STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053028	A. BUILDING: _____ B. WING _____	R 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL OAKS ASSISTED LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(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 an annual survey and a follow-up survey on August 14-15, 2019, with a telephone exit on August 16, 2019.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain floors, walls, ceiling vents, carpets, toilets, shower curtains and doorways clean and in good repair for residents' rooms (resident rooms #1, #7 and #10) and bathrooms. The findings are: Observation on 08/14/19 at 9:48 am of resident room #1 revealed: -There was browned stained carpet at the doorway with frayed edges and had separated from the floor. -There were dried yellow liquid stains on the left and back wall. -There were numerous 2-inch patches of pinhead sized black markings on the walls at the ceiling and one black patch on the wall 8 inches above the middle of the resident's bed.	D 074		

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D 074	Continued From page 1 Observation on 08/14/19 at 9:45 am of the bathroom in resident room #1 revealed: -There was a heavy build-up of brown dust and dirt in the corners of the room and at the base of the doorframe. -There were brown stains on the baseboard. -There were yellow and brown stains on the linoleum flooring. -There were black smudge marks on the walls. -There were brown and yellow stains on the toilet base under the seat. -There were yellow, black and brown stains on the floor around the base of the toilet. -The metal toilet paper holder was coated with rust. -There was a heavy coating of fuzzy gray dust on the ceiling vent. Interview on 08/14/19 at 10:12 am with a resident in room #1 revealed: -The facility had been treated for bed bugs last month, but there were still smears on the walls from the spray and heat treatments. -No staff washed the walls or painted over the smears and stains on the walls. Observation on 08/14/19 at 10:36 am of resident room #7 revealed: -There was browned stained carpet at the doorway with frayed edges and was separated from the floor. -There was a 2-inch by 2-inch patch of pinhead sized black markings on the wall above the bathroom door. Interview on 08/14/19 at 9:55 am with a resident in room #7 revealed they had never seen their bathroom being cleaned.	D 074		

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D 074	Continued From page 2 Observation on 08/14/19 at 10:38 am of resident room #10 revealed there was browned stained carpet at the doorway with frayed edges and was separated from the floor. Observation on 08/14/19 at 10:55 am of the bathroom in resident room #10 revealed: -There was a heavy build-up of brown dust and dirt in the corners of the room and at the base of the doorframe. -There were brown stains on the baseboard. -The base of the shower curtain was coated with a white and yellow film. -There were yellow and brown stains on the linoleum flooring. -There was a large gray stain on the flooring under the toilet and in the middle of the room. -The linoleum flooring under the sink was detached and curling above the floor. -There were black specks on the wall under the sink. -There was a 6-inch wide puddle of water on the floor between the toilet and the sink. -There were yellow and brown stains on the floor around the base of the toilet. Interview on 08/14/19 at 9:42 am with a resident in room #10 revealed: -The resident bathroom floors were mopped, and the toilets were cleaned (would not say how often). -The frayed carpet on the floor at the room's door could be a trip hazard. Interview on 08/15/19 at 1:45 pm with the Housekeeper revealed: -He started working at the facility on 07/17/19 and worked one day a week as a personal care aide (PCA) and four days a week as Housekeeper. -All PCAs and the Housekeeper were to assist	D 074		

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D 074	Continued From page 3 with cleaning the facility. -He vacuumed the residents' rooms and cleaned the residents' bathrooms daily using bleach and disinfectant for the stains. -He replaced the toilet paper and paper towels in the residents' bathrooms. -The vacuum did not spin when running, so he had to use a hand- held vacuum to clean the floors. -He did not dust or clean the bathroom air vents. -He was not aware the bathroom in resident room #10 had a water leak and the flooring needed repair. -He had not noticed any live bed bugs or bed bug droppings on residents' rooms' walls, he did not wash walls. -His focus for cleaning was the residents' bathrooms. Interview on 08/15/19 at 5:00 pm with the Administrator revealed: -There was one housekeeper and the PCA staff to clean the facility and residents' rooms. -She expected staff to deep clean each residents' room, bathroom, and wipe down residents' mattresses weekly. -Bathroom baseboards and corner areas should not have a build-up of dirt. -She expected needed repairs to be reported to her; there was maintenance available to do the work within 24 hours. -She tried to do a walk- through of resident areas weekly but had not done so for the last week.	D 074		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations	D 234		

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D 234	Continued From page 4 (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 1 of 3 sampled residents (Resident #2) was tested for tuberculosis (TB) disease upon admission. The findings are: Review of Resident #2's current FL-2 dated 08/06/19 revealed diagnoses included bi-polar disorder, anemia, history of left wrist fracture and acute kidney injury. Review of Resident #2's Resident Register revealed an admission date of 07/10/18. Review of Resident #2's record revealed: -There was documentation the resident had a TB skin test completed on 07/09/18 with a negative result on 07/12/18. -There was no documentation the resident had a second TB skin test completed upon admission. Interview on 08/15/19 at 3:45 pm with Resident #2 revealed: -She did not have a second TBskin test after being admitted to the facility.	D 234		

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D 234	Continued From page 5 -She did not know she needed to have a second TB skin test. -No one spoke to her about having a second TB skin test completed since she had been admitted. Interview on 08/16/19 at 9:04 am with the Resident Care Coordinator (RCC) revealed: -Residents were to have a TB skin test completed prior to admission to the facility and have a second TB skin test completed 2 to 3 weeks later. -She did not know Resident #2 did not have documentation in her records for a second TB skin test. -She was responsible for assuring residents completed TB skin testing documentation in their records. -She audited residents' records last week and did not realize that Resident #2 did not have a second TB skin test. Interview on 08/16/19 at 9:11 am with the Administrator revealed: -She did not know Resident #2 did not have two completed TB skin tests in her records. -Residents were to have a TB skin test before admission and a second TB skin test completed 30 days later. -Residents' records were audited weekly by the Administrator and the RCC. -Documentation of completed TB skin tests "fell under the radar", it was not done.	D 234		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional;	D 276		

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D 276	Continued From page 6 and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physician orders were implemented for 1 of 5 sampled residents (#1) with orders for portable oxygen and orders to check vital signs twice a month. The findings are: Review of Resident #1's current hospital FL2 dated 02/26/19 revealed diagnoses included chronic obstructive pulmonary disease (COPD), hyperlipidemia, and failure to thrive. a. Review of Resident #1's primary care provider's (PCP) New Patient Encounter report dated 06/11/19 revealed: -Resident #1 had an oxygen concentrator that he used when he was in his room. -Resident #1 reported his oxygen level dropped when he removed his oxygen. -Resident #1 reported his oxygen saturation is consistently between 85 and 87 when he was out of the facility at medical appointments. -Resident #1 had a diagnosis of COPD and was prescribed oxygen at 2 liters (L) continuous. -Resident #1 could walk half the distance of the	D 276		

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facility before having to stop to rest.
-Resident #1's oxygen saturation on room air while at rest was 94% with a pulse of 70.
-After walking the length of the facility, after approximately 3 minutes, Resident #1's oxygen saturation was 85% and his pulse was 93.
-There was an order for portable oxygen to be used at 2L via nasal canula.

Observation of Resident #1 at various times throughout the day on 08/14/19 and 08/15/19 revealed Resident #1 did not have portable oxygen in place when he was in the hallways, dining hall and on the outside of the facility.

Interview with Resident #1 on 08/14/19 at 9:34 am revealed:
-He had physician's orders for continuous oxygen.
-He did not have portable oxygen tanks to take with him when he left his room.
-When he ambulated outside of his room, he had to stop to catch his breath.
-He sometimes needed to walk to the store without any oxygen.

A second interview with Resident #1 on 08/15/19 at 12:45 pm revealed:
-The facility staff knew he needed portable oxygen, but they had not ordered it yet.
-He did not know why portable oxygen had not been ordered.

Interview with Resident #1's infectious disease provider on 08/15/19 at 1:45 pm revealed:
-Resident #1 was last seen in April 2019.
-He required oxygen at his visit in April 2019, but he did not have portable oxygen.
-Resident #1 had been trying to obtain oxygen that he could travel with.

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D 276	Continued From page 8 -Not having portable oxygen seemed to be interfering with his daily activities. Interview with Resident #1's PCP on 08/15/19 at 3:30 pm revealed: -She ordered portable oxygen for Resident #1 in June 2019 due to his report of shortness of breath when ambulating outside of his room. -She did not know Resident #1 did not have portable oxygen at the facility. -She would have expected for the facility to have ordered the portable oxygen by now. Interview with a Medication Aide (MA) on 08/15/19 at 4:12 pm revealed: -Resident #1 should have oxygen on all the time. -Resident #1 should have a "travel bag of oxygen" (portable oxygen), but he was not sure if portable oxygen was available in the facility for Resident #1. -He had not seen Resident #1 with portable oxygen when he ambulated outside of his room. -He had never seen Resident #1 having any difficulty with breathing and had not seen him stop to catch his breath while ambulating. Interview with the Resident Care Coordinator (RCC) on 08/15/19 at 4:19 pm revealed: -She was responsible for reviewing physician reports for changes and new orders. -She knew about the physician's order for portable oxygen for Resident #1. -She was responsible for ordering medical equipment and thought she had ordered portable oxygen for Resident #1 about 2 weeks ago. -Resident #1 did not currently have portable oxygen available at the facility. Interview with the Administrator on 08/15/19 at 4:20 pm revealed:	D 276		

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-She did not know about the order for portable oxygen for Resident #1.
-Portable oxygen had not been ordered for Resident #1, but she planned on ordering it on 08/16/19.

b. Review of Resident #1's current FL2 dated 02/26/19 revealed there was a physician's order to check and record vital signs 2 times monthly on the 1st and the 15th.

Review of Resident #1's electronic Medication Administratoin Record (eMAR) for July 2019 revealed:
-There was an entry for vital signs: blood pressure (BP), pulse, and temperature and vital signs were to be taken twice monthly on the 1st and 15th.
-There was no documentation of vital signs for 07/01/19 and 07/15/19.

Review of Resident #1's eMAR for August 2019 revealed:
-There was an entry for vital signs: blood pressure (BP), pulse, and temperature and vital signs were to be taken twice monthly on the 1st and 15th.
-There was no documentation of vital signs for 08/01/19.

Review of the Vital Signs Administration History for Resident #1 revealed:
-There was no documentation of BP taken on 07/01/19 and 07/15/19.
-It was documented "Resident Refused" on 08/01/19.

Interview with Resident #1 on 08/15/19 at 3:03 pm revealed:
-Staff did not check his vital signs twice a month.

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D 276	Continued From page 10 -He did not know how often his vital signs were supposed to be checked, but it had been a while since staff checked them. -Staff weighed him sometimes, but they did not check his vital signs including his BP. -He never refused to have his vital signs checked and did not have his vital signs checked in June, July, or August 2019. Interview with Resident #1's Primary Care Physician (PCP) on 08/15/19 at 3:30 pm revealed: -She wrote an order dated 10/11/18 for Resident #1's vital signs to be checked weekly due to the resident being administered BP and hypertension medication. -She signed physician's orders for Resident #1's vital signs to be checked twice a month on 02/14/19 and 02/26/19 (FL2). -Vital signs included temperature, pulse, respirations and BP. -The facility usually did not check oxygen saturation. -She did not know Resident #1's vital signs had not been checked since 06/15/19. -She expected for Resident #1's BP to be checked twice a month. Interview with a MA on 08/15/19 at 4:12 pm revealed: -He usually checked vital signs around the 15th of every month. -Vital signs included weight, BP, and pulse. -He had not seen any physician's orders for a resident's vital signs to be checked more than once a month. -He did not know if there was a physician's order for Resident #1's vital signs to be checked twice a amonth or if Resident #1's vital signs had been checked twice a month.	D 276		

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D 276	Continued From page 11 Interview with the Resident Care Coordinator (RCC) on 08/15/19 at 4:19 pm revealed: -Resident #1 had orders to have his vital signs checked twice a month. -As far as she knew, Resident #1's vital signs had been checked twice a month and should have been documented on the eMAR. -Resident #1 refused to have his vital signs checked at times, but she notified his PCP. -She did not document she notified Resident #1's PCP when he refused to have his vital signs checked. Interview with the Administrator on 08/15/19 at 4:20 pm revealed: -The Medication Aides (MAs) were responsible for checking residents' vital signs including BP, pulse and temperature. -Resident #1 had an order to check vital signs twice a month on the 1st and 15th. -She did not know vital signs were last checked for Resident #1 on 06/15/19. -She expected for Resident #1's vital signs to be checked as ordered by the physician. A second interview with the RCC on 08/15/19 at 4:46 pm revealed: -MAs were responsible for checking residents' vital signs. -MAs and the RCC were responsible for contacting PCPs with any issues regarding vital signs. -She knew Resident #1's vital signs were to be checked twice a month, but she did not know Resident #1's vital signs had not been checked since 06/15/19. -She was responsible for completing eMAR audits.	D 276		

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D 276	Continued From page 12 -She had completed eMAR audits only once since she started working in July 2019.	D 276		
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: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 2 of 5 sampled residents with diet orders for a mechanical soft (MS) diet with nectar thick liquids (Resident #4) and nutritional supplements (Resident #1). The findings are: 1. Review of Resident #4's current FL-2 dated 02/26/19 revealed: -Diagnoses included hypertension, chronic obstructive pulmonary disease, hyperlipidemia, benign prostatic hyperplasia, gastroesophageal reflux disease, constipation, insomnia, and vitamin B deficiency. -There was an order for a pureed diet with nectar thickened liquids. Review of Resident #4's physician's orders dated 06/11/19 revealed an order for a MS diet. Review of the therapeutic diet list posted in the	D 310		

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kitchen on 08/14/19 revealed:
-Resident #4 was to be served a MS diet.
-No residents were listed to be served thickened liquids.

Observation of the kitchen on 08/14/19 at 10:43 am revealed:
-There was an opened 36 ounce container of a thickener with a pharmacy label for Resident #4.
-The thickener was dispensed by the pharmacy on 02/07/19 with instructions to add as directed to all beverages.

Review of the facility's diet spreadsheet for the lunch meal on 08/14/19 revealed:
-There was a diet labeled, L3/Advanced, which indicated ground beef brisket, gravy, garlic mashed potatoes, baked zucchini, dinner roll, margarine, brownie, and coffee or tea were to be served.
-There was a diet labeled, L2/Mech Alt, which indicated ground beef brisket, soft mashed zucchini, dinner roll slurry, margarine, brownie slurry, and coffee or tea were to be served.
-There was no diet listed for MS.

Interview with the cook on 08/14/19 at 11:15 am revealed:
-He had only worked in the facility for a few months and was trained by another cook.
-Resident #4 was served a mechanical soft diet.
-There were no residents with physician's orders for thickened liquids.
-He had seen the container of thickener, but he had not been instructed to serve it in liquids for Resident #4.
-The current menu was at the sister facility because they shared menus.
-He called the sister facility this morning to find out what to serve residents.

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D 310	Continued From page 14 -He did not know if there was a therapeutic menu. Observation of the lunch meal on 08/14/19 between 12:16 pm and 12:50 pm revealed: -Resident #4 and two other residents ate their meals in a dining hall adjacent to and opened up to the main dining hall. -Resident #4 was served chopped hamburger with gravy, mashed potatoes, roll, stewed tomatoes, butterscotch pudding, water and fruit punch without thickener. -Resident #4 cut his chopped hamburger into smaller portions before eating. -Resident #4 coughed at 12:18 pm after taking a bite of mashed potatoes. -Resident #4 coughed at 12:37 pm after taking a bite of chopped hamburger. -Resident #4 coughed at 12:38 pm after drinking water. -Resident #4 ate about 50% of his meal and had some drooling as he ate. -There was no staff in direct observation of Resident #4 as he ate his meal. A second interview with the cook on 08/14/19 at 12:40 pm revealed: -He had not seen a therapeutic menu which indicated what each resident who was on a special diet was to be served. -He usually cut up meats for Resident #4 and for all residents who were to be served a MS diet. -No one reported to him Resident #4 had any issues with eating his meals. -He and the Personal Care Aides (PCAs) walked around the dining hall to check on residents during meals. Review of the facility's diet spreadsheet for the lunch meal on 08/14/19 revealed: -There was a diet labeled "L3/Advanced" which	D 310		

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indicated ground pork and veggie stir fry, rice, 1 slice of bread, stewed apples, coffee or tea were to be served.
-There was a diet labeled "L2/Mech Alt" which indicated pureed pork stir fry white rice, 1 slice of bread slurry, stewed apples, coffee or tea were to be served.
-There was not a diet specifically labeled MS.

Observation of the lunch meal on 08/15/19 between 12:07 pm and 12:35 pm revealed:
-Resident #4 was served chopped pork stir fry, a chopped egg roll, tea and water without thickener.
-At 12:15pm, a PCA took Resident #4's plate and said to him "Let me get you another plate and see if we can grind your food better."
-At 12:18pm, the PCA served Resident #4 chopped deli ham, a slice of bread, veggies, and stewed apples.
-Resident #4 had no difficulties consuming the chopped deli ham, bread, veggies, stewed apples, tea and water.

Interview with the PCA on 08/15/19 at 12:18 pm revealed:
-The PCAs usually monitored the residents in the dining hall during meals.
-She had not noticed anyone having difficulty with eating, coughing, or choking.
-She took Resident #4's plate back to the kitchen because his food had to be ground.
-She did not know what Resident #4's diet order was and did not know if Resident #4 was to be served thickened liquids.

Interview with a second cook on 08/15/19 at 7:45 am and 12:20 pm revealed:
-He had worked at the facility for 3 months and was trained by a cook at the sister facility.
-He used the diet spreadsheet to prepare meals

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for residents.
-There were 3 residents on MS diets.
-He was not sure if he should be following the "L3/Advanced" menu or the "L2/Mech Alt" menu.
-He had never asked anyone or spoken to the facility contracted Registered Dietician regarding which diet menu to use.
-He usually just chopped the meats up with a knife for Resident #4 and other residents who had orders for a MS diet.
-He sent out another plate for Resident #4 for the lunch meal on 08/15/19 because the PCA told him Resident 4's meats had to be soft.
-He sometimes ground meats for residents on a mechanical soft diet with a hand blender.
-There had been no residents on thickened liquids since he had worked at the facility.
-Resident #4 had not been served thickened liquids.
-The cooks and the PCAs monitored the dining hall during meal time.
-He had not noticed or been told anyone had difficulty eating.

Interview with the Home Health provider on 08/15/19 revealed Resident #4 received speech therapy services from 02/20/19 through 04/08/19, but no other information could be provided.

Interview with Resident #4 on 08/15/19 at 11:43 am revealed:
-He was on a pureed diet, but it was changed to MS after he told a physician (not the primary care physician) pureed foods were not giving him enough strength.
-He did not have any teeth and sometimes had trouble swallowing.
-He coughed during the lunch meal on 08/14/19 due to having trouble swallowing the chopped hamburger.

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-He wished the chopped hamburger had been "cut up a little more."
-He did not need thickened liquids because he drank better without it.

Interview with the Resident Care Coordinator (RCC) on 08/15/19 at 4:19 pm revealed:
-The Administrator was responsible for updating the therapeutic diet list and ensuring diets were served as ordered.
-She did not know for sure which diet Resident #4 was on.
-With MS diets, the meat should be cut up as fine as possible.
-There was a blender in the kitchen, but it stopped working on Tuesday, 08/13/19.
-She did not think there were any residents in the building who were on thickened liquids.

Interview with the Administrator on 08/15/19 at 5:15 pm and on 08/16/19 at 9:18 am revealed:
-She knew Resident #4 had been having difficulty with eating his meals as served.
-She did not know Resident #4 was not being served a MS meal with thickened liquids as ordered.
-She had spoken with Resident #4's PCP who wrote an order to start Resident #4 on a pureed diet until she was able to make a visit with him.

Interview with Resident #4's PCP on 08/15/19 at 8:56 am and 11:52 am revealed:
-Resident #4 should be getting nectar thickened liquids.
-She wrote an order on 02/07/19 for thickener to be added as directed for all beverages for Resident #4 due to difficulty with swallowing.
-She also wrote an order for speech therapy to evaluate and treat Resident #4.
-She thought a MS diet was okay for Resident #4

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to be on, but she did not know he was being served chopped meat rather than ground, having difficulty swallowing at times, and was coughing during meals.
-She would need to evaluate Resident #4 and would write an order on 08/15/19 for the facility to temporarily place Resident #4 on a pureed diet with thickened liquids until she saw him.
-Not serving the appropriate diet could result in Resident #4 choking and aspirating.

A second Interview with the Administrator on 08/16/19 at 9:18 am revealed:
-The Administrator and the RCC were responsible for completing record audits (4-5 records) weekly to ensure correct orders were in place, but they had not made it through every resident's record yet.
-The kitchen staff and the Medication Aides (MA's) were responsible for making sure diets were served as ordered and PCA's assisted in the dining hall during meals.

Attempted interview with the facility's contracted Registered Dietician on 08/16/19 at 10:37 am was unsuccessful.

2. Review of Resident #1's current FL2 dated 02/26/19 revealed:
-Diagnoses included vitamin D deficiency and failure to thrive.
-There was an order for nutritional supplements 3 times daily with meals.

Review of the therapeutic diet menu on 08/14/19 revealed no resident was listed as having orders for a nutritional supplement.

Observation of the refrigerator on 08/14/19 at 10:38 am revealed:

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D 310	Continued From page 19 -There were 8 cartons of nutritional supplements available. -None of the cartons were labeled with residents' names. Review of Resident #1's Medication Administration Record (MAR) for June, July, and August 2019 revealed there was no entry for nutritional supplements and no documentation of administration of nutritional supplements. Interview with a cook on 08/14/19 at 11:15 am revealed: -He was told by the cook who trained him there were 2 residents on nutritional supplements. -Resident #1 was served one nutritional supplement a day. -The PCAs served the nutritional supplements to residents. Observation of the lunch meal service on 08/14/19 between 12:16 pm and 12:50 pm revealed Resident #1 was not served a nutritional supplement with his lunch meal. Interview with Resident #1 on 08/15/19 at 8:49 am revealed: -He was supposed to be getting nutritional supplements with his meals, but he had not been getting them. -He had not had a nutritional supplement in at least 1 month. -He had not asked staff for a nutritional supplement and staff had not been offering it like they used to. Interview with a second cook on 08/15/19 at 8:52 am revealed: -Resident #1 received a nutritional supplement with lunch and dinner meals.	D 310		

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-He did not know Resident #1 had an order for a nutritional supplements 3 times daily with meals.
-The Administrator was responsible for ordering nutritional supplements for residents.
-The PCAs served nutritional supplements to residents.

Interview with Resident #1's PCP on 08/15/19 at 8:56 am revealed:
-Resident #1 should be receiving nutritional supplements 3 times daily, but she did not think she wrote the order for nutritional supplements.
-She thought Resident #1's infectious disease provider wrote the order.
-Resident #1's labs showed adequate protein levels.
-Resident #1's infectious disease provider checked his labs with each visit.
-A possible outcome of not receiving nutritional supplements could be a decrease in protein levels.

Interview with Resident #1's infectious disease provider on 08/15/19 at 1:45 pm revealed she did not see where the provider wrote an order for nutritional supplements or any mention of nutritional supplements in Resident #1's medical record.

Interview with the Administrator on 08/15/19 at 5:15 pm and 08/16/19 at 9:18 am revealed:
-She was responsible for ordering nutritional supplements.
-She thought only 1 resident was on nutritional supplements and did not know Resident #1 had orders for nutritional supplements.
-She did not know if Resident #1 had been getting his nutritional supplements as ordered.
-Nutritional supplements should be documented as given on the eMAR.

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D 310	Continued From page 21 -She did not know there was no documentation of nutritional supplements on eMAR. _____ The facility failed to serve Resident #4, MS diet and thick liquids as ordered placing him at risk for choking and aspirating and failed to serve Resident #1, with a diagnosis of a diagnosis of failure to thrive, a nutritional supplement 3 times a day as ordered placing him at risk for a decrease in protein levels. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/15/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 1, 2019.	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 by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (#1 and #2) related to 3 antiretroviral medications, 2 anti-hypertensive medications, 1 anticholinergic medication, 2 anxiety medications (Resident #1), and 1 pain medication (Resident #2).

The findings are:

1. Review of Resident #1's current FL2 dated 02/26/19 revealed diagnoses included a bloodborne infectious disease, chronic obstructive pulmonary disease (COPD), vitamin D deficiency, depression, failure to thrive, and hyperlipidemia.

a. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Tivicay 50 mg take 1 tablet daily. (Tivicay is an antiretroviral medication used to treat bloodborne infectious diseases).

Review of Resident #1's electronic Medication Administration Record (eMAR) for July 2019 revealed:
-There was an entry for Tivicay 50 mg daily scheduled at 8:00 am.
-Tivicay was not documented as administered due to "MED (medication) ON ORDER FROM

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PHARMACY" on 07/29/19 at 8:00 am.
-Tivicay was not documented as administered due to "NOT ON CART" on 07/30/19 and 07/31/19 at 8:00 am.
-There were 3 doses of Tivicay 50 mg missed.

Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed there were 30 tablets of Tivicay 50 mg dispensed on 07/01/19 with 14 tablets remaining and available for administration.

Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed:
-The pharmacy did not receive the FL2 dated 02/26/19 for Resident #1.
-The pharmacy received the physician's orders dated 02/14/19 for Resident #1.
-On 07/28/19, a Medication Aide (MA) at the facility ordered Tivicay 50 mg daily through the eMAR.
-On 06/27/19, 30 tablets of Tivicay 50 mg were dispensed.
-On 07/29/19, 30 tablets of Tivicay 50 mg were dispensed.

Interview with the MA on 08/15/19 at 12:22 pm revealed:
-She selected "not on cart" in the eMAR for Tivicay on 07/30/19 and 07/31/19.
-Medications "not on cart" meant they were either not available on the cart or ordered from the pharmacy through the eMAR.
-She attempted to order Tivicay through the eMAR on 07/30/19 and 07/31/19 but was "rejected" because Tivicay already ordered by other staff.

Interview with Resident #1 on 08/15/19 at 12:45

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D 358	Continued From page 24 pm revealed: -He did not get 3 days of medication at the end of July 2019. -When he did not get his medications at the end of July 2019, the MA told him the medications were at the facility, but they were for the August 2019 cycle, and they would not be given in July 2019. -He felt increased pain and scared when he did not receive his infectious disease medications at the end of July 2019. -He did not feel the staff communicated with other staff. Interview with Resident #1's primary care provider (PCP) on 08/15/19 at 3:30 pm revealed: -She was not aware that Tivicay was not administered for a total of 3 doses on 07/29/19, 07/30/19, and 07/31/19. -She was concerned that Tivicay was not administered as ordered because it was prescribed for an infectious disease. -She did not prescribe Tivicay for Resident #1. -Tivicay was prescribed by an Infectious Disease Provider. -The last appointment for Resident #1 with the PCP was on 06/11/19. Interview with the Resident Care Coordinator (RCC) on 08/15/19 at 4:46 pm revealed she did not know why Resident #1 did not receive Tivicay as ordered on 07/29/19, 07/30/19, and 07/31/19. Attempted telephone interview with Resident #1's Infectious Disease Provider on 08/16/19 at 09:45 am was unsuccessful. Refer to interview with a representative from the contracted pharmacy 08/15/19 at 8:50 am.	D 358		

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D 358	Continued From page 25 Refer to interview with the MA on 08/15/19 at 12:22 pm. Refer to interview with the Administrator on 08/15/19 at 4:20 pm and 08/16/19 at 12:40 pm. Refer to interview with the RCC on 08/15/19 at 4:46 pm and 08/16/19 at 12:30 pm. Refer to interview with the second MA on 08/16/19 at 11:20 am. b. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Prezcobix 800 mg take 1 tablet daily. (Prezcobix is an antiretroviral medication used to treat bloodborne infectious diseases). Review of Resident #1's electronic Medication Administration Record (eMAR) for July 2019 revealed: -There was an entry for Prezcobix 800 mg-150 mg daily scheduled at 8:00 am. -Prezcobix was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/29/19 at 8:00 am. -Prezcobix was not documented as administered due to "NOT ON CART" on 07/30/19 at 8:00 am. -There were 2 doses of Prezcobix 800 mg-150 mg missed. Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed 30 tablets of Prezcobix 800 mg-150 mg dispensed on 07/01/19 with 14 tablets remaining and available for administration. Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed:	D 358		

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-The pharmacy did not receive the FL2 dated 02/26/19 for Resident #1.
-The pharmacy received the physician's orders dated 02/14/19 for Resident #1.
-The physician's order for Prezcobix was 800 mg-150 mg 1 tablet daily.
-On 07/28/19, a medication aide (MA) at the facility ordered Prezcobix 800 mg-150 mg daily through the eMAR.
-On 06/27/19, 30 tablets of Prezcobix 800 mg-150 mg were dispensed.
-On 07/29/19, 30 tablets of Prezcobix 800 mg-150 mg were dispensed.

Interview with MA on 08/15/19 at 12:22 pm revealed:
-She selected "not on cart" in the eMAR for Prezcobix on 07/30/19.
-Medications "not on cart" meant they were either not available on the cart or ordered from the pharmacy through the eMAR.
-She attempted to order Prezcobix through the eMAR on 07/30/19 but was "rejected" because Prezcobix was already ordered by other staff.

Interview with Resident #1 on 08/15/19 at 12:45 pm revealed:
-He did not get 2 days of medication at the end of July 2019.
-When he did not get his medications at the end of July, the MA told him the medications were at the facility, but they were for the August 2019 cycle, and they would not be given in July 2019.
-He felt increased pain and scared when he did not receive his infectious disease medications at the end of July 2019.
-He did not feel the staff communicated with other staff.

Interview with Resident #1's primary care provider

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(PCP) on 08/15/19 at 3:30 pm revealed:
-She was not aware that Prezcobix was not administered for a total of 2 doses on 07/29/19 and 07/30/19.
-She was concerned that Prezcobix was not administered as ordered because it was prescribed for an infectious disease.
-She did not prescribe Prezcobix for Resident #1.
-Prezcobix was prescribed by an Infectious Disease Provider.
-The last appointment for Resident #1 with the PCP was on 06/11/19.

Interview with the Resident Care Coordinator (RCC) on 08/15/19 at 4:46 pm revealed she did not know why Resident #1 did not receive Prezcobix as ordered on 07/29/19 and 07/30/19.

Attempted telephone interview with Resident #1's Infectious Disease Provider on 08/16/19 at 09:45 am was unsuccessful.

Refer to interview with a representative from the facility contracted pharmacy 08/15/19 at 8:50 am.

Refer to interview with the MA on 08/15/19 at 12:22 pm.

Refer to interview with the Administrator on 08/15/19 at 4:20 pm and 08/16/19 at 12:40 pm.

Refer to interview with the RCC on 08/15/19 at 4:46 pm and 08/16/19 at 12:30 pm.

Refer to interview with the second MA on 08/16/19 at 11:20 am.

c. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Abacavir 300 mg take 2 tablets daily. (Abacavir is an antiretroviral

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medication used to treat bloodborne infectious diseases).

Review of Resident #1's electronic Medication Administration Record (eMAR) for July 2019 revealed:
-There was an entry for Abacavir 300 mg 2 tablets daily scheduled to be administered at 8:00 am.
-Abacavir was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/29/19 at 8:00 am.
-Abacavir was not documented as administered due to "NOT ON CART" on 07/30/19 and 07/31/19 at 8:00 am.
-There were 3 doses of Abacavir 300 mg 2 tablets missed.

Review of Resident #1's August 2019 eMAR revealed:
-There was an entry for Abacavir 300 mg 2 tablets daily scheduled to be administered at 8:00 am.
-Abacavir was not documented as administered due to "NOT ON CART" on 08/01/19 at 8:00 am.
-There was 1 dose of Abacavir 300 mg 2 tablets missed.

Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed there were 60 tablets of Abacavir 300 mg dispensed (30-day supply) on 07/01/19 with 28 tablets (14-day supply) remaining and available for administration.

Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed:
-The pharmacy did not receive the FL2 dated 02/26/19 for Resident #1.

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-The pharmacy received the physician's orders dated 02/14/19 for Resident #1.
-On 07/28/19, a medication aide (MA) at the facility ordered Abacavir 300 mg 2 tablets daily through the eMAR.
-On 06/27/19, 60 tablets of Abacavir 300 mg were dispensed.
-On 07/29/19, 60 tablets of Abacavir 300 mg were dispensed.

Interview with the MA on 08/15/19 at 12:22 pm revealed:
-She selected "not on cart" in the eMAR for Abacavir that were not on the cart on 07/30/19, 07/31/19, and 08/01/19.
-Medications "not on cart" meant they were either not available on the cart or ordered from the pharmacy through the eMAR.
-She attempted to order the Abacavir through the eMAR on 07/30/19, 07/31/19, and 08/01/19 but was "rejected" because Abacavir was already ordered by other staff.

Interview with Resident #1 on 08/15/19 at 12:45 pm revealed:
-He did not get 4 days of medication at the end of July 2019 and beginning of August 2019.
-When he did not get his medications at the end of July, the MA told him the medications were at the facility, but they were for the August 2019 cycle, and they would not be given in July 2019.
-He felt increased pain and scared when he did not receive his infectious disease medications at the end of July 2019.
-He did not feel the staff communicated with other staff.

Interview with Resident #1's primary care provider (PCP) on 08/15/19 at 3:30 pm revealed:
-She was not aware that Abacavir was not

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administered for a total of 4 doses on 07/29/19, 07/30/19, 07/31/19, and 08/01/19.
-She was concerned that Abacavir was not administered as ordered because it was prescribed for an infectious disease.
-She did not prescribe Abacavir for Resident #1.
-Abacavir was prescribed by an Infectious Disease Provider.
-The last appointment for Resident #1 with the PCP was on 06/11/19.

Interview with the Resident Care Coordinator (RCC) on 08/15/19 at 4:46 pm revealed she did not know why Resident #1 did not receive Abacavir as ordered 07/29/19, 07/30/19, 07/31/19, and 08/01/19.

Attempted telephone interview with Resident #1's Infectious Disease Provider on 08/16/19 at 09:45 am was unsuccessful.

Refer to interview with a representative from the facility contracted pharmacy 08/15/19 at 8:50 am.

Refer to interview with the MA on 08/15/19 at 12:22 pm.

Refer to interview with the Administrator on 08/15/19 at 4:20 pm and 08/16/19 at 12:40 pm.

Refer to interview with the RCC on 08/15/19 at 4:46 pm and 08/16/19 at 12:30 pm.

Refer to interview with the second MA on 08/16/19 at 11:20 am.

d. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Metoprolol 50 mg 1 tablet daily. (Metoprolol is a beta blocker medication used to treat hypertension).

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D 358	Continued From page 31 Review of Resident #1's electronic Medication Administration Record (eMAR) for July 2019: -There was an entry for Metoprolol Succ ER (Metoprolol Succinate Extended Release) 50 mg daily scheduled to be administered at 8:00 am. -Metoprolol Succ ER was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/29/19 at 8:00 am. -Metoprolol Succ ER was not documented as administered due to "NOT ON CART" on 07/30/19 at 8:00 am. -There were 2 doses of Metoprolol Succ ER 50 mg missed. Review of Resident #1's August 2019 eMAR revealed: -There was an entry for Metoprolol Succ ER 50 mg daily scheduled to be administered at 8:00 am. -Metoprolol Succ ER was not documented as administered due to "NOT ON CART" on 08/01/19 at 8:00 am. -There was 1 dose of Metoprolol Succ ER 50 mg missed. Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed 30 tablets of Metoprolol Succ ER 50 mg dispensed on 07/03/19 with 14 tablets remaining and available for administration. Interview with a representative from the facility contracted pharmacy on 08/15/19 at 8:50 am revealed: -The pharmacy did not receive the FL2 dated 02/26/19 for Resident #1. -The pharmacy received the physician's orders dated 02/14/19 for Resident #1.	D 358		

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D 358	Continued From page 32 -On 07/28/19, a medication aide (MA) at the facility ordered Metoprolol Succ ER 50 mg daily through the eMAR. -On 06/27/19, 30 tablets of Metoprolol Succ ER 50 mg were dispensed. -On 07/29/19, 30 tablets of Metoprolol Succ ER 50 mg were dispensed. Interview with the MA on 08/15/19 at 12:22 pm revealed: -She selected "not on cart" in the eMAR for Metoprolol that was not on the cart on 07/30/19 and 08/01/19. -Medications "not on cart" meant they were either not available on the cart or ordered from the pharmacy through the eMAR. -She attempted to order the Metoprolol through the eMAR on 07/30/19 and 08/01/19 but was "rejected" because Metoprolol was already ordered by other staff. Interview with Resident #1 on 08/15/19 at 12:45 pm revealed: -He did not get 3 days of medication at the end of July 2019 and beginning of August 2019. -When he did not get his medications at the end of July, the MA told him the medications were at the facility, but they were for the August 2019 cycle, and they would not be given in July 2019. -He did not feel the staff communicated with other staff. Interview with Resident #1's primary care provider (PCP) on 08/15/19 at 3:30 pm revealed: -She was not aware that Metoprolol was not administered for a total of 3 doses on 07/29/19, 07/30/19, and 08/01/19. -Metoprolol was prescribed to treat hypertension. -She was concerned that Metoprolol was not administered as ordered.	D 358		

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-When Resident #1 was not administered Metoprolol as ordered, he was at an increased risk for hypertension.
-The last appointment for Resident #1 with the PCP was on 06/11/19.
-The BP was not collected at the facility for July 2019.
-Staff documented BP of 165/118 on 08/15/19 at 2:15 pm.

Interview with the Resident Care Coordinator (RCC) on 08/15/19 at 4:46 pm revealed she did not know why Resident #1 did not receive Metoprolol as ordered on 07/29/19, 07/30/19 and on 08/01/19.

Refer to interview with a representative from the facility contracted pharmacy 08/15/19 at 8:50 am.

Refer to interview with the MA on 08/15/19 at 12:22 pm.

Refer to interview with the Administrator on 08/15/19 at 4:20 pm and 08/16/19 at 12:40 pm.

Refer to interview with the RCC on 08/15/19 at 4:46 pm and 08/16/19 at 12:30 pm.

Refer to interview with the second MA on 08/16/19 at 11:20 am.

e. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Lisinopril 20 mg 1 tablet daily. (Lisinopril is an angiotension converting enzyme (ACE) inhibitor used to treat hypertension).

Review of Resident #1's electronic Medication Administration Record (eMAR) for July 2019:
-There was an entry for Lisinopril 20 mg daily

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scheduled to be administered at 8:00 am.
-Lisinopril was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/29/19 at 8:00 am.
-Lisinopril was not documented as administered due to "NOT ON CART" on 07/30/19 at 8:00 am.
-There were 2 doses of Lisinopril 20 mg missed.

Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed 30 tablets of Lisinopril 20 mg were dispensed on 07/01/19 with 14 tablets remaining and available for administration.

Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed:
-The pharmacy did not receive the FL2 dated 02/26/19 for Resident #1.
-The pharmacy received the physician's orders dated 02/14/19 for Resident #1.
-On 07/28/19, a medication aide (MA) at the facility ordered Lisinopril 20 mg daily through the eMAR.
-On 06/27/19, 30 tablets of Lisinopril 20 mg were dispensed.
-On 07/29/19, 30 tablets of Lisinopril 20 mg were dispensed.

Interview with the MA on 08/15/19 at 12:22 pm revealed:
-She selected "not on cart" in the eMAR for Lisinopril that was not on the cart on 07/30/19.
-Medications "not on cart" meant they were either not available on the cart or ordered from the pharmacy through the eMAR.
-She attempted to order Lisinopril through the eMAR on 07/30/19 but was "rejected" because Lisinopril was already ordered by other staff.

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D 358	Continued From page 35 Interview with Resident #1 on 08/15/19 at 12:45 pm revealed: -He did not get 2 days of medication at the end of July 2019. -When he did not get his medications at the end of July, the MA told him the medications were at the facility, but they were for the August 2019 cycle, and they would not be given in July 2019. -He did not feel the staff communicated with other staff. Interview with Resident #1's primary care provider (PCP) on 08/15/19 at 3:30 pm revealed: -She was not aware that Lisinopril was not administered for a total of 2 doses on 07/29/19 and 07/30/19. -Lisinopril was prescribed to treat hypertension. -She was concerned that Lisinopril was not administered as ordered. -When Resident #1 was not administered Lisinopril as ordered, he was at an increased risk for hypertension. -The last appointment for Resident #1 with the PCP was on 06/11/19. -The BP was not collected at the facility for July 2019. -Staff documented BP of 165/118 on 08/15/19 at 2:15 pm. Interview with the Resident Care Coordinator (RCC) on 08/15/19 at 4:46 pm revealed she did not know why Resident #1 did not receive Lisinopril as ordered on 07/29/19 and 07/30/19. Refer to interview with a representative from the facility contracted pharmacy 08/15/19 at 8:50 am. Refer to interview with the MA on 08/15/19 at 12:22 pm.	D 358		

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D 358	Continued From page 36 Refer to interview with the Administrator on 08/15/19 at 4:20 pm and 08/16/19 at 12:40 pm. Refer to interview with the RCC on 08/15/19 at 4:46 pm and 08/16/19 at 12:30 pm. Refer to interview with the second MA on 08/16/19 at 11:20 am. f. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Incruse Ellipta 1 time daily. (Incruse Ellipta is an anticholinergic medication used to treat COPD). Review of Resident #1's electronic Medication Administration Record (eMAR) for July 2019: -There was an entry for Incruse Ellipta 62.5 mcg inhaler 1 puff daily scheduled to be administered at 8:00 am. -There was an entry that Incruse Ellipta may be self-administered and kept in the room. -Incruse Ellipta was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/29/19. -Incruse Ellipta was not documented as administered due to "NOT ON CART" on 07/30/19 and 07/31/19. -There were 3 doses of Incruse Ellipta 62.5 mcg missed. Review of Resident #1's August 2019 eMAR revealed: -There was an entry for Incruse Ellipta 62.5 mcg inhaler 1 puff daily scheduled to be administered at 8:00 am. -There was an entry that Incruse Ellipta may be self-administered and kept in the room. -Incruse Ellipta 62.5 mcg inhaler 1 puff was not documented as administered due to "NOT ON CART" on 08/01/19.	D 358		

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D 358	Continued From page 37 -There was 1 dose of Incruse Ellipta 62.5 mcg missed. Observation of Resident #1's room for medications on hand on 08/15/19 at 10:30 am revealed Incruse Ellipta was not available for administration. Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed: -The pharmacy did not receive the FL2 dated 02/26/19 for Resident #1. -The pharmacy received the physician's orders dated 02/14/19 for Resident #1. -The physician's orders dated 02/14/19 was for Incruse Ellipta 62.5 mcg inhale 1 puff once daily. -On 07/28/19, a medication aide (MA) at the facility ordered Incruse Ellipta 62.5 mcg daily through the eMAR. -On 06/04/19, a 30-day supply was dispensed. -On 07/30/19, a 30-day supply was dispensed. -During the first week of August 2019, the July 2019 Incruse Ellipta was returned to the pharmacy. -She did not know why the Incruse Ellipta was returned. -The PCP was the prescriber of Incruse Ellipta. Interview with Resident #1's primary care provider (PCP) on 08/15/19 at 3:30 pm revealed: -She was not aware that Incruse Ellipta was not administered as ordered on 07/29/19, 07/30/19, 07/31/19, and 08/01/19. -Incruse Ellipta was ordered by a pulmonologist to treat COPD. -She was concerned that Incruse Ellipta was not administered as ordered. -When Resident #1 was not administered Incruse Ellipta as ordered, he was at an increased risk for	D 358		

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a COPD exacerbation and shortness of breath.
-The last appointment for Resident #1 with the PCP was on 06/11/19.

Interview with Resident #1 on 08/15/19 at 11:15 am revealed:
-He had episodes of shortness of breath and wheezing.
-He stored the Incruse Ellipta in his room.
-He had not had Incruse Ellipta in 3-4 weeks.
-The facility was responsible for ordering the medications.
-He informed the staff when he needed more medication.
-He informed the MA he needed more Incruse Ellipta several times (dates unknown), but he never received the medication.
-The staff did not check to see if he had taken his medication.
-The staff did not check to see if he needed to order medication.

Interview with the MA on 08/15/19 at 12:22 pm revealed:
-She did not check the medication supply in Resident #1's room.
-She selected "not on cart" in the eMAR for Incruse Ellipta that was not on the cart on 07/30/19, 07/31/19, and 08/01/19.
-Medications "not on cart" meant they were either in Resident #1's room, not available on the cart, or ordered from the pharmacy through the eMAR.
-She attempted to order Incruse Ellipta through the eMAR that was not on the cart 07/30/19, 07/31/19, and 08/01/19 but was "rejected" because Incruse Ellipta was already ordered by other staff.

Interview with Resident #1 on 08/15/19 at 12:45 pm revealed:

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D 358	Continued From page 39 -He did not get 4 days of medication at the end of July 2019 and beginning of August 2019. -When he did not get his medications at the end of July, the MA told him the medications were at the facility, but they were for the August 2019 cycle, and they would not be given in July 2019. -He did not feel the staff communicated with other staff. Interview with the Administrator on 08/15/19 at 4:20 pm revealed: -She was not aware that Incruse Ellipta was in Resident #1's room. -She did not know that Resident #1 was out of the Incruse Ellipta. -When staff documented in the eMAR, a note should state self-administration. -She expected the staff to ask Resident #1 if he self-administered Incruse Ellipta. Interview with the Resident Care Coordinator (RCC) on 08/15/19 at 4:46 pm revealed: -She was aware that Incruse Ellipta was in Resident #1's room. -She did not know that Resident #1 was out of Incruse Ellipta. -If the Incruse Ellipta was self-administered, the MA should document on the eMAR by writing self-given and this should be done with each administration. -She did not know why Resident #1 did not receive Incruse Ellipta as ordered from 07/29/19, 07/30/19, 07/31/19, and 08/01/19. Interview with a second MA on 08/16/19 at 11:20 am revealed: -She was aware of the Incruse Ellipta in Resident #1's room. -She did not know that Resident #1 was out of the Incruse Ellipta.	D 358		

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-Resident #1 would notify the MA when he was getting low on his inhalers.
-She would ask Resident #1 if he was low on self-administered medications every other shift.
-She had not noticed Resident #1 short of breath or wheezing.

Refer to interview with a representative from the facility contracted pharmacy 08/15/19 at 8:50 am.

Refer to interview with the MA on 08/15/19 at 12:22 pm.

Refer to interview with the Administrator on 08/15/19 at 4:20 pm and 08/16/19 at 12:40 pm.

Refer to interview with the RCC on 08/15/19 at 4:46 pm and 08/16/19 at 12:30 pm.

Refer to interview with the second MA on 08/16/19 at 11:20 am.

g. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Duloxetine 20 mg 2 capsules daily. (Duloxetine is a medication used to treat depression, anxiety, and pain).

Review of Resident #1's electronic Medication Administration Record (eMAR) for July 2019:
-There was an entry for Duloxetine 20 mg 2 capsules daily scheduled to be administered at 8:00 am.
-Duloxetine was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/29/19 at 8:00 am.
-Duloxetine 20 mg 2 capsules was not documented as administered due to "NOT ON CART" on 07/30/19 at 8:00 am.
-There were 2 doses of Duloxetine 20 mg 2 capsules missed.

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D 358	Continued From page 41 Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed 60 capsules (30-day supply) of Duloxetine 20 mg were dispensed on 07/01/19 with 28 capsules (14-day supply) remaining and available for administration. Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed: -The pharmacy did not receive the FL2 dated 02/26/19 for Resident #1. -The pharmacy received the physician's orders dated 02/14/19 for Resident #1. -On 07/28/19, a medication aide (MA) at the facility ordered Duloxetine 20 mg 2 capsules daily through the eMAR. -On 06/27/19, 60 capsules of Duloxetine 20 mg were dispensed. -On 07/30/19, 60 capsules of Duloxetine 20 mg were dispensed. Interview with the MA on 08/15/19 at 12:22 pm revealed: -She selected "not on cart" in the eMAR for Duloxetine that was not on the cart on 07/30/19. -Medications "not on cart" meant they were either not available on the cart or ordered from the pharmacy through the eMAR. -She attempted to order Duloxetine through the eMAR on 07/30/19 but was "rejected" because Duloxetine was already ordered by other staff. Interview with Resident #1 on 08/15/19 at 12:45 pm revealed: -He did not get 2 days of medication at the end of July 2019. -When he did not get his medications at the end of July, the MA told him the medications were at	D 358		

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the facility, but they were for the August 2019 cycle, and they would not be given in July 2019.
-He felt increased pain and mood swings when he did not receive his Duloxetine at the end of July 2019.
-He did not feel the staff communicated with other staff.

Interview with the Resident Care Coordinator (RCC) on 08/15/19 at 4:46 pm revealed she did not know why Resident #1 did not receive Duloxetine as ordered on 07/29/19 and 07/30/19.

Interview with the Nurse Practitioner (NP) from Resident #1's mental health provider on 08/16/19 at 10:43 am revealed:
-Duloxetine was ordered for anxiety and hip pain.
-She did not know Resident #1 did not receive his Duloxetine as ordered on 07/29/19 and 07/30/19.
-She was not notified that Resident #1 did not receive his Duloxetine as ordered on 07/29/19 and 07/30/19.
-When Resident #1 was not administered Duloxetine as ordered, he was at risk for increased anxiety.
-Resident #1 was very competent and would ask if he had not received his medication.
-She expected medications to be given accurately and on time.
-Resident #1 was last seen by the NP the first week of August 2019.

Interview with Resident #1 on 08/16/19 at 11:54 am revealed:
-He noticed increased anxiety, mood swings, and difficulty sleeping when he did not receive Duloxetine at the end of July 2019.
-When Duloxetine was administered as ordered in August 2019, the anxiety and issues with sleeping decreased.

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D 358	Continued From page 43 Interview with the RCC on 08/16/19 at 12:30 pm revealed she did not see any changes in Resident #1's sleep pattern or mood during July 2019 or August 2019. Refer to interview with a representative from the facility contracted pharmacy 08/15/19 at 8:50 am. Refer to interview with the MA on 08/15/19 at 12:22 pm. Refer to interview with the Administrator on 08/15/19 at 4:20 pm and 08/16/19 at 12:40 pm. Refer to interview with the RCC on 08/15/19 at 4:46 pm and 08/16/19 at 12:30 pm. Refer to interview with the second MA on 08/16/19 at 11:20 am. h. Review of Resident #1's current FL2 dated 03/07/19 revealed an order for Hydroxyzine 10 mg 1 tablet daily (Hydroxyzine is a medication used to treat itching, anxiety and aide in sleep) Review of Resident #1's electronic Medication Administration Record (eMAR) for July 2019: -There was an entry for Hydroxyzine 10 mg 2 tablets daily scheduled to be administered at 6:00 pm. -Hydroxyzine was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/28/19, 07/29/19, and 07/30/19 at 6:00 pm. -There were 3 doses of Hydroxyzine 10 mg 2 tablets missed. Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed 60 tablets	D 358		

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D 358	Continued From page 44 (30-day supply) of Hydroxyzine 10 mg were dispensed on 07/01/19 with 32 tablets (16-day supply) remaining and available for administration. Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed: -The pharmacy did not receive the FL2 dated 02/26/19 for Resident #1. -The pharmacy received the physician's orders dated 02/14/19 for Resident #1. -On 03/07/19, a direct order was sent from the Nurse Practitioner (NP) to increase Hydroxyzine 10 mg to 2 tablets at bedtime. -On 07/30/19, a medication aide (MA) at the facility ordered Hydroxyzine 10mg 2 tablets daily through the eMAR. -On 06/27/19, 60 tablets of Hydroxyzine 10 mg were dispensed. -On 07/31/19, 60 tablets of Hydroxyzine 10 mg were dispensed. Interview with Resident #1 on 08/15/19 at 12:45 pm revealed: -He did not get 3 days of medication at the end of July 2019. -When he did not get his medications at the end of July, the MA told him the medications were at the facility, but they were for the August 2019 cycle, and they would not be given in July 2019. -He felt mood swings when he did not receive his Hydroxyzine at the end of July 2019. -He did not feel the staff communicated with other staff. Interview with the Resident Care Coordinator (RCC) on 08/15/19 at 4:46 pm revealed she did not know why Resident #1 did not receive Hydroxyzine as ordered from 07/28/19, 07/29/19,	D 358		

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D 358	Continued From page 45 and 07/30/19. Interview with the Nurse Practitioner (NP) from Resident #1's mental health provider on 08/16/19 at 10:43 am revealed: -Hydroxyzine was ordered for itching, anxiety, and sleep. -She did not know Resident #1 did not receive Hydroxyzine as ordered on 07/28/19, 07/29/19, and 07/30/19. -She was not notified that Resident #1 did not receive his Hydoxyzine as ordered on 07/28/19, 07/29/19, and 07/30/19. -When Resident #1 was not administered Hydroxyzine as ordered, he was at risk for increased anxiety. -Resident #1 was very competent and would ask if he had not received his medication. -She expected medications to be given accurately and on time. -Resident #1 was last seen the first week of August 2019. Interview with Resident #1 on 08/16/19 at 11:54 am revealed: -He noticed increased anxiety, mood swings, and difficulty sleeping when he did not receive his Hydroxyzine at the end of July 2019. -He slept less hours when he did not receive Hydroxyzine at the end of July 2019. -When Hydroxyzine was administered as ordered in August 2019, the anxiety and issues with sleeping decreased. Interview with the RCC on 08/16/19 at 12:30 pm revealed she did not notice any changes in Resident #1's sleep pattern or mood the in July 2019 or August 2019. Refer to interview with a representative from the	D 358		

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D 358	Continued From page 46 facility contracted pharmacy 08/15/19 at 8:50 am. Refer to interview with the MA on 08/15/19 at 12:22 pm. Refer to interview with the Administrator on 08/15/19 at 4:20 pm and 08/16/19 at 12:40 pm. Refer to interview with the RCC on 08/15/19 at 4:46 pm and 08/16/19 at 12:30 pm. Refer to interview with a second MA on 08/16/19 at 11:20 am. 2. Review of Resident #2's current FL-2 dated 08/06/19 revealed: -Diagnoses included left wrist fracture, bi-polar disorder, anemia, hypertension and abnormal thyroid function. -There was an order for Tramadol HCL (used to treat moderate to severe pain) 50 mg three times a day. Review of Resident #2's physician's orders revealed an order for Tramadol 50 mg three times a day, on 05/14/19. Review of Resident #2's June 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Tramadol 50 mg and scheduled to be administered three times a day at 8:00 am, 2:00 pm and 8:00 pm. -Tramadol 50 mg was not documented as administered on 06/09/19 at 8:00 pm, on 06/10/19 at 8:00 am, on 06/12/19 at 8:00 pm, on 6/13/19 at 8:00 am, on 06/14/19 at 8:00 am, on 06/17/19 at 8:00 pm, on 06/18/19 at 8:00 am and on 06/31/19 at 8:00 pm. -"Medication on Order From Pharmacy" was documented as the reason the Tramadol 50 mg	D 358		

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was not administered to Resident #2.
-There were 8 doses of Tramadol 50 mg not documented as administered for pain on the June 2019 eMAR.

Review of Resident #2's July 2019 eMAR revealed:
-There was an entry for Tramadol 50 mg and scheduled to be administered three times a day at 8:00 am, 2:00 pm and 8:00 pm.
-Tramadol 50 mg was not documented as administered on 07/01/10 at 8:00 pm, on 07/22/19 at 8:00 am and 2:00 pm, on 07/26/19 at 8:00 am and 2:00 pm, on 07/27/19 at 8:00 pm, on 07/28/19 at 8:00 am and on 07/29/19 at 8:00 am.
-"Out of Facility with Family" was documented as the reason the Tramadol was not administered to Resident #2.
-There was no documentation that Tramadol 50 mg was given to Resident #2 to take while out of the facility.
-There were 8 doses of Tramadol 50 mg initialed by the medication aide (MA) as not administered on the July 2019 eMAR.

Interview on 08/16/19 at 10:08 am with a medication aide (MA) revealed:
-The only times Resident #2 was not administered the Tramadol 50 mg in June 2019, was when the medication ran out and the MAs were waiting on the pharmacy to send it.
-If a medication was getting low, maybe 2-3 tablets left, the MA would place an order to be delivered from the pharmacy.
-When medications arrived in crates from the pharmacy, staff would check in the medications and then place on the medication cart; the medications would not be placed on the medication cart and administered until checked

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in.
-The pharmacy crates were stored in the back office.
-If a medication pass was in process and the Tramadol was not in the medication cart, a "med on order from the pharmacy" note would be made in the computer and the medication pass would continue.

Interview on 08/16/19 at 12:21 pm with a second MA revealed:
-The times in July 2019 when Resident #2 was not administered Tramadol 50 mg was when the medication was on order from the pharmacy or the resident was out of the facility.
-There was no way to document on the eMAR if a resident received medications to take out of the facility.
-When the pharmacy delivered medications, the medications were checked in before placing on the medication cart.
-If a Resident's medication was not on the cart during a medication pass, the medication was marked as not there on the eMAR because it was still in the pharmacy crate.

Attempted telephone interview on 08/18/19 at 9:48 am with a third MA was unsuccessful.

Observation on 08/14/19 at 10:45 am of resident #2 revealed she was wearing a brace on her left lower arm.

Interview on 08/15/19 at 10:45 am with Resident #2 revealed:
-The Resident had a fractured wrist and wore a brace on her left wrist.
-There had been complications, her arm was not healing and she was not able to remove the brace.

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-Her primary care physician ordered Tramadol three times a day for pain.
-When she was not given the Tramadol, she was in pain and "had the shakes and hurt all over."
-Sometimes "staff did not take the (Tramadol) out of the pharmacy crate and administer it to me."

Interview on 08/15/19 at 4:25 pm with Resident #2's family member revealed:
-The facility did not notify him that Resident #2 had missed her pain medication.
-She would have been in a lot of pain without taking the Tramadol.

Interview on 08/15/19 at 3:30 pm with the contracted Pharmacist revealed:
-If an order for a medication was ordered by 2:00 pm - 3:00 pm, it would be delivered to the facility the same day, if after 3:00 pm, the medication would be delivered the next day.
-The Pharmacist could not verify the dates and times of requested orders 30 days or more back; she could access the delivery dates.
-Tramadol 50 mg, 90 tablets for Resident #2 were delivered to the facility on 06/10/19.
-Tramadol 50 mg, 90 tablets for Resident #2 were delivered to the facility on 07/03/19.
-The number delivered would be the amount needed for 3 doses for 30 days each month.
-The Pharmacist did not know Resident #2 had missed the doses of Tramadol in June 2019 and July 2019.

Interview on 08/15/19 at 4:00 pm with the primary care provider (PCP) for Resident #2 revealed:
-Tramadol 50 mg three times a day was ordered for Resident #2 for pain.
-She had not been notified Resident #2 had not been receiving Tramadol as ordered.
-She was concerned; she wrote the order for

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D 358	Continued From page 50 Tramadol to get the resident through a period of not healing and possible surgery. Refer to interview with a representative from the facility contracted pharmacy 08/15/19 at 8:50 am. Refer to interview with the MA on 08/15/19 at 12:22 pm. Refer to interview with the Administrator on 08/15/19 at 4:20 pm and 08/16/19 at 12:40 pm. Refer to interview with the RCC on 08/15/19 at 4:46 pm and 08/16/19 at 12:30 pm. Refer to interview with the second MA on 08/16/19 at 11:20 am. Interview with a representative from the facility contracted pharmacy 08/15/19 at 8:50 am revealed: -Residents' medication refills were on a cycle fill prior to July 2019. -Cycle filled medications were delivered to the facility every month without the facility staff having to reorder. -The cycle filled medications started on the 28th of each month. -The Administrator requested medications to be called as needed instead of cycle filled. -She did not know why the Administrator requested the medications were changed from cycle filled to call as needed. -The facility staff needed to call and request medications within the last 10 doses so there was no lapse in medication administration. -The medications ordered would be delivered to the facility the same day unless the medication was a special order, and then delivery would take 2 to 3 days.	D 358		

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D 358	Continued From page 51 -The 06/28/19 cycle should have included enough medication to last through the end of July 2019. -The medication labels are the billed date and not the dispense date. Interview with the medication aide (MA) on 08/15/19 at 12:22 pm revealed: -The MAs were responsible for ordering medication. -If the medication order was "rejected" by the pharmacy, she would leave a note for the next shift. -She was recently taught how to order medications through the electronic Medication Administration Record (eMAR). -When a medication was requested from the pharmacy, no one checked when the medication was delivered to the facility by the pharmacy. -She did not know who was responsible for completing record, eMAR, and cart audits. -She did not know when record, eMAR, and cart audits were completed. Interview with the Administrator on 08/15/19 at 4:20 pm revealed: -The facility requested to stop cycle filled medications with the contracted pharmacy on 07/31/19. -August 2019 was still cycle filled and September 2019 would be the first month of call as needed orders. -She changed the pharmacy orders from cycle filled to call as needed because the medications were delivered at various times and she wanted more control on who was receiving the medications at the facility. -The RCC was responsible for sending FL2s to the pharmacy. -The RCC was responsible for performing weekly electronic Medication Administration Record	D 358		

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ROYAL OAKS ASSISTED LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(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	D 358		

(eMAR) and cart audits.
-The eMAR and cart audits were random and should have included the bulk of the cart.
-Medications received from the pharmacy should be verified by the working MA.
-The MA should notify the RCC if the medication was not received the next day.
-She expected the MAs to reorder the medications if it was not received.

Interview with the Resident Care Coordinator (RCC) on 08/15/19 at 4:46 pm revealed:
-The RCC was responsible for electronic Medication Administration Record (eMAR) and cart audits.
-She had completed one eMAR and cart audit since she became the RCC.

Interview with the second medication aide (MA) on 08/16/19 at 11:20 am revealed:
-Medications from 07/28/19 to 08/01/19 were on a cycle fill.
-The MA was responsible for ordering medications through the electronic Medication Administration Record (eMAR).
-The MA was responsible for verifying orders delivered from the pharmacy.
-If the medication was not delivered, she would call the pharmacy and then notify the Administrator.
-When a medication ran out or was in the last 10 days, she would place an order through the eMAR.
-When she selected "med (medication) on order from pharmacy" this meant she placed an order through the eMAR and the medications were out or close to being out (in the last 10 days).
-The medications were administered when she selected "med on order from pharmacy" in the eMAR.

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D 358	Continued From page 53 -If medications were not administered, for any reason, she would notify administration and the provider the same day. -She would document on the eMAR when a provider was notified. -The RCC and Administrator were responsible for eMAR and cart audits. -The RCC and Administrator completed audits monthly and with new orders. Interview with the RCC on 08/16/19 at 12:30 pm revealed: -When "med (medication) on order from pharmacy" was selected on the eMAR, this meant the medication was ordered and waiting to be brought by the pharmacy. -The medication was not at the facility when "med on order from pharmacy" was selected on the eMAR. Interview with the Administrator on 08/16/19 at 12:40 pm revealed: -When "med (medication) on order from pharmacy" was selected on the eMAR, this meant the medication was ordered and waiting to arrive. -The medication was out and not at the facility when "med on order from pharmacy" was selected on the eMAR. _____ The facility failed to administer medications as ordered for 2 of 3 residents (#1 and #2), including an antiretroviral antibiotic, an anti-hypertensive resulting in elevated blood pressure (hypertension), an anticholinergic, anti-anxiety medications resulting in increased levels of anxiety and sleep disturbances (#1), and a pain medication which could cause increased levels of pain (#2). This failure was detrimental to the health, safety and welfare of the residents; and constitutes a Type B Violation.	D 358		

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D 358	Continued From page 54 The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/16/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 1, 2019.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 3 sampled residents (#1) had physicians' orders to self-administer two eye drops, an inhaler, and a nebulizer. The findings are: Review of Resident #1's current FL2 dated	D 375		

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D 375	Continued From page 55 02/26/19 revealed: -Diagnoses included a blood borne pathogen disease, chronic obstructive pulmonary disease, vitamin D deficiency, depression, failure to thrive, and hyperlipidemia. -The resident was ambulatory and required assistance with bathing and dressing. Review of Resident #1's care plan dated 11/16/18 revealed: -The resident used a walker at times to ambulate. -The resident required supervision with activities of daily living tasks of eating, toileting, bathing, dressing, grooming, and transferring. -The resident required limited assistance with ambulation and transferring. a. Review of Resident #1's current FL2 dated 02/26/19 revealed: -There was an order for alphagan (a medication used to treat open-angle glaucoma or high fluid pressure in the eye) 0.1%, 1 drop in both eyes twice a day. -There was no order to self administer. Review of Resident #1's physician's orders dated 02/14/19 revealed an order for alphagan 0.1%, instill 1 drop into both eyes twice a day. Review of Resident #1's record revealed no physician's order to self administer alphagan 0.1%. Observation of Resident #1's medications on hand (kept in his room) on 08/15/19 at 10:30 am revealed: -The alphagan 0.1% drops were available and kept in Resident #1's room in the bedside table. -There were two 5 ml bottles of alphagan 0.1% drops dispensed on 11/28/18 (unopened) and on	D 375		

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D 375	Continued From page 56 03/21/19 (open). Review of Resident #1's June 2019 electronic medication administration records (eMARs) revealed: -There was an entry for alphagan 0.1%, instill 1 drop into both eyes twice a day scheduled at 8:00 am and 7:00 pm. -Alphagan 0.1% was documented as administered from 06/01/19 through 06/30/19. -There was no documentation on the eMAR indicating the alphagan 0.1% was self administered. Review of Resident #1's July 2019 eMARs revealed: -There was an entry for alphagan 0.1%, instill 1 drop into both eyes twice a day scheduled at 8:00 am and 7:00 pm. -Alphagan 0.1% was documented as administered from 07/01/19 through 07/23/19, 07/24/19 at 7:00 pm through 07/28/19 at 8:00 am, 07/29/19 at 7:00 pm, and 07/31/19 at 7:00 pm. -Alphagan 0.1% was not documented as administered on 07/24/19 at 8:00 am due to Resident #1 was "out of facility" for an appointment. -Alphagan 0.1% was not documented as administered on 07/28/19 at 7:00 pm, 07/29/19 at 8:00 am, 07/30/19 at 7:00 pm due to the "med on order from pharmacy". -Alphagan 0.1% was not documented as administered on 07/30/19 at 8:00 am and 07/31/19 at 8:00 am due to the medication was "not on cart". -There was no documentation on the eMAR indicating the alphagan 0.1% was self administered. Review of Resident #1's August 2019 eMARs	D 375		

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from 08/01/19 through 08/15/19 revealed:
-There was an entry for alphagan 0.1%, instill 1 drop into both eyes twice a day scheduled at 8:00 am and 7:00 pm.
-Alphagan 0.1% was documented as administered from 08/01/19 through 08/15/19 except on 08/01/19 at 8:00 am and 08/05/19 at 7:00 pm due to the medication was "not on cart".
-There was no documentation on the eMAR indicating the alphagan 0.1% was self administered.

Interview with Resident #1 on 08/15/19 at 12:45 pm revealed:
-He applied alphagan 0.1% drops, 1 drop every morning to both eyes.
-He did not know the alphagan 0.1% drops were ordered twice a day.

Interview with a medication aide (MA) on 08/16/19 at 11:20 am revealed:
-She knew Resident #1 kept the alphagan 0.1% drops in his room.
-She did not know Resident #1 was not administering the alphagan 0.1% drops as prescribed.
-She did not know Resident #1 did not have an order to self administer the alphagan 0.1% drops.
-She documented alphagan 0.1% drops were administered.

Interview with a representative from the contracted pharmacy on 08/15/19 at 8:52 am revealed:
-There was no self administer order for the alphagan 0.1% drops.
-A 30-day supply of alphagan 0.1% drops was dispensed on 03/21/19.
-If given as ordered Resident #1 would have run out of alphagan 0.1% drops on 04/21/19.

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-The facility requested a refill for alphagan 0.1% on 07/28/19.
-A 30-day supply of alphagan 0.1% drops was dispensed on 07/29/19.

Telephone interview with Resident #1's specialist provider on 08/16/19 at 11:07 am revealed:
-The alphagan 0.1% was prescribed for mild glaucoma.
-The alphagan 0.1% was ordered 1 drop into both eyes twice a day.
-Resident #1 was last seen on 04/25/19 and eye pressure was not increased.
-The provider did not know the resident was self administering the alphagan 0.1% eye drops.
-The provider expected staff to administer alphagan drops as ordered.

Refer to interview with Resident #1 on 08/15/19 at 12:45 pm.

Refer to interview with a medication aide (MA) on 08/16/19 at 11:20 am.

Refer to interview with a representative from the contracted pharmacy on 08/15/19 at 8:52 am.

Refer to interview with the Resident Care Coordinator on 08/16/19 at 12:30 pm.

Refer to interview with the Administrator on 08/16/19 at 12:40 pm.

b. Review of Resident #1's current FL2 dated 02/26/19 revealed there was no order for latanoprost 0.005% (a medication used to treat glaucoma) eye drops.

Review of Resident #1's subsequent physician's orders dated 04/25/19 revealed an order for

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D 375	Continued From page 59 latanoprost 0.005% eye drops, instill 1 drop into both eyes at bedtime. Review of Resident #1's record revealed no physician's order to self administer latanoprost 0.005%. Observation of Resident #1's medications on hand (kept in his room) on 08/15/19 at 10:30 am revealed: -The latanoprost 0.005% eye drops were available and kept in Resident #1's bedside table. -There was 1 unopened 2.5 ml bottle of latanoprost 0.005% eye drops dispensed on 04/26/19. Review of Resident #1's June 2019 electronic medication administration records (eMARs) revealed: -There was an entry for latanoprost 0.005% eye drops instill 1 drop into both eyes at bedtime scheduled at 8:00 pm. -Latanoprost 0.005% eye drops was documented as administered from 06/01/19 through 06/30/19. -There was no documentation on the eMAR indicating latanoprost 0.005% eye drops were self administered. Review of Resident #1's July 2019 eMARs revealed: -There was an entry for latanoprost 0.005% eye drops, instill 1 drop into both eyes at bedtime scheduled at 8:00 pm. -Latanoprost 0.005% eye drops was documented as administered from 07/01/19 through 07/27/19 at 8:00 pm. -Staff documented latanoprost 0.005% eye drops was not administered on 07/28/19 through 07/30/19 at 8:00 pm due to the medication was "not on cart".	D 375		

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D 375	Continued From page 60 -There was no documentation on the eMAR indicating latanoprost 0.005% eye drops were self administered. Review of Resident #1's August 2019 eMARs from 08/01/19 through 08/15/19 revealed: -There was an entry for latanoprost 0.005% eye drops, instill 1 drop into both eyes at bedtime scheduled at 8:00 pm. -Latanoprost 0.005% eye drops was documented as administered from 08/01/19 through 08/15/19 at 8:00 pm. -Staff documented latanoprost 0.005% eye drops was not administered on 08/06/19 at 8:00 pm due to the medication was "not on cart". -There was no documentation on the eMAR indicating latanoprost 0.005% eye drops were self administered. Interview with Resident #1 on 08/15/19 at 12:45 pm revealed: -He was not self administering latanoprost 0.005% eye drops. -He thought latanoprost eye drops were the same as alphagan eye drops. Interview with a medication aide (MA) on 08/16/19 at 11:20 am revealed: -She did not know Resident #1 kept the latanoprost 0.005% eye drops in his room. -She did not know Resident #1 was not administering latanoprost 0.005% eye drops as prescribed. -She did not know Resident #1 did not have an order to self administer latanoprost 0.005% eye drops. -She did not know the latanoprost 0.005% eye drops were not on the cart. -She documented latanoprost 0.005% eye drops were administered.	D 375		

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D 375	Continued From page 61 Interview with a representative from the contracted pharmacy on 08/15/19 at 8:52 am revealed: -There was no self administer order for the latanoprost 0.005% eye drops. -A 30-day supply (2.5 ml) of latanoprost 0.005% eye drops was dispensed on 04/26/19. -If given as ordered Resident #1 would have run out of latanoprost 0.005% eye drops on 05/26/19. -The facility requested a refill for latanoprost 0.005% eye drops on 07/30/19. -A 30-day supply (2.5 ml) of latanoprost 0.005% eye drops was dispensed on 07/30/19. Telephone interview with Resident #1's specialist provider on 08/16/19 at 11:07 am revealed: -Latanoprost 0.005% eye drops was prescribed for mild glaucoma. -Latanoprost 0.005% eye drops was ordered 1 drop into both eyes at bedtime. -Resident #1 was last seen on 04/25/19 and eye pressure was not increased. -The provider did not know the resident was self administering latanoprost 0.005% eye drops. Refer to interview with Resident #1 on 08/15/19 at 12:45 pm. Refer to interview with a medication aide (MA) on 08/16/19 at 11:20 am. Refer to interview with a representative from the contracted pharmacy on 08/15/19 at 8:52 am. Refer to interview with the Resident Care Coordinator on 08/16/19 at 12:30 pm. Refer to interview with the Administrator on 08/16/19 at 12:40 pm.	D 375		

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D 375	Continued From page 62 c. Review of Resident #1's current FL2 dated 02/26/19 revealed there was no order for Ipratropium/Albuterol (a medication used to treat chronic obstructive pulmonary disease). Review of Resident #1's previous physician's orders dated 02/14/19 revealed an order for Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml, use 1 vial via nebulizer every 6 hours as needed for shortness of breath. Review of Resident #1's record revealed no physician's order to self administer Ipratropium/Albuterol. Observation of Resident #1's medications on hand (kept in his room) on 08/15/19 at 10:30 am revealed: -The Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml was available and kept in a plastic storage container in Resident #1's room. -There were 60 (180 ml) vials of Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml labeled 01/17/19 (bill date) with 45 remaining. -There was a nebulizer machine located in Resident #1's room on the bedside table. Review of Resident #1's June 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml, use 1 vial via nebulizer every 6 hours as needed for shortness of breath. -Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml was not documented as administered for June 2019. -There was no documentation on the eMAR indicating the Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml was self administered.	D 375		

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Review of Resident #1's July 2019 eMAR revealed:
-There was an entry for Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml, use 1 vial via nebulizer every 6 hours as needed for shortness of breath.
-Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml was not documented as administered for July 2019.
-There was no documentation on the eMAR indicating the Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml was self administered.

Review of Resident #1's August 2019 eMAR from 08/01/19 through 08/15/19 revealed:
-There was an entry for Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml, use 1 vial via nebulizer every 6 hours as needed for shortness of breath.
-Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml was not documented as administered for August 2019.
-There was no documentation on the eMAR indicating the Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml was self administered.

Interview with Resident #1 on 08/15/19 at 12:45 pm revealed:
-He administered the Ipratropium/Albuterol 3 times a day as needed for shortness of breath.
-He experienced shortness of breath daily.
-He had been without the Ipratropium/Albuterol at least one month.

Interview with a medication aide (MA) on 08/16/19 at 11:20 am revealed:
-She knew Resident #1 kept the Ipratropium/Albuterol in his room.
-She did not know Resident #1 did not have an order to self administer the Ipratropium/Albuterol.

Interview with a representative from the contracted pharmacy on 08/15/19 at 8:52 am revealed:

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	HAL053028	A. BUILDING: _____ B. WING _____	R 08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL OAKS ASSISTED LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(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 375	Continued From page 64 -There was no self administer order for the Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml. -A 30-day supply of Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml was dispensed on 02/11/19 and 08/08/19. -The label for Ipratropium/Albuterol 0.5-3(2.5) mg/3 ml on 01/17/19 refers to the date the medication was billed. Telephone interview with Resident #1's Primary Care Provider (PCP) on 08/16/19 at 11:07 am revealed: -Resident #1 was last seen on 06/11/19. -The Ipratropium/Albuterol was prescribed for chronic obstructive pulmonary disease (COPD). -She had never observed Resident #1 short of breath. -Resident #1 was capable of self administering Ipratropium/Albuterol. Refer to interview with Resident #1 on 08/15/19 at 12:45 pm. Refer to interview with a medication aide (MA) on 08/16/19 at 11:20 am. Refer to interview with a representative from the contracted pharmacy on 08/15/19 at 8:52 am. Refer to interview with the Resident Care Coordinator on 08/16/19 at 12:30 pm. Refer to interview with the Administrator on 08/16/19 at 12:40 pm. d. Review of Resident #1's current FL2 dated 02/26/19 revealed there was no order for Ventolin (a medication used to treat chronic obstructive pulmonary disease).	D 375		

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D 375	Continued From page 65 Review of Resident #1's previous physician's orders dated 02/14/19 revealed: -There was an order for Ventolin 90 mcg inhaler, inhale 2 puffs 4 times a day as needed for wheezing. -There was an order to keep at bedside and self administer. Review of Resident #1's record revealed no assessment for Resident #1 to self administer Ventolin. Observation of Resident #1's medications on hand (kept in his room) on 08/15/19 at 10:30 am revealed there was 1 empty Ventolin inhaler located in Resident #1's rollator walker. Review of Resident #1's June 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Ventolin 90 mcg inhale 2 puffs 4 times a day as needed for wheezing (may keep at bedside and self administer). -Ventolin 90 mcg was not documented as administered for June 2019. Review of Resident #1's July 2019 eMAR revealed: -There was an entry for Ventolin 90 mcg inhale 2 puffs 4 times a day as needed for wheezing (may keep at bedside and self administer). -Ventolin 90 mcg was not documented as administered for July 2019. Review of Resident #1's August 2019 eMAR from 08/01/19 through 08/15/19 revealed: -There was an entry for Ventolin 90 mcg inhale 2 puffs 4 times a day as needed for wheezing (may keep at bedside and self administer). -Ventolin 90 mcg was not documented as	D 375		

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D 375	Continued From page 66 administered for August 2019. Interview with Resident #1 on 08/15/19 at 12:45 pm revealed: -He administered the Ventolin 2 puffs 5-6 times a day as needed for shortness of breath. -He had been without Ventolin for at least 1 month. -He told staff he was out of Ventolin (date unknown). Interview with a medication aide (MA) on 08/16/19 at 11:20 am revealed: -She knew Resident #1 kept the Ventolin in his room. -She did not know Resident #1 did not have a current order to self administer the Ventolin 90 mcg. -Resident #1 was supposed to tell staff when he needed Ventolin refilled. -Resident #1 had not told her he was out of Ventolin. Interview with a representative from the contracted pharmacy on 08/15/19 at 8:52 am revealed: -There was an order for Ventolin to be kept at the bedside and self administer. -There was 1 Ventolin inhaler dispensed on 05/06/19 and 06/03/19. Telephone interview with Resident #1's Primary Care Provider (PCP) on 08/16/19 at 11:07 am revealed: -Resident #1 was last seen on 06/11/19. -The Ventolin was prescribed for COPD. -She had never observed Resident #1 short of breath. -If Ventolin was not available Resident #1 was at an increased risk for a COPD exacerbation and	D 375		

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D 375	Continued From page 67 shortness of breath. -She did not know Ventolin was not available. Refer to interview with Resident #1 on 08/15/19 at 12:45 pm. Refer to interview with a medication aide (MA) on 08/16/19 at 11:20 am. Refer to interview with a representative from the contracted pharmacy on 08/15/19 at 8:52 am. Refer to interview with the Resident Care Coordinator on 08/16/19 at 12:30 pm. Refer to interview with the Administrator on 08/16/19 at 12:40 pm. Interview with Resident #1 on 08/15/19 at 12:45 pm. -He did not know his medications were supposed to be in a locked cabinet. -Staff did not check the medications in his room to make sure he had enough available. Interview with a medication aide (MA) on 08/16/19 at 11:20 am revealed: -She did not know the facility was required to perform an assessment on Resident #1 to evaluate competency to self administer medications. -When she administered medications for her shift she would ask Resident #1 if he had taken his self administered medications. -She never checked the medications stored in Resident #1's room to make sure they were available. -Resident #1 had not told her he was out of any medications. -She did not know Resident #1 missed	D 375		

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D 375	Continued From page 68	D 375		

medications in July and August 2019.
-When she ordered medications from the pharmacy she would document a note on the eMAR but the note did not indicate the medication was not available.
-She had not observed Resident #1 experience shortness of breath.
-She did not know the medications in Resident #1's room were supposed to be locked and secure.

Interview with a representative from the contracted pharmacy on 08/15/19 at 8:52 am revealed:
-The residents' medications were on cycle fill prior to July 2019.
-The facility staff now had to request all medications through the eMAR system when needed.

Interview with the Resident Care Coordinator on 08/16/19 at 12:30 pm.
-She did not know self administered medications were to be locked.
-She did not know Resident #1 went without medications in July and August 2019.
-She did not know if an assessment was completed for Resident #1 to self-administer medications.
-She did not know Resident #1 had medications in his room without a self administer order.
-The MA/RCC was responsible for ordering medications.

Interview with the Administrator on 08/16/19 at 12:40 pm.
-Resident #1 had not told her he was out of any medications.
-The MA/RCC was responsible for ordering medications.

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D 375	Continued From page 69 -She did not know self administered medications kept in Resident #1's room needed to be locked. -She did not know if staff monitored medications in Resident #1's room. -She did not know there were medications in Resident #1's room with no order to self administer. -To her knowledge staff did not complete an assessment for Resident #1 to evaluate his ability to self administer medications.	D 375		
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, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to nutrition and food service and medication administration. The findings are: 1. Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 2 of 5 sampled	D912		

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D912	Continued From page 70 residents with diet orders for a mechanical soft (MS) diet with nectar thick liquids (Resident #4) and nutritional supplements (Resident #1). [Refer to Tag 0310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (#1 and #2) related to 3 antiretroviral medications, 2 anti-hypertensive medications, 1 anticholinergic medication, 2 anxiety medications (Resident #1), and 1 pain medication (Resident #2). [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the	D992		

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D992	Continued From page 71 applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure documentation of an examination and screening for the presence of controlled substances was completed for 1 of 3 sampled staff (Staff C) prior to hire. The findings are: Review of Staff C's, medication aide personnel record revealed: -Staff C was hired on 04/12/17. -There was no documentation Staff A had completed the examination and screening for the presence of controlled substance. -There was no consent for a controlled substance examination and screening. Interview with Staff C on 08/16/19 at 1:31pm revealed:	D992		

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D992	Continued From page 72 -She had worked at the facility for around two years. -She remembered signing a consent and completing a controlled substance examination and screening when she was hired. -The Administrator at her time of hire was responsible for making sure controlled substance examination and screening was completed. Interview with the Administrator on 08/15/19 at 11:16am revealed: -Staff C's controlled substance examination and screening was completed prior to her starting work at the facility. -Staff C's controlled substance examination and screening should be in her personnel record, but she was unable to find it. -Currently, the Assistant Administrator was responsible for making sure controlled substance examinations and screenings were completed for staff. Interview with the Assistant Administrator on 08/16/19 at 9:43am revealed: -She was responsible for making sure controlled substance examinations and screenings were completed for applicants, but she was not employed when Staff C was hired. -She did not know a controlled substance examination and screening was not in Staff C's personnel record. -She would have Staff C complete a controlled substance examination and screening again.	D992		