STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL097015	A. BUILDING: _____ B. WING _____	R-C 11/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE GLEN MANOR	240 INDEPENDENCE AVENUE NORTH WILKESBORO, NC 28659

(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 and Wilkes County Department of Social Services conducted a follow-up survey on 11/06/19.	{D 000}		
{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 4 of 6 residents sampled including a pain medication and eye drops (Resident #1), eye drops (Resident #6) a blood pressure/angina medication (Resident #5) being unavailable to administer, and a medication for nerve pain and blood pressure/angina (Resident #3). The findings are: 1. Review of Resident #1's current FL2 dated 05/15/19 revealed diagnoses included chronic obstructive pulmonary disease (COPD), respiratory failure with hypoxia, anxiety,	{D 358}		

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{D 358}	Continued From page 1 depression, and schizophrenia/schizoaffective disorder. a. Review of Resident #1's current FL2 dated 05/15/19 revealed: -There was an order for Tramadol 50 mg 1 tablet by mouth twice a day at 8:00am and 8:00pm. -There was an order for Tramadol 50 mg 1 tablet by mouth twice a day as needed for pain. Review of Resident #1's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Tramadol 50 mg 1 tablet by mouth twice a day; 1 pill twice daily as needed for pain. -The Tramadol was entered on the eMAR for as needed (PRN) only, there was no separate entry for the scheduled Tramadol to be administered twice daily from 10/07/19-10/31/19. -Tramadol was administered as needed 10 opportunities from 10/19/19-10/31/19 as requested by the resident. Review of Resident #1's November 2019 eMAR revealed -There was an entry for Tramadol 50 mg 1 tablet by mouth twice a day; 1 pill twice daily as needed for pain. -The Tramadol order was entered on the eMAR for as needed (PRN) only, there was no separate entry for the scheduled Tramadol to be administered twice daily from 11/01/19-11/06/19. -Tramadol was administered on 11/1/19 at 12:45 pm and 8:22pm per the request of the resident. Interview with Resident #1 on 11/06/19 at 8:35am revealed: -She had been in pain and when she asked for pain medication, it was not always received.	{D 358}		

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{D 358}	Continued From page 2 -She had frequent headaches and needed pain medication. -She felt that she did not get medication she needed for her pain. A secoond interview with Resident #1 on 11/06/19 at 3:00pm revealed: -She had hip pain that feels better when resident lies down. -She had back pain. -She had experienced neck pain for the past "3-4 days". -When she reported pain to the personal care aide (PCA), the PCA rubbed her neck, which helped somewhat but she still had neck pain. -She pulled the call bell and asked the personal care aide (PCA) for pain medication but no one comes back. -She felt the need for a pain pill was needed every day but does not ask for one every day. -Pain medication was the only treatment that alleviated her neck pain in the past. -When she did not get pain medication, she had to "just deal with it". Observation of medication on hand for Resident #1 on 11/06/19 at 11:05am revealed one bottle of Tramadol with a label with instructions for 1 tablet by mouth twice a day; 1 pill twice daily as needed for pain. Interview with a medication aide (MA) on 11/06/19 at 11:05am revealed: -She understood Resident #1's Tramadol order to be only for as needed for pain. -The Tramadol 50mg order was listed under the as needed (PRN) medications in the eMAR system. -She administered medications as they appeared on the eMAR.	{D 358}		

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{D 358}	Continued From page 3 -She did not realize Resident #1 had a scheduled order for Tramadol 50mg twice daily. Telephone interview with a representative from the contracted pharmacy on 11/06/19 at 11:35am revealed: -The pharmacy received two separate orders for Tramadol. -There was one order was for Tramadol 50 mg 1 tablet twice daily. -There was a second order was for Tramadol 50 mg 1 tablet twice daily as needed for pain. -Both Tramadol 50mg orders for Resident #1 were filled only on 05/21/19. -There had been no requests for refill of Tramadol since last fill date of 05/21/19. A second interview with a MA on 11/06/19 at 12:27pm revealed: -Resident #1 occasionally complained of pain; within the last 3-4 weeks the complaints increased. -Resident #1 complained to her of hip and back pain. -Resident #1 had not been given a daily dose of Tramadol as it was entered as PRN. -She had not realized there were two orders on the eMAR for Tramadol. Observation of medication on hand on 11/6/19 at 12:31pm revealed there were 49 tablets of Tramadol remaining since the last fill date of 05/21/19. Interview with the primary care provider (PCP) 11/06/19 at 12:41pm revealed: -She prescribed Tramadol to Resident #1 for back, hip, and knee pain. -Resident #1 has cycles of shortness of breath and intermittent pain.	{D 358}		

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{D 358}	Continued From page 4 -She expected Resident #1 to be given pain medication as ordered to alleviate pain Interview with the Resident Care Coordinator (RCC) on 11/06/19 at 1:26pm revealed: -Cart audits were done on all shifts Monday through Thursday. By the end of the week all residents' medications in the facility should have been audited. -Cart audits were reviewed by the RCC and Memory Care Manager (MCM). -The RCC and the MCM were responsible for making sure medications are getting re-ordered, medication labels match the order, and medications are not expired. -The RCC did not notice the double order for Tramadol. b. Review of Resident #1's current FL2 dated 05/15/19 revealed an order for Artificial Tears 1.4% (used to treat dry eyes), instill one drop into both eyes three times daily at 8:00am, 12:00pm, and 8:00pm. Review of Resident #1's physician order dated 08/08/19 revealed an order to start Artificial Tears 1.4% 1 drop in both eyes four times daily. Review of Resident #1's October and November 2019 electronic Medication Administration Record (eMAR) revealed there was no entry for Artificial Tears 1.4% 1 drop in both eyes four times daily from 10/07/2019-11/06/2019. Observation of medications on hand for Resident #1 on 11/06/2019 at 11:05am revealed: -There were no Artificial Tears available for administration. -There was one bottle of Liquigel 1% drops with instructions to instill 1 drop in both eyes at	{D 358}		

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{D 358}	Continued From page 5 bedtime, the bottle was half full and dated last filled on 08/01/2019. Telephone interview with a representative from the contracted pharmacy on 11/06/2019 at 11:35am revealed: -Artificial Tears are "on alert" and pharmacy is waiting on an order for an available alternative. -The pharmacy received the physician order on 08/08/2019 and faxed a confirmation request to the facility of what to send since Artificial Tears were unavailable. -The pharmacy had not received a returned confirmation from facility. Interview with a medication aide (MA) on 11/06/2019 at 12:24pm revealed: -She did not know Resident #1 had an order dated 08/08/2019 discontinue Liguigel drops and to begin Artificial Tears. -She had been giving Resident #1 Liquigel drops as ordered on Liquigel bottle. -MAs were supposed to receive copies of new orders and are responsible for checking to make sure the new medications have been delivered. -She had not received a copy of the new order for Resident #1's Artificial Tears. -MAs were unable to update the eMAR. -The eMAR could only be updated by the Administrator, Resident Care Coordinator (RCC), or Memory Care Manager (MCM). Interview on 11/06/2019 at 12:41pm with Resident #1's physician revealed: -There is no difference between Artificial Tears and Liquigel drops. -She expected the facility to follow orders as written. -Resident #1 needed the lubricant eye drops daily to avoid an occurrence of dry, itchy eyes.	{D 358}		

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{D 358}	Continued From page 6 Interview on 11/06/2019 at 1:26pm with the RCC revealed: -When new physician orders were received, copies were made and given to MA's and put in resident's chart. -New physician orders were faxed to the pharmacy by either the Administrator, RCC, or MCM. -If the Administrator, RCC, or MCM was unavailable MA's could fax the new order to the pharmacy. -The Administrator approved orders in the eMAR system. -Cart audits were done on all shifts Monday through Thursday and by the end of the week all residents' medications in the facility should have been audited. -Cart audits were reviewed by the RCC and MCM. -RCC and MCM were responsible for making sure medications are getting re-ordered, medication labels match the order, and medications are not expired. -RCC did not realize the change in the order for the eye drops for Resident #1. -Follow-up should have been made with the pharmacy and the MA should be checking to see if what is being administered is on the eMAR. 2. Review of Resident #'6's current FL2 dated 10/14/19 revealed: -Diagnoses included a recent rib fracture, dementia, anxiety and osteoarthritis. -An order for FreshKote 2.7% eye drops (preservative free), used to treat dry eyes, 1 drop in each eye twice a day. Review of Resident #6's October 2019 electronic	{D 358}		

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{D 358}	Continued From page 7 Medication Administration Record (eMAR) revealed: -There was an entry for FreshKote eye drops 2.7% to be administered twice a day scheduled at 8:00am and 8:00pm. -The entry was dated 10/15/19. -There was no documentation the FreshKote eye drops were administered to Resident #6 from 10/15/19-10/31/19. -There was no documentation indicating the reason the eye drops were not administered to Resident #6. Review of Resident #6's November 2019 eMAR revealed: -There was an entry for FreshKote eye drops to be administered twice a day scheduled at 8:00am and 8:00pm. -There was documentation FreshKote eye drops were administered at 8:00am on 11/01/19-11/04/19. -FreshKote eye drops were not documented as administered on 11/05/19 at 8:00am, with no documented reason. -There was documentation FreshKote eye drops were administered at 8:00pm from 11/02/19-11/05/19. -FreshKote eye drops were not documented as administered on 11/01/19 at 8:00pm with no documented reason. Observation of Resident #6's medications available for administration on 11/06/19 at 8:10am revealed: -There was a bottle of FreshKote eye drops on the medication cart with a seal surrounding the cap. -The seal surrounding the cap on the eye drop bottle was unbroken. -The computerized pharmacy label attached to	{D 358}		

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{D 358}	Continued From page 8	{D 358}		

the eye drop bottle had a fill date of 10/31/19.
-There were no other eye drop bottles available for administration for Resident #6.

Interview with a medication aide (MA) on 11/06/19 at 12:20pm revealed:
-The MAs, the Resident Care Coordinator (RCC) or the Memory Care Manager (MCM) could begin the order process by faxing new orders to the pharmacy.
-The RCC made copies of all the new orders from the providers and a copy was given to the MAs.
-The MAs referred to the order copy to alert them as to medications that had not arrived from the pharmacy.
-The RCC reviewed the order sheets as well to assure medications arrived from the pharmacy in a timely manner.
-The MAs or the RCC would contact the pharmacy if a medication did not arrive the following evening in the tote.
-The pharmacy generally entered medication orders on the eMAR.
-The RCC and the MCM could enter orders on the eMAR as well.
-The RCC and the MCM verified new orders on the eMAR.
-She had been off for a few days so she did not know why the eye drop bottle had not been opened and administered.
-When a new eye drop bottle was opened, the MAs should date the bottle or the medication box.

Interview with the RCC on 11/16/19 at 4:40pm revealed:
-Resident #6 returned from the hospital with a new FL2 on 10/14/19.
-The FL2 should have been sent to the pharmacy upon re-admission.
-The facility used a cycle fill medication

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{D 358}	Continued From page 9	{D 358}		

reordering process for most medications.
-Eye drops, nasal sprays, insulin, as needed (PRN) medications, for example, were not sent through the cycle fill.
-These medications had to be requested by the staff.
-Cart audits were completed by the MA on each of the three shifts.
-Each shift would audit approximately 3 residents and the entire community would be completed weekly.
-The MAs were to order any medications that were low or completed at the time of their audit.
-The completed audit was documented on the weekly cart audit form and submitted to the RCC for review.

Review of the Weekly Cart Audit form completed on 10/30/19 revealed:
-Resident #6's medications were audited on 10/30/19 and FreshKote eye drops were identified as not on the cart.
-FreshKote eye drops were documented as ordered on 10/31/19.

Telephone interview with a representative from the contracted pharmacy on 11/06/19 at 4:45pm revealed:
-The pharmacy had a current order for Resident #6 for FreshKote 2.7% eye drops, one drop in each eye twice a day.
-The order was received from the facility on 10/15/19.
-The pharmacy entered the order on the eMAR on 10/15/19.
-Eye drops were not sent unless the facility staff requested.
-The FreshKote eye drops were dispensed 10/31/19 upon request of the facility staff.
-There was no fill history for these eye drops prior

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{D 358}	Continued From page 10 to 10/31/19. Interview with Resident #6's primary care provider (PCP) on 11/6/19 at at 12:41pm revealed: -There was an order for FreshKote on Resident #6's hospital discharge FL2. -FreshKote eye drops were used to treat dry eyes. -As residents age, many experience dry scratchy eyes. -The facility should order medications in a timely manner for the residents. -She would expect the facility to follow physician orders as written. Interview with the Administrator on 11/06/19 at 5:15pm revealed: -She expected the MAs to order medications within 5-10 days of the medications running out. -If a medication that was ordered did not arrive the following evening in the tote, the MA should contact the pharmacy and report to the RCC or MCM. -There was an electronic report the Care Managers could run that identified medications administered late or not administered. -The RCC and MCM should be reviewing the missed medication report to identify medications which may not be in the building. -She did not know Resident #6's FreshKote eye drops had not been requested from the pharmacy to be dispensed until 10/30/19. -She did not know Resident #6's eye drops had not been opened since dispensed on 10/30/19. 3. Review of Resident #5's current FL2 dated 07/29/19 revealed diagnoses included dementia, hypoglycemia and renal insufficiency. Review of Resident #5's subsequent physician's	{D 358}		

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{D 358}	Continued From page 11 order dated 08/29/19 revealed an order for Diltiazem HCL 180mg, used to treat hypertension and angina, to be administered daily. Review of Resident #5's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Diltiazem HCL 180mg to be administered daily at 8:00am. -There was no documentation Diltiazem HCL was administered from 10/17/19 through 10/22/19. -There was no documented reason Diltiazem HCL was not administered to Resident #5. Observation of medications available for administration for Resident #5 on 11/06/19 at 11:05am revealed: -There was a pharmacy changeover from bubble pack medications to multi-dosed packaging for the residents' medications, to be initiated on 11/06/19 on third shift. -The pharmacist had not stocked Resident #5's medications in multi-dosed packaging on the medication cart at this time. -There were no Diltiazem HCL on the medication cart at this time. Telephone interview with a representative from the contracted pharmacy on 11/06/19 at 4:45pm revealed: -The pharmacy had a current order for Resident #5's Diltiazem HCL 180mg, one capsule daily. -A refill prescription was sent from the facility on 10/22/19 for Diltiazem HCL 180mg with out any directions for administration. -A pharmacy representative contacted the facility on 10/22/19 and requested directions for the Diltiazem HCL before the medication could be filled.	{D 358}		

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{D 358}	Continued From page 12 -On 10/22/19 a 15 day supply of Diltiazem HCL 180mg was dispensed to the facility. Interview with a medication aide (MA) on 11/06/19 at 2:15pm revealed: -The MAs were responsible for contacting the pharmacy and requesting medication refills when needed -She had just returned from a leave of absence and did not know why Resident #5's Diltiazem HCL was not available for administration from 10/17/19 through 10/22/19. -Diltiazem HCL was a cycle fill medication and should be dispensed monthly without a request from the MAs. Interview with the Resident Care Coordinator (RCC) on 11/16/19 at 5:00pm revealed: -The facility used a cycle fill medication re-ordering process. -If a medication was not received from the cycle fill, the MAs were responsible for contacting the pharmacy to get the medication into the facility. -She expected the MAs to notify her if a medication was not available for administration. -She did not know Resident #5 missed 6 doses of Diltiazem HCL 180mg from 10/17/19 through 10/22/19. -She did not know of a report that could be utilized in the eMAR system to be alerted of missed medications. Review of the Weekly Cart Audit form completed on the week of 10/16/19 revealed there was no documentation Resident #5's Diltiazem HCL was not available for administration or was ordered from the pharmacy. Interview with the Administrator on 11/06/19 at 5:15pm revealed:	{D 358}		

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	HAL097015	A. BUILDING: _____ B. WING _____	R-C 11/06/2019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 13 -She expected the MAs to order medication within 5-10 days of the medications running out. -If a medication that was ordered did not arrive the following evening, the MA should contact the pharmacy and report to the RCC or MCM. -The RCC and MCM were responsible to oversee the medications. -She did not know Resident #5 had not received Diltiazem HCL 180mg daily from 10/17/19 through 10/22/19, missing 6 doses of the medication. Attempted telephone interview with Resident #3's primary care provider (PCP) on 11/06/19 at 5:00pm was unsuccessful. 4. Review of Resident #3's current FL2 dated 05/15/19 revealed diagnoses included hypertension, diabetes mellitus with neuropathy, and cerebral infarction. a. Review of Resident 3's FL2 dated 05/15/19 revealed an order for gabapentin (used to treat nerve pain) 100mg one capsule daily. Review of Resident #3's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for gabapentin 100mg scheduled for administration at 8:00pm daily. -Gabapentin was not documented as administered 10/16/19 to 10/20/19 and 10/27/19-10/30/19. -There was documentation below the entry for "reasons/comments" included "other: on order". Observation of Resident #3's medications available for administration on 11/06/19 at 4:13pm revealed there was a bubble pack of gabapentin 100mg dispensed on 10/29/19, there	{D 358}		

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	HAL097015	A. BUILDING: _____ B. WING _____	R-C 11/06/2019

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{D 358}	Continued From page 14 were 24 remaining. Telephone interview with a pharmacy representative with the contract pharmacy on 11/06/19 at 4:20pm revealed: -The pharmacy had a current order for gabapentin 100mg one capsule daily dated 07/06/19. -The pharmacy filled and dispensed 15 tablets of gabapentin 100mg on 09/12/19 and 09/30/19. -The pharmacy filled and dispensed 30 tablets of gabapentin 100mg on 10/29/19. -The facility used a cycle fill reordering process, however Resident #3 was listed as a Hospice patient in their system. -Any resident listed as a Hospice patient could only have medications reordered via a fax request. Interview with a medication aide (MA) on 11/06/19 at 4:40pm revealed: -The MAs were responsible for calling the pharmacy and requesting medication refills when not received via cycle fill. -She remembered when Resident #3 missed several doses of gabapentin. -She contacted the pharmacy 3 times to get the gabapentin 100mg delivered to the facility. -She was told by pharmacy that Resident #3 was under Hospice care and she informed that the resident was not with hospice. -When she returned to work on 10/31/19, the medication was available. -She did not know why the resident was in the pharmacy system as Hospice. -She remembered telling the Resident Care Coordinator (RCC) about the pending medication, but she could not remember when she had the conversation.	{D 358}		

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{D 358}	Continued From page 15 Interview with the RCC on 11/16/19 at 5:00pm revealed: -The facility used a cycle fill medication reordering process. -If a medication was not received from cycle fill MAs were responsible for calling the pharmacy to get the medication into the facility. -She expected the MAs to notify her if a medication was not available for administration. -She did not know of Resident #3 missing medications. -She did not know of a report that could be utilized in the eMAR system to be alerted of missed medications. -Cart audits were completed Monday-Thursday weekly by the MAs on each shift. -She was not notified via the cart audits that the gabapentin was not available for Resident #3. -Resident #3 was not a Hospice patient, and she did not know why was listed in the pharmacy system as a Hospice patient. Attempted telephone interview with Resident #3's primary care provider (PCP) on 11/6/19 at 5:00pm was unsuccessful. Interview with Resident #3 on 11/06/19 at 4:35pm revealed: -He thought he received medications as ordered. -Sometimes he missed a medication for "a day or two" if they were not able to get the medication from the pharmacy. -He had not experienced any nerve pain "recently". b. Review of Resident #3's current FL2 dated 05/15/19 revealed an order for diltiazem 100mg (a medication used for hypertension and angina) two capsules daily.	{D 358}		

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{D 358}	Continued From page 16 Review of Resident #3's October 2019 electronic Medication Administration Record (MAR) revealed: -There was an entry for diltiazem 180mg two capsules daily at 8:00am. -The diltiazem 100mg was documented as administered daily from 10/07/19-10/31/19. Review of Resident #3's November 2019 eMAR revealed: -There was an entry for diltiazem 180mg two capsules daily at 8:00am. -The diltiazem 100mg was documented as administered 11/01/19-11/03/19 and 11/06/19. -The diltiazem 100mg was not documented as administered 11/04/19-11/05/19 with the reason "on order" documented. Observation of medications available for administration for Resident #3 on 11/06/19 at 4:13pm revealed there was no diltiazem 100mg available for administration. Telephone interview with a pharmacy representative from the contracted pharmacy on 11/06/19 at 4:20pm revealed: -The pharmacy had a current order for diltiazem 100mg two capsules daily dated 09/02/19 for Resident #3. -The pharmacy dispensed 60 capsules of diltiazem 100mg on 09/02/19. -There was no other dispense dates since 09/02/19 for diltiazem. -The facility used a cycle fill reordering process, however Resident #3 was listed as a Hospice patient in their system. -Any resident listed as a Hospice patient could only have medications reordered via a fax request. -There had been no fax request from the facility	{D 358}		

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{D 358}	Continued From page 17 for diltiazem 100mg for Resident#3. Interview with a medication aide (MA) on 11/06/19 at 4:40pm revealed: -The MAs were responsible for calling the pharmacy and requesting medication refills when not received via cycle fill. -She did not realize Resident #3 was out of diltiazem. -She had not contacted the pharmacy to have diltiazem delivered to the facility for Resident #3. -She was told by pharmacy that Resident #3 was under Hospice care and she informed that the resident was not with hospice. -She did not know why the resident was in the pharmacy system as Hospice. -She had not told Resident Care Coordinator (RCC) about the diltiazem not being available. Interview with the RCC on 11/16/19 at 5:00pm revealed: -The facility used a cycle fill medication reordering process. -If a medication was not received from cycle fill MAs were responsible for calling the pharmacy to get the medication into the facility. -She expected the MAs to notify her if a medication was not available for administration. -She did not know of Resident #3 missing medications. -She did not know of a report that could be utilized in the eMAR system to be alerted of missed medications. -Cart audits were completed Monday-Thursday weekly by the MAs on each shift. -She was not notified via the cart audits that the diltiazem was not available for Resident #3. -Resident #3 was not a Hospice patient, and she did not know why was listed in the pharmacy system as a Hospice patient.	{D 358}		

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{D 358}	Continued From page 18 Attempted telephone interview with Resident #3's primary care provider (PCP) on 11/6/19 at 5:00pm was unsuccessful. Interview with Resident #3 on 11/06/19 at 4:35pm revealed: -He thought he received medications as ordered. -Sometimes he missed a medication for "a day or two" if they were not able to get the medication from the pharmacy. -He experienced chest pain "at times", however it was not frequent. The facility failed to assure medications were administered as ordered to 4 of 6 sampled residents related to a pain medication not administered as ordered after the resident complained of pain, eye drops for dry and irritated eyes not administered for 22 days (Resident #6) and a medication for hypertension and angina not administered for 6 days (Resident #5) which was detrimental to the health and safety 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 11/06/19 for this violation.	{D 358}		
{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.	{D912}		

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{D912}	Continued From page 19 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services that were adequate, appropriate and in compliance with federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 6 residents sampled including a pain medication and eye drops (Resident #1), eye drops (Resident #6) and a blood pressure/angina medication (Resident #5) being unavailable to administer, and a medication for nerve pain and blood pressure/angina (Resident #3). [Refer to Tag O358 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation)].	{D912}		