STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051062	A. BUILDING: _____ B. WING _____	R 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(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 conducted a follow up survey on July 22, 2019 - July 24, 2019.	{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: Based on observations, record reviews, and interviews, the facility failed to notify the primary care provider (PCP) for 1 of 3 sampled residents (#1) that an anti-flammatory medication was not administered as ordered; and to arrange home health services for wound care for one of 3 sampled residents (#2). The findings are: 1. Review of Resident #2's current FL-2 dated 06/03/19 revealed: -Diagnoses included dementia, hypertension constipation, insomnia, gastroesophageal reflux disease, vitamin D deficiency, chronic obstructive pulmonary disease, major depressive disorder, acute pain, nausea, other seasonal allergies, bipolar disorder, hypercholesterolemia, anxiety, heartburn, chronic pain syndrome, throat pain, generalized arthritis and fibromyalgia. -The resident was intermittently disoriented.	{D 273}		

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{D 273}	Continued From page 1 Interview with Resident #2 on 07/23/19 at 11:29 revealed: -She had to be seen at the local emergency department (ED) in June 2019 for an injury that occurred to her leg. -She was walking behind her roommate helping her to propel her wheelchair. -She had her oxygen tank that she was pushing along with her. -Another resident stopped abruptly in front of her and her roommate which caused her to bump her leg against the oxygen cylinder valve and injured her right leg. -She was sent the ED and required stitches for the wound. -She did not remember a nurse coming out to see her for the care of the wound to her leg. -The primary care provider (PCP) removed the stitches at the facility. -The wound healed as far as she knew without any problems. -She was currently receiving home health services for physical therapy but because of leg pain her therapy was on hold. Review of an After Visit Summary from a local ED for Resident #2 dated 06/23/19 revealed: -The resident was seen for a leg laceration and diagnosed with an open wound of the leg. -The resident was to return to the ED for suture removal seven days from the injury or follow-up with the PCP for removal. Review of a physician's order written by Resident #2's PCP on a "Physician Visit Summary" dated 06/24/19 revealed there was an order to start skilled nursing for right leg wound. Telephone interview with the Assistant Clinical	{D 273}		

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{D 273}	Continued From page 2 Director with Resident #2's home health agency on 07/24/19 at 8:38am revealed: -The resident had received services from the agency off and on since 2018. -A referral came into the office on 06/17/19 for physical therapy, occupational therapy and speech therapy but skilled nursing was not included on the referral. -There had been no referrals made for skilled nursing for a right leg wound on or around 06/24/19. Telephone interview with Resident #2's PCP on 07/24/19 at 4:48pm revealed: -She was not aware skilled nursing was never contacted for the care of Resident #2's leg wound, but she removed the stitches from Resident #2's leg wound earlier this month (July 2019). -She would have expected the facility staff to have contacted a home health agency for skilled nursing services for monitoring and care of the resident's leg wound at the time the order was written. -It was the responsibility of the facility to contact with home health agencies when a referral order was given. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 5:20pm and 6:00pm revealed: -She was not aware of a referral for Resident #2 to receive skilled nursing services for Resident #2's leg wound from June 2019. -She was responsible for processing residents' orders and referrals. -Resident #2 had stitches so she could not understand why the resident would have needed a nurse for wound care.	{D 273}		

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{D 273}	Continued From page 3 Interview with the Executive Director (ED) on 07/24/19 at 6:00pm revealed: -She was not aware of referral order for skilled nursing for Resident #2. -She expected for all residents' orders to be processed and completed as ordered by the RCC. 2. Review of Resident #1's current FL-2 dated 06/17/19 revealed diagnoses included anxiety, hypertension, diabetes mellitus type II, restless leg syndrome (RLS), neurogenic bladder, suprapubic catheter, and hip pain. -The resident was intermittently disoriented. -The resident required personal care assistance with bathing and dressing. -The resident was semi-ambulatory. -The resident had an indwelling catheter. Review of a hospital Visit Summary dated 07/11/19 for Resident#1 revealed there was a medication order for Prednisone 20 mg tablets take two tablets (40 mg) two times a day for three days for a chronic obstructive pulmonary disease (COPD). (Prednisone is a medication used to decrease inflammation and help people recover from COPD). Review of the July 2019 Medication Administration Record (MAR) for Resident #1 revealed there was an entry for Prednisone documented as administered at 8:00am and 8:00pm on the following days, 07/12/19, 07/13/19, and 07/14/19. Interview with the ED, the Resident Care Coordinator (RCC), and a MA on 07/23/19 at 05:00pm revealed: -The ED had a system in place where the MAs were monitoring medication administration and	{D 273}		

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{D 273}	Continued From page 4 transcription of each other along with the RCC. -The ED terminated a MA last Monday, 07/15/19 when informed by another MA via text message that the entire Prednisone regimen was not given to Resident #1. -The MA observed the other MA had documented the Prednisone was administered on the MAR; however; she observed the medication, Prednisone, was still present in the blister pack. -The ED received a picture of the July 2019 MAR for Resident #1 and the Prednisone pack via text message from the MA. -The primary care provider (PCP) was not notified that Resident #1 did not receive a dose of Prednisone, no additional information was provided. Telephone Interview with the PCP for Resident #1 on 07/24/19 on 04:48pm revealed: -She had not been notified by the facility that Resident #1 did not receive a 40 mg dose of her ordered Prednisone. -The PCP's expectations were the facility staff should have notified her that Resident #1 did not receive the Prednisone ordered on 07/11/19 and all medications should be administered as ordered. -There was the possibility of negative outcomes due to the facility's failure to assure Resident #1 received the Prednisone as ordered, including the continuation of breathing problems such as shortness of breath or a re-admission to the hospital. -The PCP was aware that Resident #1 was hospitalized from 07/09/19-07/11/19 for an exacerbation of COPD. Second interview with the ED on 07/24/19 at 4:30pm revealed: -Her expectations were to assure the	{D 273}		

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{D 273}	Continued From page 5 administration of medications by staff in accordance with PCP's orders. -Her expectations for the facility staff were to follow these 7 steps: right resident, right route, right reason, right frequency, right site, right drug, and right time. -She also expected the MAs to communicate any medication changes with the RCC.	{D 273}		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have matching therapeutic menus for food service guidance for 2 of 3 sampled residents with physician orders for a heart healthy and consistent carbohydrate diet (#1) and a no concentrated sweets (NCS) diet (#4). The findings are: 1. Review of Resident #1's current FL-2 dated 06/17/19 revealed: -Diagnoses included anxiety, hypertension, diabetes mellitus type II, restless leg syndrome (RLS), neurogenic bladder, suprapubic catheter, and hip pain. -The resident was intermittently disoriented. -There was an order for a low salt, diabetic diet.	D 296		

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D 296	Continued From page 6 Review of a hospital discharge summary for Resident #1 dated 07/11/19 revealed: -There were diet instructions for a heart healthy and consistent carbohydrate diet. -Resident #1's hemoglobin A1C laboratory (lab) result was elevated at 8% (Reference range is 4-5.6%) which meant her diabetes had not been well controlled; it was important to maintain a healthy diet. (A hemoglobin A1C is a blood test to determine the control and average of blood sugar levels over a 3 month period). -There was an order to increase Metformin dosage to 1000 mg twice daily. (Metformin is a medication used for diabetics to treat and control high blood sugars). Interview with Resident #1 on 07/22/19 at 10:55am revealed: -She was a diabetic "but it wasn't on the book for a while" and all of a sudden diabetes "pops up". -Staff checked her fingerstick blood sugar (FSBS) "about every morning". -She was not sure what the readings of her FSBS had been. Review of a Blood Sugar Monitoring document for Resident#1 revealed: -There was a FSBS result of 130 on 07/02/19. -There was a FSBS result of 153 on 07/09/19. -There was a FSBS result of 121 on 07/16/19. -There was a FSBS result of 137 on 07/23/19. Review of a therapeutic diet list posted in the facility's kitchen revealed Resident #1 was on an NCS diet. Review of a "Menus" "Week 1, Monday" form posted in the dining room revealed: -The lunch meal consisted of 1 cup of chili with a	D 296		

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D 296	Continued From page 7	D 296		

cornbread muffin, 1 cup of side salad, 2 tablespoons of dressing and pineapple in a congealed salad with cool whip.
-The menu was not labeled for a specific diet.

Observation of the lunch meal service on 07/22/19 at 12:05pm - 12:28pm revealed:
-Resident #1 was served one cup of chili with beans, one cornbread muffin, one cup of salad with dressing with 2 ½ tablespoons of ranch dressing, ¾ cup pineapple in a red colored gelatin, 12 ounces of water and 16 ounces of tea.
-Resident #1 ate 90 percent of her meal.

Interview with the medication aide/personal care aide (MA/PCA) that served Resident #1 the lunch meal on 07/22/19 at 12:24pm revealed:
-Resident #1 was a diabetic and on a diabetic diet.
-The residents' meals were prepared in another building and brought over in large containers.
-Staff plated the residents' food prior to serving.

Review of the Review of a "Menus" "Week 1, Tuesday" form posted in the dining room revealed:
-The lunch meal consisted of 2-3 ounces of baked ham, ½ cup of scalloped potatoes, ½ cup of baked apples and a roll.
-The menu was not labeled for a specific diet.

Observation of the lunch meal service on 07/23/19 at 12:23pm - 1230pm revealed:
-Resident #1 was served 2 round pieces of ham, ½ cup of scalloped potatoes, and ½ cup of baked apples with cinnamon, unsweet tea and water.
-Resident #1 ate approximately 90% of her meal.

Interview with the cook on 07/23/19 at 1:20pm revealed:

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D 296	Continued From page 8 -Resident #1 was a diabetic. -She did not have a therapeutic diet menu to guide her when she was preparing meals for Resident #1. -When she prepared diabetic meals, she would serve no sweets, sugar free foods, "stuff like that". Telephone interview with Resident #1's primary care provider (PCP) on 07/24/19 at 4:48pm revealed: -It was important for Resident #1 to follow the ordered diet. -Resident #1 was on a diet to control diabetes and if the diet was not followed as ordered there was a potential the resident's blood sugars would be elevated. -If the resident's blood sugars were elevated because of a diet order not followed then it could have potentially led to medication adjustments to control the elevated blood sugars when medication adjustments might not have been needed. Refer to the interview with the Executive Director (ED) on 07/22/19 at 11:35am. Refer to the interview with the cook on 07/22/19 at 12:52pm. Refer to a second interview with the cook on 07/22/19 at 1:00pm. Refer to the interview with the cook on 07/23/19 at 1:20pm. Refer to the telephone interview with the Registered Dietician (RD) on 07/24/19 at 10:25am.	D 296		

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D 296	Continued From page 9 Refer to the interview with the ED on 07/24/19 at 10:36am and 4:25pm. 2. Review of Resident #4's current FL-2 dated 02/20/19 revealed: -Diagnoses included schizophrenia, hypoglycemia. hypertension, diabetes mellitus type 2, vitamin D deficiency, gastroesophageal reflux disease, reflux esophagitis and allergic rhinitis. -There was an order for a no concentrated sweets (NCS) diet. -There was an order to check fingerstick blood sugars (FSBS) weekly. Interview with Resident #4 on 07/22/19 at 12:22pm revealed: -She was a diabetic. -She was on Metformin and Insulin at one time but no longer had to take either one of those medications. (Metformin and insulin are medications used for diabetics to treat and control high blood sugars). -She was on a diabetic diet to control her blood sugar levels. Review of therapeutic diet list posted in the facility's kitchen revealed Resident #4 was on an NCS diet. Review of a "Menus" "Week 1, Monday" form posted in the dining room revealed: -The lunch meal consisted of 1 cup of chili with a cornbread muffin, 1 cup of side salad, 2 tablespoons of dressing and pineapple in a congealed salad with cool whip. -The menu was not labeled for a specific diet. Observation of the lunch meal service on 07/22/19 at 12:05pm revealed:	D 296		

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D 296	Continued From page 10 -Resident #4 was served one cup of chili with beans, one cornbread muffin, one cup of salad with dressing with 2 ½ tablespoons of ranch dressing, ¾ cup pineapple in a red colored gelatin, 12 ounces of water and 16 ounces of unsweet tea. -Resident #4 ate approximately 95 percent of the meal and ate 100 percent of the gelatin and fruit served. Interview with the MA/PCA that served Resident #4 the lunch meal on 07/22/19 at 12:24pm revealed: -She knew Resident #4 was a diabetic and on a diabetic diet. -The residents' meals were prepared in another building and brought over in large containers. -Staff plated the residents' food prior to serving. Review of the Review of a "Menus" "Week 1, Tuesday" form posted in the dining room revealed: -The lunch meal consisted of 2-3 ounces of baked ham, ½ cup of scalloped potatoes, ½ cup of baked apples and a roll. -The menu was not labeled for a specific diet. Observation of the lunch meal service on 07/23/19 at 12:23pm - 1230pm revealed: -Resident #4 was served 2 round pieces of ham, ½ cup of scalloped potatoes, and ½ cup of baked apples with cinnamon, unsweet tea and water. -Resident #4 ate all her food except for the 2 slices of ham. Review of Resident #4's "Blood Sugar Monitoring" form revealed there was documentation the resident's FSBS was 135mg/dl on 07/03/19, 138mg/dl on 07/10/19 and 144mg/dl on 07/24/19.	D 296		

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Interview with the cook on 07/23/19 at 1:20pm revealed:
-Resident #4 was a diabetic.
-She did not have a therapeutic diet menu to guide her when she was preparing meals for Resident #4
-When she prepared diabetic meals, she would serve no sweets, sugar free foods, "stuff like that".

Telephone interview with Resident #4's primary care provider (PCP) on 07/24/19 at 4:48pm revealed:
-It was important for Resident #4 to follow the ordered diet.
-Resident #4 was on a diet to control diabetes and if the diet was not followed as ordered there was a potential blood the resident's blood sugars would be elevated.
-If the resident's blood sugars were elevated because an order was not followed for a specific diabetic diet then it could have potentially led to medication adjustments to control the elevated blood sugars when medication adjustments might not need have been needed.

Refer to the interview with the Executive Director (ED) on 07/22/19 at 11:35am.

Refer to the interview with the cook on 07/22/19 at 12:52pm.

Refer to a second interview with the cook on 07/22/19 at 1:00pm.

Refer to the interview with the cook on 07/23/19 at 1:20pm.

Refer to the telephone interview with the Registered Dietician (RD) on 07/24/19 at

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D 296	Continued From page 12 10:25am. Refer to the interview with the ED on 07/24/19 at 10:36am and 4:25pm Interview with the Executive Director (ED) on 07/22/19 at 11:35am revealed: -The facility currently did not have any therapeutic menus prepared by a registered dietician (RD). -She noticed when she first started working at the facility the foods on the menu were the same menus every week. -The facility owner recently purchased menu cycles for 3 weeks that included what foods would be served during each meal daily with the serving size for each food to be served. -She was planning to meet with the RD to request therapeutic diets from the RD but was trying to allow time to see which foods the residents liked or disliked from the menus that had been purchased. -She had researched online what type of foods needed to be served to diabetic residents until the therapeutic menu diets could be obtained from the RD. Interview with the cook on 07/22/19 at 12:52pm revealed: -She had worked as the cook preparing the residents' meals for approximately 2 weeks. -No salt was used when she cooked the residents' foods. Second interview with the cook on 07/22/19 at 1:00pm revealed: -She did not have a therapeutic diet menu to go by in order to prepare the residents meals. -She had not been given any specific instructions or guidelines from the ED to prepare the residents' meals.	D 296		

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D 296	Continued From page 13 Interview with the cook on 07/23/19 at 1:20pm revealed: -She determined who was a diabetic and who was not when she prepared the residents' meals by looking at the residents' diagnoses listed on the medication administration records (MARS). -The Resident Care Coordinator (RCC) or the ED would let her know what diets the residents were ordered or when a diet changed; "whatever they tell me, that's what I do." -The ED had not given her any additional information on how to prepare therapeutic meals. Telephone interview with the RD on 07/24/19 at 10:25am revealed: -When she completed the menus for the previous ED, she thought there were no therapeutic diets for any of the residents. -She had spoken with the current ED yesterday, (07/23/19) who notified her that the facility needed a therapeutic diet for a NCS and a NAS diet. -She sent the facility a rough draft copy of an NCS diet yesterday (07/23/19) to go by until she submitted a completed NCS menu spreadsheet. -She had concerns when too much starches were served to residents every day. -She had concerns when too many sweets and foods high in sugar content were served to residents which could raise the residents' blood sugar and make them more insulin resistant. - Salt intake was important for health reasons because increased salt intake could affect a resident by causing too much fluid which could lead to affecting the resident's heart and kidneys. Interview with the ED on 07/24/19 at 10:36am and 4:25pm revealed: -She was aware when a primary care provider	D 296		

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D 296	Continued From page 14 (PCP) ordered a therapeutic diet that a therapeutic spreadsheet was needed by a RD for the diet ordered. -She was aware a therapeutic menu by a RD was required for each diet offered at the facility. -She had obtained a therapeutic diet menu from the RD for an NCS diet for the cook on 07/23/19 to follow and had met with the cook about the therapeutic diet menu received from the RD. -She was planning to have the PCP review the diets for all the residents.	D 296		
{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 3 residents sampled who was diagnosed with diabetes mellitus type 2 and had a physician's orders for a no concentrated sweets (NCS) diet (#4). The findings are: Review of Resident #4's current FL-2 dated 02/20/19 revealed: -Diagnoses included schizophrenia, hypoglycemia. hypertension, diabetes mellitus type 2, vitamin D deficiency, gastroesophageal reflux disease, reflux esophagitis and allergic rhinitis. -There was an order for a no concentrated	{D 310}		

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{D 310}	Continued From page 15	{D 310}		

sweets (NCS) diet.
-There was an order to check fingerstick blood sugars (FSBS) weekly.

Interview with Resident #4 on 07/22/19 at 12:22pm revealed:
-She was a diabetic.
-She was on Metformin and Insulin at one time but no longer had to take either one of those medications. (Metformin and insulin are medications used for diabetics to treat and control high blood sugars).
-She was on a diabetic diet to control her blood sugar levels.

Review of therapeutic diet list posted in the facility's kitchen revealed Resident #4 was on an NCS diet.

Review of a "Menus" "Week 1, Monday" form posted in the dining room revealed:
-The lunch meal consisted of 1 cup of chili, a cornbread muffin, 1 cup of side salad, 2 tablespoons of dressing and pineapple in a congealed salad with cool whip (no serving size listed).
-The menu was not labeled for a specific therapeutic diet.

Observation of the lunch meal service on 07/22/19 at 12:05pm revealed:
-Resident #4 was served one cup of chili with beans, one cornbread muffin, one cup of salad with dressing with 2 ½ tablespoons of ranch dressing, ¾ cup pineapple in a red colored gelatin, 12 ounces of water and 16 ounces of unsweet tea.
-Resident #4 ate approximately 95 percent of the meal and ate 100 percent of the gelatin and fruit served.

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{D 310}	Continued From page 16 Interview with Resident #4 on 07/22/19 at 12:22pm revealed she could not drink sweet tea because it made her "sugar go up". Observation in the refrigerator on 07/22/19 at 10:36am revealed there was a large pitcher labeled unsweetened tea and a second pitcher labeled "Sweet tea" with a labeled date of 07/22/19 on both pitchers. Interview with a medication aide/personal care aide (MA/PCA) that served Resident #4 the lunch meal on 07/22/19 at 12:24pm revealed: -She knew Resident #4 was a diabetic and on a diabetic diet. -The residents' meals were prepared in another building and brought over in large containers and staff in the facility plated the residents' food prior to serving each resident. Interview with the cook on 07/22/19 at 12:52pm revealed: -She had worked as the cook preparing the residents' meals for approximately 2 weeks. -The residents were served cherry or strawberry flavored gelatin today, (07/22/19) for the lunch meal. -She had already disposed of the box of gelatin but had the "same exact" kind in a different flavor that was used for the lunch meal today, (07/22/19). Review of the label for the gelatin served during the lunch meal on 07/22/19 revealed: -There were no artificial sweeteners and no high fructose corn syrup. -In the labeled ingredients, sugar was the first listed ingredient. -There was 19 grams of sugar in a ½ cup serving.	{D 310}		

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{D 310}	Continued From page 17 Second interview with the cook on 07/22/19 at 1:00pm revealed: -She thought no high fructose corn syrup on the labeled information on the box of gelatin meant there was no added sugar and would be okay to serve to a diabetic resident. -She did not notice sugar was the first labeled ingredient in the gelatin served to the residents' during the lunch meal on 07/22/19. -She thought the labeled information on the gelatin box meant the gelatin was sugar free. -She had not noticed in the ingredients section that sugar was the first ingredient listed. -She did not have a therapeutic diet menu to go by in order to prepare the residents meals. -She had not been given any specific instructions or guidelines from the Executive Director (ED) to prepare the residents meals. -A NCS diet meant she would not add sugar to the food. Review of the Review of a "Menus" "Week 1, Tuesday" form posted in the dining room revealed: -The lunch meal consisted of 2-3 ounces of baked ham, ½ cup of scalloped potatoes, ½ cup of baked apples and a roll. -The menu was not labeled for a specific diet. Observation of the lunch meal service on 07/23/19 at 12:23pm - 1230pm revealed: -The resident was served 2 round pieces of ham, approximately ½ cup of scalloped potatoes, and approximately ½ cup of baked apples with cinnamon, unsweet tea and water. -The resident ate all her food except for the 2 slices of ham. Review of Resident #4's "Blood Sugar Monitoring"	{D 310}		

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{D 310}	Continued From page 18	{D 310}		

form revealed there was documentation the resident's FSBS was 135mg/dl on 07/03/19, 138mg/dl on 07/10/19 and 144mg/dl on 07/24/19.

Interview with the cook on 07/23/19 at 1:20pm revealed:
-Resident #4 was a diabetic.
-When she prepared Resident #4's meals, she would serve no sweets, sugar free foods, "stuff like that".
-She had already disposed of the can of apples used to prepare the residents' lunch meal today.
-She thought fruits canned in light syrup would be okay to serve to Resident #4, but she would not serve any diabetics fruits canned in heavy syrup.
-She determined who was a diabetic and who was not when she prepared the residents' meals by looking at the residents' diagnoses listed on the medication administration records (MARS).
-The Resident Care Coordinator (RCC) or the ED would let her know what diets the residents were ordered or when a diet changed; "whatever they tell me, that's what I do."
-The ED had not given her any information on how or what to prepare for residents on a NCS diet.

Telephone interview with the Registered Dietician (RD) on 07/24/19 at 10:25am revealed:
-When she completed the menus for the previous ED, she thought there were no therapeutic diets for any of the residents.
-She had spoken with the current ED yesterday, (07/23/19) who notified her that the facility needed a therapeutic diet for a NCS and a NAS diet.
-She sent the facility a rough draft copy of an NCS diet yesterday (07/23/19) to go by until she submitted a completed NCS menu spreadsheet.
-She had concerns when too much starches were

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{D 310}	Continued From page 19 served to residents every day. -She had concerns when too many sweets and foods high in sugar content were served to residents which could raise the residents' blood sugar and make them more insulin resistant. Telephone interview with Resident #4's primary care provider (PCP) on 07/24/19 at 4:48pm revealed: -Resident #4 was on a diet to control diabetes and if the diet was not followed as ordered there was a potential blood the resident's blood sugars would be elevated. -If the resident's blood sugars were elevated because an order was not followed for a specific diabetic diet then it could have potentially led to medication adjustments to control the elevated blood sugars when medication adjustments might not need have been needed. Interview with the ED on 07/24/19 at 10:36am and 4:25pm revealed: -She was aware when a PCP ordered a therapeutic diet that a therapeutic spreadsheet was needed by a RD for the diet ordered. -She was aware a therapeutic menu by a RD was required for each diet offered at the facility. -She had obtained a therapeutic diet menu from the RD for an NCS diet for the cook to follow and had met with the cook about the diet menu on 07/23/19.	{D 310}		
{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	{D 358}		

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{D 358}	Continued From page 20 by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 3 residents sampled (#1, #2, #3) including errors with inhalers (#1, #2, #3); narcotics and a steroid (#1); two pain relievers, an antifungal infections and an antacid (#2). The findings are: 1. Review of Resident #2's current FL-2 dated 06/03/19 revealed diagnoses included dementia, hypertension constipation, insomnia, gastroesophageal reflux disease, vitamin D deficiency, chronic obstructive pulmonary disease (COPD), major depressive disorder, acute pain, nausea, other seasonal allergies, bipolar disorder, hypercholesterolemia, anxiety, heartburn, chronic pain syndrome, throat pain, generalized arthritis and fibromyalgia.	{D 358}		

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{D 358}	Continued From page 21 Interview with the Executive Director (ED) on 07/23/19 at 9:40am revealed: -The resident had been an inpatient at a local rehabilitation center. -The resident was admitted to the facility from the rehabilitation center the first of June 2019. a. Review of Resident #2's current FL-2 dated 06/03/19 revealed an order for Spiriva 18mcg inhale daily. (Spiriva is an inhaled medication used to control and prevent symptoms of wheezing, shortness of breath caused by ongoing lung disease such as COPD). Review of a Discharge Summary from a local hospital for Resident #2 revealed: -The resident was admitted from 06/14/19 to 06/19/19. -The resident's discharge diagnosis was left lower lobe pneumonia resolved. -The resident was admitted with acute on chronic hypoxic (inadequate oxygen in the blood) and hypercapnic respiratory failure (a condition that limits air movement through the body, which means that less oxygen gets in and less carbon dioxide gets out) secondary to acute chronic obstructive pulmonary disease exacerbation (COPD) from left lower lobe gram negative pneumonia. Review of a Medication Release form for Resident #2 dated 06/04/19 from a local rehabilitation center revealed: -There was an entry "Dispense" 30 day supply of the medications listed. -Spiriva 18mcg was not one of the medications listed. -Resident #2's family member signed the form on 06/04/19.	{D 358}		

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{D 358}	Continued From page 22 Review of Resident #2's June 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Spiriva 18mcg CP handihaler, inhale contents of one capsule using the handihaler once daily with a scheduled administration time of 8:00am. -There was no documentation Spiriva was administered on 06/05/19, 06/06/19, 06/08/19, 06/10/19, 06/12/19, and 06/13/19 at 8:00am. -There was a posted note over the administration dates for Spiriva from 06/24/19-06/31/19 with a handwritten entry "awaiting verification, don't sign" at 8:00am. -There was a circle around the medication aides' (MAs') initials for the administration of Spiriva on 06/11/19 and 06/22/19. -There was documentation on the back of the MAR that Spiriva was "on order" on 06/11/19 at 8:00am. -There was no further documentation regarding the missed doses of Spiriva. Review of Resident #2's dispensing records dated 06/01/19 - 07/23/19 from the facility's contracted pharmacy revealed there was a quantity of a 30 day supply of Spiriva 18 mcg filled on 07/01/19 and 07/02/19. Observation of Resident #2's medications on hand on 07/23/19 at 10:40am revealed Sprivia 18mcg was on hand with a pharmacy dispensing label date of 07/02/19 for a total of 30 doses. Interview with Resident #2 on 07/23/19 at 11:09am revealed: -She wore oxygen at all times. -She was short of breathe at times especially when doing tasks. -Shortness of breathe was "just one" of her biggest problems.	{D 358}		

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{D 358}	Continued From page 23 Interview with the Resident Care Coordinator (RCC) on 07/23/19 at 3:16pm and on 07/24/19 at 5:20pm revealed: -The posted note over the administration dates for Spiriva from 06/24/19-06/31/19 with a handwritten entry "awaiting verification, don't sign" at 8:00am was done by the previous Executive Director (ED). -She could not explain why there was a note placed over the the dates for Resident #2's Sprivia not to be administered. -She could not explain why there was no documentation Resident #2's Sprivia was not administered for the dates in June 2019 because she was not working as the RCC in June 2019. Telephone interview with Resident #2's primary care provider (PCP) on 07/24/19 on 04:48 pm revealed: -She had not been notified by the facility staff that Resident #2 did not receive doses of her Sprivia in June 2019. -Sprivia was ordered to control the resident's COPD. -Her expectations were the facility staff should have notified her that Resident #2 had not received Sprivia and that all medications should be administered as ordered. -There was the possibility of negative outcomes due to the staff's failure to assure Resident #2 received her medications as ordered which included breathing problems, exacerbation of the resident's COPD and hospitalizations. Refer to a confidential staff interview. Refer to a interview with the medication aide (MA) on 07/23/19 at 10:30am.	{D 358}		

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{D 358}	Continued From page 24 Refer to the interview with the RCC on 07/23/19 at 3:16pm and on 07/24/19 at 5:20pm. Refer to the interview with the ED on 07/24/19 at 4:30pm. b. Review of Resident #2's current FL-2 dated 06/03/19 revealed an order for Salonpas patch with Lidocaine 4% apply one patch to right shoulder, right knee, right hip every day at 10:00am and remove at hour of sleep. (Salonpas is a topical patch applied to areas of the body to control pain). Review of a Medication Release form for Resident #2 dated 06/04/19 from a local rehabilitation center revealed: -There was an entry "Dispense" 30 day supply of the medications listed. -Salonpas Patch with Lidocaine 4% was listed with "#3" written beside the medication. -Resident #2's family member signed the form on 06/04/19. Review of Resident #2's June 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Salonpas patch with Lidocaine 4% apply one patch to right shoulder, right knee, right hip daily at 8:00am and remove at 8:00pm with a scheduled administration time of 8:00am to apply and 8:00pm to remove. -There was no documentation Salonpas was removed on 06/09/19 at 8:00pm. -There was a circle around the medication aides' (MAs') initials for Salonpas patch with Lidocaine 4% on 06/08/19 at 8:00am and 8:00pm, 06/10/19 at 8:00am, 06/11/19 - 06/12/19 at 8:00am and 8:00pm, 06/13/19 at 8:00am, 06/20/19 at 8:00pm, and 06/21/19 and 06/22/19 at 8:00am and	{D 358}		

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8:00pm.
-There was a posted note over the administration dates for Salonpas patch with Lidocaine 4% from 06/24/19-06/31/19 with a handwritten entry "awaiting verification, don't sign" at 8:00am and 8:00pm.
-There was documentation on the back of the MAR for that the Salonpas patch on 06/26/19 at 8:00pm was "not available, not given", 06/11/19 at 8:00pm "not available, not done", 06/12/19 at 8:00pm "not available, not done", , 06/20/19 at 8:00pm "not available, not given", 06/21/19, 06/25/19 at 8:00pm and 06/19/19 at 8:00pm "not available, not given", that Salonpas was not available and an entry on 06/13/19 "L. patch, not available".

Review of Resident #2's July 2019 medication administration record (MAR) revealed:
-There was a handwritten entry for Salonpas patch with Lidocaine 4% apply one patch to right shoulder, right knee, right hip daily at 10:00am and remove at 10:00pm.
-There was no documentation Salonpas was administered from 07/01/19 - 07/22/19 at 10:00am and removed at 10:00pm.

Interview with Resident #2 on 07/23/19 at 11:09am revealed:
-She wore a patch for pain every day and had a patch on now.
-The pain patch was removed at night.

Review of Resident #2's dispensing records dated 06/01/19 - 07/23/19 from the facility's contracted pharmacy revealed there was a quantity of a 30 day supply Salonpas Lidocaine patch filled on 06/05/19 and 07/02/19.

Observation of Resident #2's medications on

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hand on 07/23/19 at 10:40am revealed Salonpas Lidocaine 4% patch was available with a dispensing label dated 07/02/19 with a quantity of 30 dispensed.

Interview with the Resident Care Coordinator (RCC) on 07/23/19 at 3:16pm revealed:
-She was not sure why there was no documentation Resident #2's Salonpas had not been administered but she knew the resident got the patch today.
-The posted note over the administration dates for Salonpas from 06/24/19-06/30/19 with a handwritten entry "awaiting verification, don't sign" at 8:00am was done by the previous Executive Director (ED).
-She could not explain why the note was placed there not to administer.

Telephone interview with Resident #2's primary care provider (PCP) on 07/24/19 on 04:48 pm revealed she expected facility staff to administer all medications as ordered.

Refer to a confidential staff interview.

Refer to a interview with the medication aide (MA) on 07/23/19 at 10:30am.

Refer to the interview with the RCC on 07/23/19 at 3:16pm and on 07/24/19 at 5:20pm.

Refer to the interview with the ED on 07/24/19 at 4:30pm.

c. Review of Resident #2's current FL-2 dated 06/03/19 revealed an order for Nystop 100,000 units/gram powder apply to abdominal fold and under breasts three times a day. (Nystop is a topical antibiotic medication used to treat fungal

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{D 358}	Continued From page 27 skin infections). Review of Resident #2's June 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Nystop powder 100,000 units apply to areas under abdominal folds and under breasts three times a day with a scheduled administration time of 8:00am, 2:00pm and 8:00pm. -There was no documentation Nystop powder was administered on 06/05/19 at 8:00am and 2:00pm, 06/07/19, 06/08/19, 06/10/19 and 06/12/19 at 2:00pm, 06/13/19 at 2:00pm and 8:00pm, 06/20/19, 06/22/19, 06/23/19 and 06/24/19 at 2:00pm. -There was a circle around the medication aides' (MAs) initials for the administration of Nystop on 6/23/19 - 06/24/19, 06/29/19 and 06/30/19 at 8:00pm. -There was no further documentation regarding the missed doses of Nystop powder. Review of Resident #2's dispensing records dated 06/01/19 - 07/23/19 from the facility's contracted pharmacy revealed there was a quantity of a 30 day supply of Nystop Powder 100,000 unit/gm filled on 06/04/19 and 07/02/19. Observation of Resident #2's medications on hand on 07/23/19 at 10:40am revealed Nystop powder was available with a pharmacy dispensing label date of 07/02/19 for a total of 30 doses and approximately 1/2 of the Nystop powder remaining. Telephone interview with Resident #2's primary care provider (PCP) on 07/24/19 on 04:48 pm revealed she expected facility staff to administer all medications as ordered.	{D 358}		

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Refer to a confidential staff interview.

Refer to a interview with the medication aide (MA) on 07/23/19 at 10:30am.

Refer to the interview with the Resident Care Coordinator (RCC) on 07/23/19 at 3:16pm and on 07/24/19 at 5:20pm.

Refer to the interview with the Executive Director (ED) on 07/24/19 at 4:30pm.

d. Review of Resident #2's current FL-2 dated 06/03/19 revealed an order for Lyrica 100mg one capsule three times a day. (Lyrica is a pain medication used to treat nerve pain and Fibromyalgia).

Review of a Medication Release form for Resident #2 dated 06/04/19 from a local rehabilitation center revealed:
-There was an entry "Dispense" 30 day supply of the medications listed.
-Lyrica 100mg was documented with "#31" handwritten beside the medication.

Review of Resident #2's June 2019 medication administration record (MAR) revealed:
-There was a handwritten entry for Lyrica 100mg one capsule three times a day with a scheduled administration time of 8:00am, 2:00pm and 8:00pm.
-There was no documentation Lyrica was administered on 06/06/19 at 2:00pm, 06/09/19 at 8:00am and 2:00pm, and 06/12/19 at 2:00pm.
-There was no documentation regarding the missed doses of Lyrica.

Review of Resident #2's July 2019 MAR revealed:
-There was a handwritten entry for Lyrica 100mg

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one capsule three times a day with a scheduled administration time of 8:00am, 2:00pm and 8:00pm.
-There was no documentation Lyrica was administered on 07/14/19 at 8:00am and at 2:00pm.
-There was no documentation regarding the missed doses of Lyrica.

Review of Resident #2's dispensing records dated 06/01/19 - 07/23/19 from the facility's contracted pharmacy revealed there was a quantity of a 30 day supply of Lyrica 100mg filled on 07/02/19.

Observation of Resident #2's medications on hand on 07/23/19 at 10:40am revealed Lyrica was available with a pharmacy dispensing label date of 07/02/19 for a total of 90 doses with 89 tablets remaining.

Interview with Resident #2 on 07/22/19 at 10:55am revealed:
-She took pain medications that were scheduled at certain times and some pain medications that were taken as needed.
-She had pain due to "Fibromylagia" and arthritic pain.
-The pain medications she tool helped to control her pain some.

Telephone interview with Resident #2's primary care provider (PCP) on 07/24/19 on 04:48 pm revealed she expected facility staff to administer all medications as ordered.

Refer to a confidential staff interview.

Refer to a interview with the medication aide (MA) on 07/23/19 at 10:30am.

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{D 358}	Continued From page 30 Refer to the interview with the Resident Care Coordinator (RCC) on 07/23/19 at 3:16pm an on 07/24/19 at 5:20pm. Refer to the interview with the Executive Director (ED) on 07/24/19 at 4:30pm. e. Review of Resident #2's current FL-2 dated 06/03/19 revealed an order for Protonix 40 mg one tablet daily. (Protonix is a medication used to treat used to treat certain stomach and esophagus problems). Review of a Medication Release form for Resident #2 dated 06/04/19 from a local rehabilitation center revealed: -There was an entry "Dispense" 30 day supply of the medications listed. -Protonix 40mg was documented with "#30" handwritten beside the medication. Review of Resident #2's June 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Protonix 40 mg take one tablet daily with a scheduled administration time of 8:00am. -There was documentation Protonix 40 mg was administered from on 06/05/19 through 06/30/19 at 8:00am excluding 06/15/19 - 06/19/19 due to the resident being hospitalized. Review of Resident #2's July 2019 MAR revealed: -There was a handwritten entry for Protonix 40 mg take one tablet daily with a scheduled administration time of 8:00am. -There was no documentation Protonix 40 mg was administered on 07/14/19 at 8:00am. -There was no documentation regarding the missed dose of Protonix.	{D 358}		

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{D 358}	Continued From page 31 Review of Resident #2's dispensing records dated 06/01/19 - 07/23/19 from the facility's contracted pharmacy revealed there was a quantity of a 30 day supply of Protonix 40 mg filled on 07/02/19. Observation of Resident #2's medications on hand on 07/23/19 at 10:40am revealed Protonix was available with a pharmacy dispensing label dated 07/02/19 for a total of 30 doses dispensed with 16 tablets remaining. Telephone interview with Resident #2's primary care provider (PCP) on 07/24/19 on 04:48 pm revealed she expected facility staff to administer all medications as ordered. Refer to a confidential staff interview. Refer to a interview with the medication aide (MA) on 07/23/19 at 10:30am. Refer to the interview with the Resident Care Coordinator (RCC) on 07/23/19 at 3:16pm and on 07/24/19 at 5:20pm. Refer to the interview with the Executive Director (ED) on 07/24/19 at 4:30pm. f. Review of Resident #2's current FL-2 dated 06/03/19 revealed an order for Fluticasone use one spray in each nostril daily. (Fluticasone is a nasal spray used for seasonal allergies). Review of a Medication Release form for Resident #2 dated 06/04/19 from a local rehabilitation center revealed: -There was an entry "Dispense" 30 day supply of the medications listed.	{D 358}		

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{D 358}	Continued From page 32 -Fluticasone 50 mcg was documented with "1 bottle" handwritten beside the medication. -Resident #2's family member signed the form on 06/04/19. Review of a Discharge Summary from a local hospital for Resident #2 dated 06/19/19 revealed an order for Fluticasone use one spray in each nostril daily. Review of a Discharge Summary from a local hospital for Resident #2 dated 07/19/19 revealed Fluticasone was not listed with the discharge medications. Review of Resident #2's June 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Fluticasone 50 mcg use one spray in each nostril daily with a scheduled administration time of 8:00am. -There was no documentation Fluticasone was administered on 06/10/19 at 8:00am. -There was a circle around the medication aides (MAs) initials for the administration of Fluticasone 50 mcg on 06/11/19 and 06/12/19 at 8:00am. -There was a posted note over the administration dates for Fluticasone 50 mcg from 06/24/19-06/31/19 with a handwritten entry "awaiting verification, don't sign" at 8:00am. -There was documentation on the back of the MAR that Fluticasone was "on order, not given" on 06/11/19 at 8:00am. -There was no further documentation regarding the missed doses of Fluticasone. Review of Resident #2's dispensing records dated 06/01/19 - 07/24/19 from the facility's contracted pharmacy revealed Fluticasone 50 mcg had not been dispensed.	{D 358}		

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{D 358}	Continued From page 33 Observation of Resident #2's medications on hand on 07/23/19 at 10:40am revealed Fluticasone 50 mcg was not available. Interview with the Resident Care Coordinator (RCC) on 07/23/19 at 3:16pm revealed: -The posted note over the administration dates for Fluticasone 50 mcg from 06/24/19 - 06/30/19 with a handwritten entry "awaiting verification, don't sign" at 8:00am was done by the previous Executive Director (ED). -She could not explain why the note was placed there not to administer. Second interview with the RCC on 07/24/19 at 10:36am revealed: -Resident #2's primary care provider (PCP) saw the resident on 07/22/19 for a follow up and wrote an order for no medication changes. -She would clarify to see if Resident #2 should continue to take Fluticasone 50 mcg use one spray in each nostril daily. Review of an email sent to Resident #2's PCP from the RCC with a response back from Resident #2's PCP dated 07/24/19 revealed the resident was supposed to be on Fluticasone. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:36am she was responsible to review the residents' hospital discharge summary and contacted the prescribing practitioner if there were any changes or questions regarding a medication listed on the discharge summary. Refer to a confidential staff interview. Refer to a interview with the medication aide (MA) on 07/23/19 at 10:30am.	{D 358}		

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{D 358}	Continued From page 34 Refer to the interview with the Resident Care Coordinator (RCC) on 07/23/19 at 3:16pm an on 07/24/19 at 5:20pm. Refer to the interview with the Executive Director (ED) on 07/24/19 at 4:30pm. g. Review of a medication order for Resident #2 dated 06/10/19 revealed an order for Colace 100 mg twice daily. (Colace is a stool softener). Review of a Discharge Summary from a local hospital for Resident #2 dated 06/19/19 revealed an order for Colace 100 mg twice daily. Review of a hospital discharge summary signed by a prescribing practitioner dated 07/19/19 revealed Colace 100mg was not listed with the discharge medications. Review of Resident #2's June 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Colace 100 mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was a circle around the medication aides (MAs) initials for the administration of Colace 100mg on 06/11/19, 06/12/19 at 8:00pm, 06/22/19 - 06/24/19 at 8:00am, 06/25/19 - 06/26/19 and 06/28/19 at 8:00am and 8:00pm. -There was no documentation Colace 100mg was administered on 06/11/19- 06/13/19, 06/27/19 and 06/30/19 at 8:00am -There was documentation on the back of the MAR that Colace was not "available, not given" on 06/11/19, 06/12/19, 06/25/19, 06/26/19 and 06/28/19. -There was no further documentation regarding the missed doses of Colace.	{D 358}		

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{D 358}	Continued From page 35 Review of Resident #2's dispensing records dated 06/01/19 - 07/24/19 from the facility's contracted pharmacy revealed Colace 100mg had not been dispensed. Observation of Resident #2's medications on hand on 07/23/19 at 10:40am revealed Colace 100mg was not available. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:36am revealed: -Resident #2's primary care provider (PCP) saw the resident on 07/22/19 for a follow up and wrote an order for no medication changes. -She would clarify to see if Resident #2 should continue to take Colace 100 mg twice daily. Review of an email sent to Resident #2's PCP from the RCC with a response back from Resident #2's PCP dated 07/24/19 revealed the resident was supposed to be on "Colace". Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:36am she was responsible to review the residents' hospital discharge summary and contacted the prescribing practitioner if there were any changes or questions regarding a medication listed on the discharge summary. Refer to a confidential staff interview. Refer to a interview with the medication aide (MA) on 07/23/19 at 10:30am. Refer to the interview with the Resident Care Coordinator (RCC) on 07/23/19 at 3:16pm an on 07/24/19 at 5:20pm.	{D 358}		

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Refer to the interview with the Executive Director (ED) on 07/24/19 at 4:30pm.

h. Review of Resident #2's current FL-2 dated 06/03/19 revealed an order for Vitamin D2 1.25mg every week on Fridays, then stop on 06/14/19. (Vitamin D2 is a vitamin supplement).

Review of a Medication Release form for Resident #2 dated 06/04/19 from a local rehabilitation center revealed:
-There was an entry "Dispense" 30 day supply of the medications listed.
-Vitamin D2 1.25mg (50,000 units) was documented with "#4" handwritten beside the medication.
-Resident #2's family member signed the form on 06/04/19.

Review of a Discharge Summary from a local hospital for Resident #2 dated 06/19/19 revealed an order for Vitamin D2 1.25mg 50,000 units every Friday.

Review of a Discharge Summary from a local hospital for Resident #2 dated 07/19/19 revealed Vitamin D2 was not listed with the discharge medications.

Review of Resident #2's June 2019 medication administration record (MAR) revealed:
-There was a handwritten entry for Vitamin D2 1.25mg (50,000 units) one by mouth once a week on Friday with a scheduled administration time of 8:00am.
-There was documentation Vitamin D2 1.25mg had been administered on 06/07/19, 06/21/19, a circle around the medication aide's (MA's) initials on 06/28/19.
-There was documentation the resident was in

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{D 358}	Continued From page 37 the hospital on 06/14/19. Review of Resident #2's July 2019 medication administration record (MAR) revealed there was no entry for Vitamin D2 1.25mg (50,000 units) once a week. Review of Resident #2's dispensing records dated 06/01/19 - 07/24/19 from the facility's contracted pharmacy revealed Vitamin D2 1.25mg (50,000 units) had not been dispensed. Observation of Resident #2's medications on hand on 07/23/19 at 10:40am revealed Vitamin D2 1.25mg (50,000 units) was not available. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:36am revealed: -Resident #2's primary care provider (PCP) saw the resident on 07/22/19 for a follow up and wrote an order for no medication changes. -She would clarify to see if Resident #2 should continue to take Vitamin D2 1.25mg (50,000 units) weekly. Review of an email sent to Resident #2's PCP from the RCC with a response back from Resident #2's PCP dated 07/24/19 revealed the resident was supposed to be on "Vitamin D". Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:36am she was responsible to review the residents' hospital discharge summary and contacted the prescribing practitioner if there were any changes or questions regarding a medication listed on the discharge summary. Refer to a confidential staff interview.	{D 358}		

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{D 358}	Continued From page 38 Refer to a interview with the medication aide (MA) on 07/23/19 at 10:30am. Refer to the interview with the Resident Care Coordinator (RCC) on 07/23/19 at 3:16pm an on 07/24/19 at 5:20pm. Refer to the interview with the Executive Director (ED) on 07/24/19 at 4:30pm. i. Review of Resident #2's current FL-2 dated 06/03/19 revealed an order for Colestipol Micronized 1 gram take one tablet daily (Colestipol Micronized is a medication used to control high cholesterol). Review of a Medication Release form for Resident #2 dated 06/04/19 from a local rehabilitation center revealed: -There was an entry "Dispense" 30 day supply of the medications listed. -Colestipol Micronized 1gm was documented with "#14" handwritten beside the medication. -Resident #2's family member signed the form on 06/04/19. Review of a Discharge Summary from a local hospital for Resident #2 dated 06/19/19 revealed an order for Colestipol Micronized 1gm daily. Review of a hospital discharge summary signed by a prescribing practitioner dated 07/19/19 revealed Colestipol Micronized was not listed with the discharge medications, Review of Resident #2's June 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Colestipol Micronized 1gm one tablet daily with a scheduled administration time of 8:00pm.	{D 358}		

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CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(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 39 -There was a posted note over the administration dates for Colestipol Micronized 1gm from 06/24/19-06/30/19 with a handwritten entry "awaiting verification, don't sign" at 8:00am. Review of Resident #2's July 2019 medication administration record (MAR) revealed there was not an entry for Colestipol Micronized 1gm one tablet at 8:00pm. Review of Resident #2's dispensing records dated 06/01/19 - 07/24/19 from the facility's contracted pharmacy revealed Colestipol Micronized 1gm had not been dispensed. Observation of Resident #2's medications on hand on 07/23/19 at 10:40am revealed Colestipol Micronized 1gm was not available. Interview with the Resident Care Coordinator (RCC) on 07/23/19 at 3:16pm revealed: -The posted note over the administration dates for Colestipol Micronized 1gm from 06/24/19-06/30/19 with a handwritten entry "awaiting verification, don't sign" at 8:00am was done by the previous Executive Director (ED). -She could not explain why the note was placed there not to administer. Interview with the RCC on 07/24/19 at 10:36am revealed: -Resident #2's primary care provider (PCP) saw the resident on 07/22/19 for a follow up and wrote an order for no medication changes. -She would clarify to see if Resident #2 should continue to take Colestipol 1 gram. Review of an email sent to Resident #2's PCP from the RCC with a response back from Resident #2's PCP dated 07/24/19 revealed the	{D 358}		

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{D 358}	Continued From page 40 resident was supposed to be on "Colestipol". Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:36am she was responsible to review the residents' hospital discharge summary and contacted the prescribing practitioner if there were any changes or questions regarding a medication listed on the discharge summary. Refer to a confidential staff interview. Refer to a interview with the medication aide (MA) on 07/23/19 at 10:30am. Refer to the interview with the Resident Care Coordinator (RCC) on 07/23/19 at 3:16pm an on 07/24/19 at 5:20pm. Refer to the interview with the Executive Director (ED) on 07/24/19 at 4:30pm. 2. Review of Resident #1's current FL-2 dated 06/17/19 revealed diagnoses included anxiety, hypertension, diabetes mellitus type II, restless leg syndrome (RLS), neurogenic bladder, suprapubic catheter, hip pain, and chronic obstructive pulmonary disease (COPD). a. Review of Resident #1's current FL-2 dated 06/17/19 with the attached medication administration record (MAR) revealed an order for Incruse Ellipta 62.5 mcg inhaler; inhale 1 puff once daily in the morning. (Incruse Ellipta helps people with COPD breathe better by relaxing muscles in the airway). Review of a previous physician's order for Resident #1 dated 02/25/19 revealed an order for Incruse Ellipta 62.5 mcg inhaler; inhale 1 puff	{D 358}		

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{D 358}	Continued From page 41 once daily in the morning. Based on requests made to the Executive Director (ED) on 07/22/19, 07/23/19 and 07/24/19 Resident #1's May 2019 MAR was not available for review. Review of Resident #1's June 2019 MAR revealed: -There was a computer printed entry for Incruse Ellipta 62.5 mcg inhaler; inhale 1 puff once daily in the morning with a scheduled administration time of 8:00am. -There was a circle around the medication aide's (MA's) initials for Incruse Ellipta 62.5 mcg on 06/11/19, 06/15/19- 06/19/19, 06/27/19, and 06/28/19 at 8:00am (for a total of 8 doses). -There was documentation on the back of the June 2019 MAR that the Incruse Ellipta 62.5 mcg was on order on 06/11/19, 06/16/19, 06/18/19 and 06/19/19 the medication was "on order", and 06/15/19 and 06/1719 "not available, not given". -There was no further documentation regarding the missed doses of Incruse Ellipta 62.5 mcg. Review of Resident #1's dispensing records dated 05/01/-07/24/19 from the facility's contracted pharmacy revealed Incruse Ellipta with a quantity a 30 day supply filled on 05/28/19 and 06/27/19. Observation of Resident #1's medications on hand on 07/23/19 at 10:06 am revealed Incruse Ellipta inhaler was available with a pharmacy dispensing label date of 06/27/19 for a total of 30 doses. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 05:20pm revealed she did not notify Resident #1's primary care provider	{D 358}		

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{D 358}	Continued From page 42 (PCP) that she had missed 8 days of her inhaler (Incruse) in June 2019 because she did not work at the facility at that time. Telephone interview with Resident #1's primary care provider (PCP) on 07/24/19 on 04:48 pm revealed: -She had not been notified by the facility staff that Resident #1 did not receive 8 days of her Incruse (inhaler). -Her expectations were the facility staff should have notified her that Resident #1 had not received Incruse (inhaler) and that all medications should be administered as ordered. -Resident #1 was prescribed Incruse Ellipta to treat the resident's COPD. -There was the possibility of negative outcomes due to the staff's failure to assure Resident #1 received her medications as ordered which included a possible exacerbation of the resident's COPD and hospitalization. Interview with the ED on 07/24/19 at 4:30pm revealed: -She did not notify Resident #1's PCP that she had missed 8 days of her Incruse (inhaler), no additional information was provided. -Her policy was to assure the administration of medications by staff in the PCP's orders. Refer to a confidential staff interview. Refer to an interview with the medication aide (MA) on 07/23/19 at 10:30am. Refer to the interview with the RCC on 07/23/19 at 03:16pm and 07/24/19 at 05:20pm. Refer to the interview with the ED on 07/24/19 at 04:30pm.	{D 358}		

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{D 358}	Continued From page 43 b. Review of Resident #1's Hospital Emergency Department (ED) Provider Note dated 07/09/19 revealed Resident #1's chief compliant was cough and wheezing. Review of a hospital Discharge Summary for Resident #1 dated 07/11/19 revealed: -The resident was admitted on 07/09/19 and discharged on 07/11/19. -There was documentation the resident was admitted with chronic obstructive pulmonary disease (COPD) exacerbation. -There was an order for Prednisone 20 mg, take 2 tablets (40 mg total) twice daily for 3 days. (Prednisone is a medication used to decrease inflammation). Review of Resident #1's July 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Prednisone 20 mg tablets take two tablets (40mg) two times a day for three days with a scheduled administration time of 8:00am and 8:00pm -Prednisone was documented as administered at 8:00am and 8:00pm on the following days, 07/12/19, 07/13/19, and 07/14/19. Interview with the Executive Director (ED) on 07/24/19 at 4:30pm revealed: -The ED was made aware on 07/14/19 at 10:59pm of Resident #1 not receiving 1 of 6 Prednisone doses when a medication aide (MA) observed another MA document the Prednisone was administered on the July 2019 MAR; however; she observed the medication, Prednisone, was still present in the blister pack. -The PCP was not notified of the situation; no additional information was provided.	{D 358}		

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{D 358}	Continued From page 44 Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 5:20 pm revealed: -She was aware Resident #1 missed one dose of Prednisone 40 mg ordered on 07/11/19. -The RCC did not notify the primary care provider (PCP) that Resident #1 did not receive 1 of 6 doses of her Prednisone ordered on 07/11/19. Telephone Interview with Resident #1's PCP on 07/24/19 on 4:48pm revealed: -She had not been notified by the facility staff Resident #1 did not receive a 40 mg dose of her ordered Prednisone. -Her expectations were the facility staff should have notified her that Resident #1 had not received Prednisone and that all medications should be administered as ordered and could not fix what she did not know. -There was the possibility of negative outcomes due to the staff's failure to assure Resident #1 received her medications as ordered. -Resident #1's failure to receive one dose of Prednisone could have caused a continuation of breathing problems such as shortness of breath, exacerbation of COPD or a re-admission to the hospital. -She was aware that Resident #1 was hospitalized from 07/09/19-07/11/19 for an exacerbation of COPD. Refer to a confidential staff interview. Refer to an interview with the MA on 07/23/19 at 10:30am. Refer to an interview with the RCC on 07/23/19 at 3:16pm and on 07/24/19 at 5:20pm. Refer to the interview with the ED on 07/24/19 at 4:30pm.	{D 358}		

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{D 358}	Continued From page 45 c. Review of Resident #1's current FL-2 dated 06/17/19 revealed: -There was a handwritten entry to see "MAR" (medication administration record) in the medication section of the FL-2 that was attached to the FL-2. -There was an order for Clonazepam 0.5 mg tabs take one tablet two times a day. (Clonazepam is a medication used for the treatment of panic disorders and social anxiety disorder). Review of a hospital After-Visit Summary for Resident #1 dated 07/11/19 revealed for Resident #1 to stop taking Clonazepam 0.5 mg tablet. Review of Resident #1's July 2019 MAR revealed: -There was a computer printed entry for Clonazepam 0.5 mg tabs take one tablet by mouth two times a day. -Clonazepam was documented as administered at 08:00am and 08:00pm from 07/11/19-07/24/19. Observation of Resident #1's medications on hand on 07/23/19 at 10:06 am revealed Clonazepam tablets was available with a pharmacy dispensing label date of 06/27/19 for a total of 36 doses. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 5:20pm revealed: -If the RCC received a hospital discharge summary, the discharge summary would be sent to the pharmacy and orders would be clarified with the primary care provider (PCP) who electronically signed the hospital discharge summary. -She could not provide rationale why Resident #1's Clonazepam was not discontinued/transcribed on 07/11/19 as per the	{D 358}		

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{D 358}	Continued From page 46 hospital After-Visit Summary order dated 07/11/19 on the July 2019 MAR. Telephone Interview with Resident #1's PCP on 07/24/19 on 4:48pm revealed: -Her expectations were the facility staff should administer all medications as ordered. -She was not aware that the Clonazepam had been discontinued on the hospital After-Visit Summary dated 07/11/19. -She re-ordered Resident #1's Clonazepam to be restarted on 07/24/19. Interview with the Executive Director (ED) on 07/24/19 at 4:30pm revealed she was not sure why Resident #1's Clonazepam did not get transcribed correctly from the hospital After-Visit Summary dated 07/11/19 on the July 2019 MAR. Refer to a confidential staff interview. Refer to an interview with the MA on 07/23/19 at 10:30am. Refer to an interview with the RCC on 07/23/19 at 3:16pm and on 07/24/19 at 5:20pm. Refer to the interview with the ED on 07/24/19 at 4:30pm. 3. Review of Resident #3's current FL-2 dated 07/01/19 revealed: -Diagnoses included hypertension, asthma, incontinence, thyrotoxicosis with crisis, chondrocostal junction syndrome, depression and unspecified neurological disorder. -There was an order for Advair 250-50, one puff twice daily. (Advair is an inhaled medication used to prevent symptoms of asthma by opening the lung airways).	{D 358}		

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{D 358}	Continued From page 47 Review of a previous FL-2 dated 02/20/19 revealed there was an order for Advair 250-50, one puff twice daily Based on requests made to the Executive Director (ED) on 07/22/19, 07/23/19 and 07/24/19 Resident #3's May 2019 medication administration records (MARs) was not available for review. Review of Resident #3's June 2019 MAR revealed: -There was a computer printed entry for Advair 250-50, one puff twice daily, inhale one puff two times daily and rinse mouth after use with a scheduled administration time of 8:00am and 5:00pm. -There was a circle around the medication aides' (MAs) initials for the administration of Advair 250-50 on 06/11/19 from 8:00am through 5:00p on 06/13/19 and 06/14/19 at 5:00pm. -There was documentation on the back of the MAR that Advair was "on order, not given" on 06/11/19 at 8:00am, 06/11/19 at 5:00pm "not available, not given", 06/12/19 at 8:00am "not available, not given", 06/12/19 at 8:00pm "not available, not given", another entry for 06/12/19 with no documented time "not available", and 06/14/19 at 5:00pm "not available, not given". -There was no further documentation regarding the missed doses of Advair 250-50. Review of Resident #3's July 2019 MAR revealed: -There was a handwritten entry for Advair 250-50, one puff twice daily, inhale one puff two times daily with an administration time of 8:00am and 5:00pm. -There was a circle around the medication aides' (MAs) initials for the administration of Advair	{D 358}		

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{D 358}	Continued From page 48 250-50 on 07/02/19 at 5:00pm and from 07/03/19 at 8:00am through 07/04/19 at 5:00pm. -There was documentation on the back of the MAR on 07/02/19 at 8:00pm Advair was "not available, not given" and 07/03/19 at 8:00am "not available". -There was no further documentation regarding the missed doses of Advair 250-50. Review of Resident #3's dispensing records dated 05/01/19 - 07/24/19 from the facility's contracted pharmacy revealed Advair 250-50 with a quantity of a 30 day supply filled on 05/30/19 and 06/30/19. Observation of Resident #3's medications on hand on 07/23/19 at 10:24am revealed: -Advair 250-50 was on hand with a pharmacy dispensing label date of 06/30/19 for a total of 60 doses. -There was a handwritten entry not signed by a staff on the box "opened 07/05/19". Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 05:20pm revealed she did not notify Resident #3's primary care provider (PCP) that she had missed doses of her Advair inhaler in June 2019 and first of July 2019 because she did not work at the facility at that time as the RCC. Telephone interview with Resident #3's primary care provider (PCP) on 07/24/19 on 04:48pm revealed: -She had not been notified by the facility staff Resident #3 did not receive doses of the ordered Advair. -Resident #3 was prescribed Advair to keep the resident's asthma under control and prevent "flare-ups".	{D 358}		

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{D 358}	Continued From page 49 -Resident #3 could experience difficulty breathing if she missed doses of her Advair. -She would have expected to have been notified if Resident #3 missed any doses of her medication. Refer to a confidential staff interview. Refer to an interview with the medication aide (MA) on 07/23/19 at 10:30am. Refer to the interview with the RCC on 07/23/19 at 3:16pm and on 07/24/19 at 5:20pm. Refer to the interview with the Executive Director (ED) on 07/24/19 at 4:30pm. Confidential interview with a staff revealed: -There had been times recently the facility had problems processing medications ordered for residents, but the staff did not know exactly what the problem was. -The staff knew some of the residents' medications had not been in the facility recently to administer to the residents. -The current Resident Care Coordinator (RCC) and the Executive Director (ED) had told staff the medications were not delivered on time from the pharmacy because the "cycle fill" medications were not on track when they started in June 2019. Interview with the medication aide (MA) on 07/23/19 at 10:30am revealed: -The RCC was responsible for ordering the residents' medications from the pharmacy. -She notified the RCC when there were 2 or 3 doses of a medication left on hand. -She did not document when she notified the RCC about the need for residents' medication to be ordered. -She was not trained to notify the RCC when the	{D 358}		

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{D 358}	Continued From page 50	{D 358}		

resident had 2-3 doses of medication left on hand, but this was what she had done when she worked at previous facilities.
-She contacted the RCC by calling or sending a text.
-All MAs were responsible to document immediately after medications were administered to a resident by placing their initials on the date the medication was administered.
-MAs were responsible to sign the residents' MAR if medications were administered.
-All medication aides were required to document on the back of the medication administration record (MAR) when there was reason a medication was not given, in the hospital or the resident refused.
-A circle around the initials meant the medication was not given and there should be documentation on the back of the MAR for the reason not given, but at times she would forget to document on the back of the MAR.

Interview with the RCC on 07/24/19 at 05:20 pm revealed:
-There was no current medication monitoring system in place related to medication reconciliation that included reviewing the residents' medication administration records (MARs) to assure the medications had been administered as ordered.
-The current process for medication reconciliation was when a new order was received the RCC would fax the new medication order to the pharmacy.
-The RCC would confirm if the faxed order for a new medication was received by the pharmacy by placing a phone call to the pharmacist.
-She maintained a separate, personal binder which contained copies of all new PCP orders related to medications in order to track the

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{D 358}	Continued From page 51 implementation. -Once the new medication was available in-house, the RCC would add the new medication to the MAR. -The RCC confirmed the MAs also wrote new medications on the MARs and she would review when she returned to work. -The RCC would compare the MARs to the current FL-2, and primary care physician (PCP)'s orders when completing medication reconciliation on a monthly basis. -For new medication orders received after the RCC's work day ended, the MA would call or text the RCC. -The RCC would determine the priority of the medication; if the medication was urgent, she would send an email and/or text message to the pharmacist. If the medication was non-urgent, she would send the medication order via fax to the pharmacist when she arrived to work in the morning. -The RCC refilled the medication carts around the 9th of each month. -The residents' scheduled medications were sent from the pharmacy on a cycle fill except creams, inhalers, eyedrops and narcotics. -Staff had not reported to her that any of the residents' medications were not available to administer but she had noticed a MA had not signed when a resident's medication was administered approximately 1 1/2 weeks ago. -The MAs were required to verbally report the following to the RCC: for daily (QD) medications notification when 7 doses were left; for twice a day (BID) medications notification when 14 doses were left; for three times a day (TID) medications notification when 21 doses were remaining. -There was not a written policy of the notification of the RCC when there was a low supply of medications; the MAs were given this policy	{D 358}		

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	HAL051062	A. BUILDING: _____ B. WING _____	R 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(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 52 verbally. -For any new PCP orders, they should be placed in the RCC's box and would be addressed the following day. -When there were new medication orders, it was the responsibility of the RCC to make the changes to the MAR. The ED was her backup when she was out of the office. -When a medication was not given to a resident the MAs' initials would be circled on the MAR. Interview with the ED on 07/24/19 at 4:30pm revealed: -Her expectations for staff were to administer medications as ordered by hospital orders and PCP's orders. -Her expectations for the facility staff were to follow these 7 steps: right resident, right route, right reason, right frequency, right site, right drug, and right time. -She also expected the MAs to communicate with the RCC when medications were running low. -All medications would be on hold until the medication changes were clarified with the PCP. -If new medication orders came through after hours it would be the MA's responsibility to address which would include notifying the RCC. -If new medication orders came through during business hours it would be the RCC's responsibility to process. _____ The facility failed to administer medications as ordered for 3 of 3 sampled residents resulting in a resident diagnosed with chronic obstructive pulmonary (COPD) disease missing 6 doses of an inhaler used to control symptoms of wheezing and shortness of breath caused by COPD from 06/05/19-06/13/19 and required an acute hospitalization for COPD exacerbation on 06/14/19 (#2); a resident not receiving a full	{D 358}		

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{D 358}	Continued From page 53 regimen of her steroid after she was discharged from the hospital with a COPD exacerbation and not receiving an inhaler for COPD (#1); and a resident not receiving an ordered inhaler used to treat asthma and prevent flare-ups (#3). The failure of the facility to administer medications as ordered was detrimental to the health, safety and welfare of the residents, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/24/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 07, 2019.	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (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	{D 367}		

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{D 367}	Continued From page 54 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, record reviews and interviews, the facility failed to assure the medication administration records were accurate for 1 of 3 sampled residents (#2) related to a topical fungal powder, pain reliever and a medication used for acid reflux . The findings are: Review of Resident #2's current FL-2 dated 06/03/19 revealed diagnoses included dementia, hypertension constipation, insomnia, gastroesophageal reflux disease, vitamin D deficiency, chronic obstructive pulmonary disease, major depressive disorder, acute pain, nausea, other seasonal allergies, bipolar disorder, hypercholesterolemia, anxiety, heartburn, chronic pain syndrome, throat pain, generalized arthritis and fibromyalgia a. Review of Resident #2's current FL-2 dated 06/03/19 revealed there was an order for Nystop 100, 000 units/gram powder apply to abdominal fold and under breasts three times a day. (Nystop is a topical antibiotic medication used to treat fungal skin infections). Review of Resident #2's June 2019 medication	{D 367}		

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{D 367}	Continued From page 55	{D 367}		

administration record (MAR) revealed:
-There was a handwritten entry for Nystop powder 100,000 units apply to areas under abdominal folds and under breasts three times a day with a scheduled administration time of 8:00am, 2:00pm and 8:00pm.
-There was documentation Nystop powder had been administered on 06/31/19 at 8:00am and 2:00pm.
-There were 30 days in June 2019.
-There was no signature on the MAR equivalent to the initials of the staff who documented the administration for the resident's Nystop on 06/31/19.

Refer to the interview with the medication aide (MA) on 07/23/19 at 10:30am.

Refer to the interview with the Resident Care Coordinator (RCC) on 07/24/19 at 05:20 pm.

Refer to the interview with the Executive Director (ED) on 07/24/19 at 4:30pm.

b. Review of Resident #2's current FL-2 dated 06/03/19 revealed there was an order for Lyrica 100mg one capsule three times a day. (Lyrica is a pain medication used to treat nerve pain and Fibromyalgia).

Review of Resident #2's June 2019 medication administration record (MAR) revealed:
-There was a handwritten entry for Lyrica 100mg one capsule three times a day with a scheduled administration time of 8:00am, 2:00pm and 8:00pm.
-There was documentation Lyrica 100mg had been administered on 06/31/19 at 2:00pm, and 06/31/19 at 8:00am.
-There were 30 days in June 2019.

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{D 367}	Continued From page 56 -There was no signature on the MAR equivalent to the initials of the staff who documented the administration for the resident's Lyrica on 06/31/19. Refer to the interview with the medication aide (MA) on 07/23/19 at 10:30am. Refer to the interview with the Resident Care Coordinator (RCC) on 07/24/19 at 05:20 pm. Refer to the interview with the Executive Director (ED) on 07/24/19 at 4:30pm. c. Review of Resident #2's current FL-2 dated 06/03/19 there was an order for Protonix 40 mg one daily. (Protonix is a medication used to treat used to treat certain stomach and esophagus problems). Review of Resident #2's June 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Protonix 40 mg take one tablet daily with a scheduled administration time of 8:00am. -There was documentation Protonix 40 mg had been administered on 06/31/19 at 8:00am. -There were 30 days in June 2019. -There was no signature on the MAR equivalent to the initials of the staff who documented the administration for the resident's Protonix on 06/31/19. Refer to the interview with the medication aide (MA) on 07/23/19 at 10:30am. Refer to the interview with the Resident Care Coordinator (RCC) on 07/24/19 at 05:20 pm. Refer to the interview with the Executive Director	{D 367}		

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{D 367}	Continued From page 57 (ED) on 07/24/19 at 4:30pm. Interview with the medication aide (MA) on 07/23/19 at 10:30am revealed: -All MAs were responsible to document immediately after medications were administered to a resident by placing their initials on the date the medication was administered. -MAs were responsible to sign the residents' medication administration record (MAR) if medications were administered. -All medication aides were required to document on the back of the MAR when there was reason a medication was not given, in the hospital or the resident refused. -A circle around the initials meant the medication was not given and there should be documentation on the back of the MAR for the reason not given, but at times she would forget to document on the back of the MAR. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 05:20 pm revealed: -Her expectations for the MAs were to document administration of a medication with their initials, and to include their signature and initials at the bottom of the MAR. -If a medication was not given, she expected this to be documented on the MAR. -She confirmed the MARs were not reviewed for accuracy due to starting her new position recently. Interview with the Executive Director (ED) on 07/24/19 at 4:30pm revealed: -Her expectations for staff were to administer medications as ordered by hospital orders and primary care provider's (PCP's) orders. -Her expectations for the facility staff were to follow these 7 steps: right resident, right route,	{D 367}		

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{D 367}	Continued From page 58 right reason, right frequency, right site, right drug, and right time. -The MAs should not be documenting the administration of a medication unless the MA had given the medication to the resident. -If a medication was not given, she expected this to be documented on the MAR with the reason. -She confirmed the MARs were not reviewed for accuracy due to starting her new position recently.	{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. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to medication administration and nutrition and food service. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with	{D912}		

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{D912}	Continued From page 59 the facility's policies for 3 of 3 residents sampled (#1, #2, #3) including errors with inhalers (#1, #2, #3); narcotics and a steroid (#1); two pain relievers, an antifungal infections and an antacid (#2). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	{D912}		
{D935}	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:	{D935}		

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{D935}	Continued From page 60 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to assure 1 of 3 Medication Aides sampled (Staff A) hired after 10/01/13 had completed at least 5 hours of a state approved Medication Aide training prior to administering medications. The findings are: Review of Staff A's personnel record revealed: -Staff's A date of hire was 02/19/19. -There was documentation Staff A passed the state written medication exam on 01/31/12. -There was documentation of a Medication Administration Clinical Skills Competency Validation Checklist dated 03/07/19. -There was no documentation of verification of previous employment as a MA within the last 24 months prior to her employment at the facility. -There was documentation of the completion of the 15-Hour State-approved Medication	{D935}		

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{D935}	Continued From page 61 Administration Training Course for Adult Care Homes for Staff A on 07/11/19. Review of a resident's June 2019 medication administration record (MAR) revealed Staff A documented administering medication on 06/11/19 and 06/26/19. Review of the same resident's July 2019 MAR revealed Staff A documented administering medication on 07/01/19, 07/03/19, and 07/05/19-07/10/19. Interview with Staff A on 07/23/19 at 10:30am revealed: -She had worked at the facility for approximately 4 months. -She had been working as a MA and personal care aide (PCA) since she started her employment at the facility. -She had previous MA experience at other facilities. -She had recently completed a 15 hour MA training course this month (July 2019). -She had administered medications to the residents since she started working at the facility. Interview with the Executive Director (ED) on 7/24/19 at 05:00pm revealed: -All the documentation of Staff A's MA qualifications should be in her personnel record. -She believed Staff A had worked previously as a MA at another facility. -She was not aware that Staff A had not completed the 15-hour Medication Training until 07/11/19. -She was aware that Staff A had given medications to residents at the facility.	{D935}		