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D 000	Initial Comments The Adult Care Licensure Section conducted an onsite complaint investiation from 10/26/20 through 10/30/20 with an exit conference via telephone on 10/30/20.	D 000		
D 228	10A NCAC 13F .0702 (d) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule: (1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule; (2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident; (3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or (4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 2 residents were discharged for reasons related to endangering the safety of other residents, as evidenced by lacking documented incidents of prior combative	D 228		

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behaviors towards other residents (Resident #6) and sexually inappropriate comments and behaviors towards female residents (Resident #7).

The findings are:

Review of the facility "Termination, Transfer and Discharge" Policy dated 05/23/16 revealed:
-The Community may discharge a resident if the "health or safety of the resident or other residents or employees is endangered by the Residents condition or behavior".
-"Upon discharge the Community will assist the Resident to assure a safe and orderly discharge by notifying the County Department of Social Services of the discharge, explaining to the Resident or Responsible Party why the discharge is necessary, and informing the Resident or Responsible party of the appropriate discharge destination."
-"If any applicable law or regulation requires that documentation substantiating the need for discharge is required, said documentation will be provided."

1.Review of Resident #6's current FL2 dated 09/29/20 revealed:
-A diagnosis of vascular dementia.
-He was documented as ambulatory.
-He exhibited wandering behaviors.

Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 10/01/20.

Review of the Discharge Notice for Resident #6 dated 10/10/20 revealed:
-The date of discharge was 10/10/20.
-The reason for discharge was marked as "Abuse

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on other residents, punched multiple residents in the face and staff".
-The Administrator's signature was on the discharge notice.

Review of Resident #6's Incident report dated 10/09/20 revealed:
-The "Event Details" section documented "physical threats towards others" checked.
-The "Description of the Incident" section documented Resident #6 was walking down the hallway, and was agitated, when staff tried to redirect Resident #6, he was very combative and he went up to another male resident and hit him in the face.

Interview with the Special Care Coordinator (SCC) 10/27/20 at 9:25am revealed:
-She only had the one incident report on Resident #6, but "that was all".
-There had been other reported incidents of resident being combative but she had no other incident reports.

Review of Resident #6's Progress Notes dated 10/09/20 revealed:
-A resident in the facility had shared with staff he had observed Resident #7 hitting another male resident four times.
-Staff had not observed any of these incidents.
-Staff observed Resident #6 yell at same male resident he was reported as hitting and Resident #6 was redirected to his room by staff.

Review of Resident #6's Progress Notes dated 10/25/20 at 1:33pm as a late entry for 10/10/20 at 1:30pm revealed:
-Resident #6 was being combative with two residents, hitting them in the face and back.
-Staff was able to calm him down "with success".

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D 228	Continued From page 3 Review of Resident #6's Progress Notes dated 10/25/20 at 1:36pm as a late entry for 10/10/20 at 6:33pm revealed: -Resident #6 was being combative. -Staff went to local authorities to file involuntary commitment (IVC) papers on Resident #6. -Resident #6 was served IVC papers, transported to the local hospital, with discharge papers being sent with the local authorities. Telephone interview with a family member on 10/27/20 at 10:52am revealed: -The facility had not notified her of Resident #6 having any behavior problems. -She had not been notified by the facility that Resident #6 had been transferred to the hospital by authorities to be evaluated for an involuntary commitment. -The hospital had called to inform the family Resident #6 had been evaluated for his aggressive behaviors and was not found eligible for an involuntary commitment. -Resident #6 remained in the emergency room of the local hospital from 10/10/20 - 10/22/20. -She was not aware of what had happened at the facility, as the facility knew the resident had behaviors prior to admission. -She had been reassured by staff at the facility upon admission, staff were able to handle residents with behavior issues. Interview with the first shift Lead Supervisor on 10/27/20 at 10:30am revealed: -Resident #6 had become "too aggressive by shoving residents down, cursing staff and he hit a resident in the face and back". -Staff were not able to redirect him and he was involuntary committed the same day and taken to the local hospital.	D 228		

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-Resident #6 "hit multiple residents in a short time frame".
-She had not documented the mentioned behaviors for Resident #6 as she had not observed them.
-She did not have any incident reports or other documentation to verify Resident #6 had shoved any residents or hit multiple residents.

Interview with the SCC on 10/27/20 at 11:16am revealed:
-A male resident had informed her that Resident #6 had hit a male resident on 10/09/20.
-On 10/10/20 Resident #6 hit another male resident for no apparent reason other than the resident was in front of him.
-Resident #6 was monitored by staff by observing him throughout the day.
-Resident #6 became more verbal, screaming and intimidating others, he would continuously yell at the two residents he reportedly hit.
-Both male residents had reported to her they were scared of Resident #6.
-On 10/10/20 she had called the facility psychiatric Nurse Practioner (NP) regarding increasing Resident #6's medication but she declined as the NP wanted to monitor his labs but suggested if Resident #6 continued to intimidate staff and residents the facility might want to consider an IVC.
-She discussed Resident #6's behaviors with the Administrator on 10/10/20 and they both agreed to obtain the IVC on 10/10/20 .
-She had not documented any of the other aggressive behaviors Resident #6 had exhibited except for the day Resident #6 was discharged.
-She had not documented any interventions that were used with Resident #6.

Interview with a resident on 10/27/20 at 3:40pm

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revealed:
-He had observed Resident #6 hit a male resident in the face on 4 different occasions.
-He had observed Resident #6 push other residents out of his way if they were in front of him.
-He had been concerned that Resident #6 was going to hurt someone.
-He had spoken with the Administrator about his concerns regarding Resident #6 and he was no longer there.

Interview with a social worker from the local hospital on 10/28/20 at 8:45am revealed:
-She was the case manager for Resident #6.
-She had called and spoke with the family of Resident#6 regarding his transfer to the hospital and that he did not meet criteria for an involuntary commitment.
-Resident #6 had difficulty expressing himself as he was not able to communicate well and would get frustrated.
-Resident #6 did not exhibit any incidents of aggressive behaviors during his emergency department (ED) stay of 10/10/20 - 10/22/20.
-Resident #6 had a medication increase from two times a day to three times daily for Zyprexa (used to treat psychotic conditions) during his ED stay.

Interview with the Administrator on 10/28/20 at 2:40pm revealed:
-Resident #6 had "only" become combative the day 10/09/20.
-After Resident #6 hit 2 male residents in the face on 10/10/20 and the decision was made for an IVC.
-The psychiatric NP had been scheduled to see him regarding his behaviors on an upcoming visit but the facility did not feel like they could wait for her to see him.

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-She did not feel she could wait on psychiatry to come in and see Resident #6 leaving her other residents at risk.
-She expected her staff to document resident behaviors and complete incident reports as needed.
-The SCC was responsible to ensure documentation was completed.
-She was not aware staff had not documented regarding Resident #6's behaviors.

2. Review of Resident #7's current FL2 dated 10/12/20 revealed:
-Diagnoses included agitated delirium with underlying chronic dementia with prior aggressive behavior, symptoms resolved.
-He was intermittently disoriented.
-He was ambulatory.

Review of Resident #7's Resident Register revealed the resident was admitted to the facility on 10/13/20.

Review of the Discharge Notice dated 10/15/20 revealed:
-The date of discharge was 10/15/20.
-The reason for discharge was not documented.
-The Administrator's signature was on the discharge notice.

Interview with the SCC 10/27/20 at 9:25am revealed:
-There was no incident reports provided for review for Resident #7.
-She had not completed any incident reports for Resident #7.
-She was not sure why incident reports had not been completed.
-Resident #7 was discharged on 10/15/15 for inappropriate sexual behavior.

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D 228	Continued From page 7 -She was not able to provide any other documentation regarding Resident #7's behavior. Review of the IVC paperwork for Resident #7 dated 10/15/20: -It was signed by the SCC. -The reason Resident #7 was a threat was documented as "sexually harassing staff and other residents, being vulgar, touching staff and residents inappropriately". Review of Resident #7's Progress Notes dated 10/25/20 at 1:41pm as a late entry for 10/15/20 at 1:37pm revealed: -Resident #7 was found in 2 female resident rooms at different times. -Resident #7 had touched two female residents inappropriately. -The female resident told the SCC she was afraid of Resident #7. Interview with a Medication Aide (MA)/Personal Care Aide (PCA) on 10/27/20 at 10:40am revealed: -Resident #7 had to be watched as he was a "little touchy feely". -Staff had taken Resident #7 to his room on 10/15/20 and offered him his stuffed animals he used to provide reassurance and redirection. -Staff attempted to redirect him several times. -Resident #7 had been prescribed medication to suppress his sexual behaviors. -New orders could not be obtained as he had not seen the facility physician at that time. -Resident #7 would wander in and out of other resident rooms and he would be redirected. -She had not documented the incidents with Resident #7 nor any of the interventions she had mentioned.	D 228		

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Review of the Medication Administration Record for October 2020 revealed there were no medications ordered for suppression of sexual behaviors for Resident #7.

Attempted telephone interview with a family member on 10/27/20 at 11:04am was unsuccessful.

Interview with the first shift Lead Supervisor on 10/27/20 at 10:30am revealed:
-Female residents had told her they were uncomfortable with the way Resident #7 spoke to the female staff.
-She did not remember Resident #7 being inappropriate with other female residents only staff.

Interview with the SCC on 11/27/19 at 11:16pm revealed:
-Resident #7 was only at the facility a couple of days.
-Resident #7 had been in the rooms of two different female residents and had touched them inappropriately.
-She had not completed an incident report on Resident #7.

Interview with a social worker from the local hospital on 10/28/20 at 8:45am revealed:
-She was the case manager for Resident #7 during his ED stay of 10/15/20 - 10/17/20.
-Resident #7 had been transferred to a hospital in another county on 10/17/20.
-Resident #7 had not qualify for medicaid for assisted living and she had discussed options with the family.

Interview with the Administrator on 10/28/20 at 2:40pm revealed:

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D 228	Continued From page 9 -She had called Resident #7's family and discussed the discharge and transfer to the hospital by local authorities. -She expected her staff to document resident behaviors and complete incident reports as needed. -She was not aware staff had not documented regarding Resident #7's behaviors. -She had observed Resident #7 inappropriately touching a female resident on 10/15/20 but did not document the incident as he was IVC'd.	D 228		
D 230	10A NCAC 13F .0702 (f) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by: (1) notifying staff in the county department of social services responsible for placement services; (2) explaining to the resident and responsible person or legal representative why the discharge is necessary; (3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and (4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident: (A) a copy of the resident's most current FL-2; (B) a copy of the resident's most current assessment and care plan; (C) a copy of the resident's current physician orders; (D) a list of the resident's current medications;	D 230		

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(E) the resident's current medications;
(F) a record of the resident's vaccinations and TB screening;
(5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule:
(A) the regional long term care ombudsman; and
(B) the protection and advocacy agency established under federal law for persons with disabilities.

This Rule is not met as evidenced by:
Based on record review and interviews the facility failed to provide sufficient preparation and orientation to the family to ensure a safe and orderly discharge from the facility for 1 of 5 sampled residents (#2) related to failing to offer a copy of the current FL2, resident assessment and care plan, a list of current medications, medications, physician orders, or vaccination records including TB screenings.

The findings are:

Review of Resident #2's FL2 dated 08/24/20 revealed:
-Diagnoses included dementia with behavioral disorder, Chronic Obstructive Pulmonary Disease and Type 2 diabetes.
-He was intermittently disoriented.
-He was verbally abusive and injurious to others.

Review of Resident #2's care plan completed on 09/23/20 revealed:
-The care plan was completed by the Special Care Coordinator (SCC).
-Resident #2 was verbally abusive, receiving medication for mental illness/behaviors, receiving

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mental health services and always disoriented.
-Resident #2 needed a wheelchair for ambulation, an inhaler due to shortness of breath and had daily bladder incontinence.
-Resident #2 was totally dependent for toileting and transferring.
-Resident #2 required assistance for bathing, dressing and grooming.

Interview with the SCC on 10/27/20 at 4:05PM revealed:
-Resident #2 was discharged from the facility on 09/30/20 without intentions of returning because family members wanted to care for the resident at home.
-She sent Resident #2's bubble packs of medication home with the family.

Review of a Medication Release Form dated 09/30/20 revealed:
-Six days worth of medications for Resident #2 were released to the family on 09/30/20.
-The form was signed and dated by the SCC.
-The form was signed and dated by Resident #2's family member.

Interview with Resident #2's family member on 10/28/20 at 4:55PM revealed:
-She had contacted the facility a week before she planned to have Resident #2 discharged.
-She had Resident #2 discharged because she wanted to see if she was able to take care of him at home.
-She came to the facility with two other family members on 09/30/20 to have him discharged.

Interview with another family member of Resident #2 on 10/29/20 at 9:58am revealed:
-Resident #2 was discharged from the facility on 09/30/20 with the understanding that he would be

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able to be readmitted if another family member was unable to care for him at home.
-She was in the parking lot preparing to leave with Resident #2 on the day of discharge when she requested his medications.
-The SCC went back into the facility and gathered his medications and brought them out to the car.
-The medications were given to her in bubble pack card with 5-6 pills in each bubble.
-No one from the facility explained medication administration other than the bubble pack was color coded with red containers to be administered in the morning and blue containers to be administered in the evening.
-She signed a paper indicating that she had received his medications.
-She did not receive anything else from the facility.

Interview with the SCC on 10/29/20 at 3:40PM revealed:
-She had never completed a discharge nor knew the process to discharge a resident from the facility.
-The Administrator was not working the day Resident #2 was discharged from the facility.
-She gave Resident #2's medications to a family member when he was discharged.
-She explained medication administration with another family member of Resident #2.

Interview with the Administrator on 10/29/30 at 4:08Pm revealed:
-Resident #2 was discharged from the facility on 09/30/20.
-The SCC was responsible for discharging residents.
-The SCC had not been trained on the procedures for a discharge.
-The corporate office was responsible for training

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D 230	Continued From page 13 the SCC but due to Covid-19 restrictions the training had not been completed. -She did not know what paperwork was sent home with the family when Resident #2 was discharged.	D 230		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure health care referral and follow up for 2 of 5 sampled residents (#2, #1) including failure to send a resident to a scheduled follow-up appointment after being discharged from the hospital with a Urinary Tract Infection (UTI) with an order to receive an antibiotic (#2), failure to make an appointment with a physician after being evaluated in the emergency room (ER) for urinary retention, with catheter placement (#2), failure to ensure he was admitted and evaluated by the facility PCP (#2), failure to have follow-up visits after an emergency evaluation and after a hospital discharge (#1), failure to report missed medications to treat anxiety, high blood pressure, infection and cholesterol (#1) and refusal of a hormonal cream. (#1). The findings are: 1.Review of Resident #2's current FL2 dated	D 273		

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08/24/20 revealed diagnoses included dementia with behavioral disorder, Chronic Obstructive Pulmonary Disease (COPD) and Type 2 diabetes.

Review of Resident #2's hospital discharge summary orders dated 10/06/20 revealed:
-Resident #2 was admitted to the hospital from home on 10/04/20 and treated for a UTI.
-Resident #2 was prescribed cefuroxime, an antibiotic to treat infection) 500mg to be administered twice a day for 5 days with a stop date of 10/10/20.
-Resident #2 was scheduled for a follow-up appointment with his PCP for 10/08/20 at 12:45pm.

Interview with the Special Care Coordinator (SCC) on 10/28/20 at 10:15am revealed:
-Resident #2 had been discharged from the facility to home on 09/30/20 and was not expected to return.
-Resident #2 was readmitted to the facility on 10/06/20 from the hospital.
-She did not consider Resident #2 a new admission and therefore an FL2 and Resident Register had not been completed.
-She was aware that Resident #2 had yet to be seen by the facility's PCP.
-It "usually" only took a few days to be seen by the PCP when a resident was admitted but Resident #2 had not been seen because PCP had not been at the facility for several weeks due to issues at other facilities that took precedence over this admission.
-The PCP was usually at the facility every Friday and would review the hospital discharge summary when she readmitted him to the facility later this week.

Telephone interview with the facility's PCP on

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10/29/20 at 11:09am revealed:
-She was aware that Resident #2 had been discharged home from the facility on 09/30/20 and readmitted to the facility on 10/06/20.
-She was unaware that Resident #2 had been admitted from the hospital; she thought he had come directly from home.
-She did not know anything about the resident since he had returned to the facility as she had not seen him yet.
-She had not done Resident #2's admission paperwork yet because she was waiting on the SCC to submit the admission request to her corporate office.
-She called the corporate office herself, yesterday (10/28/20), and had obtained the new admission authorization.
-She had been at the facility every Friday in October.
-She was scheduled to complete Resident #2's admission paperwork on 10/30/20.

Review of Resident #2's ER discharge Instructions dated 10/11/20 revealed:
-Resident #2 was seen in the ER on 10/11/20 at 9:15am for urinary retention and had a urinary catheter placed.
-The facility was instructed to contact Resident #2's physician on 10/12/20 to schedule an appointment to remove catheter or discuss other options.

Interview with the Administrator on 10/29/20 at 4:08pm revealed:
-The SCC should have read the discharge papers and known about the follow-up appointments.
-The SCC was responsible for informing the transport staff of all appointments.
-The transporting staff maintained a calendar for appointments and there was no record that

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Resident #2 went to any appointments since he was admitted, and he did not have any appointments scheduled in the future.
-The SCC had not been "thoroughly" trained since she started in her position.
-The corporate office was responsible for training the SCC but due to Covid-19 restrictions the training had not been completed.

Attempted telephone interviews with the facility transport staff on 10/29/20 at 3:27pm and 10/30/20 at 1:14pm were unsuccessful.

2. Review of Resident #1's current FL2 dated 09/29/20 revealed:
-Diagnoses included moderate dementia, left lower extremity cellulitis, coronary artery disease, hypertension, blind, hypothyroidism, elevated cholesterol, and degenerative joint disease.
-The resident was intermittently disoriented and semi-ambulatory.
-The resident had a hearing impairment and was blind.
-The resident was a fall risk.

Review of Resident #1's Care Plan dated 08/03/20 revealed:
-The resident was totally dependent for staff assistance with bathing, dressing, and grooming/personal hygiene.
-The resident required limited assistance with eating, toileting, ambulation/locomotion, and transfers.

a. Review of Resident #1's Progress Note dated 08/21/20 at 11:08pm revealed:
-Resident #1 was trying to transfer herself to her bed from her wheelchair and fell and "gashed her leg open."
-Resident #1 was sent to the Emergency Room

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(ER) and would be receiving sutures.

Review of Resident #1's emergency room (ER) discharge summary dated 08/22/20 revealed:
-The reason for the visit was chest pain and laceration to the lower leg.
-The resident's leg laceration was closed with sutures.
-There was an order to have the sutures removed in 14 days.
-The resident was to follow-up with their primary care physician (PCP) on 08/24/20.

Review of Resident #1's physician's order dated 09/10/20 revealed for home health (HH) nursing for wound care to the left lower leg.

Telephone interview with Resident #1's HH nursing supervisor on 10/28/20 at 9:26am revealed they began providing wound care to Resident #1's left lower extremity on 09/13/20.

Review of Resident #1's facility Progress Note dated 09/16/20 at 10:46pm revealed:
-The resident complained her leg was hurting.
-The leg was hot and red around the area of her dressing.
-The staff removed the dressing, cleaned the wound, and redressed wound.
-The wound "appeared to be infected."

Review of Resident #1's ER discharge summary dated 09/17/20 revealed:
-The reason for the visit was urinary tract infection and cellulitis of left lower limb.
-There was an order to follow-up with a PCP in 3 days.

Review of Resident #1's progress note dated 09/25/20 at 3:25pm revealed:

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-The first shift Lead Supervisor was contacted by the HH nurse about Resident #1's leg.
-"The antibiotics are not working."
-The HH nurse had contacted Resident #1's physician to report continued infection in the left lower extremity wound.
-The physician had requested Resident #1 be sent out to the hospital for evaluation.

Review of Resident #1's hospital discharge summary dated 09/29/20 revealed:
-The resident was sent to the ER on 09/25/20 for evaluation for left lower extremity wound due to "failure to improve on outpatient antibiotics."
-The resident was admitted to the hospital for intravenous antibiotic treatment.
-The "cellulitis appears resolved" but, as resident had an ongoing infected wound, the hospital prescribed Septra DS (an antibiotic used to treat infection) for 7 days.
-There was an order for HH to continue wound monitoring and dressing changes.
-There was an order to follow-up with a PCP in 5-7 days.

Telephone interview with the nurse for Resident #1's PCP on 10/29/20 at 11:21am revealed:
-Resident #1 was not seen in their office on 08/24/20.
-Resident #1 last was seen by a physician in their practice on 09/10/20 for suture removal on a wound on her left lower leg.
-Resident #1 had missed acute care follow-up appointments on 09/08/20 and 09/24/20.
-Resident #1 had missed a hospital follow-up appointment on 10/05/20.
-On 09/13/20, Resident #1's HH nurse contacted their office for wound care orders for the resident.
-On 10/05/20, the physician's office spoke with Resident #1's Power of Attorney (POA) about the

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missed appointments and it was decided the POA wanted Resident #1 to be transferred into the care of the facility's Nurse Practitioner (NP) care.

Interview with the SCC on 10/28/20 at 1:54pm revealed:
-Resident #1 missed follow-up appointments on 08/24/20, 09/08/20, and 10/05/20 with her PCP.
-The appointments were missed because the facility staff were unable to get Resident #1 into the facility transport vehicle to take her to the appointments.
-Resident #1's was unable to lift her legs to climb into the vehicle.
-On 10/15/20, the SCC called Resident #1's physician and was told the resident's POA wanted the resident to see the facility NP for care.
-The SCC "immediately" added Resident #1 to the facility NP's list to be seen.

Interview with the first shift Lead Supervisor on 10/28/20 at 3:30pm revealed:
-Resident #1 missed a follow-up appointment to have sutures removed at her physician's office, because the resident was unable to "lift her legs to get in the van."
-They had to cancel the appointment and arrange alternate transportation.
-It took "2 to 3 days" to get the alternate transportation arranged.
-The facility NP was there "every Friday."

Telephone interview with Resident #1's NP on 10/29/20 at 10:31am revealed:
-She had recently taken over as primary care provider of Resident #1.
-Her admission visit with Resident #1 occurred on 10/23/20.

Interview with the Administrator on 10/29/20 at

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4:07pm revealed:
-She did not know Resident #1 had missed follow-up visits with her primary care physician.
-It was the responsibility of the SCC to inform facility transport staff of Resident #1's appointments.
-If Resident #1 was unable to get into the facility van, alternative transportation should have been arranged.
-The Medicaid transport lift van could be utilized to transport resident's to appointments, but did require additional planning to ensure availability.
-The facility did have access to lift vans at two sister facilities that could have been utilized if the Medicaid van was heavily scheduled to prevent Resident #1 from missing appointments.

Attempted telephone interview with Resident #1's Power of Attorney (POA) on 10/29/20 at 12:14pm was unsuccessful.

Attempted telephone interview with the facility transport staff on 10/29/20 at 3:27pm was unsuccessful.

b. Review of Resident #1's discharge summary dated 09/17/20 revealed:
-There was an order for Septra DS (used to treat infection) 800mg-160mg 1 tablet two times a day for 7 days.
-There was an order for Doxycycline (used to treat infection) 100mg 1 capsule two times a day for 7 days.

Review of Resident #1's current FL2 dated 09/29/20 revealed:
-There was an order for diazepam (used to treat anxiety) 10mg 1 tablet daily.
-There was an order for estradiol 0.01% (used to treat vaginal dryness) 1 application vaginally daily

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at bedtime.
-There was an order for Lovaza (used to treat elevated cholesterol) 1000mg 2 capsule two times a day.
-There was an order for Metoprolol ER (used to treat high blood pressure) 50mg 1 tablet daily.
-There was an order for Septra DS 800mg-160mg 1 tablet two times a day for 7 days.
-There was an order to discontinue the Doxycycline.

Review of Resident #1's September 2020 electronic Medication Administration Record (eMAR) revealed the following medications were documented as not administered:
-Diazepam was documented as not administered on 09/30/20 due to "waiting on medication."
-Lovaza was documented as not administered on 09/30/20 at 9:00am and 9:00pm due to "waiting on pharmacy."
-Septra DS was not administered as ordered from 09/18/20 to 09/24/20.
-Doxycycline was documented as administered starting 09/21/20 at 9:00am until "resident unavailable" starting 09/25/20 at 9:00pm.

Review of Resident #1's October 2020 eMAR revealed:
-Diazepam was documented as not administered from 10/01/20 to 10/27/20 due to "waiting on pharmacy."
-Estradiol was documented as not administered from 10/07/20 to 10/26/20 due to "resident refused."
-Lovaza was documented as not administered from 10/01/20 to 10/24/20 due to "waiting on pharmacy."
-Metoprolol ER was documented as not administered from 10/14/20 to 10/26/10 (11

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doses) due to "waiting on pharmacy."
-Septra DS was documented as not administered on 10/03/20 at 9:00am and 9:00pm due to "waiting on pharmacy."

Interview with the first shift Lead Supervisor on 10/28/20 at 3:34pm revealed she did not have any documentation of communications with Resident #1's physician concerning medications being unavailable or refused.

Telephone interview with Resident #1's PCP nurse on 10/29/20 at 11:21am revealed:
-The physician had not been notified Resident #1 missed medications due to the medications being unavailable or of refused medications during September and October 2020.
-Resident #1's care had been transferred to the facility NP on 10/05/20.

Telephone interview with the facility's NP on 10/29/20 at 10:31am revealed:
-She took over care of Resident #1 on 10/23/20.
-Resident #1 having missed doses of diazepam and having gone without the medication would have made the resident "feel crappy going through withdrawal."
-She had received a refill request from the facility for the diazepam for Resident #1 on 10/26/20.
-She had not been made aware Resident #1 had been out of Metoprolol ER from 10/14/20 to 10/26/20.
-Stopping a "beta blocker" like Metoprolol ER could cause the blood pressure to go "very high."
-The order for Septra DS dated 09/17/20 had been initiated by the emergency room physicians for left lower extremity cellulitis.
-Resident #1 not receiving Septra DS as ordered on 09/17/20 may have contributed to the resident's return to the hospital on 09/25/20.

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D 273	Continued From page 23 -The order for Doxycycline dated 09/17/20 had been initiated by the emergency room physicians for left lower extremity cellulitis. -Resident #1 not having received Doxycycline as ordered on 09/17/20 may have contributed to the resident's return to the hospital on 09/25/20. -Resident #1 not having received the estradiol as ordered may have caused the resident to experience some vaginal itching and would have been "a little uncomfortable." -Resident #1 was ordered Lovaza as a supplement for elevated cholesterol. -Resident #1 was also ordered a statin medication to reduce cholesterol levels. Interview with the Administrator on 10/29/20 at 4:07pm revealed: -The medication aides (MAs) were supposed to notify the first shift Lead Supervisor and the Special Care Coordinator (SCC) when medications were unavailable for administration. -If a medication was not in the cart, the MAs, first shift Lead Supervisor, or the SCC needed to tell her "immediately" and she would get the medication from their local backup pharmacy. -Her expectation was the primary care provider should be notified after a resident refused a medication three times. _____ The facility failed to meet the acute health care needs for 2 of 5 sampled residents (Residents #1 and #2) related to a missed follow-up appointment for Resident #2 that had been scheduled upon discharge from a local hospital for a UTI, failure to contact Resident #2's PCP after he was seen in the emergency room for urinary retention resulting in catheter placement and failure to ensure Resident #2 was evaluated by the facility PCP as ordered for 10/08/20 and 10/11/20, failure to follow-up with a physician after	D 273		

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D 273	Continued From page 24 an emergency room evaluation and a hospital evaluation (#1), contact of Resident #1's physician for missed medications including missed doses of antibiotics leading to worsening infection in a leg wound requiring a hospital admission for intravenous antibiotics; missed doses of diazepam increasing the risk of withdrawal symptoms; missed doses of Metoprolol for 11 days increasing the risk for high blood pressure (#1). The facility's failure resulted in substantial risk that harm or death could occur which constitues a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/29/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 29, 2020.	D 273		
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 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.	D 344		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on record reviews and interviews the facility failed to clarify orders with the prescribing practitioner for 1 of 5 sampled residents (#2) related to buspirone (a medication to control anxiety), cefuroxime (an antibiotic), omeprazole (a medication to control reflux), melatonin (a medication for sleep), Baza (an antifungal) and fluticasone (a nose spray for allergies).

The findings are:

Review of an FL2 for Resident #2 dated 08/24/20 revealed diagnoses included dementia with behavioral disorder, Chronic Obstructive Pulmonary Disease (COPD) and Type 2 diabetes.

Review of subsequent orders for Resident #2 revealed:
-There was an order dated 09/11/20 to start Baza antifungal cream to be applied to the right hip every day.
-There was an order dated 09/11/20 to continue fluticasone propionate 2 sprays each nostril every day.
-There was an order dated 09/11/20 to continue Melatonin 3mg daily at bedtime.
-There was an order dated 09/18/20 to start omeprazole 20mg every morning before breakfast.
-There was an order dated 09/24/20 to start buspirone 7.5mg twice a day for anxiety.

Interview with the Special Care Coordinator (SCC) on 10/28/20 at 10:15AM revealed:
-Resident #2 had been discharged from the

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facility to home on 09/30/20 and was not expected to return.
-Resident #2 was readmitted to the facility on 10/06/20 from the hospital.
-She did not consider Resident #2 a new admission and therefore an FL2 and Resident Register had not been completed.
-She was aware that Resident #2 had yet to be seen by the facility's Primary Care Provider (PCP).
-It "usually" only took a few days to be seen by the PCP when a resident was admitted but Resident #2 had not been seen because the PCP had not been at the facility for several weeks due to issues at other facilities that took precedence over this admission.
-The PCP was usually at the facility every Friday and would review the hospital discharge summary when she readmitted him to the facility later this week.

Review of Resident #2's hospital discharge summary dated 10/06/20 revealed:
-Resident #2 had been admitted to the hospital from home on 10/04/20 with a urinary tract infection.
-Resident #2 was positive for Methicillin Resistant Staph Aureus (MRSA).
-There was a new medication order for cefuroxime 500mg to be administered twice a day for 5 days with a stop date of 10/10/20.
-There was an order for Melatonin to change from 3mg daily to 9mg daily, as needed.
-There was an order for fluticasone nasal spray, 1 spray each nostril daily, as needed.
-There was an order for omeprazole 40mg to be given twice a day.

Record review revealed there was no FL2 completed upon admission on 10/06/20.

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D 344	Continued From page 27 Review of Resident #2's October 2020 electronic medication administration record (eMAR) revealed: -There was not an entry for cefuroxime 500mg to be administered for 5 days. -There was an entry for buspirone 7.5mg to be administered twice a day with a start date of 09/29/20. -There was an entry for Baza antifungal cream to be administered daily with a start date of 09/12/20 and an end date of 10/14/20. -There was an entry for Baza antifungal cream to be administered daily with a start date of 10/14/20. -There was an entry for fluticasone propionate 2 sprays each nostril daily with a start date of 09/22/20 and an end date of 10/11/20. -There was an entry for fluticasone propionate 1 spray each nostril as needed with a start date of 10/11/20/20. -There was an entry for melatonin 3mg at bedtime with a start date of 08/26/20 and an end date of 10/11/20. -There was an entry for melatonin 9mg at bedtime, as needed, with a start date of 10/10/20/20. -There was an entry for omeprazole 20mg to be administered 30 minutes before breakfast with a start date of 09/18/20. -There was an entry for omeprazole 40mg to be administered twice a day with a start date of 10/08/20 and an end date of 10/28/20. Telephone interview with a representative from the facility's contract pharmacy on 10/29/20 at 10:45am revealed: -All of Resident #2's medications had been discontinued and removed from his profile when he was discharged from the facility on 09/30/20.	D 344		

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-The discharge orders from the hospital were faxed from the facility on 10/08/20 at 9:32am.
-All hospital discharge orders were keyed into the eMAR on 10/08/20 by the pharmacy.
-Staff at the facility were able to add and delete medications also from the eMAR.

Interview with the Supervisor on 10/28/20 at 4:15pm revealed:
-Resident #2 was discharged from the facility to home on 9/30/20.
-Resident #2 was "readmitted" to the facility from the hospital on 10/6/20.
-The Special Care Coordinator (SCC) was responsible for processing paperwork when a resident was admitted from the hospital.
-She had been told by the Administrator that Resident #2 had been considered to be on "therapeutic leave" rather than discharged and when he returned to the facility all his previous medication orders were restarted.
-She did not clarify any medication orders upon Resident #2's admission from the hospital.
-She thought that any medications the resident had prior to his hospital admission were still valid unless she received specific orders to discontinue them.
-She had not received proper training for her position because of Covid-19 restrictions of personnel in the facility.

Telephone interview with the facility's Primary Care Provider (PCP) on 10/29/20 at 11:09am revealed:
-She was aware that Resident #2 had been discharged from the facility to home on 09/30/20 and readmitted to the facility on 10/06/20.
-She was unaware that Resident #2 had been admitted from the hospital; she thought he had come directly from home.

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-She was unaware that Resident #2 had been ordered an antibiotic or was positive for MRSA.
-She had not done Resident #2's admission paperwork yet because the SCC did not submit the admission request to her corporate office when the resident was readmitted to the facility.
-She had been at the facility every Friday in October and had not been informed by any staff members that Resident #2's hospital discharge medication orders needed to be clarified.
-She expected the facility to clarify medication orders.
-The resident was at risk of developing sepsis, if the antibiotic had not been administered as ordered, especially with a MRSA diagnosis.

Telephone interview with the Resident #2's behavioral Nurse Practitioner on 10/30/20 at 1:44pm revealed:
-She had only seen Resident #2 one time at the facility, on 09/24/20.
-She came to the facility every 2 weeks and the last time she was there was 10/26/20.
-The SCC had called her on 10/27/20 to request clarification of Resident #2's buspirone order.
-The SCC told her on 10/27/20 that Resident #2 had been discharged to home on 09/30/20 and readmitted to the facility on 10/06/20.
-She had been at the facility on 10/26/20 and did not understand why staff had not told her then that the order for buspirone had expired.
-Receiving buspirone intermittently was not dangerous but was not in any way beneficial in reducing Resident #2's anxiety.

Interview with the Administrator on 10/29/20 at 4:08pm revealed:
-She was unaware that Resident #2's previous admission medication orders had been used when he was readmitted to the facility rather than

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D 344	Continued From page 30 his hospital discharge orders. -The SCC was responsible for clarifying any medication orders that are received. -She expected the SCC or the Supervisor to clarify medication orders immediately. -The SCC had not been thoroughly trained since she started in her position. -The corporate office was responsible for training the SCC but due to Covid-19 restrictions the training had not been completed. _____ The facility failed to clarify medication orders after Resident #2 had been discharged to home on 09/30/20, without expecting to return, admitted to the hospital 10/04/20 and then admitted to the facility on 10/06/20. This failure to clarify medication orders resulted in the resident receiving medication from his previous admission of 08/24/20 before his 10/06/20 hospital discharge medications were obtained from the pharmacy. The omission of an antibiotic to treat a UTI and intermittent administration of a scheduled medication to treat anxiety put the resident at risk of developing sepsis and increased his probability of experiencing anxiety. The facility's failure to clarify the medication orders was detrimental to the health, safety and welfare of the resident and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 14, 2020.	D 344		

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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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (Residents #1, #2, #5) related to a medication for infection (#1 and #2), anxiety (#1), high blood pressure (#1), prevention of blood clots (#5), and for 1 of 9 residents observed during the medication passes including errors with a medication used to prevent blood clots (#8), to supplement vitamin D levels (#8), and for decreased calcium levels (#8). The findings are: 1. Review of Resident #1's current FL2 dated 09/29/20 revealed: -Diagnoses included moderate dementia, left lower extremity cellulitis/venous stasis ulcer, coronary artery disease, blind, and hypertension. -There was a physician's order for diazepam (used to treat anxiety) 10mg 1 tablet daily.	D 358		

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D 358	Continued From page 32 a. Review of the National Institute of Health warnings associated with the use of diazepam revealed: -The continued use of benzodiazepines, including diazepam, for several days to weeks may lead to clinically significant physical dependence. -Abrupt discontinuation or rapid dosage reduction of diazepam after continued use may precipitate acute withdrawal reactions, which can be life-threatening. -To reduce the risk of withdrawal reactions, use a gradual taper to discontinue diazepam or reduce the dosage. Review of Resident #1's September 2020 eMAR revealed: -There was an entry for diazepam 10mg to be administered every day at 9:00am. -The diazepam was documented as administered daily from 09/01/20 to 09/29/30. -On 09/30/20, the diazepam was documented as not administered due to "waiting on medication." Review of Resident #1's October 2020 eMAR revealed: -There was an entry for diazepam 10mg to be administered every day at 9:00am. -The diazepam was documented as not administered from 10/01/20 to 10/27/20 due to the medication being unavailable ("waiting on pharmacy.") Observation of Resident #1's medications on hand on 10/27/20 at 11:05am revealed there was no diazepam available for administration. Interview with a Medication Aide (MA) on 10/27/20 at 11:15am revealed: -They were waiting on a physician's order to get a refill on Resident #1's diazepam.	D 358		

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-The first shift Lead Supervisor had been made aware the diazepam was unavailable.
-All of the MAs made a list of all medications that were unavailable during their medication passes and put the list in a folder for the first shift Lead Supervisor at the "end" of each medication pass.
-The first shift Lead Supervisor "keeps track of messaging the doctor" to obtain orders.
-Medication cart audits were done "every week."

Interview with the first shift Lead Supervisor on 10/27/20 at 11:38am revealed:
-Diazepam 10mg tablets had just been delivered by the pharmacy for Resident #1.
-There was a delay in receiving the diazepam, because the pharmacy needed a "new" prescription from the physician before they could fill the medication.

Interview with a second MA on 10/28/20 at 10:15am revealed:
-When she noticed there was a medication she did not have for a resident during a medication pass, she would "write down all the information" and then let a Supervisor know at the end of the medication pass.
-Before she reported a medication being unavailable to a Supervisor, she would look in the medication cart again and in the medication room to "make sure it's not in the building."
-MAs were not responsible for medication cart audits.
-MAs did communicate with the first shift Lead Supervisor and Special Care Coordinator (SCC) about the medications they were "getting low on."

Interview with a third MA on 10/28/20 at 10:45am revealed:
-She had noticed Resident #1's diazepam had been out on a morning medication pass.

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-Any medications "I don't have on my pass" she wrote down and gave the information to a shift Lead Supervisor as soon as she had completed the medication pass.
-The Lead Supervisors were responsible for reviewing the list and finding out where the medications were and contacting the pharmacy to get the medications or following up with the residents' physicians to obtain orders for refills of medications.

Interview with the second shift Lead Supervisor on 10/28/20 at 12:55pm revealed:
-The first shift Lead Supervisor was responsible for performing medication cart audits "weekly."
-He thought all the residents medications were "supposed to be checked weekly."

Interview with Resident #1 on 10/27/20 at 3:08pm revealed:
-She had been taking diazepam for four years.
-She did not know if she had been receiving her diazepam.
-"It doesn't feel like it."
-"My nerves are shot."
-She had been asking the staff who administered her medications "Am I getting my nerve medicine?"
-The staff would say back to her she was getting "all we have on the cart."
-She would reply back to them "I know I'm not getting my nerve medicine."

Telephone interviews with a Pharmacist from Resident #1's pharmacy on 10/27/20 at 3:39pm and on 10/28/20 at 1:30pm revealed:
-The most recent order they had for Resident #1's diazepam was an order on an FL2 dated 09/29/20 for diazepam 10mg 1 tablet daily.
-There were 30 tablets of diazepam 10mg

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dispensed on 10/26/20 (30 day supply).

Telephone interview with the nurse of Resident #1's Primary Care Physician (PCP) on 10/27/20 at 2:55pm revealed:
-Their office received a call from the Special Care Coordinator (SCC) on 10/15/20 requesting a renewal order for the diazepam.
-The office explained to the SCC as of 10/05/20, they were no longer managing the care for Resident #1.
-The physician could not prescribe diazepam if they were not managing the resident's care.

Interview with the SCC on 10/28/20 at 1:34pm revealed:
-Resident #1 was admitted to the facility on 06/24/20 from home.
-She became aware Resident #1 was out of the diazepam on 10/15/20.
-She then faxed a request for a refill of the diazepam to her physician and "they wouldn't refill it."
-She then added Resident #1 to the list for the facility Nurse Practitioner (NP) to see on her next visit.

Interview with the first shift Lead Supervisor on 10/28/20 at 3:30pm revealed:
-She had notified the pharmacy as soon as she was made aware Resident #1's diazepam needed to be refilled.
-The pharmacy needed a new script before they could refill the diazepam.
-The pharmacy, the SCC, and the first shift Lead Supervisor had contacted Resident #1's physician's office as soon as the diazepam ran out to let them know a prescription was needed to refill the diazepam for Resident #1.
-She never received a response from the

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physician's office and the SCC then got Resident #1 transfered to the care of the facility NP.
-She did not document the communication attempts with Resident #1's physician office to obtain the prescription.

Telephone interview with the facility's NP on 10/29/20 at 10:31am revealed:
-She took over care of Resident #1 on 10/23/20.
-Resident #1 having missed doses of diazepam and having gone without the medication would have made the resident "feel crappy going through withdrawal."
-She had received a refill request from the facility for the diazepam for Resident #1 on 10/26/20.

Interview with the Administrator on 10/29/20 at 4:07pm revealed:
-Medication cart audits were done every Monday.
-It was her expectation, any medication that was missing the staff needed to "get it in the building."
-She had not been made aware Resident #1 had been without scheduled diazepam.
-It was her expectation that her staff tell her "immediately" if they were having trouble getting a medication.

b. Review of Resident #1's current FL2 dated 09/29/20 revealed Metoprolol ER (used to treat high blood pressure) 50mg daily.

Review of Resident #1's September 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Metoprolol ER 50mg 1 tablet daily scheduled at 9:00am.
-The Metoprolol ER was documented as administered from 09/01/20 to 09/30/20 for 27 occurrences out of 30 opportunities.
-The Metoprolol ER was documented as not

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administered from 09/26/20 to 09/28/20 due to the resident being out of facility.

Review of Resident #1's October 2020 eMAR revealed:
-There was an entry for Metoprolol ER 50mg 1 tablet daily scheduled at 9:00am.
-The Metoprolol ER was documented as administered from 10/01/20 to 10/27/20 for 16 occurrences out of 27 opportunities.
-The Metoprolol ER was documented as not administered from 10/14/20 to 10/26/10 due to the medication being unavailable ("waiting on pharmacy.")

Observation of Resident #1's medications on hand on 10/27/20 at 11:05am revealed there were Metoprolol ER 50mg tablets available.

Telephone interview with a Pharmacist from Resident #1's pharmacy on 10/29/20 at 10:13am revealed:
-The Metoprolol ER 50mg tablets were filled on 08/24/20 with 30 tablets (30 day supply).
-The Metoprolol ER 50mg tablets were filled on 10/15/20 with 30 tablets (30 day supply).
-As long as the scripts had refills, it only took the pharmacy staff 20-30 min to fill a prescription.

Interview with the Special Care Coordinator (SCC) on 10/29/20 at 9:42am revealed she had been unaware Resident #1's Metoprolol ER had not been available for administration from 10/14/20 to 10/26/20.

Telephone interview with the facility's Nurse Practitioner (NP) on 10/29/20 at 10:31am revealed:
-She had not been made aware Resident #1 had been out of Metoprolol ER from 10/14/20 to

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10/26/20.
-Stopping a "beta blocker" like Metoprolol ER could cause the blood pressure to go "very high."

Interview with the Administrator on 10/29/20 at 4:07pm revealed:
-Medication cart audits were done every Monday.
-It was her expectation, any medication that was missing the staff needed to "get it in the building."
-It was her expectation that her staff tell her "immediately" if they were having trouble getting a medication.

c. Review of Resident #1's emergency room (ER) discharge summary dated 09/17/20 revealed:
-Diagnoses included cellulitis of left leg and acute urinary tract infection.
-There was an order for Septra DS (used to treat infection) 800mg-160mg 1 tablet two times a day for 7 days.

Review of Resident #1's current FL2 dated 09/29/20 revealed:
-Diagnoses included moderate dementia, left lower extremity cellulitis, venous stasis ulcer, coronary artery disease, and chronic nocturnal hypoxia.
-There was an order for Septra DS 800mg-160mg 1 tablet two times a day for 7 days.

Review of Resident #1's September 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Septra DS 800mg-160mg 1 tablet two times a day for 7 days scheduled at 9:00am and 9:00pm on 09/30/20.
-The Septra DS was documented as administered on 09/30/20 at 9:00am and 9:00pm.

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Review of Resident #1's October 2020 eMAR revealed:
-There was an entry for Septra DS 800mg-160mg 1 tablet two times a day for 7 days scheduled at 9:00am and 9:00pm.
-The Septra DS was documented as administered 10 occurrences out of 12 opportunities from 10/01/20 to 10/06/20.
-On 10/03/20 at 9:00am, the medication was documented as not administered due to "waiting on pharmacy."
-On 10/03/20 at 9:00pm, the medication was documented as not administered due to "waiting on pharmacy."

Review of Resident #1's controlled medication utilization record (CMUR) for Septra DS dated 09/29/20 to 10/06/20 revealed:
-The Septra DS was documented as administered 09/29/20 at 9:00pm to 10/06/20 at 9:00pm for 13 occurrences out of 14 opportunities.
-On 10/03/20, there was no documentation of Septra DS being administered at 9:00pm.

Telephone interview with the contracted facility pharmacy on 10/27/20 at 10:44am revealed:
-A faxed order was received for Resident #1 on 09/29/20 for Septra DS 800mg-160mg 1 tablet two times a day for 7 days.
-An entry for the Septra DS was added to Resident#1's eMAR to start on 09/29/20 and end on 10/06/20.
-Resident #1 did not receive her medication supplies from the contracted facility pharmacy.

Telephone interview with a Pharmacist from Resident #1's pharmacy on 10/27/20 at 11:14am revealed:
-The pharmacy received a prescription dated

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09/17/20 for Septra DS 800mg-160mg 1 tablet two times daily for 7 days and it was filled on 09/17/20.
-The pharmacy received a prescription dated 09/29/20 for Septra DS 800mg-160mg 1 tablet two times daily for 7 days and it was filled on 09/29/20.
-The pharmacy made deliveries to the facility.
-The pharmacy did not keep records of deliveries made to the facility and could not confirm they had delivered the Septra DS filled on 09/17/20 and 09/29/20 or if it had been picked up.

Interview with the first shift Lead Supervisor on 10/27/20 at 11:35am revealed:
-The pharmacy who provided Resident #1's medications would deliver medications to the facility entrance and give them to "any" staff member.
-The date the Septra DS was started on the eMAR for Resident #1 was the date she had received the medication from the pharmacy.

Telephone interview with Resident #1's home health (HH) nursing supervisor on 10/28/20 at 9:26am revealed:
-They began providing wound care to Resident #1's left lower extremity on 09/13/20.
-They did a medication reconciliation when the client was on antibiotics.
-The facility was responsible for obtaining the antibiotics and administering the antibiotics.
-The HH nurse who made visits to care for Resident #1 had expressed her concerns with her supervisor "about the delay in starting the antibiotics" ordered on 09/17/20.
-The facility staff "kept saying" they would "pick up" the Septra DS from the local pharmacy.
-The delay in administering the Septra DS as ordered "caused some complications" and

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"certainly impacted" the resident resulting in readmission to the hospital on 09/25/20 for a worsening leg wound.

Interview with the second shift Lead Supervisor on 10/28/20 at 12:55pm revealed:
-He had found a two bottles of Septra DS in Resident #1's medications.
-One of the bottles of Septra DS had not been entered in the eMAR system and was not prompting for administration.
-He immediately reported to the first shift Lead Supervisor and the Special Care Coordinator (SCC) finding the second bottle of Septra DS in Resident #1's medications.
-The first shift Lead Supervisor and SCC told him to leave the second bottle of Septra DS where it was in the cart.
-The first shift Lead Supervisor and SCC told him they would need to add the Septra DS "to the count" and then they would move it to the narcotic lock box as per policy for any antibiotic treatment.
-A staff person must have stored the Septra DS in Resident #1's "basket" in the medication cart "without knowing what it was."

Interview with the SCC on 10/28/20 at 1:54pm revealed:
-Resident #1 was set up for delivery of medications directly to the facility from a local pharmacy.
-She was not sure of the specific date the Septra DS had been delivered to the facility.
-The local pharmacy delivery staff never required facility staff to sign to accept medications being delivered.
-The first shift Lead Supervsor was responsible for ensuring medication orders were faxed to the contracted facility pharmacy for entry into the eMAR system.

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-The SCC was the "backup person" and was responsible for checking the order entered by the pharmacy into the eMAR.

Telephone interview with Resident #1's Nurse Practitioner (NP) on 10/29/20 at 10:31am revealed:
-The order for Septra DS dated 09/17/20 had been initiated by the emergency room physicians for left lower extremity cellulitis.
-Resident #1 not receiving Septra DS as ordered on 09/17/20 may have contributed to the resident's return to the hospital on 09/25/20.

Interview with the Administrator on 10/29/20 at 4:07pm revealed:
-She did not know Resident #1 had not started the Septra DS antibiotic as ordered on 09/17/20.
-The Septra DS order should have been faxed to the facility contracted pharmacy to be added to the eMAR.
-The Septra DS order should also have been faxed to Resident #1's local pharmacy, so they could fill the prescription and deliver it.
-Once the Septra was delivered to the facility, the Medication Aides, Lead Supervisors, or SCC would have been able to facilitate getting the Septra DS stored in the narcotic box on the medication cart.
-It was the facility's policy to track antibiotic administration using the same system of documentation used for controlled substance administration to ensure antibiotics were administered correctly and to completion.
-If the local pharmacy could not deliver a medication, the first shift Lead Supervisor, the SCC, or the Administrator were able to go and pick up the medication.
-It was her expectation that her staff tell her "immediately" if they were having trouble getting a

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medication.

Review of the facility's medication administration policy revealed:
-Administration of any medication order for systemic antibiotic shall be started no later than 9:00am of the following day unless the order is designated by the physician as urgent.
-All efforts should be made to start antibiotics at the next scheduled dose.

d. Review of Resident #1's emergency room (ER) discharge summary dated 09/17/20 revealed:
-Diagnoses included cellulitis of left leg and acute urinary tract infection.
-There was an order for Doxycycline (used to treat infection) 100mg 1 capsule two times a day for 7 days.

Review of Resident #1's September 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Doxycycline 100mg 1 capsule two times a day for 7 days scheduled at 9:00am and 9:00pm.
-The Doxycycline was documented as administered as ordered from 09/21/20 at 9:00am to 09/25/20 at 9:00am.
-The Doxycycline was documented as not administered on 09/25/20 at 9:00pm to 09/27/20 at 9:00pm due to the resident being "out of facility."

Review of Resident #1's controlled medication utilization record (CMUR) for Doxycycline dated 09/21/20 to 09/25/20 revealed the Doxycycline was documented as administered 09/21/20 at 10:00am to 09/25/20 at 9:00am for 9 occurrences out of 9 opportunities.

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Review of Resident #1's hospital discharge summary dated 09/29/20 revealed:
-Resident #1 was brought to the emergency room (ER) on 09/25/20, due to failure to improve on outpatient antibiotics and worsening leg wound.
-Resident #1 was admitted to the hospital on 09/25/20 and received intravenous antibiotic therapy.
-There was an order to discontinue the Doxycycline on 09/29/20.

Telephone interview with a Pharmacist from Resident #1's pharmacy on 10/27/20 at 11:14am revealed:
-The pharmacy received a prescription dated 09/17/20 for Doxycycline 100mg 1 capsule two times daily for 7 days and it was filled on 09/17/20.
-The pharmacy did not keep records of deliveries made to the facility and could not confirm if they had delivered the Doxycycline filled on 09/17/20 or if it had been picked up.

Interview with the first shift Lead Supervisor on 10/27/20 at 11:35am revealed the date the Doxycycline was started on the eMAR for Resident #1 was the date she had received the medication from the pharmacy.

Telephone interview with Resident #1's HH nursing supervisor on 10/28/20 at 9:26am revealed:
-They began providing wound care to Resident #1's left lower extremity on 09/13/20.
-They did a medication reconciliation when the client was on antibiotics.
-The facility was responsible for obtaining the antibiotics and administering the antibiotics.
-The home health nurse who made visits to care for Resident #1 had expressed her concerns with

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her supervisor "about the delay in starting the antibiotics" ordered on 09/17/20.

Interview with the second shift Lead Supervisor on 10/28/20 at 12:55pm revealed the Doxycycline was administered to Resident #1 when it was started on the eMAR (09/21/20).

Telephone interview with Resident #1's Nurse Practitioner (NP) on 10/29/20 at 10:31am revealed:
-The order for Doxycycline dated 09/17/20 had been initiated by the emergency room physician for left lower extremity cellulitis.
-Resident #1 not receiving Doxycycline as ordered on 09/17/20 may have contributed to the resident's return to the hospital on 09/25/20.

Interview with the Administrator on 10/29/20 at 4:07pm revealed:
-She did not know Resident #1 had not started the Doxycycline antibiotic as ordered on 09/17/20.
-If the local pharmacy could not deliver a medication, the first shift Lead Supervisor, the SCC, or the Administrator were able to go and pick up the medication.
-It was her expectation that her staff tell her "immediately" if they were having trouble getting a medication.

Review of the facility's medication administration policy revealed:
-Administration of any medication order for systemic antibiotic shall be started no later than 9:00am of the following day unless the order is designated by the physician as urgent.
-All efforts should be made to start antibiotics at the next scheduled dose.

2. The medication error rate was 8% as

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evidenced by the observation of 3 errors out of 37 opportunities during the 8:00am/9:00am medication pass on 10/27/20.

Review of Resident #8's current FL2 dated 09/04/20 revealed diagnoses included vascular dementia, schizophrenia, and diastolic heart failure.

a. Review of Resident #8's current FL2 dated 09/04/20 revealed an order for aspirin 81mg daily for blood thinner.

Observation of the 8:00am medication pass on 10/27/20 revealed the aspirin 81mg was unavailable for administration.

Interview with the Medication Aide (MA) preparing Resident #8's medications for administration on 10/27/20 at 8:47am revealed:
-The aspirin 81mg was due to be administered daily at 9:00am.
-There was no aspirin available for Resident #8.
-The aspirin had been reordered however they were waiting on it to arrive from the pharmacy.
-The aspirin should arrive on the delivery from the pharmacy later in the day.
-The aspirin would be administered at the next scheduled administration time (10/28/20 at 9:00am).

Review of Resident #8's October 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for aspirin 81mg daily scheduled for 9:00am.
-The aspirin 81mg was documented as administered from 10/01/20 to 10/28/20 for 24 occurrences out of 28 opportunities.
-The aspirin 81mg was documented as not

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administered due to the medication being unavailable ("out/waiting on pharmacy) on 10/22/20, 10/25/20, 10/26/20, and 10/27/20.

Interview with the same MA on 10/28/20 at 10:30am revealed:
-The aspirin did not arrive for Resident #8 from the pharmacy.
-She had to "borrow" an aspirin 81mg tablet from another resident that morning to administer to Resident #8.

Interview with the Special Care Coordinator (SCC) on 10/28/20 at 9:42am and 1:54pm revealed:
-She had not known Resident #8's aspirin had been unavailable until it was brought to her attention after the medication pass on 10/27/20.
-There were "alot" of over the counter meds like aspirin on back order through the contracted facility pharmacy.

Telephone interview with Resident #8's Nurse Practitioner (NP) on 10/29/20 at 10:31am revealed:
-Resident #8 was ordered aspirin 81mg daily for diastolic heart failure.
-The aspirin helped to prevent blood clots as an anti-platelet and anti-inflammatory.

Interview with the Administrator on 10/29/20 at 4:07pm revealed:
-Medication cart audits were scheduled to be done every Monday.
-Any medication that was missing or low the staff were expected to reorder the medication and "get the medications in the building."
-The Medication Aides informed her they were reporting to the first shift Lead Supervisor and SCC when medication strengths did not match

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the eMAR system and medication available on the cart.
-The first shift Lead Supervisor and SCC informed her the MAs were not reporting discrepancies and missing medications to them.
-She had not been aware of the problem, because staff were not reporting the issues to her.

b. Review of Resident #8's physician order dated 10/09/20 revealed an order for calcium citrate (used to supplement calcium levels) 950mg 1 capsule two times a day.

Observation of the 8:00am medication pass on 10/27/20 revealed the medication aide (MA) prepared and administered calcium citrate 630mg/Vitamin D3 500 iu 1 tablet.

Review of Resident #8's October 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for calcium citrate 950mg 1 tablet twice daily scheduled at 8:00am and 8:00pm.
-The calcium citrate 950mg was documented as administered from 10/19/20 to 10/28/20 for 9 occurrences out of 9 opportunities.
-The calcium citrate 950mg was documented as not administered from 10/11/20 to 10/18/20 due to "waiting on pharmacy."

Interview with the first shift Lead Supervisor on 10/28/20 at 3:08pm revealed:
-She performed medication cart audits every Monday and Tuesday.
-She had ordered the correct calcium citrate from Resident #8's pharmacy.
-The NP had changed the calcium citrate order to match what was on the medication cart, because

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Resident #8's pharmacy did not have the strength she had "originally ordered."

Telephone interview with Resident #8's Nurse Practitioner (NP) on 10/29/20 at 10:31am revealed she ordered the calcium citrate for Resident #8 because the resident's calcium levels were "a little low."

Interview with the Administrator on 10/29/20 at 4:07pm revealed:
-Medication cart audits were scheduled to be done every Monday.
-Staff were supposed to compare the orders, to the eMAR, to the medications that were available for administration.
-Any medication that was missing or low the staff were expected to reorder the medication and get the medications in the building.
-The medication aides stated they were reporting to the first shift Lead Supervisor and Special Care Coordinator (SCC) when medication strengths did not match the eMAR system and medication available on the cart.
-The first shift Lead Supervisor and SCC stated the MAs were not reporting discrepancies and missing medications to them.
-She had not been aware of the problem, because staff were not reporting the issues to her.

c. Review of Resident #8's current FL2 dated 09/04/20 revealed there was an order for Vitamin D3 (used to supplement vitamin D levels) 5000 iu 1 capsule daily.

Observation of the 8:00am medication pass on 10/27/20 revealed the medication aide (MA) prepared and administered calcium citrate 630mg/Vitamin D3 500 iu 1 tablet.

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D 358	Continued From page 50 Review of Resident #8's October 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry for vitamin D3 5,000 unit 1 capsule daily. -The vitamin D3 was documented as not administered from 10/01/20 to 10/26/20 due to the medication being unavailable ("out of medication" and "waiting on pharmacy"). Interview with the first shift Lead Supervisor on 10/28/20 at 3:08pm revealed: -She performed medication cart audits every Monday and Tuesday. -She had ordered the correct strength of vitamin D3 from Resident #8's pharmacy. -The NP had changed the vitamin D3 order to match what was on the medication cart, because Resident #8's pharmacy did not have the strength she had "originally ordered." Interview with the Administrator on 10/29/20 at 4:07pm revealed: -Medication cart audits were scheduled to be done every Monday. -Staff were supposed to compare the orders, to the eMAR, to the medications that were available for administration. -Any medication that was missing or low the staff were expected to reorder the medication and get the medications in the building. -The medication aides stated they were reporting to the first shift Lead Supervisor and Special Care Coordinator (SCC) when medication strengths did not match the eMAR system and medication available on the cart. -The first shift Lead Supervisor and SCC stated the MAs were not reporting discrepancies and missing medications to them.	D 358		

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-She had not been aware of the problem, because staff were not reporting the issues to her.
3. Review of Resident #2's FL2 dated 08/24/20 revealed diagnoses included dementia with behavioral disorder, Chronic Obstructive Pulmonary Disease (COPD) and Type 2 diabetes.

Review of Resident #2's hospital discharge summary dated 10/06/20 revealed:
-Resident #2 had been admitted to the hospital on 10/04/20 with a urinary tract infection.
-Resident #2 was positive for Methicillin Resistant Staph Aureus (MRSA).
-There was a medication order for cefuroxime 500mg (an antibiotic to treat infection) to be administered twice a day for 5 days.

Review of Resident #2's October 2020 electronic medication administration record (eMAR) revealed there was not an entry for cefuroxime 500mg to be administered for 5 days.

Observation of Resident #2's medications available for administration on 10/29/20 at 9:20am revealed:
-There was one medication card containing cefuroxime 500mg (1 tablet twice daily for 2 days) that was available for administration.
-The card had been dispensed with 4 tablets and one tablet had been removed.
-The medication had been filled on 10/08/20.

Telephone interview with a representative from the facility's contract pharmacy on 10/29/20 at 10:45am revealed:
-The hospital discharge orders were faxed from the facility on 10/08/20 at 9:32am.
-All new hospital discharge orders were keyed into the electronic Medication Administration

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KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

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Record (eMAR) on 10/08/20 by the pharmacy.
-Staff at the facility were also able to add and delete medications from the eMAR.
-The pharmacy had only dispenced 4 tablets because when they received the fax, that was all that was left to administer since the order had a stop date of 10/10/20.

Interview with a MA on 10/29/20 at 9:20am revealed:
-She did not know why there was a medication card containing 3 of 4 cefuroxime pills because there was not an order for it on the eMAR.
-The Supervisor was responsible for cart audits and she conducted the audits on Mondays or Tuesdays.
-Her understanding was audits were done in order to fill medications that were low or remove medications that were no longer needed.

Interview with the Supervisor on 10/28/20 at 4:15pm and 10/29/20 at 12:16pm revealed:
-Resident #2 was discharged from the facility to home on 9/30/20.
-Resident #2 was readmitted to the facility from the hospital on 10/6/20.
-She had been told by the Administrator that Resident #2 had been considered to be on "therapeutic leave" rather than discharged.
-When Resident #2 returned from "therapeutic leave" the facility just resumed his old orders.
-She was responsible for completing medication cart audits every Monday or Tuesday.
-She had last conducted a cart audit on 10/26/20.
-She had not received proper training for her position because of Covid-19 restrictions of personnel in the facility.
-She did not know why Resident #2 had a medication card containing cefuroxime in the medication cart.

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-She did not know why Resident #2's eMAR did not contain an order for the antibiotic cefuroxime.
-All antibiotics administered were documented on a control sheet per facility policy.
-Resident #2 did not have a control sheet for cefuroxime because it was not listed on the eMAR, so she did not know who would have administered it.
-MA's did not administer medications if they were not listed on the eMAR.
-She was responsible for conducting medication cart audits weekly.
-When she conducted cart audits she only compared the "bubble packs" that contained multiple medications and bottles of medication to the medication orders.
-She did not remove medications that were not needed on the cart; that would be the responsibility of the MA.
-The pharmacy entered medication onto the eMAR, but she was also able to enter and delete medications from the eMAR and should have discovered the medication was missing from the eMAR when she conducted the cart audits.
-The last time she completed a cart audit was on 10/26/20.
-Resident #2 had gone to the ER on 10/11/20 and when he returned he pulled out the catheter that had been placed in the ER.

Review of the facility's medication administration policy revealed:
-Administration of any medication order for a systemic antibiotic shall be started no later than 9:00 am of the following day unless the order is designated by the physician as urgent.
-In the event that starting an order within the indicated timeframe is not possible due to extenuating circumstances, the physician shall be notified immediately, and documentation of such

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circumstance shall be made in the nurse's notes of the resident's medical record.

Telephone interview with the facility's Primary Care Provider (PCP) on 10/29/20 at 11:09am revealed:
-She was aware that Resident #2 had been discharged from the facility to home on 09/30/20 and readmitted to the facility on 10/06/20.
-She was unaware that Resident #2 had been admitted from the hospital; she thought he had come directly from home.
-She was unaware that Resident #2 had been ordered an antibiotic or was positive for MRSA.
-She was scheduled to complete Resident #2's admission paperwork on 10/30/20.
-She expected the facility to administer medications as ordered.
-The resident was at risk of developing sepsis, if the antibiotic had not been administered as ordered, especially with a MRSA diagnosis.

Interview with the Administrator on 10/29/20 at 4:08pm revealed:
-She was unaware before today that Resident #2 had an antibiotic order and did not receive it as ordered.
-The pharmacy had the capabilities of delivering medications twice a day to the facility so there should have been no reason the medication was omitted or delayed.
-The pharmacy, Supervisor and SCC all had the ability to enter and remove medication orders from the eMAR.
-The SIupervisor was responsible for conducting medication cart audits weekly.
-Medication cart audits consisted of comparing all orders to the medications on the cart.
-If medication cart audits had been completed correctly the errors would have been found.

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-When there was a problem with a medication she expected to be told by the Supervisor or the SCC.
-The SCC had not been thoroughly trained since she started in her position.
-The corporate office was responsible for training the SCC but due to Covid-19 restrictions the training had not been completed.

3. Review of Resident #5's current FL-2 dated 07/23/20 revealed diagnoses included dementia, hypertension and hypothyroidism.

Review of Resident #5's physician order dated 06/05/20 revealed an order for ASA 81 mg chewable tablet by mouth daily.

Review of Resident #5's October 2020 Medication Administration Record (MAR) revealed ASA 81mg was not documented as administered from 10/01/20 through 10/12/20.

Review of the facility's variance report (medications not administered as ordered) for October 2020 revealed:
-The ASA was not documented as administered to Resident #5 from 10/01/20 through 10/05/20 due to the facility was "out of medication."
-The ASA was not documented as administered to Resident #5 from 10/06/20 through 10/12/20 due to the facility was "waiting on pharmacy."

Observation of Resident #5's medication on hand on 10/29/20 at 9:05am revealed a bottle of ASA 81mg chewable tablets that were "house stock" with no resident name identified on the bottle.

An interview with the Lead 1st shift Supervisor on 10/29/20 at 9:18am revealed:
-Resident #5 had a "standing order" for ASA

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81mg chewable tablet every day.
-The ASA was on back order from the pharmacy for almost 2 weeks in October 2020.
-She should have gotten a hold order from the physician until the medication came in from the pharmacy.
-The facility did not have a local back-up pharmacy to her knowledge.

An interview with the Special Care Coordinator (SCC) on 10/29/20 at 9:35am revealed:
-When medications were not available for administration, are out the medication aides (MA's) let the Lead Supervisor know.
-She was not aware Resident #5 had been out of her ASA for 12 days.
-The MA's document medications that were getting low and medications that were out for each shift and place the documentation in a communication folder for follow-up by the Lead Supervisor.
-She was not aware until 10/29/20 that the facility had a local back-up pharmacy available.

An interview with the Hospice Family Nurse Practitioner (FNP) on 10/29/20 at 10:25am revealed:
-Staff would typically let her know when a medication was not available or needed to be discontinued if the resident refused to take it.
-She was not aware Resident #5 had been without her ASA from 10/01/20 through 10/12/20.
-She would have expected staff to make her aware of the medication being unavailable but Resident #5 was not harmed from not taking the ASA.

An interview with the first shift MA on 10/29/20 at 12:30pm revealed:
-If a medication was not available on the

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medication cart, she would check the overstock medications to see if it was available.
-If she was still unable to find the medication, she would leave a note in the communication folder for the Lead Supervisor.
-She was aware Resident #5 had been out of her ASA on several occasions at the first of the month and indicated she had placed a note in the communication folder each time she found the medication missing.

An interview with the Administrator on 10/29/20 at 4:10pm revealed:
-The medication carts were supposed to be audited every Monday by pulling all the medication orders and comparing them to what was available on the medication cart.
-Any medication that is was low the person checking the medication cart would send a notification to the pharmacy website to reorder for their primary pharmacy and they fax the information to the pharmacy being used by residents under the care of Hospice.
-Her expectations were for the MA's to give a list of missing medications to the Lead Supervisor or the SCC by placing the list in a communication folder for every shift.
-She was not aware that Resident #5 was without her ASA for 12 days.
-She was not aware the FNP had not been notified about the missed administration of ASA for 12 days.

The facility failed to meet the medication administration needs of 3 of 5 sampled residents (Residents #1, #2, and #5) related to a medicaiton for infection (#1 and #2), anxiety (#1), high blood pressure (#1), prevention of blood clots (#5), and for 1 of 9 residents observed

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D 358	Continued From page 58 during medication passes including errors with a medication used to prevent blood clotes (#8), to supplement vitamin D levels (#8), and for decreased calcium levels (#8). The facility;s failure resulted in sumstantial rish that harm or dath could occur which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/28/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 29, 2020.	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. This Rule is not met as evidenced by: The facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication orders, medication administration and health care and follow-up. The findings are: 1.Based on observations, record reviews, and interviews, the facility failed to ensure health care	D912		

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referral and follow up to meet the routine and acute healthcare needs of 2 of 5 sampled residents (#2, #1) including failure to send a resident to a scheduled follow-up appointment after being discharged from the hospital with a Urinary Tract Infection (UTI) with an order to receive an antibiotic (#2), failure to make an appointment with a physician after being evaluated in the emergency room (ER) for urinary retention resulting in catheter placement (#2), failure to ensure he was admitted and evaluated by the facility PCP (#2), failure to have follow-up visits after an emergency evaluation and after a hospital discharge (#1), failure to report missed medications to treat anxiety, high blood pressure, infection and cholesterol (#1) and refusal of a hormonal cream (#1). [Refer to tag 0273, 10A NCAC 13F .0902 (b) Health Care (Type A2 Violation)].

2.Based on observations, record reviews, and interviews, the facility failed to clarify orders with the prescribing practitioner for 1 of 5 sampled residents (#2) as related to buspirone (a medication to control anxiety), cefuroxime (an antibiotic), omeprazole (a medication to control reflux), melatonin (a medication for sleep), Baza (an antifungal) and fluticasone (a nose spray for allergies). [Refer to Tag 0344, 10A NCAC 13F .1002 (a) Medication Orders (Type B Violation)].

3.Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (#1, #2, #5) related to a medication for infection (#1 and #2), anxiety (#1), high blood pressure (#1), prevention of blood clots (#5), and for 1 of 9 residents observed during the medication passes including errors with a medication used to prevent

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D912	Continued From page 60 blood clots (#8), to supplement vitamin D levels (#8), and for decreased calcium levels (#8). [Refer to Tag 0358, 10A NCAC 13F .1004 (a) Medication Administration (Type A2 Violation)].	D912		