Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal041062	A. BUILDING: _____ B. WING _____	03/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LAWNDALE PARK	4400 LAWNDALE DRIVE GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and Guilford County Department of Social Services conducted an annual survey on March 21-23, 2018 with an exit via telephone on March 26, 2018.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (Resident #3) regarding blood pressure (BP) results and failed to schedule appointments to have International Normalized Ratio (INR) levels drawn. The findings are: Review of Resident #3's current FL2 dated 02/20/18 revealed: -Diagnoses included congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, hypertension, hyperlipidemia, obesity, and gout. -There was an order for Coumadin 6 mg daily. Review of Resident #3's Resident Register revealed an admission date of 10/09/15.	D 273	Community obtained written documentation from the physician for resident 3 stating that resident had not missed a INR draw. Health and Wellness Director or designee shall follow up with primary care physicians to confirm dates of any scheduled INR draws, Health and Wellness Director or designee shall retrain all Medication Aides on process of notifying Primary Care Physicians about vital signs per physician's orders, and audit weekly for compliance.	3/23/18 & ongoing 4/12/18

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

DDuke, Executive Director, 5/10/18

STATE FORM 6899 WN9511 If continuation sheet 1 of 35

Received + accepted. AJS 5/17/18

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D 273	Continued From page 1 1. Review of Resident #3's physicians orders revealed: -An INR level was drawn at the providers office on 01/03/18 (INR result 2.8) and an order to recheck INR level in 2 weeks (INR due 01/17/18) (normal reference range for INR is between 2.0 to 3.0). -An INR level was drawn at the providers office on 02/19/18 (INR result 1.8) with an order to recheck INR level in one week on 02/28/18. -An INR level was drawn on 02/28/18 at the provider office (INR result 2.2) and an order to schedule an appointment to recheck the INR level in two weeks (INR due 03/14/18). Staff scheduled the appointment for INR on 03/22/18 and not for 3/14/18 (INR result 2.6). Review of Resident #3's resident notes revealed: -There was no documentation that the appointments for INR levels on 01/17/18 and 03/14/18 had been scheduled or rescheduled. -There was a note documenting the resident was adamant he did not have an INR lab draw on 01/17/18 and the resident was to be seen in February 2018 instead. -There was no documentation the facility staff called to clarify the INR lab draw due on 01/17/18 with the provider's office. Telephone interview with Resident #3's Primary Care Provider's nurse on 03/23/18 at 11:15 am revealed: -The facility never called to schedule an appointment for 01/17/18 or 03/14/18 to have INR labs drawn for the resident. -The resident was not known for calling and rescheduling appointments. -The facility provided transportation to and from appointments. -The facility would call and schedule	D 273		

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D 273	Continued From page 2 appointments with the office. Interview with Resident #3 on 03/23/18 at 3:50 pm revealed: -As far as he knew his INRs were drawn on time. -The facility provided transportation to his doctor appointments. -The facility sometimes had trouble knowing when his INR levels were to be drawn. -The resident was unsure if the paperwork was misplaced or what the cause for confusion was. Interview with the Associate Executive Director (ED) on 03/23/18 at 4:25 pm revealed she did not know the resident missed two INR lab draws. 2. Review of Resident #3's physician's orders revealed: -The original order to check BP daily and send BP readings to the physician assistant (PA) was dated 06/25/16. -There were physician's orders dated 09/13/17 and 02/01/18 to check BP daily and send readings every 3 weeks to the PA. Review of Resident #3's electronic Medication Administration Records (eMARs) for January 2018, February 2018, and March 2018 revealed: -There was an entry to check BP daily and send readings every 3 weeks to the PA. -There was documentation the residents BP had been checked 82 times from January 1, 2018 through March 21, 2018. -The resident's systolic BP ranged from 103-160 and the diastolic BP ranged from 51-91 between 01/01/18 to 01/31/18. -The resident's systolic BP ranged from 142-165 and the diastolic BP ranged from 80-95 between 02/01/18 to 02/28/18. -The resident's systolic BP ranged from 139-162	D 273		

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D 273	Continued From page 3 and the diastolic BP ranged from 60-90 between 03/01/18 to 03/21/18. Review of Resident #3's resident notes revealed there was no documentation the provider had been notified of any BP results. Interview with the Executive Director (ED) on 03/22/18 at 5:30 pm revealed: -She did not know about the order to check the residents BP daily and send readings to the PA. -She did not know the staff were not sending the resident's BP readings to the PA every 3 weeks as ordered. -It was the MAs responsibility to check the residents BP and send BP readings to the PA. -She expected staff to notify providers as ordered. -When a new order was given to the facility, it was faxed to the pharmacy, but the facility staff entered the order into the system. Telephone interview with the nurse at Resident #3's Primary Care Provider's office on 03/23/18 at 11:15 am revealed: -There were no BP readings brought in or faxed to the provider's office by the facility. -The nurse did not know if the provider meant to leave the BP order off the FL2 dated 02/20/18 but it was an active order prior to the FL2 dated 02/20/18. Telephone interview with the facility's contracted pharmacy representative on 03/23/18 at 11:45 am revealed: -The pharmacy did not print off or manage eMARs for the facility. -The pharmacy did not enter or change orders for the facility. -The pharmacy filled medication orders and	D 273		

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D 273	Continued From page 4 would send the medication to the facility. -The facility had faxed over the FL2 dated 02/20/18. -The pharmacy had looked over the FL2 dated 02/20/18 and orders were never changed in their system. -They would add BP check daily to eMAR immediately. Interview with a first shift medication aide (MA) on 03/23/18 at 3:30 pm revealed: -She checked Resident #3's BP daily, but had not been sending readings to the PA every 3 weeks. -She had sent the BP readings in the past but could not recall the last time the BP readings were sent to the provider. -She followed what was listed on the eMAR. -She accepted responsibility that she had overlooked the instructions on the eMAR to send BP readings to the PA every 3 weeks. Interview with a second shift MA on 03/23/18 at 3:45 pm revealed: -She did not know about the order to check Resident #3's BP daily and send BP readings to the PA every 3 weeks. -She was not responsible for obtaining the resident's BP. -The resident's BP was obtained by the first shift MA. Interview with Resident #3 on 03/23/18 3:50 pm revealed: -The facility staff checked his BP every day. -He did not know if the staff were sending BP readings to the PA. Interview with the Associate Executive Director (ED) on 03/23/18 at 4:25 pm revealed: -She started working at the facility on 03/12/18.	D 273		

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D 273	Continued From page 5 -The contracted pharmacy did not enter orders into the facility's eMAR system. -She did not know if the facility printed off the eMARs or if the contracted pharmacy printed the eMARs. -To her knowledge the contracted pharmacy was able to look at the orders in the eMAR system. -The facility nurse and the clinical support staff completed random eMAR audits. -The new eMARs were compared to the old eMARs each month; this was the responsibility of the nurse and the clinical support staff. -She did not know about the order to check the residents BP daily and send readings to the PA. -She did not know staff were not sending the resident's BP readings to the PA every 3 weeks as ordered. The facility failed to notify the primary care provider of a resident's blood pressure results; schedule appointments to have INR levels drawn; and transport the resident to scheduled appointments to have INR levels obtained. This failure was detrimental was to the health and safety of the resident and constitutes a Type B Violation. A Plan of Protection was provided by the facility on 03/23/18 as follows: -The facility will immediately update physicians orders on the eMAR. -The facility will schedule mandatory retraining for all MAs on completion and verification of the new order tracking form, as well as, FL2 compliance. -The Health and Wellness Director (HWD), Resident Care Coordinator (RCC), and/or Resident Care Aide will audit the new order tracking form as orders are received for accuracy and verification. -The HWD, RCC, or lead Resident Care Aide will	D 273	-Physicians orders updated on eMAR Mandatory retraining for all MA on medication administration, completion and verification of new order tracking, and FL2 compliance. HWD or designee will audit new order tracking form as orders are received for accuracy and verification.	3/23/18 4/12/18 3/23/2018 & ongoing

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D 273	Continued From page 6 conduct monthly eMAR audits. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, MAY 12, 2018 .	D 273	-Monthly eMAR audits will be conducted by HWD, RCC, or designee. **Referring to tag D273, D344, D358	4/27/2018 & ongoing
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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure contact with the physician for clarification of medication orders for 1 of 5 sampled residents (Resident #3) with orders for an analgesic and an anti-inflammatory. The findings are: 1. Review of Resident #3's current FL2 dated 02/20/18 revealed diagnoses included congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, hypertension,	D 344		

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D 344	Continued From page 7 hyperlipidemia, obesity, and gout. Review of Resident #3's Resident Register revealed an admission date of 10/09/15. a. Review of Resident #3's current FL2 dated 02/20/18 revealed there was no order for acetaminophen (used to treat minor pain) 325 mg twice daily. Review of Resident #3's signed physician's orders dated 02/01/18 revealed there was an order for acetaminophen 325 mg twice daily. Review of Resident #3's February 2018 elecronic Medication Administration Record (eMAR) revealed: -There was an entry for acetaminophen 325 mg twice daily at 8:00 am and 8:00 pm. -There was documentation of administration at 8:00 am and 8:00 pm from 02/01/18 to 02/28/18. -The eMAR did not reflect the order change on the FL2 dated 02/20/18 to discontinue the acetaminophen 325 mg twice daily. Review of Resident #3's March 2018 eMAR revealed: -There was an entry for acetaminophen 325 mg twice daily at 8:00 am and 8:00 pm. -There was documentation of administration at 8:00 am and 8:00 pm from 03/01/18 to 03/21/18. -The eMAR did not reflect the order change on the FL2 dated 02/20/18 to discontinue the acetaminophen 325 mg twice daily. b. Review of Resident #3's current FL2 dated 02/20/18 revealed there was an order for colchicine 0.6 mg (used to treat gout) twice a day as needed for gout.	D 344		

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D 344	Continued From page 8 Review of Resident #3's signed physician's orders dated 02/01/18 revealed there was an order for colchicine 0.6 mg every 12 hours as needed for gout attacks. Review of Resident #3's February 2018 electronic Medication Administration Record (eMAR) revealed there was an entry for colchicine 0.6 mg every 12 hours as needed for gout attacks. Review of Resident #3's March 2018 eMAR revealed there was an entry for colchicine 0.6 mg every 12 hours as needed for gout attacks. Review of Resident #3's record revealed no documentation the physician was notified for clarification of medication orders. Review of medications on hand for Resident #3 on 03/23/18 at 3:00 pm revealed: -Acetaminophen 325 mg tablet was available for administration. -Instructions were 325 mg tablet twice daily. -Colchicine 0.6 mg tablets was available for administration but the staff were using the colchicine 0.6 mg give one tablet twice daily as needed for gout flareups. Interview with the Health and Wellness Nurse (HWN) on 03/22/18 at 4:05 pm revealed: -The HWN and the clinical support staff completed random eMAR audits. -The new eMARs were compared to the old eMARs each month; this was the responsibility of the HWN and the clinical support person. -She was not aware the acetaminophen and colchicine were continuing to be administered although they were not on the FL2 dated 02/20/18.	D 344		

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D 344	Continued From page 9 Interview with the Executive Director (ED) on 03/22/18 at 5:30 pm revealed: -The HWN and the clinical support completed random eMAR audits. -The new eMARs were compared to the old eMARs each month; this was the responsibility of the HWN and the clinical support person. -There was nothing in place to keep track of the audit process. -She was not aware the acetaminophen and colchicine were continuing to be administered although they were not on the FL2 dated 02/20/18. Interview with Resident #3's Primary Care Provider on 03/23/18 at 11:15 am revealed: -The provider did not want to continue the acetaminophen 325 mg twice daily. -The provider did not want to continue the colchicine 0.6 mg every 48 hours. The provider was unaware the resident was continuing to receive the acetaminophen 325 mg twice daily and colchicine 0.6 mg every 48 hours. -All orders on the FL2 were current and correct. Telephone interview with facility's contracted pharmacy representative on 03/23/18 at 11:45 am revealed: -The pharmacy did not print off or manage eMARs for the facility. -The pharmacy did not enter or change orders for the facility. -The pharmacy filled medication orders and would send the medication to the facility. -The facility had faxed over the FL2 dated 02/20/18. -The contracted pharmacy had looked over the FL2 dated 02/20/18 and orders were never changed. -They would make changes to the medication	D 344		

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D 344	Continued From page 10 orders immediately. Interview with Resident #3 on 03/23/18 at 3:50 pm revealed: -The staff administered all his medications. -The resident was unable to recall the medications he was ordered. Interview with the Associate Executive Director on 03/23/18 at 4:25 pm revealed: -She started working at the facility 03/12/18. -The contracted pharmacy does not enter orders into the facility's system. -She was unsure if the facility printed off the eMARs or if the contracted pharmacy printed the eMARs. -To her knowledge the contracted pharmacy was able to look at the orders in the system. -The HWN and the clinical support completed random eMAR audits. -The new eMARs were compared to the old eMARs each month; this was the responsibility of the HWN and the clinical support person. -She was not aware the acetaminophen and colchicine were continuing to be administered although they were not on the FL2 dated 02/20/18.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies	D 358		

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D 358	Continued From page 11 and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 5 sampled residents (Resident #3) with orders for insulin, a diuretic, a beta blocker, a vasodilator, an analgesic, and an anti-inflammatory. The findings are: 1. Review of Resident #3's current FL2 dated 02/20/18 revealed diagnoses included congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, hypertension, hyperlipidemia, obesity, and gout. a. Review of Resident #3's current FL2 dated 02/20/18 revealed there was an order for lantus insulin 100 units/ml (a slow-acting insulin used to lower elevated blood sugar levels) 40 units once daily. Review of Resident #3's subsequent physician's orders dated 12/14/17 revealed: -There was an order for lantus insulin 100 units/ml, inject 30 units subcutaneously one time a day. Review of Resident #3's signed physician's orders dated 02/01/18 revealed: -There was an order for lantus insulin 100 units/ml, inject 30 units subcutaneously one time a day.	D 358		

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D 358	Continued From page 12 Review of Resident #3's February 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for lantus insulin 100 units/ml, 30 units once daily at 8:00 pm. -There was documentation of administration daily at 8:00 pm from 02/01/18 to 02/28/18. -The eMARS did not reflect the order change on 02/20/18 for lantus insulin 100 units/ml, inject 40 units subcutaneously once daily on the FL2. -The resident's blood sugars ranged from 70-267. Review of Resident #3's March 2018 eMAR revealed: -There was an entry for lantus insulin 100 units/ml, 30 units once daily at 8:00 pm. -There was documentation of administration daily at 8:00 pm from 03/01/18 to 03/21/18. -The eMARS did not reflect the order change on 02/20/18 for lantus insulin 100 units/ml, inject 40 units subcutaneously once daily on the FL2. -The resident's blood sugars ranged from 84-250. Observations of medications on hand for Resident #3 on 03/23/18 at 3:00 pm revealed: -Lantus insulin 100 units/ml was available for administration. -Instructions were to inject 30 units subcutaneously once daily. Refer to interview with the Health and Wellness nurse (HWN) on 03/22/18 at 4:05 pm. Refer to interview with the Executive Director (ED) on 03/22/18 at 5:30 pm. Refer to interview with Resident #3's Primary Care Provider on 03/23/18 at 11:15 am.	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 Refer to telephone interview with the facility's contracted pharmacy representative on 03/23/18 at 11:45 am. Refer to interview with Resident #3 on 03/23/18 at 3:50 pm. Refer to interview with the Associate Executive Director on 03/23/18 at 4:25 pm. b. Review of Resident #3's current FL2 dated 02/20/18 revealed there was an order for torsemide 20 mg (used to treat fluid retention) 4 tablets every morning and 2 tablets in the evening. Review of Resident #3's signed physician's orders dated 02/01/18 revealed an order for torsemide 20 mg, 4 tablets twice daily. Review of Resident #3's February 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for torsemide 20 mg, 4 tablets twice daily at 8:00 am and 8:00 pm. -There was documentation of administration at 8:00 am and 8:00 pm from 02/01/18 to 02/28/18. -The eMARS did not reflect the order change on 02/20/18 for torsemide 20 mg tablets, 4 tablets every morning and 2 tablets every evening. Review of Resident #3's March 2018 MAR revealed: -There was an entry for torsemide 20 mg, 4 tablets twice daily at 8:00 am and 8:00 pm. -There was documentation of administration at 8:00 am and 8:00 pm from 03/01/18 to 03/21/18. -The eMARS did not reflect the order change on 02/20/18 for torsemide 20 mg tablets, 4 tablets every morning and 2 tablets every evening.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ha1041062	A. BUILDING: _____ B. WING _____	03/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LAWNDALE PARK	4400 LAWNDALE DRIVE GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 14 Observations of medications on hand for Resident #3 on 03/23/18 at 3:00 pm revealed: -Torsemide 20 mg tablets was available for administration. -Instructions were for torsemide 20 mg, 4 tablets twice daily. Refer to interview with the Health and Wellness nurse (HWN) on 03/22/18 at 4:05 pm. Refer to interview with the Executive Director (ED) on 03/22/18 at 5:30 pm. Refer to interview with Resident #3's Primary Care Provider on 03/23/18 at 11:15 am. Refer to telephone interview with the facility's contracted pharmacy representative on 03/23/18 at 11:45 am. Refer to interview with Resident #3 on 03/23/18 at 3:50 pm. Refer to interview with the Associate Executive Director on 03/23/18 at 4:25 pm. c. Review of Resident #3's current FL2 dated 02/20/18 revealed there was an order for carvedilol 12.5 mg (used to treat high blood pressure) twice daily. Review of Resident #3's signed physician's orders dated 02/01/18 revealed: -There was an order for carvedilol 25 mg twice daily. Review of Resident #3's subsequent physician's orders revealed an order dated 02/13/18 for carvedilol 25 mg twice daily with a meal.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BROOKDALE LAWNDALE PARK	4400 LAWNDALE DRIVE GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 15 Review of Resident #3's February 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for carvedilol 25 mg twice daily at 8:00 am and 5:00 pm. -There was documentation of administration at 8:00 am and 5:00 pm from 02/01/18 to 02/28/18. -The eMAR did not reflect the order change on the FL2 dated 02/20/18 for Carvedilol 12.5 mg twice daily. Review of Resident #3's March 2018 eMAR revealed: -There was an entry for carvedilol 25 mg twice daily at 8:00 am and 5:00 pm. -There was documentation of administration at 8:00 am and 5:00 pm from 03/01/18 to 03/21/18. -The eMAR did not reflect the order change on the FL2 dated 02/20/18 for Carvedilol 12.5 mg twice daily. Observations of medications on hand for Resident #3 on 03/23/18 at 3:00 pm revealed: -Carvedilol 12.5 mg tablets was available for administration. -Instructions were for carvedilol 25 mg twice daily. Refer to interview with the Health and Wellness nurse (HWN) on 03/22/18 at 4:05 pm. Refer to interview with the Executive Director (ED) on 03/22/18 at 5:30 pm. Refer to interview with Resident #3's Primary Care Provider on 03/23/18 at 11:15 am. Refer to telephone interview with the facility's contracted pharmacy representative on 03/23/18 at 11:45 am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 16 Refer to interview with Resident #3 on 03/23/18 at 3:50 pm. Refer to interview with the Associate Executive Director on 03/23/18 at 4:25 pm. d. Review of Resident #3's current FL2 dated 02/20/18 revealed there was an order for Novolog Insulin 100 units/ml (a fast-acting insulin used to lower elevated blood sugar levels) 10 units three times a day as needed for blood sugar greater than 150. Review of Resident #3's subsequent physician's orders dated 12/14/17 revealed: -There was an order for Novolog flexpen 100 units/ml, inject 6 units subcutaneously before meals, give if blood sugar greater than 150. Review of Resident #3's signed physician's orders dated 02/01/18 revealed: -There was an order for Novolog insulin 100 units/ml, inject 6 units subcutaneously before meals, give if blood sugar greater than 150. Review of Resident #3's February 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Novolog flexpen 100 units/ml, inject 6 units subcutaneously before meals, give if blood sugar greater than 150. -The resident's blood sugars ranged from 70-267. -Staff documented administration of Novolog for blood sugar 28 of 84 opportunities. -The eMARS did not reflect the order change on 02/20/18 for Novolog insulin 100 units/ml, inject 10 units subcutaneously before meals, give if blood sugar greater than 150.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal041062	A. BUILDING: _____ B. WING _____	03/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 17 Review of Resident #3's March 2018 eMAR revealed: -There was an entry for Novolog flexpen 100 units/ml, inject 6 units subcutaneously before meals, give if blood sugar greater than 150. -The resident's blood sugars ranged from 84-250. -Staff documented administration of Novolog for blood sugar 23 of 62 opportunities. -The eMARS did not reflect the order change on 02/20/18 for Novolog insulin 100 units/ml, inject 10 units subcutaneously before meals, give if blood sugar greater than 150. Observations of medications on hand for Resident #3 on 03/23/18 at 3:00 pm revealed: -Novolog insulin 100 units/ml was available for administration. -Instructions were to inject 6 units subcutaneously before meals, give if blood sugar greater than 150. Refer to interview with the Health and Wellness nurse (HWN) on 03/22/18 at 4:05 pm. Refer to interview with the Executive Director (ED) on 03/22/18 at 5:30 pm. Refer to interview with Resident #3's Primary Care Provider on 03/23/18 at 11:15 am. Refer to telephone interview with the facility's contracted pharmacy representative on 03/23/18 at 11:45 am. Refer to interview with Resident #3 on 03/23/18 at 3:50 pm. Refer to interview with the Associate Executive Director on 03/23/18 at 4:25 pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 18 e. Review of Resident #3's current FL2 dated 02/20/18 revealed there was an order for hydralazine hcl 25 mg (used to treat high blood pressure and heart failure) 3 tablets three times a day. Review of Resident #3's signed physician's orders dated 02/01/18 revealed there was an order for hydralazine hcl 100 mg three times a day. Review of Resident #3's February 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for hydralazine hcl 100 mg tablet three times daily at 8:00 am, 2:00 pm, and 8:00 pm. -There was documentation of administration at 8:00 am, 2:00 pm, and 8:00 pm from 02/01/18 to 02/28/18. -The eMAR did not reflect the order change on the FL2 dated 02/20/18 for hydralazine 25 mg tablets give 3 tablets three times a day. Review of Resident #3's March 2018 eMAR revealed: -There was an entry for hydralazine hcl 100 mg tablet three times a day. -There was documentation of administration at 8:00 am, 2:00 pm, and 8:00 pm from 3/01/18 to 03/12/18. -The eMAR did not reflect the order change on the FL2 dated 02/20/18 for hydralazine 25 mg tablets give 3 tablets three times a day until 03/12/18. Observations of medications on hand for Resident #3 on 03/23/18 at 3:00 pm revealed: -Hydralazine hcl 25 mg tablets was available for administration.	D 358		

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D 358	Continued From page 19 -Instructions were 25 mg tablet give 3 tablets three times a day. Refer to interview with the Health and Wellness nurse (HWN) on 03/22/18 at 4:05 pm. Refer to interview with the Executive Director (ED) on 03/22/18 at 5:30 pm. Refer to interview with Resident #3's Primary Care Provider on 03/23/18 at 11:15 am. Refer to telephone interview with the facility's contracted pharmacy representative on 03/23/18 at 11:45 am. Refer to interview with Resident #3 on 03/23/18 at 3:50 pm. Refer to interview with the Associate Executive Director on 03/23/18 at 4:25 pm. f. Review of Resident #3's current FL2 dated 02/20/18 revealed there was no order for acetaminophen (used to treat minor pain) 325 mg twice daily. Review of Resident #3's signed physician's orders dated 02/01/18 revealed there was an order for acetaminophen 325 mg twice daily. Review of Resident #3's February 2018 eMAR revealed: -There was an entry for acetaminophen 325 mg twice daily at 8:00 am and 8:00 pm. -There was documentation of administration at 8:00 am and 8:00 pm from 02/01/18 to 02/28/18. -The eMAR did not reflect the order change on the FL2 dated 02/20/18 to discontinue the acetaminophen 325 mg twice daily.	D 358		

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D 358	Continued From page 20 Review of Resident #3's March 2018 eMAR revealed: -There was an entry for acetaminophen 325 mg twice daily at 8:00 am and 8:00 pm. -There was documentation of administration at 8:00 am and 8:00 pm from 03/01/18 to 03/21/18. -The eMAR did not reflect the order change on the FL2 dated 02/20/18 to discontinue the acetaminophen 325 mg twice daily. Observations of medications on hand for Resident #3 on 03/23/18 at 3:00 pm revealed: -Acetaminophen 325 mg tablet was available for administration. -Instructions were 325 mg tablet twice daily. Refer to interview with the Health and Wellness nurse (HWN) on 03/22/18 at 4:05 pm. Refer to interview with the Executive Director (ED) on 03/22/18 at 5:30 pm. Refer to interview with Resident #3's Primary Care Provider on 03/23/18 at 11:15 am. Refer to telephone interview with the facility's contracted pharmacy representative on 03/23/18 at 11:45 am. Refer to interview with Resident #3 on 03/23/18 at 3:50 pm. Refer to interview with the Associate Executive Director on 03/23/18 at 4:25 pm. g. Review of Resident #3's current FL2 dated 02/20/18 revealed there was no order for colchicine 0.6 mg (used to treat gout) every 48 hours.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 21 Review of Resident #3's signed physician's orders dated 02/01/18 revealed there was an order for colchicine 0.6 mg every 48 hours. Review of Resident #3's February 2018 eMAR revealed: -There was an entry for colchicine 0.6 mg every 48 hours. -There was documentation of administration every 48 hours from 02/01/18 to 02/28/18. -The eMAR did not reflect the order change on the FL2 dated 02/20/18 to discontinue the colchicine 0.6 mg every 48 hours. Review of Resident #3's March 2018 eMAR revealed: -There was an entry for colchicine 0.6 mg every 48 hours. -There was documentation of administration every 48 hours from 03/01/18 to 03/21/18. -The eMAR did not reflect the order change on the FL2 dated 02/20/18 to discontinue the colchicine 0.6 mg every 48 hours. Review of Resident #3's Resident Register revealed an admission date of 10/09/15. Observations of medications on hand for Resident #3 on 03/23/18 at 3:00 pm revealed: -Colchicine 0.6 mg tablets was available for administration. -Instructions were 0.6 mg give one tablet twice daily as needed for gout flareups. Refer to interview with the Health and Wellness nurse (HWN) on 03/22/18 at 4:05 pm. Refer to interview with the Executive Director (ED) on 03/22/18 at 5:30 pm.	D 358		

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D 358	Continued From page 22 Refer to interview with Resident #3's Primary Care Provider on 03/23/18 at 11:15 am. Refer to telephone interview with the facility's contracted pharmacy representative on 03/23/18 at 11:45 am. Refer to interview with Resident #3 on 03/23/18 at 3:50 pm. Refer to interview with the Associate Executive Director on 03/23/18 at 4:25 pm. 2. The medication pass error rate was 10% as evidenced by the observation of 3 errors out of 30 opportunities during the 8:00 am- 9:00 am medication pass on 3/22/18. Review of Resident #3's current FL2 dated 02/20/18 revealed diagnoses included congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, hypertension, hyperlipidemia, obesity, and gout. a. Observation of the medication pass on 3/22/18 at 7:50 am revealed: -Carvedilol 25mg was administered to Resident #3 at 7:50 am by a medication aide (MA). -The resident was in the hallway at the medication cart. -The prescription label on the medication package read, "carvedilol 25 mg tablets take one tablet twice daily." Review of Resident #3's signed physician's orders dated 02/01/18 revealed that there was an order for carvedilol 25 mg twice daily. Review of Resident #3's subsequent physician's	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 23 orders dated 02/13/18 revealed an order for carvedilol 25 mg twice daily with a meal. Review of Resident #3's current FL2 dated 02/20/18 revealed there was an order for carvedilol 12.5 mg (used to treat high blood pressure) twice daily. Review of Resident #3's March 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for carvedilol 25 mg twice daily, at 8:00 am and 5:00 pm. -The eMARs did not reflect the order change on 02/20/18 for Carvedilol 12.5 mg twice daily. -Carvedilol 25 mg tablet was documented as administered at 8:00 am on 3/22/18. Interview on 3/22/18 at 8:00 am with a MA revealed: -She had worked in the facility for 19 years. -She read the eMAR for each resident before she removed the medications from the cart. -She read the labels for each medication as she placed the medication in the medicine cup for administration to the resident. -She made sure she administered the medications as written on the eMAR. Refer to interview with the Health and Wellness nurse (HWN) on 03/22/18 at 4:05 pm. Refer to interview with the Executive Director (ED) on 03/22/18 at 5:30 pm. Refer to interview with Resident #3's Primary Care Provider on 03/23/18 at 11:15 am. Refer to telephone interview with the facility's contracted pharmacy representative on 03/23/18	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 24 at 11:45 am. Refer to interview with Resident #3 on 03/23/18 at 3:50 pm. Refer to interview with the Associate Executive Director on 03/23/18 at 4:25 pm. b. Observation of the medication pass on 3/22/18 at 7:50 am revealed: -Acetaminophen 325 mg one tablet was administered to Resident #3 at 7:50 am by a medication aide (MA). -The resident was in the hallway at the medication cart. -The prescription label on the medication package read, "MAPAP 325 mg tablets take one tablet twice daily." Review of Resident #3's signed physician's orders dated 02/01/18 revealed there was an order for acetaminophen 325 mg twice daily. Review of Resident #3's current FL2 dated 02/20/18 revealed there was an order for acetaminophen 500 mg (used to treat pain) every six hours as needed for headache. Acetaminophen 325 mg scheduled twice daily was not on the FL2. Review of Resident #3's March 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for acetaminophen 325 mg twice daily at 8:00 am and 8:00 pm. -The eMARs did not reflect the order change on 02/20/18 for acetaminophen 500 mg one capsule every six hours as needed for headache. -Acetaminophen 325 mg tablet was documented as administered at 8:00 am on 3/22/18.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 25 Interview on 3/22/18 at 8:00 am with a MA revealed: -She had worked in the facility for 19 years. -She read the eMAR for each resident before she removed the medications from the cart. -She read the labels for each medication as she placed the medication in the medicine cup for administration to the resident. -She made sure she administered the medications as written on the eMAR. Refer to interview with the Health and Wellness nurse (HWN) on 03/22/18 at 4:05 pm. Refer to interview with the Executive Director (ED) on 03/22/18 at 5:30 pm. Refer to interview with Resident #3's Primary Care Provider on 03/23/18 at 11:15 am. Refer to telephone interview with the facility's contracted pharmacy representative on 03/23/18 at 11:45 am. Refer to interview with Resident #3 on 03/23/18 at 3:50 pm. Refer to interview with the Associate Executive Director on 03/23/18 at 4:25 pm. c. Observation of the medication pass on 3/22/18 at 7:50 am revealed: -Colchicine 0.6 mg one tablet was administered to Resident #3 at 7:50 a.m by a medication aide (MA). -The resident was in the hallway at the medication cart. -The prescription label on the medication package read, "colchicine 0.6 mg tablet take one	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 26 tablet twice a day as needed for gout." Review of Resident #3's signed physician's orders dated 02/01/18 revealed there was an order for colchicine 0.6 mg every 48 hours. Review of Resident #3's current FL2 dated 02/20/18 revealed there was an order for colchicine 0.6 mg (used to treat gout) twice a day as needed for gout. Colchicine 0.6 mg every 48 hours was not on the FL2. Review of Resident #3's March 2018 eMAR revealed: -There was an entry for colchicine 0.6 mg every 48 hours. There was no listed time for administration. -The eMARs did not reflect the order change on 02/20/18 for colchicine 0.6 mg every 48 hours to be discontinued. -Colchicine 0/6 mg tablet was documented as administered at 8:00 am on 3/22/18. Interview on 3/22/18 at 8:00 am with a MA revealed: -She had worked in the facility for 19 years. -She read the eMAR for each resident before she removed the medications from the cart. -She read the labels for each medication as she placed the medication in the medicine cup for administration to the resident. -She made sure she administered the medications as written on the eMAR. Refer to interview with the Health and Wellness nurse (HWN) on 03/22/18 at 4:05 pm. Refer to interview with the Executive Director (ED) on 03/22/18 at 5:30 pm.	D 358		

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	hal041062	A. BUILDING: _____ B. WING _____	03/26/2018

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D 358	Continued From page 27 Refer to interview with Resident #3's Primary Care Provider on 03/23/18 at 11:15 am. Refer to telephone interview with the facility's contracted pharmacy representative on 03/23/18 at 11:45 am. Refer to interview with Resident #3 on 03/23/18 at 3:50 pm. Refer to interview with the Associate Executive Director on 03/23/18 at 4:25 pm. Interview with the Health and Wellness nurse (HWN) on 03/22/18 at 4:05 pm revealed: -The HWN and the clinical support staff completed random eMAR audits. -The new eMARs were compared to the old eMARs each month; this was the responsibility of the HWN and the clinical support person. -She did not know the FL2 orders were not being followed. Interview with the Executive Director (ED) on 03/22/18 at 5:30 pm revealed: -The HWN and the clinical support staff completed random eMAR audits. -The new eMARs were compared to the old eMARs each month; this was the responsibility of the HWN and the clinical support person. -There was nothing in place to keep track of the audit process. -She did not know the FL2 orders were not being followed. Interview with Resident #3's Primary Care Provider on 03/23/18 at 11:15 am revealed: -The provider did not know the FL2 orders were not being followed. -The expectations were for the facility staff to	D 358		

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D 358	Continued From page 28 administer medications as ordered. -All orders on the FL2 were current and correct. Telephone interview with the facility's contracted pharmacy representative on 03/23/18 at 11:45 am revealed: -The pharmacy did not print off or manage eMARs for the facility. -The pharmacy did not enter or change orders for the facility. -The pharmacy filled medication orders and would send the medication to the facility. -The facility had faxed over the FL2 dated 02/20/18. -The contracted pharmacy had looked over the FL2 dated 02/20/18 and orders were never changed. -They would make changes to the medication orders immediately. Interview with Resident #3 on 03/23/18 at 3:50 pm revealed: -The staff administered all medications. -The resident did not know of all the medications he was currently taking. Interview with the Associate Executive Director on 03/23/18 at 4:25 pm revealed: -She started working at the facility 03/12/18. -The contracted pharmacy did not enter orders into the facility's eMAR system. -She was unsure if the facility printed off the eMARs or if the contracted pharmacy printed the eMARs. -To her knowledge the contracted pharmacy was able to look at the orders in the eMAR system. -The facility nurse and the clinical support staff completed random eMAR audits. -The new eMARs were compared to the old eMARs each month; this was the responsibility of	D 358		

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D 358	Continued From page 29 the nurse and the clinical support person. -She did not know the FL2 orders were not being followed. The facility failed to assure medications were administered as ordered to Resident #3 with orders for insulin; which can cause unstable blood sugar levels, a diuretic; which can cause symptoms of dehydration, heart arrhythmias, altered kidney function, a beta blocker; which can cause tachycardia, heart palpitations and headaches, a vasodilator; which can cause a rapid decrease in blood pressure and heart rate, an analgesic; which can cause increased pain, and an anti-inflammatory; which can cause nausea, vomiting and abdominal pain from extended use if not administered as ordered. The failure to assure medications were administered as ordered by the licensed prescribing practitioner was detrimental to the health and safety of the residents and constitutes a Type B Violation. A Plan of Protection was provided by the facility on 03/23/18 as follows: -The facility will immediately update physicians orders on the eMAR. -The facility will schedule mandatory retraining for all MA's on completion and verification of the new order tracking form, as well as, FL2 compliance. -The Health and Wellness Director (HWD), Resident Care Coordinator (RCC), and/or Resident Care Aide will audit the new order tracking form as orders are received for accuracy and verification. -The HWD, RCC, or lead Resident Care Aide will conduct monthly eMAR audits. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, MAY 12,	D 358		

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D 358	Continued From page 30 2018 .	D 358		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure disclosure information was completed for 1 of 2 sampled residents (Resident #1) admitted to the Special Care Unit (SCU). The findings are: Review of Resident #1's current FL2 dated 4/8/17 revealed diagnoses included vascular dementia, schizophrenia, and anxiety.	D 463		

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D 463	Continued From page 31 Review of the Resident Register for Resident #1 revealed an admission date of 8/3/15 to the SCU. Review of Resident #1's record revealed no disclosure information. Interview with the Resident Care Coordinator (RCC) on 3/23/18 at 4:05 pm revealed: -She assisted the Health and Wellness Director (HWD) with admitting new residents. -She assisted with thinning the records. -She was did not know the disclosure was not completed. Interview with the Health and Wellness Director (HWD) on 3/23/18 at 4:05 pm revealed: -She and the RCC were responsible for admitting new residents. -Each admission packet contained a disclosure information sheet. -Once signed, a copy of the disclosure information sheet was placed in the resident's record. -She was unable to locate Resident #1's disclosure information sheet. Interview with the Associate Executive Director on 3/23/18 at 4:15 pm revealed: -She began working at the facility 1 week ago. - She did not know why the facility did not have the disclosure information sheet for Resident #1. -All files and records for Resident #1 had been checked and no disclosure information sheet was located. Interview with Resident #1's contact person on 3/26/18 at 12:00 pm revealed: -She did not recall receiving or signing a disclosure information sheet for Resident #1.	D 463	-Special Care Unit Disclosure was signed by Resident's Responsible Party and added to the resident's record. -The Executive Director, Health & Wellness Director or Designee shall ensure all residents have a signed Special Care Unit Disclosure form included in their record.	3/23/18 & ongoing

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D 463	Continued From page 32 -A medicare/medicaid program had been responsible for setting up the admission for the resident. -She knew the resident was admitted to a locked SCU. -She would sign the disclosure information sheet so it would be in the resident's record. Interview with the Resident Care Coordinator (RCC) on 3/23/18 at 4:05 pm revealed: -She assisted the Health and Wellness Director (HWD) with admitting new residents. -She assisted with thinning the records. -She was unaware the disclosure was not completed. Interview with the Health and Wellness Director (HWD) on 3/23/18 at 4:05 pm revealed: -She and the RCC were responsible for admitting new residents. -Each admission packet contained a disclosure information sheet. -Once signed, a copy of the disclosure information sheet was placed in the resident's record. -She was unable to locate Resident #1's disclosure information sheet. Interview with the Associate Executive Director on 3/23/18 at 4:15 pm revealed: -She had only begun working at the facility 1 week ago. - She did not know why the facility did not have the disclosure information sheet for Resident #1. -All files and records for Resident #1 had been checked and no disclosure information sheet was located. Interview with Resident #1's contact person on 3/26/18 at 12:00 pm revealed:	D 463		

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D 463	Continued From page 33 -She did not recall receiving or signing a disclosure information sheet for Resident #1. -A medicare/medicaid program had been responsible for setting up the admission for the resident. -She knew the resident was admitted to a locked SCU. -She would sign the disclosure information sheet so it would be in the resident's record.	D 463		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration and health care. The findings are: 1. Based on observations, record reviews and interviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (Resident #3) regarding blood pressure (BP) results and failed to schedule appointments to have International Normalized Ratio (INR) levels drawn. [Refer to Tag 0273, 10A NCAC 13F	D912	The community shall verify that residents receive appropriate care and services in accordance with federal and state laws, rules and regulations through oversight, supervision, training and assessment/ identification of care, medication administration, and/or health care. Oversight and supervision of residents rights will be provided by Executive Director, Health and Wellness Director, Resident Care Coordinator, RN Case Manager, Supervisors and/or Designee(s).	3/23/18 & ongoing

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D912	Continued From page 34 .0902(b) Health Care (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 5 sampled residents (Resident #3) with orders for insulin, a diuretic, a beta blocker, a vasodilator, an analgesic, and an anti-inflammatory. [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		