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THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section completed an annual and follow-up survey and complaint investigation on 04/15/21, 04/16/21 and 04/19/21 with an exit via telephone on 04/20/21.	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: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure doors and floors were kept clean and in good repair in 3 of 14 resident bedrooms (301, 307, and 311) on the third floor. The findings are: Observations of resident rooms on 04/15/21 between 9:15 am - 9:40 am revealed: -The bathroom in room 307 had sewage that seeped from under the toilet and formed a black build-up around the base and coated the surrounding tiles. -There was extensive staining around the entire toilet. -There was a very strong overwhelming smell of sewage.	D 074		

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-There was a sheet with yellowish browns stains placed on the floor to the left of the toilet that was wet.
-The carpet in room 307 was stained and had something reddish in color that appeared to be growing.
-Room #311 had a closet door that was off the tract and was propped in front of the residents clothing that was hanging in the closet.

Interview with the resident residing in room 307 on 04/15/21 9:25 am revealed:
-The bathroom toilet had previously been repaired about 5-7 months ago due to leaking around the base.
-The sewage smell bothered him.
-He was told the toilet and the floor in the bathroom would be fixed.
-He walked bare footed and had a bandage on his left foot due to ulcers and sometimes the bandage got wet when he walked in the bathroom.
-He did not know if the carpet in his room had ever been cleaned.

Interview with the two residents residing in room 311 on 04/15/21 9:35 am revealed:
-The closet door had been broken and off the tract for three weeks.
-One resident had to physically move the door to get to his clothes and the other resident could not slide the closet door on his side completely open to get to his clothing in the closet.
-The closet door was heavy and hard to move.

Interview with housekeeping staff on 04/15/21 at 9:39 am revealed:
-She had only worked at the facility for two weeks and the bathroom floor in room 307 had been black and odorous since she was hired.

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D 074	Continued From page 2	D 074		

-She mopped the bathroom floor daily.
-She used an abrasive powder with bleach and a sanitizing agent to scrub the bathroom floor (did not specify date), but it did not remove the black from the tiles or from around the toilet.
-She did not know who placed the sheet to the left of the toilet.
-She had vacuumed the carpet in room 307 but she had not shampooed, or steam cleaned it.

Interview with a medication aide (MA) on 04/15/21 at 9:30 am revealed:
-Housekeeping mopped all the bathroom floors daily but the bathroom floor in room 307 did not come clean and the odor never went away.
-The resident in room 307 was legally blind and sometimes missed the toilet.
-The sheet on the floor was to absorb some of the sewage from the toilet and to help absorb urine when the resident missed the toilet.
-She did not know how long the carpet had been dirty, but it had been "for a while".
-The previous maintenance had quit and the current maintenance staff had only been at the facility for 3 weeks.
-Maintenance staff cleaned the hall carpets, but she did not know if he had cleaned the carpets in the resident's room.

Interview with a Maintenance Staff on 04/15/21 at 10:50 am revealed:
-He had only worked at the facility for 3 weeks and was doing all he could.
-He knew about the bathroom in room 307.
-He scrubbed the bathroom floor (did not specify date) in room 307 but the tiles did not come clean and the odor did not go way.
-He would have to replace the tiles on the bathroom floor and would check the wax seal in the toilet, when he replaced the tiles.

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D 074	Continued From page 3 -He had not had a chance to shampoo or steam clean the carpet in room 307. Interview with the Administrator on 04/15/21 at 11:00 am revealed: -She did not know about the leaking toilet in room 307 or about the dirty carpet. -She did not know about the broken closet door in room 311. -She had not had a chance to do a walk through to see what areas needed to be worked on. -Her focus had been on providing adequate staff to provide personal care and getting medications to the facility. Interview with a representative from the cleaning crew on 04/15/21 at 4:25 pm revealed: -They had been contracted to vacuum the resident rooms on the third floor. -He had seen toilets with black around them previously and they were like that because the wax seal had gone bad and sewage was seeping from underneath the toilet and into the tiles. -The floor tiles would have to be replaced. -The sewage would continue to seep from under the toilet if the wax seal was not replaced. -He would clean it the best he could. Observation of Room 301 on 04/15/21 at 11:40 am revealed the bathroom floor tiles in front of the bathtub were broken and raised up creating a fall hazard. Interview with the resident who resided in room 301 on 04/15/21 at 11:40 am revealed: -He didn't know how long the tiles had been broken. -He had not informed staff the tiles were broken. -He didn't remember it causing him to fall.	D 074		

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D 074	Continued From page 4 Interview with a personal care aide (PCA) on 04/15/21 at 11:45 am revealed: -She had not noticed the broken bathroom floor tile in room 301. -The resident who resided in the room was independent and did not need help with personal care or ambulating to the restroom. -She would let the Maintenance staff know if she found anything broken. Interview with the first shift medication aide (MA) on 04/15/21 at 11:50 am revealed: -She had not noticed the tile broken in the bathroom floor of room 301. -She had not informed maintenance of the broken bathroom floor tiles. -Staff would inform the Maintenance staff or the Administrator when they found things that needed to be fixed. Interview with the Administrator on 04/15/21 at 12:00 pm revealed: -The Maintenance staff completed repairs as they were reported. -She did not know the bathroom floor tiles were broken in room 301. -Staff reported needed repairs to the Administrator or the Maintenance staff. Interview with the Maintenance staff on 04/15/21 at 12:05 pm revealed: -He made needed repairs as they were reported. -He did not know the bathroom floor tile in room 301 was broken. -He did not receive any report from staff that room 301's bathroom tile needed repaired. _____ The facility failed to ensure floors were kept clean and in good repair as evidenced by a sewage leak from underneath a toilet in a resident room	D 074		

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D 074	Continued From page 5 causing sewage stains on the flooring, and ongoing exposure to raw sewage in the bathroom which could cause the risk of infection, and broken floor tile in a resident room causing an uneven surface for residents to walk on. This failure was detrimental to the health and safety of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/15/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 04, 2021.	D 074		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;	D 164		

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D 164	Continued From page 6 (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (Staff B), who administered insulin to residents completed training on the care of diabetic residents prior to the administration of insulin. The findings are: Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B's date of hire was 02/07/21. -There was no documentation Staff B completed training on the care of diabetic residents. Review of residents' March and April 2021 Medication Administration Records (MARs) revealed there was documentation Staff B administered insulin to residents on 24 occasions from 03/05/21 through 04/09/21. Interview with Staff B on 04/19/21 at 3:50 pm revealed: -She worked as a MA at the facility and administered medications to residents. -When she worked, she administered medications including insulin injections. -She did not remember completing any formal diabetic care training.	D 164		

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D 164	Continued From page 7 -She was hired as a personal care aide (PCA) in February 2021. -The former Administrator asked her to begin training as a MA including working on the medication cart in late February 2021. -She trained one week on the medication cart with an MA that was no longer employed at the facility. Interview with the Administrator on 04/19/21 at 4:10 pm revealed: -All MAs were to receive training for care of diabetic residents. -The facility's Registered Nurse (RN) was responsible for training MAs on the care of diabetic residents. -There had not been a qualified RN employed at the facility during the time Staff B should have received diabetic training. -The new Resident Care Director (RCD) was hired to begin 04/19/21. -The RCD is a Registered Nurse (RN). -The new RCD would be responsible for training MAs on diabetic care. -Staff B was hired by the previous Administrator. -Staff B was working as a MA when she became the Administrator in March 2021. -She did not know Staff B had not completed diabetic care training. Interview with the facility's Contracted RN on 04/19/21 at 4:20 pm revealed: -She was a temporarily contracted in late March 2021 to help train MAs as well as other tasks within the facility. -The Administrator gave her the tasks she needed to complete for the facility, such as MA training. -She did not know Staff B needed diabetic care training.	D 164		

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D 164	Continued From page 8 Interview with the RCD on 04/19/21 at 4:25 pm revealed: -She was a registered nurse and was hired on 04/19/21. -MAs should have diabetic care training. -She was responsible for MA diabetic care training. -The contracted RN would assist with MA diabetic care training when needed. -She did not know Staff B needed diabetic care training.	D 164		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a	D 188		

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census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)
(D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments.
(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure required staffing hours were met on second and third shifts based on a census of 31-40 for 3 of 42 shifts from 03/21/21 to 04/03/21.

The findings are:

Review of the facility census record from 03/21/21 to 03/31/21 revealed there was a census of 40 residents.

Review of staff timecards from 03/21/21 to 03/31/21 revealed:
-On 03/23/21 there was a total of 16 hours of staff coverage on third shift, with a shortage of 8 hours.
-On 03/28/21 there was a total of 17.5 hours of staff coverage on second shift, with a shortage of 6.5 hours.

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Review of the facility census record from 04/01/21 to 04/03/21 revealed there was a census of 40 residents.

Review of timecards from 04/01/21 to 04/03/21 revealed that on 04/01/21 there was a total of 16.75 hours of staff coverage on third shift, with a shortage of 7.25 hours.

Interview with a PCA on 04/15/21 at 11:20 am revealed:
-She worked first shift.
-There were normally 2 PCAs on each floor and an MA on first shift.
-There were occasional staff call-outs causing there to be 1 PCA on the floor.
-The Administrator would attempt to have other PCAs come in to cover the shift when staff called-out.

Interview with a MA on 04/15/21 at 4:20 pm revealed:
-There was an MA and 2 PCAs on each shift on each floor.
-When there were call-outs or the shift was short-staffed, the Medication Manager (MM), Business Office Manager (BOM) or the Administrator would pass medications.
-The MM, BOM and the Administrator have had to pass medications frequently in the last month.

Interview with a second MA on 04/16/21 at 7:55 am revealed:
-She worked third shift and stayed over 04/16/21 because the first shift MA did not come to work.
-When staff called-out for third shift, the Administrator would attempt to have other staff work to cover each shift.
-If other MAs would not cover a shift, the MM, BOM or the Administrator would pass

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D 188	Continued From page 11 medications for that shift/floor. -There were usually 2 MAs and 1 PCA who floated between third and fourth-floors on third shift. Interview with the BOM on 04/16/21 at 9:30 am revealed: -The Administrator was responsible for the staff schedule. -The schedule was usually covered, but there had been daily staff call-outs. -She filled in as a MA that morning (04/16/21) because there was a staff call-out. -She filled in on all shifts often due to call-outs. -The Administrator and MM also helped fill in as the MA when needed. Interview with the Administrator on 04/19/21 at 2:40 pm revealed: -She was responsible for the staff schedule. -Staff would not show up to work and called-out daily. -When she was not able to find staff to cover shifts, she would pass medications on any of the 3 shifts. -The BOM and MM would also fill-in for short shifts. -If she knew the 3 shifts were short staffed, either she, the BOM or the MM would have worked any shift on the short staffed floor.	D 188		
D 238	10A NCAC 13F .0703 (c-4) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations The results of the complete examination required in Paragraph (b) of this Rule are to be entered on	D 238		

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the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:

(4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs.

This Rule is not met as evidenced by:
Based on record reviews, and interviews, the facility failed to ensure FL2s included complete information and was clarified by the primary care provider (PCP) for 3 of 6 sampled residents (Residents #2, #3 and #7) who had no medication orders listed on the current FL2s.

The findings are:

1. Review of Resident #2's current FL2 dated 01/19/21 revealed:
-Diagnoses included depression, anxiety, bipolar disorder, rheumatoid arthritis, kidney failure, tachycardia, sinusitis, constipation, anemia, vitamin D deficiency, hypernatremia, chronic obstructive pulmonary disease (COPD), pain, hypertension, and gastroesophageal reflux disease (GERD).
-There was a medication order for Advair disk aero (used to treat COPD) with no dosage or frequency.
-There was a medication order for clonazepam 1mg (used to treat anxiety) with no frequency.
-There was a medication order for doxepin 25mg (used to treat depression) with no frequency.
-There was a medication order for Humira 40/0.4ml (used to treat rheumatoid arthritis) with

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D 238	Continued From page 13 no frequency. -There was a medication order for hydroxychloroquine 200mg (used to treat rheumatoid arthritis) with no frequency. -There was a medication order for Latuda 120mg (used to treat schizophrenia) with no frequency. -There was a medication order for omeprazole 40mg (used to treat acid reflux) with no frequency. -There was a medication order for vitamin B-12 (used to treat B-12 deficiency) with no frequency. -There was a medication order for vitamin D3 2000IU (50mcg) (used to treat vitamin D deficiency) with no frequency. -There was a medication order for senexon-x 8.6mg (used to treat constipation) with no frequency. -There was a medication order for tizanidine 4mg (used to treat muscle spasms) with no frequency. -There was a medication order for tramadol 50mg (used to treat pain) with no frequency. -There was a medication order for melatonin 10mg (50mcg) (used to treat insomnia) with no frequency. -There was a medication order for omeprazole 40mg (used to treat acid reflux) with no frequency. -There was a medication order for prazosin 1mg (used to treat high blood pressure) with no frequency. -There was a medication order for promethazine 25mg (used to treat to treat nausea) with no frequency. -There was a medication order for albuterol sulfate 90mcg (used to treat COPD and shortness of breath) with no frequency. -There was no order for duloxetine 60mg twice daily (used to treat depression and anxiety). -There was no order for flexeril 5mg three times daily as needed for muscle spasms (used to treat	D 238		

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muscle spasms).
-There was no order for miralax 17mg twice daily (used to treat constipation).

Review of Resident #2's physician's orders revealed:
-There were no physician's orders updated after the current FL2 dated 01/19/21.
-There were no orders that verified the frequency of the medications ordered on the current FL2 dated 01/19/21.
-There were no administration frequencies documented on the MARs for Advair disk aero, clonazepam 1mg, doxepin 25mg, Humira 40/0.4ml, hydroxychloroquine 200mg, Latuda 120mg, omeprazole 40mg, vitamin B-12, vitamin D3 2000IU, senexon-x 8.6mg, tizanidine 4mg, tramadol 50mg, melatonin 10mg, omeprazole 40mg, prazosin 1mg, promethazine 25mg and albuterol sulfate 90mcg.

Review of Resident #2's January, February, March, and April 2021 medication administration records (MARs) revealed:
-There was an entry for advair diskus 250-50mcg 1 puff twice daily scheduled for administration at 8:00 am and 8:00 pm.
-There was an entry for clonazepam 1mg three times daily scheduled for administration at 8:00 am 2:00 pm and 8:00 pm.
-There was an entry for doxepin 25mg at bedtime scheduled for administration at 8:00 pm.
-There was an entry for Humira 40/0.4ml injection scheduled every 14 days.
-There was an entry for hydroxychloroquine 200mg once daily scheduled for administration at 8:00 am.
-There was an entry for Latuda 120mg once daily scheduled for administration at 8:00 am.
-There was an entry for omeprazole 40mg once

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D 238	Continued From page 15 daily scheduled for administration at 6:30 am. -There was an entry for vitamin B-12 once daily scheduled for administration at 8:00 am. -There was an entry for vitamin D3 2000IU once daily scheduled for administration at 8:00 am. -There was an entry for senexon-x 8.6mg twice daily scheduled for administration at 8:00 am and 8:00 pm. -There was an entry for tizanidine 4mg every six hours scheduled at 6:00 am, 12:00 pm, 6:00 pm and 12:00 am. -There was an entry for tramadol 50mg four times daily scheduled for administration at 8:00 am 12:00 pm, 4:00 pm, and 8:00 pm. -There was an entry for melatonin 10mg at bedtime scheduled for administration at 8:00 pm. -There was an entry for omeprazole 40mg at bedtime scheduled for administration at 8:00 pm. -There was an entry for prazosin 1mg at bedtime scheduled for administration at 8:00 pm. -There was an entry for promethazine 25mg every six hours as needed for nausea. -There was an entry for albuterol sulfate 90mcg inhale 2 puff every six hours as needed for shortness of breath. -There was an entry for duloxetine 60mg twice daily scheduled for administration at 8:00 am and 8:00 pm. -There was an entry for Flexeril 5mg three times daily as needed for muscle spasms. -There was an entry for miralax 17gm twice-daily scheduled for administration at 8:00 am and 8:00 pm. -There were entries for 17 of 20 medications not ordered on the current FL2 dated 01/19/21. Interview with medication manager (MM) 04/15/21 at 9:32 am revealed: -She was not aware Resident #2's FL2 was incomplete.	D 238		

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-She did not have time to independently check each resident's record.

Telephone interview with the Administrator on 04/20/21 at 2:17 pm revealed:
-The MM was responsible to review medication orders and ensure the orders were complete.
-If the order was not complete the MM was supposed to contact the resident's PCP to clarify the order.
-The facility's system was the MM was responsible for auditing the resident's records daily to ensure orders accurately.

2. Review of Resident #3's current FL2 dated 02/07/21 revealed:
-Diagnoses included essential hypertension, schizo-affective disorder, unspecified lesions of the mucosa, anxiety disorder and major depressive disorder.
-There were no medications listed on the FL2.
-There was documentation as "See attached MAR" typed in the space for medication orders to be listed on Resident #3's FL2.
-Resident #3's medication administration record dated 03/01/21-03/31/21 was attached to the FL2.

Review of Resident #3's record revealed there was no documentation the primary care provider (PCP) was contacted for clarification of medication orders.

Interview with the facility's Contracted Nurse on 04/16/21 at 2:25 pm revealed:
-She was contracted in March 2021 by the facility to assist in resident record audits for FL2s, but had not been able to do so yet due to her updating resident's Licensed Health Professional Support evaluations.

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D 238	Continued From page 17 -Residents' FL2s should have a current list of medications and should be reviewed by the PCP. -She did not know Resident #3's FL2 did not include current medications listed on the FL2. Interview with the Administrator on 04/16/21 at 2:30 pm revealed: -The residents' PCP should have written current medication orders on the FL2s. -The PCP had not included current medication orders on FL2s, but would request staff to attach copies of the current physicians' order sheets (POS) or MARs to the FL2s. Interview of the Administrator on 04/19/21 at 1:13 pm revealed a consultant nurse had been hired in March 2021 to help audit records and determine residents who needed updated FL2s. Telephone interview with the Resident #3's PCP on 04/19/21 at 10:40 am revealed: -She visited the facility every Tuesday to assess residents and reviewed the current medications listed on their FL2s; then sign the FL2s. -Resident #3's FL2 was signed on a Sunday 02/07/21, a day in which she would not have been at the facility. -She would not have signed an FL2 without current medication orders listed on the FL2 for any resident. -She did not remember and could not find documentation when she last assessed Resident #3 for her to sign the current FL2. -The previous Resident Care Director (RCD) completed the residents' FL2 forms before she arrived at the facility for the PCP to sign. 3. Review of Resident #7's current FL2 dated 02/14/21 revealed: -There were diagnoses including paranoid	D 238		

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schizophrenia and reflux esophagitis.
-There were no medication orders listed on the FL2.
-There was documentation on Resident #7's FL2 as "See attached MAR" was typed in the space for the medication list.
-Resident #7's MAR dated 03/01/21-03/31/21 with medications documented on was attached to the FL2.

Review of Resident #7's March 2021 Medication Administration Record (MAR) revealed:
-There was an entry for Humalog (a rapid acting insulin) insulin before breakfast, lunch, and dinner using scale of 18 units for fingerstick blood sugar (FSBS) over 250 and give additional 6 units for FSBS over 400 for a total of 24 units of Humalog.
-There was an entry to check FSBS 3 times a day before meals.
-There was an entry for Lantus (a long acting insulin) insulin 20 units at bedtime.
-There was an entry for Vitamin D 1.25mg (a vitamin supplement) every Friday.
-There was an entry for fluoxetine 20mg (used to treat depression) every day.
-There was an entry for omeprazole 20mg (used to treat acid reflux) twice a day.
-There was an entry for vitamin B12 500mcg (a vitamin supplement) once daily.
-There was an entry for metformin ER 750 ER (used to treat diabetes) twice a day, with breakfast and supper.
-There was an entry for olanzapine 5mg (used to treat depression) twice a day.
-There was an entry for olanzapine 15mg at bedtime.
-There was an entry for clonazepam 0.5mg (used to treat anxiety) at bedtime.
-There was an entry for divalproex 500mg (used to treat mental disorders) 2 tablets at bedtime.

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D 238	Continued From page 19 -There was an entry for fenofibrate 54mg (used to treat elevated triglycerides) at bedtime. -There was an entry for Systane (lubricating eye drops) each eye at bedtime. Review of Resident #7's record revealed there was no documentation the Primary Care Provider (PCP) was contacted for clarification of medication orders. Interview with the facility's Contracted Nurse (CN) on 04/16/21 at 2:25 pm revealed: -Residents' FL2s should have current medications listed on the FL2 and reviewed by the PCP. -Resident #7's FL2 dated 02/14/21 should not have a March 2021 MAR with medications listed and documented as administered from 03/01/21 to 03/03/21 attached to the FL2 as current medications. -She was contracted in March 2021 to assist in resident record audits for FL2s but has not been able to do so yet due to her updating resident's Licensed Health Professional Services (LHPS) assessments. Interview with the Administrator on 04/16/21 at 2:30 pm revealed: -She was not working at the facility in February 2021. -She started working at the facility on 03/03/21. -The residents' provider should routinely write in current medications on the FL2s. -The PCP had not listed current medications on FL2s. -At the present time, the PCP had staff to attach copies of the physicians' order sheets (POS) or MARs. Interview of the Administrator on 04/19/21 at 1:13	D 238		

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D 238	Continued From page 20 pm revealed a consultant Nurse had been hired in March 2021 to help audit records, update LHPS evaluations, and update residents' FL2s. Telephone interview with the facility's PCP on 04/19/21 at 10:40 am revealed: -The previous RCD would fill out the residents FL2 forms before she got to the facility. -She visited the facility every Tuesday to assess residents and review the current medication orders listed on their FL2s; then sign the FL2s. -Resident #7's FL2 was dated on a Sunday 02/14/21, a day in which she would not have visited at the facility. -She signed updated POS for most residents in February 2021 because the Administrator at the time was updating residents' FL2 when auditing records. -The facility should have included the signed POS dated February 2021 attached to the FL2. -She would not have signed an FL2 without current medication orders listed for any resident. -She did not have a copy of the signed POS from February 2021.	D 238		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at	D 270		

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substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur.

THIS A TYPE A2 VIOLATION

Based on observations, interviews and record reviews the facility failed to provide adequate supervision for 1 of 2 sampled residents (#6) with a history of falls resulting in a laceration requiring sutures and required emergency room (ER) evaluation on 3 occasions.

The findings are:

Review of the facility's Accident Policy (no date) revealed:
-Anytime a resident experienced an accident or incident, even if there was no visible injury, an Incident/Accident Report had to be completed immediately.
-All incidents or accidents involving the residents must be documented in the resident's medical record.

Review of Resident #6's current FL2 dated 02/16/21 revealed:
-Diagnoses included encephalopathy, diabetes mellitus type II, hypertension, mild cognitive impairment, chronic obstructive pulmonary disease (COPD), coronary artery disease, heart disease, major depressive disorder, falls, and muscle weakness.
-Resident #6 was intermittently disoriented.
-Resident #6 was semi-ambulatory.

Review of Resident #6's care plan dated 02/16/21 revealed:
-Resident #6 was sometimes disoriented.
-Resident #6 had adequate memory.
-Resident # 6 was non-ambulatory and needed a

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wheelchair.
-Resident #6 had limited strength in her upper extremities.
-Resident #6 required extensive assistance with ambulation and transferring.

Review of Resident #6's licensed health professional support (LHPS) dated 01/29/21 revealed:
-Her condition changed, and she required more care.
-She had several falls.
-She ambulated with a walker and frequently forgot her oxygen when she ambulated.

Review of Resident #6's incident/accident reports revealed:
-On 01/15/21 at 9:15 pm, Resident #6 yelled for help and was found on the floor beside her bed lying on her right side.
-She stated she had been asleep and fell out of the bed and hit her head on the nightstand.
-There was documentation of two skin tears on her right arm.
-Emergency Medical Services (EMS) was called and assessed the resident, but she refused to go to the emergency room.
-There was no documentation of increased supervision, monitoring, or interventions put in place after the fall on 01/15/21 to prevent Resident #6 from falling.

Review of Resident #6's 24-Hour Follow-Up Report for the incident/accident report dated 01/15/21 revealed:
-The next morning the resident was unsteady on her feet.
-The resident complained of pain in her right arm.
-On second shift the resident fell out of bed and was sent to the local emergency room (ER).

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-On third shift after the resident returned from ER, she slept most of the night and did not have any complaints.
-There was no documentation of increased supervision, monitoring, or interventions put in place after the 01/15/21 fall to prevent Resident #6 from falling.

Review of Resident #6's care notes revealed:
-There were no care notes documented on 01/15/21.
-There was no documentation of increased supervision or monitoring for Resident #6.
-There was no documentation of interventions put in place after the 01/15/21 fall to prevent Resident #6 from falling.

Attempted telephone interview with the medication aide (MA), who completed the incident/accident report, on 04/19/21 at 9:58 am was unsuccessful.

Review of Resident #6's incident/accident reports revealed:
-On 01/16/21 at 7:40 pm, Resident #6 yelled for help and was found on the floor beside her bed sitting "Indian style".
-She stated she fell out of the bed again.
-There was documentation she was bleeding from her chin from a laceration about 2 inches long, and she complained of head and back pain.
-There was no documentation of increased supervision, monitoring, or interventions put in place after the 01/16/21 fall to prevent Resident #6 from falling.

Review of Resident #6's 24-Hour Follow-Up Report for the incident/accident report dated 01/16/21 revealed:
-During third shift, the resident remained at the

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hospital.
-The resident returned to the facility around 11:00 am.
-The resident had stitches in her chin and a new prescription.
-There was no documentation for third shift on the report.
-There was no documentation of increased supervision, monitoring, or interventions put in place after the 01/16/21 fall to prevent Resident #6 from falling.

Review of Resident #6's care notes revealed:
-There were no care notes documented on 01/16/21
-There was no documentation of increased supervision or monitoring for Resident #6.
-There was no documentation of interventions put in place after the 01/16/21 fall to prevent Resident #6 from falling.

Review of Resident #6's hospital discharge summary dated 01/16/21 revealed:
-The reason for the ER visit was documented as a fall.
-Resident #6's chin laceration was repaired with stitches.

Attempted telephone interview with the medication aide (MA), who completed the incident/accident report, on 04/19/21 at 9:58 am was unsuccessful.

Review of Resident #6's hospital discharge summary dated 01/19/21 revealed:
-The reason for the ER visit was documented as a fall.
-Resident #6 was diagnosed with a contusion of her right knee and low back pain.

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Review of Resident #6's incident/accident reports revealed there was no report available for the fall on 01/19/21.

Review of Resident #6's 24-Hour Follow-Up Report for incident/accident report revealed there was no follow-up report dated 01/19/21.

Review of Resident #6's care notes revealed:
-There were no care notes documented on 01/19/21
-There was no documentation of increased supervision or monitoring for Resident #6.
-There was no documentation of interventions put in place after the 01/19/21 fall to prevent Resident #6 from falling.

Review of Resident #6's hospital discharge summary dated 01/26/21 revealed:
-The reason for the ER visit was documented as a fall.
-Resident #6 was diagnosed with a contusion of her scalp and back, and while at the ER, the stitches from a previous injury were removed.

Review of Resident #6's EMS report dated 01/26/21 revealed she was transported to a local ER due to a fall due to possible stroke.

Review of Resident #6's incident/accident reports revealed there was no report available for the fall on 01/26/21.

Review of Resident #6's 24-Hour Follow-Up Report for Incident/accident report revealed there was no follow-up report dated 01/26/21 revealed:

Review of Resident #6's care notes revealed:
-There were no care notes documented on 01/26/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-There was no documentation of increased supervision or monitoring for Resident #6.
-There was no documentation of interventions put in place after the 01/26/21 fall to prevent Resident #6 from falling.

Review of Resident #6's record revealed there were no incident/accident reports or care notes available for February and March 2021.

Review of Resident #6's incident/accident reports revealed:
-On 04/11/21 at 9:10 am, Resident #6 called for help and was found on her bottom complaining of pain.
-She said she had gone to the bathroom and was trying to assist herself. She stumbled backwards and hit her back against.
-There was documentation she complained of left leg and back pain.
-There was no documentation of increased supervision, monitoring, or interventions put in place to prevent Resident #6 from falling.

Review of Resident #6's 24-Hour Follow-Up Report for Incident/accident report dated 04/11/21 revealed:
-There was no documentation for second shift.
-There was documentation staff checked on the resident around every 2 hours during the night.
-The resident complained of being sore from her fall.
-The next day, the resident remained sore from her fall.
-There was no documentation of increased supervision, monitoring, or interventions put in place after the 04/11/21 fall to prevent Resident #6 from falling.

Review of Resident #6's care notes revealed:

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-There were no care notes documented on 04/11/21.
-There was no documentation of increased supervision or monitoring for Resident #6.
-There was no documentation of interventions put in place after the 04/11/21 fall to prevent Resident #6 from falling.

Review of Resident #6's incident/accident reports revealed:
-On 04/12/21 at 12:15 am, Resident #6 was found on the floor laying on her right side
-She said she was going to the bathroom.
-There was documentation she had some bleeding from her right knee. Her knee was cleaned, and antibiotic ointment was applied.
-There was no documentation of increased supervision, monitoring, or interventions put in place after the 04/12/21 fall to prevent Resident #6 from falling.

Review of Resident #6's 24-Hour Follow-Up Report for Incident/accident report dated 04/12/21 revealed:
-During first shift, the resident complained of mild pain.
-There was no documentation during second shift.
-There was documentation staff checked on the resident every two hours through the night.
-There was no documentation of increased supervision, monitoring, or interventions put in place after the 04/12/21 fall to prevent Resident #6 from falling.

Review of Resident #6's care notes revealed:
-There were no care notes documented on 04/12/21.
-There was no documentation of increased supervision or monitoring for Resident #6.

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D 270	Continued From page 28 -There was no documentation of interventions put in place after the 04/12/21 fall to prevent Resident #6 from falling. Attempted telephone interview on 04/19/21 at 9:58 am with the medication aide (MA) who completed the incident/accident report was unsuccessful. Review of Resident #6's incident/accident reports revealed: -On 04/14/21 at 2:37 pm, Resident #6 yelled that she had fell. Staff went to check on her. -She said she did not know what she was trying to do. -There was no documentation of injury. -There was no documentation of increased supervision, monitoring, or interventions put in place after the 04/14/21 fall to prevent Resident #6 from falling. Review of Resident #6's 24-Hour Follow-Up Report for the incident/accident report dated 04/14/21 revealed: -There was no documentation for second shift. -There was documentation staff checked on the resident around every 2 hours during the night. -There was no documentation for first shift the next day. -There was no documentation of increased supervision, monitoring, or interventions put in place after the 04/14/21 fall to prevent Resident #6 from falling. Review of Resident #6's care notes revealed: -There were no care notes documented on 04/14/21. -There was no documentation of increased supervision or monitoring for Resident #6. -There was no documentation of interventions put	D 270		

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in place after the 04/14/21 fall to prevent Resident #6 from falling.

Interview with the MA, who completed the incident/accident report, on 04/19/21 at 9:59 am revealed:
-She was administering medication to another resident and a housekeeper came and got her to help the Resident #6 who had fallen.
-The resident was sitting straight up in the floor.
-Resident #6 had a lot of falls.
-When a resident fell the MA was responsible for checking on the resident every 2 hours.
-No one had ever requested she do increased checks, whether 15-minute or 30-minute checks for Resident #6 or any other resident.

Interview with Resident #6 on 04/19/21 at 10:13 am revealed:
-She had to go to the ER due to falls "quite a few times".
-The falls made her hurt worse.
-No one at the facility ever tried to find out what caused her falls, they just brushed her off.
-She had never been offered a chair or bed alarm as a reminder to call for assistance and she had never had a fall mat or physical therapy.
-She could not call for help unless she was right beside the call bell or yelled for assistance.

Interview with Resident #6's former Primary Care Provider (PCP) on 04/19/21 at 12:30 pm revealed:
-She knew the resident had multiple falls.
-She had obtained a walker and wheelchair for the resident.
-She had ordered PT to evaluate and treat in the past (no date given).
-The resident did not like to wear her oxygen and would take it off, then became hypoxic and she

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fell.
-Multiple falls could cause broken bones and if a resident hit their head it could cause bleeding on the brain, a stroke, and multiple hospital visits.
-The resident transitioned to hospice care and their primary provider on 01/27/21.

Interview with Resident #6's hospice physician on 04/19/21 at 10:56 am revealed:
-Resident #6 was admitted to hospice on 01/27/21.
-The resident was a fall risk.
-The resident was on oxygen.
-The resident had frequent hallucinations of snakes and alligators after her.
-Hospice had inquired about the use of a chair alarm, bed alarm, and fall mat but facility staff said they were not allowed because they were considered restraints.

Interview with a medication aide (MA) on 04/19/21 at 10:21 am revealed:
-Resident #6 had 3 falls last week.
-When a resident fell, the MA had to complete a incident/accident report, assess for injuries, call 911 if bleeding or the resident hit their head, and notify the physician.
-The MA also had to complete a 24-hour report in which the resident's condition and vital signs were documented for 3 shifts following the incident.
-Nothing had been done to intervene with Resident #6's falls as evidenced by no medication changes, no fall mat, no physical therapy, and no increased checks.
-She had never been instructed to do 15-minute or 30-minute checks on a resident who had a fall.
-The facility used to have a fall policy that stated staff would check on the resident every 2 hours after an incident, but the current Administrator did away with that policy.

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D 270	Continued From page 31 Interview with the Administrator on 04/19/21 at 10:44 am revealed: -When a resident fell, the MA would assess for injury and check the resident's vital signs. -If a resident hit their head, they were automatically sent to the ER. -The MA completed an incident/accident form and was supposed to document on each shift following the incident, for 24 hours, on the 24-Hour Report. -Staff were supposed to monitor the resident every 2 hours and as needed but they did not increase supervision and the facility did not use 15-30 minute check logs. _____ The facility failed to provide supervision for 1 of 2 sampled residents (#6) with a history of falls resulting in Resident #6, having 7 falls which resulted in multiple trips to the emergency room with a chin laceration requiring several stitches, a scalp contusion, a knee contusion, and skin tears. This failure resulted in substantial risk of physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/16/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 20, 2021.	D 270		
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:	D 276		

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D 276	Continued From page 32 (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement orders for 1 of 6 sampled residents (#1) who had a history of edema and an order for compression stockings. The findings are: Review of Resident #1's current FL2 dated 08/12/20 revealed: -Diagnoses included stroke, bipolar, chronic pain, constipation, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and hyperthyroidism. -There was an order for compression stockings daily on at 10:00 am, off at bedtime. Review of Resident #1's February, March, and April 2021 medication administration record (MAR) revealed there was no entry for compression stockings. Observation of Resident #1's feet and legs on 04/19/21 at 10:58 am revealed:	D 276		

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-Resident #1 was not wearing compression stockings.
-Resident #1 had on multi-colored socks with a ribbed elastic top-edge.
-The socks left a small indention in the resident's leg.
-The resident had some puffiness above the indention in both legs.

Interview with Resident #1 on 04/19/21 at 11:01 am revealed:
-She was ordered the compression stockings due to her history of edema.
-She had edema in her calves, legs, and feet.
-Some days she had more edema than other days.
-She had at least two pairs of compression stockings.
-She applied the compression stockings herself.
-Some days she did not feel like applying the compression stockings, so she did not put them on.
-Facility staff had not offered to assist her with applying the compression stockings.

Interview with the medication manager (MM) on 04/19/21 at 4:50 pm revealed:
-She had worked at the facility since late February 2021.
-Two to 3 weeks ago, she took over the role as MM.
-In her role as MM, she was responsible for ensuring orders were documented on the MARs.
-She was supposed to check each resident record to ensure current orders were documented on the MARs.
-She had not had time to independently check each residents' MARs with current orders to ensure they were documented on the MAR.
-She did not know Resident #1 had an order for

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D 276	Continued From page 34 compression stockings. Interview with a medication aide (MA) on 04/20/21 at 2:29 pm revealed: -She did not know Resident #1 had an order for compression stockings. -Resident #1 had never asked for assistance with putting on or taking off compression stockings. -The MM was responsible for making sure orders were documented on the MAR. Telephone interview with Resident #1's Primary Care Provider (PCP) on 04/19/21 at 12:37 pm revealed: -She expected Resident #1 to wear the compression hose daily, especially if there was edema present in her legs. -The facility should have the order on the MAR to remind the MA to put the hose on in the morning and take them off at bedtime. -When she wrote an order, she expected the facility to implement the order. Telephone interview with the Administrator on 04/20/21 at 2:16 pm revealed: -She was not aware Resident #1 had an order for compression stockings that was not implemented. -The MM was responsible for checking each resident records to make sure current orders were documented on the MAR. -The MM was responsible for making sure the order for compression stockings was documented on the MAR. -The MA was responsible for ensuring Resident #1 was wearing compression stockings as ordered.	D 276		

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D 280	Continued From page 35	D 280		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed on 2 of 6 sampled residents (#3 and #4) for the identified tasks of oxygen administration and monitoring and inhalation medication by machine (#4), and ambulation with an assistive device and an enema (#3).	D 280		

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D 280	Continued From page 36 The findings are: 1. Review of Resident #4's current FL2 dated 02/14/20 revealed: -Diagnoses were not documented on the FL2. -There was no documentation for cognitive status, ambulation, bowel or bladder status, or care assessment. -There was an order for Xopenex (used to treat COPD) 0.63mg/3 ml vial via nebulizer 3 times daily for shortness of breath. Review of Resident #4's previous FL2 dated 11/26/18 revealed: -Diagnoses included encephalopathy, chronic pain syndrome, muscle weakness, major depressive disorder, abnormality of gait, anxiety disorder, chronic obstructive pulmonary disease (COPD). -Resident #4 was semi-ambulatory, and continent to bowel and bladder. -There was an order for continuous oxygen at 3 liters per minute. -There was an order for Xopenex (used to treat COPD) 0.63mg/3 ml vial via nebulizer 3 times daily for shortness of breath. Review of Resident #4's signed physician's orders dated 10/06/20 revealed: -There was an order for continuous oxygen at 4 liters per minute documented on the physician's orders with a date of change from 3 liters per minute to 4 liters per minute on 06/05/20. -There was an order for Xopenex (used to treat COPD) 0.63mg/3 ml vial via nebulizer 3 times daily for shortness of breath. Review of Resident #4's signed physician's orders dated 12/22/20 revealed:	D 280		

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-There was an order for continuous oxygen at 4 liters per minute.
-There was an order for Xopenex (used to treat COPD) 0.63mg/3 ml vial via nebulizer 3 times daily for shortness of breath.

Review of Resident #4's LHPS evaluation dated 03/20/20 revealed LHPS identified tasks of oxygen administration and monitoring and inhalation medication by machine.

Review of Resident #4's LHPS evaluation revealed there was no documentation of a LHPS evaluation completed since 03/20/20.

Observation on 04/19/20 at 12:43 pm revealed:
-Resident #4 was sitting in her recliner in her room and wearing her nasal cannula in correct position.
-Resident #4's oxygen concentrator was set to 4 liters per minute.
-Resident #4 had a nebulizer machine located on the top of the nightstand next to her hospital bed.

Interview with a medication aide (MA) on 04/16/21 at 8:45 am revealed Resident #4 was administered nebules through her nebulizer daily.

Interview with Resident #4 on 04/19/21 at 12:43 pm revealed:
-She used oxygen for her COPD.
-She had used oxygen for more than 2 years.
-She had a medication she was administered routinely through the nebulizer.

Refer to the interview with the Administrator on 04/16/21 at 2:30 pm.

Refer to interview with the Contracted Nurse on 04/19/21 at 3:00 pm.

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D 280	Continued From page 38 2. Review of Resident #3's current FL2 dated 02/07/21 revealed: -Diagnoses included essential hypertension, schizo-affective disorder, unspecified lesions of the mucosa, anxiety disorder and major depressive disorder. -The resident was documented as ambulatory. -The resident was documented as incontinent of bowel and bladder. Review of Resident #3's Licensed Health Professional Health (LHPS) evaluation dated 04/08/20 revealed LHPS identified tasks of oxygen administration, transferring assistance and staff assist with transferring to a wheel chair. Review of Resident #3's record on 04/15/21 revealed: -There was a physician's order dated 10/11/20 for an enema once daily as needed for constipation. -There was no documentation of an order to administer oxygen. -There was no documentation of an order for a wheel chair. Review of Resident #3's LHPS evaluations revealed there was no quarterly documentation of an LHPS evaluation completed from 04/08/20 through 04/16/21. Observation of Resident #3 on 04/15/20 at 11:10 am revealed: -The resident was sitting on her bed in her room with her hand on a walker. -The resident was not wearing an oxygen canula. Interview with Resident #3 on 04/19/21 at 11:10 am revealed: -She had been able to walk with a walker for	D 280		

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D 280	Continued From page 39 several months. -She has not needed the enema for about 3 month. Refer to the interview with the Administrator on 04/16/21 at 2:30 pm. Refer to interview with the Contracted Registered Nurse (RN) on 04/19/21 at 3:00 pm. _____ Interview with the Administrator on 04/16/21 at 2:30 pm revealed: -Residents' LHPS evaluations should be completed quarterly. -The previous Resident Care Director (RCD) would have been responsible to track when residents' LHPS evaluations needed to be updated. -The Contract RN had been completing and updating LHPS evaluations as she audited residents' records. -The new RCD and the Contract RN were now responsible to audit records and update LHPSs for all residents. Interview with the Contract RN on 04/19/21 at 3:00 pm revealed: -She had been contracted by the facility about 2 weeks ago to provide nursing duties including reviewing medication orders, auditing medication orders and medication administration records (MARs) for correctness, and auditing residents' records for completeness. -The facility had experienced a lot of staff turnover including the RNs who were contracted to update residents' LHPS evaluations. -She had located some completed LHPS evaluations in various stacks and boxes of facility paperwork. -She was in the process of updating residents'	D 280		

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D 280	Continued From page 40 LHPS evaluations due to the results of her audit of LHPS evaluations and inability to locate documentation for LHPS evaluations.	D 280		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to serve a therapeutic diet for 1 of 1 sampled resident who had an order for nectar thickened liquids (#10). The findings are: Review of Resident #10's current FL2 dated 02/04/20 revealed diagnoses included failure to thrive, memory impairment, and stroke. Review of Resident #10's physician's orders revealed: -There was a physician's order sheet dated 10/06/20 with orders for a regular diet with ground meats and nectar liquids. -There was an order dated 12/08/20 for "thickened liquids" with no consistency. Observation of the kitchen and food storage	D 310		

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areas on 04/15/21 at 9:48 am revealed:
-There was no current list of residents with Therapeutic diets posted in the kitchen for the guidance of food service staff.
-In the food storage area there were 24 each 4-ounce containers of nectar consistency pre-thickened cranberry juice, there were 4 each 4-ounce containers of nectar consistency pre-thickened water, and 6 each 4-ounces of nectar consistency pre-thickened orange juice.
-There was a powdered food and beverage thickener in a can available for the kitchen staff.

Review of the directions on the canister of thickener revealed:
-The directions for mixing 8 fluid ounces for a nectar thick consistency included adding 2 tablespoons plus two teaspoons of thickener to a liquid.
-The mixing directions instructed adding level measurements to the desired liquid and stir well with a spoon or fork for 15 seconds until thickener was dissolved and allowing 1 to 4 minutes to reach desired thickness.

Observation of the lunch meal on 04/15/21 from 12:00 pm to 12:31 pm revealed:
-At 12:05 pm, the personal care aide (PCA) served Resident #10 an 8-ounce cup of tea with ice.
-The iced tea was not a nectar thick consistency but was a regular thin consistency.
-Resident #10 drank two swallows of the tea and left the table.

Interview with the PCA on 04/15/21 at 12:36 pm revealed:
-She asked Resident #10 what she wanted to drink and the resident asked for tea.
-She gave Resident #10 the iced tea.

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-The cook had made her aware the nectar pre-thickened beverage was for Resident #10.
-She was not aware she had to thicken the tea before serving it to Resident #10.
-She did not know there was powdered thickener in the kitchen.
-No one had trained her or made her aware of how to thicken Resident #10's beverages.
-When she served meals in the dining room and if Resident #10 asked for beverages that were not pre-thickened she served the resident the requested beverage and did not add thickener.

Interview with the morning cook on 04/15/21 at 9:48 am and 12:51 pm revealed:
-The Dietary Manager did not show up for work yesterday.
-There was no therapeutic diet list posted in the kitchen to follow when serving meals.
-She did not need a therapeutic diet list because she remembered the diets ordered for each resident.
-The nectar consistency pre-thickened liquids in the food storage area were for Resident #10.
-She gave the PCA 3 each 4-ounce containers of nectar consistency pre-thickened beverages (2 cranberries and 1 water).
-She told the PCA to serve the pre-thickened beverages to Resident #10.
-She did not know the PCA served Resident #10 tea with ice that was not thickened.

Observation of the dinner meal on 04/15/21 from 5:00 pm to 5:45 pm revealed:
-The Business Office Manager (BOM) and PCA delivered the beverages and the meals to the residents.
-Resident #10 was served an 8-ounce cup of cranberry juice without ice.
-The cranberry juice was not of nectar thick

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consistency but was a thin consistency.
-At 5:02 pm, the surveyor intervened and asked the PCA working in the dining room about Resident #10's beverage consistency.
-At 5:10 pm, the surveyor suggested staff remove the thin cranberry juice and replace it with the consistency ordered.

Interview with the BOM on 04/15/21 at 5:04 pm revealed:
-She thought Resident #10 was ordered nectar thickened liquids.
-The cook told her to mix 1 tablespoon of thickener in the 8-ounces of cranberry juice that was served to Resident #10.
-She stirred the nectar thick beverages before she served it to Resident #10 because it needed time to get thicker.
-She previously worked as a medication aide (MA) and knew how to thicken liquids.
-She knew Resident #10's beverage was not thick enough and needed more thickener added.
-She did not add more thickener because the cook insisted to only add 1 tablespoon of thickener to the beverage served to Resident #10.
-She did not know there were nectar pre-thickened beverages in the food storage area.
-She did not see the list with the residents' diets because she was not allowed to enter the kitchen.
-She depended on the cook to make her aware of what to serve each resident.

Interview with the evening cook on 04/15/21 at 5:27 pm revealed:
-He did not know residents' diets ordered because there was no therapeutic diet list posted in the kitchen.

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-He thought there was a diet list posted in the kitchen but he just checked and there was no diet list posted.
-He did not know the facility had nectar pre-thickened liquids.
-He did not recall telling the BOM to only use 1 tablespoon of thickener in Resident #10's beverage.
-He previously worked at other facilities and knew how to thicken liquids.
-He knew he had to read the instructions on the container of thickener.
-There was no therapeutic diet list posted in the kitchen, so he did not know the type of liquid consistency ordered Resident #10.

Interview with the Director of Quality on 04/15/21 at 4:43 pm revealed:
-The Dietary Manager left yesterday and took all the paperwork including the therapeutic diet list.
-She also thought he took the diet orders and menus.
-She had not checked Resident #10's record for a current diet order.
-She did not know if anyone had been assigned to observe meals to ensure diets were served as ordered.

Interview with Resident #10 on 04/16/21 at 12:25 pm revealed:
-She had difficulty swallowing.
-She did not eat much food because it was difficult to swallow.
-She was not always served thickened liquids.
-She was not sure of the liquid consistency ordered.

Interview with Resident #10's Primary Care Provider (PCP) on 04/16/21 at 2:49 pm revealed:
-Resident #10 had a stroke one and one-half to

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D 310	Continued From page 45 two years ago. -A result of the stroke was that Resident #10 had swallowing difficulties and was ordered thickened liquids. -The facility staff prepared the diet orders and FL2s and prefilled them out. -Resident #10 had no assessment to change her diet order. -Resident #10 should receive nectar thick liquids. Interview with the medication manager (MM) on 04/19/21 at 4:50 pm revealed: -She had worked at the facility since late February 2021. -Two to 3 weeks ago, she took over the role as MM. -She did not know Resident #10 was ordered nectar thickened liquids. -In her role as MM, she was responsible for ensuring current orders were being followed. -She had not had time to independently check each resident's record to view the current orders. Telephone interview with the Administrator on 04/20/21 at 2:16 pm revealed: -She was not aware Resident #10 had an order for "thickened liquids." -The MM was responsible for checking each resident record to make sure current orders were documented on the MAR. -Resident #10's PCP was in the facility every Tuesday, the MM should have clarified the order to make sure Resident #10 received the correct diet ordered.	D 310		
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 46 (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: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur. THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (Resident #8 and #9) sampled during the 8:00 am medication pass on 04/16/21 related to a medication to treat anxiety (#8), and a medication to treat diabetic neuropathy (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and #11) for record reviews related to a medication used to thin the blood, a medication to treat bipolar disorder, a medication for nausea, and a laxative (#1); a medication for pain, and a medication for muscle spasms (#2); a medication for acid reflux, a medication for anxiety, a medication for insomnia, a vitamin supplement, and a medication to treat depression (#4); a medication to treat acid reflux, a medication for diabetic neuropathy, and a steroidal medication for breathing (#6); and a medication to treat diabetes (#7 and #11).	D 358		

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D 358	Continued From page 47 The findings are: 1. The medication error rate was 6% as evidenced by the observation of 2 errors out of 31 opportunities during the 8:00 am medication pass on 04/16/21. a. Review of Resident #8's current FL2 dated 08/18/20 revealed diagnoses included chronic pain syndrome, closed fracture, muscle weakness, insomnia, anxiety disorder, paraplegic, and lack of coordination. Review of Resident #8's physician's orders revealed: -There was an order dated 03/30/21 for diazepam 10mg (used to treat anxiety, muscle relaxation and spasms in paraplegic) three times a day. Do not give within 2 hours of administering Oxycodone/Oxycontin (narcotic pain relievers). -There was an order dated 03/31/21 for Oxycontin ER 20mg (a long acting pain reliever) every 12 hours. Observation of the 8:00 am medication pass on 04/16/21 revealed: -At 8:10 am, the morning medication aide (MA) on the fourth floor prepared 7 oral medications, including one diazepam 10mg and one Oxycontin ER 20mg. -She administered all the medications at the same time with a cup of water to the resident in his room. Observations of Resident #8's medications on hand on 04/16/21 at 8:30 am revealed a card labeled diazepam 10mg one tablet three times a day, do not give within 2 hours of administering Oxycodone/Oxycontin, dispensed on 03/31/21 for	D 358		

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D 358	Continued From page 48 30 tablet with 11 tablets remaining. Review of Resident #8's April 2021 Medication Administration Record (MAR) revealed: -There was an entry for diazepam 10mg one tablet 3 times day, (no information for do not give within 2 hours of oxycodone/oxycontin) scheduled to be administered at 8:00 am, 12:00 pm, and 4:00 pm. -There was an entry for Oxycontin 20mg ER every 12 hours scheduled for 8:00 am and 8:00 pm. -Diazepam 10mg and Oxycontin 20mg ER were documented as administered at 8:00 am daily from 04/02/21 to 04/16/21. Interview with the morning MA on the fourth floor on 04/16/21 at 11:30 am revealed: -She administered medications according to the scheduled time on the MAR. -The MAR did not have a warning or information for do not take within 2 hours of taking Oxycodone/Oxycontin. -She did not realize until it was pointed out that the bubble package from the pharmacy had the directions that included not taking diazepam 10mg within 2 hours of Oxycontin. -She did not read the direction on the bubble package completely. -The MAs did not have access to medication orders but had to depend on the MARs and medication labels for directions for medication administration. Interview with the Administrator on 04/16/21 at 4:30 pm revealed: -The MAs should administer medications according to the medication order by reading the MAR and the label on the package. -If there was a question or the MAR and label did	D 358		

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not match, the MA should request assistance from the Medication Manager (MM), the Resident Care Director, or the Contract Registered Nurse to ensure medications were administered as ordered.

b. Review of Resident #9's current FL2 dated 10/20/20 revealed diagnoses included neuropathy, diabetes mellitus, hypertension, insomnia, depression anemia and vitamin B deficiency.

Review of Resident #9's physician's orders revealed there was an order dated 10/26/20 for gabapentin 100mg (used to treat nerve pain) one capsule two times a day and three capsules (300mg) at bedtime.

Observation of the 8:00 am medication pass on 04/16/21 revealed:
-She had difficulty finding Resident #9's medications on the cart but did find them.
-At 8:20 am, the morning medication aide (MA) on the third floor prepared 5 and one-half tablets of oral medications that did not include the gabapentin 100mg capsule.

Review of Resident #9's April 2021 Medication Administration Record (MAR) revealed:
-There was an entry for gabapentin 100mg one capsule two times a day at 8:00 am and 2:00 pm.
-The 04/16/21 block to document 8:00 am administration of gabapentin 100mg on the MAR was blank.

Observations of Resident #9's medications on hand on 04/16/21 at 9:30 am revealed a card labeled gabapentin 100mg capsule take 1 cap daily at 8:00 am and 2:00 pm with seven out of thirty capsules remaining.

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D 358	Continued From page 50 Interview with the morning MA on the third floor on 04/16/21 at 8:25 am revealed: -She administered medications according to the residents' MARs. -She worked third shift and stayed over on first shift to help out. -She could not find all of Resident #9's medications at first, but she eventually found them in the medication cart. -She was nervous and just missed the gabapentin. -If she found that she had missed administering a medication she would go back and give it if it was within the hour that the medication was scheduled. 2. Review of Resident #7's current FL2 dated 02/14/21 revealed: -There were diagnoses including paranoid schizophrenia and reflux esophagitis. -There were no medication orders listed on the FL2. -There was documentation on Resident #7's FL2 as "See attached MAR"(Medication Administration Record) typed in the space for the medication list. -Resident #7's MAR dated 03/01/21-03/31/21 with medications documented as administered on 03/01/21, 03/02/21, and 03/03/21, was attached to the FL2. Review of Resident #7's Primary Care Provider (PCP's) progress notes dated 02/09/21 revealed laboratory test results in February 2021 documented a 15.8 as the value for Hemoglobin A1C (a laboratory value that measure blood sugar levels over a period of 2 to 3 months instead of at a given time like FSBS test). According to the American Diabetic Association, a	D 358		

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D 358	Continued From page 51 Hemoglobin A1C less than 8.5 was desirable in older population with other illnesses, like diabetes. Review of Resident #7's March 2021 MAR attached to the current FL2 revealed: -There was an entry for Humalog (a rapid acting insulin given to lower blood sugar levels) insulin before breakfast, lunch, and dinner using scale of 18 units subcutaneously (SQ) for fingerstick blood sugar (FSBS) over 250 and give additional 6 units for FSBS over 400 for a total of 24 units of Humalog. -There was an entry to check FSBS 3 times a day before meals. Review of Resident #7's PCP's order dated 04/06/21 revealed an order for Humalog insulin 14 units SQ 3 times daily before meals, hold if FSBS less than 100, and give 4 extra units if FSBS more than 400 for a total of 18 units. Review of Resident #7's April 2021 MAR revealed: -There was a handwritten entry for Humalog insulin before breakfast, lunch, and dinner, and scheduled for 7:30 am, 12:00 pm, and 5:00 pm using scale of 18 units SQ for FSBS over 250 and give additional 6 units for FSBS over 400 for a total of 24 units of Humalog with documentation for Humalog insulin from 04/01/21 to 04/08/21. The order was discontinued on 04/08/21 instead of 04/06/21. -There was a handwritten entry for Humalog insulin before meals (breakfast, lunch, and dinner) using scale of 14 units SQ 3 times daily before meals, hold if FSBS less than 100, and give 4 extra units if FSBS more than 400 for a total of 18 units. -Humalog insulin was administered incorrectly at	D 358		

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D 358	Continued From page 52 7:30am on 3 of 8 opportunities from 04/06/21 to 04/14/21 as follows: -On 04/07/21, FSBS was 223, Resident #7 should have received 14 units of insulin, no insulin was documented as administered. -On 04/08/21, FSBS was 145, Resident #7 should have received 14 units of insulin, no insulin was documented as administered. -Humalog insulin was administered incorrectly at 12:00 pm on 1 of 8 opportunities on 04/07/21 when FSBS was 451 and Resident #7 should have received 18 units and 24 units (18 units plus 6 units from previous order) was documented as administered. -Humalog insulin was administered incorrectly at 5:00 pm on 5 of 8 opportunities from 04/06/21 to 04/14/21 as follows: -On 04/07/21, FSBS was 122, Resident #7 should have received 14 units of insulin, no insulin was documented as administered. -On 04/09/21, FSBS was 182, Resident #7 should have received 14 units of insulin, no insulin was documented as administered. -On 04/10/21, FSBS was 167, Resident #7 should have received 14 units of insulin, no insulin was documented as administered. -On 04/13/21, FSBS was 196, Resident #7 should have received 14 units of insulin, no insulin was documented as administered. -On 04/14/21, FSBS was 151, Resident #7 should have received 14 units of insulin, no insulin was documented as administered. Interview with a medication aide (MA) on 04/16/21 at 5:29 pm revealed: -She routinely worked the second (3:00 pm to 11:00 pm) shift. -MAs did not see original orders written by the PCP. -The Medication Manager (MM) was responsible	D 358		

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to enter new orders on the MARs and the MAs were supposed to administer medications according to the MAR.
-Resident #7 had recently started insulin injections.
-The PCP had made some changes to his insulin doses.
-She did not administer Resident #7's Humalog on 4 of the 8 opportunities for 5:00 pm doses in April 2021 because she did not realize Resident #7's Humalog insulin order changed to administer 14 units before meals and only hold if FSBS was less than 100.
-She was administering Humalog from memory according to the old parameters to administer if the FSBS was greater than 250.
-She did not read the order on the MAR completely.

Interview with the MM on 04/16/21 at 4:00 pm revealed:
-She entered orders on the residents' MARs for insulin and any new orders until the pharmacy had a chance to place the order on the MAR to be sent out at the first of each month.
-She did not have a system in place to routinely monitor medication administration because she had only been at the current position for less than a month, and had been a MA prior to being asked to to be the MM.
-There had been a lot of MA turnover.
-She had been staffing as a MA to fill call-outs for the last 2 weeks.
-She did not know Resident #7's insulin was not being administered according to the most recent physician's orders.

Interview with the Contract Registered Nurse on 04/19/21 at 3:00 pm revealed:
-She had been working at the facility for 3 weeks.

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-She was contracted to assist with reviewing residents' medications, and auditing records.
-She had not been able to complete chart audits because she was trying to catch up on residents' out of date Licensed Health Professional Support evaluations.
-She was told the MM was responsible to enter orders on the residents' MARs.
-There was not a system to audit the medication orders entered by the MM for accuracy on a routine basis.
-There had been a lot of staffing changes within the last 3 months, including the MM, and Resident Care Director.

Telephone interview with Resident #7's PCP on 04/19/21 at 12:43 pm revealed:
-Resident #7 had been taking an oral medication for diabetes for a long time.
-She started Resident #7 on insulin in February 2021 in response to a laboratory test result that revealed a Hemoglobin A1C of 15.8 which reflected blood sugar levels much too high.
-She had changed Resident #7's insulin therapy as the resident's FSBS values improved.
-She expected the facility to follow the current orders to help control Resident #7's diabetes and decrease the long-term damage to organs (kidney and eyes).

3. Review of Resident #11's current FL2 dated 06/27/20 revealed:
-Diagnoses included depression, hypertension, and diabetes.
-There was an order for Novolog 100 unit/ml inject 16 to 20 units into the skin 2 times a day as needed for blood sugar over 250.

Review of Resident #11's laboratory test results dated 01/19/21 revealed a Hemoglobin A1C (a

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laboratory value that measures blood sugar levels over a period of 2 to 3 months instead of at a given time like FSBS test) of 10.1. According to the American Diabetic Association, a Hemoglobin A1C less than 8.5 was desirable in older population with other illnesses, like diabetes.

Review of Resident #11's physician's orders dated 01/09/21 revealed:
-There was an order for Novolog (a rapid acting insulin) Flexpen 100units/ml inject 16 units subcutaneously (SQ) before breakfast and before supper as needed for fingerstick blood sugar (FSBS) over 250.
-There was an order for Novolog Flexpen 100units/ml inject additional 4 units SQ before breakfast and before supper as needed for FSBS over 400.

Review of Resident #11's Primary Care Provider's (PCP's) order dated 04/06/21 revealed:
-There was an order to discontinue FSBS before meals, breakfast and supper.
-There was an order for FSBS before all meals.
-There was an order to discontinue Novolog orders.
-There was an order for Novolog 14 units before meals, hold if FSBS less than 100, and give 4 extra units if FSBS more than 400 for a total of 18 units.

Review of Resident #11's PCP's subsequent order dated 04/13/21 revealed:
-There was an order for FSBS before meals.
-There was an order to discontinue previous Novolog orders.
-There was an order for Novolog 16 units before meals, hold if FSBS less than 100, and give 4 extra units if FSBS more than 400.

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D 358	Continued From page 56 Review of Resident #11's April 2021 medication administration record (MAR) revealed: -There was an entry for FSBS before breakfast scheduled at 7:30 am, and an entry for FSBS before dinner scheduled at 4:30 pm. -There was an entry for Novolog Flexpen insulin for FSBS over 250 give 16 units, FSBS over 400 give additional 4 units for a total of 20 units for a total of Novolog. -There was no entry for Novolog Flexpen insulin 14 units before meals, hold if FSBS less than 100, and give 4 extra units if FSBS more than 400 for a total of 18 units dated 04/06/21. -There was no entry for the order for Novolog 16 units before meals, hold if FSBS less than 100, and give 4 extra units (to equal 20 units) if FSBS more than 400 dated 04/13/21. -Novolog insulin was administered incorrectly at 7:30 am on 13 of 13 opportunities from 04/06/21 to 04/19/21 with examples as follows: -On 04/07/21, FSBS was 124, Resident #11 should have received 14 units of insulin, no insulin was documented as administered. -On 04/08/21, FSBS was 162, Resident #11 should have received 14 units of insulin, no insulin was documented as administered. -On 04/10/21, FSBS was 367, Resident #11 should have received 14 units of insulin, 16 units of insulin was documented as administered. -On 04/12/21, FSBS was 281, Resident #11 should have received 14 units of insulin, 16 units of insulin was documented as administered. -On 04/18/21, FSBS was 349, Resident #11 should have received 14 units of insulin, 16 units of insulin was documented as administered. -There was no FSBS and no Novolog insulin documented as administered at 12:00 pm for 13 of 13 opportunities from 04/07/21 to 04/19/20 therefore it could not be determined if Resident #11 should have received Novolog insulin.	D 358		

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-Humalog insulin was documented administered incorrectly at 5:00 pm on 6 of 13 opportunities from 04/06/21 to 04/19/21 as follows:
-On 04/08/21, FSBS was 453, Resident 11 should have received 18 units of insulin, 20 units of insulin was documented as administered.
-On 04/10/21, FSBS was 459, Resident 11 should have received 18 units of insulin, 20 units of insulin was documented as administered.
-On 04/12/21, FSBS was 202, Resident 11 should have received 14 units of insulin, no units of insulin was documented as administered.

Interview with a medication aide (MA) on 04/16/21 at 5:29 pm revealed:
-She routinely worked the second (3:00 pm to 11:00 pm shift).
-MAs did not see original orders written by the Primary Care Provider (PCP).
-The Medication Manager (MM) was responsible to enter new orders on the MARs and the MAs were supposed to administer medications according to the MAR.
-Resident #11 had insulin injections for a long time.
-The PCP had made some changes to her insulin doses.
-She administered Resident #11's Novolog according to the MAR.
-She did not know Resident #11's Novolog insulin order changed to administer 16 units before meals and only hold if FSBS was less than 100 since it was not on the MAR, therefore she did not do a FSBS at lunch or administer insulin to the resident when she worked.

Interview with the MM on 04/16/21 at 4:00 pm revealed:
-She entered orders on the residents' MARs for insulin and any new orders until the pharmacy

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had a chance to place the order on the MAR to be sent out at the first of each month.
-She did not have a system in place to routinely monitor medication administration because she had only been at the current position for less than a month, and had been a MA prior to being asked to to be the MM.
-There had been a lot of MA turnover.
-She had been staffing as a MA to fill call-outs for the last 2 weeks.
-She did not know how she overlooked changing Resident #11's Novolog insulin on 04/07/21 and again on 04/13/21.

Interview with Resident #11 on 04/19/21 at 9:20 am revealed she had a blood sugar that was high occasionally but the MA did not give insulin because she said the order on her MAR stated she did not receive her mealtime insulin unless her FSBS was greater than 250.

Telephone interview with Resident #11's PCP on 04/19/21 at 12:43 pm revealed:
-She expected the facility to follow the current orders to help control Resident #11's diabetes and decrease the long-term damage to organs (kidney and eyes).
-She did not not know why the facility failed to change Resident #11's insulin orders when she requested the change.
-Thee had been an ongoing issue with her writing orders and the facility not starting or changing the orders correctly.
-She had written the same orders more than one time before the staff got the order correct on several occasions.

Interview with the Contracted Registered Nurse on 04/19/21 at 3:00 pm revealed:
-She had been working at the facility for 3 weeks.

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-She was contracted to assist with reviewing residents' medications, and auditing records.
-She had not been able to complete chart audits because she was trying to catch up on residents' out of date Licensed Health Professional Support evaluations.
-She was told the MM was responsible to enter orders on the residents' MARs.
-There was not a system to audit the medication orders entered by the MM for accuracy on a routine basis.
-There had been a lot of staffing changes within the last 3 months, including the MM, and Resident Care Director.

4. Review of Resident #4's current FL2 dated 02/14/20 revealed diagnoses were not documented on the FL2.

Review of Resident #4's previous FL2 dated 11/26/18 revealed diagnoses included encephalopathy, chronic pain syndrome, muscle weakness, major depressive disorder, abnormality of gait, anxiety disorder, and chronic obstructive pulmonary disease (COPD).

a. Review of Resident #4's FL2 dated 02/14/20 and signed physician's orders dated 12/22/20 revealed there was an order for lorazepam 0.5mg (used to treat anxiety) two times a day, at 2:00 pm and 8:00 pm daily.

Review of Resident #4's April 2021 Medication Administration Record (MAR) revealed:
-There was an entry for lorazepam 0.5mg tablet one tablet daily at 2:00 pm and daily at 8:00, scheduled for administration at 2:00 pm and 8:00 pm daily.
-Lorazepam 0.5mg was documented as administered 2 times a day from 04/01/21 to

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04/09/21.
-Lorazepam 0.5mg was documented as not administered (initials circled on the front of the MAR) beginning 04/10/21 through 04/19/21 at 2:00 pm.
-There were 19 doses of lorazepam 0.5mg documented as not administered from 04/10/21 to 04/19/21.
-Documentation reviewed on the back of the MAR revealed documentation was not complete for the reason for not administering lorazepam 0.5mg for each time the initials were circled each day.
-Reasons lorazepam 0.5mg was not administered per documentation on the back of the MAR included: "needs reorder" on 04/16/21 at 2:00 pm, "awaiting pharmacy" on 04/16/21 at 8:00 pm, "waiting script refill" on 04/18/21 at 2:00 pm, "awaiting pharmacy" on 04/18/21 at 8:00 pm, and "awaiting pharmacy" on 04/19/21 at 2:00 pm.

Review of Resident #4's controlled substance count sheets (CSCS) along with controlled medications to assist the facility with tracking administration of controlled substance revealed:
-There was no current CSCS for lorazepam 0.5mg available for review.
-There was a CSCS for lorazepam 0.5mg documented as dispensed on 03/05/21, received on 03/06/21 with instructions to take one tablet daily at 2:00 pm and daily at 8:00 pm.

Telephone interview with a medication technician at the facility's contracted pharmacy on 04/20/21 at 10:02 am revealed:
-The pharmacy dispensed Resident #4's lorazepam 0.5mg tablets on 03/05/21 for a quantity of 60 tablets with instructions to take one tablet daily at 2:00 pm and daily at 8:00 pm.
-There were no refills on the medication order for lorazepam 0.5mg sent on 03/05/21.

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-The pharmacy would have sent the facility notification that Resident #4 needed a new order to refill lorazepam 0.5mg tablet when a request to refill the medication was sent to the pharmacy.
-There was no current order for lorazepam 0.5mg tablets at the pharmacy prior to an order received on 04/19/21 from Resident #4's primary care provider (PCP).

Telephone interview with Resident #4's PCP on 04/19/21 at 12:51 pm revealed:
-She did not know Resident #4 was out of lorazepam 0.5mg for 9 days.
-Resident #4 took lorazepam for help with anxiety associated with COPD and labored breathing.
-The facility should contact her immediately when a resident was out of a medication by texting, or emailing her to let her know.
-She wanted residents to have medications on hand for administration when the medications were ordered.
-She routinely sent the pharmacy an electronic order for a medication when she was informed by the facility that a resident was out of a medication.

Interview with the current Medication Manager (MM) on 04/19/21 at 3:43 pm revealed:
-The facility was on a cycle refill from the contracted pharmacy meaning the pharmacy refilled a month supply of residents' maintenance medications automatically.
-Not all medications were on cycle fill.
-Narcotic medications, topical medications, and most controlled medications were not cycle fill and had to be reordered by calling the pharmacy or faxing refill/reorder request.
-Medication aides (MA) could reorder medications from the pharmacy.
-She did not know Resident #4 was not receiving

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lorazepam 0.5mg twice daily for more than 9 days.

Interview with a second shift MA on 04/19/21 at 4:00 pm revealed:
-The MAs were told by the former Medication Manager (MM) not to contact the PCP or call the pharmacy for medications that were not available for administration.
-The MAs were supposed to tell the former MM when a resident did not receive a cycle filled maintenance medication or needed a controlled medication order.
-The MA had informed the current MM at least once in the past week (not sure of the day) that Resident #4 did not have lorazepam 0.5mg available for administration.

Interview with Resident #4 on 04/19/21 at 4:40 pm revealed:
-She had been out of lorazepam 0.5mg for several days.
-She took lorazepam 0.5mg to help with anxiety from the lack of being able to breath normally due to her COPD.
-Her shortness of breath caused her to be anxious and her being anxious made her breath more rapid and fueled her shortness of breath.

Telephone interview with the Administrator on 04/20/21 at 12:35 pm revealed:
-The MAs should be ordering medications before residents ran out of medication.
-The current MM started on 03/22/21 and had been staffing medication carts a lot of shifts which decreased her ability to audit medication carts and residents' records for medications that were not available for administration.
-The MAs and the MM should be communicating to ensure residents had medications available to

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be administered as ordered.
-The facility's PCP ordered medications for residents electronically to the contracted pharmacy.
-The facility had been working hard since she came early March 2021 to decrease residents' medication outages.

b. Review of Resident #4's signed physician's orders dated 10/06/20 and 12/22/20 revealed there was an order for famotidine (used to treat acid reflux and heartburn) 40mg one-half (0.5) tablet two times a day.

Review of Resident #4's April 2021 Medication Administration Record (MAR) revealed:
-There was an entry for famotidine 40mg tablet take one-half tablet twice a day scheduled for administration at 6:30 am and 4:30 pm daily.
-Famotidine 40mg was documented as administered 2 times a day from 04/01/21 to 04/17/21.
-There were 3 doses of famotidine 40mg documented as not administered (initials circled on the front of the MAR) on 04/18/21 at 6:30 am and 4:30 pm, and on 04/19/21 at 6:30 am.
-There was no documentation for the reason famotidine 40mg was not administered on the back of the MAR.

Observation of medication on hand for administration on 04/19/21 at 10:00 am revealed there was no famotidine 40mg for Resident #4 available for administration on the medication cart or in the facility's overstock medications.

Telephone interview with a medication technician at the facility's contracted pharmacy on 04/20/21 at 10:05 am revealed:
-The pharmacy dispensed Resident #4's

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famotidine 40mg on 02/10/21 for a quantity of 15 tablets (30 doses) with instructions for take one-half tablet twice a day.
-On 03/10/21, the pharmacy again dispensed a quantity of 15 tablets (30 doses) with instructions for take one-half tablet twice a day.
-The facility had a cycle fill for routine medications.
-The cycle fill was delivered in the evening on 04/16/21 but Resident #4 did not receive a refill on famotidine 40mg tablets because there were no refills remaining.

Interview with a MA on 04/19/21 at 4:00 pm revealed:
-The MAs were told by the former Medication Manager (MM) not to contact the PCP or call the pharmacy for medications that were not available for administration.
-The MAs were supposed to tell the former MM when a resident did not receive a cycle filled maintenance medication or needed a controlled medication order.
-The MA did not know Resident #4 was out of famotidine 40mg because it was administered by third shift and she worked first shift.

Interview with Resident #4 on 04/19/21 at 4:40 pm revealed:
-She had been out of famotidine 40mg for two days.
-She took her stomach pill (famotidine 40mg) because it helped with acid reflux and indigestion from her hiatal hernia.
-She had a lot of heartburn and pain when she did not take the medication.
-She asked the staff for a dose of an antacid she had on her "as needed" orders to help with the reflux but it did not work as well as the famotidine.

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Telephone interview with the Administrator on 04/20/21 at 12:35 pm revealed:
-The MAs should be ordering medications before residents ran out of medication.
-The current MM started 03/22/21 and had been staffing medication carts a lot of shifts which decreased her ability to audit medication carts and residents' records for medications that were not available for administration.
-The MAs and the MM should be communicating to ensure residents had medications available to be administered as ordered.
-The facility's PCP ordered medications for residents electronically to the contracted pharmacy.
-The facility had been working hard since she came early March 2021 to decrease residents' medication outages.

c. Review of Resident #4's signed physician's orders dated 10/06/20 and 12/22/20 revealed there was an order for mirtazapine (used to treat major depression disorder) 30mg at bedtime for mood.

Review of Resident #4's medication orders revealed there was no order to discontinue mirtazapine 30mg available for review.

Review of Resident #4's pre-printed January 2021 Medication Administration Record (MAR) revealed:
-There was an entry for mirtazapine 30mg scheduled for administration at 8:00 pm daily.
-There was a handwritten entry to stop mirtazapine 30mg dated 01/06/21 written on the documentation section of the MAR.
-There was no other entry for mirtazapine 30mg on the January 2021 MAR.

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D 358	Continued From page 66 Review of Resident #4's pre-printed February 2021, March 2021, and April 2021 MARs revealed: -Mirtazapine 30mg was not listed on the MAR for administration. -There was no documentation for administration of mirtazapine 30mg. Interview with the Medication Manager (MM) on 04/16/21 at 9:50 am revealed: -She had been working at the facility since 03/22/21 as the MM. -She entered all new orders on the residents' MARs until the pharmacy had a chance to place the order on the MAR to be sent out at the first of each month. -She did not have a system in place to routinely monitor medication administration because she had only been at the current position for less than a month, and had been a medication aide (MA) prior to being asked to be the MM. -She was responsible for ensuring all medications were in the building and for auditing MARs to ensure medications were being administered as ordered, but she had not had a chance to audit MAR's. -There had been a lot of MA turnover. -She had been staffing as a MA to fill call outs for the last 2 weeks. Interview with the Administrator on 04/19/21 at 11:27 am revealed: -She did not handle medications unless she had to fill in on the medication cart when a MA called out. -All medications go through the MM. -The MM was responsible for faxing all new orders to the contracted pharmacy and writing all new orders on the MARs. -The MM followed up to ensure medications were	D 358		

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in the building to be administered.
-The MM and a MA had been checking the MARs at the end of the month for the next month to ensure the orders were correct.
-She did not know if the MARs for April 2021 were reviewed prior to being placed on the medication carts.
-She expected medications to be administered as ordered.

Telephone interview with Resident #4's Mental Health Provider (MHP) on 04/19/21 at 3:06 pm revealed:
-His last documented visit with Resident #4 was 03/12/21.
-He was able to view residents' MARs on some of his visits but not all the visits.
-He had not discontinued Resident #4's mirtazapine 30mg according to his last medication review on 03/12/21.
-Resident #4 should be taking mirtazapine 30mg at bedtime each night.
-There had been an ongoing problem with residents receiving medications that he had ordered due to facility or pharmacy issues.

Telephone interview with a medication technician at the facility's contracted pharmacy on 04/20/21 at 10:12 am revealed:
-The last documented dispensing for mirtazapine 30mg for Resident #4 was 12/13/20 for 30 doses from the facility's previous contracted pharmacy that was now part of the current contracted pharmacy.
-The transition from the previous pharmacy to the current pharmacy was done from pharmacy records and signed physicians's orders between November 2020 and December 2020.
-There were a few instances when medications needed to be corrected on the MARs after

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transition.
-Resident #4's current medication profile did not have mirtazapine 30mg listed as one of the medications.
-The signed physician's order at the pharmacy did not have mirtazapine 30mg listed, therefore the pharmacy would have not included the medication on the preprinted MARs.
-The pharmacy had no documentation of an order to discontinue mirtazapine 30mg was ever sent to the pharmacy by the facility.

d. Review of Resident #4's signed physician's orders dated 10/06/20 and 12/22/20 revealed there was an order for melatonin (used to treat insomnia) 10mg at bedtime for insomnia.

Review of Resident #4's medication orders revealed there was no order to discontinue melatonin 10mg available for review.

Review of Resident #4's pre-printed January 2021 Medication Administration Record (MAR) revealed:
-There was an entry for melatonin 10mg scheduled for administration at 8:00 pm daily.
-There was a handwritten entry to stop melatonin dated 01/06/21 written on the documentation section of the MAR.
-There was no other entry for mirtazapine 30mg on the January 2021 MAR.

Review of Resident #4's pre-printed February 2021, March 2021, and April 2021 MARs revealed:
-Melatonin 10mg was not listed on the MAR for administration.
-There no documentation for administration of melatonin 10mg.

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D 358	Continued From page 69 Interview with the Medication Manager (MM) on 04/16/21 at 9:50 am revealed: -She had been working at the facility since 03/22/21 as the MM. -She entered all new orders on the residents' MAR until the pharmacy had a chance to place the order on the MAR to be sent out at the first of each month. -She did not have a system in place to routinely monitor medication administration because she had only been at the current position for less than a month, and had been a medication aide (MA) prior to being asked to be the MM. -She was responsible for ensuring all medications were in the building and for auditing MARs to ensure medications were being administered as ordered, but she had not had a chance to audit MAR's. -There had been a lot of MA turnover. -She had been staffing as a MA to fill call outs for the last 2 weeks. Interview with the Administrator on 04/19/21 at 11:27 am revealed: -She did not handle medications unless she had to fill in on the medication cart when a MA called out. -All medications go through the MM. -The MM was responsible for faxing all new orders to the contracted pharmacy and writing all new orders on the MARs. -The MM followed up to ensure medications were in the building to be administered. -The MM and a MA had been checking the MARs at the end of the month for the next month to ensure the orders were correct. -She did not know if the MARs for April 2021 were reviewed prior to being placed on the medication carts. -She expected medications to be administered as	D 358		

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D 358	Continued From page 70 ordered. Telephone interview with Resident #4's Mental Health Provider (MHP) on 04/19/21 at 2:43 pm revealed: -His last documented encounter with Resident #4 was on 03/12/21. -He was able to view residents' MARs on some of his visit and not on others. -He had not discontinued Resident #4's melatonin 10mg according to his last medication review on 03/12/21. -Resident #4 should be taking melatonin 10mg at bedtime each night. -There had been an ongoing problem with residents receiving medications that he had ordered due to facility or pharmacy issues. Telephone interview with a medication technician at the facility's contracted pharmacy on 04/20/21 at 10:12 am revealed: -The last documented dispensing for melatonin 10mg for Resident #4 was 12/13/20 for 30 doses from the facility's previous contracted pharmacy that was now part of the current contracted pharmacy. The medication was documented as returned. -The transition from the previous pharmacy to the current pharmacy was done from pharmacy records and signed physicians's orders between November 2020 and December 2020. -There were a few instances when medications needed to be corrected on the MARs after transition. -Resident #4's current medication profile did not have melatonin 10mg listed as one of the medications. -The pharmacy sent the facility a cycle fill list monthly for approval before the medications were processed with the monthly cycle fill.	D 358		

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-Review of Resident #4's cycle fill authorizations revealed the facility marked melatonin 10mg as "discontinued" with the December 2020 cycle fill authorization.
-The pharmacy had no documentation an order to discontinue melatonin 10mg was ever sent to the pharmacy by the facility.

e. Review of Resident #4's signed physician's orders dated 10/06/20 revealed there was an order for Vitamin B-12 1000mcg (used to treat a deficiency of Vitamin B 12) once daily.

Review of Resident #4's medication orders revealed there was no order to discontinue Vitamin B 12 1000mcg available for review.

Review of Resident #4's pre-printed December 2020 Medication Administration Record (MAR) revealed:
-There was an no entry for Vitamin B-12 1000mcg.
-There was a handwritten entry for Vitamin B-12 1000mcg daily hand-written on the MAR.
-Vitamin B-12 1000mcg was scheduled for administration at 8:00 am daily.

Review of Resident #4's pre-printed January 2021 MAR revealed:
-There was an no entry for Vitamin B-12 1000mcg.
-There was a handwritten entry for Vitamin B-12 1000mcg daily hand-written on the MAR.
-Vitamin B-12 1000mcg was scheduled for administration at 8:00 am daily.

Review of Resident #4's pre-printed February 2021, March 2021, and April 2021 MARs revealed:
-Vitamin B-12 1000mcg was not listed on the

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D 358	Continued From page 72 MAR for administration. -There no documentation for the administration of Vitamin B-12 1000mcg. Interview with the Medication Manager (MM) on 04/16/21 at 9:50 am revealed: -She had been working at the facility since 03/22/21 as the MM. -She did not have a system in place to routinely monitor medication administration because she had only been at the current position for less than a month, and had been a medication aide (MA) prior to being asked to be the MM. -She was responsible for ensuring all medications were in the building and for auditing MARs to ensure medications were being administered as ordered, but she had not had a chance to audit MAR's. -She did not know Resident #4's Vitamin B-12 1000mcg was not being administered as ordered. Interview with the Administrator on 04/19/21 at 11:27 am revealed: -She did not handle medications unless she had to fill in on the medication cart when a MA called out. -All medications go through the MM. -The MM followed up to ensure medications were in the building to be administered. -The MM and a MA had been checking the MARs at the end of the month for the next month to ensure the orders were correct. -She expected medications to be administered as ordered. Telephone interview with Resident #4's Primary Care Provider (PCP) on 04/19/21 at 12:51 pm revealed: -Vitamin B-12 1000mcg was still listed on her current list of medications for Resident #4.	D 358		

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D 358	Continued From page 73 -She had not discontinued Vitamin B-12 1000mcg for Resident #4. -The physician's ordered she signed in December 2020 should have listed Vitamin B-12 1000mcg as a current medication. -The current contracted pharmacy had started supplying medications in December 2020 after merging with the previous pharmacy was her understanding. -She had several residents with medications that dropped from the MAR or physician's orders which she and the facility had been working to correct. -Apparently, Resident #4's Vitamin B-12 1000mcg was one of the medications that was on the MAR from the previous facility and being administered but then did not appear on the February 2021 and due to turnover with staff in the medication manager position, and nursing positions was overlooked. -She would send a new order to the contracted pharmacy to restart the medication immediately. Telephone interview with a medication technician at the facility's contracted pharmacy on 04/20/21 at 10:12 am revealed: -Vitamin B-12 1000mcg was dispensed on cycle fill monthly on 11/13/20 and 12/13/20 for one tablet daily and a quantity of 30 tablets. -The last documented dispensing for Vitamin B-12 1000mcg for Resident #4 was 01/11/21 for 30 tablets. -The transition from the previous pharmacy to the current pharmacy was done from pharmacy records and signed physicians's orders between November 2020 and December 2020. -There were a few instances when medications needed to be corrected on the MARs after transition. -Resident #4's current medication profile did not	D 358		

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have Vitamin B-12 1000mcg listed as one of the medications.
-The pharmacy sent the facility a cycle fill list monthly for approval before the medications were processed with the monthly cycle fill.
-Review of Resident #4's cycle fill authorizations revealed the facility marked Vitamin B-12 1000mcg as "discontinued" with the February 2021 cycle fill authorization.
-The pharmacy had no documentation an order to discontinue Vitamin B-12 1000mcg was ever sent to the pharmacy by the facility.

5. Review of Resident #1's current FL2 dated 08/12/20 revealed diagnoses included stroke, bipolar, chronic pain, constipation, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and hyperthyroidism.

a. Review of Resident #1's physician's orders revealed:
-There was an order dated 11/20/20 for Lamictal 100mg take one tablet daily at 8:00 am with 25mg for a total dose of 125mg once daily (used to treat bipolar); take one daily at 8:00 pm.
-There was an order dated 03/25/21 to discontinue Lamictal 100mg at 8:00 pm.
-There was an order dated 04/08/21 with instructions to discontinue Lamictal 100mg and 25mg; start Lamictal 100mg one and one-half tablet (150mg) once daily.

Review of Resident #1's March 2021 medication administration record (MAR) revealed:
-There was an entry for Lamictal 100mg scheduled for administration at 8:00 pm.
-There was documentation Lamictal 100mg at 8:00 pm was administered after the discontinued date on 03/25/21 from 03/26/21 through 03/31/21.

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D 358	Continued From page 75 Review of Resident #1's April 2021 MAR revealed: -There was a hand-written entry for Lamictal 150mg (take 1 and ½ tablet) daily scheduled for administration at 8:00 am. -There was documentation Lamictal 150mg was administered at 8:00 am from 04/10/21 through 04/18/21. -There was an entry for Lamictal 25mg take one tablet daily at 8:00 am with 100mg to equal 125mg scheduled for administration at 8:00 am. -There was documentation Lamictal 125mg was administered at 8:00 am from 04/01/21 through 04/18/21 after the medication was discontinued on 04/08/21. -There was an entry for Lamictal 100mg at bedtime scheduled for administration at 8:00 pm. -There was documentation Lamictal 100mg was administered at 8:00 pm after the medication was discontinued on 03/25/21. -Lamictal 100mg at 8:00 pm was documented as administered from 04/01/21 through 04/18/21. -Based on MAR documentation Resident #1 was administered 225mg of Lamictal daily from 04/01/21 through 04/10/21, which was not the correct ordered dose. -Resident #1 was administered 275mg of Lamictal daily from 04/10/21 through 04/18/21, which was not the correct ordered dose. Observation of Resident #1's medications on hand at the facility on 04/19/21 at 3:01 pm revealed there was no Lamictal available for administration. Interview with Resident #1 on 04/19/21 at 11:27 am revealed: -She was aware of what her medications looked like. -She knew when she was administered Lamictal.	D 358		

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D 358	Continued From page 76 -Last week the medication aide (MA) started to administer her 175mg of Lamictal in the morning and 100mg of Lamictal at bedtime. -She trusted the MA to administer the medication as ordered. -This morning, she was not administered Lamictal because the MA said she was out of Lamictal. -She did not think that she should be out of the medication because she just got a new order two weeks ago. Interview with the MA on 04/19/21 at 3:15 pm revealed: -She administered Resident #1's Lamictal as documented on the MAR. -She administered Resident #1 Lamictal 150mg plus 25mg of Lamictal at 8:00 am. -She did not see Resident #1's medication orders. -The medication manager (MM) was responsible for making sure medication orders on the MAR were accurate. -MAs had been instructed by the Administrator not to contact Primary Care Providers (PCP) regarding the administration of medications. -The MM was responsible for contacting the PCP. Interview with a second MA on 04/19/21 at 4:15 pm revealed: -She administered Resident #1 Lamictal 100mg at 8:00 pm because it was documented on the MAR. -She did not see the resident's orders. -The MM was responsible for ensuring medication orders on the MAR were accurate. Interview with the MM on 04/19/21 at 4:50 pm revealed: -She was responsible for ensuring orders on the MAR was accurate.	D 358		

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D 358	Continued From page 77 -She had worked in the MM position for two or three weeks and did not have time to independently check each resident record. -She was responsible for contacting the PCP to clarify medication orders. -She wrote Resident #1's order for Lamictal 150mg on the MAR, but she did not contact the provider to clarify if the Lamictal 25mg in am or the 100mg of Lamictal in the pm should be administered. -Resident #1's Lamictal 150mg was delivered from the pharmacy on the 3rd shift on 04/16/21. -She did not work on the weekend, and the MA on duty did not check the medication delivery tote for Resident #1's Lamictal. Telephone interview with a representative at the facility's contracted pharmacy on 04/20/21 at 11:32 am revealed: -On 03/25/21, the pharmacy received an order that discontinued Lamictal 100mg at 8:00 pm. -Resident #1's current order for Lamictal was received on 04/08/21, which increased Lamictal 125mg in the am to 150mg once daily in the am. -Lamictal 150mg was filled on 04/10/21 and 9 tablets were dispensed; enough to last the resident until the facility's cycle fill date on 04/16/21. -On 04/16/21, the pharmacy dispensed 30 tablets of 150mg of Lamictal. Interview with the Contract Registered Nurse on 04/19/21 at 3:00 pm revealed: -She was contracted to assist the MM with reviewing residents' medications, and auditing records. -Due to other obligations she had not been able to audit Resident #1's record. -As far as she knew, the facility did not have a system in place to ensure the MM accurately	D 358		

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D 358	Continued From page 78 documented medications on the MARs. Telephone interview with Resident #1's Mental Health Provider (MHP) on 04/20/21 at 1:50 pm revealed. -On 03/25/21, he discontinued Lamictal 100mg at bedtime and continued 125mg in the am. -On 04/08/21 he discontinued all Resident #1's Lamictal 125mg in the am and ordered Lamictal 150mg once daily. -For therapeutic effect Lamictal should be gradually increased and not suddenly increased. -If the facility administered 275mg of Lamictal daily without the gradual increase the biggest risk to the resident would be a "fatal rash." -The facility should have contacted him to clarify the order before administering 275mg of the medication. -Also, Lamictal should not be abruptly stopped. -Not administering the medication without a gradual decrease in dosage could cause seizure activity. Telephone interview with the Administrator on 04/20/21 at 2:17 pm revealed: -The MM was responsible for auditing the MARs daily to ensure medications were administered as ordered. -She expected the MM to contact the resident's PCP if she was not sure how an order should be administered. -The MM should have noticed the entries for Lamictal on the MAR and contacted the pharmacy or the MHP before the medication was administered. -She did not know Resident #1 was not administered Lamictal this morning. -When medications were received, they were checked in by the MM or the MA on duty on the third shift.	D 358		

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D 358	Continued From page 79 -She expected that medications were ordered timely, and no resident was without medication. b. Review of Resident #1's physician's orders revealed there was an order dated 04/06/21 to discontinue Xarelto once daily (anticoagulant used to thin the blood) and to start aspirin 81mg at bedtime (used to thin the blood). Review of Resident #1's April 2021 medication administration record (MAR) revealed: -There was an entry for Xarelto once daily which had been discontinued on 04/06/21. -There was an entry for aspirin 81mg scheduled for administration at 8:00 pm. -The medication aide's (MA) initials were circled from 04/08/21 through 04/18/21. -There was no documentation on the MAR why the MA initials were circled. Observation of Resident #1's medications on hand at the facility on 04/19/21 at 3:01 pm revealed aspirin 81mg was not available for administration. Interview with Resident #1 on 04/19/21 at 11:27 am revealed: -She previously had a blood clot in her lungs and was ordered Xarelto. -In February 2021 (unable to recall the exact date) she had a tooth extraction with significant bleeding that caused her a hospital stay. -After the hospital visit, she refused Xarelto for one and one-half months. -In April 2021, she asked her Primary Care Provider (PCP) about replacing Xarelto. -The PCP ordered aspirin 81mg. -As of today's, date (04/19/21), she had not received aspirin 81mg.	D 358		

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Telephone interview with a representative at the facility's contracted pharmacy on 04/20/21 at 11:32 am revealed:
-The pharmacy did not have an order for aspirin 81mg for Resident #1.
-The pharmacy still showed Xarelto as an active medication and was not aware Xarelto had been discontinued.

Interview with the medication aide (MA) on 04/19/21 at 3:15 pm revealed:
-Aspirin 81mg was printed on Resident #1's MAR but the medication was never received at the facility.
-Resident #1 did sometimes order over-the-counter medications but she was not sure about the aspirin.
-She had made the medication manager (MM) aware Resident #1 did not have aspirin.
-She documented on the 24-hour shift reports Resident #1 did not have aspirin 81mg available for administration.
-The 24-hour shift reports were given to the Administrator each day.

Interview with the medication manager (MM) on 04/19/21 at 4:50 pm revealed:
-Resident #1 ordered some of her medications.
-The thought Resident #1 had ordered aspirin 81mg.
-She had not followed up with the resident to ensure the medication was received.
-The MA should have informed her that Resident #1 did not have aspirin 81mg for administration.
-She was supposed to check the medication carts to ensure medications were available for administration, but she did not have time.

Telephone interview with Resident #1's Primary care Provider (PCP) on 04/16/21 at 2:53 pm

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revealed:
-Resident #1 had a history of pulmonary embolism and was ordered Xarelto.
-On 04/09/21, she discontinued Xarelto and ordered Resident #1 aspirin 81mg at bedtime.
-She was not aware Resident #1 was not administered the aspirin 81mg as ordered.
-She was in the facility every Tuesday, so if the facility had difficulty getting Resident #1's aspirin someone should have informed her.
-She expected medication to be administered as ordered.
-Her residents should not miss more than one dose of medication before she was contacted.
-On numerous occasions, she had told facility staff to let her know when there was a problem getting medication for her residents.

c. Review of Resident #1's current FL2 dated 08/12/20 revealed there were orders for promethazine 25mg one tablet daily and promethazine 25mg one tablet every six hours as needed for nausea (used to treat nausea).

Review of Resident #1's April 2021 medication administration record (MAR) revealed:
-There was an entry for promethazine 25mg daily scheduled for administration at 6:30 am.
-There was an entry for promethazine 25mg every six hours as needed for nausea.
-There was documentation with staff circled initials from 04/06/21 through 04/15/21 and documented on the back of the MAR "no promethazine not available - awaiting pharmacy."

Observation of Resident #1's medications on hand on 04/15/21 at 9:33 am revealed promethazine 25mg was not available for administration.

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Interview with Resident #1 on 04/15/21 at 9:24 am revealed:
-She had been out of her promethazine for 12 days.
-She previously had cancer and received treatments that made her sick and nauseated.
-Although the cancer was in remission, she still experienced a lot of nausea.
-It was important that she received the promethazine to keep from being nauseated.
-She had been sick on the stomach ever since the medication was out.

Interview with the medication aide (MA) on 04/15/21 at 8:38 am revealed:
-Resident #1 had been out of promethazine 25mg for almost ten days.
-Residents being out of medications was a continual problem at the facility.
-The MA was not allowed to call the pharmacy to follow up on medications not available.
-The MAs were supposed to tell the MM that a refill was needed when there was between 5 and 10 doses remaining.
-The Administrator had informed the MAs to let the medication manager (MM) know when a resident's medication needed to be refilled.
-The MM was responsible for contacting the pharmacy to reorder medications.
-She had made the MM and the Administrator aware that Resident #1 was still out of the promethazine.

Interview with the MM on 04/15/21 at 9:32 am revealed:
-Her role was to check medications on the medication cart.
-She made sure medications were administered as ordered.
-She notified the pharmacy of medication refills.

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D 358	Continued From page 83 Interview with the MM on 04/19/21 at 4:50 pm revealed: -The MA was also able to order medications from the pharmacy if there was a prescription available. -She did not know Resident #1 was still out of promethazine. -If there was a problem getting the medication the MA should have made her aware. -If the resident's Primary Care Provider (PCP) needed to be contacted she was responsible for contacting the PCP. Interview with Resident #1's PCP on 04/16/21 2:53 pm revealed: -Resident #1 had chronic nausea as a result of previous cancer treatment. -She ordered Resident #1 promethazine 25mg scheduled daily in the morning and as needed every six hours. -She expected Resident #1's medications to be administered as ordered. -On Tuesday, 04/13/21, she found out from Resident #1 that the resident had been without promethazine for almost two weeks. -She was in the facility weekly, and no one made her aware Resident #1 was not administered promethazine. -She wanted to be notified if there was a problem getting medications for her residents. Telephone interview with a repreentative from the facility's contracted pharmacy on 04/20/21 at 11:32 am revealed: -The pharmacy received an order on 01/21/21 for Resident #1's promethazine 25mg once daily and promethazine 25mg every six hours as needed for nausea. -On 01/25/21, the pharmacy dispensed 150	D 358		

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tablets of promethazine 25mg.
-The order for promethazine 25mg dated 01/21/21 did not have any refills.
-On 04/13/21, the facility sent the pharmacy a refill request for promethazine 25mg.
-The pharmacy denied the request because a new prescription was needed.
-The pharmacy representative faxed a prescription denial to the facility anytime a prescription was denied.

Telephone interview with the Administrator on 04/20/21 at 2:17 pm revealed:
-She did not know Resident #1 was out of promethazine.
-The MA should have reported the medication was out to the MM.
-The MM was responsible for ensuring that residents' medications were available for administration.
-She expected all resident's medications to be in-house and available for administration.

d. Review of Resident #1's physician's order dated 12/22/20 revealed an order for senokot-s 8.6mg 2 tablets twice daily (used to treat constipation).

Review of Resident #1's March 2021 medication administration record (MAR) revealed:
-There was an entry for senokot-s 8.6mg scheduled for administration at 8:00 am and 6:00 pm.
-There was documentation the medication aide (MA) circled initials at 8:00 am and 6:00 pm 03/26/21 through 03/31/21.
-There was no explanation on the back of the MAR why the MA circled her initials.

Review of Resident #1's April 2021 MAR

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revealed:
-There was an entry for senokot-s 8.6mg scheduled for administration at 8:00 am and 6:00 pm.
-There was documentation the MA circled initials at 8:00 am and 6:00 pm from 04/01/21 through 04/19/21.
-There was documentation on the back of the MAR "awaiting pharmacy - on order."

Observation of Resident #1's medications on hand at the facility on 04/19/21 at 3:01 pm revealed senokot-s 8.6mg was not available for administration.

Interview with Resident #1 on 04/15/21 at 9:24 am revealed:
-She did not realize that she was out of senokot-s.
-No one said anything to her about the senokot-s not being available.
-She had taken senokot-s since October 2020, due to certain medications causing her to sometimes have a difficult time with bowel movements.
-She had been sick on the stomach but thought it was related to not getting a nausea medication.
-She had not noticed that her bowel movements were more difficult than usual.

Interview with the medication aide (MA) on 04/15/21 at 8:38 am revealed:
-Resident #1 had been out of senokot-s for over one month.
-She had made the medication manager (MM) and the Administrator aware that Resident #1 was out of some of her medications, including the senokot-s.
-She did not re-order Resident #1's senokot-s because the MM was responsible for re-ordering

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medications.
-Resident #1 ordered some of her medications that were less expensive over-the-counter.
-She was not sure if Resident #1 ordered the senokot-s.
-The MM was responsible to ensure medications were available for administration.
-If a medication was not available the MM was supposed to follow through to find out why the medication was not available.

Interview with the MM on 04/19/21 at 4:50 pm revealed:
-Her role was to check medications on the medication cart daily.
-She made sure medications were administered as ordered.
-She notified the pharmacy of medication refills.
-She had not obtained a refill for Resident #1's senokot-s because she did not know the resident was out of senokot-s.

Telephone interview with Resident #1's PCP on 04/16/21 2:53 pm revealed:
-Resident #1 was ordered senokot-s because the resident was ordered several medications that caused constipation.
-She expected medications ordered to be administered as ordered.
-She did not want a resident to miss more than one dose of medications.

Telephone interview with a representative from the facility's contracted pharmacy on 04/20/21 at 11:32 am revealed:
-The pharmacy received an order for senokot-s 8.6mg twice daily on 10/20/20.
-The medication was filled on 10/20/20 and a quantity of 120 tablets was dispensed.
-The senokot-s 8.6mg was not on automatic refill.

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-The facility had to call and request the medication to be refilled.
-Senokot-s 8.6mg had not been filled since 10/20/20.

Telephone interview with the Administrator on 04/20/21 at 2:17 pm revealed:
-She did not know Resident #1 was out of senokot-s.
-Resident #1 should not be ordering her medications.
-She expected the MA to inform the MM when a resident had one week of medications left.
-The MM was supposed to check the medication cart daily to ensure medications were available for administration.
-She expected all residents' medications to be available for administration.

6. Review of Resident #2's current FL2 dated 01/19/21 revealed diagnoses included bipolar disorder, depression/anxiety, chronic pain, kidney failure, tachycardia, sinusitis, chronic obstructive pulmonary disease (COPD), and vitamin D deficiency.

a. Review of Resident #2's current FL2 dated 01/19/21 revealed there was an order for tramadol 50mg with no frequency (used to treat pain).

Review of Resident #2's previous physician's order dated 12/22/20 revealed there was an order for tramadol 50mg 1 tablet four times daily.

Review of Resident #2's April 2021 medication administration record (MAR) revealed:
-There was an entry for tramadol 50mg scheduled for administration at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm.

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D 358	Continued From page 88 -There was documentation the medication aide (MA) circled initials on 04/11/21 at 4:00 pm and 8:00 pm; on 04/12/21 at 8:00 am, 12:00 pm, 4:00 pm and 8:00 pm, 04/13/21 at 8:00 am, 12:00 pm, 4:00 pm and 8:00 pm and 04/14/21 at 8:00 am 12:00 pm, 4:00 pm, and 8:00 pm; and on 04/15/21 at 8:00 am and 12:00 pm. -There was documentation on the back of the MAR the medication was not administered "reordered." Observation of Resident #2's medications on hand on 04/15/21 at 9:03 am revealed tramadol 50mg was not available for administration. Interview with Resident #2 on 04/15/21 at 9:15 am revealed: -She had not received tramadol in several days. -The MA told her they were waiting for the pharmacy to send her tramadol. -Without tramadol, she was in so much pain that she felt shaky and had a difficult time sleeping. Telephone interview with a representative from the facility's contracted pharmacy on 04/19/21 at 12:01 pm revealed: -Resident #2's tramadol was not on automatic refill. -The pharmacy required a new prescription for each refill. -Tramadol 50mg four times daily was filled on 03/22/21 and 83 tablets were dispensed. -If tramadol 50mg was administered as ordered, the medication would have lasted 20 and ½ days. -The facility requested a refill of tramadol 50mg, but it was denied because a new prescription was needed. -The pharmacy representative faxed a prescription denial to the facility anytime a prescription was denied.	D 358		

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-The pharmacy obtained a verbal order from the resident's Primary Care Provider (PCP) on 04/15/21.
-The pharmacy filled tramadol 50mg and dispensed 29 tablets.

Telephone interview with Resident #2's PCP on 04/16/21 at 2:53 pm revealed:
-She did not know Resident #2 was out of tramadol 50mg until 04/15/21 when staff told her the pharmacy needed a refill request because a new prescription was needed.
-She called the verbal order directly to the pharmacy.
-She did not want Resident #2 to be without her medications at a minimum of 24 hours.

Interview with the MA on 04/15/21 at 9:38 am revealed:
-Resident #2 was out of tramadol 50mg.
-The medication had been out for almost 4 days.
-She told the medication manager (MM) that Resident #2 out of tramadol.
-It was the facility's policy to reorder medications when there was at least one week of medications left.
-She had reminded the MM that Resident #2 was out of tramadol daily since 04/12/21.
-She reminded the MM about Resident #2 being out of tramadol every day since 04/12/21.

Interview with the MM on 04/19/21 at 4:50 pm revealed:
-She was responsible for ensuring the residents had medications available for administration.
-She had contacted the pharmacy regarding a refill of Resident #2's tramadol but was unable to recall the date when she contacted the pharmacy.

Telephone interview with the Administrator on

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04/20/21 at 2:17 pm.
-Resident #2 should have never run out of tramadol.
-She expected the MAs to let the MM know when a medication was down to a one-week supply.
-The MM should also be checking the medication cart daily to ensure medications were available for administration.

b. Review of Resident #2's physician's orders dated 12/24/20 there was an order for flexeril 5mg three times daily as needed for muscle spasms (used to muscle spasms).

Review of Resident #2's April 2021 medication administration record (MAR) revealed:
-There was an entry for flexeril 5mg three times daily as needed for muscle spasms.
-There was documentation flexeril 5mg was last administered on 04/16/21 at 8:00 pm.
-There was no further documentation related to the administration of flexeril on the MAR.

Observation of Resident #2's medications on hand on 04/19/21 at 3:10 pm revealed flexeril 5mg was not available for administration.

Interview with Resident #2 on 04/19/21 at 4:40 pm revealed:
-She requested flexeril several times and the medication aide (MA) told her that she was out of flexeril.
-She needed the flexeril to help with muscle spasms.
-Due to not receiving flexeril she was trembling with muscle spasms.

Telephone interview with a representative at the facility's contracted pharmacy on 04/19/21 at 12:01 pm revealed:

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D 358	Continued From page 91 -Resident #2's flexeril 5mg three times daily as needed for muscle spasms was filled on 02/27/21 and a quantity of 90 tablets was dispensed. -Flexeril 5mg was filled on 04/16/21 and a quantity of 90 tablets was dispensed. -The medication was delivered to the facility on 04/16/21 at 10:43 pm and signed for the named medication aide on duty. Telephone interview with Resident #2's PCP on 04/16/21 at 2:53 pm revealed: -She did not know Resident #2 had been without flexeril 5mg. -When she ordered medications, she expected them to be administered. -Resident #2 should never be without medication for more than 24 hours. Interview with the MA on 04/19/21 at 3:38 pm revealed: -Resident #2's medications were usually reordered when there were 5 tablets remaining. -She was not sure about flexeril because it was an as-needed medication. -The Administrator told MAs to let the medication manager (MM) know when medications needed to be reordered. Interview with the MM on 04/19/21 at 4:50 pm revealed: -She was not aware Resident #2 asked for flexeril and it was not administered. -Resident #2's flexeril 5mg was delivered to the facility in the medication tote that was delivered after 10:00 pm by the pharmacy 04/16/21. -She usually checked in the medications delivered by the pharmacy. -When Resident #2's flexeril was delivered it was after 10:00 pm on Friday, 04/16/21, and she was off the weekend.	D 358		

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-The MA that received the tote should have opened it and put the medications on the medication cart.

Telephone interview with the Administrator on 04/20/21 at 2:17 pm revealed:
-She expected the MAs to let the MM know when a medication was down to a one-week supply even as-needed medications.
-Resident #2 should have never been denied the administration of flexeril.
-She did not know the MA on the second received Resident #2's flexeril and left the medication in the tote for the MM to put on the medication cart on Monday morning.
-When medications were received, she expected the third shift MA to check the tote and put the medications on the medication cart.

7. Review of Resident #6's current FL2 dated 02/16/21 revealed diagnoses included encephalopathy, diabetes mellitus type II, hypertension, mild cognitive impairment, chronic obstructive pulmonary disease (COPD), coronary artery disease, heart disease, major depressive disorder, falls, and muscle weakness.

a. Review of Resident #6's current FL2 dated 02/16/21 revealed there was an order for famotidine (used to treat gastroesophageal reflux) 20mg 2 times a day at 6:00 am and 4:30 pm.

Review of Resident #6's March 2021 Medication Administration record (MAR) revealed:
-There was an entry for famotidine 20mg 1 tablet 2 times daily scheduled for administration at 6:00 am and 4:30 pm daily.
-Famotidine was not documented as administered (by circled initials indicating not

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administered) 36 of 60 opportunities.
-There was a documented reason of "drug unavailable/awaiting pharmacy" for 33 of 60 missed opportunities and a documented reason of "resident refused" for 3 of 60 missed opportunities.

Review of Resident #6's April 2021 MAR revealed:
-There was an entry for famotidine 20mg 1 tablet 2 times daily scheduled for administration at 6:00 am and 4:30 pm daily.
-Famotidine was not documented as administered (by circled initials indicating not administered) 15 of 30 opportunities.
-There was a documented reason of "drug unavailable/awaiting pharmacy" for 3 of 60 opportunities.
-There was no documented reason for famotidine not being administered for 12 of 30 missed opportunities.

Observation of Resident #6's medications on hand on 04/16/21 at 4:30 pm revealed:
-There was 1 partially filled blister packs of famotidine 20mg tablets with instructions to take 1 tablet (20mg) 2 times a day at 6:00 am and 4:30 pm.
-The famotidine had a dispense date of 04/06/21.
-There were 14 of 60 capsules remaining.

Interview with a medication aide (MA) on 04/16/21 at 10:30 am revealed:
-She administered medications to Resident #6 and circled the dose of famotidine several times on Resident #6's March and April MAR.
-Circled initials on the MAR meant the medication was not administered.
-Resident #6 did not have any famotidine for a few weeks because the contracted pharmacy had

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not sent any.
-She had called the pharmacy in March 2021 (she did not document when she called the pharmacy) , but they still did not receive any famotidine from the contracted pharmacy.
-She was not allowed to call the primary care provider (PCP) because the Medication Manager (MM) was responsible for doing that.
-The MM was responsible for auditing the medication carts to ensure medications were in the building and auditing the MARs to ensure all medications were administered as ordered.

Interview with a second MA on 04/19/21 at 10:21 am revealed:
-She had administered medications to Resident #6 and circled a dose of famotidine one time on Resident #6's March and April MAR.
-Circled initials on the MAR meant the medication was not administered.
-Resident #6 did not have any famotidine because the MA's did not let hospice know she needed a refill.
-The MAs were supposed to let hospice know the resident needed a refill on medication when they had 8 or 9 remaining tablets of any medication.
-She had called hospice in March 2021 (she did not document when she called the pharmacy) to let them know that Resident #6 was out of famotidine.
-She was not allowed to call the primary care provider (PCP) because the Medication Manager (MM) was responsible for doing that.
-The MM was responsible for auditing the medication carts to ensure medications were in the building and auditing the MARs to ensure all medications were administered as ordered.

Interview with the Administrator on 04/19/21 at 11:27 am revealed she did not know Resident #6

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had missed 6 doses of famotidine in March 2021 or 15 doses in April 2021.

b. Review of Resident #6's current physician's order dated 01/05/21 revealed there was an order for gabapentin (used to treat diabetic neuropathy) 100mg 3 times a day.

Review of Resident #6's March 2021 MAR revealed:
-There was an entry for gabapentin 100 mg 1 tablet 3 times daily scheduled for administration at 8:00 am, 2:00 pm, and 8:00 pm daily.
-Gabapentin was not documented as administered (by circled initials indicating not administered) 27 of 90 opportunities.
-There was a documented reason of "drug unavailable/awaiting pharmacy" for 9 of 27 missed opportunities and a documented reason of "resident refused for 3 of 27 opportunities.
-There was no documented reason for gabapentin not being administered for 15 of 27 missed opportunities.

Observation of Resident #6's medications on hand on 04/16/21 at 4:30 pm revealed:
-There was 1 partially filled blister packs of gabapentin 100mg tablets with instructions to take 1 tablet (100mg) 3 times a day at 8:00 am, 2:00 pm, and 8:00 pm daily.
-The gabapentin had a dispense date of 03/21/21.
-There were 24 of 90 tablets remaining.

Interview with a medication aide (MA) on 04/16/21 at 10:30 am revealed:
-She administered medications to Resident #6 and circled the dose of gabapentin several times on Resident #6's March MAR.
-Circled initials on the MAR meant the medication

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was not administered.
-Resident #6 did not have any gabapentin for a few weeks because the contracted pharmacy had not sent any.
-She had called the pharmacy in March 2021 (she did not document when she called the pharmacy), but they still did not receive any gabapentin from the contracted pharmacy.
-She was not allowed to call the primary care provider (PCP) because the Medication Manager (MM) was responsible for doing that.
-The MM was responsible for auditing the medication carts to ensure medications were in the building and auditing the MARs to ensure all medications were administered as ordered.

Interview with a second MA on 04/19/21 at 10:21 am revealed:
-She administered medications to Resident #6 and circled a dose of gabapentin on Resident #6's March and April MAR.
-Resident #6 did not have any gabapentin because the MA's did not let hospice know she needed a refill.
-The MAs were supposed to let hospice know the resident needed a refill on medication when they had 8 or 9 remaining tablets of any medication.
-She had called hospice in March 2021 (she did not document when she called the pharmacy) to let them know that Resident #6 was out of gabapentin.
-The MM was responsible for auditing the medication carts to ensure medications were in the building and auditing the MARs to ensure all medications were administered as ordered.

Interview with a third MA on 04/19/21 at 10:21 am revealed:
-She administered medications to Resident #6 and circled a dose of gabapentin one time on

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Resident #6's March and April MAR.
-Circled initials on the MAR meant the medication was not administered.
-Resident #6 did not have any gabapentin because the MAs did not reorder from the pharmacy when they were supposed to.
-She had called the pharmacy in March and April 2021 (she did not document when she called the pharmacy).
-She was not allowed to call the primary care provider (PCP) because the Medication Manager (MM) was responsible for doing that.

Interview with the Administrator on 04/19/21 at 11:27 am revealed she did not know Resident #6 had missed 27 doses of gabapentin in March 2021.

c. Review of Resident #6's current physician's order dated 03/26/21 revealed there was an order for prednisone (used to treat COPD) 10mg tablets with the following taper dosages: 4 tablets daily for 2 days, then 3 tablets daily for 2 days, then 2 tablets daily for 2 days, then 1 tablet daily or 2 days then discontinue.

Review of Resident #6's March 2021 MAR revealed:
-There was an entry for prednisone 10mg tablets with the following taper dosages: 4 tablets daily for 2 days, then 3 tablets daily for 2 days, then 2 tablets daily for 2 days, then 1 tablet daily or 2 days scheduled for administration at 8:00 am beginning on 03/30/21.
-Prednisone was documented as administered for 1 of 1 opportunity.
-Prednisone was documented as administered 1 time on 03/30/21 at 8:00 am (and should have continued on the April 2021 MAR).

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D 358	Continued From page 98 Review of Resident #6's April 2021 MAR revealed: -There was no entry for prednisone 10mg tablets with the following taper dosages: 4 tablets daily for 2 days, then 3 tablets daily for 2 days, then 2 tablets daily for 2 days, then 1 tablet daily or 2 days scheduled for administration at 8:00 am beginning on 03/30/21. -There should had been 7 remaining doses administered the first week of April. Observation of Resident #6's medications on hand on 04/16/21 at 4:30 pm revealed: -There was 1 blister pack of prednisone 10mg tablets with instructions to take 4 tablets daily for 2 days, then 3 tablets daily for 2 days, then 2 tablets daily for 2 days, then 1 tablet daily or 2 days. -There were 20 prednisone 10mg tablets dispensed on 03/30/21 and 20 prednisone 10mg tablets remained in the blister pack. Interview with a medication aide (MA) on 04/16/21 at 10:30 am revealed: -She administered medications to Resident #6. -She had a blister pack of prednisone 10mg tablets on the cart. -The blister pack was dispensed on 03/30/21. -She did not know why the prednisone 10mg had not carried over to the April MAR. -The MM was responsible for ensuring that all MARs were checked and updated before going on the cart at the beginning of the month, but she helped do half of the MARs for the fourth floor. -She did not review Resident #6's MAR at the beginning of April 2021 and she was not sure if the MM had reviewed the April MAR for Resident #6. -The MM was responsible for auditing the medication carts to ensure medications were in	D 358		

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the building and auditing the MARs to ensure all medications were administered as ordered.

Interview with another MA on 04/19/21 at 10:21 am revealed:
-She had administered medications to Resident #6.
-She did not recall administering prednisone to Resident #6.
-She believed prednisone fell off the MAR because April MAR checks were not completed by the MM.
-April MARs were not put on the medication cart until the second or third day of April.
-The MM was responsible for transposing all orders onto the MAR and ensure they were correct.
-The MAs could not ensure the MARs were correct because they were not allowed to see the orders.
-The MM was responsible for auditing the medication carts to ensure medications were in the building and auditing the MARs to ensure all medications were administered as ordered.

Interview with the MM on 04/16/21 at 9:50 am revealed:
-She entered all new orders on the residents' MAR until the pharmacy had a chance to place the order on the MAR to be sent out at the first of each month.
-She did not have a system in place to routinely monitor medication administration because she had only been at the current position for less than a month, and had been a MA prior to being asked to be the MM.
-She was responsible for ensuring all medications were in the building and for auditing MARs to ensure medications were being administered as ordered but she had not had a chance to audit

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D 358	Continued From page 100 MAR's. -There had been a lot of MA turnover. -She had been staffing as a MA to fill call outs for the last 2 weeks. Attempted interview with the MM on 04/19/21 and 04/20/21 was unsuccessful. Interview with the Administrator on 04/19/21 at 11:27 am revealed: -She did not know why prednisone had not been administered to Resident #6. -She did not know why or how prednisone fell off the MAR for April 2021. -She did not handle medications unless she had to fill in on the medication cart when a MA called out. -All medications go through the MM. -The MM was responsible for faxing all new orders to the contracted pharmacy and writing all new orders on the MARs. -The MM followed up to ensure medications were in the building to be administered. -The MM and a MA had been checking the MARs at the end of the month for the next month to ensure the orders were correct. -She did not know if the MARs for April 2021 were reviewed prior to being placed on the medication carts. -She expected medications to be administered as ordered. _____ The facility failed to ensure medications were administered as ordered by the licensed prescribing provider for 2 of 2 residents (Resident #8 and #9) sampled during the 8:00 am medication pass on 04/16/21 related to a resident with chronic pain not receiving a medication to treat anxiety (#8), and a resident not receiving a medication to treat diabetic neuropathy placing	D 358		

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D 358	Continued From page 101 the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and #11) which resulted in a resident with a history of pulmonary embolism placed at risk for a blood clot due to not receiving a medication used to thin the blood, at risk for increased behaviors due to not receiving a medication to treat bipolar disorder, increased risk for abdominal discomfort due to a history of constipation and not receiving a laxative (#1); a resident experiencing continued pain due to not receiving a medication for pain, and a medication for muscle spasms (#2); a resident with a history of hiatal hernia, chronic obstructive pulmonary disease (COPD), depression and insomnia experiencing abdominal and esophageal pain due to not receiving a medication for acid reflux, unnecessary anxiety from breathing difficulty associated with COPD and not receiving a medication for anxiety, and increased depression due to not receiving a medication for insomnia, and a medication to treat depression (#4); a medication for diabetic neuropathy causing increased pain requiring a stronger pain reliever, and not receiving a steroidal medication post hospitalization for a COPD exacerbation (#6); and two residents with elevated blood sugars not receiving a short acting insulin which could result in elevated blood sugars and nerve and organ damage (#7 and #11). The facility's failure to administer medications as ordered placed the residents at substantial risk of physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/16/20 for this violation. CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 20, 2021.	D 358		

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D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 1 of 6 sampled residents (#1) for a sleep medication. The findings are: Review of Resident #1's current FL2 dated 08/12/20 revealed: - Review of Resident #1's current FL2 dated 08/12/20 revealed:	D 367		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 103 -Diagnoses included stroke, bipolar, chronic pain, constipation, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and hyperthyroidism. -Melatonin 5mg (a supplement used to treat insomnia) with no frequency for administration. Review of Resident #1's physician's orders dated 12/22/20 revealed there was an order for melatonin 5mg, 2 tablets (10mg) at bedtime. Review of Resident #1's physician's orders dated 02/01/21 revealed melatonin 5mg, 2 tablets (10mg) at bedtime was changed to 3mg, 3 tablets (9mg) at bedtime. Review of Resident #1's April 2021 medication administration record (MAR) revealed: -There was an entry for melatonin 10mg scheduled for administration at 9:00 pm. -There was documentation melatonin 10mg was administered 13 of 18 opportunities. -There was an entry for melatonin 9mg scheduled for administration at 9:00 pm. -There was documentation melatonin 9mg was administered 18 of 18 opportunities. Observation of Resident #1's medications on hand at the facility on 04/19/21 at 3:01 pm revealed: -Melatonin 3mg, 3 tablets (9mg) was available for administration. -The medication was filled on 02/01/21 and a quantity of 90 tablets was dispensed. -There was a total of 3 days of melatonin 3mg, 3 tablets left. -There was no melatonin 10mg on the medication cart. Telephone interview with a representative from	D 367		

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D 367	Continued From page 104	D 367		

the facility's contracted pharmacy on 04/19/21 at 12:01 pm revealed:
-The pharmacy received an order on 02/01/21 for melatonin 3mg, 3 tablets (9mg) at bedtime.
-The pharmacy filled and dispensed 90 tablets on 02/01/21.
-As of today's date, 04/19/21, the facility had not requested a refill of the melatonin 3mg, 3 tablets at bedtime.
-Melatonin 5mg 2 tablets were last dispensed on 10/05/20 with a quantity of 60 tablets dispensed.
-The first and last time the pharmacy dispensed melatonin 5mg 2 tablets at bedtime was 10/05/20.

Interview with Resident #1 on 04/19/21 at 11:27 am revealed:
-Nightly, she was administered three tablets of melatonin 3mg for a total of 9mg.
-When she started getting the 9mg, the 10mg was stopped.
-She knew the difference between the 9mg and the 10mg because 9mg was three tablets with a number 3 on the tablet.
-The 10mg was two 5mg tablets.
-She was sure that she was administered 9mg of melatonin at bedtime.

Interview with a medication aide (MA) on 04/20/21 at 4:09 pm revealed:
-She worked the second shift and usually administered Resident #1's melatonin at bedtime.
-She administered Resident #1 the melatonin that was available in the medication cart.
-The medication manager (MM) was responsible for ensuring orders on the MAR were accurate.
-She had no explanation why she documented the administration of melatonin 9mg and melatonin 10mg.

Telephone interview with the Administrator on

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D 367	Continued From page 105 04/20/21 at 4:15 pm revealed: -The MM was responsible for auditing the MARs daily to ensure medication orders on the MARs were accurate. -The MM should have identified there were two orders for melatonin on Resident #1's MAR. -The facility did not have a system to audit behind the MM to ensure medication orders on the MAR were accurate. -She did not have an explanation why there were two orders for Resident #1's melatonin on the MAR. -She expected the MA to review the medication label before administering the medication and signing the MAR. -The MA should have identified there were two orders for melatonin on the MAR and notified the MM.	D 367		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of	D 392		

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D 392	Continued From page 106 controlled substances for 1 of 7 residents sampled (#4) who received medication for severe pain. The findings are: Review of Resident #4's current FL2 dated 02/14/20 revealed diagnoses were not completed on the FL2. Review of Resident #4's previous FL2 dated 11/26/18 revealed diagnoses included encephalopathy, chronic pain syndrome, muscle weakness, major depressive disorder, abnormality of gait, anxiety disorder, chronic obstructive pulmonary disease (COPD). Review of Resident #4's physician's orders revealed an order dated 03/02/21 for 25 tablets of hydrocodone/acetaminophen (a narcotic pain reliever used to treat moderate to severe pain) 5/325mg take 1 tablet every 6 hours as needed (prn) for up to 7 days for severe pain. Telephone interview with a medication technician at the facility's contracted pharmacy on 04/20/21 at 10:00 am revealed: -The pharmacy dispensed 25 tablets of hydrocodone/acetaminophen 5/325mg take 1 tablet every 6 hours as needed (prn) for up to 7 days for severe pain on 03/03/21. -The pharmacy delivery ticket was signed by a medication aide at the facility on 03/03/21 at 10:40 pm. -The pharmacy routinely sends a control substances count sheets (CSCS) with narcotic medications to be used by the facility for logging administration and tracking the controlled substance inventory. -The pharmacy had no documentation for the	D 392		

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D 392	Continued From page 107 return of any hydrocodone/acetaminophen 5/325mg for Resident #4. Review of Resident #4's March 2021 Medication Administration Record (MAR) revealed: -There was a handwritten entry for hydrocodone/acetaminophen 5/325mg take 1 tablet every 6 hours as needed (prn) for pain with space for documentation indicated from 03/02/21 to 03/07/21 (should have been 03/02/21 to 03/08/21 to allow for 7 days). -Hydrocodone/acetaminophen 5/325mg had prn scheduled as the time for administration. -Hydrocodone/acetaminophen 5/325mg was documented as administered for 11 doses on the front of the MAR from 03/03/21 to 03/07/21. -There was an entry for "STOP" handwritten on days 03/08/21 through 03/11/21. -There were no subsequent documentation for administration of hydrocodone/acetaminophen 5/325mg in March 2021. -A total of 14 tablets of hydrocodone/acetaminophen 5/325mg should be remaining. Review of Resident #4's April 2021 MAR revealed: -There was a preprinted entry for hydrocodone/acetaminophen 5/325mg take 1 tablet every 6 hours as needed for pain with prn scheduled as time for administration. -Hydrocodone/acetaminophen 5/325mg was not documented as administered from 04/01/21 through 04/19/21. Review of Resident #4's control substances count sheets (CSCS) revealed there was no CSCS for 25 hydrocodone/acetaminophen 5/325mg tablets dispensed on 03/03/21 available for review.	D 392		

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D 392	Continued From page 108 Observation of Resident #4's medications on hand on 04/19/21 revealed there was no hydrocodone/acetaminophen 5/325mg tablets on hand for the resident and no accounting for 14 tablets remaining from 25 tablets dispensed on 03/03/21. Interview with Resident #4 on 04/19/21 at 3:40 pm revealed: -She received some doses on a pain medication after she had surgery on her wrist on 03/02/21. -She remembered she only had the medication available for a few days because the way the provider wrote the order for the medication. -She did not remember when she was administered the last dose or exactly how many doses she received, only she had the pain medication for a few days. Interview with the Administrator on 04/19/21 at 4:45 pm revealed: -The Administrator started working -According to a medication technician for the facility's contracted Pharmacy, Resident #4's hydrocodone/acetaminophen 5/325mg was signed for by a staff when received by the facility on 03/03/21. -Controlled substance were supposed to be placed on the medication cart under double lock and the CSCS was supposed to be placed in the controlled medication log binder on the cart. -The controlled medication was logged out on the CSCS when administered and reconciled between shift changes. -When the CSCS was completed for documentation or administration for the quantity of medication dispensed, the completed sheet should be filed in the resident's record for tracking. -Controlled substances discontinued for use were	D 392		

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D 392	Continued From page 109 pulled from the medication cart by the Resident Care Coordinator (RCC), logged on a pharmacy return form, and placed in a locked controlled substance returns container until picked up by the contracted pharmacy delivery driver. -On 04/16/21 and 04/19/21, the Administrator, Contracted Nurse, and Medication Manager had searched through Resident #4's current supply of medications on the medication cart, including any overstock, and the facility's control substance returns storage for hydrocodone/acetaminophen 5/325mg dispensed on 11/04/20. -The staff were unable to locate the remaining hydrocodone/acetaminophen 5/325mg dispensed on 03/03/21. -The medication aide (MA) that signed for Resident #4's hydrocodone/acetaminophen 5/325mg dispensed on 03/03/21 no longer worked at the facility. -The Resident Care Coordinator (RCC) at the time would have been the staff that removed discontinued medications from the medication cart and would have been responsible for completing a Controlled Return sheet and sending the medication back to the contracted Pharmacy. The RCC left the facility 4 weeks ago. -The former RCC had not answered attempted phone calls or responded to telephone messages left by the Administrator. -Currently, the facility has a Medication Manager responsible for removing medications from the medication cart and the MAR. -A copy of the CSCS and the Controlled Drug Return sheet should be available for review but were unable to be found. -The Administrator had contacted the contracted pharmacy on 04/19/21 requesting documentation for return of Resident #4's hydrocodone/acetaminophen 5/325mg dispensed on 03/03/21 but was told there was no	D 392		

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D 392	Continued From page 110 documentation for the return of the medication. -Resident #4's hydrocodone/acetaminophen 5/325mg dispensed on 03/03/21 was missing the CSCS and the remaining 14 tablets, with no administration documented, could not be accounted for. Interview with the Medication Manager (MM) on 04/19/21 at 5:00 pm revealed: -She started working at the facility on 03/10/21 or 03/11/21 while the former RCC was still working at the facility. -She had not seen any hydrocodone/acetaminophen 5/325mg for Resident #4. -She would have completed a Controlled Substance Return form and sent the medication to the pharmacy if she had been responsible for returning the discontinued medication. Interview with a first shift medication aide (MA) on 04/20/21 at 1:49 pm revealed: -She recalled Resident #4 had some hydrocodone/acetaminophen 5/325mg on the medication cart after her surgery in March 2021. -There was a CSCS sheet in the controlled log book on the medication cart. -The RCC or the MM would have been responsible to remove the CSCS and the medication unless the CSCS was documenting a zero count and the medication card was empty. -The MAs were responsible to remove completed CSCS and place in a bin for the RCC or MM to process. -She did not know when or who removed Resident #4's hydrocodone/acetaminophen 5/325mg from the medication cart. she did not witness the removal. The facility failed to ensure a readily retrievable	D 392		

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D 392	Continued From page 111 record of controlled substances by documenting the administration and disposition of Resident #4's hydrocodone/acetaminophen 5/325mg with 14 tablets unaccounted for. The failure of the facility to locate the Controlled Substance Count Sheets or documentation that controlled drugs were returned to the pharmacy was detrimental to the safety, health, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/19/20 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 04, 2021.	D 392		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to notify the county Department of Social Services (DSS) of incidents for 2 of 2 sampled residents (#4 and #6) related to 2 incidents requiring referral for emergency medical evaluation or treatment for Resident #4 and incidents requiring referral for emergency medical evaluation or treatment for Resident #6.	D 451		

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D 451	Continued From page 112 The findings are: Review of the facility Reporting of Accidents and Incidents Policy (not dated) revealed: -The facility will notify the county department of social services in the event of any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or any treatment other than first aide. -The report will provide the following information: residents name, name of staff who discovered the accident or incident, name of person preparing the report, when, where, and how the accident or incident occurred, nature of the injury, what was done for the resident, time of notification to the residents responsible party, and signature of the administrator. -The report will be sent to the county within 48 hours after the accident or incident. 1. Review of Resident #4's current FL2 dated 02/14/20 revealed: -Diagnoses were not completed on the FL2. -There was no documentation for cognitive status, ambulation, bowel or bladder status, or care assessment. Review of Resident #4's previous FL2 dated 11/26/18 revealed: -Diagnoses included encephalopathy, chronic pain syndrome, muscle weakness, major depressive disorder, abnormality of gait, anxiety disorder, chronic obstructive pulmonary disease (COPD). -Resident #4 was semi-ambulatory, continent to bowel and bladder, and had continuous oxygen at 3 liters.	D 451		

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D 451	Continued From page 113 Review of Resident #4's emergency medical services reports (EMS) revealed: -There was a patient care report dated 02/05/21 documenting Resident #4 was transported out of the facility at 7:30 am for "left wrist pain". -There was a patient care report dated 02/12/21 documenting Resident #4 was transported out of the facility at 1:54 pm for "fiberglass cast". Review of the facility's binder for Incident and Accident (I/A) Reports on 04/19/21 revealed: -The binders was divided into months of the year. -The I/A reports completed for residents were filed by the month in which the I/A report was completed. -There were no I/A reports filed in the binder for Resident #4 documenting incidents on 02/05/21 or 02/12/21. Review of Resident #4's hospital encounter form dated 02/05/21 revealed: -The primary diagnosis was left wrist pain. -There were instructions for self care of a fractured wrist included. -There were instructions for care of a cast or splint. Review of Resident #4's hospital encounter form dated 02/12/21 revealed: -The primary diagnosis for the encounter was left wrist pain and cast discomfort. -There were instructions for care of a cast or splint. Telephone interview with the DSS Adult Home Specialist (AHS) on 04/20/21 at 10:34 am revealed she had not received any notification from the facility of Resident #4's referral for emergency medical evaluation or treatment for incidents that occurred on 02/05/21 or 02/12/21.	D 451		

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D 451	Continued From page 114 Refer to interview with a medication aide (MA) on 04/20/21 at 1:30 pm. Refer to interview with a second MA on 04/20/21 at 2:04 pm. Refer to interview with the Resident Care Director (RCD) on 04/20/21 at 4:35 pm. Refer to interview with the Administrator on 04/19/21 at 12:42 pm. 2. Review of Resident #6's current FL2 dated 02/16/21 revealed: -Diagnoses included encephalopathy, diabetes mellitus type II, hypertension, mild cognitive impairment, chronic obstructive pulmonary disease (COPD), coronary artery disease, heart disease, major depressive disorder, falls, and muscle weakness. -Resident #6 was intermittently disoriented. -Resident #6 was semi-ambulatory. Review of Resident #6's incident/accident (I/A) reports revealed: -On 01/15/21 at 9:15 pm, Resident #6 yelled for help and was found on the floor beside her bed lying on her right side. -She stated she had been asleep and fell out of the bed and hit her head on the nightstand. -There was documentation of two skin tears on her right arm. -Emergency Medical Services (EMS) was called and assessed the resident, but she refused to go to the emergency room. Review of Resident #6's care notes revealed there were no care notes documented on 01/15/21.	D 451		

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D 451	Continued From page 115 Telephone interview with the Adult Home Specialist (AHS) with the local department of Social Services (DSS) on 04/19/21 at 3:18 pm revealed: -The county had not received any incident/accident reports from the facility. -She looked specifically for an incident/accident report dated 01/15/21 but did not have one. Review of Resident #6's I/A reports revealed: -On 01/16/21 at 7:40 pm, Resident #6 yelled for help and was found on the floor beside her bed sitting "Indian style". -She stated she fell out of the bed again. -There was documentation she was bleeding from her chin from a laceration about 2 inches long, and she complained of head and back pain. Review of Resident #6's EMS report dated 01/16/21 revealed she was transported to a local Emergency Room (ER) due to a chin laceration that required stitches. Review of Resident #6's hospital discharge summary dated 01/19/21 revealed: -The reason for the ER visit was documented as a fall. -Resident #6 was diagnosed with a contusion of her right knee and low back pain. Review of Resident #6's I/A reports revealed there was no report available for the fall on 01/19/21. Review of Resident #6's hospital discharge summary dated 01/26/21 revealed: -The reason for the ER visit was documented as a fall. -Resident #6 was diagnosed with a contusion of	D 451		

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D 451	Continued From page 116	D 451		

her scalp and back, and while at the ER, the stitches from a previous injury were removed.

Review of Resident #6's I/A reports revealed there was no report available for the fall on 01/26/21.

Review of the facility's binder for I/A Reports on 04/19/21 revealed:
-The binders were divided into months of the year.
-The I/A reports completed for residents were filed by the month in which the I/A report was completed.
-There were no I/A reports filed in the binder for Resident #6 documenting incidents on 01/19/21 or 01/26/21.

Telephone interview with the local DSS AHS on 04/19/21 at 3:18 pm revealed she had not received any notification from the facility of Resident #6's referral for emergency medical evaluation or treatment for incidents that occurred on 01/15/21, 01/16/21, 01/19/21, or 01/26/21.

Refer to interview with a medication aide (MA) on 04/20/21 at 1:30 pm.

Refer to interview with a second MA on 04/20/21 at 2:04 pm.

Refer to interview with the Resident Care Director (RCD) on 04/20/21 at 4:35 pm.

Refer to interview with the Administrator on 04/19/21 at 12:42 pm.

_____

Interview with a MA on 04/20/21 at 1:30 pm revealed:
-The MAs fill out the incident/accident reports

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THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

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D 451	Continued From page 117	D 451		

after an incident/accident.
-The MA gave the incident/accident report to the medication manager (MM) or the RCD.
-The MM or RCD reviewed the incident and gave the incident/accident report to the Administrator.
-The Administrator was responsible for sending the reports to the county for anything above a band-aid.

Interview with a second MA on 04/20/21 at 2:04 pm revealed:
-The MAs completed the incident/accident reports and placed them in a mailbox for the MM or the nurse to review.
-The MAs were not responsible for sending the incident/accident reports to the county and had never been asked or instructed to do so.

Interview with the Resident Care Director (RCD) on 04/20/21 at 4:35 pm revealed:
-She was just hired and her first day was 04/19/21.
-She would be responsible for ensuring the incident/accident reports were sent to the county and she would keep the fax confirmation for documentation.

Interview with the Administrator on 04/19/21 at 12:42 pm revealed:
-She did not have fax confirmations for any of the incidents/accident reports.
-She did not know the incident/accident reports had not been sent to the county.
-The medication aides were responsible for completing an incident/accident report when there was an incident or accident.
-The incident /accident report was supposed to have time, date, what happened, who was notified, and any injury obtained with the incident/accident.

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D 451	Continued From page 118 -The medication manager and the RCD were responsible for ensuring the reports were sent to the county for anything above a band-aid. -There had not been a RCD in the building for the last 5 weeks.	D 451		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration, implementation, housekeeping and furnishings, controlled substances, personal care and supervision and Ach medication aides; training and competency. The findings are: 1. Based on observations, interviews, and record reviews, the Administrator failed to ensure the overall management, operations, policies and procedures and total operations of the facility were implemented, maintained, and in substantial compliance with the rules and statutes to meet and maintain rules related to housekeeping and furnishings, personal care and supervision, medication administration, controlled substances, and Adult Care Home Medication Aide training	D912		

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D912	Continued From page 119	D912		

and competency. [Refer to Tag D0980, G.S. D131-25 Implementation (Type A2 Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (Resident #8 and #9) sampled during the 8:00 am medication pass on 04/16/21 related to a medication to treat anxiety (#8), and a medication to treat diabetic neuropathy (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and #11) for record reviews related to a medication used to thin the blood, a medication to treat bipolar disorder, a medication for nausea, and a laxative (#1); a medication for pain, and a medication for muscle spasms (#2); a medication for acid reflux, a medication for anxiety, a medication for insomnia, a vitamin supplement, and a medication to treat depression (#4); a medication to treat acid reflux, a medication for diabetic neuropathy, and a steroidal medication for breathing (#6); and a medication to treat diabetes (#7 and #11).[Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].

3. Based on observations, interviews and record reviews the facility failed to provide adequate supervision for 1 of 2 sampled residents (#6) with a history of falls resulting in a laceration requiring sutures and required emergency room (ER) evaluation on 3 occasions. [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].

4. Based on interviews and record reviews, the facility failed to ensure the completion of the 5, 10, or
15-hour medication aide training and the medication aide clinical skills validation for 2 of 3

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D912	Continued From page 120 sampled staff (Staff A and B) who administered medication. [Refer to Tag D0935, G.S. 131D-4.5B(b) Ach Medication Aides; Training And Competency (Type B Violation)]. 5. Based on observations and interviews, the facility failed to ensure doors and floors were kept clean and in good repair in 3 of 14 resident bedrooms (301, 307, and 311) on the third floor. [Refer to Tag D0074, 10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings (Type B Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances for 1 of 7 residents sampled (#4) who received medication for severe pain. [Refer to Tag D0392, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].	D912		
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	D935		

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D935	Continued From page 121 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 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 interviews and record reviews, the facility failed to ensure the completion of the 5, 10, or 15-hour medication aide training and the medication aide clinical skills validation for 2 of 3 sampled staff (Staff A and B) who administered medication. The findings are:	D935		

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D935	Continued From page 122 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A's date of hire was 03/22/21 as a personal care aide (PCA). -She accepted the Medication Manager (MM) position on 04/09/21. -There was no documentation Staff A completed the state approved 5, 10 or 15 hour medication training. -There was documentation of employment for the previous 6 months at another facility as a MA. -There was documentation she passed the state approved medication aide written exam in December 2014. Review of a Medication Administration Record (MAR) revealed Staff A administered medication 04/02/21 and 04/04/21. Telephone interview with Staff A on 04/20/21 at 3:57 pm revealed: -She was hired in March 2021 as a PCA and took the MM position on 04/09/21. -She received MA training and passed the test in another facility in 2014. -She worked as a MM at the facility and administered medications as a MA to residents as needed when staffing was short. -She completed some medication training with the facility contract nurse at the end of March 2021. -The facility contract nurse printed the completed certificates, but she did not know if she filed them in her personnel record. Interview with the Administrator on 04/19/21 at 4:10 pm revealed: -She became the Administrator on 03/03/21. -All missing MA training, Medication	D935		

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D935	Continued From page 123 Administration Clinical Skills Validation, and state medication exams could not be found, "We don't have it". -The MAs personnel records had been reviewed and they were unable to find them. -The previous Resident Care Director (RCD) and Administrator was responsible for making sure all training and validation were completed by MAs prior to passing medications. -There had not been a qualified nurse employed at the facility during the time Staff A should have received Medication Administration Clinical Skills Validation and 5 hour medication aide training. -The new RCD was hired to begin 04/19/21. -The new RCD would be responsible for Medication Administration Clinical Skills Validation 5, 10 and 15 hour medication aide training. -She validated employment for Staff A for the previous 6 months at a previous facility, where they both were previously employed. -She did not realize Staff A needed validation of employment as a MA for the previous 24 months. Refer to interview with facility's Contract Nurse on 04/19/2021 at 4:20 pm. Refer to interview with the RCD on 04/19/21 at 4:25 pm. 2. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B's date of hire was 02/07/21. -There was no documentation Staff B completed a Medication Administration Clinical Skills Validation Checklist. -There was no documentation Staff B had passed the state medication aide exam. -There was no documentation Staff B had completed the state approved 5 hour medication training.	D935		

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D935	Continued From page 124 -There was no verification of employment as a MA at another Adult Care Home for the previous 24 months. Review of a Medication Administration Record (MAR) revealed Staff B administered medication 04/02/21 through 04/05/21, 04/14/21 and 04/16/21. Interview with Staff B on 04/19/21 at 3:50 pm revealed: -She was hired in February 2021 as a personal care aide (PCA). -The previous Administrator asked her to train on the medication cart at the end of February 2021. -She was trained on the medication cart by a previously employed MA. -She was not familiar with the Medication Administration Clinical Skills Validation Checklist. -She did not complete any 5, 10 or 15 hour medication training. -She did not take the state approved medication aide written exam. -She did not know she needed to be checked off and have 5 hour medication training from a nurse before she could administer medications to residents. Interview with the Administrator on 04/19/21 at 4:10 pm revealed: -She became the Administrator on 03/03/21. -All missing MA training, Medication Administration Clinical Skills Validation, and state medication aide written exams could not be found, We don't have it. -The MAs personnel records had been reviewed and they were unable to find them. -The previous Resident Care Director (RCD) and Administrator was responsible for making sure all training and validation were completed by MAs	D935		

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D935	Continued From page 125	D935		

prior to passing medications.
-There had not been a qualified nurse employed at the facility during the time Staff B should have received Medication Administration Clinical Skills Validation and 5 hour medication aide training.
-The new RCD was hired to begin 04/19/21.
-The new RCD would be responsible for Medication Administration Clinical Skills Validation and the 5, 10 and 15 hour medication aide training.
-Staff B was hired by the previous Administrator.
-Staff B was working as a MA when she became Administrator in March 2021.
-She did not know Staff B did not have Medication Administration Clinical Skills Validation.
-She did not know Staff B did not have 5 hour medication aide training.

Interview with the facility's Contracted Nurse on 04/19/21 at 4:20 pm revealed:
-She was a temporarily contracted in late March 2021 to help train MAs as well as other tasks within the facility.
-The Administrator gave her the tasks she needed to complete for the facility, such as MA training or Licensed Health Professional Support evaluations for residents.
-She did not know Staff A did not have state approved 5 hour medication aide training.
-She did not know Staff B did not have state approved 5 hour medication aide training.
-She did not know Staff B did not have Medication Administration Clinical Skills Validation Checklist.

Interview with Resident Care Director (RCD) on 04/19/21 at 4:25 pm revealed:
-She had a hire date of 04/19/21 as the RCD.
-MAs should have Medication Administration Clinical Skills Validation before administering medications to residents.

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D935	Continued From page 126 -She was responsible for 5, 10 and 15 hour MA training. -A contracted nurse would assist with MA training when needed. _____ The facility failed to ensure the Medication Administration Clinical Skills Validation was completed for 1 of 3 staff and the 5 hour training for 2 of 3 staff prior to administering medications to the residents, placing the residents at risk for medication administration errors. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/19/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 04, 2021.	D935		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the overall management, operations, policies and procedures and total operations of the facility	D980		

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D980	Continued From page 127	D980		

were implemented, maintained, and in substantial compliance with the rules and statutes to meet and maintain rules related to housekeeping and furnishings, personal care and supervision, medication administration, controlled substances, and Adult Care Home Medication Aide training and competency.

The findings are:

Interview with the Administrator on 04/20/21 at 4:01 pm revealed:
-She had begun her role as Administrator in March 2021.
-The building had a lot of issues she had been working on.
-It was everyone's responsibility to ensure all the residents were supervised but she was ultimately responsible for ensuring staff did their jobs.
-The Medication Manager (MM) and Resident Care Director (RCD) were responsible for everything clinical but she was ultimately responsible for ensuring they did their job correctly.
-The RCD and herself were responsible to ensure the facility was adequately staffed.
-She was responsible for ensuring compliance with of the rules and regulations within the facility.
-She was ultimately responsible for all staff and departments within the facility.

Interview with MA on 04/20/21 at 4:27 pm revealed:
-MAs were responsible for administering medications as ordered.
-The MM was responsible for ensuring all medications were in the building.
-The RCD was responsible for all clinical staff and training.
-The Administrator was responsible for the entire

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D980	Continued From page 128 facility. Interview with the RCD on 04/20/21 at 4:35 pm revealed: -She had just started her position on 04/19/21. -She was responsible for everything clinical which included ensuring medications were in the building and administered as ordered, medication and cart audits, training medication aides, and ensuring the care team provided supervision for the residents. -The Administrator was ultimately responsible for the entire facility. Interview with the RCD on 04/21/21 at 12:08 pm revealed the Administrator was no longer employed at the facility as of 04/21/21. Non-Compliance was identified at violation level in the following rule areas: 1. Based on observations, interviews and record reviews the facility failed to provide adequate supervision for 1 of 2 sampled residents (#6) with a history of falls resulting in a laceration requiring sutures and required emergency room (ER) evaluation on 3 occasions. [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (Resident #8 and #9) sampled during the 8:00 am medication pass on 04/16/21 related to a medication to treat anxiety (#8), and a medication to treat diabetic neuropathy (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and #11) for record reviews related to a medication used to thin the blood, a medication to treat bipolar	D980		

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D980	Continued From page 129 disorder, a medication for nausea, and a laxative (#1); a medication for pain, and a medication for muscle spasms (#2); a medication for acid reflux, a medication for anxiety, a medication for insomnia, a vitamin supplement, and a medication to treat depression (#4); a medication to treat acid reflux, a medication for diabetic neuropathy, and a steroidal medication for breathing (#6); and a medication to treat diabetes (#7 and #11). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 3. Based on observations and interviews, the facility failed to ensure doors, and floors were kept clean and in good repair in 3 of 14 resident bedrooms (301, 307, and 311) on the third floor. [Refer to tag 0074 10A NCAC 13F .0306 (a)(1) Housekeeping and Furnishings (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances for 1 of 7 residents sampled (#4) who received medication for severe pain. [Refer to Tag D0392, 10A NCAC 13F .1008 (a) Controlled Substances (Type B Violation)] 5. Based on interviews and record reviews, the facility failed to ensure the completion of the 5, 10, or 15-hour medication aide training and the medication aide clinical skills validation for 2 of 3 sampled staff (Staff A and B) who administered medication. [Refer to Tag D935 G.S. 131D-4.5B(b) Ach Medication Aide; Training and Competency (Type B Violation).]	D980		

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D980	Continued From page 130 The facility failed to ensure responsibility for the overall management, administration, supervision and operation of the facility which resulted in a resident (#6) with 7 falls which resulted in multiple trips to the emergency room with a chin laceration requiring several stitches, a scalp contusion, a knee contusion, and skin tears; medications were not administered as ordered for 6 of 9 sampled residents which resulted in a resident with a history of pulmonary embolism placed at risk for a blood clot due to not receiving a medication used to thin the blood, not receiving a medication to treat bipolar disorder which could result in increased behaviors, not receiving a laxative which could result in increased abdominal discomfort and constipation (#1); a resident not receiving a medication for pain and a medication for muscle spasms resulting in increased pain (#2); a resident not receiving a medication for acid reflux which resulted in abdominal and esophageal pain, not receiving a medication to treat the anxiety resulting in unnecessary anxiety from breathing difficulty associated with COPD and not receiving a medication for insomnia, and depression resulting in increased depression (#4); a resident not receiving a medication for diabetic neuropathy resulting in increased pain requiring a stronger pain reliever, and not receiving a steroidal medication post hospitalization for a COPD exacerbation (#6); and two residents with elevated blood sugars not receiving a short acting insulin which could result in nerve and organ damage (#7 and #11); failed to ensure floors were kept clean and in good repair as evidenced by a sewage leak from underneath a toilet in a resident room causing sewage stains on the flooring, and ongoing exposure to raw sewage in the bathroom increasing the risk of infection; failed to ensure a readily retrievable record of controlled substances	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	R 04/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

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D980	Continued From page 131 of hydrocodone/acetaminophen 5/325mg (#4) resulting in 14 tablets unaccounted for; and failed to ensure the Medication Administration Clinical Skills Validation was completed for 1 of 3 staff and the 5 hour training for 2 of 3 staff prior to administering medications to the residents which placing the residents at risk for medication administration errors. This failure placed residents at substantial risk of physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on April 20, 2021. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 20, 2021.	D980		