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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, a follow-up survey and a complaint investigation on 7/18/17, 7/19/17 and 7/20/17. The complaint investigation was initiated by the Onslow County Department of Social Services on 7/10/17.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure one resident room was free of hazards as evidenced by the presence of clutter and insects [roaches, flies, and "roly- poly" bugs (also known as pillbugs)]. The findings are: Observation of Resident Room #57 on 07/18/17 at 11:45am revealed: - There were 2 dead flies on the windowsill and 2 dead flies on the floor. - There were 3 roly-poly bugs (pillbugs) on the floor in front of the closets, and 3 dead pillbugs in the open space (approximately one inch deep)	D 079		

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D 079	Continued From page 1 behind the the chest of drawers by the window. Observation of the resident closets in Room #57 on 7/18/17 from 11:55am to 12:05pm revealed: - Both closets were filled with clothing and personal possessions. - The closet floors were dusty. - The ceiling tiles in the closet had gaps between them and the metal frame of the ceiling. - The ceilings were dusty, and had some brown and black spots that may indicate water leaks. Observation of the closet on the left in Room #57 on 7/18/17 from 11:55am to 12:05pm revealed: - Clothing was on hangers that were neatly spaced on the clothes rod. - The floor of the closet had boxes containing clothing and personal possessions on the floor. - The boxes reached to the bottom hems of shirts hung on the clothes rod. Observation of the closet on the right in Room #57 on 7/18/17 from 12:05pm to 12:15pm revealed: - There were four live roaches crawling on the metal door frame, ceiling, and interior walls of the closet. - There was a dark spot on the upper right-hand corner of the closet's ceiling and rear wall. One roach crawled up there. - The other three roaches crawled down the metal door frame to enter the room, and disappeared under the chest of drawers and the bed on the window side of the room. - The clothes rod was jam-packed with clothing. - There were piles of clothes with visible stains and food debris on the closet's floor and top shelf. - The clothing on the closet floor smelled of sweat and urine. - There were personal possessions, including	D 079		

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toiletries and reading material, on the closet floor.
- The floor was dusty and dirty.

Observation of the chest of drawers next to the window in Room #57 on 7/18/17 from 12:15pm to 12:30pm revealed:
- There was a pile of wrinkled, unfolded T-shirts, pants, and socks.
- Personal possessions including toiletries, magazines, and handwritten notes were present in the pile of clothing.

Continued observation of Room #57 at 12:45pm on 7/18/17 revealed:
- A second chest of drawers was placed against the wall opposite the closets.
- Nightstands and beds were also placed against this wall.
- Personal possessions (shoes, books, and individualized activity materials) were on the floor for about two feet in front of this second chest of drawers.
- The floor of the room was dusty and dirty.
- Dead insects were present under the beds and behind the nightstands and chests of drawers.

Interview with a Housekeeper at 12:30pm on 7/18/17 revealed:
- Floors were mopped and swept daily.
- It was difficult to clean Room #57 because of all of the residents' possessions.
- It seemed someone was always napping in Room #57, the staff tried to not disturb the residents.
- The residents in Room #57 needed to put some of their belongings in storage.
- She believed the exterminators came to the facility at least monthly, and whenever they are contacted by the Administrator.

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Interviews with both residents who resided in Room #57 at 1:45pm on 7/19/17 revealed:
- Both residents denied seeing roaches in their room.
- Facility staff cleaned their room and bathroom daily.
- Both residents denied having enough space to store all their belongings in their room.
- One resident complained when facility staff tried to rearrange his possessions.
- One resident never saw facility staff clean his closet.

Interview at 2:00pm on 7/19/17 with a Personal Care Aide (PCA) who worked in the back hall where Room #57 was located revealed:
- The residents who resident in Room #57 were very private, and wanted their privacy respected.
- Both residents were active in the community, and did not spend much time in Room #57.
- They both liked to save everything.
- They did not want staff looking through their belongings.
- They did not want facility staff telling them what to do about their possessions.
- She had observed Room #57 being cleaned by Housekeeping staff.

Interview at 4:15pm on 7/19/17 with a Medication Aide (MA) revealed:
- Both residents who lived in Room #57 had too many articles of clothing in their room.
- Their families visited frequently, but were not informed that their room had too much clutter.
- The residents did not complain about bugs in their room.
- There used to be a lot of roaches in the facility, "residents complained a lot in the past year, not so much now."
- Some residents had complained, so the facility

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D 079	Continued From page 4 administrator would call the exterminator to spray their room for bugs both on a scheduled and a "as needed" basis. Interview with the Administrator at 1:30pm on 7/20/17 revealed: - Both residents who resided in Room #57 "were hoarders". - They wanted to store their possessions in their room. - Housekeeping did not go into the residents' closets to clean. - She would have the closets of Room #57 cleaned immediately. - Any needed repairs in Room #57 would be completed immediately. - She would have the clothing on top of the chest of drawers next to the window immediately laundered. - She would have the clothing on the floor of the closet in the closet on right side of the room laundered immediately. - She would talk to the residents and make arrangements to store their possessions elsewhere in the facility or removed by their responsible parties. - The contracted pest control company was good about coming to give services whenever needed. - She would contact the pest control company as soon as possible to check Room# 57 and other rooms on the back hallway for roaches and other insects. - She would have the building checked for any needed repairs "to keep the bugs out". Attempted telephone interviews with employees of the pest control company on 7/19/17 and on 7/20/17 were not returned before the close of the survey.	D 079		

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D 079	Continued From page 5 Attempted telephone interviews on 7/19/17 and on 7/20/17 with family members of the two residents who resided in Room #57 were not returned before the close of the survey.	D 079		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews, and interviews, the facility failed to assure staff responded immediately for 1 of 1 sampled residents (#6) who required cardiopulmonary resuscitation (CPR) according to facility's policies and CPR training after the resident became unresponsive and her pulse and respirations were absent when assessed by staff. The findings are: Review of Resident #6's FL-2 dated 11/21/16 revealed no diagnoses listed. Review of a hospital discharge summary dated 11/22/16 revealed: -Resident #6 was admitted to a local hospital on 11/17/16 and discharged on 11/22/16 to this	D 271		

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facility.
-Discharge diagnoses included acute and chronic respiratory failure with hypercapnia, chronic anemia, chronic obstructive respiratory disease (COPD) exacerbation, depression, hyperkalemia, pneumonia, chronic kidney disease (stage III), hyperlipidemia and hypertension.

Review of the hospital admission history and physical dated 11/18/16, the resident was admitted to the hospital on 11/17/16 from home with a diagnoses of pneumonia of the left lower lobe and chronic respiratory failure.

Review of the Resident Register revealed Resident #6 was admitted to the facility on 11/22/16.

Review of a "Resident Information" document revealed the resident's code status was documented as "Full Code".

Review of an Accident/Injury Report dated 11/22/16 (11:25pm) revealed:
-Resident #6 was observed lying on the floor in her room.
-The resident was "unable to respond" and was "unable to arouse".
-There were no injuries present and the resident was "foaming from mouth".
-The resident's "pulse palpated, unable to obtain".
-"[The local emergency medical service (EMS) and the local police department] responded and began CPR".
-"EMS pronounced [the resident deceased] at the facility and [a local funeral home] accepted body."
-The report was completed by one of the facility's 3rd shift supervisor.

Review of "Charting Notes" for Resident #6

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(documented by the 3rd shift supervisor) dated 11/23/16 revealed:
-"supervisor in at 10:45 shift changed were reported. 2nd shift supervisor informed me that we had a new resident on the blue hall and gave her name and to inform the aide she would be a two hour check."
-"I counted the back hall med's with the supervisor. Then went to the front hall med's. While we were counting, the aide came and said [Resident #6] had fallen in the bathroom.
-"[the 2nd shift supervisor] went ahead to check [vital signs]. I went to check resident. When I [entered] the room I saw resident on [left] side in the bathroom with head lying against her walker."
-"I called her by name, no answer. I left to call 911 and [Resident Care Coordinator]. 911 here."

Review of a county EMS report dated 11/22/17 revealed:
-The county EMS received an emergency call from the facility staff at 11:35pm and EMTs were dispatched and were enroute to the facility at 11:37pm.
-The EMTs arrived at the facility at 11:41pm and at the patient at 11:45pm.
-The patient was in cardiac arrest before arrival of the EMTs.
-Resuscitation and ventilation were attempted and chest compressions initiated.
-The estimated time of cardiac arrest before arrival of the EMTs was more than 20 minutes.
-CPR was started by the EMTs at 11:46pm.
-The call was closed at 1:29am.

Review of the EMT narrative documentation on the EMS Report dated 11/22/17 revealed:
-[Patient] found lying slumped over her walker. [Patient was not breathing and didn't have a pulse. Told by staff [patient just came from [local

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D 271	Continued From page 8 hospital] today from having pneumonia. There conflicting stories as to whether or not the fall was witnessed by staff on the scene. We were told [patient] was last seen about 1 hour ago and that someone may have been in there to help the [patient] use the bathroom. CPR was not being performed by the staff on the scene. Interview the Resident Care Coordinator (RCC) on 7/19/17 at 9:00am revealed: -Resident #6 was admitted to the facility "late in the evening" on 11/22/16. -The resident's oxygen concentrator and hospital bed had been delivered the day before admission. -On 11/21/16, she was at home and received a call from the 3rd shift supervisor who informed her Resident #6 had fallen during change of 2nd and 3rd shift and had passed away. -The EMS was at the facility when the supervisor called the RCC. -The next morning (11/22/16) the RCC talked to a personal care aide (PCA) who stated she assisted Resident #6 to the bathroom and the resident fell when coming out of the bathroom and the PCA called for help from the medication aides (MA). -The RCC received another call from the 3rd shift supervisor, who informed her the resident had no pulse and no respirations and EMS was at the facility. -Resident #6 was admitted to the facility as full code status. -Any resident who was DNR status had an original signed DNR form which was placed inside the front of the resident's medical chart. -The supervisor did not mention if staff had started CPR or implemented any resuscitive measures. -Any resident who went into cardiac arrest and	D 271		

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was full code status, CPR should be implemented by staff immediately.
-The facility's policy required all MAs and supervisors to be CPR certified and the PCAs may be required to be CPR certified.

Interview with the Business Office Manager on 7/19/17 at 9:20am revealed:
-Per facility's policy, all facility staff were required to be CPR certified.
-When new staff was hired, the staff was asked if CPR certification was current, if not current, new staff was required to become CPR certified within 6 months after hired. If not, the staff was taken off the schedule until completion of CPR class.
-At the time Resident #6 expired on 11/22/16, the 3rd shift supervisor, the former 2nd shift supervisor on duty and 2 of the 4 PCA's who were in the resident's room were CPR certified.
-The 2nd shift supervisor and one of the PCAs was no longer working at the facility.

Interview with the 1st shift supervisor on 7/19/17 at 10:45am revealed:
-She worked as 3rd shift supervisor until a few months ago and worked on 11/22/16 (3rd shift).
-She came to work at 10:30pm on 11/22/16 and was informed by the former 2nd shift supervisor, a new resident (Resident #6) was admitted earlier this evening.
-While counting medications at the medication cart with the former 2nd shift supervisor, a PCA came to the nurse's station and informed us Resident #6 was on the floor in her bathroom.
-The supervisor and the former 2nd shift supervisor went to the resident's room and observed the resident on the floor with her head leaning on her walker. The resident was unresponsive.
-The 3rd shift supervisor assessed the resident's

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pulse but could not feel a pulse and the resident was not breathing.
-The 3rd shift supervisor did not start CPR because "I panicked and froze, I thought her neck was broken".
-The 3rd shift supervisor did not observe other staff who was present start CPR.
-The 3rd shift supervisor sent a PCA to call 911 and EMS arrived to the facility in about 7-10 minutes and pulled the resident out of the bathroom and started CPR immediately, but the resident's fingers had started turning blue.
-The emergency medical technicians (EMT) placed a "tube down [the resident's] throat" and "worked on her" about 30 minutes.
-The resident's pulse started a few times but faded out and the EMT's informed the staff the resident had expired.
-The 3rd shift supervisor called the RCC and informed her of the resident's death and the RCC called the resident's family.
-The local police came to the facility before the resident's body was moved and took statements from the staff.
-The resident's family came to the facility after the funeral home removed the body from the facility.
-The 3rd shift supervisor was CPR certified at the time of Resident #6's death and understood that CPR was to be implemented if a resident did not have an original "Do Not Resuscitate" (DNR) document at the facility.
-Since the resident did not have a DNR document in the facility, the resident was full code status and CPR should have been started before EMS arrived.
-She had performed CPR in the past.

Interview with a 3rd shift PCA on 7/20/17 at 7:50am revealed:
-She was hired on 9/3/16 and worked at the

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D 271	Continued From page 11 facility as a PCA on 3rd shift. -She was CPR certified when hired and was recertified in January 2017. -On 11/22/16, as soon as she entered the facility, was informed by other staff that the new resident had fallen. -After clocking in, the PCA went to Resident #6's room to assist the staff but did not go in the resident's room because the 3rd shift supervisor, the former 2nd shift supervisor and 2 PCAs were in the room. -The 3rd shift PCA did not observe anyone performing CPR and no one directed her to start CPR. -A staff member informed her, the resident did not have a pulse. Interview with a former PCA on 7/20/17 at 3:20pm revealed: -The former PCA worked on 11/22/16 (2nd shift) and was informed that Resident #6 was admitted to the facility earlier the same evening. -Near the end of the 2nd shift, Resident #6 requested assistance with ambulating to the bathroom. She assisted the resident with ambulating (with a walker) to the bathroom and left the resident in the bathroom. -When she returned to the room to assist the resident out of the bathroom, the resident had removed her oxygen cannula. The PCA assisted the resident up from the commode and the resident walked to the bathroom door with her walker and went down to her knees inside the bathroom at the door. -The resident stated she was ok and the PCA left the room and went to the nurse's station to get help to get the resident off the floor. -She informed the 3rd shift supervisor of the incident and went back to the resident's room with the supervisor.	D 271		

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-The resident was on the floor and unconscious.
-The supervisor put her hand to the resident's neck and stated the resident did not have a pulse and was dead.
-The supervisor left the room and called EMS.
-Another staff member checked the resident for a pulse and asked what happened.
-There were 2 more PCAs and the 2nd shift supervisor in the resident's room and no one started CPR.
-The former PCA was not CPR certified.
-When EMS arrived, they attempted to revive the resident, but it was too late.

Interview with the Executive Director (ED) on 7/19/17 at 1:00pm revealed:
-Resident #6 was admitted to the facility and moved in on 11/22/16.
-The resident was at the facility less than 12 hours before she died.
-When the resident was admitted, she was a full code. A DNR order was not in place.
-She received notification from the RCC on 11/22/16 the resident was found in her room unresponsive.
-The staff called EMS, who arrived to the facility in a "timely manner."
-She was not aware the staff on duty did not initiate CPR before EMS arrived.
-The staff remained in the resident's room and worked together to assist EMS during their attempt to revive the resident using CPR.
-Facility policy required all staff providing direct resident care to be CPR certified either before hire or scheduled for CPR class after hire.
-Per facility's policy, staff was required to start CPR for any resident who was a full code and went into cardiac arrest.

The ED did not provide the written facility policy

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which addresses emergency interventions.

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The facility failed to assure the initiation of CPR in accordance with the facility's policy and CPR training for 1 of 1 resident (Resident #6) who was found on the bathroom floor by staff without a pulse or respirations. The facility's failure to initiate CPR to attempt to revive Resident #6 resulted in the death of a resident and constitutes a TYPE A1 Violation.

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Review of the facility's Plan of Protection dated 7/20/17 revealed:
-All staff will be in-serviced prior to their next scheduled shift regarding CPR procedures and the company policies and procedures as it relates to initiation of CPR.
-An audit of staff files will begin immediately to determine/monitor CPR certified staff in the facility.
-If any staff is identified unclear on CPR procedures and the company policies and procedures, immediate training/clarity will be provided to ensure residents are protected from further risk.
-CPR procedures will be reviewed with staff during annual training to ensure on-going compliance.

THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 19, 2017.

D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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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:
Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the prescribing practitioner for 1 of 2 residents (#7) observed during the medication pass including errors with a blood pressure medication (Coreg), an anti-infective medication (Minocycline), and a dietary supplement (Magnesium Oxide).

The findings are:

The medication error rate was 12% as evidenced by observations of 3 errors out of 25 opportunities during the 8:00am medication pass on 07/19/2017.

Review of Resident #7's current FL-2 dated 04/10/2017 revealed:
-A diagnosis of Acute Heart Failure.
-The FL-2 was generated from a hospitalization for 04/02/2017 through 04/10/2017.
-There was a handwritten note in the medication section of the FL-2 to "see transfer summary".

A. Review of the hospital discharge summary dated 04/10/2017 revealed a physician's order for Carvedilol (generic for Coreg and used to treat

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heart failure and high blood pressure) 12.5milligrams (mg) tablet every 12 hours.

Review of subsequent physician's orders revealed:
-On 04/18/2017 there was a physician's order for Coreg 12.5mg twice a day.
-On 05/01/2017 there was a physician's order to increase Coreg 25mg twice a day.
-On 07/06/2017 there was a copy of physician orders with the physician signature which included an order for Coreg "F/C" 25mg tablet take one tablet twice daily.

Interview with the Medication Aide (MA) on 07/19/2017 at 8:00am revealed:
-Coreg 25mg tablet was not on the medication cart.
-The MA would "check cubby" for the Coreg.
-Resident #7 was supposed to be administered the Coreg at 8:00am.

Observation of the medication pass on 07/19/2017 at 8:02am revealed:
-The MA administered 12 medications in tablet form to Resident #7 which did not include Coreg 25mgs.
-The MA went to the medication room, looked in a locked cabinet and removed a blister pack of medication from the cabinet. The MA then stated that was the Coreg for Resident #7. The MA returned to the medication cart with the blister pack of medication.

Observation of the medication pass on 07/19/2017 at 8:13am revealed the Medication Aide (MA) prepared and administered to Resident #7 Coreg 12.5mg one tablet with water.

Review of Resident #7's electronic Medication

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Administration Records (eMARs) for 07/2017 revealed:
-There was an entry for Coreg "F/C" 25mg tablet twice a day.
-The Coreg 25mg tablet was scheduled for administration at 8:00am and 8:00pm daily.

Interview with the MA on 07/19/2017 at 11:20am revealed:
-She had only administered Coreg 12.5mgs to Resident #7 on the morning of 07/19/2017.
-She was not aware of the 05/01/2017 order increasing the Coreg from 12.5mgs to 25mgs twice daily.
-She usually worked on the front hall medication cart.
-She "should check the medication three times".
-She knew she was supposed to check the medication when she removed the medication from the medication cart, when she "popped" the medication in preparation for administering, and when she put the medication away.
-She was "running late this morning" and "sometimes you let your nerves get the best of you".

Observations of medications on hand in the medication room on 07/19/2017 at 11:45am revealed:
-The MA looked in the locked cabinet in the medication room and removed two pharmacy dispensed blister packs of Coreg 25mg tablets.
-The Coreg 25mg tablets were labeled as dispensed from the pharmacy on 06/28/2017, quantity of 60 tablets.
-There were 60 tablets on hand.

Interview with the MA on 07/19/2017 at 11:45am revealed somebody had not taken the 12.5mg tablets out of the medication storage or had

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forgotten to put a direction change label on the blister pack of Coreg 12.5mg tablets.

Telephone interview with the pharmacy provider representative on 07/19/2017 at 12:30pm revealed:
-The current order for Coreg was for 25mg twice daily dated 05/01/2017.
-Coreg 25mg had been dispensed to the facility on 06/28/2017 quantity of 60 tablets.
-The last time Coreg 12.5mg tablet was dispensed to the facility was 04/18/2017 quantity of 60 tablets.

Telephone interview with the Pharmacist at the provider pharmacy on 07/19/2017 at 12:50pm revealed:
-On 05/02/2017, Coreg 25mg quantity 60 was dispensed and delivered to the facility for a month supply.
-The potential effects of the resident being administered a lower dose of Coreg than was ordered could be that the resident's blood pressure would be elevated.

Interview with the Resident Care Coordinator (RCC) on 07/19/2017 at 1:20pm revealed she did not know the frequency of blood pressure checks for Resident #7 but would have a staff member check the resident's blood pressure.

Interview with Resident #7 on 07/19/2017 at 1:30pm revealed:
-The resident denied dizziness.
-The resident complained of feeling tired.
-The resident complained having sinus problems.

Observation and interview of a MA on 07/19/2017 at 1:35pm revealed:
-The MA checked Resident #7's blood pressure in

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the right wrist with a digital blood pressure monitor.
-The MA stated at 1:37pm that the resident's blood pressure reading was 120/58 and the pulse was 90.

Interview with the Primary Care Provider on 07/19/2017 at 5:40pm revealed Resident #7's a potential problem of the resident getting a lower dose of Coreg than what was ordered would be a "bump" in the resident's blood pressure and the resident's blood pressure was "okay".

Refer to interview with the Medication Aide dated 07/19/2017 at 11:30am.

Refer to interview with the Resident Care Coordinator dated 07/19/2017 at 1:10pm.

B. Review of a Resident Appointment Form dated 07/06/2017 revealed a physician's order to initiate Minocycline 100mg twice daily for one month.

Review of a prescription dated 07/06/2017 for Resident #7 revealed:
-Instructions for Minocycline 100mg capsule take one capsule two times a day for folliculitis.
-There was a quantity of 60 capsules prescribed.
-There were no refills prescribed.

Interview with the Medication Aide (MA) on 07/19/2017 at 8:01am revealed:
-The administration of Minocycline 100mg capsule to Resident #7 was completed on Sunday [07/16/2017].
-The MA did not know why the instructions to administer Minocycline to Resident #7 was still on the eMAR.

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Observation of the MA on 07/19/2017 at 8:02am revealed the MA administered 12 medications in tablet form to Resident #7 which did not include Minocycline 100mgs.

Review of Resident #7's electronic Medication Administration Records (eMARs) for 07/2017 revealed:
-There was a printed entry for Minocycline HCL 100mg capsule twice a day for folliculitis.
-The Minocycline HCL 100mg capsule was scheduled for administration at 8:00am and 8:00pm daily.
-There was documentation of administration for the Minocycline 100mg capsule at 8:00am and 8:00pm daily from 7/12/2017 through 07/15/2017, and for 8:00pm on 07/16/2017.
-There were circled staff initials for 8:00am on 07/16/2017 and from 8:00am on 07/17/2017 through 8:00pm on 07/18/2017.

Interview with the MA on 07/19/2017 at 11:50am revealed:
-She had not administered Minocycline 100mg capsule to Resident #7 on the morning of 07/19/2017.
-There was no Minocycline in the medication cart to administer to Resident #7.

Telephone interview with the pharmacy provider representative on 07/19/2017 at 12:30pm revealed:
-The pharmacy received an order from the facility by fax on 07/10/2017 that was dated 07/06/2017 for Minocycline 100mg capsule two times a day, quantity of 60, for a 30 day supply, no refills.
-The pharmacy dispensed a quantity of 8 capsules of Minocycline 100mg to the facility on 07/11/2017.

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-The remaining 52 capsules of Minocycline 100mg was put on back order and was being sent to the facility on today (07/19/2017).
-The back order of Minocycline should have been sent to the facility prior to 07/15/2017 based on the instructions for Resident #7 to be administered one capsule two times a day.
-The pharmacy had not received any telephone calls from the facility notifying the pharmacy of the need for additional Minocycline 100mg capsules for Resident #7.
-The pharmacy would have expected the facility to contact the pharmacy if the facility was running low on the medication, but the pharmacy should have sent the back order sooner.

Telephone interview with the Pharmacist at the provider pharmacy on 07/19/2017 at 12:50pm revealed:
-If the resident was prescribed the Minocycline for a rash, the rash could worsen or there may be no effect to the resident because of the medication being stopped.
-If the Primary Care Provider (PCP) was going to be in the facility, the PCP could evaluate the resident.

Observation of Resident #7 on 07/19/2017 at 1:30pm revealed there were reddish colored raised areas scattered over the upper and lower right arm.

Interview with Resident #7 on 07/19/2017 at 1:35pm revealed:
-The resident denied dizziness.
-The resident complained of feeling tired.
-The resident complained having sinus problems.

Interview with the PCP on 07/19/2017 at 5:40pm revealed:

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D 358	Continued From page 21 -The PCP did not think there would be any problem with regards to the administration of the Minocycline to Resident #7 being stopped. -After effects of the antibiotic remained in the resident's body for 48 - 72 hours. -After several days of having the Minocycline administered, the resident should not have a flare up. Refer to interview with the Medication Aide dated 07/19/2017 at 11:30am. Refer to interview with the Resident Care Coordinator dated 07/19/2017 at 1:10pm. C. Review of a Resident Appointment Form for Resident #7 dated 04/18/2017 revealed a physician's order Magnesium Oxide (vitamin supplement) 400mg daily. Review of subsequent physician's order for the Magnesium Oxide revealed: -On 04/23/2017 there was a physician's order for Magnesium Oxide 400mg tablet take two tablets daily. -On 07/06/2017 there was a copy of physician orders with the physician signature which included an order for Magnesium Oxide 400mg tablet take 2 tabs (800mg) every day. Observation of the MA on 07/19/2017 at 8:02am revealed the MA administered 12 medications in tablet form to Resident #7 which included Magnesium Oxide 400mg one tablet. Review of Resident #7's electronic Medication Administration Records (eMARs) for 07/2017 revealed: -There was a printed entry for Magnesium Oxide	D 358		

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400mg tablet take 2 tablsts (800mg) every day.
-The Magnesium Oxide was scheduled for administration at 8:00am daily.

Interview with the MA on 07/19/2017 at 11:50am revealed:
-She administered Magnesium Oxide 400mg one tablet to Resident #7 on the morning of 07/19/2017.
-The eMAR instructions were for Magnesium Oxide 400mg two tablets to equal 800mg to be administered.
-She was not aware of the 04/23/2017 order increasing the Magnesium Oxide from 400mg to 800mg daily.
-She usually worked on the front hall medication cart.
-She "should check the medication three times".
-She knew she was supposed to check the medication when she removed the medication from the medication cart, when she "popped" the medication in preparation for administering, and when she put the medication away.
-She was "running late this morning" and "sometimes you let your nerves get the best of you".

Telephone interview with the pharmacy provider representative on 07/19/2017 at 12:30pm revealed:
-The current order for Magnesium Oxide was for 400mg take 2 tablets daily.
-Magnesium Oxide 400mg take 2 tablets daily was dispensed to the facility on 07/13/2017.

Telephone interview with the Pharmacist at the provider pharmacy on 07/19/2017 at 12:50pm revealed:
-There probably would not be any effect to the resident if the Magnesium Oxide 800mg was

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missed one time.
-If the Magnesium Oxide was being administered in the wrong dose consistently, the resident's lab value would want to be repeated.

Interview with Resident #7 on 07/19/2017 at 1:35pm revealed:
-The resident denied dizziness.
-The resident complained of feeling tired.
-The resident complained having sinus problems.

Interview with the PCP on 07/19/2017 at 5:40pm revealed:
-The PCP did not think there would be any problem with regards to the administration of the Magnesium Oxide 400mg being administered to Resident #7 instead of Magnesium Oxide 800mg.
-The PCP would have Resident #7's Magnesium level lab checked.

Refer to interview with the Medication Aide dated 07/19/2017 at 11:30am.

Refer to interview with the Resident Care Coordinator dated 07/19/2017 at 1:10pm.

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Interview with the Medication Aide on 07/19/2017 at 11:30am revealed:
-Medication Aides were responsible for removing discontinued medications from the medication cart.
-Medication Aides should place a label on medication containers if there are direction changes for administering the medication.
-Medication Aides were supposed to perform audits of the medication carts daily which consisted of printing the physician's orders and eMARs, and comparing them to the medications on hand.

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D 358	Continued From page 24 -If there was not enough medication on hand for a resident, the medication aides were supposed to order the medication or contact the pharmacy to find out the status of the medication. -The Resident Care Manager checked the audits forms performed by the medication aides. -The pharmacy delivered medications to the facility on the same day ordered or the next day. Interview with the Resident Care Coordinator on 07/19/2017 at 1:10pm revealed: -A new medication cart audit had recently been implemented at the facility to ensure all resident medications were in the facility and to make sure physician orders matched the eMAR instructions. -It looked like the medication cart audits had not been done correctly by the medication aides. -All medication aides were supposed to audit medications for a certain number of residents each day. -She recently started reviewing the medication aide audits daily. -She used to review the medication audits weekly.	D 358		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure the residents received care and services that were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to staff failing to	D914		

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D914	Continued From page 25 initiate CPR to a resident. The findings are: Based on record reviews, and interviews, the facility failed to assure staff responded immediately for 1 of 1 sampled residents (#6) who required cardiopulmonary resuscitation (CPR) according to facility's policies and CPR training after the resident became unresponsive and her pulse and respirations were absent when assessed by staff. [Refer to Tag 0271, 10A NCAC 13F. 0901(c) Personal Care and Supervision (Type A1 Violation)].	D914		