STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	R-C 11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section completed a follow up survey on 11/23/21 through 11/24/21.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: UNABATED TYPE B VIOLATION Based on observations, record reviews and interviews the facility failed to ensure referrals to meet the acute healthcare needs for 2 of 5 sampled residents who had an order for dressing changes to a wound (#2), had orders to contact the Primary Care Provider (PCP) if blood pressures were out of range (#2 & #4) and was refusing a medication that was ordered to protect the stomach (#2). The findings are: 1. Review of Resident #2's current FL2 dated 03/31/21 revealed: -Diagnoses included dementia, gastroesophageal reflux disease and renal disease. -An order to check blood pressures daily. Review of the facility's Missed or Refused Medication policy revealed: -Missed or refused medications are documented in the resident's MAR and the provider, responsible party is notified and documented. -The Medication Aide (MA) and/or the Resident Care Coordinator (RCC) notifies the prescribing	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 273}	Continued From page 1	{D 273}		

provider immediately using the Medication Notification form after 3 consecutive refusals.
-The RCC evaluates the resident refusals and contacts the physician and responsible party if the resident is continually refusing medication and documents the communication on the Care Coordinator Meeting Progress Note.

a. Interview with Resident #2 on 11/23/21 at 9:17am during the initial tour revealed her back hurt due to a back surgery she had a long time ago.

Review of an Infectious Disease office note dated 10/20/21 revealed Resident #2 was seen on 10/20/21 for a follow-up for a chronic spinal wound infection with area of increased swelling and erythema (redness of the skin) with concern for relapsed infection.

Review of an Infectious Disease office note dated 11/17/21 revealed:
-Resident #2 presented to the office with a wound in the thoracic (chest) area that was several centimeters in diameter and had erythema, edema (swelling caused by excess fluid), soft tissue swelling and was tender to palpate.
-There was an order to apply a clean, dry dressing to wound once daily and as needed until it healed.

Review of Resident #2's November 2021 Medication Administration Record (MAR) revealed:
-There was an electronic entry dated 11/20/21 to apply a gauze pad to wound on lower back once daily until healed.
-There was documentation Resident #2 refused treatment on 11/20/21 through 11/23/21.

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	HAL061011	A. BUILDING: _____ B. WING _____	R-C 11/24/2021

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{D 273}	Continued From page 2 Interview with the Divisional Clinical Services Director on 11/23/21 at 3:23pm revealed: -Because the order for the dressing changes was entered on the MAR as daily, without a specific time, it automatically was set to a default time of 1:00am. -The Medication Aides (MAs) attempted to change the dressing but Resident #2 refused to allow them to do it at 1:00am. -The MA should have informed the Resident Care Coordinator (RCC) that Resident #2 refused to have the dressing changed and that the treatment was on the MAR at 1:00am. -The PCP should have been informed the dressing changes were being refused. Telephone interview with a nurse from the Infectious Disease office on 11/23/21 at 4:18pm revealed: -The wound on Resident #2's back was draining on 11/17/21 when the doctor examined her. -Not changing the dressing could make the wound worse and become more infected. -The doctor who wrote the order expected the facility to follow the order and inform her if the treatment was refused. Observation of the wound on 11/23/21 at 4:57pm revealed: -The facility's Licensed Health Professional Support (LHPS) nurse uncovered the wound so it could be seen. -The wound in the middle of her back was surrounded by red and inflamed tissue. Interview with the LHPS nurse on 11/23/21 at 5:15pm revealed: -The wound needed more than a dry dressing as it was draining, had green slough coming out of it and it was red.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 273}	Continued From page 3 -She contacted the Infectious Disease office, described the wound to the nurse and was told it had gotten worse since the previous week. Interview with Resident #2 on 11/23/21 at 4:08pm and 4:57pm revealed: -Her back hurt from a wound that started 2-3 weeks ago. -She forgot that the doctor put a dressing on her wound on 11/17/21. -She did not remember anyone ever coming into her room at 1:00am to ask if the dressing could be changed. Interview with the RCC on 11/24/21 at 8:53am revealed: -Resident #2 went to the Infectious Disease doctor on 11/27/21 and returned with orders to change the dressing on the wound daily. -She informed the facility's Primary Care Provider (PCP) and sent the order to pharmacy so it could be placed on the MAR. -Because there was not a specified time on the order the default time from pharmacy was 1:00am. -She was not aware Resident #2 refused to have the dressing changed and the MAs did not write a progress note about the resident refusing the dressing change. -MAs, per policy, should report treatment refusals to the RCC after 3 refusals. Interview with a third shift MA on 11/24/21 at 11:03am revealed: -Resident #2 refused to have the dressing changed on the wound when she attempted to do it on 11/22/21. -She informed the RCC the dressing change treatment was scheduled at 1:00am and suggested it be changed but she did not	{D 273}		

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{D 273}	Continued From page 4	{D 273}		

remember if she mentioned the treatment was being refused.
-She did not know if the time was changed.

Interview with the Administrator on 11/24/21 at 9:28am revealed:
-He thought MAs had been trained to document treatment refusals in the progress notes.
-The RCC was responsible for ensuring orders were implemented or followed up with after a refusal.
-The MAs should have informed the RCC immediately after the first wound dressing was refused.
-The MAs should have noticed a 1:00am treatment time was inappropriate and notified the RCC immediately.
-He was informed yesterday (11/23/21) the dressing changes were being refused.

Telephone interview with Resident #2's PCP on 11/24/21 at 11:15am revealed:
-The wound on Resident #2's back looked larger and was draining so she recommended a referral to a wound specialist but Resident #2's family member refused and wanted her to see an Infectious Disease specialist instead.
-Resident #2 was seen by the Infectious Disease doctor last week and was ordered daily dressing changes.
-It was very important for the facility to communicate with her about residents.
-She was not informed until yesterday (11/23/21) that the dressing changes were being refused.
-She expected herself as well as the Infectious Disease doctor to be informed of the refusals.
-The risk of infection increased if the wound did not have the dressing changed daily.

b. Review of Resident #2's Physician Order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	R-C 11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

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{D 273}	Continued From page 5 Report dated 10/07/21 revealed an order for sucralfate suspension, 100mg/ml, 10 ml three times daily (a medication ordered to protect the esophagus). Review of Resident #2's October 2021 Medication Administration Record (MAR) revealed: -There was an entry for sucralfate suspension, 100mg/ml, 10 ml three times daily. -There was documentation Resident #2 refused the sucralfate suspension, 100mg/ml, 10 ml at 8:00am on 10/14/21. -There was documentation Resident #2 refused the sucralfate suspension, 100mg/ml, 10 ml at 2:00pm on 10/10/21, 10/13/21 and 10/14/21. -There was documentation Resident #2 refused the sucralfate suspension, 100mg/ml, 10 ml at 8:00pm on 10/04/21, 10/05/21, 10/08/21, 10/09/21, 10/10/21, 10/14/21, 10/18/21, 10/19/21, 10/22/21, 10/23/21, 10/24/21, 10/27/21, 10/28/21, 10/29/21 and 10/31/21. Review of Resident #2's November 2021 MAR revealed: -There was an entry for sucralfate suspension, 100mg/ml, 10 ml three times daily. -There was documentation Resident #2 refused the sucralfate suspension, 100mg/ml, 10 ml at 8:00am on 11/11/21. -There was documentation Resident #2 refused the sucralfate suspension, 100mg/ml, 10 ml at 8:00pm on 11/01/21, 11/02/21, 11/5/21, 11/06/21, 11/07/21, 11/10/21, 11/15/21, 11/16/21, 11/19/21, 11/20/21 and 11/21/21. Interview with Resident #2 on 11/23/21 at 4:08pm revealed: -She did not remember refusing the sucralfate suspension that was ordered to protect her	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	R-C 11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

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{D 273}	Continued From page 6	{D 273}		

stomach.
-She frequently had an upset stomach and vomited so she would not refuse to take that medication.
-When her medications were brought to her she took them but she would not know if a medication was missing because she took so many.

Interview with a first shift MA on 11/23/21 at 3:14pm revealed:
-Resident #2 occasionally refused sucralfate suspension because she was sleepy or nauseous.
-She never called the PCP when the medication was refused because the PCP saw her 2-3 times a month and reviewed the MAR when she was at the facility.

Interview with a second MA on 11/24/21 at 11:03pm revealed:
-Resident #2 usually took the sucralfate suspension during the day but frequently refused the 8:00pm dose.
-She did not know she should and was never trained to inform the RCC or the PCP if a medication was refused.

Interview with the RCC on 11/24/21 at 8:53am revealed:
-She was not aware Resident #2 was frequently refusing the sucralfate suspension.
-She did not review the MAR to see if medications were being refused.
-MAs could write progress notes in addition to documenting refusals on the MAR, which can be pulled up on a report.
-There was no documentation in progress notes from the MAs that the sucralfate suspension was refused.
-The MAs should have told her about the frequent

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	HAL061011	A. BUILDING: _____ B. WING _____	R-C 11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 273}	Continued From page 7	{D 273}		

evening refusals.
-After 3 medication refusals she informed the PCP.
-The MAs should know to inform the RCC of medication refusals, but the newly hired MAs may not have been trained to report refusals.
-The PCP reviewed the Physician Order Report when she was at the facility, but not the MAR, so the PCP would not know about the refusals unless she was told.

Interview with the Administrator on 11/24/21 at 9:28am revealed:
-MAs should document medication refusals in the progress notes and to the best of his knowledge they had been trained to do that.
-The MAs should then inform the RCC of the medication refusal.
-The RCC was responsible for notifying the PCP about medication refusals.

Interview with the Divisional Clinical Services Director on 11/23/21 at 3:23pm revealed:
-The resident's PCP should be contacted after a resident refused 3 consecutive doses of medication.
-She was not aware refusals were not being communicated to the PCP.
-Refusals should be documented on the MAR along with a progress note.

Telephone interview with Resident #2's PCP on 11/24/21 at 11:15am revealed:
-It was very important for the facility to communicate with her about the residents.
-Resident #2 had chronic esophagitis and the Sucralfate suspension was ordered to coat the esophagus and protect it from erosions.
-Resident #2 had chronic anemia, a result of esophagitis.

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	HAL061011	A. BUILDING: _____ B. WING _____	R-C 11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

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{D 273}	Continued From page 8 -It was very important for Resident #2 to take the sucralfate suspension to protect the esophagus and prevent further anemia. -She needed to know the medication was being refused so she could talk with Resident #2 about the importance of taking the medication. c. Review of Resident #2's Physician Order Report dated 10/07/21 revealed an order for blood pressure checks daily at 8pm and to notify the physician if the systolic pressure is greater than 160 or less than 100 or the diastolic pressure is greater than 90 or less than 40. Review of Resident #2's October 2021 Medication Administration Record (MAR) revealed: -There was an entry to check blood pressures at 8:00pm and call the physician if the systolic pressure was greater than 160 or less than 100 or the diastolic pressure was greater than 90 or less than 40. -There was documentation the blood pressure reading was 140/94 on 10/04/21. -There was documentation the blood pressure reading was 168/99 on 10/05/21. -There was documentation the blood pressure reading was 141/94 on 10/08/21. -There was documentation the blood pressure reading was 142/91 on 10/09/21. -There was documentation the blood pressure reading was 125/91 on 10/21/21. -There was no documentation the physician was contacted for any of the above readings. Review of Resident #2's November 2021 MAR revealed: -There was an entry to check blood pressures at 8:00pm and call the physician if the systolic pressure was >160 or <100 or the diastolic	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 273}	Continued From page 9	{D 273}		

pressure was >90 or <40.
-There was documentation the blood pressure reading was 145/97 on 11/20/21.
-There was documentation the blood pressure reading was 134/92 on 11/21/21.
-There was no documentation the physician was contacted for any of the above readings.

Interview with a first shift MA on 11/23/21 at 3:14pm revealed:
-If a blood pressure was ever out of range the PCP was contacted that day.
-If a blood pressure was out of range, the Resident Care Coordinator (RCC) would recheck the blood pressure with a manual blood pressure cuff.
-Calls to physicians were documented in progress notes.
-She never checked resident #2's blood pressure because it was ordered for 8:00pm.
-All MAs had the phone number for the PCP, they could contact her at any time and she did not know why the PCP was not contacted about blood pressure readings.

Interview with a second MA on 11/24/21 at 11:03pm revealed:
-She did not remember if she ever called a PCP about a blood pressure being out of range.
-She was never trained to document in progress notes if a blood pressure was out of range.

Interview with the RCC on 11/24/21 at 8:53am revealed:
-The MAs documented blood pressure reading in progress notes if they are out of range and necessitate contacting the PCP but there was no documentation the PCP had been contacted about Resident #2 blood pressures.
-The MA was responsible for contacting the PCP

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	HAL061011	A. BUILDING: _____ B. WING _____	R-C 11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

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{D 273}	Continued From page 10 if the blood pressure was out of range according to the parameters written in the order. Interview with the Administrator on 11/24/21 at 9:28am revealed: -If a resident had a blood pressure reading that was out of range the RCC would recheck it with a manual blood pressure cuff. -He expected the MAs to contact the PCP immediately if it was part of the order. -The MAs documented communications with the PCP in the resident's progress notes. Interview with the Divisional Clinical Services Director on 11/23/21 at 3:23pm revealed: -A resident's PCP should be contacted according to the blood pressure parameters in the order. -The facility's PCP did not have any documentation of being contacted about blood pressures being out of range. Telephone interview with Resident #2's PCP on 11/24/21 at 11:15am revealed: -It was very important for the facility to communicate with her about the residents. -Resident #2's blood pressure elevated if there was something wrong with her. -She was unaware Resident #2 had blood pressure reading that should have been reported. -If she was aware of Resident #2's blood pressure readings she would have checked on her when she was at the facility. 2. Review of Resident #4's current FL2 dated 03/24/21 revealed diagnoses included pleural effusion (collection of fluid around the lungs) and diabetes. Review of Resident #4's signed physician order sheet dated 10/07/21 revealed a physician's order	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

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{D 273}	Continued From page 11	{D 273}		

to check blood pressure twice daily and to notify MD if systolic blood pressure (SBP) was greater than 160 or less than 100 or diastolic blood pressure (DBP) was greater than 90.

Review of Resident #4's October electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry to check blood pressure twice daily notify MD if SBP>160 or <100, DBP>90.
-There was documentation the blood pressure was 156/99 on 10/23/21.
-There was no documentation the physician was contacted.

Review of Resident #4's November eMAR revealed:
-There was a computer-generated entry to check blood pressure twice daily notify MD if SBP was greater than 160 or less than 100, DBP greater than 90.
-There was documentation the blood pressure was 135/92 on 11/02/21.
-There was documentation the blood pressure was 140/91 on 11/08/21.
-There was no documentation the physician was contacted.

Interview with a medication aide (MA) on 11/24/21 at 10:04am revealed:
-She was responsible for checking the residents blood pressure if they had an order from the primacy care provider (PCP).
-If the blood pressure reading was elevated then she would recheck the blood pressure with a manual cuff.
-There was no documentation a blood pressure was rechecked.
-She knew she needed to call the PCP if the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 273}	Continued From page 12	{D 273}		

blood pressure readings were elevated and then document she had called on a progress note.
-She had not contacted the provider about elevated blood pressures recently.

Interview with the Resident Care Coordinator (RCC) on 11/24/21 at 8:53am revealed:
-The MAs documented blood pressure readings the in progress notes if they are out of range and the PCP was contacted.
-There was no documentation the PCP had been contacted about Resident #4's blood pressures.
-The MAs were responsible for contacting the PCP if the blood pressure readings were out of range according to the parameters written in the order.

Interview with the Divisional Clinical Services Director on 11/23/21 at 3:23pm revealed:
-A resident's PCP should be contacted according to the blood pressure parameters in the order.
-The facility's PCP did not have any recent documentation of being contacted about blood pressures being out of range for any resident.

Telephone interview with Resident #4's PCP on 11/24/21 at 11:15am revealed:
-It was very important for the facility to communicate with her about the residents.
-She did not know Resident #4 had several elevated blood pressure readings.
-She was in the process of adjusting medications for Resident #4.
-Resident #4 was experiencing some dizziness and she thought it was caused by rapid changes in blood pressure.
-It was important for the facility to contact her when Resident #4's blood pressure was elevated so she could continue to adjust her medications to try to prevent the resident from having

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	R-C 11/24/2021

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MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(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 273}	Continued From page 13 dizziness. Interview with the Administrator on 11/24/21 at 9:28am revealed: -If a resident had a blood pressure reading that was out of range, the RCC would recheck it with a manual blood pressure cuff. -He expected the MAs to contact the PCP immediately if a blood pressure order specified to. -The MAs documented the communication with the PCP in the resident's progress notes. _____ The facility failed to inform the Primary Care Provider (PCP) that a resident refused to have the dressing changed on a wound, resulting in the wound becoming red and inflamed (#2); failed to inform the PCP a resident frequently refused to take a medication prescribed to protect the esophagus (#2) and failed to contact the PCP for guidance when 2 residents, who had parameters for blood pressures readings which necessitated informing the PCP, resulting in the PCP not being alerted to assess residents for ongoing elevated blood pressures (#2 and #4) and a resident that needed a medication adjusted to prevent dizziness (#4). This failure was detrimental to the health 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 11/23/21 for this violation.	{D 273}		
{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	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 367}	Continued From page 14 following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the electronic Medication Administration Record (eMAR) for 1 of 5 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL2 dated 10/04/21 revealed: -Diagnoses included Alzheimer's Disease, macular degeneration, depression, and hyperlipidemia. -There was a physician's order for aspirin (a blood thinner) 81mg take 1 tablet daily. Review of a physician's order from Resident #1's orthopedic provider dated 11/17/21 revealed: -Resident #1 was scheduled for surgery on	{D 367}		

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{D 367}	Continued From page 15 11/24/21. -Resident #1 needed to stop taking aspirin for 7 days prior to surgery. Review of Resident #1's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for aspirin 81mg take 1 tablet daily scheduled to be administered at 8:00am. -Aspirin was documented as administered at 8:00am daily from 11/01/21 through 11/14/21 and 11/18/21 through 11/23/21. Observation of Resident #1's medication on hand on 11/23/21 at 11:50am revealed: -Resident #1's medications were packed in multi drug dose pack. -Aspirin was included in the medication card for Resident #1's morning medications. Interview with the Special Care Coordinator (SCC) on 11/23/21 at 11:50am revealed: -Resident #1 was having surgery to repair a broken wrist. -She knew Resident #1's aspirin was on hold for her surgery and thought she had discontinued the medication on the eMAR. -She did not administer the aspirin to Resident #1 today (11/23/21) or yesterday (11/22/21) when she administered medications during the morning medication pass. -She removed it from Resident #1's morning medications when she "popped" the medications out of the medication card and disposed of the aspirin. -She did not know why she documented the aspirin was administered to Resident #1. Interview with a medication aide (MA) on 11/23/21	{D 367}		

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{D 367}	Continued From page 16 at 4:24pm revealed: -She did not administer the aspirin to Resident #1 on 11/20/21 even though she had documented on the eMAR it was administered. -She knew Resident #1's aspirin was discontinued. -She removed the aspirin from the medication card and threw it away before she administered Resident #1's morning medications. -She forgot to correct the documentation on the eMAR to show she did not administer the aspirin. -She did not tell the SCC the eMAR was incorrect. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 11/24/21 at 11:15am revealed: -Only medications that were administered to a resident should be documented as administered on the eMAR. -She reviewed a resident's eMAR before she evaluated the resident during a visit. -She expected the eMARs to be accurate so she could make decisions on the care of the residents. Interview with the Administrator on 11/24/21 at 9:28am revealed: -The MAs were responsible for accurately documenting all medications that were administered to each resident. -The MAs should not document a medication was administered if it was not. -The Resident Care Coordinator (RCC) and the SCC were responsible for auditing the eMARs to make sure they were accurate. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.	{D 367}		

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{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 all residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to heath care referral. The findings are: Based on observations, record reviews and interviews the facility failed to ensure referrals to meet the acute healthcare needs for 2 of 5 sampled residents who had an order for dressing changes to a wound (#2), had orders to contact the Primary Care Provider (PCP) if blood pressures were out of range (#2 & #4) and was refusing a medication that was ordered to protect the stomach (#2). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Unabated Type B Violation).]	{D912}		