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	HAL025035	A. BUILDING: _____ B. WING _____	05/09/2019

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on May 07, 2019 - May 09, 2019.	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: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure the facility was free of obstructions and hazards as evidenced by detachable/handheld shower head fixtures with a long looped flexible hose dangling directly over and ten inches from the toilets in all residents' shared restrooms in the Special Care Unit (SCU). The findings are: Observations on the Green-West section of the Special Care Unit (SCU) of the facility on 05/09/19 at 8:22am revealed there were detachable/handheld shower head fixtures with a long looped flexible hose dangling directly over the toilets in the residents' three shared restrooms, in rooms: #6, #30 and #31..	D 079		

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Confidential interviews with staff revealed:
-There were at least three known residents on the Green-West section of the SCU that used the shared restrooms independently without staff.
-The staff thought "it was odd" to have shower fixtures installed over the toilets in the residents' shared restrooms.
-The staff thought due to the residents' dementia, they could possibly be injured by the flexible hose hanging over the toilets.
-Some residents could possibly be injured using the bathroom independently because "they could get the cord wrapped around their neck and not know any better".
-There were some residents that wandered in and out of resident rooms and shared restrooms.

Interview with two housekeepers on 05/09/19 at 8:30am revealed:
-The two housekeepers were not sure why the detachable shower head fixtures were installed over the toilets in the shared restrooms on the Green-West section of the SCU.
-The housekeepers had never seen staff use the shower fixtures in the shared restrooms when assisting the residents with personal care.
-The housekeepers were not sure if any water supply was connected to the shower head fixtures over the toilets.

Observation of a female resident on 05/09/19 at 8:39am revealed the resident entered the shared resident restroom without staff and closed the door.

Interview with a personal care aide (PCA) on 05/09/19 at 8:41am revealed the female resident used the restroom independently without staff.

Observation of the female resident on 05/09/19 at

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D 079	Continued From page 2 8:42am revealed the female resident ambulated out of the shared resident restroom without staff. Interview with the female resident on 05/09/19 at 8:43am revealed: -She had "no idea" why there was a shower fixture over the toilet. -She had never used the shower fixture or tried to turn the water on. Observations on the Blue-East section of the SCU of the facility on 05/09/19 at 8:14am revealed there were detachable/handheld shower head fixtures with a long looped flexible hose dangling directly over the toilets in the residents' four shared restrooms, in rooms: #41, #42, #49 and #65. Interview on 05/09/19 at 8:15am with another resident revealed: -"I have no clue why there is a shower head above the toilet." -The shower head and hosing had always been there since she was admitted to the facility. Interview with the Medication Aide (MA) on 05/09/19 at 8:25am revealed: -The shower heads were installed above each semi-private room shared toilet in February 2018 after the facility opened. -Management had not told her why the shower heads were above the toilets. -All residents with shared bathrooms use the common shower in the hall, but use the toilet in their shared bathroom. -All of the residents in the facility wander, with the exception of a few that were temporarily displaced from an Assisted Living facility. -She was not aware of any residents getting	D 079		

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D 079	Continued From page 3 tangled up in the shower hose but it was a possibility that it could happen since they had dementia and went into those bathrooms independently. Interview with a PCA on 05/09/19 at 8:35am revealed: -She had been employed at the facility since June 2018. -The shower heads and hosing had always been above the semi-private rooms toilets. -She had never been instructed on what to do with them. -All residents wandered from room to room on the unit. Interview on 05/09/19 at 9:15am with the Administrator revealed: -The shower heads and hosing were installed over the toilets in the semi-private bathrooms after the facility reopened in early 2018. -Management at the corporate office were discussing the plan for the shower heads. -They had not discussed with the staff what to do with them because the water is turned off to them. -They had not educated the staff on safety precautions with the residents regarding the shower heads and tubing. -It was their thought if a resident got their head stuck in the tubing, the shower head would release since it was not locked in. The facility failed to keep the Special Care Unit facility free from obstructions and hazards as evidenced by no safety precautions taken by the facility to secure dangling long looped hoses for non-operable detachable/handheld shower head fixtures installed directly over and ten inches from the toilets in all residents' shared restrooms which	D 079		

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D 079	Continued From page 4 posed potential risk of injuries to the residents diagnosed with dementia who accessed the restrooms independently without staff supervision. The facility's failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ A Plan of Protection (POP) was submitted by the facility in accordance with G.S. 131D-34 on 05/09/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 23, 2019	D 079		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure foods were stored in a manner to prevent contamination as evidenced by expired foods in the pantry, and unlabeled food in the pantry and freezer. The findings are: Observation of the kitchen pantry on 05/07/19 at 2:57pm revealed: -There was one large plastic storage bin with handwritten dates of "3/5, "3-28-15", "5/18" and labeled contents as "Tea", "concentrate", "sweet"	D 283		

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and other faded handwritten labels that were unreadable on the bin's lid.
-The large plastic storage bin contained an opened bag closed at one end with a plastic twist tie that was approximately 1/4th full of a dry, small, hard granulated, yellow colored substance that was not labeled with a date or contents.
-There was a second smaller food bin with a blue lid containing one 2 lb, 3 ounce opened bag of sweetened whole grain oat cereal with approximately half of the cereal remaining with no opened date.
-There was approximately six boxes of variety instant grits with 12 single serve packets in each box with a "best if used by" date of 04/28/19 stored on the bottom of the storage shelf positioned on the right side of the pantry's entrance door.
-There were four prepared graham cracker crusts stacked together in an opened plastic cover with no opened date and no labeled expiration date stored on the second shelf of the storage rack positioned on the right side of the pantry's back wall.
-There were two unopened, 2.25 lbs boxes of scalloped potatoes that were without expiration dates stored on the middle storage shelf positioned on the left side of the pantry's back wall.
-There were three 5.31 lbs containers of instant mashed potatoes that were without expiration dates stored on the middle second storage shelf positioned on the pantry's back wall.
-There was approximately five unopened packages of soft tortillas with a stamped manufactured date of 03/18/18. The packages were sticky and the outer plastic packages had stuck together, stored on the bottom storage shelf positioned on the left side of the pantry's back wall.

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D 283	Continued From page 6 -The soft tortilla packages had a foul smelling odor. -There were two stacks of bowls with four bowls in each stack of a dry oat cereal covered with plastic wrap. -Two of the bowls were dated with a handwritten entry of "5/6" and the other six bowls were not labeled with a date, stored on the bottom storage shelf beside of the soft tortillas with the odor. -There were six unopened 2 lb, 4 ounce boxes of rice pilaf without expiration dates stored on the second shelf of the middle storage rack positioned in the middle of the pantry's back wall. -There were five unopened 58 ounce bags of white bread stuffing that were without expiration dates, stored in the second shelf of the middle storage rack positioned in the middle of the pantry's back wall. -There were approximately four large unopened bags of uncooked medium pasta shells with stamped dates of 11/13/18, 04/17/19, 03/07/19 and 01/17/19 and one opened bag of uncooked medium pasta shells with approximately 1/4th of the pasta remaining with no opened date. The bags of uncooked pasta were stored on the bottom shelf of a storage rack positioned on the left wall of the pantry. -There were approximately eleven large clear packages of dry cake mixes without expiration dates, stored in a large open plastic bin on the bottom shelf of the middle storage rack positioned in the middle of the pantry's back wall. Observation of the kitchen's reach- in freezers on 05/07/19 at 3:29pm revealed: -There were approximately seven corndogs wrapped with plastic wrap not labeled with a date. -There was approximately thirty frozen pink colored meat patties in an opened plastic bag that was closed with the end of the bag tied in a knot	D 283		

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that was not labeled with a date or contents.
-There was approximately fifteen frozen light brown colored meat patties in an opened plastic bag that was closed with the end of the bag tied in a knot that was not labeled with a date or contents.
-There were approximately four unopened plastic bags of frozen oval breaded meat patties that were approximately 2 lbs each not labeled with a date or contents and there was no expiration date.
-There were three unopened cubes of frozen meat cubes that were approximately 2 lbs each not labeled with a date or contents and there were no expiration dates.
-There were approximately two unopened bags and one opened bag of small brown colored round meat patties that were approximately 2 lbs. each not labeled with a date and contents. There was a third resealable bag of the small brown colored meat patties with approximately twelve meat patties that was not labeled with a date and contents.
-There were five unopened large rolls of frozen ground beef with no labeled date.
-There were three unopened plastic bags of frozen chicken legs that were approximately 2 lbs each with no labeled date.
-There were three unopened plastic bags of frozen meatballs with approximately 2 lbs. in each bag with no labeled date.

Interview with the cook on 05/07/19 at 3:41pm revealed:
-The pink colored meat patties in the freezer were hamburgers, the light brown colored meat patties in the opened plastic bags was Salisbury steak, the breaded meat patties and the cubed frozen meat was chicken and the small brown colored patties was sausage.

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-She was trained to label foods with date and contents when food packages were open or when she placed the food in a different package.
-None of the food in the freezer was "that old" because the dietary manger (DM) did not re-order the same foods until that food was out.
-She placed the corndogs in the freezer just a few days ago and she wrote a date on the plastic wrap but one of the other cooks could have thrown the outer wrap away with the labeled date.
-The contracted food supplier delivered food yesterday (05/07/19).

Interview with the DM on 05/08/19 at 11:25am revealed:
-She did not date dry foods when opened or stored in the pantry.
-She was responsible for ordering the residents' food for the facility week.
-She mainly stocked the food on the shelves in the pantry, freezer and refrigerators when the foods was delivered.
-When food was received from the contracted food supplier, she always dated canned goods with the date the food was delivered but never dated boxed or bagged items in the pantry.
-Food was used "quickly" and did not stay on the shelf long.
-She ordered food using the menu as a guide of what foods needed to be ordered each week.
-She knew how old foods were in the pantry because she rotated the foods stored.
-She checked the rotation of the food stored in the pantry each time food was delivered to the facility to make sure the already stored foods on the shelf was moved to the front of the storage shelves and the new food being delivered was placed in the back of the storage shelves.
-She did not know how long the two unopened, 2.25 lbs boxes of scalloped potatoes had been on

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the shelf and because there was no stamped expiration was not sure when the food would expire.
-Food was delivered to the facility from the contracted food supplier in bulk packaging boxes that had stickers with the date of delivery.
-She discarded most of these bulk packaging boxes with the date of delivery and stored some foods directly on the storage shelves without labeling the food packaging with any dates.
-She thought the dates on the unopened, uncooked medium pasta bags was the manufactured date.
-All of the uncooked medium pasta bags were delivered yesterday (05/07/19) except the opened bag of uncooked medium pasta and she was unsure how long the opened bag of pasta had been on the shelf.
-Some of the dry cake mixes were delivered yesterday (05/07/19) but the yellow cake mix packages were not.
-She thought the single serve instant grits were purchased for preparedness of the hurricane in the fall of 2018.
-The instant grits had not been served to the residents because residents were served only the cooked style grits.
-The flour tortillas had not been on the menu rotation since the summer of 2018 and had not been served to the residents. She would discard them today (05/08/19).
-She was not sure how long the containers of instant mashed potatoes had been on the shelf but thought there was no potential hazards with that type of dry food.

A second interview with the cook on 05/08/19 at 5:55pm revealed:
-The large plastic storage bin containing the opened bag of dry, granulated, yellow colored

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substance that was not labeled with a date or contents was probably couscous.
-She thought the couscous had not been served to the residents in 9 months.

Confidential interview with a staff revealed if food was not labeled and dated there would be no way to tell how old it was.

Interview with the DM on 05/09/19 at 10:00am revealed:
-She had worked in the facility for 13 years.
-She did not label and date foods stored in the freezer.
-"Pretty much" all food in the freezer was used up in one week.
-She "personally' stocked the kitchen's freezer when food was delivered weekly.
-All of the foods left on the freezers shelf was moved to the front of the storage shelves and the new food being delivered was placed in the back of the freezers storage shelves.
-She "occasionally" would label foods and "occasionally" did not because it depended on what type of food it was and if the food would be immediately used again.
-It was hard to label food in the freezer because when the handwritten date was " ....touched the date would rub off".
-The food out of the bulk packaging boxes were packs left over from a recent previous shipment.
-She checked for expiration dates weekly in the kitchen's pantry and discarded the foods if expired.

Interview with the Administrator on 05/09/19 at 11:30am revealed:
-She monitored the kitchen and food storage areas almost every day.
-She "spot checked" for expired foods when she

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D 283	Continued From page 11 monitored the kitchen but had not seen any expired foods. -She expected dietary staff to label all foods with date and contents when the food package was opened. -She expected staff to have a system in place to know how old all foods was.	D 283		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 2 residents (#6) who had physician's orders for a pureed diet and 1 of 1 resident (#6) who had a physician's order for nectar thickened liquids. The findings are: Review of Resident #6's current FL2 dated 11/06/18 revealed: -Diagnoses included dementia, mental retardation, unspecified psychosis,	D 310		

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hypothyroidism, hypertension, degenerative osteoarthritis, gastroesophageal reflux disease and allergic rhinitis.
-There was an order for a no added table salt (NATS) and a nectar thick liquid diet.
-There was an order for a named brand nutritional shake supplement, drink one shake daily with meals.

Review of a subsequent physician's order for Resident #6 dated 04/15/19 revealed an order for a level 1 dysphagia pureed diet (A pureed diet that should be "pudding like" with no foods requiring chewing) with nectar thickened.

Review of the facility's therapeutic diet list revealed Resident #6 was on a puree diet with nectar thickened liquids and a named brand nutritional shake three times daily.

Observation of the lunch meal on 05/08/19 at 12:13pm revealed:
-Resident #6 was in the dining room.
-Resident #6 was served nectar thickened water and tea.
-The resident was served a plated food consisting of approximately 1 and 1/4th cup of chicken that had small fibrous strands of chicken that was not in a smooth and soft consistency, approximately ½ cup of pureed green beans in a thin liquid and approximately ¾ cup of mashed potatoes that was in a smooth consistency.
-Staff assisted the resident to eat his entire lunch by providing feeding assistance throughout the meal.
-The resident did not have any coughing during the meal and ate 100 percent of the meal.

Observation of the supper meal on 05/08/19 at 5:03pm revealed:

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D 310	Continued From page 13 -Resident #6 was in the dining room. -Resident #6 was served nectar thickened water and tea. -The resident was served approximately 1 and 1/4th cup of pureed lasagna, mashed potatoes and pureed vegetables with no lumps or clumps that would require chewing. Based on observations, interviews and record review, it was determined Resident #6 was not interviewable. Interview with the cook on 05/08/19 at 5:13pm revealed: -She always used the commercial grade food processor to puree foods. -She was trained to make sure all pureed foods were mixed and blended into a smooth consistency without any clumps and should have a "whipped" texture. -She prepared the supper meal tonight (05/08/19.) Observation in the kitchen with the dietary manager (DM) on 05/09/19 at 11:20am revealed: -The DM had stored plated servings of pureed beets for the residents who had an order for a pureed therapeutic diet on a prep table in the kitchen. -The beets were in a pureed consistency surrounded by a thin liquid in one divided section of the plate. -The DM pureed hamburger patties in gravy using a commercial grade food processor. -The DM plated the hamburger patties and gravy in the prepared divided sectioned plates with the already prepared pureed beets with the thin liquids. -The hamburger and gravy had small ground pieces of hamburger and was not in a smooth	D 310		

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D 310	Continued From page 14 texture. Interview with the DM on 05/09/19 at 11:23am revealed: -She always used the food processor to puree foods when preparing food for the residents' with a physician ordered pureed diet. -She tried to make sure the pureed foods were smooth but the smoothness of the food depended on the type food being pureed. -The hamburger meat could not be pureed any smoother. -She could add more liquid, thickener or instant potatoes to the pureed hamburger meat and gravy to see if that would change the consistency of the pureed meat. -She would add a thickener such as thickener or instant mashed potatoes to the beets. Observation in the kitchen with the DM on 05/09/19 at 11:25am revealed: -The DM placed the hamburger and gravy mixture back into the food processor and added thickener and water. -The hamburger mixture was in a smooth consistency without any small ground pieces. Observation of the plated food for Resident #6 on 05/09/19 at 12:09pm revealed the beets were in a pureed, smooth consistency without any thin liquids. Telephone interview with Resident #6's primary care provider (PCP) on 05/09/19 at 2:07pm revealed: -It was important for staff to assist Resident #6 with his meals. -Resident #6 could possibly tolerate finely ground foods without difficulty if he was assisted from staff.	D 310		

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D 310	Continued From page 15 -The PCP was most concerned that all liquids including broth and juices from foods were in a nectar thick liquid because of safety concerns for Resident #6 to prevent the possibility of choking on thin liquids. Interview with the Administrator on 05/09/19 at 11:30am revealed: -She expected for dietary staff to assure all therapeutic diets were served as ordered by the primary care provider. -She last monitored the residents' meals served Monday, 05/06/19 and did not notice any issues with the residents' meals.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	D 344		

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D 344	Continued From page 16 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 2 of 5 sampled residents (Resident #1 and #5) regarding an order for an anti-coagulant, a medication to treat high cholesterol, a narcotic medication to treat pain, and a vitamin. The findings are: 1.Review of Resident #5's current FL2 dated 1/18/19 revealed diagnoses included acute encephalopathy and seizure. Review of Resident #5's Resident Register revealed an admission date of 04/10/18. Review of Resident #5's physician's orders revealed there was an order dated 04/08/19 to restart Plavix 75 mg once daily (used to reduce the risk of heart disease and stroke). Review of Resident #5's April 2019 electronic medication administration record (eMAR) revealed there was no entry for Plavix 75 mg once daily. Review of Resident #5's May 2019 electronic medication administration record (eMAR) revealed there was no entry for Plavix 75 mg once daily. Interview with Resident #5 on 05/19/19 at 8:20am revealed she did not know the exact medications that she was taking.	D 344		

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D 344	Continued From page 17 Telephone interview with Resident #5's contracted pharmacy on 05/08/19 at 12:56pm revealed: -There was no active order for Plavix in the system. -There was no order for Plavix dated 04/08/19in the system. -A manual discharge was entered into the system on 01/12/19 and 01/18/19. -Plavix was last dispensed on 08/16/18 for a quantity of 21 tablets. Observation of medication on hand for administration for Resident #5 on 05/08/19 at 12:47pm revealed there were no for Plavix 75 mg on hand. Refer to the facility process for transcribing new Physician orders. Interview with a medication aide (MA) on 05/09/19 at 11:25am revealed: -The facility used bucket the system for when new orders were received for the residents. -The MAs faxed the orders or prescriptions to the facility's pharmacy when received. -The MAs put the new order in the new order folder located on the wall in the medication rooms on each unit. -The Memory Care Coordinator (MCC) or the lead Supervisor in charge (SIC) would come and check the folders throughout the day for the new orders. -The MAs do not put the orders in the system. -If the medication from the new order did not appear on the eMAR the MAs inform the MCC and she would tell the MAs to call the pharmacy to see why the medication was missing. -If the medication order was faxed to the facility the process of the bucket system was the same	D 344		

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except the MAs from each unit would have to check that unit's folder in the front office for the faxed order.
-The front office fax folders were checked several times throughout the day for new faxes.
-If a prescription would come over and the resident was not at the facility or in the hospital, then the bucket system process was the same.
-The prescription would be faxed to the pharmacy with a cover letter which would inform the pharmacy not to send or to hold the medication.
-The pharmacy would then know not to send the medication until we asked for the medication to be sent, but the medication would be added to the resident's profile while the resident was in the hospital.

Interview with a second MA on 05/09/19 at 12:10pm revealed:
-The facility used the bucket system for processing new physician orders.
-She made a copy of the new order and placed them in the physicians' folder and the original order would go through the bucket system process.
-The only reason she could think of why an order would not have followed the bucket process would have been if there was an order from the physician to hold the medication.
-Under all other circumstances the bucket system process would have been followed.
-The MAs faxed the orders or prescriptions to the facility's pharmacy.
-The MAs put the new order in the new order folder located on the wall in the medication rooms on each unit.
-The Memory Care Coordinator (MCC) or the lead Supervisor in charge (SIC) would come and check the folders throughout the day for the new orders.

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-She did not know what to do if a medication did not show up on the eMAR.
-If the medication order was faxed to the facility the process of the bucket system was the same except the MAs from each unit would have to check that unit's folder in the front office for the faxed order.
-The front office fax folders were checked several times throughout the day for new faxes.
-If a prescription would have come over and the resident was in the hospital, then the bucket system process would be the same.
-The prescription would have still been faxed to the pharmacy with a cover letter which would inform the pharmacy to hold the medication, so the medication would still been added to the resident's profile while the resident was in the hospital, but the medication would not have been sent to the facility until the resident returned to the facility.

Review of Resident #5's record revealed there was no documentation Resident #5's provider had been contacted to validate the physician's order dated 04/08/19 to restart Plavix 75 mg once daily.

Review a Resident #5's cardiologist progress note dated 03/26/19 revealed:
-Resident #5 had a history of chronic mild dementia, multivessel coronary artery disease with a known chronic total occlusion of distal left anterior descending (LAD) and known multivessel stenting with recommendation for life long aspirin and Plavix.
-Resident #5 would continue her Plavix and aspirin for the "rest of her life due to her coronary artery disease".
-The physician wrote instructions for the facility.

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D 344	Continued From page 20 Telephone interview on 05/08/19 at 1:19pm with Resident #5's Cardiologist nurse revealed: -Per the physician's notes in the system Resident #5 had a history of having a stent placed. -Plavix 75mg daily was on Resident #5's medication list. -The resident was last seen in the office on 04/03/19. -The prescription for Plavix 75mg had been faxed to the facility on 04/08/19. -Per the physician notes the physician had not been contacted regarding Resident #5's Plavix order. -For Resident #5 the medication was used to keep her from having a stroke, a heart attack, forming a clot and dying. Interview on 05/09/19 at 10:00am with Resident #5's Primary Care Provider (PCP) revealed: -She did not know Resident #5's Plavix order had not been restarted. -She did not know Resident #5 had not taken the Plavix in a month. -She thought Resident #5 was taking the Plavix. -She was made aware of the order for the Plavix a month ago. -Plavix helped platelets from sticking together and to keep stents open which Resident #5 had. -Resident #5 had a thrombus in January 2019 and was placed on a blood thinner. -When the blood thinner was stopped the Plavix was restarted. -Missing the multiple doses of this medication could cause Resident #5 to be hospitalize with "bigger problems". -She expected to be informed of all new orders for Resident #5. Interview with the Administrator on 05/08/19 at 2:50pm revealed:	D 344		

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-Resident #5 was out of the facility on 04/07/19 with her family and was admitted to the hospital.
-Resident #5 was not in the building on 04/08/19 when the prescription for Plavix was sent.
-Resident #5 went from the hospital to a rehab facility and then returned to the facility.

Interview with the Administrator on 05/09/19 at 12:20pm revealed:
-Sometimes cover sheets were sent to the pharmacy requesting that the medication not be sent to the facility on a case by case basis.
-Resident #5 had gone to a rehab facility and she did not know if she was going to return to the facility.
2. Review of Resident #1's current FL-2 dated 01/10/19 revealed diagnoses included dementia, extremity weakness, anxiety, leukopenia, malnutrition, atrial fibrillation, rheumatoid arthritis and anemia.

a. Review of Resident #1's record revealed there was an order on 04/11/19 to discontinue Simvastatin 20 mg daily.

Review of a Physician Order Report for 03/25/19 to 04/25/19 signed by the PCP on 04/25/19 revealed an order for Simvastatin 20 mg daily.

Review of Resident #1's April 2019 medication administration record (MAR) revealed there was documentation Simvastatin 20 mg was administered at 8:00pm from 04/01/19 - 04/30/19.

Review of Resident #1's May 2019 MAR revealed there was documentation Simvastatin 20 mg was administered at 8:00pm from 05/01/19 - 05/06/19.

Review of Resident #1's medications on hand on 05/07/19 at 10:00am revealed there was no

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D 344	Continued From page 22 Simvastatin in the medication cart. Review of the pharmacy dispensing record for Resident #1 revealed that Simvastatin 20 mg was last re-filled on 03/14/19 for a supply of 28 tablets. Interview with a pharmacist at the facility's pharmacy on 05/07/19 at 12:47pm revealed: -An order for Resident #1, dated 04/11/19, was faxed to the pharmacy to discontinue Simvastatin 20 mg daily. -They had not received any additional orders for Simvastatin 20 mg daily -The pharmacy discontinued the medications in the electronic MAR (eMAR) system and they were removed from the MAR at the pharmacy side. -The facility had to discontinue the medications in the eMAR as well, so the medications would be removed from appearing on the MAR at the facility side. -There had been problems with this situation with the new eMAR at the facility. Refer to interview with a Medication Aide (MA) on 05/07/19 at 10:04am. Refer to the facility process for transcribing new Physician orders. Refer to the interview with the Administrator on 05/09/19 at 10:45am. b. Review of Resident #1's record revealed there was an order on 04/11/19 to discontinue Hydrocodone-acetaminophen 5-325 mg tablet three times a day as needed for pain. Review of Resident #1's April 2019 medication	D 344		

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administration record (MAR) revealed there was documentation Hydrocodone-acetaminophen 5-325 mg tablet was administered at 12:42pm on 04/11/19.

Review of Resident #1's May 2019 MAR revealed there was an entry that Hydrocodone-acetaminophen 5-325 mg tablet three times a day as needed for pain was a current order, but no documentation that Hydrocodone-acetaminophen 5-325 mg tablet was administered.

Review of Resident #1's medications on hand on 05/07/19 at 10:00am revealed there was no Hydrocodone-acetaminophen 5-325 mg in the medication cart.

Review of the pharmacy dispensing record for Resident #1 revealed that Hydrocodone-acetaminophen 5-325 mg was last re-filled on 04/07/19 for a supply of 9 tablets.

Review of a Physician Order Report for 03/25/19 to 04/25/19 signed by the PCP on 04/25/19 revealed an order for Hydrocodone-acetaminophen 5-325 mg tablet three times a day as needed for pain.

Interview with a pharmacist at the facility's pharmacy on 05/07/19 at 12:47pm revealed:
-An order for Resident #1, dated 04/11/19, was faxed to the pharmacy to discontinue Hydrocodone-acetaminophen 5-325 mg tablet three times a day as needed for pain.
-They had not received any additional orders for the Hydrocodone-acetaminophen 5-325 mg.
-The pharmacy discontinued the medications in the electronic MAR (eMAR) system and they were removed from the MAR at the pharmacy

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side.
-The facility had to discontinue the medications in the eMAR as well, so the medications would be removed from appearing on the MAR at the facility side.
-There had been problems with this situation with the new eMAR at the facility.

Refer to interview with a Medication Aide (MA) on 05/07/19 at 10:04am.

Refer to the facility process for transcribing new Physician orders.

Refer to the interview with the Administrator on 05/09/19 at 10:45am.

c. Review of Resident #1's record revealed there was an order on 04/18/19 to discontinue Vitamin B12 1,000 mcg daily.

Review of Resident #1's April 2019 MAR revealed there was documentation Vitamin B12 1,000 mcg was administered at 8:00am from 04/01/19 - 04/30/19.

Review of Resident #1's May 2019 MAR revealed there was documentation Vitamin B12 1,000 mcg was administered at 8:00am from 05/01/19 - 05/06/19.

Review of Resident #1's medications on hand on 05/07/19 at 10:00am revealed there was no Vitamin B12 in the medication cart.

Review of the pharmacy dispensing record for Resident #1 revealed that Vitamin B12 was last re-filled on 03/28/19 for a supply of 28 tablets.

Review of a Physician Order Report for 03/25/19

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D 344	Continued From page 25 to 04/25/19 signed by the PCP on 04/25/19 revealed an order for Vitamin B12 1,000 mcg daily. Interview with a pharmacist at the facility's pharmacy on 05/07/19 at 12:47pm revealed: -An order for Resident #1, dated 04/18/19, was faxed to the pharmacy to discontinue Vitamin B12 1,000 mcg daily. -They had not received any additional orders for the Vitamin B12 1,000 mcg daily. -The pharmacy discontinued the medication in the electronic MAR (eMAR) system and they were removed from the eMAR at the pharmacy side. -The facility had to discontinue the medications in the eMAR as well, so the medications would be removed from appearing on the eMAR at the facility side. -There had been problems with this situation with the new eMAR at the facility. Refer to interview with a Medication Aide (MA) on 05/07/19 at 10:04am. Refer to the facility process for transcribing new Physician orders. Refer to the interview with the Administrator on 05/09/19 at 10:45am. _____ Interview with a Medication Aide (MA) on 05/07/19 at 10:04am revealed: -When the primary care provider (PCP) wrote a new medication order, the MA would fax it to the pharmacy. -The pharmacy would transcribe the order in the eMAR. -The Memory Care Coordinator (MCC), the lead Supervisor in charge (SIC), or the Administrator	D 344		

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would transcribe the order in the eMAR as well on the facility side.
-If the order was not transcribed on the facility side, it would still appear on the eMAR but the pharmacy would not see it on their end.

Review of the facility process for transcribing new Physician orders revealed the orders were placed in the following buckets as each step was completed:
-Bucket #1 -The new physician order had been faxed to the pharmacy by the MA and waiting for the order to appear in the eMAR.
-Bucket #2 -The new order appeared in eMAR and was waiting for the medication to arrive from pharmacy.
-Bucket #3 -The medications had not been delivered because the order may had been incomplete, required physician clarification, needed a hard copy because of a controlled medication or required prior authorization by the physician.
-Bucket #4 -The order required follow-up by the facility with another clinical or support service group, because it was a non-medication order such as labs, diet, oxygen therapy or other miscellaneous order.
-Bucket #5 -The order had been processed and medications received or the physician order had been implemented and the order can be filed in the resident record.

Interview with the Administrator on 05/09/19 at 10:45am revealed:
-She was not aware that some PCP medication orders appeared in the eMAR viewed by the facility but not in the eMAR viewed by the pharmacy.
-There had been issues with the new eMAR system and they were trying to work on them with

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	HAL025035	A. BUILDING: _____ B. WING _____	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS OF TRENT	2915 BRUNSWICK AVENUE NEW BERN, NC 28562

(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 344	Continued From page 27 the Pharmacy. -The MCC, SIC or she approved new orders entered by the pharmacy in the eMAR once they compared them with the PCP order, but she thought it was being updated in the eMAR at the facility side. -They used a "bucket" system to complete orders. -The MAs were responsible for daily medication cart audits. -She would immediately investigate the issue with the pharmacy and the new eMAR company _____ The facility's failure to assure clarification of a medication used to help prevent blood platelets from sticking together and prevent blood clots for Resident #5 who had a known history of a cardiac stent, coronary artery disease with a known chronic total occlusion with recommendation for life long aspirin and Plavix use and a recent thrombus resulted in the resident not receiving the medication for 17 days which placed the resident at increased risk for a stroke, heart attack , clot formation and possible death. The facility's failure was detrimental to the health, safety, and welfare of Resident #5 and constitutes a Type B Violation. _____ A Plan of Protection (POP) was submitted by the facility in accordance with G.S. 131D-34 on 05/09/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 23, 2019.	D 344		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 367		

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D 367	Continued From page 28 (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records were accurate and complete for 1 of 5 residents sampled (#1) who was taking a medication to treat high cholesterol, a narcotic medication to treat pain, and a vitamin. The findings are: Review of Resident #1's current FL-2 dated	D 367		

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01/10/19 revealed diagnoses included dementia, extremity weakness, anxiety, leukopenia, malnutrition, atrial fibrillation, rheumatoid arthritis and anemia.

a. Review of Resident #1's current FL-2 dated 01/10/19 revealed there was an order for Simvastatin 20 mg daily.

Review of Resident #1's record revealed there was an order on 04/11/19 to discontinue Simvastatin 20 mg daily.

Review of Resident #1's April 2019 medication administration record (MAR) revealed there was documentation Simvastatin 20 mg was administered at 8:00pm from 04/01/19 - 04/30/19.

Review of Resident #1's May 2019 MAR revealed there was documentation Simvastatin 20 mg was administered at 8:00pm from 05/01/19 - 05/06/19.

Observation of Resident #1's medications on hand on 05/07/19 at 10:00am revealed there was no Simvastatin in the medication cart.

Review of the pharmacy dispensing record for Resident #1 revealed Simvastatin 20 mg was last re-filled on 03/14/19 for a supply of 28 tablets.

Interview with a pharmacist at the facility's pharmacy on 05/07/19 at 12:47pm revealed:
-An order for Resident #1, dated 04/11/19, was faxed to the pharmacy to discontinue Simvastatin 20 mg daily.
-The pharmacy discontinued the medication in the electronic MAR (eMAR) system and it was removed from the MAR at the pharmacy side.
-The facility had to discontinue the medication in the eMAR as well, so the medication would be

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removed from appearing on the MAR at the facility side.
-There had been problems with this situation with the new eMAR at the facility.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

Interview with a Medication Aide (MA) on 05/07/19 at 10:04am revealed:
-The Simvastatin 20mg was discontinued on 04/11/19 and was not given after that date.
-She was not sure why it was documented in the eMAR as given.
-When the primary care provider (PCP) wrote a medication order, the MA would fax it to the pharmacy.
-The pharmacy would transcribe the order in the eMAR.
-The Memory Care Coordinator (MCC), the lead Supervisor in charge (SIC), or the Administrator would transcribe the order in the eMAR as well on the facility side.
-If the order was not transcribed on the facility side, it would still appear on the eMAR but the pharmacy would not see it on their end.

Refer to the facility process for transcribing new provider orders.

Refer to interview with the Administrator on 05/09/19 at 10:45am.

b. Review of Resident #1's current FL-2 dated 01/10/19 revealed there was an order for Hydrocodone-acetaminophen 5-325 mg tablet three times a day as needed for pain.

Review of Resident #1's record revealed there

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D 367	Continued From page 31 was an order on 04/11/19 to discontinue Hydrocodone-acetaminophen 5-325 mg tablet three times a day as needed for pain. Review of Resident #1's April 2019 medication administration record (MAR) revealed there was documentation Hydrocodone-acetaminophen 5-325 mg tablet was administered at 12:42pm on 04/11/19. Review of Resident #1's May 2019 MAR revealed there was an entry that Hydrocodone-acetaminophen 5-325 mg tablet three times a day as needed for pain was a current order, but no documentation that Hydrocodone-acetaminophen 5-325 mg tablet was administered. Observation of Resident #1's medications on hand on 05/07/19 at 10:00am revealed there was no Hydrocodone-acetaminophen 5-325 mg in the medication cart. Review of the pharmacy dispensing record for Resident #1 revealed Hydrocodone-acetaminophen 5-325 mg was last re-filled on 04/07/19 for a supply of 9 tablets. Interview with a pharmacist at the facility's pharmacy on 05/07/19 at 12:47pm revealed: -An order for Resident #1, dated 04/11/19, was faxed to the pharmacy to discontinue Hydrocodone-acetaminophen 5-325 mg tablet three times a day as needed for pain. -The pharmacy discontinued the medication in the electronic MAR (eMAR) system and it was removed from the MAR at the pharmacy side. -The facility had to discontinue the medication in the eMAR as well, so the medication would be removed from appearing on the MAR at the facility side.	D 367		

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-There had been problems with this situation with the new eMAR at the facility.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

Interview with a Medication Aide (MA) on 05/07/19 at 10:04am revealed:
-The Hydrocodone-acetaminophen 5-325 mg was discontinued on 04/11/19 and was not given after that date.
-She was not sure why it was documented in the eMAR as given.
-When the primary care provider (PCP) wrote a medication order, the MA would fax it to the pharmacy.
-The pharmacy would transcribe the order in the eMAR.
-The Memory Care Coordinator (MCC), the lead Supervisor in charge (SIC), or the Administrator would transcribe the order in the eMAR as well on the facility side.
-If the order was not transcribed on the facility side, it would still appear on the eMAR but the pharmacy would not see it on their end.

Refer to the facility process for transcribing new provider orders.

Refer to interview with the Administrator on 05/09/19 at 10:45am.

c. Review of Resident #1's current FL-2 dated 01/10/19 revealed there was an order for Vitamin B12 1,000 mcg daily.

Review of Resident #1's record revealed there was an order on 04/18/19 to discontinue Vitamin B12 1,000 mcg daily.

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D 367	Continued From page 33 Review of Resident #1's April 2019 medication administration record (MAR) revealed there was documentation Vitamin B12 1,000 mcg was administered at 8:00am from 04/01/19 - 04/30/19 Review of Resident #1's May 2019 MAR revealed there was documentation Vitamin B12 1,000 mcg was administered at 8:00am from 05/01/19 - 05/06/19. Observation of Resident #1's medications on hand on 05/07/19 at 10:00am revealed there was no Vitamin B12 in the medication cart. Review of the pharmacy dispensing record for Resident #1 revealed Vitamin B12 was last re-filled on 03/28/19 for a supply of 28 tablets. Interview with a pharmacist at the facility's pharmacy on 05/07/19 at 12:47pm revealed: -An order for Resident #1, dated 04/18/19, was faxed to the pharmacy to discontinue Vitamin B12 1,000 mcg daily. -The pharmacy discontinued the medication in the electronic MAR (eMAR) system and it was removed from the MAR at the pharmacy side. -The facility had to discontinue the medication in the eMAR as well, so the medication would be removed from appearing on the MAR at the facility side. -There had been problems with this situation with the new eMAR at the facility. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Interview with a Medication Aide (MA) on 05/07/19 at 10:04am revealed:	D 367		

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D 367	Continued From page 34 -The Vitamin B12 was discontinued on 04/18/19 and was not given after that date. -She was not sure why it was documented in the eMAR as given. -When the primary care provider (PCP) wrote a medication order, the MA would fax it to the pharmacy. -The pharmacy would transcribe the order in the eMAR. -The Memory Care Coordinator (MCC), the lead Supervisor in charge (SIC), or the Administrator would transcribe the order in the eMAR as well on the facility side. -If the order was not transcribed on the facility side, it would still appear on the eMAR but the pharmacy would not see it on their end. Refer to the facility process for transcribing new provider orders. Refer to interview with the Administrator on 05/09/19 at 10:45am. Review of the facility process for transcribing new provider orders revealed the orders were placed in the following buckets as each step was completed: -Bucket #1 - The new PCP order had been faxed to the pharmacy by the MA and waiting for the order to appear in the eMAR. -Bucket #2 - The new order appeared in eMAR and waiting for the medication to arrive from pharmacy. -Bucket #3 - The medications had not been delivered because the order may had been incomplete, required PCP clarification or needed a hard copy because of a controlled medication. -Bucket #4 - The order required follow-up because it was a non-medication order such as labs, diet, oxygen therapy or other miscellaneous	D 367		

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D 367	Continued From page 35 order. -Bucket #5 - The order had been processed and medications received or the PCP order had been implemented and the order can be filed in the resident record. Interview with the Administrator on 05/09/19 at 10:45am revealed: -She was not aware that some medication orders appeared in the eMAR viewed by the facility but not in the eMAR viewed by the pharmacy. -There had been issues with the new eMAR system and they were trying to work on them with the Pharmacy. -There was a possibility with the new eMAR system that the MA could sign off all medications as given rather than signing off each individual medication as they were given. -The MCC, SIC or she approved new orders entered by the pharmacy in the eMAR once they compared them with the PCP order, but she thought it was being updated in the eMAR at the facility side. -They used a "bucket" system to complete orders. -The MAs were responsible for daily medication cart audits. -She would immediately investigate the issue with the pharmacy and the new eMAR company.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 36 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication orders and housekeeping and furnishings. 1. Based on observations, interviews, and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 2 of 5 sampled residents (Resident #1 and #5) regarding an order for an anti-coagulant, a medication to treat high cholesterol, a narcotic medication to treat pain, and a vitamin. [Refer to Tag D0344 10A NCAC 13F .1002(a) Medication Orders (Type B Violation).] 2. Based on observations and interviews, the facility failed to assure the facility was free of obstructions and hazards as evidenced by detachable/handheld shower head fixtures with a long looped flexible hose dangling directly over and ten inches from the toilets in all residents' shared restrooms in the Special Care Unit (SCU). [Refer to Tag D0079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation).]	D912		