a minimum of 50 days. -She did not see any request to fill voltaren gel prior to 07/28/20. -This medication is mostly used for joint pain associated with some type of osteoarthritis. Telephone interview on 10/19/20 at 2:15pm with a previous second shift MA revealed: -Before she passed away, Resident #11 continually complained about pain, and the complaints about pain got worse after she returned from the hospital on 07/28/20. -She did not know Resident #11 had voltaren gel as needed for pain. -She looked at the eMARs but did not realize voltaren gel was on the eMARs. -She would leave notes for the first shift staff regarding the resident's pain and to contact the	D 358		

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resident's PCP.
-She did not contact the PCP because she worked during second shift and the doctor's office was closed.

Telephone interview on 10/19/20 at 2:46pm with a previous MA/supervisor revealed:
-Voltaren gel was never sent from the pharmacy.
-Her and other MAs called the pharmacy to inquire about the voltaren gel, but it was never delivered to the facility.
-Sometimes she used another resident's voltaren gel to help Resident #11 with the pain.
-She did not document on the eMAR that she used the other resident's voltaren gel because it did not belong to Resident #11.
-She did not contact the resident's PCP about the pain, and she did not document when she contacted the pharmacy regarding Resident #11 not having her own voltaren gel.

Telephone interview on 10/21/20 at 2:34pm with a first shift MA revealed:
-After Resident #11 returned from the hospital on 07/28/20, she complained more about pain even with the ordered medication.
-She did not remember ever using voltaren gel on Resident #11, she did not recall the resident ever asking for voltaren gel.
-She did not offer voltaren gel to Resident #11 because she did not know she had voltaren gel for pain.

Telephone interview on 10/21/20 at 11:58am with a second shift MA revealed:
-Each time Resident #11 was in pain the resident complained of severe hip pain.
-She did not know voltaren gel was at the facility for Resident #11.
-Although she reviewed the eMARs and

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administered Resident #11's medications she did not know voltaren gel was available to use for pain.
-When Resident #11 complained of pain she left a note for the MA on first shift to call the resident's PCP.

Telephone interview on 10/21/20 at 9:00pm with a MA revealed:
-Resident #11 had scheduled medications for pain.
-She used voltaren gel on Resident #11 when she complained of leg pain.
-She was unable to explain why she did not document on the eMAR when she applied voltaren gel on Resident #11.
-When she worked the third shift, she was responsible for checking the medication cart for unused and discontinued medications.
-She sent Resident #11's voltaren gel back to the pharmacy due to non-use.
-When Resident #11 complained about pain she documented in the supervisor's binder for the RCC and ED to be informed the resident was in more pain.

Telephone interview on 10/23/20 at 3:54pm with the Executive Director (ED) revealed:
-She had no idea why staff did not use the voltaren gel to help with Resident #11's pain.
-Staff were aware if a resident had an as needed medication it should be on the medication cart.
-If for some reason the medication was not on the cart staff were to get the medication as soon as possible.
-She did not know why staff would say they did not know that Resident #11 had voltaren gel when it was listed on the eMAR.
-She expected staff to use the medications ordered and if that did not work then staff were to

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D 358	Continued From page 77 contact the resident's PCP. Attempted interviews on 10/21/20 at 2:52pm and 10/23/20 at 9:24am with the previous RCC were unsuccessful. c. Review of Resident #11's hospital discharge summary report dated 07/28/20 revealed an order for tylenol 500mg as needed for pain at bedtime. Review of Resident #11's current FL-2 dated 08/03/20 revealed an order for tylenol 500mg as needed for pain at bedtime. Review of Resident #11's progress notes revealed: -On 08/03/20 first/second shift 7:00am to 7:00pm, Resident #11 leg gave out and the resident complained of pain. -On 08/09/20 first/second shift 7:00am to 7:00pm, Resident #11 legs "went weak" on the way to shower and had to sit down twice. -On 08/09/20 second shift 7:00pm to 11:00pm, Resident #11 was crying due to pain. -On 08/09/20 third shift 11:00pm to 7:00am, Resident #11 was crying saying her right hip and leg were hurting. -On 08/19/20 second shift 3:00pm to 11:00pm, Resident #11 was refusing to get out of bed due to increased pain in her hip and leg. Review of Resident #11's July 2020 eMARs revealed: -There was no entry for tylenol 500mg as needed for pain at bedtime on the eMAR. -There was no documented tylenol 500mg as needed for pain at bedtime was administered from 07/28/20 to 07/31/20. -There was documentation Resident #11 was hospitalized from 07/16/20 to 07/28/20.	D 358		

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D 358	Continued From page 78 Review of Resident #11's August 2020 eMARs revealed: -There was an entry for tylenol 500mg as needed for pain at bedtime. -There was no documented tylenol 500mg as needed for pain at bedtime was administered from 08/01/20 to 08/25/20. Telephone interview on 10/19/20 at 10:15pm with a third shift MA revealed: -The resident always complained about leg pain. -Resident #11 went out to the hospital a couple of times due to leg pain. -She did not realize Resident #11 had tylenol 500mg as needed (PRN) for pain bedtime. -She documented several times on the progress notes in the supervisor binder that Resident #11 complained about leg pain. -She thought the RCC and the ED looked at the progress notes and they contacted the PCP. -She administered medications to Resident #11, and she had access to the eMARs, but she had not realized the hospital discharge medication list dated 07/28/20 had changed tylenol 500mg from a scheduled medication three times daily to an as needed at bedtime. Telephone interview on 10/20/20 at 9:48am with a representative from the facility's contracted pharmacy revealed: -On 07/28/20, Resident #11's tylenol 500mg was changed from a scheduled medication three times daily to an as needed medication for pain at bedtime. -Tylenol 500mg was filled on 07/15/20 and 180 tablets were dispensed. -Resident #11 should have had tylenol left when she returned from the hospital on 07/28/20. -There were no requests made by facility staff to	D 358		

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refill the medication.

Telephone interview on 10/21/20 at 2:34pm with first shift MA revealed:
-Resident #11 complained daily about being in constant pain.
-Once she offered tylenol to Resident #11 and the resident refused the tylenol saying it did not work. After that she did not attempt anymore to offer tylenol to Resident #11.
-She did not contact the resident's PCP to inform the tylenol did not help with the resident's pain or that the resident was still in pain.

Telephone interview on 10/19/20 at 2:15pm with a previous second shift MA revealed:
-Before she passed away, Resident #11 continually complained about pain, and the complaints about pain got worse after she returned from the hospital on 07/28/20.
-She did not know that tylenol 500mg had changed from three times daily to as needed at bedtime.
-She administered medications and she was able to view the eMARs, but she did not notice that tylenol was not a scheduled medication any more.

Telephone interview on 10/21/20 at 11:58am with a second shift MA revealed:
-Each time Resident #11 was in pain, the resident said that her hip hurt "really bad."
-She thought Resident #11's tylenol was a scheduled medication three times daily.
-Although she administered medications and reviewed the eMARs she did not know tylenol had changed to an as needed medication at bedtime.
-When Resident #11 complained of pain she left a note for the MA on first shift to call the resident's PCP.

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D 358	Continued From page 80 Telephone interview on 10/21/20 at 9:00pm with a MA revealed: -Resident #11 continually complained about pain. -She never offered Resident #11 tylenol 500mg as needed for pain at bedtime because she did not know the order for tylenol had changed. Telephone interview on 10/23/20 at 3:54pm with the Executive Director (ED) revealed: -She did not know staff were not following the eMARs. -She was not aware the MAs did not offer tylenol to assist with Resident #11 with pain. -She expected staff to use the medications orders and if that did not work then staff were to contact the resident's PCP. Attempted interviews on 10/21/20 at 2:52pm and 10/23/20 at 9:24am with the previous RCC were unsuccessful. d. Review of Resident #11's current FL-2 dated 08/03/20 revealed medication orders included cetirizine 10mg 1 tablet once (used to treat allergy symptoms). Review of Resident #11's hospital discharge summary report dated 07/28/20 revealed an order for cetirizine 10mg 1 tablet once daily. Review of Resident #11's July 2020 electronic Medication Administration Records (eMARs) revealed: -There was an entry for cetirizine 10mg tablet once daily scheduled for administration at 9:00am. -There was documentation cetirizine 10mg was not available for administration 2 of 3 opportunities from 07/29/20 to 07/31/20. -There was documentation on the eMAR that the	D 358		

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D 358	Continued From page 81 medication was ordered. Review of Resident #11's August 2020 eMARs revealed: -There was an entry for cetirizine 10mg tablet once daily scheduled for administration at 9:00am. -There was documentation cetirizine 10mg was not available for administration 10 of 25 opportunities from 08/01/20 to 08/25/20. - "Physically unable to take" was the reason documented why cetirizine was not administered. Telephone interview on 10/21/20 at 5:22pm with a previous MA/supervisor revealed: -Resident #11 was out of cetirizine 10mg for a long time because no one could find the medication. -Resident #11 was without cetirizine for 10 or more days. -Cetirizine was later found in the oxygen room, no one knew how the medication ended up in that room. -She tried to reorder the medication from the pharmacy, but the pharmacist said the medication had already been delivered to the facility and it could not be refilled again. Telephone interview on 10/20/20 at 9:28am with a representative from the facility's contracted pharmacy revealed: -A 14-day supply of cetirizine was filled and dispensed on 07/28/20. -Initially, the pharmacy did not have payment information for the cetirizine, so they dispensed a 14-day supply until the insurance had approved the medication. -Prior to 07/28/20, 30 tablets of cetirizine were filled dispensed on 02/14/20, 03/15/20, 04/17/20, 05/17/20, 06/16/20.	D 358		

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-After 06/16/20 cetirizine was not refilled again until the 07/28/20.
-On 08/10/20, the pharmacy refilled cetirizine and dispensed a 30-day supply.
-The pharmacy did not offer automatic refills, therefore a request had to be made for each medication to be refilled.
-The pharmacy offered several ways for the facility staff to request a medication refill that included: electronic request could be made directly from the resident's profile in the eMAR, from the pharmacy website, staff could call via telephone and request a refill or they could pull the sticker from the medication card and fax the request to the pharmacy.

Telephone interview on 10/23/20 at 3:39pm with the Executive Director (ED) revealed:
-She was not aware Resident #11 missed 12 doses of cetirizine.
-There were morning meetings and staff were asked if there were any concerns or medications not available.
-In addition, the RCC was able to run a report to identify when medications were not administered.

e. Review of Resident #11's current FL-2 dated 08/03/20 revealed medication orders included a multivitamin tab take 1 tablet daily (used to treat vitamin deficiency).

Review of hospital discharge summary report dated 07/28/20 revealed an order for a multivitamin tab take 1 tablet daily.

Review of Resident #11's July 2020 electronic Medication Administration Records (eMARs) revealed:
-There was an entry for a multivitamin scheduled for administration once daily at 9:00am.

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D 358	Continued From page 83 -There was documentation the multivitamin was not available for administration 2 of 3 opportunities from 07/29/20 to 07/31/20. -There was documentation on the eMAR the medication was ordered on 07/30/20 and 07/31/20. Review of Resident #11's August 2020 eMARs revealed: -There was an entry for a multivitamin scheduled for administration once daily at 9:00am. -There was documentation the multivitamin was not available for administration 18 of 25 opportunities from 08/01/20 to 08/25/20. -There was documentation on the eMAR the multivitamin was "physically unable to take." Telephone interview on 10/19/20 at 2:46pm and 10/21/20 at 5:22pm with a previous MA/supervisor revealed: -Resident #11 had been on a one-a-day multivitamin before her hospitalization in July 2020. -After Resident #11 returned from the hospital on 07/28/20 the multivitamin changed to a different brand. -The MAs did not know the new brand name of the multivitamin and several times they sent the multivitamin back to the pharmacy. -One time the medication was in the cart, but the MA did not administer the multivitamin because she did not know the new brand name. -She was not sure exactly how many days the multivitamin was not administered but she thought it was for a long time. -The RCC even told MAs to stop sending the medication back to the pharmacy and that the new multivitamin was correct. -The MAs should have read the medication label and the eMARs and checked with the pharmacy if	D 358		

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D 358	Continued From page 84 they were not sure about Thera. Telephone interview on 10/20/20 at 9:38am with a representative from the facility's contracted pharmacy revealed: -Previously, Resident #11 had a multivitamin which serviced the same purpose but the physical appearance was different. -The orders received on 07/28/20 specified the name brand of the new multivitamin. -On 07/28/20, the pharmacy dispensed 14 of the new multivitamin tablets. -On 08/17/20, facility staff made a request for the new multivitamin. -On 08/18/20, the pharmacy dispensed 30 tablets. -If the MAs did not know about the new multivitamin, they should have contacted the pharmacy instead not administering the medication. -She was unable to see if the medication had been returned to the pharmacy and re-dispensed to the facility. Telephone interview on 10/23/20 at 3:39pm with the Executive Director (ED) revealed: -She was not aware Resident #11 missed 20 doses of the multivitamin. -All staff had to do was contact the pharmacy and the pharmacy would send the medication over that night. -A resident should not be without a medication. -She expected the MAs to administer medications as ordered. -If the MA was unsure about a medication, she should contact the pharmacy. -There was a morning meeting everyday asking staff if there were any clinical concerns and if there were any medications not available. -No staff had mentioned that Resident #11 did not	D 358		

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get the multivitamin.

f. Review of Resident #11's current FL-2 dated 08/03/20 revealed a medication order for vitamin B12 1000mcg 1 tablet daily (used to treat low blood levels of B12).

Review of hospital discharge summary report dated 07/28/20 revealed an order for vitamin B12 1000mcg 1 tablet daily.

Review of Resident #11's July 2020 electronic Medication Administration Records (eMARs) revealed:
-There was an entry for vitamin B12 once daily scheduled for administration daily at 9:00am.
-There was documentation vitamin B12 was not available for administration 2 of 3 opportunities from 07/29/20 to 07/31/20.
-There was documentation on the eMAR the medication was ordered on 07/30/20 and 07/31/20.

Review of Resident #11's August 2020 eMARs revealed:
-There was an entry for vitamin B12 once daily scheduled for administration daily at 9:00am.
-There was documentation vitamin B12 was not available for administration 14 of 25 opportunities from 08/01/20 to 08/25/20.
-There was documentation on the eMAR "physically unable to take."

Telephone interview on 10/21/20 at 5:22pm with a previous MA/supervisor revealed:
-They (MAs) thought Resident #11 had run out of B12 and they were waiting on the pharmacy.
-Days later B12 was found in the backup medication cart.
-They did not check the backup medication cart

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for the B12.
-The previous RCC used to audit the medication cart monthly by checking the eMARs with the medications on the cart to see medications that were not administered.
-The ED stopped the RCC from doing the audits and the ED was supposed to do the cart audit.
-She did not know if the ED performed the cart audit.
-Extra medication was put in the back-up medication cart.
-The facility's system was to check the back-up cart before calling the pharmacy to refill a medication.
-For some reason no one, including herself checked the back-up cart.

Telephone interview on 10/20/20 at 9:44am with a representative from the facility's contracted pharmacy revealed:
-Prior to 07/28/20, vitamin B12 was last filled and dispensed on 06/16/20 for a 30-day supply.
-On 07/28/20, the pharmacy dispensed a 14-day supply of vitamin B12 because they were waiting on approval from the insurance.
-On 08/14/20, the pharmacy dispensed a 30-day supply of vitamin B12.
-The pharmacy did not offer automatic refills, therefore a request had to be made for each medication to be refilled.
-The facility staff would request a refill and then the systems would kick back with a message that it was too soon for a refill.

Telephone interview on 10/23/20 at 3:39pm with the Executive Director (ED) revealed:
-She was not aware Resident #11 missed 16 doses of vitamin B12.
-When medications were received from the pharmacy staff had to sign with the pharmacy and

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they were to open the tote and verify the medication was received.
-Third shift placed the medication on the medication cart, but the medication was received on another shift the MA could put the medication on the cart.
-As soon as there was a problem with vitamin B12 the RCC should have been notified.
-If the pharmacy was unable to send the medication the staff should find out why.
-Once the staff figured out why the medication was not available, they needed to contact the resident's PCP.
-There were daily morning meetings asking staff if there were any medications not available.
-No resident should be without a medication that long.
-If a medication was not received by the next day the MAs needed to find out why the medication was not received and continue checking until the medication was received.

2. Review of Resident #1's current FL-2 dated 05/14/20 revealed:
-Diagnoses included schizoaffective, bipolar, vascular dementia, diabetes mellitus type II, hypertension, chronic obstructive pulmonary disease, gastroesophageal reflux, and osteoporosis.
-The resident was intermittently disoriented, COPD
-There was an order for depakote 125mg 1 tablet in the morning and Depakote 500mg 2 tablets (1000mg) at bedtime (used to treat bipolar disorder).

a. Review of Resident #1's September 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for depakote 125mg once

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daily scheduled for administration at 8:00am and administered as ordered.
-There was an entry for depakote 500mg 2 tablets (1000mg) once daily at bedtime scheduled for administration at 8:00pm.
-There was documentation depakote 500mg 2 tablets (1000mg) was not available for administration 6 of 30 opportunities from 09/01/20 to 09/30/20.
-There was no documentation on 09/01/20 and 09/16/20.
-There were circled initials on 09/08/20, 09/11/20, 09/13/20, and 09/15/20.
-The reason documented on the eMAR for circled initials was "physically unable to take."

Review of Resident #1's Patient Prescription Record revealed:
-Depakote 500mg 2 tablets (1000mg) was filled on 01/15/20 and 180 tablets were dispensed.
-Depakote 500mg 2 tablets (1000mg) was filled on 04/11/20 and 180 tablets were dispensed.
-Depakote 500mg 2 tablets (1000mg) was filled on 07/29/20 and 180 tablets were dispensed.
-Depakote 500mg 2 tablets (1000mg) was filled on 10/05/20 and 180 tablets were dispensed.

Review of Resident #1's record revealed there was no documentation the family had been notified regarding Resident #1's depakote being low, there was no documentation if the medication was ordered and waiting on the pharmacy.

Telephone interview on 10/14/20 at 10:29am with Resident #1's family member revealed:
-He picked up Resident #1's depakote from the pharmacy and gave the medication to a named medication aide (MA) at the facility.
-The MA gave the medication to another staff

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person (name unknown) and they misplaced the medication.
-The facility eventually replaced the medication, but it was almost one month.

Telephone interview on 10/14/20 at 10:36am with Resident #1's power of attorney (POA) revealed:
-Resident #1 had bipolar disorder and had schizophrenia and took depakote to help bipolar disorder.
-Resident #1 was to be administered depakote 125mg in the morning and 1000mg at bedtime.
-A family member picked up a three-month supply of depakote from the pharmacy and dropped the medication off at the facility.
-The medication was out before the three months were up, and the facility staff were asking to refill the medication again.
-The pharmacy refused to refill depakote because the medication had been dispensed.
-She had problems with facility staff requesting Resident #1's medications refills before the medication was out.
-Facility staff waited until the medication was out, then ordered the medication, causing Resident #1 to go 3-4 days without her medication.

Telephone interview on 10/14/20 at 12:15pm with a pharmacist from the pharmacy that filled Resident #1's medications revealed:
-Each refill of depakote 500mg 2 tablets (1000mg) at bedtime should have lasted Resident #1 for 90 days.
-The refill on 07/29/20 should have lasted at least until 10/29/20.
-If the 90-day supply of depakote 500mg 2 tablets was lost, then she did not know what was administered in August 2020.
-Resident #1 depakote was not on automatic refill, a refill had to be requested.

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D 358	Continued From page 90 -Their system had no way to identify when a medication was picked up. -The fill date was the date they physically filled the medication, and not necessarily the date the refill was requested. -Depakote could stay in the system for 1 week, give or take a couple of days depending on the resident's health. -Resident #1 got a new order for depakote 500mg 2 tablets (1000mg) on 09/18/20. -Depakote was filled on 10/05/20 and 180 tablets were dispensed. Telephone interview on 10/19/20 at 2:46pm with a former MA/supervisor revealed: -Resident #1 was administered depakote twice daily, 125mg in the morning and 1000mg at bedtime. -The resident was out of the 1000mg for several days because the medication could not be found. -Resident #1's family did not use the pharmacy the facility contracted with and the family had to pick the resident's medications up and bring them to the facility. -When Resident #1's medications were refilled the MA was to call in the refill. -Then MA called the resident's POA to let her know to pick the medication up. -There was no system that documented when the medications were dropped by Resident #1's family member. -The person receiving the medication was supposed to put the medication on the medication cart. -When Resident #1's depakote was lost, it was discovered that the MA who received the depakote left the medication on the counter near the medication room and the medication was never located. -The Executive Director (ED) moved the	D 358		

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depakote and misplaced the medication.
-The family was contacted regarding the depakote and the POA said the medication was dropped off and named a specific MA that received the medication.
-The facility eventually paid for the medication to be refilled.
-Some days (unable to recall how many) the ED told staff to administer 8 tablets of the 125mg depakote.

Telephone interview on 10/21/20 at 2:30pm with a first shift MA revealed:
-Resident #1's medications were not dispensed through the facility's contacted pharmacy.
-When Resident #1's medications needed to be refilled, she called the private pharmacy and then she called the resident's family member to let them know the medication was being filled.
-She was unable to recall if she received Resident #1's depakote.
-There was no system in place to document when Resident #1's medications were dropped by family members.
-The Resident Care Coordinator (RCC) and the ED tried to find out what happened to Resident #1's depakote, but it never turned up.

Telephone interview on 10/22/20 at 2:34pm with a first shift MA revealed:
-Resident #1 did not get her medications from the pharmacy used by the facility, so the refill had to be called directly to the pharmacy.
-She could not remember if she was the staff that received Resident #1's depakote from the family.
-There was no system for receiving medications dropped by family members.
-She could not recall how long Resident #1 was out of depakote.
-A resident should not go without a medication for

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one day.
-After the first day without a medication she was to call the pharmacy and inquire what was going on.
-There should be documentation in the comment section of the eMARs if the family was called about the medication.
-If there was no documentation and she did not know if the family was called.

Telephone interview on 10/20/20 at 12:02pm with the mental health provider (NP) revealed:
-The RCC called and told her (unable to recall the exact date) the resident did not get the depakote.
-She did not know if it was the facility's or the resident's family's fault the resident did not have depakote.
-Depakote stayed in the resident's system two or three weeks.
-Based on the time frame given by the facility staff Resident #1 should have had depakote in her system.
-If Resident #1 had increased behaviors it was likely not because the resident was out of depakote.

Interview on 10/23/20 at 3:01pm with the ED revealed:
-The MA told her that she did not have the depakote, she was handed a bag and was not sure what was in the bag.
-She was later was told that another MA received the depakote from Resident #1's family.
-No one at the facility knew what happened to the depakote.
-When Resident #1's medications were brought to the facility by the family the person receiving the medication was supposed to take the medication information form and put it in the pharmacy folder to show the medication had

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come in.
-Staff were supposed to document that in the nurses notes that they received the medication.
-Staff could have received the medication and did not write it down.
-She expected the MA to call the pharmacy 5 days before the medication ran out to request a refill.
-In addition, she expected the MAs to call the resident's family member 5 days before the medication was out to ensure they were aware the medication was needed.

b. Review of Resident #1's current FL-2 dated 05/14/20 revealed an order for omeprazole 40mg (used to treat acid reflux) once daily.

Review of Resident #1's September 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for omeprazole 40mg once daily scheduled for administration at 8:00am.
-There was documentation omeprazole 40mg was not available for administration 15 of 30 opportunities from 09/01/20 to 09/30/20.
-There was documentation omeprazole 40mg was on order from 09/12/20 through 09/26/20.

Review of Resident #1's Patient Medication Record from the pharmacy revealed:
-The pharmacy filled and dispensed 30 tablets of omeprazole 40mg on 01/15/20.
-The pharmacy filled and dispensed 90 tablets of omeprazole 40mg on 02/07/20.
-The pharmacy filled and dispensed 60 tablets of omeprazole 40mg on 06/12/20.
-The pharmacy filled and dispensed 90 tablets of omeprazole 40mg on 09/25/20.

Telephone interview on 10/14/20 at 10:36am with

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D 358	Continued From page 94 Resident #1's power of attorney (POA) revealed: -The facility did not inform her that Resident #1 was out of omeprazole. -Resident #1's medications were filled for a 90-day supply. -She had problems with facility staff requesting Resident #1's medications refills before the medication was out. -Facility staff waited until they administered the last pill, or they called for refill after the medication was out causing Resident #1 to be without medications for 3-4 days. Telephone interview on 10/14/20 at 12:25pm with a pharmacist at the pharmacy used to fill Resident #1's medications revealed: -The patient prescription record showed the date omeprazole was filled, the quantity dispensed, the prescription number and the cost of the medication. -The record did not provide a date omeprazole was picked up at the pharmacy or the date a refill request was made. -Based on the refill dates and quantity dispensed, Resident #1 would have been out of omeprazole 40mg between May and June 2020 and between August and September 2020, unless the resident had a large quantity of the medication that was not dispensed by their pharmacy. Telephone interview on 10/19/20 at 10:26pm with the third shift MA revealed: -She left notes for the former RCC and ED informing that Resident #1 had 10 tablets of omeprazole left, she left another note when the resident had 4 tablets left and she left several notes when the medication was out. -She left notes because the ED was responsible for ensuring the medications were available for administration.	D 358		

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-When there was a 5-day supply of the medication left a refill should be requested.
-She did not know why it took so long to get Resident #1's omeprazole, "it's an over-the-counter medication and easy to get."
-Resident #1 was seen by the in-house doctor, who was in the facility weekly, so staff could have informed her that Resident #1 did not get omeprazole.

Telephone interview on 10/21/20 at 2:34pm with first shift MA revealed:
-She did not know why Resident #1 was out of omeprazole in September 2020.
-The facility's protocol was to reorder medications 5 days before the medication was out.
-Resident #1 medications were not filled at the pharmacy used by the facility.
-Resident #1's family picked up her medications at private pharmacy.
-The MA was supposed to call the pharmacy to reorder the medication and then call the resident's family member to pick-up the medication.
-There should be documentation when the family was notified to pick-up the medication.

Telephone interview on 10/15/20 at 2:15pm with Resident #1's Primary Care Provider (PCP) revealed:
-She did not remember specifically being told about this medication but if the facility gave her a notice it would be via a physician notification form.
-She wanted to be notified if a medication was not administered as ordered in writing via a physician notification form.
-She was in the facility weekly on Thursdays and the facility was able to make her aware during these visits to the facility.

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D 358	Continued From page 96 -She expected medications to be administered as ordered using the physician notification form so there was documentation. Telephone interview on 10/23/20 at 3:03pm with the Executive Director (ED) revealed: -The family was notified about the omeprazole and they did not bring the medication to the facility. -There was no documentation to show the family was notified. -The pharmacy should have been notified before the medication was out, she did not know exactly when the medication was out. -She recalled hearing a MA inform Resident #1's family member that the resident was out of omeprazole, but she was unable to recall the date when the family was notified. -In the contract when a family did not use the facility's pharmacy the responsibility was on the family to provide the medication. -The MA should notify the family when there was 5 days of the medication left. -The MA should document if they notified the family member to obtain Resident #1's medication. -If there was no documentation she could not say when or if Resident #1's family was notified. -She previously spoke with Resident #1's family about using their pharmacy to make it easier for the resident to get medications, but the family refused due to cost. 3. Review of Resident #4's current FL-2 dated 01/28/20 revealed: -Diagnoses included Alzheimer's disease, joint pain, major depressive disorder, anxiety and seizure disorder. -The resident was constantly disoriented. -The resident was ambulatory using a wheelchair	D 358		

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D 358	Continued From page 97 with assistance. Review of Resident #4's Hospice Physician's Orders dated 06/19/20 to 09/18/20 revealed: -Diagnoses included Alzheimer's disease, dementia, primary osteoarthritis right shoulder, primary osteoarthritis left shoulder and inflammatory bone pain. -There was an order for Hydrocodone-Acetaminophen 5-325mg. (Norco, a controlled substance used to treat moderate to severe pain), 1 tablet, by mouth, 4 times a day for pain. Review of Resident #4's August 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Norco, take 1 tablet 5-325mg. tablet 4 times a day for pain at 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was documentation no Norco 5-325mg. tablets were administered to Resident #4 on 08/02/20 at 8:00pm, on 08/03/20 at 8:00 am, at 12:00pm, at 5:00pm or at 8:00pm and the reason documented was "physically unable to take." -There was documentation for 08/02/20 at 9:29pm that read "waiting on meds to come in from pharmacy". -There was documentation for 08/03/20 at 3:46pm that read "called hospice to notify". -Resident #4 was not administered 5, scheduled and consecutive doses of medication for pain. Review of Resident #4's September 2020 eMAR revealed: -There was an entry for Norco, take 1 tablet 5-325mg. tablet 4 times a day for pain at 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was documentation no Norco 5-325mg. tablets were administered to Resident #4 on	D 358		

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09/04/20 at 12:00pm, at 5:00pm, at 8:00pm, on 09/05/20 at 8:00am, at 12:00pm, at 5:00pm, at 8:00pm, on 09/06/20 at 8:00am, at 12:00 pm, at 5:00pm, or 8:00pm, on 09/07/20 at 8:00am, at 12:00pm, at 5:00pm, or 8:00 pm, on 09/11/20 at 08:00am, and 8:00 pm.
-There was documentation of exceptions for 09/04/20 at 12:21pm, 4:15pm, on 09/05/20 at 09:32am, at 11:17am, at 6:10pm, at 7:02pm, on 09/06/20 at 9:23am, at 1:28pm, at 5:02pm, at 7:57pm, on 09/07/20 at 8:27am, at 12:47pm, at 4:27pm, at 8:02pm, on 09/11/20 at 10:34am that read "physically unable to take".
-There was documentation for 09/04/20 at 4:15pm and 09/05/20 at 6:10pm that read "notify hospice", on 09/05/20 at 7: 02pm "notified hospice", and on 09/11/20 "resident was having a seizure".
-Resident #4 was not administered 16 scheduled, 12 consecutive, doses of medication for pain.

Review of Resident #4's October 2020 eMAR revealed:
-There was an entry for Norco take 1 tablet 5-325mg. tablet 4 times a day for pain at 8:00am, 12:00pm, 5:00pm, and 8:00pm.
-There was documentation no Norco 5-325mg. tablets were administered to Resident #4 on 10/11/20 at 12:00pm, at 5:00pm, or 8:00 pm, on 10/12/20 at 8:00am, 12:00pm, 5:00pm, or 8:00pm.
-There was documentation of exceptions for 10/11/20 at 12:23pm, at 4:32pm, and 7:48pm, on 10/12/20 at 7:25am, at 1:58pm, at 5:21pm and 7:23pm that read "physically unable to take".
-There was documentation for 10/11/20 at 12:23pm that read "notified personal care provider (PCP) last week - defaulted to hospice for new script", on 10/12/20 at 1:58pm that read "advised hospice order pending", on 10/12/20 at

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D 358	Continued From page 99 7:23pm that read "order pending". -Resident #4 was not administered 7, scheduled and consecutive doses of medication for pain. Telephone interview on 10/19/20 at 12:07pm with a medication aide (MA) revealed: -Resident #4's pain medication, Norco, could not be ordered from the facility primary care provider (PCP) because hospice managed her pain medications and the order was to be signed by the hospice physician. -In August 2020, She did not order the Norco for Resident #4 in time and the medication ran out; she did not have a reason for not ordering the medication in a timely manner. -She should have called hospice when there were 10 doses of the medication left and Resident #4 would not have missed her pain medication. -She was not sure if there was a back-up pharmacy or how to order a 2-3 day supply of Norco for Resident #4. -In September 2020, Resident #4's Norco ran out, it was not ordered in time to have the pain medication on hand to administer to Resident #4. -Resident #4 missed 15 doses of Norco while waiting for the order to be processed. -There was poor communication for ordering Resident #4's Norco pain medication. Attempted telephone interviews on 10/22/20 to 10/23/20 with a second MA were unsuccessful. Attempted telephone interviews on 10/22/20 with a third MA were unsuccessful. Telephone interview on 10/21/20 at 12:59pm with the former Resident Care Coordinator (RCC) revealed: -She worked at the facility as an RCC until 09/08/20.	D 358		

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D 358	Continued From page 100 -The facility primary care (PCP) provider for the facility did not manage Resident #4's pain medications, hospice did. -Hospice was to receive the Norco medication refill requests, the order would be written and signed by their physician and sent to the pharmacy to fill and dispense. -The MAs should notify hospice when Resident #4's Norco was getting low. -She did not know why the Norco was unavailable because the hospice nurses always asked if residents needed any medication refills. -She was not notified when Resident #4's Norco ran out in August 2020, no one reported to her the Norco medication needed to be refilled. -She was not notified when Resident #4's Norco ran out in September 2020. -Norco was used for pain control for Resident #4, if the Norco was not administered as ordered, Resident #4 would have to "suffer" through the pain. -She taught the MAs to watch the medication bubble pack cards to see when the medication was in the blue area on the card, this meant a request for refill was needed before the medication ran out. -The exceptions phrase on the MAR, "physically unable to take" meant the medication was not on hand. -She made sure the phone numbers for hospice, the pharmacy and the PCP were easily available to the MAs. -The Executive Director (ED) was responsible for reviewing the residents' MARs for medication administration concerns. Telephone interview on 10/23/20 at 2:47pm with Resident #4's Power of Attorney (POA) revealed: -The facility staff called sometimes and let him know how Resident #4 was doing.	D 358		

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D 358	Continued From page 101 -He received no calls that Resident #4 missed doses of her Norco pain medication in August, September and October 2020. -Resident #4 was often in pain and needed her medication. Telephone interview on 10/21/20 at 1:20pm with the Hospice Office Manager revealed: -The facility needed to notify a hospice nurse or the hospice office if a hospice resident needed a medication refill. -Hospice was to receive the medication request, forward the request to the Medical Director for review, write the order, sign it and forward the order to the pharmacy to fill and dispense to the facility. -Nurses went to the facility at least once a week to assess their patients and ask questions of the MA staff about the residents' needs of supplies and medication refills. -If needed, the hospice nurse could write the medication order and contact the Medical Director for review and signing to send to the pharmacy for processing. -If a resident needed supplies or medication refills and a nurse was not at the facility, the MA should call the hospice office and make a request by phone. -If the call was after business hours, the MA would be able to talk with the hospice on-call service and request a medication refill. -The MA should not wait until the medication ran out to request a medication refill. -The facility should keep up with the amount of medication they had on hand, so residents did not run out and miss their ordered dosages. Telephone interview on 10/21/20 at 4:05pm with Resident #4's Hospice Nurse revealed: -When hospice nurses visit the facility, they do	D 358		

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assessments, treatments and check on supplies for the residents.
-Facility MAs were consulted for updates on hospice residents to determine if they needed supplies or medication refills.
-The MAs should tell her if a resident needed a medication refill and she could work to get the medication to the facility that same evening.
-She instructed the facility staff on how to make an order request to hospice for Resident #4 when the order for Norco was written on 05/07/20.
-She made visits to the facility to see Resident #4 in August 2020 on 08/05/20, 08/12/20, 08/17/20, 08/21/20, 08/24/20, 08/27/20 and 08/28/20.
-She made visits to the facility to see Resident #4 in September 2020 on 09/01/20, 09/03/20, 09/08/20, 09/10/20, 09/11/20, 09/14/20, 09/18/20, 09/21/20, 09/24/20, 09/228/20 and 09/30/20.
-She made visits to the facility to see Resident #4 in October 2020 on 10/02/20, 10/05/20, 10/07/20, 10/09/20 and 10/12/20.
-On her visits to the facility in August, September and October to date (10/21/20), she was not told by the MA staff that Resident #4 needed refills for the Norco pain medication.
-The hospice telephone and fax numbers were readily available to staff at the facility, staff needed to call as soon as the medication was getting low.
-Someone must have realized the Norco pain medication on hand was getting low for Resident #4 in August, September and October 2020 and did not request a refill in a timely manner.
-Resident #4 was non-verbal and could not tell the MAs she was in pain, she could only tense her face and grind her teeth.

Telephone interview on 10/23/20 at 11:01am with the Hospice Physician for Controlled Drugs revealed:

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D 358	Continued From page 103 -Resident #4 was prescribed Norco 5-325mg. 4 times a day, to relieve pain and suffering. -Resident #4 was in the end stages of Alzheimer's disease and was constantly having pain at a level of 6 out of 10. -He was not aware of the missed doses in August, September and October 2020; he was not notified by the facility. -He was very concerned to find out Resident #4 missed 22 doses of her medication during those months. -He expected the doses of Norco to be administered as ordered. Telephone interview on 10/21/20 at 3:05pm with a representative from the facility's contracted pharmacy revealed: -The facility sent a fax on 08/02/20 at 11:07pm requesting a refill of Norco for Resident #4. -The facility did not make the request to hospice to get a signed prescription order and the pharmacy could not fill the order until they had the order sent from hospice. -The pharmacy forwarded the request to hospice on 08/03/20 at 6:52 am to be processed and returned to the pharmacy to fill and deliver to the facility. -According to the pharmacy Delivery Manifest, the Hydrocodone-APAP 5-325mg. tab (Norco), was delivered to the facility on 08/03/20 at 9:05pm. -The facility could call the pharmacy to request refills during the day and after hours speak to the on-call pharmacist, but the pharmacy would have to forward the request for order from hospice. -Resident #4's doses of Norco would not have run out on 08/02/20 for the 8:00pm dose - 08/03/20 8:00 dosage if hospice had been notified 4 days in advance of the last dosage being administered and the pharmacy had a signed order for the refill.	D 358		

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D 358	Continued From page 104 -Resident #4 missed 5 consecutive doses of her pain medication in August 2020. -The facility sent a fax on 09/03/20 at 6:52am requesting a refill of Norco for Resident #4. -The pharmacy needed a hard copy order from the hospice physician to fill the order. -The pharmacy expected the facility to send the refill request up to 4 to 5 days ahead of when the medication would run out. -On 09/07/20, the pharmacy sent a 3-day supply of Norco for Resident #4, delivered at 7:42pm. -On 09/09/20, the pharmacy delivered the ordered refill of Norco for Resident #4 to the facility at 8:36pm. -Resident #4 missed 15 consecutive doses of her pain medication in September 2020. -The facility sent a fax on 10/11/20 (Sunday) at 3:18pm requesting a refill of Norco for Resident #4, the order was signed by a nurse practitioner. -According to the pharmacy Delivery Manifest, the Hydrocodone-APAP 5-325mg. tab (Norco), was delivered to the facility on 10/13/20 at 10:55am. -The facility did not send the order for Resident #4's pain medication, Norco, before it ran out and Resident #4 missed 7 consecutive doses of her pain medication in October 2020. Attempted telephone interview on 10/23/20 with the Resident Care Coordinator (RCC) was unsuccessful. Based on observations, attempted interview and record review, Resident #4 was not interviewable. Telephone interview on 10/23/20 at 2:40pm with the ED revealed: -Resident #4 was a hospice patient; nurses came often to assess her and ask staff if she needed supplies or medication refills. -If the hospice nurse asked the MAs if Resident	D 358		

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#4's Norco needed a refill, they should have told her.
-Resident #4 missed some doses of her pain medication in August, September and October.
-When a request for a Norco refill forResident #4 was needed on 09/23/20, she learned the refill request for Resident #4 should be referred to the hospice physician and not the PCP.
-The pharmacy required the prescription to be signed by the hospice physician.
-It would have been more efficient to send the request for Resident #4's Norco directly to hospice.
-She did not know about the hospice procedure for getting the Norco refilled for Resident #4.
-The MAs were responsible for administering medication as ordered.
-The MAs were supposed to inform the RCC or the ED if there were any concerns about a resident's medication.
-The RCC was responsible for monitoring residents' medications; if a problem was found the RCC would let her know.
-The RCC was supposed to audit the medication carts and eMARs weekly.
-It was the RCC's responsibility to assure Resident #4 had her medication administered as ordered.

4. Review of Resident #20's FL-2 dated 08/20/20 revealed diagnoses included allergies, anxiety, depression, history of deep vein thrombosis, gastroesophageal reflux disease, insomnia, rectal prolapse, and onychomycosis.

Review of Resident #20's physician's orders dated 10/01/20 revealed there was an order for Lasix 10 mg daily (used to treat swelling).

Review of Resident #20's electronic Medication

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D 358	Continued From page 106 Administration Record (eMAR) for October 2020 revealed: -There was an entry for Lasix 20mg ½ tablet (10mg) daily to be administered at 9:00am. -Lasix was not documented as administered for 7 of 9 opportunities between 10/01/20 and 10/09/20. -There was no documentation why Lasix was not administered on 10/01/20. -There was documentation Lasix was not administered on 10/02/20 due to "physically unable to take, medication not given - new order - will start 10/03;" on 10/03/20 due to "physically unable to take, re-order pharmacy - new order;" on 10/04/20 due to "unable to take medicine, not in from pharmacy;" and on 10/05/20, 10/07/20, 10/08/20, and 10/09/20 due to " physically unable to take." -Lasix 20mg ½ tablet was discontinued on 10/09/20. -There was an entry for Lasix 20mg 1 tablet daily at 9:00am with a start date of 10/10/20. -There was documentation Lasix 20mg 1 tablet daily was administered daily from 10/10/20 through 10/15/20. Review of a physician's notification form for Resident #20 dated 10/07/20 revealed: -The Executive Director (ED) documented the note to the primary care provider (PCP). -There was documentation Resident #20 missed Lasix due to pharmacy delay - please assess at physician follow up. -There was no documentation how many doses of Lasix were missed. Observation on 10/17/20 at 10:17am of Resident #20 revealed: -Resident #20's right and left feet were extremely swollen and rounded on the top.	D 358		

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D 358	Continued From page 107 -There was indentation on both ankle areas where the top of Resident #20's socks rested. Interview on 10/15/20 at 10:08am with Resident #20 revealed: -She told the PCP she needed "fluid pills" because her feet were swelling up. -Her feet were still swollen. -She did not know if she was being administered Lasix for the swelling in her feet. -She wore bedroom shoes, but could not wear regular shoes. Telephone interview on 10/13/20 at 2:35pm with a representative from the facility contracted pharmacy revealed: -There was a physician's order dated 10/01/20 for Lasix 10mg 1 tablet daily. -Lasix 10mg was not dispensed to the facility when the pharmacy first tried to fill it on 10/01/20 but he did not know why. -There was no documentation the facility contacted the pharmacy to inquire about Lasix 10mg. -The pharmacy received an order for Lasix 20mg 1 tablet daily and Lasix 20mg was dispensed to the facility on 10/09/20 with a quantity of 30. Telephone interview on 10/16/20 at 1:46pm with a second representative from the facility contracted pharmacy revealed: -There was a physician's order for Lasix 10mg daily received by the facility and billed on 10/01/20, but the billing was voided. -A representative from the pharmacy called the facility to inform staff billing was denied for the Lasix 10mg daily and there was no response or new order for Lasix. -The pharmacy a had signed October 2020 eMAR printed on 10/06/20 at 9:43pm and Lasix	D 358		

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was not included on the eMAR.
-There was a physician's order signed on 10/08/20 for Lasix 20mg daily.
-The physician's order for Lasix 20mg was faxed to the pharmacy from the facility on 10/08/20 at 11:58pm and delivered to the facility on 10/09/20.
-On 10/15/20, the pharmacy received a physician's notification form dated 10/07/20 which documented Resident #20 missed Lasix due to pharmacy delay - please assess at physician follow up.

Interview with the Resident Care Coordinator (RCC) on 10/15/20 at 10:18am revealed:
-Medication orders were submitted to the pharmacy by the RCC and the ED. If neither the RCC or ED were available, then the medication aides (MA) sent the medication orders to the pharmacy.
-She did not know if Lasix had been ordered for Resident #20.
-After looking at the eMAR, the RCC indicated Lasix was received in the facility on 10/09/20 and was first administered to Resident #20 on 10/10/20 at 9:00am.
-She did not know why Lasix was not in the facility or administered between 10/01/20 and 10/09/20.

Interview on 10/15/20 at 11:07am with a MA revealed:
-She did not remember if Lasix was in the facility and available for administration from 10/01/20 to 10/09/20.
-She did not remember she documented Lasix as not administered due to "physically unable to take" on 10/05/20 and documented Lasix as administered on 10/06/20.
-She had not contacted the pharmacy regarding Resident #20's Lasix.

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D 358	Continued From page 109 Interview on 10/15/20 at 11:19am with a second MA revealed: -Usually, if she did not see a medication on the medication cart, she would look in the back up cart for the medication. -If the medication was not in the back up cart, then she would call the pharmacy to see where the medication was. -She knew Resident #20's Lasix was not on the medication cart, but she had not looked in the back up cart or contacted the pharmacy for the medication and she did not know why. Interview on 10/15/20 at 12:03pm with Resident #1's PCP revealed: -There was an order for Lasix for Resident #20 due to swelling in her feet. -She did not know staff had not administered Lasix to Resident #20 from 10/01/20 through 10/09/20. -She expected staff to let her know Lasix was not administered and to follow up with the pharmacy. -Not administering Lasix as ordered could cause a delay in improvement of Resident #20's edema. -She expected staff to administer medication as ordered. -She found a physician notification form on 10/15/20 which was dated 10/07/20. -The physician notification form was to notify her Resident #20 had missed her medication, but she was not aware Resident #20 was not administered Lasix prior to coming in the facility on 10/15/20. Telephone interview on 10/15/20 at 4:40pm with the ED revealed: -MAs were responsible for faxing new orders to the pharmacy and the pharmacists put the new orders on the eMAR. -The RCC was responsible for verifying the entry	D 358		

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of the new order on the eMAR and approving the entry.
-If a medication was not received from the pharmacy, MAs and the RCC were responsible for contacting the pharmacy to find out why the medication was not delivered.
-The RCC was responsible for making sure medication was in the facility.

Telephone interview on 10/16/20 at 3:53pm with the ED revealed:
-She documented on the eMAR on 10/02/20 "medication not given - new order - will start 10/02."
-She documented on the eMAR on 10/03/20 "reorder pharmacy - new order."
-She notified the pharmacy on 10/03/20 that the facility had not received Lasix 10mg, but she did not remember what was told to her.
-She recognized on 10/07/20 that Lasix 10mg was not in the facility and she followed up with the PCP on 10/08/20 when she came to the facility.
-She did not remember if she called the pharmacy on 10/07/20.
-Resident #20 had swelling in her feet since she was admitted to the facility, but she had not seen Resident #20's feet as swollen as they are now.
-The MA Supervisor should have let the RCC know the medication was not in the facility and the RCC should have followed up with the pharmacy.

5. Review of Resident #16's current FL-2 dated 09/07/20 revealed:
-Diagnoses included schizophrenia, paranoid type, leukemia, and diabetes.
-There was an order for prazosin 4mg at bedtime (an antihypertensive medication that can also be used to treat nightmares).
-There was an order for lorazepam 2mg at

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D 358	Continued From page 111 bedtime (a medication used to treat anxiety). a. Review of Resident #16's hospital discharge summary dated 09/08/20 revealed: -He had very vivid and graphic dreams/nightmares. -His prazosin was increased to 4mg on 09/01/20 during his hospital stay. Review of Resident #16's September 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry dated 09/08/20 for prazosin 2mg, two capsules (4mg) at bedtime. -There was no documentation of administration for 09/08/20. -The prazosin was circled, indicating not administered, from 09/09/20 to 09/17/20. -The reason the prazosin was not administered was "physically unable to take". Telephone interview on 10/15/20 at 2:00pm with a representative from the facility's contracted pharmacy revealed: -They received an order for prazosin 4mg at bedtime on 09/08/20. -Sixty 2mg tablets were dispensed to the facility on 09/08/20. Telephone interview on 10/19/20 at 2:52pm with a medication aide (MA) revealed: -Circled initials on the eMAR indicated the medication was not administered. -"Physically unable to take" noted on the eMAR usually meant the medication was not available to administer. -She did not remember if the prazosin was not there on 09/12/20 when she documented the medication as not administered and noted "physically unable to take"	D 358		

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D 358	Continued From page 112 -The MA was responsible to call the pharmacy when a medication was not available. -If the pharmacy was contacted it should have been documented in the supervisor's notebook. -She could not locate the September 2020 supervisor's notebook. -She could not remember if she contacted the pharmacy about the prazosin. Telephone interview on 10/21/20 at 10:26am with the mental health nurse practitioner (NP) revealed: -Resident #16 took prazosin for nightmares. -She expected medications to be administered as ordered. -The MAs were responsible to administer medications to the residents. -The Resident Care Coordinator (RCC) was responsible to ensure medications were available to administer. -She expected the facility to notify her within 24 hours if a resident did not receive a prescribed medication. -She was unsure if the facility had notified her of the missed doses of prazosin. Telephone interview on 10/22/20 at 1:05pm with the Executive Director (ED) revealed: -The pharmacy was to be called the first instance a medication was not available to administer. -It was the MA's responsibility to contact the pharmacy when a medication was not available to administer. -She contacted the pharmacy when the medication was not on the cart and was told it would be with the next delivery. -She did not remember what day she contacted the pharmacy. -MAR audits were supposed to be done weekly by the RCC and turned into her.	D 358		

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D 358	Continued From page 113 b. Review of Resident #16's hospital discharge summary dated 09/08/20 revealed he was to receive lorazepam 2mg at bedtime. Review of the physician order dated 09/09/20 revealed: -Current lorazepam orders were discontinued. -Lorazepam 0.5mg was to be administered twice daily at 8:00am and 2:00pm. -Lorazepam 1mg was to be administered at bedtime. Review of Resident #16's September 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry dated 09/08/20 for lorazepam 1mg, two tablets (2mg) at bedtime. -The entry was discontinued on 09/09/20. -There was no documentation lorazepam 2mg was administered at bedtime. Continued review of Resident 16's September 2020 eMAR revealed: -There was an entry dated 09/09/20 for lorazepam 0.5mg, one tablet at 8:00am and 2:00pm. -There was an entry dated 09/09/20 for lorazepam 0.5mg, two tablets (1mg) at bedtime. -The entries were documented as administered from 09/10/20 to 09/30/20. Review of Resident #16's pharmacy generated control substance count sheets (CSCS) for the 1mg tablets revealed he received two 1mg tablets (2mg) at 9:00pm from 09/11/20 to 09/16/20. Telephone interview on 10/15/20 at 2:00pm with a representative from the facility's contracted pharmacy revealed:	D 358		

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D 358	Continued From page 114 -Lorazepam 1mg 30 tablets was dispensed to the facility on 09/08/20. -The pharmacy clarified Resident #16's lorazepam order with the mental health nurse practitioner (NP) on 09/09/20 because it was different than what was prescribed for him prior to his hospitalization. -The clarified order for Resident #16 was lorazepam 0.5mg, one tablet at 8:00am and 2:00pm, and two tablets at bedtime. -Lorazepam 0.5mg 120 tablets was dispensed to the facility on 09/09/20. -When a medication was discontinued it would not appear on the eMAR to be administered. -The MAs were taught by the pharmacy to administer medications according to the eMAR, not what was printed on the medication label. -The facility would have had lorazepam 1mg and 0.5mg tablets on hand for Resident #16. Telephone interview on 10/21/20 at 10:26am with the mental health NP revealed: -The pharmacy contacted her on 09/09/20 to discuss Resident #16's lorazepam order. -On 09/09/20, she changed Resident #16's lorazepam order to 0.5mg, one tablet at 8:00am and 2:00pm and two tablets at bedtime. -The medication aides (MA) were responsible to administer medications to the residents. -She expected medications to be administered as ordered. -The facility notified her of Resident #16 receiving incorrect doses of lorazepam at bedtime, but she could not remember when that was. Telephone interview on 10/19/20 at 2:52pm with a MA revealed: -When administering medications, the MA was to compare the directions on the eMAR with the directions on the bubble pack.	D 358		

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D 358	Continued From page 115 -The medication was to be administered according to the eMAR. -She was aware of medication errors at the facility but could not remember details. Telephone interview on 10/22/20 at 1:05pm with the Executive Director (ED) revealed: -It was the MAs responsibility to administer medications as ordered. -She noticed Resident #16 received the incorrect dose of lorazepam at bedtime when she was administering medications. -She was not sure what date she noticed the error. -The correct lorazepam dose for Resident #16 was on the eMAR. -She instructed the MA to notify the mental health NP of the error. -If an order was changed and the medication on hand could still be administered, the medication bubble pack was flagged with a sticker indicating the order was changed. -The lorazepam bubble pack containing the 1mg tablets was flagged with a sticker indicating the order was changed. -She re-educated the MAs present at the time to read the medication dose on the eMAR each time a medication was administered. -All medications errors were to be reported to the Resident Care Coordinator and the provider. Attempted interview on 10/19/20 at 2:50pm with Resident #16 was unsuccessful. Attempted interviews on 10/21/20 at 10:00am and on 10/22/20 at 10:58am with one of the medication aide (MA) that documented administration of lorazepam to Resident #16 were unsuccessful.	D 358		

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D 358	Continued From page 116 6. Review of Resident #5's current FL-2 dated 08/13/20 revealed diagnoses included anxiety, hypertension, and congestive heart failure. Review of Resident #5's physician's orders revealed: -There was an order dated 09/02/20 for Norco 5/325 (a combination of hydrocodone and acetaminophen used to treat mild to moderate pain) take one-half tablet 3 times a day for pain with a quantity of 45 tablets (90 doses). -There was a signed physician's order and prescription order dated 10/08/20 for disc Norco 5/325 take one-half tablet 2 times a day for pain. Review of Resident #5's September 2020 electronic Medication Administration Record (eMAR) and controlled substance count sheets (CSCS) for hydrocodone 5mg/acetaminophen 325 revealed: -There was an entry for hydrocodone 5mg/acetaminophen 325 mg one-half tablet 3 times a day scheduled for administration at 8:00am, 12:00pm, and 4:00pm daily on the eMAR. -There was documentation for the administration of 80 doses as ordered from 09/04/20 to 09/30/20 (refused on 09/17/20 at 12:00pm) on the eMAR and CSCS. Review of Resident #5's October 2020 eMAR and CSCS for hydrocodone 5mg/acetaminophen 325 revealed: -There was an entry for hydrocodone 5mg/acetaminophen 325 mg one-half tablet 3 times a day scheduled for administration at 8:00am, 12:00pm, and 4:00pm daily and discontinued on 10/08/20. -There was documentation for administration of 10 doses of hydrocodone 5mg/acetaminophen	D 358		

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D 358	Continued From page 117 325 mg one-half tablet 3 times a day from 10/01/20 to 10/04/20 at 8:00am on the eMAR and CSCS. -There was documentation hydrocodone 5mg/acetaminophen 325 mg was not administered on the eMAR for 13 consecutive doses (4 days) with documentation by initials circled on the eMAR and reason given "physically unable to take" and notes for "medication has been reordered, waiting on med (medication) to come in from pharmacy, call pharmacy, and waiting on pharmacy to bring medications" for 14 doses from 10/04/20 at 12:00pm to 10/08/20 at 4:00pm. Observation of Resident #5's medication on hand for administration on 10/15/20 at 5:00pm revealed there was a medication bubble pack of hydrocodone 5mg/acetaminophen 325 with instruction for one-half tablet twice a day for pain dispensed on 10/08/20 for 60 each of one-half tablet with 46 one-half tablets remaining. Interview on 10/15/20 at 12:30pm with the primary care provider (PCP) revealed: -She ordered a 30 day supply of hydrocodone 5mg/acetaminophen 325 for Resident #5 on 09/03/20. -The facility did not contact her for a new order for Resident #5 prior to her scheduled appointment on 10/08/20. -She was available by fax and phone messaging for staff to request medications. -Resident #5 did not complain about excessive pain on her encounter on 10/08/20. -She reduced the frequency of dosing from 3 times a day to 2 times a day on 10/08/20 because the resident's pain was better and to reduce the risk of sedation and possible increased risk for fall.	D 358		

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D 358	Continued From page 118 Interview on 10/15/20 at 4:15pm with Resident #5 revealed: -She did not suffer a lot when she was out of her hydrocodone 5mg/acetaminophen 325 for 4 days. -The PCP gave her the medication to help with her discomfort because it was stronger than plain acetaminophen. -The PCP reduced the dose to one-half tablet twice a day because the 3 times a day dosing made very sleepy. -She did not have as much pain and discomfort from her arthritis when she was taking the medication. Telephone interview on 10/15/20 at 9:01am with a representative from the facility's contracted pharmacy revealed: -Refills of controlled substances could be requested from the pharmacy when there were no more than six days' worth of medication left to be administered. -Narcotics required a new order that either the facility or the pharmacy had to contact the PCP for the new order. Telephone interview on 10/14/20 at 11:11am with a medication aide (MA) revealed: -When "physically unable to take" was documented on the eMAR, it meant the medication was not available for administration because the medication was on order from the pharmacy. -Medication refills could be requested electronically through the medication administration system. -The system would indicate if the request had been accepted by the pharmacy. -If the request was rejected, the MA had to call the pharmacy for further information.	D 358		

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D 358	Continued From page 119 Telephone interview on 10/16/20 at 4:33pm with the former Resident Care Coordinator (RCC) revealed: -Her last day of employment at the facility was 09/08/20. -There were problems at the facility related to the administration of controlled substances. -The MAs did not request refills for medications, including controlled substances, until the medication was no longer available for administration. -She instructed the MAs to let her know when controlled substances were almost out so she could request a written prescription from the providers but some staff did not reorder the medication correctly. -She kept refill request instructions on a board in her office; the MAs had access to the instructions but would not follow them. -The MAs were supposed to inform the providers through a phone call or fax when medications had been missed for three days. -There was a form the MA could fax to the provider but the MAs did not consistently use the form. -She reviewed the eMARs every Monday or Friday and followed up with the PCP regarding missed medications. -She was aware some residents ran out of pain medications before the pharmacy or facility had obtained a new order. Refer to the telephone interview on 10/16/20 at 5:08pm with a former MA. Refer to the second telephone interview on 10/19/20 at 10:19am with the same former MA. Refer to the telephone interview on 10/20/20 at	D 358		

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D 358	Continued From page 120 2:30pm with a first shift MA. Refer to the telephone interview on 10/21/20 at 10:09pm with a third shift MA. Refer to the telephone interview with the ED on 10/22/20 at 12:55pm. 7. Review of Resident #13's current FL-2 dated 01/07/20 revealed diagnoses included diabetes mellitus type II, hypertension, chronic pain, and neuropathy. Review of Resident #13's physician's orders revealed an order dated 07/06/20 for oxycodone 20mg tablet (a narcotic medication used to treat moderate to severe pain) one every 6 hours as needed with a quantity of 120 tablets. Review of Resident #13's controlled substance count sheets (CSCS) for oxycodone 20mg revealed there were 4 CSCS for 4 cards of 28 tablets and one CSCS for one card of 8 tablets received with the medication dated 07/07/20. Review of Resident #13 July and August 2020 electronic Medication Administration Record (eMARs) and CSCS revealed: -There were 120 tablets of oxycodone 20mg dispensed on 07/07/20 that were documented for administered everyday at 9:00am, 1:00pm, 5:00pm and 9:00pm from 07/08/20 at 5:00pm to 08/06/20 at 9:00pm. -Oxycodone 20mg was documented as not administered by initial circled on the eMAR for 3 doses on 08/07/20 at 9:00am, 1:00pm, and 5:00pm with documentation for "physically unable to take" and "waiting on script" documented on the eMAR.	D 358		

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D 358	Continued From page 121 Review of Resident #13's physician's orders revealed an order dated 08/07/20 for oxycodone 20mg one tablet 4 times a day with a quantity of 120 tablets. Review of Resident #13's CSCS for oxycodone 20mg revealed there were 2 CSCS for documenting administration of 60 doses on each, with documented administration of the 120 doses received on 08/07/20. Review of Resident #13's August 2020 and CSCS revealed 120 tablets of oxycodone dispensed on 08/07/20 were documented as administered 4 times a day, each day at 9:00am, 1:00pm, 5:00pm and 9:00pm, from 08/07/20 at 9:00pm to 08/31/20. Continued review of Resident #13's September 2020 eMAR and CSCS revealed: -Oxycodone 20mg was documented as administered from 09/01/20 at 9:00am to 09/06/20 at 5:00pm. -Oxycodone 20mg was documented as not administered by initial circled on the eMAR for 3 doses on 09/06/20 at 9:00pm and 09/07/20 at 9:00am and 1:00pm with documentation for "physically unable to take" and "waiting on script" documented on the eMAR. Review of Resident #13's physician's orders revealed an order dated 09/07/20 for oxycodone 5mg/5ml oral solution 20mls (20mg dose) 4 times a day with a quantity of 160mls and an order dated 09/08/20 for 2400mls 20mls 4 times a day for pain to equal 32 days supply. Review of Resident #13's September 2020 and October 2020 eMARs and CSCS revealed: -There were CSCS received labeled take 20mls 4	D 358		

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times a day for pain.
-There were 2560 mls of oxycodone 5mg/5ml oral solution dispensed on 09/07/20 and 09/08/20 documented for administered 4 times a day, at 9:00am, 1:00pm, 5:00pm and 9:00pm from 09/07/20 at 5:00pm to 09/30/20 at 9:00pm on the September 2020 eMAR.
-Oxycodone 5mg/5ml oral solution was documented as administered at 9:00am, 1:00pm, 5:00pm and 9:00pm from 10/01/20 at 9:00am to 10/10/20 at 5:00pm on the October 2020 eMAR.
-There were 3 doses on 10/10/20 at 9:00pm, 10/11/20 at 9:00am, and 10/11/20 at 1:00pm documented as not administered by initial circled on the October 2020 eMAR with documentation for "physically unable to take" documented on the eMAR.

Based on record review and interview, Resident #13 was not administered 3 doses of oxycodone 20 mg on 08/07/20, 3 doses of oxycodone 20mg on 09/06/20 and 09/07/20, and 3 doses on 10/10/20 and 10/11/20 due to the medication not being ordered in a timely manner.

Review of Resident #13's physician's orders revealed an order dated 10/10/20 for oxycodone 5mg/5ml oral solution 20mls (20mg dose) for 2400mls with instructions for 20mls 4 times a day for pain. CSCS were received with the medication labeled take 20mls 4 times a day for pain.

Review of Resident #13's October 2020 eMARs and CSCS revealed:
-There was an entry for oxycodone 5mg/5ml oral solution 20mls (20mg dose) 20mls 4 times a day for pain scheduled for administration at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There was documentation oxycodone 5mg/5ml oral solution 20mls (20mg dose) was

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D 358	Continued From page 123 administered form 10/12/20 at 6:00pm to Observation of Resident #13's medication on hand for administration on 10/15/20 at 12:04pm revealed there were 4 bottles of 480mls and one partial bottle with 240msl remaining (total of 2160mls) remaining with instructions take 20mls 4 times daily for pain. Interview on 10/15/20 at 5:00pm with Resident #13 revealed: -He ran out of his pain medication every month for one or two days before he received his new supply. -Staff did not order his pain medication in time for him to not run out. -When he was without his pain medication he would usually lay in the bed with as little movement as possible to help with the pain. -He was able to ambulate in his wheelchair independently when he had his routine pain medication. Telephone interview on 10/16/20 at 3:15pm with Resident #13's primary care provider (PCP) revealed: -Resident #13 had chronic pain. -He ordered a month supply of Resident #13's oxycodone with each order. -He expected to be contacted by the facility (or pharmacy) when a 7 to 10 days supply remained of the medication. -He was aware Resident #13's oxycodone sometimes ran out before the facility requested a new order because there was sometimes more than a month between medication request. -The facility's refill request repeatedly were no made until the resident was out of medication. -Resident #13 could experience increased pain, stomach cramping, and/or anxiety if he ran out of the medication.	D 358		

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D 358	Continued From page 124 Telephone interview on 10/15/20 at 9:01am with a representative from the facility's contracted pharmacy revealed refills of controlled substances could be requested from the pharmacy when there were no more than six days' worth of medication left to be administered. Telephone interview on 10/16/20 at 4:33pm with the former Resident Care Coordinator (RCC) revealed: -Her last day of employment at the facility was 09/08/20. -There were problems at the facility related to the administration of controlled substances. -The MAs did not request refills for medications, including controlled substances, until the medication was no longer available for administration. -She instructed the MAs to let her know when controlled substances were almost out so she could request a written prescription from the providers but some staff did not reorder the medication correctly. -She kept refill request instructions on a board in her office; the MAs had access to the instructions but would not follow them. -The MAs were supposed to inform the providers through a phone call or fax when medications had been missed for three days. -There was a form the MA could fax to the provider but the MAs did not consistently use the form. -She reviewed the eMARs every Monday or Friday and followed up with the PCP regarding missed medications. -She was aware some residents ran out of pain medications before the pharmacy or facility had obtained a new order.	D 358		

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D 358	Continued From page 125 Refer to the telephone interview on 10/16/20 at 5:08pm with a former MA. Refer to the second telephone interview on 10/19/20 at 10:19am with the same former MA. Refer to the telephone interview on 10/20/20 at 2:30pm with a first shift MA. Refer to the telephone interview on 10/21/20 at 10:09pm with a third shift MA. Refer to the telephone interview with the ED on 10/22/20 at 12:55pm. 8. Review of Resident #14's current FL-2 dated 01/09/20 revealed: -Diagnoses included cerebral palsy, mild mental retardation, anxiety, depression, psychosis, and insomnia. -There was an order for clonazepam (a controlled substance used to treat anxiety) 0.5mg take ½ tablet (0.25mg) twice a day. Review of Resident #14's six-month physician orders signed on 08/27/20 revealed there was an order for clonazepam 0.5mg take ½ tablet (0.25mg) three times daily scheduled for administration at 8:00am, 12:00pm, and 10:00pm. Review of Resident #14's September 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry for clonazepam 0.5mg take ½ tablet (0.25mg) three times daily scheduled for administration at 8:00am, 12:00pm, and 10:00pm. -There was documentation clonazepam 0.25mg had been administered 62 of 90 opportunities.	D 358		

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D 358	Continued From page 126 -There was documentation clonazepam 0.25mg had not been administered 2 of 90 opportunities because Resident #14 was out of the facility. -There was documentation Resident #14 refused clonazepam 0.25mg on one occasion. -There was documentation clonazepam 0.25mg was withheld per physician orders on one occasion. -There were three dates on which the administration of the 10:00pm dose of clonazepam 0.25mg had not been documented. -There was documentation 14 doses of clonazepam 0.25mg were not administered from 8:00am on 09/10/20 through 10:00pm on 09/11/20; at 12:00pm on 09/12/20; on 09/16/20; and from 12:00pm on 09/17/20 through 12:00pm on 09/18/20; the exception entry was "physically unable to take." -There was documentation on 09/16/20 and 09/18/20 indicating clonazepam 0.25mg was on order from the pharmacy. Telephone interview on 10/15/20 at 9:01am with a representative from the facility's contracted pharmacy revealed: -The pharmacy dispensed 90 doses of clonazepam 0.25mg for Resident #14 on 08/06/20. -Refills of controlled substances could be requested from the pharmacy when there were no more than six days' worth of medication left to be administered. -Facility staff contacted the pharmacy on 09/08/20 to request a refill of clonazepam 0.25mg for Resident #14. -The pharmacy needed a written order before the clonazepam 0.25mg would be dispensed. -Ten doses of clonazepam 0.25mg were dispensed on Saturday, 09/12/20. -The on-call physician may have written the order	D 358		

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to cover the weekend until Resident #14's mental health nurse practitioner (NP) could write a new order.
-The pharmacy dispensed 90 doses of clonazepam 0.25mg for Resident #14 on 09/18/20.

Telephone interview on 10/19/20 at 10:19am with a former MA revealed she could not remember if she called the pharmacy on 09/10/20 and asked the pharmacist to contact the mental health NP to request a new order for Resident #14's clonazepam 0.25mg.

Telephone interview on 10/21/20 at 3:13pm with Resident #14 revealed the facility had run out of one of her medications, but she could not remember the date or the medication.

Telephone interview on 10/21/20 at 10:09pm with a second MA revealed:
-Resident #14 had missed clonazepam for two days while the facility was waiting for the mental health NP to write an order.
-She could not remember if she administered the last clonazepam 0.25mg tablet on 09/08/20 at 8:00am; if the controlled substance count sheet indicated there were four tablets left on that date, there had to be four tablets left.
-From 09/16/20-09/18/20, the MAs were waiting for Resident #14's clonazepam 0.25mg to be delivered from the pharmacy.
-She documented administration of clonazepam 0.25mg on 09/17/20 but the entry may have been an error since on 09/16/20 and 09/18/20 she documented the medication was on order from the pharmacy.
-She did not contact the pharmacy or the mental health NP about Resident #14 not receiving clonazepam 0.25mg on 09/12/20, 09/16/20, or

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09/18/20.
-She did not inform the RCC or the ED about Resident #14 not receiving clonazepam 0.25mg on 09/12/20, 09/16/20, or 09/18/20.

Telephone interview on 10/22/20 at 12:55pm with the ED revealed:
-Resident #14's clonazepam was not at the facility from 09/16/20-09/18/20.
-She did not know if anyone reported to the mental health NP that Resident #14 had missed multiple doses of clonazepam; the mental health NP should have been notified.
-She could not remember when the third shift MA spoke with her about Resident #14's missed doses of clonazepam.
-Resident #14 was aware the clonazepam was not available for administration in September 2020.
-Resident #14 had asked for the clonazepam in September 2020.

Attempted telephone interviews on 10/14/20 at 11:05am and 10/16/20 at 10:17am with the mental health NP were unsuccessful.

Refer to the telephone interview on 10/16/20 at 5:08pm with a former MA.

Refer to the second telephone interview on 10/19/20 at 10:19am with the same former MA.

Refer to the telephone interview on 10/20/20 at 2:30pm with a first shift MA.

Refer to the telephone interview on 10/21/20 at 10:09pm with a third shift MA.

Refer to the telephone interview with the ED on 10/22/20 at 12:55pm.

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D 358	Continued From page 129 _____ Telephone interview on 10/16/20 at 5:08pm with a former medication aide (MA) revealed: -There were many times when medication was not available for administration. -Some of the MAs would not request refills of controlled substances within enough time for the pharmacy to dispense the medication if another written order was required. -Sometimes it was difficult to reach the providers when a medication order was needed. Second telephone interview on 10/19/20 at 10:19am with the same former medication aide (MA) revealed: -She left voice messages for the providers regarding needing a new order for medications but there was no guarantee the provider would receive the message. -She also informed the former Resident Care Coordinator (RCC) when medication was not available for administration. -The former RCC used to review the medication carts to make sure the ordered medication was available for administration. -The Executive Director (ED) began reviewing the medication carts after the former RCC stopped working at the facility. -She did not know how often the ED reviewed the medication carts. Telephone interview on 10/20/20 at 2:30pm with a first shift medication aide (MA) revealed: -The first staff who realized an ordered medication was not available for administration should request the medication from the pharmacy. -A request for a medication refill could be ordered electronically on the medication administration system; the system would indicate if a refill had	D 358		

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been requested.
-Some MAs would fax a refill request to the pharmacy.
-Either way of requesting a refill was permissible.
-She would call the pharmacy if a requested medication was not delivered.
-She was not sure when the provider was supposed to be notified about missed medication.
-She did not know how many doses could be missed before the provider was supposed to be notified.
-She had never informed the provider about missed medication.

Telephone interview on 10/21/20 at 10:09pm with a third shift medication aide (MA) revealed:
-The exception "physically unable to take" on the electronic Medication Administration Record (eMAR) meant the medication was not at the facility.
-The pharmacy preferred refill requests to be sent when there were ten doses of a medication left.
-She requested refills when there were five doses left because sometimes insurance would not pay for a medication if the refill was requested too soon.
-She would peel the sticker from the medication bubble pack and fax it to the pharmacy when a refill was needed.
-Some MAs requested refills through the computer system.
-Sometimes she called the pharmacy for a refill if a medication was not available; she checked the back-up medication storage cart before she called the pharmacy.
-She wrote notes on the board near the MA station so staff would know when to order medication.
-The MA or supervisor was responsible for notifying the provider when a medication was not

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available for administration.
-The MA or supervisor would fax the provider or put a note on the Resident Care Coordinator's (RCC) door regarding missed medication.
-The provider was supposed to be notified by the MA, supervisor, or RCC after two days if a medication was missed, depending on the medicine.
-The RCC was responsible for auditing the medication carts and the eMARs; she did not know how often the audits were done.
-She also audited the medication carts and eMARs weekly on third shift.
-She compared the medication available to be administered to the entries on the eMAR.
-Subsequent shifts would know if a medication had been requested from the pharmacy by reviewing the shift report.
-She routinely reported medication that had not been administered to the first shift supervisor since the RCC and Executive Director (ED) were not at the facility when she left at the end of third shift.

Telephone interview with the Executive Director (ED) on 10/22/20 at 12:55pm.
-The medication aide (MA) was supposed to request refills of controlled substances when there were five doses left.
-The exception "physically unable to take" meant the medication was not in the facility or a resident was unable to swallow.
-The pharmacy was supposed to be notified after one dose was missed if the medication was not available at the facility.
-If a second dose was missed, the pharmacy and the provider were supposed to be notified by the staff administering the resident's medication.
-She routinely called the pharmacy if a requested medication was not delivered.

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D 358	Continued From page 132 -She asked the PCP for a stat order if a second dose was missed. -Medication refills could be requested electronically through the medication administration system. -The MA was supposed put a note in the system after a medication had been requested from the pharmacy. -The MA was supposed to inform the RCC or the ED if there were any concerns about administration of a resident's medication. -The RCC was supposed to follow-up on medication administration concerns reported by the MA. -The RCC was supposed to audit the medication carts and eMARs weekly. -The MA was responsible for administering medication as ordered. _____ The facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner related to a resident not receiving an anti-epileptic medication to control seizures resulting the resident being hospitalized due to seizures, not applying an osteoarthritis medication gel resulting in the resident experiencing increased pain and not receiving a pain medication resulting in severe and prolonged pain causing the resident to cry out in pain and unable to ambulate at baseline (#11), not having a medication for bipolar disorder available for administration and not having available for administration a medication for gastroesophageal reflux (#1), running out of a narcotic pain reliever for joint pain resulting in unnecessary discomfort (#4), not receiving a medication for pain resulting in unnecessary discomfort (#5), and not receiving lasix for swelling resulting in swollen feet and ankles (#20). This failure to ensure medications were available and administered as ordered by	D 358		

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D 358	Continued From page 133 the prescribing provider placed residents at substantial risk for serious physical harm and neglect of residents would occur and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/15/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 22, 2020.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure records of the receipt and administration of controlled substances were maintained, accurate and reconciled for 2 of 4 residents sampled who were prescribed controlled substances. The findings are: 1. Review of Resident #16's current FL-2 dated 09/07/20 revealed: -Diagnoses included schizophrenia, paranoid type, leukemia, and diabetes. -There was an order for lorazepam 2mg at	D 392		

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bedtime (a medication used to treat anxiety).

Review of the physician's order dated 09/09/20 revealed:
-There was an order to discontinue current lorazepam orders.
-There was an order for lorazepam 0.5mg twice daily at 8:00am and 2:00pm
-There was an order for lorazepam 1mg at bedtime.

a. Review of Resident #16's September 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg
-Lorazepam 0.5mg was documented as administered on 09/21/20 at 8:00am.

Review of Resident #16's lorazepam 0.5mg control substance count sheets (CSCS) revealed:
-There were five columns that required documentation when signing out a controlled substance; date, time, amount given, amount left, and signature.
-Documentation of the entry dated 09/21/20 at 9:00am revealed no documentation in the amount given, amount left and the signature columns.

Telephone interview on 10/19/20 at 2:52pm with a medication aide (MA) revealed:
-When signing out a controlled substance, all columns on the CSCS should be documented.
-She saw incomplete documentation once or twice and reported it to the supervisor on duty and it was fixed.

Telephone interview on 10/22/20 at 1:05pm with the Executive Director (ED) revealed:
-The MAs were responsible for completely documenting controlled substances on the CSCS.

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-When a MA signed out a controlled substance, they were to write the date, time, amount given, amount left and sign the entry on the CSCS.
-If the entry on the CSCS was lacking any information it was not complete accounting of the controlled substance.

b. Review of Resident #16's October 2020 electronic Medication Administration Record (eMAR) revealed lorazepam 0.5mg was circled, indicating not administered on 10/06/20 at 8:00am.

Review of Resident #16's lorazepam 0.5mg CSCS revealed:
-On 10/06/20 at 8:00am one tablet was administered.
-There was no documentation the medication had been wasted.

Telephone interview on 10/19/20 at 2:52pm with a medication aide (MA) revealed:
-When administering a controlled substance, she administered the medication to the resident, then documented on the CSCS.
-If she had wasted the medication, she would have documented it as wasted.
-She was not sure why the medication was circled indicating it was not administered.

Telephone interview on 10/22/20 at 1:05pm with the Executive Director (ED) revealed:
-The MA who removed the lorazepam 0.5mg dose on 10/06/20 at 8:00am did not follow facility protocol for documenting controlled substances.
-She did not know why there was a discrepancy, but the documentation was not accurate.

2. Review of Resident #14's current FL-2 dated 01/09/20 revealed:

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D 392	Continued From page 136 -Diagnoses included cerebral palsy, mild mental retardation, anxiety, depression, psychosis, and insomnia. -There was an order for clonazepam (a controlled substance used to treat anxiety) 0.5mg take ½ tablet (0.25mg) twice a day. Review of Resident #14's six-month physician orders signed on 08/27/20 revealed there was an order for clonazepam 0.5mg take ½ tablet (0.25mg) three times daily scheduled for administration at 8:00am, 12:00pm, and 10:00pm. Review of Resident #14's August 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry for clonazepam 0.5mg take ½ tablet (0.25mg) three times daily. -There were 92 of 93 doses of clonazepam 0.25mg documented as administered from 08/01/20-08/31/20. -One dose of clonazepam was documented as not administered at 8:00am on 08/25/20 because Resident #14 refused the medication. Review of Resident #14's September 2020 eMAR revealed: -There was an entry for clonazepam 0.5mg take ½ tablet (0.25mg) three times daily scheduled for administration at 8:00am, 12:00pm, and 10:00pm. -There were 62 of 90 doses of clonazepam 0.25mg documented as administered from 09/01/20-09/30/20. -Two doses of clonazepam had not been administered because Resident #14 was out of the facility. -Fourteen doses of clonazepam had not been administered and contained the exception	D 392		

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"physically unable to take."
-One dose of clonazepam had been withheld per physician orders.
-One dose of clonazepam had not been administered because Resident #14 refused the medication.
-There were three blank spaces related to the administration of the 10:00pm dose of clonazepam.
-There were seven spaces from 10:00pm on 09/28/20 through 10:00pm on 09/30/20 that had two dashes in each space; Resident #14 was hospitalized from 09/28/20-10/02/20.

Telephone interview on 10/15/20 at 9:01am with a representative from the facility's contracted pharmacy revealed:
-The pharmacy dispensed 90 doses of clonazepam 0.25mg for Resident #14 on 08/06/20.
-Ten doses of clonazepam 0.25mg were dispensed on Saturday, 09/12/2020.

Review of Resident #14's controlled substance count sheet (CSCS) for clonazepam 0.5 mg take ½ tablet (0.25mg) three times daily revealed:
-There was electronically printed information indicating the pharmacy had dispensed 90 doses of clonazepam 0.25mg on 08/06/20.
-The count started on 08/09 (no year listed) with a dose administered at 1:00pm, leaving a balance of 89.
-The last entry was dated 09/09 and was illegible.
-There were 87 entries documenting a dose was administered.
-There were three incomplete or illegible entries at the bottom of the CSCS; two were dated 09/08 at 8:00pm and one was dated 09/09 at (time illegible)

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THE BRADFORD VILLAGE OF KERNERSVILLE - WES	602 PINEY GROVE ROAD KERNERSVILLE, NC 27284

(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 392	Continued From page 138 -There were four entries dated 08/20/20 at 7:00am, 8:00am, (time illegible), and 8:00pm. (Three doses were documented as administered on Resident #14's August 2020 eMAR.) -There was an entry dated 08/27/20 at 8:00pm indicating a medication aide (MA) added a dose (from 37 doses remaining to 38 doses remaining) instead of subtracting a dose (from 37 doses remaining to 36 doses remaining) after administering the medication. -The entry dated 08/28/20 at 8:00am indicated "dropped in water." (There was documentation on Resident #14's August 2020 eMAR indicating clonazepam 0.25mg was administered on 08/28/20 at 8:00am.) -The entry dated 08/28/20 at an illegible time indicated "spilled water." (There was documentation on Resident #14's August 2020 eMAR indicating clonazepam 0.25mg was administered on 08/28/20 at 12:00pm.) -There were four entries dated 08/28/20 at 8:00am, (time illegible), 1:00pm, and 8:00pm. (Two clonazepam 0.25mg tablets were discarded and three tablets were documented as administered on Resident #14's August 2020 eMAR.) -There was an entry dated 09/02/20 that was not documented as administered on Resident #14's September 2020 eMAR. -At 10:00pm on 08/19/20 and 08/21/20 clonazepam 0.25mg was documented as administered on Resident #14's August 2020 eMAR, but was not documented on the CSCS. Telephone interview on 10/19/20 at 3:58pm with a MA who is no longer employed at the facility revealed: -Controlled substance counts were done with the oncoming MA at the end of each shift. -During two different medication passes on	D 392		

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D 392	Continued From page 139 08/28/20 she was interrupted by a resident, causing her to spill a large amount of water and resulting in two clonazepam tablets being wasted. -She did not give Resident #14 clonazepam 0.25mg at 10:00pm on 09/09/20; she worked first shift. -She must have forgotten to log out from the computer and someone else administered the medication under her name. Telephone interview on 10/21/20 at 10:09pm with a second MA revealed: -Controlled substances were counted at the change of shift by the outgoing and oncoming MAs. -One MA reviewed the medication bubble pack, the other MA reviewed the CSCS, and both confirmed the numbers matched. -If there were discrepancies, she checked the eMAR to see who gave the last dose. -She would flag discrepancies and let the other MA correct the CSCS the next time the MA worked. -She had written an MA's initials on the side of the signature space on the CSCS so the MA could sign the CSCS the next time she worked. -Errors should not have occurred if counts were being done at the end of each shift. -She always counted the controlled substances at the end of the shift. -If the number of tablets in the bubble pack matched the number on the CSCS, she did not review the administration time. -She would not accept responsibility or take the keys to the medication cart if the count was not right. -She reviewed the controlled substances during third shift on Wednesday so the nurse practitioner (NP) could write orders on her Thursday visits to the facility.	D 392		

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D 392	Continued From page 140 -The Resident Care Coordinator (RCC) and the Executive Director (ED) reviewed the CSCS when it was completed. -The RCC and the ED would help to solve errors in the count. -Sometimes she helped other shifts administer medication. -She signed medication out on the CSCS and administered it under the other MA's name if the other MA was already logged on the computer. -She did not know why the MA added instead of subtracted when administering Resident #14's clonazepam on 08/27/20. -If an entry was not made on the CSCS on 09/19/20 at 8:00pm, the medication may not have been administered to Resident #14. -She did not know why Resident #14's clonazepam 0.25mg was signed out twice for the 8:00am dose on 09/20/20. -Resident #14 may have received two doses of clonazepam 0.25mg on the morning of 09/20/20. -She could not remember if she had administered the last clonazepam 0.25mg tablet on 09/08/20 at 8:00am. -If the count sheet indicated there were four tablets left after she administered Resident #14's clonazepam 0.25mg tablet at 8:00am on 09/08/20, there had to be four tablets left. Telephone interview on 10/22/20 at 12:55pm with the Executive Director (ED) revealed: -Discrepancies between the CSCS and the eMAR occurred if the MAs were not signing in or out of the computer system. -She instructed the MAs to make sure their name was showing at the bottom of the computer screen to indicate which MA was logged in on the computer -When she administered a controlled substance, she had the eMAR on the computer screen and	D 392		

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D 392	Continued From page 141 the CSCS sheet and the medication bubble pack in front of her. -She removed the controlled substance from the bubble pack, administered the medication, and made sure the resident swallowed the medication. -She then documented on the CSCS and on the eMAR. -She expected the oncoming MA to refuse to accept the keys to the medication cart if the controlled substance count was inaccurate. -No on reported to her that Resident #14 may have received two clonazepam 0.25mg doses on the morning of 08/20/20. -She did not know why no one noticed the MA had added instead of subtracted Resident #14's clonazepam 0.25mg dose on 08/27/20. -Staff may not have been counting at the end of each shift. -The previous RCC was responsible for auditing the CSCS in August 2020 and September 2020. -There were no reports of errors with Resident #14's CSCS in August 2020 or September 2020. -She could not explain how Resident #14's clonazepam 0.25mg continued to be documented on the CSCS and the eMAR when there should not have been any medication available for administration. -The MA was responsible for administering controlled substances as ordered. Based on telephone interviews and reviews of Resident #14's CSCS and August 2020-September 2020 eMARs: -The last available clonazepam 0.25mg tablet would have been administered at 10:00pm on 09/07/20. -The CSCS did not accurately reconcile with the quantity dispensed or the eMARs.	D 392		

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D912	Continued From page 142	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to Adult Care Home Medication Aide training and competency, Training on Cardio-Pulmonary Resuscitation, and Medication Administration. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 8 of 9 sampled residents (Residents #1, #4, #5, #11, #13, #14, #16 and #20), related to a medication for bipolar disorder and a medication for gastroesophageal reflux disease (#1), a narcotic pain medication (#4, #5, and #13), an anti-epileptic medication to control seizures, an osteoarthritis gel medication as needed for arthritic pain, an as needed pain medication, a medication for low blood levels of B12, a medication for vitamin deficiency, and an antihistamine to prevent allergy symptoms (#11),	D912		

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D912	Continued From page 143 an anti-anxiety medication (#14), a medication used to treat nightmares and a medication for anxiety (#16), and a medication used to treat fluid retention (#20). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff B and C) who administered medications had documentation of a completed the 5, 10, or 15-hour medication administration training course or the medication aide employment verification form (Staff B) and had successfully passed the written medication aide exam within 60 days of completing their medication clinical skills competency validation (Staff C). [Refer to Tag D0935, G.S. 131D-4.5B(b) Adult Care Home Medication Aides; Training and Competency (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all residents were free from physical abuse and neglect related health care. The findings are: Based on observations, interviews and record reviews, the facility failed to ensure the health	D914		

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D914	Continued From page 144 care needs were met for 3 of 11 sampled residents including failure to contact the primary care provider for refusal of medications, the resident's decline in health, inability to get out of bed and reposition herself due to weakness, crying due to pain, vomiting and altered mental status resulting in the resident's death (#11), notifying the primary care provider for not applying anti-thrombotic hose (#20), and notifying the primary care provider for a resident's weight gain (#7). [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A	D935		

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D935	Continued From page 145 NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff B and C) who administered medications had documentation of a completed the 5, 10, or 15-hour medication administration training course or the medication aide employment verification form (Staff B) and had successfully passed the written medication aide exam within 60 days of completing their medication clinical skills competency validation	D935		

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D935	Continued From page 146	D935		

(Staff C).

The findings are:

1. Review of Staff B's, the Administrator's, personnel record revealed:
-Staff B was hired on 12/17/19.
-There was documentation Staff A passed the written medication aide (MA) exam on 10/26/07.
-There was documentation of a Medication Clinical Skills Competency Validation dated 01/30/20.
-There was no documentation Staff A completed the 5, 10, or 15-hour medication administration training course and no documentation of the MA employment verification form .

Review of a resident's August, September, and October 2020 electronic Medication Administration Record (eMAR) revealed:
-Staff B documented the administration of medications 7 days in August 2020.
-Staff B documented the administration of medications 10 days in September 2020.
-Staff B documented the administration of medications 1 day in October 2020.

Telephone interview on 10/22/20 at 11:00am with Staff B revealed:
-She had worked at the facility since 2019 as the Executive Director (ED), but she was also a MA.
-She filled in as a MA and administered medication when she needed to.
-She passed her MA exam in 2007 and had not received the 5, 10, or 15-hour medication aide training. However, she had sat in on a few 15-hour training classes.
-When she was first hired at the facility, she requested employment verification forms from previous facilities, but she did not receive them

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D935	Continued From page 147	D935		

back.
-She did not follow up with the facilities for the employment verification forms because she had to "hop on the cart."
-The Business Office Manager (BOM) was responsible for auditing personnel record to make sure 5, 10, or 15-hour MA training was completed for MAs.
-Personnel records were last audited sometime within the first two weeks of September 2020.
-Her personnel record was not pulled during the last audit.

Telephone interview on 10/22/20 at 1:16pm with the BOM revealed she did not know the ED did not have documentation of her 5, 10, or 15-hour training or MA employment verifications in her personnel record.

Refer to telephone interview on 10/22/20 at 1:16pm with the BOM revealed:

2. Review of Staff C's, medication aide's (MA), personnel record revealed:
-Staff C was hired on 02/03/20.
-There was documentation Staff C completed a 15-hour medication administration training course on 02/21/20.
-There was documentation of a Medication Clinical Skills Competency Validation dated 02/21/20.
-There was no documentation Staff C passed the written MA exam.

Review of a resident's August, September 2020 electronic Medication Administration Record (eMAR) revealed:
-Staff C documented the administration of medications 11 days in August 2020.
-Staff C documented the administration of

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D935	Continued From page 148 medications 1 day in September 2020 and had not passed the written MA exam. Telephone interview on 10/21/20 at 10:35am with Staff C revealed: -She had worked at the facility since 02/03/20 as a personal care aide. -She completed the MA clinical skills competency validation and 15-hour medication administration training in February 2020, and she trained as a MA in March and April 2020. -She started working on the floor as a MA and independently administering medication in June 2020. -She sent in a request to the state to take the written MA exam on 03/25/20, but she had not received a confirmed exam date. -She did not know she needed to pass the written MA exam within 60 days of completing the MA clinical skills competency validation. -She did not know she was not supposed to administer medication if she had not passed the written MA exam within 60 days of completing the MA clinical skills competency evaluation. -She was "pulled off" the medication cart at the end of August, but she filled in for a coworker and administered medications one day in September 2020. Interview on 10/15/20 at 4:40pm with the Executive Director (ED) revealed: -Staff C had been administering medication since February 2020. -She found out Staff C had not passed her written MA exam during an audit in August 2020. -Staff C was "pulled" from the medication cart at the end of August 2020. -Staff C should not have administered medication in August 2020. -The business office manager (BOM) was	D935		

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D935	Continued From page 149 responsible for tracking when the written MA exam should be taken. Telephone interview with the BOM on 10/22/20 at 1:16pm revealed: -She knew MAs should pass a written MA exam within 60 days of completing the MA clinical skills competency validation. -If a MA did not pass their written MA exam within 60 days after completing the MA clinical skills competency validation, the MA should stop administering medication. -She knew Staff C had not passed her written MA exam only because the ED told her earlier in the week. Refer to telephone interview on 10/22/20 at 1:16pm with the BOM revealed: _____ Telephone interview on 10/22/20 at 1:16pm with the BOM revealed: -She started working as BOM in September 2020. -She was responsible for maintaining staff personnel records and for auditing personnel records. -She had not audited personnel records since she started working as BOM, but she was in the process of creating a system for monitoring the records. _____ The facility failed to ensure medication aides had completed the 5, 10 or 15-hour state approved medication aide training prior to performing unsupervised medication aide duties (Staff B) and had successfully passed the written medication aide exam within 60 days of completing their medication clinical skills competency validation (Staff C). This failure increased the risk for medication errors and was detrimental to the health, safety and welfare of the residents which	D935		

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D935	Continued From page 150 constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/15/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 7, 2020.	D935		