STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 09/22/21 and 09/23/21.	{D 000}		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 3 of 5 sampled residents (#1, #2, #5) regarding orders for notification of the primary care provider (PCP) of blood sugars outside of ordered parameters (#1), notification of the PCP for blood pressures outside of the ordered parameters (#2), checking a resident's pulse (heart rate) as ordered (#5), and checking oxygen levels for 2 residents who were receiving oxygen (#2, #5). The findings are: 1. Review of Resident #1's current FL-2 dated 07/14/21 revealed diagnoses included diabetes mellitus and hypertension. Review of Resident #1's physician orders dated 07/14/21 revealed: -There was an order to obtain a fingerstick blood sugar (FSBS) three times daily; use per sliding scale.	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 276}	Continued From page 1 -FSBS were ordered to be checked at 7:30am, 11:30am and 5:00pm. -Sliding scale insulin for Novolog Flexpen U-100 Insulin was ordered as follows: -If blood sugar was 150-200, give 2 units of insulin. -If blood sugar was 201-250, give 4 units of insulin. -If blood sugar was 251-300, give 6 units of insulin. -If blood sugar was 301-350, give 8 units of insulin. -If blood sugar was 351-400, give 10 units of insulin. -If blood sugar was 401-500, give 12 units of insulin. -If blood sugar was greater than 500, give 12 units of insulin and call the primary care physician (PCP). Review of Resident #1's August 2021 electronic medication record (eMAR) revealed: -There was an order to obtain the residents FSBS three times a day, at 7:00am, 11:30am and 5:00pm with parameters to call the PCP if blood sugars were greater than 500. -There was an entry on 08/30/31 with a FSBS of 500 documented at 5:00pm, with 12 units of insulin administered. -There was an entry on 08/31/21 with a FSBS of 543 documented at 5:00pm, with 12 units of insulin administered. -There was no documentation that Resident #1's PCP was notified of the FSBS over 500 on 08/30/21 or 08/31/21 on the eMAR. Review of Resident #1's September 2021 eMAR revealed: -There was an order to obtain the residents FSBS three times a day, at 7:00am, 11:30am and	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 276}	Continued From page 2 5:00pm with parameters to call the PCP if blood sugars were greater than 500. -There was an entry on 09/02/21 with a FSBS of 500 documented at 5:00pm, with 12 units of insulin administered. -There was an entry on 09/05/21 with a FSBS of 597 documented at 11:30am, with 12 units of insulin administered. -There was an entry on 09/06/21 with a FSBS of 585 documented at 11:30am, with 12 units of insulin administered. -There was no documentation that Resident #1's PCP was notified of the FSBS over 500 on 09/02/21, 09/05/21 or 09/06/2 on the eMAR. Interview with a medication aide (MA) on 09/23/21 at 11:14 revealed: -She was expected to contact Resident #1's PCP if his FSBS was over 500. -MAs were expected to fax an update to the PCP if his FSBS was over 500. -She did not know why she did contact the PCP when his FSBS was over 500. Review of physician orders and electronic progress notes revealed there was no documentation of communication with the PCP about Resident #1's FSBS being over 500 on 08/30/21, 08/31/21, 09/02/21, 09/05/21 and 09/06/21. Interview with a second MA on 09/23/21 at 2:04pm revealed: -When Resident #1's FSBS was over 500 she faxed a report to the PCP. -She would scan the faxed report into the facility's electronic records for the Resident Care Coordinator (RCC) to review the next day. -The PCP would contact the RCC or MA with any new orders.	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 276}	Continued From page 3 -She did not call the PCP when the residents FSBS was over 500 because MAs had been directed by the RCC to fax a report instead of calling the PCP. Interview with the RCC on 09/23/21 at 3:20pm revealed: -MAs were expected to fax a report to Resident #1's PCP if his FSBS was over 500. -She and the Administrator had directed MAs to fax reports to the PCP instead of calling them. -She was not aware that MAs had not contacted the resident's PCP when his FSBS was over 500. -She expected MAs to contact her if the residents FSBS was over 500 and she would call the PCP. Interview with the Administrator on 09/23/21 at 6:21pm revealed: -She expected MAs to report to her, the RCC, and the PCP if a residents FSBS was over 500. -MAs faxed reports to the PCP instead of calling the PCP. -She and the RCC needed to establish a new policy to ensure the PCP is contacted as soon as possible if a residents FSBS was over 500. Attempted telephone interview with Resident #1's PCP on 09/23/21 at 4:40pm was unsuccessful. 2. Review of Resident #2's current FL-2 dated 08/10/21 revealed diagnoses included diabetes mellitus type 2, hypoxia (low oxygen in your blood), acute respiratory disease, hypertension (high blood pressure), history of stroke, and history of sarcoidosis (inflammatory disease that most commonly affects the lungs). a. Review of Resident #2's hospital discharge summary dated 08/10/21 and signed by a hospital provider revealed:	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 276}	Continued From page 4	{D 276}		

-The resident was admitted to the hospital on 08/06/21 for evaluation of worsening shortness of breath and fatigue for about a week.
-The resident was admitted for suspected congestive heart failure exacerbation, hypertensive urgency (very high blood pressure usually with no acute organ damage), and acute renal (kidney) failure.
-The resident was discharged from the hospital on 08/10/21 with a diagnosis of hypertensive urgency.

Review of Resident #2's current FL-2 dated 08/10/21 and signed by the primary care provider (PCP) revealed there was an order to take blood pressure (BP) daily, contact primary care provider (PCP) if BP was out of the following parameters: systolic blood pressure (SBP) > (greater than) 180 or diastolic blood pressure (DBP) > 100.

Review of Resident #2's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for BP to be checked and contact the PCP for SBP > 180 or DBP > 100.
-The resident's BP was documented daily from 09/01/21 - 09/22/21.
-The resident's BP ranged from 116/70 - 175/106 from 09/01/21 - 09/22/21.
-The resident's DBP was 102 on 09/01/21 and 106 on 09/06/21.
-There was no documentation on the eMAR that the resident's PCP was notified of the two DBPs >100.

Interview with a medication aide (MA) on 09/23/21 at 2:04pm revealed:
-Resident #2's BP was checked daily at 8:00am.
-If the resident's BP was outside of the parameters, the MAs would fax the PCP at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 276}	Continued From page 5	{D 276}		

time the parameter was obtained and scan the fax sheet into the electronic system.
-The Resident Care Coordinator (RCC) would see the fax in the electronic system and file it in the resident's electronic file.
-For Resident #2's BP of 170/102 on 09/01/21, there would be a fax to the PCP if the PCP was notified.
-She did not document contact with the PCP on the eMAR or in the electronic progress notes.
-If there was no faxed document, the PCP was not notified.
-She did not know why she did not notify the PCP on 09/01/21 for the DBP > 100.

Interviews with Resident #2 on 09/22/21 at 10:05am and 09/23/21 at 4:51pm revealed:
-The MAs checked her BP every day.
-Her BP "went high" sometimes.
-She could not describe how she felt when her BP was high except it made her feel "funny".

Interview with the RCC on 09/23/21 at 5:55pm revealed if a resident's BP was outside of the ordered parameters, the MAs were responsible for faxing the PCP.

Attempted telephone interview with Resident #2's PCP on 09/23/21 at 4:40pm was unsuccessful.

b. Review of Resident #2's signed physician's order sheets dated 06/30/21 revealed there was an order to check pulse oxygen every day. (Pulse oxygen is the amount of oxygen levels in the blood. A pulse oximeter is a device used to measure the amount of oxygen levels in the blood.)

Review of Resident #2's FL-2 dated 08/10/21 and signed by the primary care provider (PCP)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 276}	Continued From page 6	{D 276}		

revealed there was an order to check pulse oxygen every day.

Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for pulse (heart rate) once a day but the special instructions for the entry was to check pulse oxygen (oxygen levels) every day with scheduled time of 9:00am.
-There were rows for pulse and results to be documented.
-The resident's pulse was documented daily and ranged from 59 - 119 from 08/01/21 - 08/31/21.
-There was no row to document the resident's pulse oxygen levels.
-There were no entries on the eMAR documenting any pulse oxygen levels as ordered.

Review of Resident #2's September 2021 eMAR revealed:
-There was an entry for pulse once a day but the special instructions for the entry was to check pulse oxygen every day with scheduled time of 9:00am.
-There were rows for pulse and results to be documented.
-The resident's pulse was documented daily and ranged from 83 - 109 from 09/01/21 - 09/22/21.
-There was no row to document the resident's pulse oxygen levels.
-There were no entries on the eMAR documenting any pulse oxygen levels as ordered.

Interview with a medication aide (MA) on 09/23/21 at 2:04pm revealed:
-She had not noticed the special instructions on Resident #2's eMAR for the pulse entry noted to check the pule oxygen levels.
-She had not checked the resident's pulse oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 276}	Continued From page 7	{D 276}		

levels.
-There was a pulse oximeter in the medication cart that could be used to check a resident's oxygen level.

Observation of the medication cart on 09/23/21 at 4:10pm revealed there was a pulse oximetry machine in the top drawer of the medication cart.

Interview with Resident #2 on 09/23/21 at 4:51pm revealed:
-She had breathing problems and she also used oxygen, inhalers, and a nebulizer machine.
-The physical therapist (PT) usually checked her oxygen levels when she had physical therapy a few times per week.
-Her oxygen levels were "running good" when PT checked it.
-The facility staff did not check her oxygen levels.

Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 6:29pm revealed:
-She was not aware Resident #2's oxygen levels were not being checked as ordered.
-The MAs should report any discrepancy on the eMARs to her.
-She expected the MAs to check the resident's oxygen levels as ordered.

Attempted telephone interview with Resident #2's PCP on 09/23/21 at 4:40pm was unsuccessful.

3. Review of Resident #5's current FL-2 dated 09/15/21 revealed diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, weakness, and end stage renal disease (ESRD).

a. Review of Resident #5's current FL-2 dated 09/15/21 revealed there was an order to check

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 276}	Continued From page 8 the resident's pulse oximeter (blood oxygen saturation) daily. Review of Resident #5's previous physician's orders dated 06/30/21 revealed there was an order to check the resident's pulse oximeter daily. Review of Resident #5's current assessment and care plan dated 07/13/21 revealed the resident was short of breath and required oxygen. Review of Resident #5's current Licensed Health Professional Support (LHPS) quarterly evaluation and review dated 08/31/21 revealed: -The resident required oxygen administration and monitoring. -The resident wore 2 liters per minute of continuous oxygen via nasal cannula. Observation of the medication cart on 09/23/21 at 4:18pm revealed a pulse oximeter machine was present on the medication cart for use. Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed: -There was no entry to obtain the resident's pulse oximeter daily. -There was no documentation that the resident's pulse oximeter had been obtained daily. Review of Resident #5's vital sign results from 07/01/21-09/22/21 revealed the resident's pulse oximeter reading was never documented as obtained. Interview with Resident #5 on 09/22/21 at 2:12pm revealed: -The facility obtained his vital signs once per month.	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 276}	Continued From page 9 -The facility did not check his vital signs daily. Interviews with the Resident Care Coordinator (RCC) on 09/23/21 at 9:33am and 5:53pm revealed: -Orders for residents were faxed to the pharmacy by medication aides (MA) or the RCC when received from the residents' provider. -The pharmacy then processed the order and entered the order onto the resident's eMAR as a pending order. -The order was then approved for use by the RCC or the Administrator and would become an active task. -There was no process in place to ensure accuracy of the orders that were approved matched the original order. -Tasks such as vital signs should appear on the eMAR if there was a current order for a resident. -If a task did not show up on a resident's eMAR, the MAs would not know to perform the task. -If a vital sign task did not show up on a resident's eMAR, there was nowhere else the task or information would be documented. -She was not aware that Resident #5's order to obtain his pulse oximeter daily was not on his eMAR. -She must have missed the order when she performed chart audits. -The pharmacy should have entered the order when she faxed the FL-2 to them. -If the pharmacy did not enter an order for tasks such as vital signs, it was the RCC or Administrator's responsibility to enter the order manually. -She was responsible to ensure orders appeared accurately on the eMAR so the staff knew to perform the task as ordered. -She was concerned that the order was not being carried out because Resident #5's primary care	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 276}	Continued From page 10 provider (PCP) ordered the task for a reason. Interview with the Administrator on 09/23/21 at 6:21pm revealed: -She was not aware that Resident #5's order to obtain his pulse oximeter daily was not on his eMAR. -If the pharmacy did not enter an order for tasks such as vital signs or weights on a resident's eMAR, it was the RCC's responsibility to enter the order manually. -She expected the RCC to ensure accuracy of orders on the eMAR when approving them from the pharmacy as compared to the original order to ensure residents received the care that was ordered. Telephone interview with a pharmacist with the facility's contracted pharmacy on 09/23/21 at 10:50am revealed: -The pharmacy had not received a fax from the facility for Resident #5's FL-2 dated 09/15/21. -Once an order was received from the facility via fax, it was entered onto the corresponding resident's eMAR and sent back to the facility for approval to make it active. -It was the facility's responsibility to ensure the order was accurate prior to approving an order. -If the facility found that an order was inaccurate or missing, they could request that the pharmacy clarify and fix the order, or the facility could clarify and fix the order themselves manually. -The pharmacy could not see when the facility had approved an order. -The pharmacy did not usually enter vital sign or weight orders unless they were attached to a medication order. -Entering vital sign orders that were not attached to a medication order was a courtesy and something the pharmacy would only do upon	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 276}	Continued From page 11 request from the facility. Attempted telephone interview with Resident #5's PCP on 09/23/21 at 4:40pm was unsuccessful. b. Review of Resident #5's current FL-2 dated 09/15/21 revealed there was an order to check the resident's pulse (heart rate) daily. Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed: -There was no entry to obtain the resident's pulse daily. -There was no documentation that the resident's pulse had been checked daily. Review of Resident #5's vital sign results from 07/01/21-09/22/21 revealed the resident's pulse was documented once on 09/18/21 at 92 beats per minute. Interview with Resident #5 on 09/22/21 at 2:12pm revealed: -The facility checked his vital signs once per month. -The facility did not check his vital signs daily. Interviews with the Resident Care Coordinator (RCC) on 09/23/21 at 9:33am and 5:53pm revealed: -Orders for residents were faxed to the pharmacy by medication aides (MA) or the RCC when received from a resident's provider. -The pharmacy then processed the order and entered the order onto the resident's eMAR as a pending order. -The order was then approved for use by the RCC or the Administrator and would become an active task.	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 276}	Continued From page 12 -There was no process in place to ensure accuracy of the orders that were approved matched the original order. -Tasks such as vital signs and weights should appear on the eMAR if there was a current order for a resident. -If a task did not show up on a resident's eMAR, the MAs would not know to perform the task. -If a vital sign task did not show up on a resident's eMAR, there was nowhere else the task or information would be documented. -She was not aware that Resident #5's order to obtain his pulse daily was not on his eMAR. -She must have missed the order when she performed chart audits. -Pharmacy should have entered the order when she faxed the FL-2 to them. -If the pharmacy did not enter an order for tasks such as vital signs, it was the RCC or Administrator's responsibility to enter the order manually. -She was responsible to ensure orders appeared accurately on the eMAR so the staff knew to perform the task as ordered. -She was concerned that the order was not being carried out because Resident #5's ordered the task for a reason. Interview with the Administrator on 09/23/21 at 6:21pm revealed: -She was not aware that Resident #5's order to obtain his pulse daily was not on his eMAR. -If the pharmacy did not enter an order for tasks such as vital signs on a resident's eMAR, it was the RCC's responsibility to enter the order manually. -She expected the RCC to ensure accuracy of orders on the eMAR when approving them from the pharmacy as compared to the original order to ensure residents received the care that was	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 276}	Continued From page 13 ordered. Telephone interview with a pharmacist with the facility's contracted pharmacy on 09/23/21 at 10:50am revealed: -The pharmacy had not received a fax from the facility for Resident #5's FL-2 dated 09/15/21. -Once an order was received from the facility via fax, it was entered onto the corresponding resident's eMAR and sent back to the facility for approval to make it active. -It was the facility's responsibility to ensure orders were accurate prior to approving an order. -If the facility found that an order was inaccurate or missing, they could request that the pharmacy clarify and fix the order, or the facility could clarify and fix the order themselves manually. -The pharmacy could not see when the facility had approved an order. -The pharmacy did not usually enter order vital sign orders unless they were attached to a medication order. -Entering vital sign orders that were not attached to a medication was a courtesy and something the pharmacy would only do upon request from the facility. Attempted telephone interview with Resident #5's primary care provider (PCP) on 09/23/21 at 4:40pm was unsuccessful.	{D 276}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 14	D 344		

resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to clarify medication and treatment orders for 2 of 5 sampled residents (#1, #2) including oxygen, inhaled medications for breathing problems, and a diuretic for swelling (#2); and for a medication for enlarged prostate and a Vitamin D supplement (#1).

The findings are:

1. Review of Resident #2's current FL-2 dated 08/10/21 revealed diagnoses included diabetes mellitus type 2, hypoxia (low oxygen in your blood), acute respiratory disease, hypertension (high blood pressure), history of stroke, and history of sarcoidosis (inflammatory disease that most commonly affects the lungs).

a. Review of Resident #2's physician's order dated 05/01/21 revealed an order for oxygen 3 liters per minute (LPM) continuous, check every shift. (Oxygen is used to treat low blood oxygen levels and symptoms of lung disease such as shortness of breath.)

Review of Resident #2's signed physician's order sheets dated 06/30/21 revealed an order for oxygen per nasal canula (NC) at 2 LPM as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 15	D 344		

needed (prn) for shortness of breath.

Review of Resident #2's hospital discharge summary dated 08/10/21 and signed by a hospital provider revealed:
-The resident was admitted to the hospital on 08/06/21 for evaluation of worsening shortness of breath and fatigue for about a week.
-The resident was admitted for suspected congestive heart failure exacerbation, hypertensive urgency (very high blood pressure usually with no acute organ damage), and acute renal (kidney) failure.
-The resident was discharged from the hospital on 08/10/21 with a diagnosis of hypertensive urgency.
-There was an order for oxygen inhale 2 LPM (did not specify if continuous or prn).

Review of Resident #2's FL-2 dated 08/10/21 and signed by a hospital provider revealed an order for oxygen 2 LPM via NC continuous.

Review of Resident #2's second FL-2 dated 08/10/21 and signed by the primary care provider (PCP) revealed an order for oxygen per NC at 2 LPM prn for shortness of breath.

Review of Resident #2's clarification orders by the PCP for the hospital visit dated 08/10/21 revealed:
-There was a clarification order to continue Prednisone (a steroid for inflammation), Humulin R insulin per sliding scale (insulin lowers blood sugar), and Diltiazem (for heart/blood pressure).
-There were no other medications or treatments listed on the clarification orders.
-The order for oxygen was not clarified.

Review of Resident #2's August 2021 electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 16	D 344		

medication administration record (eMAR) revealed:
-There was an entry for oxygen per NC at 2 LPM prn for shortness of breath.
-Documentation for prn oxygen was blank with none documented as administered.
-There was no other entry for oxygen on the eMAR.

Review of Resident #2's September 2021 eMAR revealed:
-There was an entry for oxygen per NC at 2 LPM prn for shortness of breath.
-Documentation for prn oxygen was blank with none documented as administered.
-There was no other entry for oxygen on the eMAR.

Observation of Resident #2 on 09/23/21 at 4:51pm revealed:
-The resident was in the hallway near the dining room sitting on the seat of her rolling walker.
-The resident had a portable oxygen tank with her.
-The resident was wearing her oxygen tubing and receiving oxygen at 3 LPM.

Interview with Resident #2 on 09/22/21 at 10:05am revealed:
- She had breathing problems and she was supposed to wear her oxygen all the time but sometimes she did not wear it when she was in her room.
-She received oxygen at 3 LPM and that was the setting on her oxygen concentrator and portable oxygen tank.

Interview with a medication aide (MA) on 09/23/21 at 11:40am revealed:
-Resident #2 received oxygen at 3 LPM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 17 -She was not aware of any discrepancies with the resident's oxygen orders. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/23/21 at 5:37pm revealed: -The most current order for oxygen was from 03/08/21 for 2 LPM as needed for shortness of breath and to check every shift. -The pharmacy did not receive either of Resident #2's FL-2s dated 08/10/21 or the hospital discharge orders dated 08/10/21. -New FL-2s or any new orders should be sent to the pharmacy by the facility. Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 5:55pm revealed: -The MAs should clarify any incomplete or unclear orders. -She or the MAs were responsible for clarifying orders. -She did not clarify Resident #2's orders dated 08/10/21 because she used the FL-2 signed by the PCP after the resident returned to the facility on 08/10/21. -She did not think about both FL-2s and the hospital discharge orders being dated the same date and having conflicting orders. Attempted telephone interview with Resident #2's PCP on 09/23/21 at 4:40pm was unsuccessful. Refer to interview with the Administrator on 09/23/21 at 6:20pm. b. Review of Resident #2's signed physician's order sheets dated 06/30/21 revealed an order for Furosemide 40mg 1 tablet twice daily. (Furosemide is a diuretic used to treat swelling.)	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 18	D 344		

Review of Resident #2's hospital discharge summary dated 08/10/21 and signed by a hospital provider revealed:
-The resident was admitted to the hospital on 08/06/21 for evaluation of worsening shortness of breath and fatigue for about a week.
-The resident was admitted for suspected congestive heart failure exacerbation, hypertensive urgency (very high blood pressure usually with no acute organ damage), and acute renal (kidney) failure.
-The resident was discharged from the hospital on 08/10/21 with a diagnosis of hypertensive urgency.
-There was an order for Furosemide 40mg 1 tablet once daily.

Review of Resident #2's FL-2 dated 08/10/21 and signed by a hospital provider revealed an order for Furosemide 40mg 1 tablet once daily.

Review of Resident #2's second FL-2 dated 08/10/21 and signed by the primary care provider (PCP) revealed an order for Furosemide 40mg 1 tablet twice daily.

Review of Resident #2's clarification orders by the PCP for the hospital visit dated 08/10/21 revealed:
-There was a clarification order to continue Prednisone (a steroid for inflammation), Humulin R insulin per sliding scale (insulin lowers blood sugar), and Diltiazem (for heart/blood pressure).
-There were no other medications or treatments listed on the clarification orders.
-The order for Furosemide was not clarified.

Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 19	D 344		

-There was an entry for Furosemide 40mg 1 tablet twice a day scheduled for 8:00am and 2:00pm.
-Furosemide 40mg was documented as administered twice daily from 08/01/21 - 08/31/21, except on 08/07/21 - 08/10/21 when the resident was in the hospital.

Review of Resident #2's September 2021 eMAR revealed:
-There was an entry for Furosemide 40mg 1 tablet twice a day scheduled for 8:00am and 2:00pm.
-Furosemide 40mg was documented as administered twice daily from 09/01/21 - 09/22/21, except on 09/18/21 - 09/19/21 when the resident was on leave with family.

Interview with a medication aide (MA) on 09/23/21 at 11:40am revealed:
-She administered Resident #2's Furosemide according to the instructions on the eMAR.
-She was not aware of any discrepancies with the resident's orders for Furosemide.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/23/21 at 5:37pm revealed:
-The most current order on file for Furosemide for Resident #2 was an FL-2 dated 06/16/21 with an order to take 40mg twice daily.
-The pharmacy did not receive either of Resident #2's FL-2s dated 08/10/21 or the hospital discharge orders dated 08/10/21.
-New FL-2s or any new orders should be sent to the pharmacy by the facility.
-The pharmacy usually entered medication orders into the eMAR system and the facility staff was responsible for reviewing the orders and approving the order before the order became

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 20	D 344		

active on the eMAR.

Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 5:55pm revealed:
-The MAs should clarify any incomplete or unclear orders.
-She or the MAs were responsible for clarifying orders.
-She did not clarify Resident #2's orders dated 08/10/21 because she used the FL-2 signed by the PCP after the resident returned to the facility on 08/10/21.
-She did not think about both FL-2s and the hospital discharge orders being dated the same date and having conflicting orders.

Attempted telephone interview with Resident #2's PCP on 09/23/21 at 4:40pm was unsuccessful.

Refer to interview with the Administrator on 09/23/21 at 6:20pm.

c. Review of Resident #2's physician's orders dated 07/21/21 revealed an order for Wixela Inhub 250/50mcg inhale 1 puff two times a day. (Wixela Inhub is used to treat breathing disorders and lung disease. Wixela Inhub is the generic brand of Advair.)

Review of Resident #2's hospital discharge summary dated 08/10/21 and signed by a hospital provider revealed:
-The resident was admitted to the hospital on 08/06/21 for evaluation of worsening shortness of breath and fatigue for about a week.
-The resident was admitted for suspected congestive heart failure exacerbation, hypertensive urgency (very high blood pressure usually with no acute organ damage), and acute renal (kidney) failure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 21	D 344		

-The resident was discharged from the hospital on 08/10/21 with a diagnosis of hypertensive urgency.
-There was an order for Advair (brand name for Wixela Inhub) 500/50mcg inhale 1 puff twice daily.

Review of Resident #2's FL-2 dated 08/10/21 and signed by a hospital provider revealed an order for Advair inhale 1 puff twice daily but there was no strength included in the order.

Review of Resident #2's second FL-2 dated 08/10/21 and signed by the primary care provider (PCP) revealed an order for Wixela Inhub 250/50mcg inhale 1 puff twice daily.

Review of Resident #2's clarification orders by the PCP for the hospital visit dated 08/10/21 revealed:
-There was a clarification order to continue Prednisone (a steroid for inflammation), Humulin R insulin per sliding scale (insulin lowers blood sugar), and Diltiazem (for heart/blood pressure).
-There were no other medications or treatments listed on the clarification orders.
-The order for Advair (Wixela Inhub) was not clarified.

Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Wixela Inhub with device 250/50mcg per dose inhale 1 puff twice daily scheduled for administration at 8:00am and 8:00pm.
-Wixela Inhub was documented as administered from 08/01/21 - 08/31/21, except on 08/06/21 - 08/10/21 when the resident was in the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 22	D 344		

Review of Resident #2's September 2021 eMAR revealed:
-There was an entry for Wixela Inhub with devise 250/50mcg per dose inhale 1 puff twice daily scheduled for administration at 8:00am and 8:00pm.
-Wixela Inhub was documented as administered from 09/01/21 - 09/22/21 except on 09/17/21 - 09/19/21 when the resident was on leave with family.

Interview with Resident #2 on 09/22/21 at 10:05am revealed:
-She had breathing problems and she used an inhaler.
-She was not sure how often she took the inhaler.

Interview with a medication aide (MA) on 09/23/21 at 11:40am revealed:
-She administered Resident #2's Advair according to the instructions on the eMAR.
-She was not aware of any discrepancies with the resident's orders for Advair.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/23/21 at 5:37pm revealed:
-The most current order on file for Advair was an electronic prescription dated 07/21/21 for Advair 250/50mcg inhale 1 puff twice a day.
-The pharmacy did not receive either of Resident #2's FL-2s dated 08/10/21 or the hospital discharge orders dated 08/10/21.
-New FL-2s or any new orders should be sent to the pharmacy by the facility.
-The pharmacy usually entered medication orders into the eMAR system and the facility staff was responsible for reviewing the orders and approving the order before the order became active on the eMAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 23 Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 5:55pm revealed: -The MAs should clarify any incomplete or unclear orders. -She or the MAs were responsible for clarifying orders. -She did not clarify Resident #2's orders dated 08/10/21 because she used the FL-2 signed by the PCP after the resident returned to the facility on 08/10/21. -She did not think about both FL-2s and the hospital discharge orders being dated the same date and having conflicting orders. Attempted telephone interview with Resident #2's PCP on 09/23/21 at 4:40pm was unsuccessful. Refer to interview with the Administrator on 09/23/21 at 6:20pm. d. Review of Resident #2's physician's orders dated 07/21/21 revealed an order for Duoneb inhale contents of 1 amp (3ml) via nebulizer every 4 hours as needed for wheezing / shortness of breath. (Duoneb is used to treat breathing disorders and lung disease.) Review of Resident #2's hospital discharge summary dated 08/10/21 and signed by a hospital provider revealed: -The resident was admitted to the hospital on 08/06/21 for evaluation of worsening shortness of breath and fatigue for about a week. -The resident was admitted for suspected congestive heart failure exacerbation, hypertensive urgency (very high blood pressure usually with no acute organ damage), and acute renal (kidney) failure. -The resident was discharged from the hospital	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 24	D 344		

on 08/10/21 with a diagnosis of hypertensive urgency.
-There was an order for Duoneb inhale contents of 1 amp via nebulizer every 6 hours as needed for wheezing and shortness of breath for up to 12 days.

Review of Resident #2's FL-2 dated 08/10/21 and signed by a hospital provider revealed an order for Duoneb inhale contents of 1 amp via nebulizer every 6 hours as needed up to 12 days.

Review of Resident #2's second FL-2 dated 08/10/21 and signed by the primary care provider (PCP) revealed an order for Duoneb inhale contents of 1 amp via nebulizer every 4 hours as needed for wheezing / shortness of breath.

Review of Resident #2's clarification orders by the PCP for the hospital visit dated 08/10/21 revealed:
-There was a clarification order to continue Prednisone (a steroid for inflammation), Humulin R insulin per sliding scale (insulin lowers blood sugar), and Diltiazem (for heart/blood pressure).
-There were no other medications or treatments listed on the clarification orders.
-The order for Duoneb was not clarified.

Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Duoneb inhale contents of 1 amp via nebulizer every 4 hours as needed for wheezing / shortness of breath.
-Duoneb was documented as administered on one occasion on 08/22/21 at 3:06pm.

Review of Resident #2's September 2021 eMAR revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 25	D 344		

-There was an entry for Duoneb inhale contents of 1 amp via nebulizer every 4 hours as needed for wheezing / shortness of breath.
-No Duoneb was documented as administered in September 2021.

Interview with Resident #2 on 09/22/21 at 10:05am revealed:
-She had breathing problems and used a nebulizer machine.
-She was not sure how often she used the nebulizer medication.

Interview with a medication aide (MA) on 09/23/21 at 11:40am revealed:
-She administered Resident #2's Duoneb according to the instructions on the eMAR.
-She was not aware of any discrepancies with the resident's orders for Duoneb.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/23/21 at 5:37pm revealed:
-The most current order for Duoneb was dated 07/21/21 to inhale 1 amp via nebulizer every 4 hours as needed for wheezing / shortness of breath.
-The pharmacy did not receive either of Resident #2's FL-2s dated 08/10/21 or the hospital discharge orders dated 08/10/21.
-New FL-2s or any new orders should be sent to the pharmacy by the facility.
-The pharmacy usually entered medication orders into the eMAR system and the facility staff was responsible for reviewing the orders and approving the order before the order became active on the eMAR.

Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 5:55pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 26	D 344		

-The MAs should clarify any incomplete or unclear orders.
-She or the MAs were responsible for clarifying orders.
-She did not clarify Resident #2's orders dated 08/10/21 because she used the FL-2 signed by the PCP after the resident returned to the facility on 08/10/21.
-She did not think about both FL-2s and the hospital discharge orders being dated the same date and having conflicting orders.

Attempted telephone interview with Resident #2's PCP on 09/23/21 at 4:40pm was unsuccessful.

Refer to interview with the Administrator on 09/23/21 at 6:20pm.

2. Review of Resident #1's current FL-2 dated 07/14/21 revealed diagnoses included diabetes mellitus and hypertension.

Review of physician's orders dated 09/20/21 for Resident #1 revealed:
-There was an order for Cholecalciferol 25mg (Vitamin D3-1,000 units) take two tablets one time daily.
-There was an order for Tamsulosin HCL 0.4mg (used to treat the symptoms of an enlarged prostate) take one capsule at bedtime.

Observation of Resident #1's medications on hand on 09/23/21 at 11:14am revealed:
-There was a bottle of Cholecalciferol 25mg with instructions to administer two tablets by mouth every day.
-The medication label on the bottle had a fill date of 03/29/21.
-There was a bottle of Tamsulosin HCL 0.4mg with instructions to administer one tablet by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 27	D 344		

mouth at bedtime.
-The medication label on the bottle had a fill date of 05/12/21.

Review of Resident #1's September 2021 eMAR revealed:
-Cholecalciferol 25mg and Tamsulosin HCL 0.4mg were not listed on the eMAR.
-There was no documentation on the eMAR that Resident #1 had received Cholecalciferol 25mg or Tamsulosin HCL 0.4mg.

Interview with a medication aide (MA) on 09/23/21 at 11:14 revealed:
-She did not know why Cholecalciferol and Tamsulosin HCL were not on Resident #1's eMAR.
-She could not remember if she had administered the Cholecalciferol or Tamsulosin HCL to Resident #1.
-She followed instructions on the eMAR when she administered medications.

Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 9:33am revealed:
-Orders for residents were faxed to the pharmacy by MAs or the RCC when received.
-The pharmacy processed the orders and entered the orders into the eMAR as a pending order.
-The order was then approved for use by the RCC or the Administrator and would become active.
-There was no process in place to ensure the accuracy of orders that are approved matched the original order.
-She was responsible to ensure orders appeared accurately on the eMAR.

Interview with the Administrator on 09/23/21 at 6:21pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 28	D 344		

-She was not aware that Resident #1 had Cholecalciferol and Tamsulosin on the medication cart.
-She was not aware that Cholecalciferol and Tamsulosin were not listed on Resident #1's eMAR.
-The MAs were expected to only document medications on hand and administered to a resident to ensure accuracy of eMARs.
-She expected staff to report to her, the RCC, or the PCP if a resident was not able to get their medications as ordered.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 09/23/21 at 10:50am revealed:
-Once an order was received from the pharmacy via fax, it was entered onto the corresponding resident's eMAR and sent back to the facility for approval to make it active.
-It was the facility's responsibility to ensure the order was accurate prior to approving the order.
-If the facility found that an order was inaccurate, they could request that the pharmacy clarify and fix the order, or the facility could clarify and fix the order themselves manually.

A second telephone interview with a pharmacist with the facility's contracted pharmacy on 09/23/21 at 5:44pm revealed:
-Cholecalciferol and Tamsulosin were not listed on Resident #1's profile.
-There were not any orders for Cholecalciferol or Tamsulosin for Resident #1.
- Cholecalciferol and Tamsulosin were not on his current FL-2 and had not been dispensed to the facility for Resident #1.

Attempted telephone interview with Resident #1's PCP on 09/23/21 at 4:40pm was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 344	Continued From page 29 Refer to interview with the Administrator on 09/23/21 at 6:20pm. Interview with the Administrator on 09/23/21 at 6:20pm revealed: -The MAs and the RCC were responsible for clarifying orders if needed. -The RCC was responsible for approving orders in the eMAR system. -She expected the RCC to compare orders with the entries on the eMAR system to ensure accuracy.	D 344		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, 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 Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 5 residents (#6, #7, #8) observed during the medication passes including errors with a medication for mood disorders (#8), medications held without an order	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 30 (#6), and an inhaler (#7); and for 2 of 5 sampled residents (#2, #5) for record review including errors with holding medications without an order, administering medications outside of ordered times, not having ordered medications on hand, and not administering skin barrier cream as ordered (#5), and administration of expired insulin (#2). The findings are: 1. The medication error rate was 16% as evidenced by the observation of 5 errors out of 30 opportunities during the 8:00am and 9:00am medication passes on 09/23/21. a. Review of Resident #8's current FL-2 dated 08/20/21 revealed: -Diagnoses included mild mental retardation. -There was an order for Seroquel 50mg (used for mood disorders) every morning. -There was an order for Seroquel 50mg every day at noon. Observation of the 8:00am medication pass on 09/23/21 revealed the medication aide (MA) prepared and administered 1 tablet of Seroquel 50mg to Resident #8 at 7:39am. Review of Resident #8's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Seroquel 50mg with instructions to administer each morning scheduled at 9:00am. -There was a discontinued entry that ended on 09/19/21 for Seroquel 50mg with instructions to administer each day at noon scheduled for 12:00pm. -There was an entry for Seroquel 50mg with	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 31	{D 358}		

instructions to administer each morning and again at noon scheduled for 8:00am.
-Seroquel 50mg was documented as administered by the MA on 09/23/21 at 8:00am.
-Seroquel 50mg was documented as administered again by the MA on 09/23/21 at 9:00am.
-There was no documentation that the resident received Seroquel 50mg on 09/23/21 at 12:00pm.
-Resident #8 received two morning doses instead of one morning dose and one noon dose of Seroquel that day, 09/23/21.

Observation of Resident #8's medications on hand on 09/23/21 at 12:55pm revealed a bottle of Seroquel 50mg with instructions to administer one tablet by mouth every morning and 1 tablet every day at noon.

Interview with the MA on 09/23/21 at 12:43pm revealed:
-Resident #8 was supposed to get Seroquel 50mg each day at 9:00am and 12:00pm.
-It was the facility policy to read the instructions on the eMAR and medication label prior to administration of medications.
-She did not read the instructions prior to administering the Seroquel 50mg at 7:39am which stated to give at noon.
-The 12:00pm dose popped up on the eMAR in the computer to be administered at 8:00am.
-She did not know why the 12:00pm dose was popping up in the eMAR for administration at 8:00am but realized it when it did not pop up at 12:00pm because she was used to administering both a morning dose and a noon dose to Resident #8.
-She did not remember that she had already administered a dose of Seroquel (at 7:39am on 09/23/21) when she administered the 9:00am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 32	{D 358}		

dose to Resident #8 that day (09/23/21).
-She administered Resident #8's 12:00pm dose at 7:39am and the 9:00am dose at 8:51am.
-The resident was never disoriented or confused but was frequently drowsy and napped a lot during the day.

Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 5:53pm revealed:
-She was not sure why Resident #8's 12:00pm dose of Seroquel was popping on the eMAR to be administered at 8:00am.
-She expected the MAs to read medication instructions when administering medications and to clarify any issues with her, the Administrator, or the resident's provider prior to administering any medications.
-She or the Administrator were responsible for approving orders that had been entered by the pharmacy into the eMAR system prior to making the orders active in the residents' eMARs for administration.
-There was no process in place to compare original orders to the orders pending approval from the pharmacy for accuracy.

Interviews with the Administrator on 09/23/21 at 1:48pm and 6:21pm revealed:
-She was unsure how Resident #8's 12:00pm dose of Seroquel 50mg was changed to be administered at 8:00am.
-She was concerned that Resident #8 received two doses of Seroquel that morning (09/23/21) and it was a medication error.
-She expected the MAs to administer medications as ordered and clarify medication orders as needed prior to administration.
-She expected the MAs to read the medication label instructions as part of the six rights of medication administration prior to administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 33 -She expected the RCC to ensure accuracy of orders when approving them from the pharmacy as compared to the original order. Telephone interview with Resident #8's mental health provider (MHP) on 09/23/21 at 4:27pm revealed: -He was not aware that Resident #8 had received two doses of Seroquel that morning (09/23/21). -He expected the facility to notify him of medication errors per standard procedure. -If he had been made aware, he would have given orders for close observation of the resident for sedation, unsteadiness, and falls, as well as to increase the resident's fluid intake, and monitor blood pressure and pulse twice daily for five days. -Depending on how many excess doses the resident received, he would have possibly held the Seroquel for up to seven days because the resident was small and elderly. -He expected the facility to administer medications as ordered and clarify any medication changes that did not make sense. -He had not ordered any changes to Resident #8's medication administration times and she was to get one 50mg dose of Seroquel at 9:00am and again at 12:00pm each day. Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable. b. Review of Resident #6's current FL-2 dated 09/15/21 revealed: -Diagnoses included hypertension (high blood pressure), hypothyroidism (low functioning thyroid), gastro-esophageal reflux disease (GERD), anxiety, tremor, and subdural hematoma (a pool of blood between the brain and the outermost covering).	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 34 -There was an order for Aspirin 81mg (used as a blood thinner) once daily. -There was an order for Tylenol 325mg (used as mild pain reliever), take two tablets three times per day. -There was an order for Daily-Vite (multivitamin supplement) one tablet daily. -There was an order for Lisinopril 10mg (used to lower blood pressure) once daily. Observation of the 8:00am and 9:00am medication pass on 09/23/21 revealed the medication aide (MA) did not administer Resident #6's Aspirin 81mg one tablet, Tylenol 325mg two tablets, Daily-Vite one tablet, and Lisinopril 10mg one tablet. Review of Resident #6's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 81mg to be administered daily at 9:00am. -The Aspirin 81mg was documented as held for 09/23/21. -There was an entry for Tylenol 325mg two tablets to be administered three times daily at 8:00am, 2:00pm, and 8:00pm. -The Tylenol 325mg was documented as held on 09/23/21 at 8:00am. -There was an entry for Daily-Vite one tablet to be administered daily at 9:00am. -The Daily-Vite was documented as held on 09/23/21. -There was an entry for Lisinopril 10mg to be administered daily at 9:00am. -The Lisinopril was documented at held on 09/23/21. Review of Resident #6's physician's order dated 09/16/21 revealed:	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 35 -There was an order to hold Aspirin beginning 09/19/21 for five days prior to surgery on 09/23/21. -There was no order to hold the Tylenol, Daily-Vite, or Lisinopril. Review of a hospital after visit summary for Resident #6 dated 09/21/21 revealed: -The resident was scheduled to have a cholecystectomy (gallbladder surgery) on 09/23/21. -There was a list of the resident's medications with intermittent medications highlighted. -The resident's Aspirin, Tylenol, Daily-Vite, and Lisinopril were not highlighted. -There were no specific instructions regarding any of the medications and the document was not signed by a provider. Interview with the MA on 09/23/21 at 8:05am revealed: -Resident #6's hospital after visit summary paperwork was from her pre-operative appointment for her surgery that was supposed to take place later that day (09/23/21). -The highlighted medications on the paperwork were the medications the resident was supposed to take before the procedure and the other medications that were not highlighted were to be held. -She was given these instructions by another staff member. Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 9:33am revealed: -She expected staff to administer medications as ordered. -Staff were not to hold medications without orders. -She expected staff to clarify and ensure orders	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 36 were accurate prior to medication administration or holding medication. Interview with the Administrator on 09/23/21 at 3:35pm revealed: -MAs were not to hold medications for residents unless they had a signed order to do so from the resident's provider. -She was unable to locate a signed order to hold Resident #6's Tylenol, Daily-Vite, and Lisinopril. -Holding medications without an order was considered a medication error. -She expected staff to clarify and ensure they had a signed order to hold medications prior to doing so. Attempted telephone interview with Resident #6's primary care provider on 09/23/21 at 4:40pm was unsuccessful. c. Review of Resident #7's current FL-2 dated 07/28/21 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD). -There was an order for Advair Diskus 500-50mcg/dose, inhale one puff by mouth twice daily. (Advair is an inhaler medication used to treat COPD.) Observation of the 8:00am medication pass on 09/23/21 at 7:30am revealed: -The medication aide (MA) did not administer Advair to Resident #7. -Resident #7 stated that he had already taken the medication in his room. Observation of Resident #7's medications on hand on 09/23/21 at 7:30am revealed an empty box with a label for Resident #7's Advair with a pharmacy label to administer one puff by mouth	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 37 twice daily. Review of Resident #7's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Advair Diskus 500-50 mcg/dose, inhale one puff by mouth twice daily. -The Advair was documented as administered by the MA on 09/23/21. Interview with the MA on 09/23/21 at 1:32pm revealed: -She did not administer Resident #7's Advair that morning because the resident self-administered it prior to her medication administration pass. -She knew this because he told her during the morning medication pass on 09/23/21. Observation of Resident #7's room on 09/23/21 at 1:43pm revealed an Advair inhaler with 57 doses remaining stored in a mirrored medicine cabinet in the bathroom. Interview with Resident #7 on 09/23/21 at 1:44pm revealed: -He had been taking Advair twice daily for the last 12 years. -He had a self-administration order from his doctor to administer his inhalers by himself in his room. -Staff did not watch him take the Advair, he just told them when he took it. -He administered his Advair that morning prior to coming down the hall for his morning medication pass. Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 5:53pm revealed: -There was no self-administer order on file for Resident #7's Advair.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 38 -Staff were expected to administer medications to residents as ordered. Interview with the Administrator on 09/23/21 at 1:48pm revealed: -The facility's policy for self-administration required documentation that the resident could competently self-administer the medication via a self-administration check off assessment as well as a signed order from the resident's primary care provider (PCP). -If that documentation was present, the PCP verbally confirmed with her that facility staff did not have to observe the resident take the medications each day. -It was acceptable for the MAs to document a self-administered medication as administered if the resident told them they took the medication. Attempted telephone interview with Resident #7's PCP on 09/23/21 at 4:40pm was unsuccessful. 2. Review of Resident #5's current FL-2 dated 09/15/21 revealed diagnoses included chronic obstructive pulmonary disease (COPD), end stage renal disease (ESRD), anemia, hypertension, and weakness. a. Review of Resident #5's current FL-2 dated 09/15/21 revealed: -There was an order for Calcium Acetate (phosphate binder) 667mg, take two capsules three times daily. -There was an order for Colace 100mg (stool softener), take one capsule daily. -There was an order Ferrous Sulfate 325mg (iron supplement), take one tablet twice daily. -There was an order for Aspirin 81mg (blood thinner), take one tablet daily. -There was an order Celexa 20mg (treats	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 39	{D 358}		

depression), take one tablet daily.
-There was an order for Protonix 40mg (treats reflux), take one tablet twice daily.
-There was an order for Miralax 17g (treats constipation), dissolve in 8 ounces of beverage of choice daily.
-There was an order for Cinacalcet 60mg (calcium binder), take one tablet once daily with largest meal of day.
-There was an order for Clonidine 0.1mg (treats high blood pressure), take one tablet twice daily.
-There was an order for Proscar 5mg (treats enlarged prostate), take one tablet daily.

Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Calcium Acetate 667mg, take two capsules three times daily at 8:00am, 12:00pm, and 5:00pm.
-Calcium Acetate was documented as "Not Administered: Resident Unavailable" on 09/01/21, 09/03/21, 09/06/21, 09/10/21, 09/15/21, 09/20/21, 09/22/21 for the 8:00am doses; the resident missed 7 of 22 8:00am doses in September 2021.
-There was an entry for Colace 100mg, take one capsule daily at 8:00am.
-Colace was documented as "Not Administered: Resident Unavailable" on 09/01/21, 09/03/21, 09/06/21, 09/10/21, 09/15/21, 09/20/21, 09/22/21; the resident missed 7 of 22 doses in September 2021.
-There was an entry Ferrous Sulfate 325mg, take one tablet twice daily at 8:00am and 8:00pm.
-Ferrous Sulfate was documented as "Not Administered: Resident Unavailable" on 09/01/21, 09/03/21, 09/06/21, 09/10/21, 09/15/21, 09/20/21, 09/22/21 for the 8:00am doses; the resident missed 7 of 22 8:00am doses in September

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 40 2021. -There was an entry for Aspirin 81mg, take one tablet daily at 8:00am. -Aspirin was documented as "Not Administered: Resident Unavailable" on 09/01/21, 09/03/21, 09/06/21, 09/10/21, 09/15/21, 09/20/21, 09/22/21; the resident missed 7 of 22 doses in September 2021. -There was an entry Celexa 20mg, take one tablet daily at 8:00am. -Celexa was documented as "Not Administered: Resident Unavailable" on 09/01/21, 09/03/21, 09/06/21, 09/10/21, 09/15/21, 09/20/21, 09/22/21; the resident missed 7 of 22 doses in September 2021. -There was an entry for Protonix 40mg, take one tablet twice daily at 8:00am and 8:00pm. -Protonix was documented as "Not Administered: Resident Unavailable" on 09/01/21, 09/03/21, 09/06/21, 09/10/21, 09/15/21, 09/20/21, 09/22/21 for the 8:00am doses; the resident missed 7 of 22 8:00am doses in September 2021. -There was an entry for Miralax 17g, dissolve in 8oz of beverage of choice daily at 8:00am. -Miralax was documented as "Not Administered: Resident Unavailable" on 09/01/21, 09/03/21, 09/06/21, 09/10/21, 09/15/21, 09/20/21, 09/22/21; the resident missed 7 of 22 doses in September 2021. -There was an entry for Cinacalcet 60mg, take one tablet once daily with largest meal of day at 8:00am. -Cinacalcet was documented as "Not Administered: Resident Unavailable" on 09/01/21, 09/03/21, 09/06/21, 09/10/21, 09/15/21, 09/20/21, 09/22/21; the resident missed 7 of 22 doses in September 2021. -There was an entry for Clonidine 0.1mg, take one tablet twice daily at 8:am and 8:00pm. -Clonidine was documented as "Not	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 41 Administered: Resident Unavailable" on 09/01/21, 09/03/21, 09/06/21, 09/10/21, 09/15/21, 09/20/21, 09/22/21 for the 8:00am dose; the resident missed 7 of 22 8:00am doses in September 2021. -There was an entry for Proscar 5mg, take one tablet daily at 8:00am. -Proscar was documented as "Not Administered: Resident Unavailable" on 09/03/21, 09/06/21, 09/10/21, 09/15/21, 09/20/21, 09/22/21; the resident missed 6 of 22 doses in September 2021. Interview with Resident #5 on 09/23/21 at 12:25pm revealed: -He left the facility for dialysis on Mondays, Wednesdays, and Fridays around 5:30am. (Dialysis is a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly.) -He never refused his medications. -The facility staff did not offer to administer most of his morning medications prior to him leaving for dialysis, but if they did, he would take everything but the blood pressure medication. -He would not take the blood pressure medication because the staff at the dialysis center told him not to take his blood pressure medications on dialysis days to avoid dropping his blood pressure too low. Interview with a medication aide (MA) on 09/22/21 at 4:25pm revealed: -Today (09/22/21) was her first day working as a MA but she was a personal care aide (PCA) previously. -She worked first shift and normally arrived for her shift at 6:30am. -The medication pass started at 7:00am on first shift.	{D 358}		

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	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 42 -Resident #5 went to dialysis on Mondays, Wednesdays, and Fridays. -Resident #5 was unavailable for his 8:00am medication pass on dialysis days because he left for dialysis prior to her arrival for her shift. -She was unsure what the facility's policy was about administering medications when a resident was outside of the facility. -She was taught to document "Not Administered: Resident out of facility" when a resident was out of the facility and unavailable during their scheduled medication pass time. Interview with a second MA on 09/22/21 at 4:34pm revealed: -She usually worked first shift and medication pass started at 7:00am on first shift. -Resident #5 usually left for dialysis around 5:00am on Mondays, Wednesdays, and Fridays. -On Resident #5's dialysis days, the MAs would hold his medications except Zofran (used for nausea and vomiting) and Clonazepam (used for anxiety). -She knew to hold all his medications except those two medications because that's what she was told to do by another staff member. -She was not aware of any orders from Resident #5's primary care provider (PCP) to hold any medications on his dialysis days. Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 9:33am revealed: -Resident #5 left for dialysis on Mondays, Wednesdays, and Fridays before breakfast between 5:30am and 6:00am. -Morning medication pass started at 7:00am. -She thought Resident #5 had been refusing his medication prior to leaving for dialysis, but if that were the case, the MAs should have documented the resident's medications as "refused" instead of	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 43 "not administered". -There was no order for Resident #5's morning medications to be held on dialysis days. -The facility had not contacted Resident #5's PCP to notify her that he was missing his medications or to request the time of administration be changed to accommodate him going to dialysis so as to not miss any doses; she did not know why. -The MAs were not to hold medication without an order and should contact the PCP if the resident missed more than three doses. Interview with the Administrator on 09/23/21 at 6:21pm revealed: -She was not aware that Resident #5 was not receiving his medications as ordered on his dialysis days. -She expected staff to report to her, the RCC, or the resident's PCP if a resident was not receiving their medications as ordered for clarification on what to do. -Staff should have called or faxed Resident #5's PCP to clarify whether to hold or how to administer his medications on dialysis days. -She expected staff to administer medications as ordered. -The MAs were not to hold medications without a signed order from the resident's PCP to hold the medications. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/23/21 at 10:50am revealed: -There were no orders on file to hold Resident #5's medications on his dialysis days. -If the resident was routinely missing doses of his medications, it could lead to absorption issues because of his kidney impairments which could leave either too much or too little of a medication	{D 358}		

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	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

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SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 44 in his system. -Depending on the medication, having too much or too little of a medication in the resident's system could exacerbate the condition the medication was used to treat or could lead to blood pressure issues due to his need for dialysis. Attempted telephone interview with Resident #5's PCP on 09/23/21 at 4:40pm was unsuccessful. b. Review of Resident #5's current FL-2 dated 09/15/21 revealed: -There was an order for Clonazepam 0.5mg (used for anxiety), take on tablet three times daily. -There was an order for Zofran 4mg (used for nausea and vomiting), take one tablet before dialysis every Monday, Wednesday, and Friday. Review of Resident #5's September 2021 electronic medication administration record revealed: -There were eleven medications frequently documented as "Not Administered: Resident Unavailable" on Mondays, Wednesdays, and Fridays on 09/01/21, 09/03/21, 09/06/21, 09/10/21, 09/15/21, 09/20/21, and 09/22/21 at the 8:00am doses. -There was an entry for Clonazepam 0.5mg, take one tablet three times daily at 8:00am, 2:00pm, and 8:00pm. -The Clonazepam 0.5mg was documented as administered as ordered every day at 8:00am, 2:00pm, and 8:00pm with zero missed doses. -There was an entry for Zofran 4mg, take one tab before dialysis on Monday, Wednesday, and Friday at 8:00am. -The Zofran 4mg was documented as administered every Monday, Wednesday, and	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

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SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 45 Friday as ordered except one missed dose on 09/13/21 which was documented that Resident #5 refused the medication. Interview with Resident #5 on 09/23/21 at 12:25pm revealed: -He left the facility for dialysis on Mondays, Wednesdays, and Fridays around 5:30am. -The facility staff did not offer to administer most of his morning medications prior to him leaving for dialysis except for his "nausea medication and his nerve pill". -Third shift staff would administer those two medications to him prior to him leaving for dialysis. Interview with a medication aide (MA) on 09/22/21 at 4:25pm revealed: -This was her first day working as an MA but had been a personal care aide (PCA) previously. -She worked first shift and normally arrived for her shift at 6:30am and the morning medication pass started at 7:00am. -Resident #5 went to dialysis on Mondays, Wednesdays, and Fridays. -Resident #5 was already gone to dialysis when she arrived for her shifts on those days. -Any medications documented as administered on Resident #5's dialysis days would have been administered by the third shift MAs prior to him leaving for dialysis around 5:00am. -She was not sure why any scheduled morning medications would have been administered to Resident #5 prior to him leaving for dialysis because they were not scheduled until 8:00am. Interview with a second MA on 09/22/21 at 4:34pm revealed: -She usually worked first shift and the medication pass started at 7:00am on first shift.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 46 -Sometimes she would work third shift and had done so a couple of times in the last month. -Resident #5 usually left for dialysis around 5:00am on Mondays, Wednesdays, and Fridays. -On Resident #5's dialysis days, the MAs would hold his medications except for Zofran and Clonazepam in which they administered around 5:00am. -She did not know why the MAs only gave those two medications to Resident #5 or why they administered the medications earlier than the 8:00am scheduled time that they were due. -The facility policy was to administer medications as ordered no more than one hour before or one hour after the scheduled time for administration. -She was not aware of any orders to administer medications to Resident #5 early on his dialysis days but she thought the resident asked for those two medications on his dialysis days before he left the facility. Interview with a third MA on 09/22/21 at 5:00pm revealed: -She always worked third shift and was responsible for administering medications to residents. -Resident #5 normally left for dialysis on Mondays, Wednesdays, and Fridays just after 5:00am. -She normally administered Resident #5's Clonazepam and Zofran around 5:00am on his dialysis days. -She thought Resident #5's Clonazepam and Zofran were scheduled around 7:00am each morning. -The facility's policy was to administer medications as ordered no more than one hour before or one hour after the scheduled administration time. -She only administered Resident #5 those two	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 47	{D 358}		

medications two hours before the scheduled administration time because he requested them, even though they were not due to be administered at that time.
-She did not offer to administer any other medications to Resident #5 from his morning medication pass on those days because he did not request them and they were not due to be administered at that time.

Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 9:33am revealed:
-Resident #5 left for dialysis on Mondays, Wednesdays, and Fridays before breakfast between 5:30am and 6:00am.
-The morning medication pass started at 7:00am.
-The facility's policy was to administer medications as ordered no more than one hour before or one hour after the scheduled time of administration.
-Any morning medications administered to Resident #5 on his dialysis days must have been given to him by third shift prior to him leaving which would have been outside the facility's policy of administration times.
-There was no order to administer Resident #5's early on dialysis days.
-The facility had not contacted Resident #5's PCP to request the time of administration be changed to accommodate him going to dialysis and not missing any doses; she did not know why.

Interview with the Administrator on 09/23/21 at 6:21pm revealed:
-She was not aware that Resident #5 was not getting his medications as ordered on his dialysis days.
-She expected staff to report to her, the RCC, or the resident's PCP if a resident was not getting their medications as ordered for clarification on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 48	{D 358}		

what to do.
-The MAs or the RCC should have called or faxed Resident #5's PCP to clarify whether to hold or how to administer his medications on dialysis days.
-She expected the MAs to administer medications as ordered.
-The MAs were not to administer medication outside of one hour before or one hour after the scheduled administration time.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/23/21 at 10:50am revealed:
-There were no orders on file to administer Resident #5's medications early on his dialysis days.
-Medications should not be administered more than one hour before or one hour after the scheduled administration time due to Resident #5 kidney impairment which caused absorption issues and his need for dialysis.
-Depending on the medication, having too much or too little of a medication in the resident's system could exacerbate the condition the medication was used to treat or could lead to blood pressure issues due to his need for dialysis.

Attempted telephone interview with Resident #5's PCP on 09/23/21 at 4:40pm was unsuccessful.

c. Review of Resident #5's current FL-2 dated 09/15/21 revealed an order for Cinacalcet 60mg (calcium binder) take one tablet daily with largest meal of the day.

Review of a physician's order sheet dated 06/30/21 from Resident #5's dialysis provider revealed an order for Cinacalcet 60mg take one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 49 table every day with largest meal with 11 refills. Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Cinacalcet 60mg take one tablet each day with largest meal scheduled at 8:00am. -Cinacalcet was documented as administered as ordered on 09/02/21, 09/04/21, 09/05/21, 09/07/21, 09/08/21, 09/09/21, 09/11/21, 09/12/21, 09/14/21, 09/17/21, 09/18/21, and 09/19/21. -Cinacalcet was documented as "Not Administered: Resident Unavailable" on 09/01/21, 09/03/21, 09/06/21, 09/10/21, 09/15/21, 09/20/21, and 09/22/21. -Cinacalcet was documented as "Not Administered: REFUSED" on 09/13/21. -Cinacalcet was documented as "Not Administered: Drug/Item Unavailable" on 09/16/21. -Cinacalcet was documented as "Not Administered: Refill was sent 09/20/21 to pharmacy" on 09/21/21. Observation of Resident #5's medications on hand on 09/23/21 at 4:18pm revealed there was no Cinacalcet on hand for the resident. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/23/21 at 5:11pm revealed: -The last time the pharmacy filled Resident #5's Cinacalcet was on 07/16/21 for a 30-day supply. -The pharmacy had been unable to refill Resident #5 because insurance was denying coverage for the medication. -Resident #5 would not have had any Cinacalcet on hand after the 30-day supply ran out from 07/16/21.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 50 -Insurance had stated that the dialysis provider should have provided Resident #5's Cinacalcet to him. -It was important for Resident #5 to have his Cinacalcet as ordered because his kidney function was compromised and he required dialysis, the Cinacalcet was used to bind calcium in the resident's blood stream to ensure his calcium levels did not get too high. Review of Resident #5's progress notes dated 04/13/21-09/22/21 revealed: -On 06/25/21 a refill request for Cinacalcet was faxed to Resident #5's dialysis provider. -On 06/30/21 a call was attempted to Resident #5's dialysis provider to get an update on the Cinacalcet. -On 07/06/21, a nurse from Resident #5's dialysis provider stated they were waiting on the doctor to sign Resident #5's Cinacalcet order. -09/17/21 a call was placed to Resident #5's dialysis provider to request a refill for his Cinacalcet; the provider's office stated the doctor was not in but would sign the order the following week. Interview with a medication aide (MA) on 09/23/21 at 4:18pm revealed: -She did not think they had the Cinacalcet on hand for Resident #5 for a long time. -If she remembered correctly, Resident #5's insurance would not pay for it. -She could not remember the last time Resident #5's Cinacalcet had been available. Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 5:53pm revealed: -She was not aware that Resident #5 did not have any Cinacalcet on hand. -She was not sure why it was documented that	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 51	{D 358}		

the resident received the medication if it was unavailable.
-The MAs were responsible to perform weekly medication cart audits to ensure all residents had their ordered medications on hand.
-She knew the staff had requested a refill for Resident #5's Cinacalcet based on his last audit, but did not know it had not come in.
-Last night (09/22/21) she received a letter from the pharmacy that Resident #5's insurance would not pay for his Cinacalcet from the pharmacy.

Interview with the Administrator on 09/23/21 on 6:21pm revealed:
-She was not aware that Resident #5 did not have Cinacalcet on hand.
-She expected staff to perform weekly cart audits accurately to ensure all residents had their ordered medications on hand.
-She expected staff to report to her, the RCC, or the PCP if a resident was not able to get their medications as ordered.

Attempted telephone interview with Resident #5's PCP on 09/23/21 at 4:40pm was unsuccessful.

d. Review of Resident #5's current FL-2 dated 09/15/21 revealed an order for Baza Protect cream (used as a skin protectant to prevent breakdown), apply topically to buttocks every day and as needed.

Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Baza Protect every day as needed: apply topically to buttocks every day and as needed.
-There was no scheduled time to administer the Baza Protect cream, it was to be administered

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	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 52 PRN (as needed). -Baza Protect cream was documented as administered on 09/03/21, 09/06/21, 09/10/21, 09/16/21, 09/18/21, 09/20/21. -The resident missed 23 doses of scheduled Baza Protect cream from 09/01/21-09/23/21. Review of Resident #5's pharmacy consultation report dated 07/20/21 revealed: -There was a pharmacist recommendation to clarify that the Baza Protect cream was to be administered daily and as needed. -There was a signed order dated 08/03/21 that Resident #5's primary care provider (PCP) agreed with the clarification order. Review of a physician order sheet dated 09/23/21 revealed another clarification order from Resident #5's PCP to administer the Baza Protect cream daily and as needed after soiling to prevent skin breakdown. Interview with a medication aide (MA) on 09/22/21 at 4:34pm revealed: -The instructions on Resident #5's Baza skin protectant cream read to administer once daily and as needed. -She was not sure why Resident #5's Baza cream was not popping to administer daily on his eMAR. -If the instructions to an order were not clear, it was the MA's or RCC's responsibility to clarify the order so that it showed correctly on the eMAR. -It was the Resident Care Coordinator's (RCC's) responsibility to review orders and ensure they were accurate on the eMAR. -If a medication did not pop up on the eMAR to administer, the MAs would not know to administer it. -It was the facility's policy to administer medications as ordered.	{D 358}		

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	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 53 Interview with the RCC on 09/23/21 at 9:33am revealed: -When a new or clarified order arrived, the she or the MAs would fax the order to the pharmacy who would then enter the order onto the resident's eMAR as a pending order for approval. -It was her or the Administrator's responsibility to approve orders from the pharmacy once entered onto the eMAR. -There was no process in place to ensure accuracy of medication orders on the eMAR when approving the orders. -She was unsure why Resident #5 had only been getting his Baza cream as needed because the order had been clarified on 08/03/21 to receive daily and as needed. Interview with the Administrator on 09/23/21 at 6:21pm revealed: -She expected Resident #5 to receive his medications accurately as ordered. -She expected the RCC to ensure accuracy of orders on residents eMAR prior to approving the orders as compared to the original order. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/23/21 at 10:50am revealed: -The facility was responsible for faxing orders and clarifications to the pharmacy. -Once an order or clarification was received from the facility, it was the pharmacy's responsibility to enter the new order or clarification onto the resident's eMAR. -The pharmacy had not received any clarification orders for Resident #5's Baza cream on or around 08/03/21. -Resident #5's original order for Baza cream had been entered on 06/30/21 as two separate	{D 358}		

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	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 54 orders; one order was scheduled for daily administration; the other order was entered as needed. -It was the facility's responsibility to accept and approve the orders once they had been entered by the pharmacy. -The pharmacy was unable to see when the facility had accepted or declined an order. Attempted telephone interview with Resident #5's PCP on 09/23/21 at 4:40pm was unsuccessful. 3. Review of Resident #2's current FL-2 dated 08/10/21 revealed diagnoses included diabetes mellitus type 2, hypoxia (low oxygen in your blood), acute respiratory disease, hypertension, history of stroke, and history of sarcoidosis (inflammatory disease that most commonly affects the lungs). a. Review of Resident #2's FL-2 dated 08/10/21 and signed by a hospital provider revealed an order for Humulin R insulin twice a day before breakfast and dinner per sliding scale: 250 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; and > (greater than) 400 = 5 units. (Humulin R insulin lowers blood sugar.) Review of Resident #2's hospital discharge summary dated 08/10/21 and signed by a hospital provider revealed an order for Humulin R insulin twice a day before breakfast and dinner per sliding scale: 250 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; and > 400 = 5 units. Review of Resident #2's FL-2 dated 08/10/21 and signed by the primary care provider (PCP) revealed there was no order for insulin. Review of Resident #2's clarification orders by the	{D 358}		

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	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 55 PCP for the hospital visit dated 08/10/21 revealed there was a clarification order to continue the hospital order for Humulin R insulin per sliding scale. Observation of Resident #2's medications on hand on 09/23/21 at 11:40am revealed: -There was one vial of Humulin R insulin dispensed on 08/11/21. -There was an auxiliary sticker on the insulin bottle with date opened documented as 08/10/21. -There were instructions on the label to discard unused medication after 31 days. Interview with a medication aide (MA) on 09/23/21 at 11:50am revealed: -She had not noticed Resident #2's Humulin R insulin had expired. -The MAs were supposed to put the date opened on the insulin vial when it was first used and discard when the medication expired. -The MAs were not supposed to administer expired insulin. -She did not know why the open date was documented as 08/10/21 since she documented the first dose was administered on 08/12/21. (If opened on 08/12/21, the insulin expired on 09/12/21 and should not have been administered after 09/12/21.) -She had administered insulin to Resident #2 after it expired but did not realize it was expired until now. -Resident #2 did not have any other Humulin R insulin on hand. Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Humulin R insulin twice a day before breakfast and before supper per	{D 358}		

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	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 56 sliding scale: 250 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; and > 400 = 5 units. -Humulin R sliding scale insulin was scheduled at 8:00am and 5:00pm and the first dose was documented as administered at 8:00am on 08/12/21. Review of Resident #2's September 2021 eMAR revealed: -There was an entry for Humulin R insulin twice a day before breakfast and before supper per sliding scale: 250 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; and > 400 = 5 units. -Humulin R sliding scale insulin was scheduled at 8:00am and 5:00pm. -The resident's blood sugars at 8:00am and 5:00pm ranged from 159 - 483 from 09/01/21 - 09/22/21. -The resident's blood sugar was documented as 250 or above on 25 occasions and required administration of Humulin R sliding scale insulin on those 25 occasions. -There were 12 of the 25 occasions from 09/13/21 - 09/22/21 (after the insulin expired on 09/12/21) when the resident's blood sugar was documented as 250 or above and required administration of Humulin R sliding scale insulin. -The resident would have received expired insulin on those 12 occasions. Interview with the same MA on 09/23/21 at 2:04pm revealed: -She administered Humulin R sliding scale insulin to Resident #2 on 09/14/21, 09/16/21, and 09/17/21. -She had not noticed the insulin was expired when she administered it on those occasions. Interview with a second MA on 09/23/21 at 4:10pm revealed:	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 57 -She administered Humulin R sliding scale insulin to Resident #2 on 09/13/21, 09/14/21, and 09/21/21 at 5:00pm. -She was not aware the insulin was expired when she administered it. Interview with a third MA on 09/23/21 at 4:19pm revealed: -She administered Humulin R sliding scale insulin to Resident #2 on 09/16/21 at 5:00pm. -The MAs did medication cart audits weekly including checking for expired medications. -She had not noticed Resident #2's Humulin R insulin had expired. -The MAs were not supposed to administered expired insulin. -Resident #2's insulin should have been reordered before it expired. -Resident #2 did not have any other Humulin R insulin on hand. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/23/21 at 5:37pm revealed: -The pharmacy dispensed 1 vial of Humulin R insulin on 08/11/21 for Resident #2. -This was the only time the pharmacy had dispensed any Humulin R insulin for the resident. -The facility faxed a refill request for the Humulin R insulin today, 09/23/21 at 3:00pm. -The cut off for refills was 12:00pm so the Humulin R insulin would be sent to the facility tomorrow, 09/24/21. -The pharmacy put a sticker on the insulin vials so the facility staff could document when the insulin was first opened so they would know when it expired. -Expired insulin should not be administered because it might not be as potent and not work as well to keep the resident's blood sugar regulated.	{D 358}		

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	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

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SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 58 Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 5:55pm revealed: -The MAs were responsible for documenting the open date on insulin when the first dose was used. -The MAs were responsible for replacing the insulin prior to the expiration date. -Expired insulin should not be administered to any resident. -She was not aware Resident #2's Humulin R insulin was expired and had been administered to the resident after it expired. Interview with Resident #2 on 09/23/21 at 4:51pm revealed: -The MAs checked her blood sugar and she received sliding scale insulin if she needed it. -She did not have any symptoms with high or low blood sugar so she could not tell when her blood sugar was high or low. b. Review of Resident #2's FL-2 dated 08/10/21 revealed: -There was an order for Pantoprazole 40mg 1 tablet twice daily. (Pantoprazole is used to treat acid reflux disease.) -There was an order for Ferrous Sulfate 325mg 1 tablet twice daily. (Ferrous Sulfate is used to treat iron deficiency anemia.) Review of Resident #2's Swallow Precautions form signed and dated 08/07/21 by a speech pathologist revealed: -The resident's current diet was soft and bite sized with thin liquids. -The resident's medications should be crushed in puree as needed. -The form was not signed by a prescribing practitioner.	{D 358}		

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	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

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SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 59 Review of Resident #2's barium swallow report dated 08/30/21 revealed the resident was diagnosed with dysphagia (difficulty swallowing). Interview with a medication aide (MA) on 09/23/21 at 11:40am revealed: -Resident #2 had swallowing problems so she crushed all of the resident's medications except she opened any capsules and added the contents to the crushed tablets. -She had not noticed the instructions on the labels for the Pantoprazole and Ferrous Sulfate was not to crush or chew those medications. Interview with a second MA on 09/23/21 at 12:04pm revealed: -Resident #2 had swallowing problems so she crushed all the resident's medications including the Pantoprazole and Ferrous Sulfate tablets. -She opened the capsules and put those contents with the crushed tablets. -She did not know if the resident had an order to crush medications. Interview with a third MA on 09/23/21 at 4:19pm revealed: -The MAs had to crush Resident #2's medications because the resident had swallowing problems. -She usually crushed all of Resident #2's medications (including Pantoprazole and Ferrous Sulfate) except she opened capsules and put the contents with the crushed medications. -She was not aware Resident #2's Pantoprazole and Ferrous Sulfate should not be crushed. Review of Resident #2's physician's orders revealed no order to crush the resident's medications.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 60 Observation of Resident #2's medications on hand on 09/23/21 at 11:40am revealed: -There was a multi-dose pack with a start date of 09/21/21. -The multi-dose pack included Ferrous Sulfate 325mg tablets with a label warning, don't chew/crush, swallow whole. -There was a bubble card of Pantoprazole 40mg tablets dispensed on 09/06/21 with a label warning, do not chew or crush; swallow whole. Review of Resident #2's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Pantoprazole 40mg 1 tablet twice a day scheduled for administration at 8:00am and 8:00pm. -Pantoprazole was documented as administered from 09/01/21 - 09/22/21 except from 09/17/21 - 09/19/21 when the resident as on leave with family. -There was no documentation on the eMAR indicating if Pantoprazole could be crushed. -There was an entry for Ferrous Sulfate 325mg 1 tablet twice a day scheduled for administration at 9:00am and 8:00pm. -Ferrous Sulfate was documented as administered from 09/01/21 - 09/22/21 except from 09/17/21 - 09/19/21 when the resident as on leave with her family. -There was no documentation on the eMAR indicating if Ferrous Sulfate could be crushed. Interview with Resident #2 on 09/23/21 at 4:51pm revealed: -She was still having problems swallowing; sometimes it bothered her and sometimes it did not. -The MAs crushed all her medications except they opened any capsules before administering	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 61 them to her. -The crushed medications were bitter but the medications did not cause her stomach to hurt. -She was not currently having any issues with heartburn. Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 5:55pm revealed: -Resident #2 did not have an order to crush medications. -Resident #2 did not have any standing orders with an order to crush medications. -The primary care provider (PCP) should have been contacted after the resident's swallowing study to obtain an order to crush the resident's medications. -The MAs should use a "do no crush" (DNC) list to determine if a medication could be crushed. -She was looking for the facility's DNC list but had not been able to locate it yet. Review of the facility's DNC list on 09/23/21 revealed medications that should not be crushed included Pantoprazole and Ferrous Sulfate. _____ The failure of the facility to administer medications as ordered resulted in duplicate administration of Seroquel which could have caused increased level of sedation, injury, or possible health concerns (#8), medications being held without an order prior to surgery (#6), and self-administration of an inhaler without an order (#7) for 3 of 5 residents observed during the medications passes; and administration of medications outside of scheduled ordered times or routinely holding medications for a resident on dialysis which could have caused unstable levels of a medication in his body (#5), not having medications on hand and documenting them as administered (#5), not administering skin barrier	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

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{D 358}	Continued From page 62 protectant cream as ordered to prevent skin breakdown (#5); and administering expired insulin which could have led to decrease effectiveness of the medication (#2). The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/23/21 and 09/24/21 for this violation.	{D 358}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (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:	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 63 Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 3 of 6 sampled residents (#2, #5, #8) including inaccurate documentation of sliding scale insulin (#2); a calcium binder for a resident receiving dialysis (#5); and a medication used to treat mood disorders (#8). The findings are: 1. Review of Resident #2's current FL-2 dated 08/10/21 revealed diagnoses included diabetes mellitus type 2, hypoxia (low oxygen in your blood), acute respiratory disease, hypertension, history of stroke, and history of sarcoidosis (inflammatory disease that most commonly affects the lungs). Review of Resident #2's FL-2 and hospital discharge summary dated 08/10/21 revealed an order for Humulin R insulin before breakfast and dinner per sliding scale: 250 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; and > (greater than) 400 = 5 units. (Humulin R insulin lowers blood sugar.) Review of Resident #2's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Humulin R insulin twice a day before breakfast and before supper per sliding scale: 250 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; and > 400 = 5 units. -Humulin R sliding scale insulin was scheduled at 8:00am and 5:00pm. -There was a row to document staff's initials, a row to document blood sugar, and a row to document results. -The resident's blood sugars at 8:00am and	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 64 5:00pm ranged from 159 - 483 from 09/01/21 - 09/22/21. -The resident's blood sugar was documented as 250 or above on 25 occasions and required administration of Humulin R sliding scale insulin on those 25 occasions. -Humulin R sliding scale was not documented as administered on 13 of the 25 occasions it was required to be administered according to the order. -Documentation for Humulin R insulin on those 13 occasions did not indicate any amount of insulin was administered. -No amount of sliding scale insulin was documented at 8:00am on 09/07/21, 09/14/21, 09/16/21, or 09/17/21 when the resident's blood sugar ranged from 257 - 333 and would have required either 2 or 3 units of insulin on those occasions based on the sliding scale. -No amount of sliding scale insulin was documented at 5:00pm on 09/03/21, 09/04/21, 09/07/21, 09/08/21, 09/10/21, 09/13/21, 09/14/21, 09/16/21, or 09/21/21 when the resident's blood sugar ranged from 262 - 400 and would have required either 2, 3, or 4 units of insulin on those occasions based on the sliding scale. Interview with a medication aide (MA) on 09/23/21 at 2:04pm revealed: -She initialed and documented Resident #2's blood sugar in the Humulin R sliding scale insulin entry on 09/07/21, 09/14/21, 09/16/21, and 09/17/21. -She administered the Humulin R insulin according to the sliding scale on those dates but there was nowhere on the eMAR to document the amount administered. -A results box would pop up on the eMAR so she documented the blood sugar in that box.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 65 Interview with a second MA on 09/23/21 at 4:10pm revealed: -The Humulin R insulin sliding scale was on the instructions on the eMAR so she did not have to document the amount she administered to the resident. -She thought the eMAR system automatically filled in the amount administered since the scale was on the eMAR. -For the results box, she usually typed "no change in condition" because she did not know that was where she needed to type the amount administered. -She administered Humulin R sliding scale insulin to Resident #2 on 09/04/21, 09/08/21, 09/10/21, 09/13/21, 09/14/21, and 09/21/21 at 5:00pm. -She did not document the amount administered on the eMAR because she thought the eMAR automatically noted the amount. Interview with a third MA on 09/23/21 at 4:19pm revealed: -She did not know why the amount she administered for Resident #2's Humulin R sliding scale insulin did not print on the eMAR. -She administered Humulin R sliding scale insulin to Resident #2 on 09/03/21, 09/07/21, and 09/16/21 at 5:00pm. -She did not document the amount administered on the eMAR because she thought the eMAR automatically noted the amount. Interview with Resident #2 on 09/23/21 at 4:51pm revealed: -Her blood sugar was checked 3 times a day and she received sliding scale insulin if she needed it. -She did not have any symptoms with high or low blood sugar so she could not tell when her blood sugar was high or low.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 66	D 367		

Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 5:55pm revealed:
-She was not aware the amount of Humulin R sliding scale insulin being administered to Resident #2 was not always documented on the eMARs by the MAs.
-She expected the MAs to notify her of any discrepancies or problems with entering information on the eMARs.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 09/23/21 at 4:40pm was unsuccessful.

2. Review of Resident #8's current FL-2 dated 08/20/21 revealed:
-Diagnoses included mild mental retardation.
-There was an order for Seroquel 50mg (used for mood disorders) every morning.
-There was an order for Seroquel 50mg every day at noon.

Review of Resident #8's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Seroquel 50mg with instructions to administer each morning scheduled at 9:00am.
-Seroquel 50mg was documented as administered every day in September 2021 at 9:00am.
-There was a discontinued entry that ended on 09/19/21 for Seroquel 50mg with instructions to administer each day at noon scheduled for 12:00pm.
-Seroquel 50mg was documented as administered on 09/01/21-09/05/21 and 09/08/21-09/19/21 at 12:00pm.
-Seroquel 50mg was documented as "Not Administered: Drug/Item Unavailable" on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 67	D 367		

09/06/21-09/07/21 at 12:00pm.
-There was an entry for Seroquel 50mg with instructions to administer each morning and again at noon scheduled for 8:00am.
-Seroquel 50mg was documented as administered on 09/18/21-09/23/21 at 8:00am.
-Seroquel 50mg was not documented as administered at noon (12:00pm) on 09/20/21-09/23/21.
-Resident #8 had two morning doses and a noon dose of Seroquel documented as administered on 09/18/21-09/19/21 instead of one morning dose and one noon dose.
-Resident #8 had two morning doses of Seroquel documented as administered on 09/20/21-09/23/21 instead of one morning dose and one noon dose.

Observation of Resident #8's medications on hand on 09/23/21 at 12:55pm revealed one bottle of Seroquel 50mg with instructions to administer one tablet by mouth every morning and 1 tablet every day at noon.

Interview with the medication aide (MA) on 09/23/21 at 12:43pm revealed:
-Resident #8 was supposed to get Seroquel 50mg each day at 9:00am and 12:00pm.
-The 12:00pm dose popped up on the eMAR in the computer to be administered at 8:00am that day (09/23/21).
-She did not know why the 12:00pm dose of Seroquel was popping up on the eMAR for administration at 8:00am, but realized the error that day (09/23/21) when it did not pop up at 12:00pm, because she was used to administering both a morning dose at 9:00am and a noon dose at 12:00pm to Resident #8.
-She administered Resident #8's 12:00pm dose of Seroquel at 7:39am and the 9:00am dose at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 68	D 367		

8:51am that day (09/23/21).
-She did not realize that Resident #8's 8:00am administration of Seroquel had instructions to give the dose at 12:00pm (noon), she did not know why the eMAR administration time was inaccurate.
-She did not realize she had administered two doses of Seroquel that morning (09/23/21) until the noon dose did not pop up on Resident #8's eMAR.
-The resident was never disoriented or confused but was frequently drowsy and napped a lot during the day.

Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 5:53pm revealed:
-When a new order, clarification, or refill order was received, she or the MA would fax the order to the pharmacy.
-The pharmacy would then enter the order into the resident's eMAR and send it back to the facility for approval before it was active for medication administration.
-She or the Administrator were responsible for approving orders that had been entered by the pharmacy into the eMAR system prior to making the orders active in the residents' eMARs for administration.
-There was no process in place to compare original orders to the orders pending approval from the pharmacy for accuracy.
-She was not sure why Resident #8's 12:00pm dose of Seroquel was popping on the eMAR to be administered at 8:00am.
-She expected the MAs to read medication instructions when administering medications and to clarify any issues or errors on the eMAR with her, the Administrator, or the resident's provider prior to administering any medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 69 Interviews with the Administrator on 09/23/21 at 1:48pm and 6:21pm revealed: -She was unsure how Resident #8's 12:00pm dose of Seroquel 50mg was appeared on the eMAR to be administered at 8:00am. -She was concerned that Resident #8 received two morning doses and a noon dose of Seroquel on 09/18/21-09/19/21 instead of one morning dose and one noon dose, and two morning doses of Seroquel on 09/20/21-09/23/21 instead of one morning dose and one noon dose. -She expected the MAs to read the medication label instructions as part of the six rights of medication administration prior to administration. -She expected the MAs to administer medications as ordered and clarify medication orders or eMAR errors as needed prior to administration. -She expected MAs to report eMAR errors to her or the RCC as identified. -She expected the RCC to ensure accuracy of orders on the eMAR when approving them from the pharmacy as compared to the original order for safe medication administration. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 09/23/21 at 10:50am revealed: -The facility was responsible for faxing new orders, clarifications, and refills to the pharmacy. -Once received, the pharmacy was responsible to enter new orders, clarifications, and refills onto the resident's eMAR which would subsequently be sent back to the facility for approval before becoming active on the resident's eMAR for medication administration. -It was the facility's responsibility to ensure accuracy of the order prior to approving the order to become active on the resident's eMAR. -If an order was incorrect during the approval period, it was the facility's responsibility to notify	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 70	D 367		

the pharmacy to correct the order or manually correct the order themselves.
-The pharmacy was unable to see when an order had been approved and become active on a resident's eMAR.

Telephone interview with Resident #8's mental health provider (MHP) on 09/23/21 at 4:27pm revealed:
-He was not aware that Resident #8 received two morning doses and a noon dose of Seroquel on 09/18/21-09/19/21 instead of one morning dose and one noon dose, and two morning doses of Seroquel on 09/20/21-09/23/21 instead of one morning dose and one noon dose.
-He expected the facility to notify him of medication errors per standard procedure.
-If he had been made aware, he would have given orders for close observation of the resident for sedation, unsteadiness, and falls, as well as to increase the resident's fluid intake, and monitor blood pressure and pulse twice daily for five days.
-Depending on how many excess doses the resident received, he would have possibly held the Seroquel for up to seven days because the resident was small and elderly.
-He expected the facility to administer medications as ordered and clarify if any medication changes on the eMAR did not make sense.
-He had not ordered any changes to Resident #8's medication administration times and she was to get one 50mg dose of Seroquel at 9:00am and one 50mg dose of Seroquel at 12:00pm each day.

Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 71 3. Review of Resident #5's current FL-2 dated 09/15/21 revealed an order for Cinacalcet 60mg (calcium binder) take one tablet daily with largest meal of the day. Review of a physician's order sheet dated 06/30/21 from Resident #5's dialysis provider revealed an order for Cinacalcet 60mg take one table every day with largest meal with 11 refills. Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Cinacalcet 60mg take one tablet each day with largest meal scheduled at 8:00am. -Cinacalcet was documented as administered as ordered on 09/02/21, 09/04/21, 09/05/21, 09/07/21, 09/08/21, 09/09/21, 09/11/21, 09/12/21, 09/14/21, 09/17/21, 09/18/21, and 09/19/21. Observation of Resident #5's medications on hand on 09/23/21 at 4:18pm revealed there was no Cinacalcet on hand for the resident. Interview with a medication aide (MA) on 09/23/21 at 4:18pm revealed: -She did not think they had the Cinacalcet on hand for Resident #5 for a long time. -If she remembered correctly, Resident #5's insurance would not pay for it. -She could not remember the last time Resident #5's Cinacalcet had been available. -She did not know how or why Resident #5's Cinacalcet would be documented as administered on his eMAR because the medication was unavailable. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/23/21 at	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 72 5:11pm revealed: -The last time the pharmacy filled Resident #5's Cinacalcet was on 07/16/21 for a 30-day supply. -The pharmacy had been unable to refill Resident #5's Cinacalcet because insurance was denying coverage for the medication. -Resident #5 would not have had any Cinacalcet on hand after the 30-day supply ran out, which would have been approximately 08/15/21. -Insurance had stated that the dialysis provider should have provided Resident #5's Cinacalcet to him. -It was important for Resident #5 to have his Cinacalcet as ordered because his kidney function was compromised and he required dialysis, the Cinacalcet was used to bind calcium in the resident's blood stream to ensure his calcium levels did not get too high. -She was not sure why Resident #5's eMAR showed documentation that the resident had received Cinacalcet because it should not have been available to the resident after 08/15/21. Interview with the Resident Care Coordinator (RCC) on 09/23/21 at 5:53pm revealed: -She was not aware that Resident #5 did not have any Cinacalcet on hand. -She was not sure why Resident #5's eMAR showed documentation that the resident received the Cinacalcet if the medication was unavailable. -The MAs were responsible to perform weekly medication cart audits to ensure all residents had their ordered medications on hand. -The MAs were expected to only document medications on hand and administered to a resident to ensure accuracy of eMARs. -She knew the staff had requested a refill for Resident #5's Cinacalcet, but did not know the medication had not come in. -Last night (09/22/21) she received a letter from	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 73 the pharmacy that Resident #5's insurance would not pay for his Cinacalcet. Interview with the Administrator on 09/23/21 on 6:21pm revealed: -She was not aware that Resident #5 did not have Cinacalcet on hand. -She was not sure why Resident #5's eMAR showed documentation that the resident received the Cinacalcet if it was unavailable. -She expected staff to perform weekly cart audits accurately to ensure all residents had their ordered medications on hand. -The MAs were expected to only document medications on hand and administered to a resident to ensure accuracy of eMARs. -She expected staff to report to her, the RCC, or the PCP if a resident was not able to get their medications as ordered. Attempted telephone interview with Resident #5's PCP on 09/23/21 at 4:40pm was unsuccessful.	D 367		
{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	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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
{D912}	Continued From page 74 as related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 5 residents (#6, #7, #8) observed during the medication passes including errors with a medication for mood disorders (#8), medications held without an order (#6), and an inhaler (#7); and for 2 of 5 sampled residents (#2, #5) for record review including errors with holding medications without an order, administering medications outside of ordered times, not having ordered medications on hand, and not administering skin barrier cream as ordered (#5), and administration of expired insulin (#2). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation)].	{D912}		