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
	HAL031018	A. BUILDING: _____ B. WING _____	R-C 08/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VILLAGE	235 NORTH NC 41 BEULAVILLE, NC 28518

(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 the Duplin County Department of Social Services conducted a follow-up survey and complaint investigation from August 14, 2018 through August 20, 2018, with a exit conference via telephone on August 21, 2018. The complaint investigation was initiated by the Duplin County Department of Social Services on July 05, 2018.	D 000	Responses to the cited deficiency does not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set-forth in the Corrective Action Report, the Plan of Correction is prepared solely as a matter of compliance with State Law.	
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure floor coverings were clean and in good repair in 1 of 6 sampled resident's rooms (Room #39) which had several pieces of laminate floor covering missing. The findings are: Review of Resident #5's current FL2 dated 09/26/17 revealed: -Diagnoses included dementia, major depressive disorder, gastroesophageal reflux disease, gout karasakoff syndrome, history of alcohol abuse in remission) and history of colon cancer. -Resident #5 was incontinent of bowel and	D 074	Flooring in Room 39 shall be replaced and maintained to prevent further damage from urination or any spills that may occur. Housekeeping staff will inspect room twice daily to ensure room is clean is odor free. Resident will be prompted to toilet every two hours while awake by PCS staff. Care Manager and Care Manager Assistant will monitor.	10-10-18 09-28-18

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

Reviewed + accepted 10/5/18
Darlene Kay Penn RN

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D 074	Continued From page 1 bladder. -Resident #5 was non-ambulatory. -Resident #5 had a wheelchair. Observation on 08/14/18 at 11:15 am of Resident #5's room revealed: -There were 2 beds in the room. -Only one resident resided in the room. -Resident #5 was not in the room. -Several of the laminate flooring was missing from the area under and around Resident #5's bed, revealing the intact tile floor underneath. -The pieces of laminate remaining on the floor were approximately 6 inches wide and varying in length from 18 to 36 inches. -The area of missing laminate was approximately 7 boards wide and varying in length from 18 to 48 inches. -The difference in height from the laminate floor to the exposed tile floor was less than 1/4 inch. Interview on 08/15/18 at 8:30 am with a housekeeper revealed: -Resident #5 had urinated on the floor in his room, near his bed "the whole time he had been here". -Resident #5 would often urinate on the floor or into drink cups or drink bottles. -She kept Resident #5's room as clean as she could. -She swept and mopped the room as many times as it needed it every day. -The laminate flooring was removed yesterday by another staff member. -The flooring was removed because it was no longer adhering to the tile floor underneath. -The loose laminate had become a trip hazard and need to be removed, for staff and resident safety. -Staff often encouraged Resident #5 to use the	D 074		

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D 074	Continued From page 2 toilet in his bathroom. Interview on 08/16/17 at 8:10 am with a personal care aide (PCA) revealed: -Resident #5 "has always done that" in reference to spilling urine on the floor from the drinking cups he urinated in. -"His floor is always a mess". -Housekeeping mopped his floor several times each day to keep the floor as clean as possible. -She removed the sheets from Resident #5's bed and sanitized the plastic covered mattress every day. -Resident #5 got clean sheets every day. -She removed the laminate flooring yesterday from underneath and near Resident #5's bed, because the laminate was no longer sticking to the tile floor beneath it. -She felt the laminate had become a trip hazard, even though Resident #5 was in a wheel chair. -She moved Resident #5's bed to cover most of the area where the laminate was missing. -Resident #5 wore incontinent briefs, but he would pull it down to urinate into a cup or bottle or glass. -Resident #5 spilled urine onto the floor several times each day. -Staff had encouraged Resident #5 to use the bathroom for urination instead of the soda cans and cups he would bring to his room. Interview on 08/14/18 at 5:00 pm with Resident #5's family member revealed: -Resident #5 had lived at the facility since September 2017. -Resident #5 had a history of urinating into cups, plates, bowls, corners, and trash cans. Interview on 08/14/18 at 4:40 pm with the Maintenance Director reveled:	D 074		

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D 074	Continued From page 3 -He had provided maintenance for the facility for 4 months. -He routinely came to the building 3 times each week. -He did a walk through inspection each week when he was in the facility. -The floor in Resident #5's room was intact when he conducted his walk through inspection last week. -The laminate flooring in Resident #5's room was removed by a staff member yesterday and he had received a work order to repair the floor today. Interview on 08/16/17 at 11:45 am with the Administrator revealed: -Resident #5 had displayed the behavior of urinating into dishes, cups, bottles and cans since he had been admitted to the facility. -Staff constantly encouraged him to use the bathroom instead of cups and soda cans and drink bottles for urination. -Resident #5 had been provided with urinals, but he would not use them. -The laminate flooring had been removed on 08/13/18 by staff in order to avoid a trip hazard on Resident #5's room. Based on observations and interviews through out the survey, Resident #5 was determined to be not interviewable. Observations through out the survey on 08/14 - 08/20/18, at various times, revealed a portion of the laminate flooring was still missing from Resident #5's room.	D 074		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing	D 075		

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D 075	Continued From page 4 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure rooms had no chronic unpleasant odors in 1 of 6 sampled resident's rooms (Resident #5) which had a very strong odor of urine. The findings are: Observations through out the survey on 08/14 - 08/20/18 revealed Room # 39 continued to have a strong urine odor, despite the floor appeared clean, the box fan continuously blew air from the hallway and the screened window remained open. Observation on 08/14/18 at 11:15 am of Resident #5's room (Room # 39) revealed: -There were 2 beds in the room. -A box fan sat on the floor, near the door, and pushed air into the room from the hallway. -The screened window was open about 6 inches. -There was only one resident who resided in the room. -Resident #5 was not in the room. -A very strong odor of urine, despite the appearance of a recently mopped floor. Review of Resident #5's current FL2 dated 09/26/17 revealed: -Diagnoses included dementia, major depressive disorder, gout karasakoff syndrome, history of	D 075		

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D 075	Continued From page 5 alcohol abuse (in remission) and history of colon cancer. -Resident #5 was incontinent of bowel and bladder. -Resident #5 was non-ambulatory. -Resident #5 had a wheelchair. Interview on 08/15/18 at 8:30 am with a housekeeper revealed: -Resident #5 has urinated on the floor in his room, near his bed "the whole time he had been here". -Resident #5 would often urinate on the floor or into drink cups or drink bottles. -She kept Room #39 as clean as she could. -She swept and mopped the room as many times as it needed it every day. -She usually mopped the floor in Room #39 several times a day, due to the urine puddles and drips near the bed. -"That smell is always here, we try to keep as clean as we can, but the smell is always here". -Staff encouraged Resident #5 daily to use the toilet in his bathroom. Interview on 08/16/17 at 8:10 am with a personal care aide (PCA) revealed: -Resident #5 "has always done that" in reference to spilling urine on the floor from the drinking cups he urinated in. -"His floor is always a mess". -Housekeeping mopped his floor several times each day to keep the floor as clean as possible. -She removed the sheets from Resident #5's bed and sanitized the plastic covered mattress every day. -Resident #5 got clean sheets every day. -"His room always smells like this". -Resident #5 wore incontinent briefs, but he would pull it down to urinate into a cup or bottle or	D 075		

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D 075	Continued From page 6 glass. -Staff frequently encouraged Resident #5 to use the bathroom for urination instead of the soda cans and cups he would bring to his room. Interview on 08/14/18 at 5:00 pm with Resident #5's family member revealed: -Resident #5 had lived at the facility since September 2017. -"The staff do the best they can to keep his room clean". -"It always smells like that". Interview on 08/14/18 at 4:40 pm with the Maintenance Director reveled: -He had provided maintenance for the facility for 4 months. -He routinely came to the building 3 times each week. -He did a walk through inspection each week when he was in the facility. -He was aware of the strong, chronic urine odor in Resident #5's room. -"The only way for me to fix that (odor) is to replace the whole floor and shoe molding in there". -He had discussed the urine odor with the Administrator and they were "trying to decide what to do". Interview on 08/16/17 at 11:45 am with the Administrator revealed: -Resident #5 had displayed the behavior of urinating into dishes, cups, bottles and cans since he had been admitted to the facility. -Staff constantly encouraged him to use the bathroom instead of cups and soda cans and drink bottles for urination. -Resident #5 had been provided with urinals, but he would not use them.	D 075		

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D 075	Continued From page 7 -She was aware of the strong urine odor in Resident#5's room. -Staff mopped the floor in Resident #5's room several times each day and placed a box fan on the floor to improve the air circulation. Based on observations and interviews through out the survey, Resident #5 was determined to be not interviewable.	D 075		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders for off-loading boots and every 30 minute checks were implemented for 1 of 5 sampled residents (#4). The findings are:	D 276	Off -loading boots are to remain on at all times. Medication Aides are responsible for ensuring boots are applied and checked every 2 hours to ensure proper placement and to ensure that off-loading boots are not restrictive of proper circulation. MA will document these checks in the Quick Mar. Care Manager will check Quick Mar daily for to ensure the off-loading boots have been applied and checked every 2 hours.	9-28-18

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D 276	Continued From page 8 Review of Resident #4's current FL-2 dated 01/05/18 revealed diagnoses included acute renal failure, schizoaffective disorder, sepsis and complicated urinary tract infection. a. Review of physician's orders dated 01/08/18 and 06/18/18 for Resident #4 revealed there was an order for off-loading boots on both feet at all times to promote skin integrity. Review of Resident #4's current care plan dated 05/25/18 revealed there was documentation the resident was to wear off-loading boots on both feet at all times. Observation on 08/14/18 at 12:15pm revealed Resident #4 was lying in a hospital bed that had full length side rails up on both sides with the covers on from his abdomen to his knees and there were no off-loading boots on either foot. Observations on 08/15/18 at 9:33am revealed: -Resident #4 was lying in bed and had the covers removed by the personal care aide (PCA). -Resident #4 was not wearing off-loading boots on either foot. -Resident #4 had a silver dollar sized area of redness with a pea sized calloused area at the center on both heels. Interview with the PCA on 08/15/18 at 9:33am revealed Resident #4 had heel "booties" he was supposed to wear, but he did not like to keep them on. Observation on 08/16/18 at 9:12am revealed: -Resident #4 was lying in bed and did not have off-loading boots on either foot. -The off-loading boots were underneath two pairs of sweat pants in a wheelchair which was on the	D 276		

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D 276	Continued From page 9 other side of the room near the closet. Interview with Resident #4 on 08/16/18 at 9:18am revealed: -He was supposed to wear the (off-loading) boots at all times. -Staff "hardly ever put them [sic] (off-loading boots) on." -He did not know where the off loading boots were kept, but were probably in the room somewhere. -His feet did not hurt. Interview with a second PCA on 08/16/18 at 9:41am revealed: -The PCAs were responsible for putting the off-loading boots on Resident #4's feet. -The off-loading boots were put on when the PCAs got Resident #4 out of the bed. Interview with two PCAs on 08/16/18 at 3:29pm revealed: -They thought the off-loading boots were supposed to be on Resident #4's feet at bedtime. -The PCA who trained them told them what each resident's needs were like when to put the off-loading boots on Resident #4's feet. Interview with a medication aide (MA) on 08/16/18 at 9:41am revealed she thought Resident #4 was supposed to wear the off-loading boots all the time, but she would have to check the order. Interview with a second MA on 08/18/18 at 3:23pm revealed: -She was not sure if the off-loading boots for Resident #4 were noted in the ADL book for the PCAs. -The MAs documented the off-loading boots were	D 276		

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D 276	Continued From page 10 on Resident #4 each shift on the eMAR; anything the MAs documented, the MAs were responsible for. -The MAs were responsible for making sure Resident #4 was wearing the off-loading boots on both feet at all times. Review of Resident #4's June, July and August 2018 electronic medication administration record (eMAR) revealed: -There was an entry for off-loading boots to wear on both at all times. -Staff documented the off-loading boots were worn each shift from 06/01/18 through 08/14/18. Review of electronic charting notes dated 05/29/18 through 08/13/18 for Resident #4 revealed there was no documentation Resident #4 refused to wear the off-loading boots. Review of Resident #4's June, July and August 2018 Activities of Daily Living (ADL) Logs revealed there was no documentation for Resident #4 to wear off-loading boots at all times. Review of a skilled nurse (SN) visit note dated 08/15/18 for Resident #4 revealed there was documentation that no skin breakdown was noted. Telephone interview with a home health (HH) representative on 08/16/18 at 9:34am revealed: -Resident #6 was followed by HH and the nurse assessed the resident's skin for breakdown with each visit. -The HH nurse visited on 08/15/18 and there was no skin breakdown concern. Telephone interview with the Nurse Practitioner (NP) on 08/17/18 at 10:31am revealed:	D 276		

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D 276	Continued From page 11 -He was not aware of any issues concerning Resident #4 wearing the off-loading boots. -The off-loading boots were ordered for Resident #4 to help maintain circulation and to provide protection from developing pressure sores. -It had been "a while" since Resident #4 had any sores on his feet. Interview with the Assistant Resident Care Manager (ARCM) on 08/16/18 at 12:18pm revealed: -The Administrator and the Resident Care Manager (RCM) implemented the care plan on admission for each resident; the care plan was filed in the resident's record for the MAs to refer to. -Any individual assistance needs were documented on the electronic record which both MAs and PCAs had access to. -For the off-loading boots documented on Resident #4's eMAR, the MA "clicks on those and signs off that those were on". -The PCAs know when to put the off-loading boots on Resident #4 from being told by the MAs. -Resident #4 did not have any problem wearing the off-loading boots when he was up in his wheelchair, but he did have a problem wearing the off-loading boots while in the bed. -"He's (Resident #4) contracted and they (off-loading boots) have a tendency to slide off because they're only held on by a Velcro strap." b. Review of a "Physician's Restraint Order" dated 07/23/18 for Resident #4 revealed: -There was an order for side rails to be used for safety while the resident was in bed. -There was an order for the resident to be checked every 30 minutes while the side rails were in use.	D 276	Personal Care Staff will check all residents who have side rails every 30 minutes if resident is in the bed. These checks will be documented in the Restraint Book located at each Nurse's station. Care Manager will check Restraint book daily.	9-28-18

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D 276	Continued From page 12 Review of a "Restraint Care Plan" and "Restraint Assessment" dated 07/03/18 for Resident #4 revealed: -The side rails were used for turning and positioning only and the side rails did not qualify as a restraint. -There was no documentation for medical symptoms that required the use of the side rails or which alternatives had been attempted. Interview with the Licensed Health professional Support (LHPS) nurse on 08/16/18 at 12:00pm revealed: -She had assisted with the documentation of the orders related to Resident #4's side rails. -The order to check Resident #4 every 30 minutes meant the staff should check the resident every 30 minutes when the resident was in bed and the side rails were up. -Staff were supposed to check and make sure Resident #4 did not get "caught up in the side rail" with an arm or a leg stuck between the rails. -Staff should have been documenting the 30 minute checks in a 30 minute check book. Observation on 08/14/18 at 12:15pm revealed Resident #4 was lying in bed with full length side rails up on both sides of the bed. Interview with a personal care aide (PCA) on 08/16/18 at 9:41am revealed staff checked Resident #4 every two hours. Interview with two PCAs on 08/16/18 at 3:29pm revealed: -Staff checked all residents every two hours, some residents were checked every 15 minutes. -Residents with side rails in use while in bed were checked every two hours because most of the residents with side rails in use could not get out of	D 276		

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D 276	Continued From page 13 the bed. -None of the residents with side rails in use tried to get out of the bed. Interview with a medication aide (MA) on 08/18/18 at 3:23pm revealed: -There was a restraint book in the medication room where staff documented every 30 minute checks. -She could not find the restraint book. Telephone interview with a second MA on 08/16/18 at 2:19pm revealed: -Residents with side rails in use were checked every two hours. -Staff checked residents with side rails in use to make sure the resident was not "lodged" in the side rail or had their legs hanging over the side rails. Interview with the Administrator on 08/16/18 at 3:42pm revealed the 30 minute checks should have been done for residents with side rails in use, but the 30 minutes checks had not been done.	D 276		
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.	D 358		

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D 358	Continued From page 14 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure a diuretic medication (hydrochlorothiazide) and an antibiotic eye drop (ciprofloxacin) were administered as ordered by the primary care provider for 2 of 6 sampled residents (#5 and #6). The findings are: 1. Review of Resident #6's current FL-2 dated 10/23/17 revealed diagnoses included type II diabetes mellitus, hypertension, osteoarthritis, chronic obstructive pulmonary disease and peripheral neuropathy. Interview with Resident #6 on 08/14/18 at 12:15pm revealed: -She had an infection in both of her eyes. -Her eyes itched and burned. -She had seen the doctor on 08/13/18. -The doctor had ordered some eye drops for her, but she had not received the eye drops. Observations on 08/14/18 at 12:15pm and 08/15/18 at 9:08am revealed Resident #6's had red sclera and redness of her eye lids on both eyes. Review of a primary care provider (PCP) order dated 08/13/18 for Resident #4 revealed an order for ciprofloxacin 0.3% eye drops one drop in each eye twice daily for five days. (Ciprofloxacin is an antibiotic used to treat infection.) Interview with Resident #6 on 08/15/18 at 9:08am revealed she had not received the eye drops ordered by the doctor.	D 358	Medication Aides will complete medication cart audits weekly to ensure all medications as ordered by provider are readily available for administration. Care Manager and Assistant will randomly conduct med cart audits to ensure MA's are properly conducting cart audits and also to ensure all medications are readily available for administration as ordered. All new medication orders will be flagged and placed in a folder to be kept by the RCM-A until such order has arrived, then the order shall be filed in the resident's chart. If there is a delay in receiving the new order RCM-A will contact the providing the pharmacy and determine if the provider may need to prescribe a comparable substitution.	9-28-18 9-28-18 9-28-18

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D 358	Continued From page 15 Observations on 08/15/18 at 9:11am revealed: -The medication aide (MA) asked Resident #6, "Why are you crying?" -Resident #6 responded, "Because I ain't [sic] got my eye drops." Interview with the MA on 08/15/18 at 9:13am revealed: -There was no order for any eye drops on Resident #6's electronic medication administration record (eMAR). -If there was a new order, it would have shown up on the electronic eMAR. -Some times medications would come in and the order would not be on the eMAR. -There were no eye drops on the medication cart for Resident #6. -There were no eye drops in the medication refrigerator for Resident #6. -She did not know what else to say, "There was no order and there were no eye drops." Review of Resident #6's August 2018 eMAR revealed: -There was documentation the eMAR was printed on 08/15/18. -There was no entry for ciprofloxacin eye drops. Telephone interview with a second MA on 08/16/18 at 2:19pm revealed: -If a resident told the MA the doctor wrote an order for a medication that was not on the eMAR, the MA would check the resident's record for the order. -If there was a doctor's order for a medication and the medication was not in the facility, the MA would call the pharmacy. Interview with the Assistant Resident Care	D 358		

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D 358	Continued From page 16 Coordinator (ARCM) on 08/15/18 at 10:33am revealed: -New orders for antibiotics were called into the pharmacy STAT (urgent). -Oral antibiotics were STAT, the order for ciprofloxacin for Resident #6 was "an eye drop". -The ciprofloxacin order for Resident #6 was sent to the pharmacy on 08/13/18. -The pharmacy called on 08/14/18, and said they had notified (name of a staff) that there was a national shortage on ciprofloxacin eye drops and the order would need to be clarified with the doctor. -There was no staff working at the facility by the name the pharmacy gave. -She called the pharmacy on 08/15/18. -She called and clarified the order with the doctor on 08/15/18. -She did not have a specific response as to why there was a delay from 08/13/18 to 08/15/18 on clarification of the antibiotic eye drop order for Resident #6. -The orders for Resident #6's eye drops were not in the resident's record because they were new orders. -She had new orders in a file in her office. -She faxed all new orders to pharmacy which were reviewed by the Pharmacist and posted on the eMAR. -She or the Resident Care Manager (RCM) checked and approved new orders entered by the Pharmacist on the eMAR. -She and the RCM were on call 24 hours a day, seven days a week to approve new orders. Interview with a third MA on 08/16/18 at 3:57pm revealed: -She had worked on the evening on 08/13/18. -She did not speak with the pharmacy at approximately 7:00pm on 08/13/18.	D 358		

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D 358	Continued From page 17 -She did not receive a fax from the pharmacy on 08/13/18. -She was not aware of the order from the PCP for ciprofloxacin eye drops for Resident #6. -Normally any new orders were communicated at shift change, but no one had told her about the eye drops for Resident #6. Telephone interview with a pharmacy technician on 08/15/18 at 3:22pm revealed: -The pharmacy received the order for ciprofloxacin eye drops for Resident #6 on 08/13/18. -There was a national shortage of ciprofloxacin eye drops and the pharmacy alerted the facility on 08/13/18 at 7:05pm by fax and spoke with (name of staff) on 08/13/18 at 7:07pm. -The same alert notice was sent to the facility again by fax on 08/15/18 at 9:06am. Interview with the ARCM on 08/16/18 at 4:42pm revealed: -The pharmacy did not send a fax notification about the ciprofloxacin eye drops for Resident #6 on 08/13/18. -She had actually called the pharmacy to resend the fax on 08/16/18 and did get the fax. -She told MAs about new medication orders during the shift change report. -If the MAs did not see the new order on the eMAR, the MA was expected to call the ARCM or the RCM. -The staff did notify her on Tuesday that the order for the ciprofloxacin eye drops for Resident #6 was not on the eMAR; she did not remember which staff notified her. -She then contacted the pharmacy before 9:00am on 08/15/18. -She and the RCM were responsible for follow up with the pharmacy.	D 358		

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D 358	Continued From page 18 -Once a new order was faxed to the pharmacy, the facility did not normally see the new order on the eMAR until the following day. Telephone interview with the PCP for Resident #6 on 08/15/18 at 11:01am revealed: -He had ordered Resident #6 ciprofloxacin eye drops to treat conjunctivitis (bacterial infection of the eye). -He thought 24 hours would be a reasonable time to expect that an antibiotic such as ciprofloxacin eye drops were administered. -He was contacted on 08/15/18, by facility staff to clarify the order for ciprofloxacin eye drops for Resident #6. -He ordered another type of antibiotic eye drop for Resident #6 on 08/15/18. Review of a PCP telephone order dated 08/15/18 for Resident #4 revealed: -There was an order to discontinue the ciprofloxacin eye drops. -There was an order to start trimethoprim/polymyxin eye drops one drop every six hours for five days. Interview with Resident #6 on 08/16/18 at 9:12am revealed she had received her first eye drops that morning (08/16/18) and her eyes felt better. 2. Review of Resident #5's current FL2 dated 09/26/17 revealed: -Diagnoses included dementia, major depressive disorder, gastroesophageal reflux disease, gout, karasakoff syndrome, history of alcohol abuse (in remission) and history of colon cancer. -Medication orders included an order for hydrochlorothiazide (HCTZ) 25 mg, (used to reduce excess fluid and lower blood pressure) 1	D 358		

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D 358	Continued From page 19 tablet to be given by mouth daily. Review of Resident #5's June 2018 Medication Administration Record (eMAR) revealed documentation of HCTZ 25 mg administered every day at 9 am. Observation of Resident #5's July 2018 eMAR revealed: -Documentation of HCTZ 25 mg administration every day at 9 am, with the exception of July 31, 2018, when documentation revealed "held per MD orders". Observation of Resident #5's August 2018 eMAR revealed: -Documentation HCTZ 25 mg was not administered on 08/01/18 through 08/09/18, documentation revealed "held per MD orders". -Documentation revealed Resident #5 received HCTZ 25 mg as ordered for the remainder of the month. Observation on 08/14/18 at 2:45 pm of medications available for administration for Resident #5 revealed no HCTZ 25 mg was available for administration. Interview on 08/15/18 at 10:45 am with a medication aide (MA) revealed: -She usually administered the first shift medications to Resident #5. -Resident #5 was administered HCTZ 25 mg every day with his morning medication pass, usually around 9 am. -She had no idea why the HCTZ 25 mg was not available for administration for Resident #5. -MAs requested refills for medications as needed. Telephone with a pharmacy representative on	D 358		

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D 358	Continued From page 20 08/15/17 at 10:35 am revealed: -The pharmacy had an order dated 09/29/2017 for HCTZ 25 mg to be administered daily for Resident #5. -The fill history of the medication was 09/27/17 with 30 tablets, 10/26/17 with 30 tablets, 11/28/17 with 30 tablets, 12-25-17 with 30 tablets, 01/24/18 with 30 tablets, 02/23/18 with 30 tablets, 03/25/18 with 30 tablets, 04/24/18 with 30 tablets. -The last time the pharmacy filled the prescription for Resident #5 HCTZ 25 mg was 04/24/18 with 30 tablets. -The pharmacy had not sent any further refills to the facility because no one from the facility had requested any refills of HCTZ 25 mg for Resident #5. Interview on 08/15/2018 at 12:00 pm with the primary care provider for Resident #5 revealed: -She received a telephone call on 08/10/18 that Resident #5 did not have HCTZ 25 mg available, and had been out of that medication since 07/31/18. -She gave a verbal order to hold the HCTZ 25 mg for the 10 days it was not available for administration. -She did not know why the HCTZ 25 mg was not available for administration. -She was informed by facility staff the HCTZ had arrived on 08/10/17 and was available for administration. -She had no idea what was happening at the pharmacy concerning the refill of this medication. -She would discontinue the 09/29/17 order for HCTZ 25 MG today and write an new order to begin today. -Resident #5's blood pressure was well within normal limits, so she felt the missed doses did not have a detrimental effect on him. -She expected the facility toadminister	D 358		

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D 358	Continued From page 21 medications as ordered. Observation on 08/16/18 at 7:30 am of medication available for administration for Resident #5 revealed a bubble pack of HCTZ 25 mg, filled 08/15/16 with 30 tablets. Interview on 08/14/18 at 5:00 pm with a Resident # 5 family member revealed: -He was unaware of the exact medication prescribed for Resident #5. -He depended on the facility to administer medications as ordered for Resident #5. Based on observations and attempted interviews through out the survey, Resident #5 was determined to be not interviewable. Interview on 08/15/18 at 3:30 pm with the Assistant Resident Care Coordinator (ACRM) revealed: -She performed complete cart audits every month. -MAs conducted cart audits weekly. -No discrepancies had been noted on the cart audits in reference to Resident #5's HCTZ, except that the HCTZ bottle filled on 03/25/18 with 30 tablets had been returned to the pharmacy on 07/31/18, because the cart audit, completed on the same date, revealed an excess of HCTZ for Resident #5. Interview on 08/14/18 at 3:15 pm with the Resident Care Coordinator (RCM) revealed: -The facility had requested a refill for Resident #5's HCTZ on 08/08/18. -He did not know why there was no HCTZ available for administration for Resident #5. Interview on 08/15/18 at 11:00 am with the	D 358		

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D 358	Continued From page 22 Administrator revealed: -Cart audits were performed weekly on every resident by the MAs and monthly by the ACRM. -She did not know why there was no HCTZ available for administration for Resident #5.	D 358		