Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL004003	A. BUILDING: _____ B. WING _____	R 07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW TERRACE OF WADESBORO	123 ANSON HIGH SCHOOL ROAD WADESBORO, NC 28170

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D 000	Initial Comments The Adult Care Licensure Section and Anson County Department of Social Services conducted a follow up survey and complaint investigation on July 23 - 26, 2019.	D 000	Responses to cited deficiences do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiency or Corrective Action Report; the Plan of Correction is prepared soley as a matter of compliance with State Law.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure health care referral and follow up to meet the acute health care needs of 3 of 6 sampled residents (Residents #1, #2, and #3) inlcuding falure to notify Resident #1's primary care provider of high blood presssure readings; Resident #2's provider, who ordered a psychiatric consult, related to the resident's anxiety; and Resident #3's provider, who ordered a valproic acid blood level, and a speech therapy consult to evaluate the resident's swallowing. The findings are: 1. Review of Resident #2's current FL-2 dated 04/11/19 revealed:	D 273	Resident records were audited to determine any issues requiring referral or follow up. All identified issues were reported to Physician and followed up with immediately. The Executive Director (ED), Director of Resident Care (DRC) and/or designee will be responsible for ensuring all ordered referrals, medication orders and labs are completed as ordered. Order Processing System (Bucket System) will be utilized daily to ensure orders are processed accurately. ED,DRC and/or Designee will continue to audit resident records with focus on referral and follow up, with any concerns noted addressed with residents physician. ED, DRC and or designee will educate staff on follow up, to include notification of Physician for vitals out of parameters. POC Date: 9/9/2019	9/9/19

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: LPN/ED — (X6) DATE: 9/3/19

Reviewed and accepted with addendum on p. 80 provided by ED on 9/12/19. 09/13/19

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D 273	Continued From page 1 -Diagnoses included history of cerebrovascular accident, hypertension, and hyperlipidemia. -The medications listed were lisinopril 5 mg po QD and aspirin 81 mg po QD. -Resident #2 required total care for bathing, feeding and dressing. Review of Resident #2's medical record revealed a physician order dated 04/18/19 for a referral for psychiatric consult. Review of Resident #2's Licensed Health Professional Support evaluation dated 04/20/19 revealed: -Resident #2 was very agitated at times. -Resident #2 had been ordered a medication to help with anxiety/agitation. -Resident #2 required monitoring to help prevent falls for her safety. -Resident #2 needed to be monitored for the effects of clonazepam and for over sedation. -Resident #2 required assistance with ambulation using assistive device (wheelchair). Interview with pharmacy representative on 07/25/19 at 9:23 am revealed: -The pharmacy had not received any order for Zoloft for Resident #2 on or near 04/18/19 when Resident #2's primary care provider had ordered the Zoloft 25 mg by mouth every day on 04/18/19. -The only order received for Resident #2 on or about 04/18/19 was for clonazepam 0.5 mg tab (0.25mg) by mouth twice daily for 3 days, then at bedtime as needed for anxiety or sleep. -This order was received on 04/18/19 and filled on 04/19/19. -The order was on a hard prescription pad. Interview with Resident #2's current primary care provider (PCP) on 07/26/19 at 9:42 am revealed:	D 273		

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D 273	Continued From page 2 -She would expect the facility to follow up on all physician orders. -The psychiatric evaluation could have helped discover the reason Resident #2 was depressed and the cause to why she had declined. -Resident #2 receiving the Zoloft as prescribed could have improved her mood and behaviors. Interview with the Director of Resident Care (DRC) on 07/25/19 at 3:30 pm and on 07/26/18 at 10:45 am revealed: -He had been in the position of DRC since the first part of July 2019. -There was a stack of papers on the floor beside the filing cabinet that was here when he started. -He was currently working to get those papers filed. -The DRC and Executive Director searched the stack of papers to find any orders for Resident #2 which had not been filed into her medical record. -The Director of Resident Care was responsible for approving the physician orders when they were faxed to the pharmacy. -He was not there in April 2019 and could not speak to how part of the physician's orders were not followed through other than the hard copy of the clonazepam being sent to the pharmacy. Interview with the Executive Director (ED) on 07/25/19 at 10:45 am revealed: -He had been in the ED position since the first part of July 2019. -The DRC was responsible to assure medication orders were transcribed and administered as ordered. -He was not the ED in April 2019 and could not speak to how part of the physician's orders was not followed through other than the hard copy of the clonazepam being sent to the pharmacy.	D 273		

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D 273	Continued From page 3 Attempted interview on 07/25/19 at 9:05 am with Resident #2 revealed Resident #2 was only alert to person, not to place or time. Attempted telephone interview with prescribing provider for the psychiatric consult and laboratory tests on 07/25/19 at 9:58 am was unsuccessful. Attempted telephone interviews with Resident #2's responsible party and the power of attorney on 07/25/19 at 9:13 am and 9:16 am were unsuccessful. 2. Review of Resident #3's current FL-2 dated 05/29/19 revealed: -Diagnoses included type II diabetes mellitus, autistic disorder, dysphagia and schizo-affective disorder. -There was an order for speech therapy. a. Review of hospital discharge summary and FI-2 dated 05/06/19 for Resident #3 revealed: -Resident #3 was admitted to the hospital on 05/01/19 with a diagnosis of pneumonia. -There was documentation Resident #3 had an x-ray video of his esophagus which showed "penetration" of thin and nectar thick liquids. -There was an order for a speech therapy evaluation and treatment. -There was documentation Resident #3 needed to be on a dysphagia diet. Review of a Physician Order sheet dated 07/24/19 for Resident #3 revealed: -Resident #3 was ordered a speech therapy referral in May 2019 which had not been done. -Speech therapy to start for evaluation and treatment at next visit to the facility. Telephone interview with Resident #3's guardian	D 273		

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D 273	Continued From page 4 on 07/24/19 at 10:47am revealed: -She did not know anything about a speech therapy referral for Resident #3 from 05/29/19. -Normally whenever Resident #3 need therapy, the therapist would contact her, but she had not been contacted. Interview with a medication aide (MA) on 07/25/19 at 3:27pm revealed: -She had not returned to work until the end of June 2019, so she did not know what happened with the referral for speech therapy for Resident #3. -Normally MAs talked to the in-house therapists for all speech therapy referrals and gave them a copy of the referral order. -There was a folder at the front desk for speech therapy referrals that came in after hours; the therapists checked the folder every morning. -The former Resident Care Coordinator (RCC) would have been responsible for re-admission orders dated 05/06/19 for Resident #3. -The former RCC left in early July 2019, then the Director of Resident Care (DRC) took over the former RCC's responsibilities. Telephone interview with Resident #3's primary care provider (PCP) on 07/25/19 at 2:54pm revealed: -She was not able to recall specifically reviewing Resident #3's re-admission orders from the hospital dated 05/06/19. -Re-admission orders were normally reviewed when the resident had the follow up visit with the PCP after returning from the hospital. -Staff had told her on 07/24/19 Resident #3 had an order dated 05/06/19 for a speech referral. -The referral was ordered because there was concern that aspiration was the cause of Resident #3's pneumonia.	D 273		

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D 273	Continued From page 5 -Resident #3 was seen by her colleague at the facility on 07/24/19 and a mobile chest x-ray was ordered. -Resident #3 would be seen by speech therapy when the therapist was next at the facility. Interview with the DRC on 07/26/19 at 10:45am revealed: -He started on 07/08/19 at the facility as the DRC. -He did not know what system was in place prior to 07/08/19 for medication orders and referrals. -Referral orders for speech therapy were forwarded to the in house therapists via a box at the front desk. -He contacted the liaison for the speech therapist via phone or text to let them know about the referral. -He followed up with the liaison in a few days if he did not hear anything back about the referral. -The former Resident Care Coordinator (RCC) would have been responsible for making the referral for speech therapy for Resident #3. Telephone interview with the in house therapy liaison on 07/26/19 at 12:12pm revealed: -She had not received a speech therapy referral for Resident #3 in May 2019. -When orders for a speech therapy referral came into the facility, the orders were given to her. -She screened for necessity and insurance coverage, contacted the family and followed up with the DRC. Interview with the Administrator on 07/24/19 at 9:34am revealed: -Resident #3's PCP discontinued the order dated 05/29/19 for the speech therapy evaluation on 07/24/19. -The PCP wrote a new order dated 07/24/19 for a speech therapy evaluation with the speech	D 273		

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D 273	Continued From page 6 therapist next visit to the facility. -The PCP ordered a mobile chest x-ray to rule out any "adverse events" and would see Resident #3 on 07/24/19. Attempted telephone interview with the former Resident Care Coordinator (RCC) on 07/25/19 at 11:37am was unsuccessful. b. Review of a mental health provider (MHP) visit note dated 03/22/19 revealed fasting laboratory work including a valproic acid level was ordered. Review of a MHP visit note dated 04/19/19 revealed there was documentation the laboratory work including valproic acid level was ordered on the previous visit on 03/22/19. Review of a MHP visit note dated 05/10/19 revealed there was documentation the MHP was awaiting laboratory results including valproic acid. Review of a MHP visit note dated 06/21/19 revealed there was documentation the MHP was awaiting laboratory results including valproic acid. Telephone interview with the mental health provider (MHP) on 07/26/19 at 5:00pm revealed: -There was no valproic acid level result for the lab draw initially ordered 03/22/19. -She had ordered the valproic acid level to make sure the level was not too high or too low. Interview with the Director of Resident Care (DRC) on 07/26/19 at 4:00pm revealed blood work was drawn 03/25/19 but there was no laboratory result for valproic acid for Resident #3. Interview with the Administrator on 07/26/19 at 5:30pm revealed:	D 273		

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D 273	Continued From page 7 -Staff were expected to follow through on referral orders using the bucket system where orders were placed in a series of folders for each step in the order management process. -The bucket system makes it so there was always follow up; he was not sure if the former RCC and Administrator were utilizing the bucket system. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. 3. Review of Resident #1's current FL-2 dated 06/05/19 revealed: -Diagnoses included hypertension, atrial fibrillation, diabetes mellitus type II, chronic pain disorder, lumbar disc disease, osteopenia, cognitive impairment, and intertrochanteric fracture of left femur. -The resident had orders to receive at least 2 medications used to lower blood pressure (Amlodipine and Losartan). -There was an order to check the resident's blood pressure once daily in the evening. Review of Resident #1's standing orders signed and dated on 02/08/19 revealed: -There were orders for the primary care provider (PCP) to be notified for vital sign parameters unless otherwise noted. -The PCP was to be notified for systolic blood pressure (SBP) less than (<) 80 or greater than (>) 200. -The PCP was to be notified for diastolic blood pressure (DBP) < 50 or >110. Review of Resident #1's May 2019 - July 2019 electronic medication administration records (e-MARs) revealed: -The resident's blood pressure was scheduled to	D 273		

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D 273	Continued From page 8 be checked every evening between 4:00pm - 7:00pm. -The resident's DBP was >110 on 2 occasions that would have required notification of the PCP. -The resident's blood pressure was 191/119 on 05/20/19. -The resident's blood pressure was 179/114 on 05/21/19. -There was no documentation on the e-MAR that the PCP was notified of the two DBPs > 110. -The resident's blood pressure ranged from 100/66 - 191/119 from 05/01/19 - 05/31/19. -The resident's blood pressure ranged from 129/75 - 189/82 from 06/01/19 - 06/30/19. -The resident's blood pressure ranged from 133/72 - 180/81 from 07/01/19 - 07/22/19. -There was no documentation of the standing order for the blood pressure parameters included on the e-MARs. Review of Resident #1's progress notes revealed no documentation the resident's PCP was notified of the resident's blood pressure readings outside of the parameters as ordered. Interview with Resident #1 on 07/26/19 at 5:30pm revealed: -The facility staff checked her blood pressure every day. -She had problems with high blood pressure, and she had a "little bit of dizziness once in a while". Interview with a medication aide (MA) on 07/26/19 at 1:00pm revealed: -She was not aware of a policy or standing order for blood pressure parameters. -If a resident's SBP was >140, she would contact the PCP. -She had initialed checking Resident #1's blood pressure in May 2019 when it was 191/119 and	D 273		

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D 273	Continued From page 9 179/114. -She thought she rechecked the blood pressure when it was high, but she could not recall what the blood pressure was when rechecked. -She did not recall notifying the PCP. Interview with a second MA on 07/25/19 at 3:24pm revealed: -She was not aware of any facility policy or standing orders for blood pressure parameters. -If she checked a resident's blood pressure and it was 150/100, she would check for signs of distress. -She would notify the Director of Resident Care (DRC) and the PCP. -She did not recall if Resident #1's blood pressure had been high when she checked it. Interview with a third MA on 07/26/19 at 11:00am revealed: -She was not aware of any facility policy or standing orders for blood pressure parameters. -She would contact the PCP if a resident's SBP was between 180 - 190 or the DBP was > 100. -She did not recall if Resident #1 had any high blood pressures. Interview with the DRC on 07/26/19 at 12:15pm revealed: -He just started working as the DRC on 07/08/19. -He was not aware Resident #1 had standing orders for blood pressure parameters. -The blood pressure parameters should be included on the e-MARs so the MAs would have access to the order. -He expected the MAs to notify the DRC and PCP of any high or low blood pressures Telephone interview with Resident #1's PCP on 07/25/19 at 9:42am revealed:	D 273		

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D 273	Continued From page 10 -The facility staff had not notified her of any high blood pressure readings for Resident #1. -If the facility staff had notified her of Resident #1's high blood pressures, she would have given an order for them to check the resident's blood pressure more frequently for a few days. -Then she would have reviewed the blood pressure readings and re-evaluated the resident's medications. _____ The facility failed to follow up with Resident #2's provider, who ordered a psychiatric consult, related to the resident's anxiety, which resulted in the resident continuing to suffer from depression and anxiety. Resident #1, who had diagnoses of hypertension and atrial fibrillation, had two consecutive high blood pressure readings of 191/119 and 179/114 that staff failed to notify the PCP. The facility failed to schedule a referral for speech therapy for Resident #3, who had a history of dysphagia and a recent hospitalization for pneumonia, and failed to assure a valproic acid level ordered on 03/22/19 was done for Resident #3. The facility's failure to meet routine health care needs was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/26/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 9, 2019.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service	D 282		

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D 282	Continued From page 11 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Noncompliance continues. Based on observations, interviews and record reviews, the facility failed to assure the kitchen and food storage areas were kept clean and free of contamination. The findings are: Observations of the kitchen on 07/23/19 from 11:15am until 11:25am revealed: -There was a thick accumulation of yellow and brown grease and food spillage build up around the burner knobs of the stove. -There was a thick accumulation of brown and dark brown grease build up on and around the ends of the oven handles and around the edges of the oven doors. -There was an accumulation of a black charred substance on the oven doors and on the walls and the bottom of the ovens. -There was a black substance on the kitchen floor along the edge of the stove, around the bases of the sink and counter stands and around the floor drains. -There was a thick accumulation of a white substance and rust on three of three drain covers on the kitchen floor. -There was a thick accumulation of a brown substance and food debris on along the edges and at the corners of the kitchen floor under the	D 282	Dietary Manager (DM) educated on importance of kitchen cleanliness. DM to visit sister community for further training. Kitchen cleaning schedule re-implemented with dietary staff informed of immediate write up given for any laps of cleaning schedule and duties not met. ED and/or DM will ensure deep cleaning of kitchen is performed bi-monthly for 3 months. ED and/or designee will perform random observations of kitchen along with review of cleaning log to ensure cleanliness and compliance. POC Date: 9/9/19	9/9/19

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D 282	Continued From page 12 sinks and work tables in the kitchen and on the pantry floor along the edges and under the shelves. -There was a black substance on the floor around the base of the pantry shelf. -There was food debris on the floor under the cooler shelves. -There was a thick brown substance on the floor along the edges in the cooler. -There were dark brown stains with food debris stuck to the stain on the freezer floor. -There were pieces of cardboard, frozen food and an ice cream cup on the freezer floor. Interview with the cook on 07/23/19 at 11:15am revealed: -All kitchen staff were responsible for cleaning the kitchen each day. -She referred all further questions to the Dietary Manager (DM).. -Interview with the DM on 07/23/19 at 11:19am revealed: -There was a daily cleaning schedule where each staff was assigned areas to clean. -None of the kitchen staff had been cleaning along the edges of floors, in corners and under shelves to remove build up. -The facility was in the middle of a management change over the last four to six weeks. -Many of the kitchen procedure were in the process of change for improvement. -All kitchen staff were in the process of deep cleaning the kitchen, pantry and cooler including the floors and under shelves and tables. Review of Facility Cleaning Charts for the kitchen dated 06/27/19 through 07/22/19 revealed: -There were areas listed under daily after each which included the floors; there was	D 282		

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D 282	Continued From page 13 documentation the floors were cleaned 22 of 26 opportunities. -There were areas listed under weekly cleaning which included cleaning and organizing the refrigerator; there was documentation the refrigerator was cleaned 4 of 4 opportunities. -There were areas listed under weekly cleaning which included cleaning and organizing the freezer; there was documentation the freezer was cleaned 3 of 4 opportunities. -There were areas listed under weekly cleaning which included cleaning and organizing the pantry; there was documentation the pantry was cleaned 3 of 4 opportunities. -There were areas listed under weekly cleaning which included cleaning and organizing the pantry; there was documentation the refrigerator and freezer were cleaned 3 of 4 opportunities. -There were areas listed under weekly cleaning which included cleaning shelves; there was documentation shelves were cleaned 3 of 4 opportunities. -There were areas listed under weekly cleaning which included floors and grouting; there was no documentation the floor and grouting were cleaned 4 of 4 opportunities. Second interview with the DM on 07/24/19 at 10:15am revealed: -Kitchen staff swept and mopped the floors in the kitchen twice each day, morning and evening. -Kitchen staff were supposed to sweep and mop the cooler and pantry floors each week. -There were no initials documented next to the floor and grouting on the cleaning chart because it was not being done. -Both the cook and the dietary aide shared the responsibility of cleaning the kitchen. -She was responsible for checking the kitchen each day to make sure staff completed assigned	D 282		

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D 282	Continued From page 14 tasks. Interview with the Director of Resident Care (DRC) on 07/26/19 at 9:51am revealed: -There were no individual assignments for what each kitchen staff was responsible to clean each day. -There was a cook and a dietary aide and they each knew what they were supposed to do each day. Interview with the Administrator on 07/23/19 at 11:25am revealed: -The county environmental inspection had just been completed on 07/06/19 and the kitchen had received a score of 99. -He conducted random inspections of the cleanliness of the kitchen often. -The floors under kitchen work spaces and pantry and cooler shelving would be pressure washed on 07/23/19.	D 282		
D 307	10A NCAC 13F .0904(e)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (e) Therapeutic Diets in Adult Care Homes: (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA diets, low sodium diets or thickened liquids, unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian. This Rule is not met as evidenced by:	D 307	Resident Diet Orders reviewed for accuracy and assurance of correct copy maintained in residents record. Dietary staff to be updated weekly with any new diet orders or changes in Residents diet order. Diet Order print out to be kept available for dietary staff. ED, DRC and/or designee to complete random dining walk through with focus on diet accuracy for each resident biweekly. POC Date: 9/9/19	9/9/19

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D 307	Continued From page 15 Noncompliance continues. Based on observations, interviews and record reviews, the facility failed to assure 1 of 1 sampled resident (#3), who had a history of dysphagia, had diet orders clarified for consistency of food and liquids. The findings are: Review of Resident #3's current FL-2 dated 05/29/19 revealed: -Diagnoses included type II diabetes mellitus, autistic disorder, dysphagia and schizo-affective disorder. -There was an order for thickened liquids. Review of hospital discharge summary and FI-2 dated 05/06/19 for Resident #3 revealed: -Resident #1 was admitted to the hospital on 05/01/19 with a diagnosis of pneumonia. -There was documentation Resident #3 had an x-ray video of his esophagus which showed "penetration" of thin and nectar thick liquids. -There was an order for a speech therapy evaluation and treatment. -There was documentation Resident #3 needed to be on a dysphagia diet. Review of a diet order sheet dated 07/22/19 for Resident #3 revealed: -There was an order for a regular diet. -There was no notation for thickened liquids of any consistency. Review of a Diet Order Report dated 07/23/19 revealed: -Resident #3 was ordered a mechanical soft diet. -There was no documentation of consistency of liquids for Resident #3.	D 307		

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D 307	Continued From page 16 Review of an undated therapeutic diet order list posted in the kitchen revealed Resident #3 was on a mechanical soft diet with nectar thickened liquids. Review of a Physician Order sheet dated 07/24/19 for Resident #3 revealed: -Resident #3 was ordered a speech therapy referral in May 2019 which had not been done. -Speech therapy to start for evaluation and treatment at next visit to the facility. -Resident #3 was currently receiving nectar thick liquids; discontinue honey thick liquids. -Continue regular mechanical soft diet. Observations during the breakfast meal on 07/24/19 from 8:14am until 9:00am revealed: -Resident #3 was seated in the dining room at 8:14am and had a personal reusable drink bottle half full of a nectar thick orange colored beverage. -At 8:30am, Resident #3 was given nectar thick milk for his cereal and nectar thickened coffee. -Resident #3 finished his breakfast meal, drinking more than 90% of the nectar thickened orange colored drink, milk and coffee without incident at 9:00am. Interview with Resident #3's guardian on 07/24/19 at 10:47am revealed: -Resident #3 had been on nectar thickened liquids for a couple of years. -Resident #3 had trouble swallowing, things would not go down the right way and cause him to cough. -Resident #3 had pneumonia more than six months ago and the doctors were concerned it could have been caused by choking on liquids. -The doctors wanted to change Resident #3 to	D 307		

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D 307	Continued From page 17 honey thickened liquids (more than six months ago), but he refused because he did not like the taste. -The order was changed back to nectar thickened liquids (more than six months ago). -She did not know if Resident #3's pneumonia in May 2019 had been caused by aspirating on food and/or drink. -Usually when Resident #3 had pneumonia, aspiration was the cause because when the resident "got something down there and did not cough it up, it turned into pneumonia." Telephone interview with Resident #3's primary care provider (PCP) on 07/26/19 at 9:42am revealed: -There was a concern when Resident #3 was in the hospital (05/01/19 -05/06/19) that the resident might need honey thick liquids instead of nectar thick. -There was concern that Resident #3 may have aspirated on nectar thick liquid and may have needed a thicker consistency. -The Director of Resident Care (DRC) was working hard to fix things at the facility. Interview with the Administrator on 07/24/19 at 9:34am revealed: -Resident #3's primary care provider (PCP) discontinued the order for honey thickened liquids on 07/24/19. -The PCP wrote a new order dated 07/24/19 for nectar thickened liquids. -The PCP ordered a mobile chest x-ray to rule out any "adverse events" and would see Resident #3 on 07/24/19. Attempted telephone interview with the former Resident Care Coordinator (RCC) on 07/25/19 at 11:37am was unsuccessful.	D 307		

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D 307	Continued From page 18 Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.	D 307		
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. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. Non-compliance continues with increased severity resulting in residents place at substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur. THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer	D 358	Director of Resident Care (DRC) reviewed physician orders verifying medication record matches Physician orders. Medication Aides educated on 7/25/19 by Registered Nurse (RN) related to medication administration of all medications and insulin. Omnicare Pharmacy completed audit of medication records on 8/20/19 and 8/21/19. Pharmacist completed review on 8/21/19. ED, DRC and/or designee will review medication administration compliance report daily ED, DRC and or designee will ensure medication cart audits are completed weekly to verify medication available. ED, DRC and/or designee will monitor medication compliance during medication pass weekly for 2 months to ensure compliance. POC Date: 8/25/19	8/25/19

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D 358	Continued From page 19 medications as ordered and in accordance with the facility's policies for 3 of 6 residents (#6, #7, #8) observed during the medication passes including errors with insulins (#8), an oral antifungal for infection (#6), and a lubricant eye drop (#7); and for 4 of 6 residents sampled (#1, #2, #3, #6) for record review including errors with insulin (#6), a blood pressure medication (#1), medications for anxiety and depression (#2); and multiple medication errors including medications for sleep/depression, high blood pressure, and diabetes for Resident #3. The findings are: 1. The medication error rate was 11% as evidenced by the observation of 4 errors out of 34 opportunities during the 7:00am - 9:00am and the 11:30am/12:00pm medication passes on 07/24/19. a. Review of Resident #8's current FL-2 dated 06/27/19 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, schizophrenia, and arthritis. -There was an order for Levemir FlexTouch insulin, inject 18 units at bedtime. (Levemir is long-acting insulin used to lower blood sugar.) -There was an order for Novolog Flexpen, inject 6 units 3 times a day before meals. (Novolog is rapid-acting insulin used to lower blood sugar. According to the manufacturer, the Novolog Flexpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.) Review of Resident #8's July electronic medication administration record (e-MAR) revealed:	D 358		

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D 358	Continued From page 20 -There as an entry for Levemir FlexTouch, inject 18 units at bedtime with a scheduled administration time of 8:30pm. -There was an entry for Novolog Flexpen, inject 6 units 3 times a day before meals with scheduled administration times of 7:00am, 12:00pm, and 5:00pm. -The resident's blood sugar ranged from 86 - 398 from 07/01/19 - 07/24/19. Observation of the 12:00pm medication pass on 07/24/19 revealed: -The medication aide (MA) pulled a Levemir FlexTouch insulin pen from the medication cart and asked Resident #8 to follow her to the Business Office Manager's office so she could administer the resident's insulin. -The MA did not take the medication cart, which had the computer with the e-MAR, with her to the business office. -The resident's blood sugar was 241 at 11:13am. -The MA pressed the push button at the end of the insulin pen twice before dialing the dose. -The MA dialed the Levemir insulin pen to 6 units and administered it to the resident at 11:14am. -The MA did not prime the insulin pen with a 2-unit air shot. -The MA did not check the insulin label or the e-MAR prior to administering the insulin. -The MA left the business office and walked back to the medication cart. -The MA then pulled up Resident #8's e-MAR on the computer screen. -There was an entry on the computer screen for Novolog Flexpen 6 units to be administered at 12:00pm. -The MA did not administer any Novolog insulin to the resident. -There was no entry on the e-MAR computer screen for Levemir insulin at that time.	D 358		

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D 358	Continued From page 21 -The MA attempted to document on the e-MAR that 6 units of Novolog insulin had been administered. Interviews with the MA on 07/24/19 at 11:15am and 11:55am revealed: -She had picked up the wrong insulin pen and administered Levemir instead of Novolog to the resident. -She should have administered 6 units of Novolog to Resident #8 instead of Levemir. -She should have read the label and compared it to the e-MAR. -She did not recall having any specific training about the use of insulin pens except a former Executive Director had told her to "double pump" the push button on the pen prior to dialing the dose but she did not know why. -She did not know she was supposed to perform a 2-unit air shot. -She would contact Resident #8's primary care provider (PCP) about the insulin error to find out what actions needed to be taken. Interview with the MA on 07/24/19 at 11:25am revealed: -She had contacted Resident #8's PCP about the insulin error. -She received a verbal order to recheck the resident's blood sugar at 1:30pm, hold the Novolog lunchtime dose, and only administer 12 units of Levemir at bedtime instead of 18 units. Interview with Resident #8 on 07/24/19 at 4:00pm revealed: -She received insulin today (07/24/19) but she did not know what kind of insulin she received. -She denied any symptoms of high or low blood sugar.	D 358		

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D 358	Continued From page 22 Interview with the Administrator on 07/24/19 at 12:15pm revealed: -The MAs had been trained to read the e-MARs and medication labels and compare them prior to administering medications. -The MA had contacted Resident #8's PCP about the insulin error. -They would recheck the resident's blood sugar at 1:30pm and they would monitor the resident. Review of Resident #8's blood sugar report revealed the resident's blood sugar was rechecked and it was 218 at 1:40pm on 07/24/19. Interview with the Director of Resident Care (DRC) on 07/24/19 at 1:46pm revealed: -The MAs had been trained to read the e-MARs and medication labels prior to administering medications. -The MAs should perform a 2-unit air shot prior to dialing the scheduled dose when using insulin pens. -Resident #8's PCP had been notified of the insulin error. -He planned to have all of the MAs retrained on insulin administration on 07/25/19. Telephone interview with Resident #8's PCP on 07/25/19 at 9:42am revealed: -The facility notified her of the medication error with Resident #8's insulin on 07/24/19. -Resident #8 was a "borderline brittle diabetic". -She was concerned that the resident receiving the wrong insulin could potentially cause hyperglycemia or hypoglycemia depending on whether it was long-acting or rapid-acting insulin. -She was more concerned about the resident not getting her Novolog insulin since it was rapid-acting and could lead to hyperglycemia when not administered on time.	D 358		

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D 358	Continued From page 23 b. Review of Resident #6's current FL-2 dated 10/30/18 revealed: -Diagnoses included cognitive communication deficit, atherosclerotic heart disease, and muscle weakness. -There was an order for Fluconazole 200mg 1 tablet daily. (Fluconazole is an antifungal used to treat infections.) Review of Resident #6's July 2019 electronic medication administration record (e-MAR) revealed: -There was an entry for Fluconazole 200mg 1 tablet once a day. -Fluconazole was scheduled for administration at 9:00am. Observation of the morning medication pass on 07/24/19 revealed: -The medication aide (MA) prepared and administered 7 oral medications to Resident #6 at 8:06am. -The MA did not prepare or administer Fluconazole to the resident. Interview with the MA on 07/24/19 at 1:29pm revealed: -He usually administered all of Resident #6's morning medications together, including those scheduled for 7:00am, 8:00am, and 9:00am. -He thought he saw the entry for Fluconazole "flash" across the e-MAR screen when he was clicking the administered button. -He did not administer the Fluconazole after seeing it on the e-MAR screen but he could not explain why he did not administer it. -He should have administered the Fluconazole. Observation of Resident #6's medication on	D 358		

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D 358	Continued From page 24 07/24/19 revealed there was one bubble card of Fluconazole 200mg tablets with 15 of 30 tablets remaining that were dispensed on 06/24/19. Interview with the Director of Resident Care (DRC) on 07/24/19 at 1:46pm revealed: -The MAs had been trained to read the e-MARs and administer the medications as ordered. -The Fluconazole should have been administered to Resident #6 that morning (07/24/19) during the morning medication pass. -He would notify Resident #6's primary care provider (PCP) of the medication error with Fluconazole. Telephone interview with Resident #6's PCP on 07/25/19 at 9:42am revealed: -The facility notified her of the medication error with Resident #1's Fluconazole on 07/24/19. -She could not recall why Resident #1 was taking Fluconazole. -It could have been for a rash or it could have been for a urinary tract infection. -She was not concerned about the resident missing one dose of the medication. -She expected the resident's medications to be administered as ordered. Interview with Resident #6 on 07/25/19 at 4:27pm revealed the resident did not know if he took Fluconazole or if he had missed any doses. c. Review of Resident #7's current FL-2 dated 07/03/19 revealed: -Diagnoses included type 2 diabetes, hypertension, major depressive disorder, muscle weakness, thyrotoxicosis, sever protein calorie malnutrition, and anxiety disorder. -There was an order for Refresh Liquigel 1%, 1 drop in both eyes 3 times a day. (Refresh	D 358		

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D 358	Continued From page 25 Liquigel is a lubricant eye drop for dry, irritated eyes.) Review of Resident #7's July 2019 electronic medication administration record (e-MAR) revealed: -There was an entry for Refresh Liquigel 1%, instill 1 drop in both eyes 3 times a day. -Refresh Liquigel was scheduled for administration at 8:00am, 2:00pm, and 8:00pm. Observation of the morning medication pass on 07/24/19 revealed: -There was an over-the-counter bottle of Refresh Tears 0.5% with Resident #7's name hand written on it. -There was a handwritten opened date of 07/12/19 written below the resident's name. -The medication aide (MA) administered Refresh Tears 0.5%, 1 drop in each eye to Resident #7 at 8:34am. (Refresh Tears is a lubricant eye drop with 0.5% of the active ingredient. Refresh Liquigel contains 1% of the active ingredient so it is twice as potent as Refresh Tears.) -The resident was administered Refresh Tears instead of Refresh Liquigel as ordered. Interview with the MA on 07/24/19 at 1:35pm revealed: -She thought the resident's family member had brought the eye drops to the facility. -She had not noticed the Refresh Tears 0.5% did not match the Refresh Liquigel 1% on the e-MAR. -She should have checked the label with the e-MAR. Interview with the Director of Resident Care (DRC) on 07/24/19 at 1:46pm revealed: -If a family brought medications to the facility for a resident, the MAs should compare what the	D 358		

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D 358	Continued From page 26 family brought with the physician's order and the e-MAR to make sure it matched. -The MAs had been trained to compare the medication labels with the e-MARs when administering medications and if it did not match they should stop and get clarification. -He did not know Resident #7 had the wrong eye drops on hand. -He would notify the resident's primary care provider (PCP) about the error. Telephone interview with Resident #7's PCP on 07/25/19 at 9:42am revealed: -The facility notified her of the medication error with Resident #7's eye drops on 07/24/19. -She was not concerned about the resident receiving the wrong strength of Refresh Tears since it was a lubricant eye drop for dry eyes. 2. Review of Resident #6's current FL-2 dated 10/30/18 revealed diagnoses included cognitive communication deficit, atherosclerotic heart disease, and muscle weakness. Review of a computer printed note in Resident #6's record revealed the resident was admitted from a sister facility on 06/24/19. Review of Resident #6's physician's order dated 03/28/19 revealed there was an order to check blood sugar before meals and at bedtime. Review of Resident #6's physician's order dated 04/15/19 revealed there was an order for Humalog insulin, inject 7 units at lunch and dinner, hold for blood sugar less than 90 or if resident did not plan to eat. (Humalog is rapid-acting insulin used to lower blood sugar.) Review of Resident #6's physician's order dated	D 358		

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D 358	Continued From page 27 04/25/19 revealed there was an order to hold insulin if blood sugar was less than 140. Review of Resident #6's July 2019 electronic medication administration record (e-MAR) revealed: -There was an entry to check blood sugar before meals and at bedtime with scheduled times of 6:30am, 11:30am, 5:30pm, and 9:00pm. -The resident's blood sugar ranged from 152 - 326 from 07/01/19 - 07/24/19 with 69 refusals documented. -There was an entry for Humalog 7 units with lunch and with supper, hold for blood sugar less than 140 or if resident did not plan to eat. -Humalog was scheduled to be administered at 7:00am and 7:00pm instead of with lunch and supper. -Humalog was documented as administered 5 times at 7:00am instead of at lunch as ordered. -Humalog was documented as refused on 19 days at 7:00am from 07/01/19 - 07/24/19. -Humalog was documented as administered 3 times at 7:00pm instead of at supper as ordered. -Humalog was documented as refused on 20 days at 7:00pm from 07/01/19 - 07/23/19. Interviews with a medication aide (MA) on 07/24/19 at 10:14am and 10:30am revealed: -He had not noticed that the instructions for Humalog on the e-MAR were to administer at lunch and supper but the times scheduled were 7:00am and 7:00pm. -Lunch was usually served at 12:00pm and supper at 5:00pm so the times scheduled on the e-MAR did not match the order. -He had always offered the Humalog insulin during the 7:00am medication pass because that was when it appeared on the screen of the e-MAR to be administered.	D 358		

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D 358	Continued From page 28 -He had not administered any Humalog at 7:00am because the resident had always refused it when he worked. Interview with a second MA on 07/24/19 at 11:55am revealed: -She had not noticed the times scheduled on the e-MAR for Resident #6's Humalog insulin did not match the instructions. -She had not offered any Humalog insulin to Resident #6 at lunch because it did not come up as an entry on the e-MAR to be administered at lunch. Interview with Resident #6 on 07/25/19 at 4:27pm revealed: -Staff were checking his blood sugar 4 times a day but he told them to "quit that". -Staff wanted to administer insulin to him 4 times a day but he "cut them back" to once a day. -He did not know what time he usually received insulin. -He did not like to take the insulin because he was sleepy all the time. -He did not know if his primary care provider (PCP) knew he only took insulin once a day. Interview with the Director of Resident Care (DRC) on 07/24/19 at 1:46pm revealed: -He just started working as the DRC on 07/08/19. -He was not aware Resident #6's Humalog order was entered incorrectly on the July 2019 e-MAR. -The facility's contracted pharmacy usually entered the orders on the e-MARs and the DRC usually approved orders before they became active on the e-MAR. -He did not know why the order would have been approved on the e-MAR since it was done prior to him working at the facility. -He was in the process of checking medication	D 358		

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D 358	Continued From page 29 orders and MARs but had not completed the audit process. -The MAs had been trained to read the e-MARs and if something did not match, the MAs were supposed to notify the DRC. -No one had reported the discrepancy on the e-MAR with Resident #6's Humalog insulin. -He was aware the resident refused blood sugar checks and insulin frequently and the PCP had been notified. -He would notify Resident #6's PCP about the error with the resident's Humalog insulin. Telephone interview with Resident #6's PCP on 07/25/19 at 9:42am revealed: -Resident #6 came to this facility from a sister facility around the end of June 2019. -She did not understand how his orders for insulin got entered incorrectly on the e-MAR. -She was aware Resident #6 refused insulin and blood sugars frequently. -She expected the insulin to be offered according to the orders and administered if the resident did not refuse. -Humalog should have been administered at lunch and supper. 3. Review of Resident #1's current FL-2 dated 06/05/19 revealed: -Diagnoses included hypertension, atrial fibrillation, diabetes mellitus type II, chronic pain disorder, lumbar disc disease, osteopenia, cognitive impairment, and intertrochanteric fracture of left femur. -There was an order for Losartan 100mg 1 tablet at bedtime. (Losartan lowers blood pressure.) Review of Resident #1's June 2019 and July 2019 electronic medication administration records (e-MARs) revealed:	D 358		

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D 358	Continued From page 30 -There was an entry for Losartan 100mg at bedtime with a scheduled administration time of 8:00pm. -Losartan was not documented as administered on 06/30/19, 07/01/19, 07/03/19, and 07/07/19 due to being unavailable and ordered. -The resident's blood pressure ranged from 129/75 - 189/82 from 06/01/19 - 06/30/19. -The resident's blood pressure ranged from 133/72 - 180/81 from 07/01/19 - 07/22/19. Observation of Resident #1's medications on 07/26/19 at 10:35am revealed: -There was a weekly multidose pack with a start date of 07/23/19 and an end date of 07/29/19. -There were 4 tablets of Losartan 100mg left to be administered in the weekly multidose pack. Review of Resident #1's progress notes revealed no documentation regarding the resident's missed doses of Losartan in July 2019. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/26/19 at 4:55pm revealed: -There was a 30 day supply of Losartan 100mg tablets dispensed on 05/07/19. -It appeared the Losartan may have been out of refills. -The pharmacy received a refill request from the facility on 07/07/19. -The pharmacy started sending weekly cycle fills the first week of July 2019. -The pharmacy dispensed 8 Losartan 100mg tablets on 07/07/19 that were delivered to the facility on 07/08/19. -The pharmacy dispensed 7 Losartan 100mg tablets on 07/09/19. -The pharmacy dispensed 7 Losartan 100mg tablets on 07/23/19.	D 358		

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D 358	Continued From page 31 Interview with Resident #1 on 07/26/19 at 5:30pm revealed: -She did not know the names of the medications she took. -She had problems with high blood pressure, and she had a "little bit of dizziness once in a while". -She was not sure if the facility had run out of any of her medications. Interview with a medication aide (MA) on 07/25/19 at 3:24pm revealed: -The residents' medications usually came in a weekly or monthly cycle fill from the pharmacy. -If a medication did not come in, the MAs were supposed to contact the pharmacy. -She documented Resident #1's Losartan was on order on 07/01/19 and 07/07/19 but she did not recall why it was unavailable. -She did not recall if the PCP was notified. Interview with a second MA on 07/26/19 at 9:23am revealed: -She did not recall why Resident #1 was out of Losartan. -If it was documented as waiting on a prescription, it was probably because the resident was out of refills for that medication. -The MAs usually reported any missed doses to the Director of Resident Care (DRC). -The MAs should call or fax the resident's primary care provider (PCP) if 1 dose of medication was missed due to a medication being unavailable. -She could not remember if she called the PCP about Resident #1's Losartan being unavailable. -It would be documented in the progress notes if she had called the PCP. Interview with a third MA on 07/26/19 at 1:00pm revealed:	D 358		

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D 358	Continued From page 32 -She did not recall Resident #1's Losartan being unavailable. -The Losartan probably needed refills. -The MAs should let the PCP or the DRC know when a resident needed refills. -She did not contact Resident #1's PCP about the Losartan being unavailable. Interviews with the DRC on 07/25/19 at 10:55am and 07/26/19 at 12:15pm revealed: -He just started working as the DRC on 07/08/19. -He was not aware Resident #1 missed doses of Losartan from 06/30/19 - 07/07/19. -The MAs should notify the DRC if a medication was unavailable. Telephone interview with Resident #1's PCP on 07/25/19 at 9:42am revealed: -She did not recall the facility notifying her of Resident #1 missing doses of Losartan in July 2019. -She was concerned that the resident missed the doses because the resident had high blood pressure. -Potential outcomes of missing the doses of Losartan could include higher blood pressure, heart attack, stroke, or hypertensive crisis. 4. Review of Resident #3's current FL-2 dated 05/29/19 revealed: -Diagnoses included type II diabetes mellitus, autistic disorder, dysphagia and schizo-affective disorder. -There was documentation to see attached medication list. a. Review of hospital instructions dated 05/06/19 for Resident #3 revealed an order for Augmentin 825/125mg every 12 hours for two days.	D 358		

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D 358	Continued From page 33 Review of a PCP order dated 06/17/19 for Resident #3 revealed an order for Augmentin 825/125mg every 12 hours for seven days. Review of Resident #3's May 2019 electronic medication administration record (eMAR) revealed there was no entry for Augmentin. Review of Resident #3's June 2019 eMAR revealed: -There was an entry for Augmentin 875/125mg every 12 hours for seven days. -There was documentation the Augmentin was administered from 06/18/19 at 8:00am through 06/24/19 at 8:00pm. Interview with a medication aide (MA) on 07/25/19 at 10:48am revealed she did not remember what happened with administering Augmentin in May 2019. Interview with a second MA on 07/25/19 at 4:47pm revealed she remembered Resident #3 being on Augmentin but she could not remember whether that was in May 2019, June 2019 or both. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/25/19 at 9:03am revealed: -The pharmacy received new and changed medication orders for Resident #3 from hospital discharge instructions dated 05/06/19 which were readmission orders. -There was an order for Augmentin 875/125mg every 12 hours for two days. Telephone interview with a second pharmacy technician at the facility's contracted pharmacy on 07/25/19 at 12:07pm revealed the pharmacy	D 358		

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D 358	Continued From page 34 dispensed 4 Augmentin 875/125mg tablets on 05/06/19 and 14 tablets on 06/17/19. Telephone interview with a medical office assistant at Resident #3's private PCP on 07/26/19 at 1:18pm revealed: -Resident #3 was seen on 06/17/19 for FL-2 papers and had a low grade fever at the visit. -A chest x-ray was done and a prescription for Augmentin was written. Telephone interview with Resident #3's guardian on 07/26/19 at 4:42pm revealed: -She had taken Resident #3 to his private PCP in June 2019 for a new FL-2. -Resident #3 still had some congestion and a cough; the PCP was worried Resident #3 might still have some infection in his lungs and prescribed an antibiotic. Telephone interview with Resident #3's PCP on 07/26/19 at 9:42am revealed: -She was not sure why Resident #3 was ordered Augmentin on 06/17/19; the resident was seen by another provider who ordered the medication. -If Resident #3 was ordered to complete a course of Augmentin that had been started while in the hospital 05/01/19 - 05/06/19 and the course was not completed, there would be concern that the resident could develop multidrug resistant organisms and possible relapse of the pneumonia. Interview with the Director of Resident Care (DRC) on 07/26/19 at 10:45am revealed he did not know who the provider was that wrote the order for the Augmentin for Resident #3 dated 06/17/19. b. Review of a Physician's Order sheet dated	D 358		

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D 358	Continued From page 35 03/20/19 attached to the FL-2 dated 05/06/19 for Resident #3 revealed there was an order for Trazadone 100mg daily. Review of Resident #3's May 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Trazadone 100mg daily at bedtime. -From 05/15/19 at 6:50pm through 05/30/19 at 7:34pm there was documentation the Trazadone was not administered because the medication was ordered and was not available. Review of Resident #3's June 2019 eMAR revealed: -There was an entry for Trazadone 100mg daily at bedtime. -There was documentation the Trazadone was not administered from 06/07/19 at 7:42pm through 06/18/19 at 8:08am because the medication was ordered and not available. -On 06/14/19 at 7:30pm there was documentation the Trazadone was administered. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/25/19 at 9:03am revealed the pharmacy dispensed 30 Trazadone 100mg tablets on 04/04/19 for Resident #3; the next dispense of Trazadone was not until 07/02/19. Telephone interview with Resident #3's primary care provider (PCP) on 07/25/19 at 2:54pm revealed she would be concerned if Resident #3 was without Trazadone because there was a risk of withdrawal symptoms including agitation, anxiety and difficulty sleeping. Refer to interview with a medication aide (MA) on	D 358		

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D 358	Continued From page 36 07/25/19 at 10:48am. Refer to interview with a second MA on 07/25/19 at 11:09am. Refer to interview with a third MA on 07/25/19 at 3:27pm. Refer to interview with a fourth MA on 07/25/19 at 4:32pm. Refer to second interview with the fourth MA on 07/25/19 at 5:05pm. Refer to telephone interview with a fifth MA on 07/26/19 at 9:08am. Refer to telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/25/19 at 9:03am. Refer to telephone interview with the Front-End Manager at the facility's contracted pharmacy on 07/25/19 at 9:45am. Refer to attempted telephone interview with the former Resident Care Coordinator (RCC) on 07/25/19 at 11:37am. Refer to telephone interview with Resident #3's PCP on 07/25/19 at 2:54pm. Refer to second telephone interview with Resident #3's PCP on 07/26/19 at 9:42am. Refer to interview with the mental health provider (MHP) on 07/26/19 at 11:56am. Refer to interview with the DRC on 07/26/19 at 10:45am.	D 358		

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D 358	Continued From page 37 Refer to interview with the Administrator on 07/26/19 at 5:30pm. c. Review of a Physician's Order sheet dated 06/17/19 for Resident #3 revealed there was an order for Lisinopril 2.5mg daily. Review of Resident #3's June 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Lisinopril 2.5mg daily. -There was documentation the Lisinopril was not administered from 06/14/19 at 7:46am through 06/18/19 at 8:08am. -On 06/19/19 at 9:35am there was documentation all medications were not sent by the pharmacy and the MA called to get the medications as soon as possible. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/25/19 at 12:07pm revealed the pharmacy dispensed 30 Lisinopril 2.5mg tablets on 02/05/19, 7 tablets 05/01/19, 28 tablets 05/14/19, 12 tablets 06/19/19 and 28 tablets on 07/02/19. Telephone interview with Resident #3's primary care provider (PCP) on 07/25/19 at 2:54pm revealed she would be concerned if Resident #3 was without Lisinopril because there was a risk of a cerebral vascular accident, heart attack and hypertensive crisis. Refer to interview with a medication aide (MA) on 07/25/19 at 10:48am. Refer to interview with a second MA on 07/25/19 at 11:09am.	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 38 Refer to interview with a third MA on 07/25/19 at 3:27pm. Refer to interview with a fourth MA on 07/25/19 at 4:32pm. Refer to second interview with the fourth MA on 07/25/19 at 5:05pm. Refer to telephone interview with a fifth MA on 07/26/19 at 9:08am. Refer to telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/25/19 at 9:03am. Refer to telephone interview with the Front-End Manager at the facility's contracted pharmacy on 07/25/19 at 9:45am. Refer to attempted telephone interview with the former Resident Care Coordinator (RCC) on 07/25/19 at 11:37am. Refer to telephone interview with Resident #3's PCP on 07/25/19 at 2:54pm. Refer to second telephone interview with Resident #3's PCP on 07/26/19 at 9:42am. Refer to interview with the mental health provider (MHP) on 07/26/19 at 11:56am. Refer to interview with the DRC on 07/26/19 at 10:45am. Refer to interview with the Administrator on 07/26/19 at 5:30pm. d. Review of a Physician's Order sheet dated	D 358		

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D 358	Continued From page 39 07/22/19 for Resident #3 revealed there was an order for Metformin 1000mg twice daily. Review of Resident #3's June 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Metformin 1000mg twice daily. -There was no documentation the Metformin was administered from 06/16/19 at 7:00pm through 06/19/19 at 7:00pm. -There was documentation the Metformin was not administered on 06/20/19 at 8:17am and 6:59pm because the medication was ordered, and the facility was waiting for delivery. Telephone interview with a second pharmacy technician at the facility's contracted pharmacy on 07/25/19 at 12:07pm revealed the pharmacy dispensed 28 Metformin 1000mg tablets on 04/23/19, 14 tablets 06/19/19, 12 tablets 06/19/19 and 56 tablets 07/02/19. Telephone interview with Resident #3's primary care provider (PCP) on 07/25/19 at 2:54pm revealed she would be concerned if Resident #3 was without Metformin because his blood sugar levels would be uncontrolled. Refer to interview with a medication aide (MA) on 07/25/19 at 10:48am. Refer to interview with a second MA on 07/25/19 at 11:09am. Refer to interview with a third MA on 07/25/19 at 3:27pm. Refer to interview with a fourth MA on 07/25/19 at 4:32pm.	D 358		

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D 358	Continued From page 40 Refer to second interview with the fourth MA on 07/25/19 at 5:05pm. Refer to telephone interview with a fifth MA on 07/26/19 at 9:08am. Refer to telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/25/19 at 9:03am. Refer to telephone interview with the Front-End Manager at the facility's contracted pharmacy on 07/25/19 at 9:45am. Refer to attempted telephone interview with the former Resident Care Coordinator (RCC) on 07/25/19 at 11:37am. Refer to telephone interview with Resident #3's PCP on 07/25/19 at 2:54pm. Refer to second telephone interview with Resident #3's PCP on 07/26/19 at 9:42am. Refer to interview with the mental health provider (MHP) on 07/26/19 at 11:56am. Refer to interview with the DRC on 07/26/19 at 10:45am. Refer to interview with the Administrator on 07/26/19 at 5:30pm. --- Interview with a medication aide (MA) on 07/25/19 at 10:48am revealed: -The pharmacy kept sending multi-dose cards for Resident #3, but some of the medications (including Lisinopril, Metformin and Trazadone)	D 358		

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D 358	Continued From page 41 were not there. -MAs kept calling the pharmacy and the pharmacy would say they were going to send the medications, but they did not. -This went on for approximately one week and she had told the former Resident Care Coordinator (RCC). -She could not remember when this happened; she had not documented contacting the pharmacy or notifying the former RCC. -MAs were supposed to enter that medications were not given and document a reason note whenever a medication was not available for administration. -When refills were needed, the MA removed the pharmacy sticker from the medication card, affixed the sticker to a refill form and faxed the form to the pharmacy. -If there was no sticker the MA wrote the information on the refill form and faxed the request to the pharmacy. -MAs assisted with new medication orders by faxing the order to the pharmacy, the pharmacy entered the new order on the electronic medication administration record (eMAR) and the Director of Resident Care (DRC) or the Administrator approved all medication orders. -Paper prescriptions were placed in a plastic bag and given to the pharmacy transporter; pharmacy sent the medications to the facility. Interview with a second MA on 07/25/19 at 11:09am revealed: -She had documented the note dated 06/19/19 on Resident #3's eMAR. -The pharmacy would send a new multi-dose card each week for Resident #3 and there were medications that were missing (including Lisinopril, Metformin and Trazadone). -She contacted the pharmacy each week after the	D 358		

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D 358	Continued From page 42 new card came about the missing medications. -Each week pharmacy would say they would send the missing medications in a "bingo" card, but never sent them. -She notified the former RCC on 06/19/19 about Resident #3's missing medications. -She knew "it was a pretty good while," but could not remember how long Resident #3 was without some of his medications. -The pharmacy finally sent all of Resident #3's medications in the new multi-dose cards, but she could not remember when that was. Interview with a third MA on 07/25/19 at 3:27pm revealed: -Any MA on the cart was able to request medication refills. -The facility was on 7 day multi-dose packagaes which were cycle filled automatically by the pharmacy, but not all the residents were on the multi-dose packages. -She had not returned to work until the end of June 2019, so she did not know what happened with Resident #3's medications. -The former RCC left in early July 2019, then the DRC took over the former RCC's responsibilities. Interview with a fourth MA on 07/25/19 at 4:32pm revealed: -Normally the MAs were able to see on the computer screen notes entered for medications by the last MA who gave the medication such as "waiting for pharmacy," but the MA was supposed to check and make sure the medication had not come in before documenting the medication was not given. -She did remember there was some problem with getting Resident #3's medications from the pharmacy in May and June 2019. -Resident #3 had medications (including	D 358		

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D 358	Continued From page 43 Lisinopril, Metformin and Trazadone) that were out of stock for several weeks. -She and another MA contacted the facility's contracted pharmacy representative; she sent pictures of what medications the facility had and Resident #3's medication list. -This happened in June 2019, but she could not remember the date. Second interview with the fourth MA on 07/25/19 at 5:05pm revealed: -She notified the former RCC that the resident had been out of his medications for several weeks. -The former RCC handled everything including notifying Resident #3's primary care provider (PCP). -The former RCC would have documented notifying the PCP. -She notified the former RCC the same day she documented contacting the facility's contracted pharmacy (06/19/19). Telephone interview with a fifth MA on 07/26/19 at 9:08am revealed: -She remembered Resident #3 being out of medications in May and June 2019, but she could not remember which medications and for how long. -She was not sure if Resident #3 was any different or having any symptoms when he was not getting his medications. -She did not know if Resident #3's PCP had been notified about the resident being out of medications. -The facility had problems with getting medication refills from January through March 2019. -The facility switched to multi-dose packs in April or May 2019 and that helped with the problem of getting medication refills.	D 358		

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D 358	Continued From page 44 -The former RCC did not help staff to get medication refills when there were problems like with Resident #3. -The MAs had done everything they could to get Resident #3's medications. -The MAs told the former RCC about medications being late due to all medications being scheduled at the same time; the former RCC blamed the pharmacy and did not do anything about it. Attempted telephone interview with the former Resident Care Coordinator (RCC) on 07/25/19 at 11:37am was unsuccessful. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/25/19 at 9:03am revealed: -The pharmacy received new and changed medication orders for Resident #3 from hospital discharge instructions dated 05/06/19 which were readmission orders. -The new orders allowed the pharmacy to fill the orders for 30 days and then the facility would have to send a new order. -There were issues with refilling medications because the facility sent refill requested based on outdated orders for Resident #3. -The pharmacy was not able to refill Resident #3's medications because the orders were out of date and not properly signed. -The facility made multiple refill request attempts, but the pharmacy canceled the request before medications were sent to the facility. Telephone interview with the Front-End Manager at the facility's contracted pharmacy on 07/25/19 at 9:45am revealed: -Pharmacy staff would have contacted the facility about needing properly signed orders for Resident #3.	D 358		

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D 358	Continued From page 45 -She did not see any notes in the pharmacy computer system with dates or times of contact with the facility. Telephone interview with Resident #3's PCP on 07/25/19 at 2:54pm revealed: -She was not able to recall specifically reviewing Resident #3's re-admission orders from the hospital dated 05/06/19. -Re-admission orders were normally reviewed when the resident had the follow up visit with the PCP after returning from the hospital. -She did not know if Resident #3 had a hospital follow up visit with her following his hospital discharge on 05/06/19. -She did not know Resident #3 had been out of multiple medications for three to six weeks in May and June 2019. Second telephone interview with Resident #3's PCP on 07/26/19 at 9:42am revealed: -She either sent new orders to the facility via fax or gave verbal orders on the phone that she signed on the next visit to the facility. -She occasionally texted orders and had her office staff send orders to the facility. -She signed orders every Monday when she was at the facility. Interview with the mental health provider (MHP) on 07/26/19 at 11:56am revealed: -Resident #3 was last seen on 06/21/19; the resident received mental health (MH) services for autism and hallucinations. -She had not been contacted about Resident #3's medications. -She would be concerned Resident #3 would experience a return of hallucinations, possible discontinuation syndrome and/or increased anxiety and agitation.	D 358		

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D 358	Continued From page 46 -She had not seen any changes in Resident #3's behavior. Interview with the DRC on 07/26/19 at 10:45am revealed: -He started on 07/08/19 at the facility as the DRC. -He did not know what system was in place prior to 07/08/19 for medication orders. -The former RCC and Administrator would have been responsible for reconciling readmission orders for Resident #3 on 05/06/19 and new FL-2 orders dated 05/29/19. -New orders were faxed to the pharmacy and pharmacy entered the orders on the eMAR. -He reviewed the orders entered by the pharmacy and compared the new orders on the eMAR with the written orders. -Any orders prior to readmission were discontinued. -After reviewing the orders and the eMAR, he printed a Physician's Order sheet for the primary care provider to review and sign at the next visit to the facility. -This process was not done by the former RCC and former Administrator. -On review of what happened with Resident #3's medications in May and June 2019, all that was needed to have the PCP sign refill orders. -He had the PCP sign medication orders for Resident #3 on 07/22/19. -The former RCC and former Administrator would have been responsible for reconciling Resident #3's readmission orders and eMAR for errors or clarification needs. -He reviewed eMARs daily for documentation and did random cart audits to monitor for compliance with medication administration. -Staff were expected to document medications given. -Staff were expected to document medications	D 358		

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D 358	Continued From page 47 that were not given and the reason why. -Staff were expected to contact the resident's PCP for any medications that were not given. -Staff were expected to follow up on any medication that was not available for administration; staff were not expected to document the medication was not available and just keep it moving. Interview with the Administrator on 07/26/19 at 5:30pm revealed: -For readmission orders, staff were expected to compare new orders to the eMAR and clarify any orders that may need clarification. -The MAs were responsible for faxing new orders to the pharmacy and the DRC reviewed and approved the new orders. -The MA was responsible for making sure the any new medications were in the facility and DRC was responsible for follow up the next day to assure new medications had arrived. -If a medication was not in the facility, the MAs were expected to contact the pharmacy and notify the DRC. -If the MAs were not able to get a medication in the facility, then they were expected to contact the resident's PCP and document in the resident's progress note. -This process should have been followed with Resident #3's medications in May and June 2019. -The MAs were responsible for faxing medication refills to the pharmacy. -He watched MAs administer medications and counseled staff on any concerns. -He had not had the time since starting on 07/01/19 to complete reviews of eMARs for residents. Based on observations, interviews and record reviews, it was determined Resident #3 was not	D 358		

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D 358	Continued From page 48 interviewable. 5. Review of Resident #2's current FL-2 dated 04/11/19 revealed: -Diagnoses included history of cerebrovascular accident, hypertension, and hyperlipidemia. -The medications listed were lisinopril 5 mg by mouth every day and aspirin 81 mg by mouth every day. -Resident #2 was legally blind in both eyes. Review of Resident #2's medical record revealed a physician order dated 04/18/19 as follows: -There was an order for Zoloft 25 mg by mouth daily. -There was an order for clonazepam 0.5 mg ½ tab by mouth twice a day for 3 days, then at bedtime (hours of sleep) as needed for anxiety or sleep. a. Review of Resident #2's April 2019 electronic medication administration record (eMAR) revealed: -There was an electronic entry for clonazepam 0.5 mg tab (0.25mg) by mouth twice daily for 3 days. -The date for the clonazepam order was 04/18/19 through 04/20/19 -There was documentation for clonazepam administered at 7:00 pm on 04/20/19 through 07/24/19. -There was documentation for clonazepam administered at 7:00 am on 04/21/19 through 07/24/19. -The clonazepam was administered twice a day for 4 days and once on 1 day, not twice a day for 3 days as ordered. -There was an electronic entry for clonazepam 0.5 mg tab by mouth at bedtime as needed for anxiety or sleep.	D 358		

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D 358	Continued From page 49 -The date for the clonazepam order was 04/24/19 through 05/05/19. -There was documentation for clonazepam administered on 04/25/19 at 7:14 pm, 04/26/19 at 6:28 pm, 04/27/19 at 5:57 pm, 04/28/19 at 7:35 am, 04/29/19 at 4:54 pm and 04/30/19 at 1:06 pm. Review of Resident #2's May 2019 eMAR revealed: -There was an electronic entry for clonazepam 0.5 mg tab by mouth at bedtime as needed for anxiety or sleep. -The date for the clonazepam order was 04/24/19 through 05/05/19. -There was documentation for clonazepam administered on 05/02/19 at 11:11 pm, 05/03/19 at 6:10 pm, and 05/04/19 at 1:17 pm. -There was an electronic entry for clonazepam 0.5 mg tab by mouth at bedtime. -The date for the clonazepam order was 05/03/19 through 05/06/19. -There was documentation for clonazepam administered on 05/06/19 at 1:00 am. -There was an electronic entry for clonazepam 0.5 mg tab by mouth at bedtime. -The date for the clonazepam order was 05/06/19 through 05/10/19. -There was documentation for clonazepam administered on 05/06/19 through 05/09/19 at 7:00 pm. -There was an electronic entry for clonazepam 0.5 mg tab by mouth twice a day. -The date for the clonazepam order was 05/10/19 through 06/06/19. -There was documentation for clonazepam administered on 05/10/19 through 05/31/19 at 7:00 am and 7:00 pm. Review of Resident #4's June 2019 eMAR	D 358		

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D 358	Continued From page 50 revealed: -There was an electronic entry for clonazepam 0.5 mg tab by mouth twice a day. -The date for the clonazepam order was 06/06/19 through 07/10/19. -There were documentations for clonazepam administered on 06/07/19 through 06/30/19 at 7:00 am and 7:00 pm. -There were documentations of refusals of clonazepam on 06/12/19 at 7:30 am, 06/18/19 at 7:45 am, 06/19/19 at 7:50 am and 06/30/19 at 9:21 am. Review of Resident #4's July 2019 eMAR revealed: -There was an electronic entry for clonazepam 0.5 mg tab by mouth twice a day. -The date for the clonazepam order was 06/06/19 through 07/10/19. -There were documentations for clonazepam administered on 07/01/19 through 07/10/19 at 7:00 am and 7:00 pm. -There were no refusals of clonazepam documented. -There was an electronic entry for clonazepam 0.5 mg tab by mouth twice a day. -The date for the clonazepam order was 07/10/19 and was open ended with no end date noted. -There were documentations for clonazepam being administered on 07/10/19 through 07/23/19 at 7:00 am and 7:00 pm. -There were no refusals documented. Interview with pharmacy representative on 07/25/19 at 9:23 am revealed: -The order for clonazepam 0.5 mg was on a "hard" prescription (meaning a prescription pad) since it was a controlled substance. -The order for clonazepam was 0.5 mg tab (0.25mg) by mouth twice daily for 3 days, then at	D 358		

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D 358	Continued From page 51 bedtime as needed for anxiety or sleep. -This order for clonazepam was received on 04/18/19 and filled on 04/19/19. Interview with Resident #2's current primary care provider (PCP) on 07/26/19 at 9:42 am revealed she would expect the facility to follow up on all physician orders. Interview with the psychiatric nurse practitioner (PNP) on 07/26/19 at 11:43 am revealed: -Resident #2 was alert to self but disoriented to place and time. -Resident #2 had been aggressive towards staff in June. -If Resident #2 had been given the clonazepam as prescribed, it could have possibly helped with her agitation and anxiety. Attempted telephone interview with prescribing provider for the clonazepam on 07/25/19 at 9:58 am was unsuccessful. Refer to interview with a second medication aide (MA) on 07/25/19 at 3:27 pm. Refer to interviews with the Director of Resident Care (DRC) on 07/25/19 at 3:30 pm and on 07/26/18 at 10:45 am. Refer to interview with the Executive Director (ED) on 07/25/19 at 10:45 am. b. Review of Resident #2's medical record revealed a physician order dated 04/18/19 for an order for Zoloft 25 mg by mouth daily. Review of Resident #2's April 2019 electronic medication administration record (eMAR) revealed:	D 358		

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	HAL004003	A. BUILDING: _____ B. WING _____	R 07/26/2019

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D 358	Continued From page 52 -There was no order for Zoloft noted on the eMAR. -There was no documentation Zoloft was administered. Review of Resident #2's May 2019 eMAR revealed: -There was no order for Zoloft noted on the eMAR. -There was no documentation Zoloft was administered. Review of Resident #4's June 2019 eMAR revealed: -There was no order for Zoloft noted on the eMAR. -There was no documentation Zoloft was administered. Review of Resident #4's July 2019 eMAR revealed: -There was no order for Zoloft noted on the eMAR. -There was no documentation Zoloft was administered. Interview with pharmacy representative on 07/25/19 at 9:23 am revealed the pharmacy had not received any order for Zoloft for Resident #2 on or near 04/18/19. Interview with Resident #2's current primary care provider (PCP) on 07/26/19 at 9:42 am revealed: -She would expect the facility to follow up on all physician orders. -Resident #2 receiving the Zoloft as prescribed could have improved her mood and behaviors. Interview with the psychiatric nurse practitioner (PNP) on 07/26/19 at 11:43 am revealed:	D 358		

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D 358	Continued From page 53 -Resident #2 was alert to self but disoriented to place and time. -Resident #2 had been aggressive towards staff in June. -If Resident #2 had been given the Zoloft as prescribed, it could have possibly helped with her agitation and anxiety. Attempted telephone interview with prescribing provider for the Zoloft on 07/25/19 at 9:58 am was unsuccessful. Refer to interview with a second medication aide (MA) on 07/25/19 at 3:27 pm. Refer to interviews with the Director of Resident Care (DRC) on 07/25/19 at 3:30 pm and on 07/26/18 at 10:45 am. Refer to interview with the Executive Director (ED) on 07/25/19 at 10:45 am. Interview with a second medication aide (MA) on 07/25/19 at 3:27 pm revealed: -Physician orders were faxed to the pharmacy by the MAs and put on tracking forms. -The Director of Resident Care (DRC) was able to approve physician orders remotely and did not have to come in to the facility to put them in to the system. -The current DRC started in the position the first part of July 2019. Interview with the Director of Resident Care (DRC) on 07/25/19 at 3:30 pm and on 07/26/18 at 10:45 am revealed: -He had been in the position of DRC since the first part of July 2019. -There was a stack of papers on the floor beside the filing cabinet that was here when he started.	D 358		

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D 358	Continued From page 54 -He was currently working to get those papers filed. -The DRC and Executive Director searched the stack of papers for any physician orders for Resident #2 which had not been filed into her medical record. -The Director of Resident Care was responsible for approving the physician orders when they were faxed to the pharmacy. -He was not there in April 2019 and could not speak to how part of the physician's orders were not followed through other than the hard copy of the clonazepam being sent to the pharmacy. Interview with the Executive Director (ED) on 07/25/19 at 10:45 am revealed: -He had been in the ED position since the first part of July 2019. -The Director of Resident Care was responsible to assure medication orders were transcribed and administered as ordered. -He was not the ED in April 2019 and could not speak to how part of the physician's orders was not followed through other than the hard copy of the clonazepam being sent to the pharmacy. The facility failed to administer medications as ordered for 3 of 6 residents observed during the medication passes resulting in an 11% medication error rate with 4 errors out of 34 opportunities. The medication aide (MA) administered long-acting insulin to Resident #8 instead of short-acting insulin putting the resident as risk of hyperglycemia. Resident #6, a brittle diabetic, received Humalog insulin at 7:00am and 7:00pm instead of at lunch and supper as ordered. Resident #2 did not receive medications for anxiety and depression as ordered resulting in the resident having mood and behavior issues. Resident #3 did not receive multiple medications	D 358		

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D 358	Continued From page 55 including Trazadone resulting in concern for withdrawal symptoms, Lisinopril resulting in concern for hypertension and Metformin resulting in concern for uncontrolled diabetes. The failure of the facility to administer medications as ordered placed residents at substantial risk of death or serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/24/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 25, 2019.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. 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 within one hour before or after the prescribed or scheduled times for 13 residents (#7, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20) during the morning medication pass on 07/25/19 resulting in several medications with multiple administration times being administered too close to the next	D 364	Medication Aides educated on 7/25/19 by Registered Nurse (RN) related to medication administration of all medications and insulin to include administration pass times. ED, DRC and/or designee will review medication administration compliance report daily. ED, DRC and/or designee will monitor medication compliance during medication pass weekly for 2 months to ensure compliance. ED, DRC and/or designee will monitor physician orders for proper medication pass times. Medication Aides will wear special identification to identify they are in process of passing medications to prevent interruptions. POC date: 9/9/19	9/9/19

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D 364	Continued From page 56 scheduled administration times; and for 1 of 5 residents sampled (#3) whose rapid-acting insulin was administered late. The findings are: Review of the facility's resident census report dated 07/23/19 revealed: -The current census was 58 residents. -There was 1 resident in the hospital so there were 57 residents in the facility. -There were 28 residents residing on the 100 hall. -There were 29 residents residing on the 200 hall. Interview with a resident on 07/23/19 at 12:14pm revealed residents received medications "when they (medication aides) get around to giving them." 1. Observation of the 100 hall on 07/25/19 at 9:24am revealed there was one medication aide (MA) passing medications. Interview with the 100 hall MA on 07/25/19 at 9:24am revealed: -She usually started the morning medication pass at 7:00am and she usually finished at 9:00am. -The morning medications were scheduled at 7:00am, 8:00am, and 9:00am. -She was running behind this morning because she assisted a resident who fell earlier. -The resident did not have any injuries and it took the MA just a "few minutes" to help the resident. -She still had 5 residents to administer medications to on the 100 hall including Residents #7, #15, #16, #17, and #18. -Another MA was assigned to administer medications on the 200 hall but that MA was currently assisting a resident with toileting. -She had not notified facility management that	D 364		

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D 364	Continued From page 57 she was running late with the medication pass. -There was no system or procedure to notify anyone when the MAs were running late with the medication pass. -The MAs kept administering medications until they finished. Observation of the 100 hall on 07/25/19 at 9:40am revealed the MA was still in the hallway with the medication cart administering medications. A second interview with the 100 hall MA on 07/25/19 at 9:40am revealed: -She just finished administering medications to Residents #7 and #17. -She still had to administer medications to Residents #15, #16, and #18. -She also had to administer medications to Resident #19; she had forgotten about this resident earlier (at 9:24am) when she reported she only had 5 residents left. Observation of the 100 hall on 07/25/19 at 9:56am revealed the MA was standing at the medication cart in the hallway talking with another staff. A third interview with the 100 hall MA on 07/25/19 at 9:56am revealed: -She was talking with the other staff about getting Resident #15 out of the activity room so she could administer the resident's medications. -She still had to administered medications to Residents #15 and #16. -She also had to administer medications to Resident #20; she had forgotten about this resident earlier (at 9:24am) when she reported she only had 5 residents left.	D 364		

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D 364	Continued From page 58 Observation of the 100 hall on 07/25/19 at 10:19am revealed the 100 hall MA came out of a resident's room and started pushing the medication cart toward the nurses' station. A fourth interview with the 100 hall MA on 07/25/19 at 10:19am revealed she had just finished administering medications to Resident #15 and she had completed the morning medication pas for the 100 hall. Observation of the 200 hall on 07/24/19 at 9:50am revealed there was one MA passing medications. Interview with the 200 hall MA on 07/24/19 at 9:50am revealed: -She had just finished assisting a resident with toileting and was starting back on the morning medication pass on the 200 hall. -She had assisted the resident with toileting because the personal care aide (PCA) was in the activity room assisting with activities. -The medications were scheduled for 8:00am. -She still had to administer medications to 5 residents including Residents #9, #10, #11, #12, and #13. Observation of the 200 hall on 07/25/19 at 10:12am revealed the MA was still in the hallway administering medications. A second interview with the 200 hall MA on 07/25/19 at 10:12am revealed she just finished the 5 residents, but she still had to administer medications to Resident #14. A third interview with the 200 hall MA on 07/25/19 at 10:20am revealed: -She had just finished administering medications	D 364		

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D 364	Continued From page 59 to Resident #14 and the morning medication pass for 200 hall was completed. -She usually started the medication pass at 7:00am and she usually finished between 9:00am - 9:30am. -The 5 residents (#9, #10, #11, #12, #13) came from a sister facility around the end of June 2019 and she had not been administering their medications until about a week ago. -Prior to that, staff from the sister facility had been coming to administer those residents' medications. -It took longer to administer the morning medications because she was not familiar with those residents because they were "new" to her. -She had not reported to anyone that she was running late administering medications. Interview with the Director of Resident Care (DRC) on 07/25/19 at 10:55am revealed: -There were usually 2 MAs assigned to administer medications on first shift. -The MAs usually arrived to the facility and did shift counts for controlled substances at 6:45am. -The MAs usually started the morning medication pass at 7:00am and they were finished by 9:30am. -Most of the morning medications were scheduled for 7:00am or 8:00am. -No one had reported any concerns about medications being administered late. -The MAs should let him know if they needed assistance or were running late with the medication passes. Interview with the Administrator on 07/25/19 at 10:55am revealed: -The MAs should report to him or the DRC if they run late with the medications. -There were usually 2 MAs assigned to	D 364		

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D 364	Continued From page 60 administer medications but there were usually other staff working on the floor who were also MAs and could assist. -He or the DRC could also assist if needed. -There were some residents who were admitted from a sister facility around the end of June 2019. -The MAs from the sister facility had been coming to administer medications to those residents but those MAs stopped coming about 2 weeks ago. -No one had reported any concerns about medications being administered late. -They would notify the facility's contracted primary care provider (PCP) about the residents' morning medications being administered late today (07/25/19). Telephone interview with the facility's contracted PCP on 07/25/19 at 9:42am revealed: -The facility notified her on 07/24/19 about residents' morning medications on that day (07/24/19) being administered late. -She had concerns about certain medications being administered late such as medications for hypertension, diabetes, anxiety, Parkinson's disease, pain, and mood disorders. -Medications ordered more than once a day needed to be administered on time to avoid overdose/underdose and allow the medication time to titrate. -Medications administered too close together or too far apart could lead to unwanted side effects. Review of the July 2019 electronic medication administration records (e-MARs) for the 13 residents who received morning medications late on 07/25/19 revealed: -One of the 13 residents had a medication scheduled once a day at 7:00am. -All 13 of the residents had medications scheduled once a day at 8:00am.	D 364		

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D 364	Continued From page 61 -Two of the 13 residents had medications scheduled once a day at 9:00am. -Eleven of the 13 residents had medications ordered more than once a day, some with multiple administration times. [For medications with multiple administrations, consistent time intervals were necessary to prevent side effects and adverse reactions.] -Nine of the 13 residents had medications scheduled twice a day. -Seven of the 13 residents had medications scheduled 3 times a day. -One of the 13 residents had a medication scheduled 4 times a day. -Medications with administration times more than once a day included medications for depression; hyperthyroidism; dry eyes; high blood pressure; prevention of blood clots; Alzheimer's dementia; low potassium levels; seizures or mood disorders; nerve pain; psychosis; Parkinson's disease or involuntary movements; moderate to severe pain; iron deficiency anemia; mild pain/ fever; anxiety; and acid reflux. a. Review of Resident #7's current FL-2 dated 07/03/19 revealed diagnoses included hypertension, major depressive disorder, muscle weakness, thyrotoxicosis, type 2 diabetes, severe protein calorie malnutrition, anxiety disorder - unspecified, and other specified disorder of the brain. Review of Resident #7's July 2019 electronic medication administration record (e-MAR) revealed: -There were 7 medications scheduled to be administered once a day at 8:00am including Amlodipine and Lisinopril (both for high blood pressure); Daily Vite and Vitamin B1 (vitamin supplements); Oxybutynin (for bladder spasms);	D 364		

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D 364	Continued From page 62 Protonix (for acid reflux); and Aspirin (for prevention of heart disease). -Buspirone (for anxiety) and Methimazole (for hyperthyroidism) were scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm. -Refresh Tears (for dry eyes) was scheduled 4 times a day at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -All of the medications scheduled for 8:00am on 07/25/19 were documented as administered at 9:35am, 35 minutes beyond the allowed 1-hour time frame. -Medications scheduled for 8:00am were documented as being administered late on 7 other days, up to 20 minutes beyond the 1-hour time frame allowed. Interview with Resident #7 on 07/26/19 at 4:58pm revealed she thought her medications were administered on time. b. Review of Resident #9's current FL-2 dated 06/09/19 revealed diagnoses included congestive heart failure, atrial fibrillation, hyperlipidemia, non-traumatic subarachnoid hemorrhage, fracture of orbital floor, fracture of neck, and hard of hearing. Review of Resident #9's July 2019 electronic medication administration record (e-MAR) revealed: -There were 5 medications scheduled to be administered once a day at 8:00am including Losartan/Hydrochlorothiazide (for high blood pressure); Zyprexa (for psychosis); Omeprazole (for acid reflux); Potassium Chloride ER (for low potassium); and Vitamin D3 (for Vitamin D deficiency). -All of the medications scheduled for 8:00am on 07/25/19 were documented as administered at	D 364		

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D 364	Continued From page 63 10:03am, 1 hour and 3 minutes beyond the allowed 1-hour time frame. -Medications scheduled for 8:00am were documented as being administered late on 3 other days, up to 1 hour and 13 minutes beyond the 1-hour time frame allowed. -There were 2 medications scheduled twice a day at 7:00am and 7:00pm including Coreg (lowers blood pressure) and Eliquis (prevents blood clots). -The medications scheduled for 7:00am on 07/25/19 were documented as administered at 10:03am, 2 hours and 3 minutes beyond the allowed 1-hour time frame. -Medications scheduled for 7:00am and 7:00pm were documented as being administered late on 16 other occasions, up to 2 hours and 13 minutes beyond the 1-hour time frame allowed. Interview with Resident #9 on 07/26/19 at 5:36pm revealed: -He did not know what time he usually received his medications. -He got medications whenever staff "drop off" the medications. c. Review of Resident #10's current FL-2 dated 03/07/19 revealed diagnoses included depressive disorder, hyperlipidemia, hypertension, congenital anemia, Bell's palsy, low potassium, and constipation. Review of Resident #10's July 2019 electronic medication administration record (e-MAR) revealed: -There were 3 medications scheduled to be administered once a day at 8:00am including Chlorthalidone (diuretic used to treat swelling and high blood pressure); Nifedipine ER (for high blood pressure); and Vitamin D3 (for Vitamin D	D 364		

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D 364	Continued From page 64 deficiency). -Medications scheduled for 8:00am on 07/25/19 were documented as administered at 9:57am, 57 minutes beyond the allowed 1-hour time frame. -Medications scheduled for 8:00am were documented as being administered late on 6 other days, up to 2 hours and 11 minutes beyond the 1-hour time frame allowed. -Namenda (for Alzheimer's dementia) was scheduled twice a day at 7:00am and 7:00pm. -Namenda scheduled for 7:00am on 07/25/19 was documented as administered at 9:57am, 1 hour and 57 minutes beyond the allowed 1-hour time frame. -Namenda was documented as being administered late on 17 other occasions, up to 3 hours and 11 minutes beyond the 1-hour time frame allowed. -Potassium Chloride ER (for low potassium) was scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm. -Potassium Chloride ER scheduled for 8:00am on 07/25/19 was documented as administered at 9:57am, 57 minutes beyond the allowed 1-hour time frame. -Potassium Chloride ER was documented as being administered late on 17 other occasions, up to 2 hours and 11 minutes beyond the 1-hour time frame allowed. Interview with Resident #10 on 07/26/19 at 5:44pm revealed: -She had already received medications today. -She did not know what time she got her medications each day. d. Review of Resident #11's current FL-2 dated 09/07/18 revealed diagnoses included depressive disorder, cancer in situ prostate, gastric ulcer, diarrhea, moderate intellectual disability,	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL004003	A. BUILDING: _____ B. WING _____	R 07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 364	Continued From page 65 hyperlipidemia, and hypercholesterolemia. Review of Resident #11's July 2019 electronic medication administration record (e-MAR) revealed: -There were 2 medications scheduled to be administered once a day at 8:00am including Zoloft (for depression) and Omeprazole (for acid reflux). -Medications scheduled for 8:00am on 07/25/19 were documented as administered at 10:06am, 1 hour and 6 minutes beyond the allowed 1-hour time frame. -Medications scheduled for 8:00am were documented as being administered late on 2 other days, up to 1 hour and 15 minutes beyond the 1-hour time frame allowed. -Centrum Silver (a vitamin supplement) was scheduled at 9:00am. -Centrum Silver on 07/25/19 was documented as administered at 10:06am, 6 minutes beyond the allowed 1-hour time frame. -Centrum Silver was documented as being administered late on 2 other occasions, up to 15 minutes beyond the 1-hour time frame allowed. -Divalproex DR (for seizures or mood disorders) was scheduled twice a day at 7:00am and 7:00pm. -Divalproex DR scheduled for 7:00am on 07/25/19 was documented as administered at 10:06am, 2 hours and 6 minutes beyond the allowed 1-hour time frame. -Divalproex DR was documented as being administered late on 14 other occasions, up to 2 hours and 15 minutes beyond the 1-hour time frame allowed. Interview with Resident #11 on 07/26/19 at 5:49pm revealed: -He usually received 3 medications in the	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 364	Continued From page 66 morning and 2 medications at night. -He usually got his medications on time but sometimes he did not get his morning medications until after he ate breakfast. -He did not have any side effects from his medications. e. Review of Resident #12's current FL-2 dated 02/27/19 revealed diagnoses included bipolar disorder with psychosis, shortness of breath, QT syndrome, and abnormal electrocardiogram. Review of Resident #12's July 2019 electronic medication administration record (e-MAR) revealed: -There were 4 medications scheduled to be administered once a day at 8:00am including Duloxetine (for depression); Protonix (for acid reflux); Aspirin (for prevention of heart disease); and Thera Multivitamin (a vitamin supplement). -Medications scheduled for 8:00am on 07/25/19 were documented as administered at 10:09am, 1 hour and 9 minutes beyond the allowed 1-hour time frame. -Medications scheduled for 8:00am were documented as being administered late on 2 other days, up to 1 hour and 18 minutes beyond the 1-hour time frame allowed. -Risperdal (for psychosis) was scheduled to be administered twice a day at 7:00am and 7:00pm. -Risperdal scheduled for 7:00am on 07/25/19 was administered at 10:09am, 2 hours and 9 minutes beyond the allowed 1-hour time frame. -Risperdal was documented as being administered late on 15 other occasions, up to 2 hours and 18 minutes beyond the 1-hour time frame allowed. -Gabapentin (for seizures, mood disorders, or nerve pain) was scheduled to be administered 3 times a day at 8:00am, 2:00pm, and 8:00pm.	D 364		

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D 364	Continued From page 67 -Gabapentin scheduled for 8:00am on 07/25/19 was administered at 10:09am, 1 hour and 9 minutes beyond the allowed 1-hour time frame. -Gabapentin was documented as being administered late on 2 other occasions, up to 1 hour and 18 minutes beyond the 1-hour time frame allowed. Interview with Resident #12 on 07/26/19 at 5:40pm revealed: -He usually received his morning medications at breakfast time, but they were sometimes late. -Sometimes his morning medications were as late as 10:00am. -He also received medications between 1:30pm - 2:00pm and between 7:00pm - 7:30pm. -He did not have any side effects from his medications. f. Review of Resident #13's current FL-2 dated 06/06/19 revealed diagnoses included chronic obstructive pulmonary disease, acute/chronic kidney disease, heart failure, schizophrenia, bipolar disorder, and cognitive impairment. Review of Resident #13's July 2019 electronic medication administration record (e-MAR) revealed: -There were 4 medications scheduled to be administered once a day at 8:00am including Amlodipine (for high blood pressure); Furosemide (a diuretic for excess fluid and high blood pressure); Aspirin (for prevention of heart disease); and Vitamin D3 (for Vitamin D deficiency). -Medications scheduled for 8:00am on 07/25/19 were documented as administered at 10:00am, 1 hour beyond the allowed 1-hour time frame. -Medications scheduled for 8:00am were documented as being administered late on 2	D 364		

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D 364	Continued From page 68 other days, up to 1 hour and 21 minutes beyond the 1-hour time frame allowed. -There were 2 medications scheduled to be administered twice a day at 7:00am and 7:00pm including Coreg (for high blood pressure) and Zyprexa (for psychosis). -Medications scheduled for 7:00am on 07/25/19 were administered at 10:00am, 2 hours beyond the allowed 1-hour time frame. -Medications scheduled for 7:00am and 7:00pm were documented as being administered late on 18 other occasions, up to 2 hours and 21 minutes beyond the 1-hour time frame allowed. Interview with Resident #13 on 07/26/19 at 4:55pm revealed: -His scheduled medication times were 8:00am and 8:00pm. -He usually got his medications on time. g. Review of Resident #14's current FL-2 dated 06/06/19 revealed diagnoses included dementia, depression, hypertension, osteoporosis, hyperlipidemia, and history of basal cell carcinoma. Review of Resident #14's July 2019 electronic medication administration record (e-MAR) revealed: -There were 3 medications scheduled to be administered once a day at 8:00am including Citalopram (for depression); Aricept (for Alzheimer's dementia); and Vitamin D3 (for Vitamin D deficiency). -Medications scheduled for 8:00am on 07/25/19 were documented as administered at 10:23am, 1 hour and 23 minutes beyond the allowed 1-hour time frame. -Medications scheduled for 8:00am were documented as being administered late on 7	D 364		

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D 364	Continued From page 69 other days, up to 1 hour and 40 minutes beyond the 1-hour time frame allowed. Interview with Resident #14 on 07/26/19 at 6:15pm revealed: -She usually got her medications in the morning before breakfast. -She did not recall if the medications had been administered late. -She did not have any side effects from her medications. h. Review of Resident #15's current FL-2 dated 02/20/19 revealed diagnoses included vascular dementia without behavioral disturbance, schizoaffective disorder, unspecified intellectual disabilities, anxiety disorders, overactive bladder, and unsteadiness on feet. Review of Resident #15's July 2019 electronic medication administration record (e-MAR) revealed: -There were 4 medications scheduled to be administered once a day at 8:00am including Amlodipine (for high blood pressure); Furosemide (a diuretic for excess fluid and high blood pressure); Vesicare (for bladder spasms); and Zyrtec (for seasonal allergies). -Medications scheduled for 8:00am on 07/25/19 were documented as administered at 10:23am, 1 hour and 23 minutes beyond the allowed 1-hour time frame. -Medications scheduled for 8:00am were documented as being administered late on 4 other days, up to 42 minutes beyond the 1-hour time frame allowed. -There were 5 medications scheduled to be administered once a day at 9:00am including Ferrous Sulfate (for iron-deficiency anemia); Acetaminophen (for pain/fever); Aspirin (for	D 364		

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D 364	Continued From page 70 prevention of heart disease); Folic Acid (a vitamin supplement); and Vitamin D3 (for Vitamin D deficiency). -Medications scheduled for 9:00am on 07/25/19 were documented as administered at 10:23am, 23 minutes beyond the allowed 1-hour time frame. -Tegretol (for seizures or mood disorders) was scheduled to be administered twice a day at 8:00am and 4:00pm. -Tegretol scheduled for 8:00am on 07/25/19 was documented as administered at 10:23am, 1 hour and 23 minutes beyond the allowed 1-hour time frame. -Tegretol was documented as being administered late on 4 other occasions, up to 42 minutes beyond the 1-hour time frame allowed. -Risperdal (for psychosis) was scheduled to be administered twice a day at 9:00am and 9:00pm and it was administered at 10:23am on 07/25/19, 23 minutes beyond the allowed 1-hour time frame. -Benztropine (for involuntary movements) was scheduled to be administered 3 times a day at 9:00am, 3:00pm, and 9:00pm. -Benztropine scheduled for 9:00am on 07/25/19 was documented as administered at 10:23am, 23 minutes beyond the allowed 1-hour time frame. Interview with Resident #15 on 07/26/19 at 5:36 pm revealed her medications were administered "on time, all the time". i. Review of Resident #16's current FL-2 dated 02/20/19 revealed diagnoses included dementia, hypertension, and hypothyroidism. Review of Resident #16's July 2019 electronic medication administration record (e-MAR) revealed:	D 364		

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D 364	Continued From page 71 -There were 3 medications scheduled to be administered once a day at 8:00am including Amlodipine (for high blood pressure); Hydrochlorothiazide (a diuretic that lowers blood pressure); and Levothyroxine (for hypothyroidism). -Medications scheduled for 8:00am on 07/25/19 were documented as administered at 10:04am, 1 hour and 4 minutes beyond the allowed 1-hour time frame. Interview with Resident #16 on 07/26/19 at 5:45pm revealed: - She did not get her medications on time. - All staff were late giving medications and it was no particular staff. - She had not discussed her concerns about late medications with anyone. j. Review of Resident #17's current FL-2 dated 07/11/19 revealed diagnoses included dementia, low back osteoarthritis, insomnia, and dyspepsia. Review of Resident #17's July 2019 electronic medication administration record (e-MAR) revealed: -There were 4 medications scheduled to be administered once a day at 8:00am including Lisinopril (for high blood pressure); Citalopram (for depression; Potassium Chloride ER (for low potassium); and Omeprazole (for acid reflux). -Medications scheduled for 8:00am on 07/25/19 were documented as administered at 9:37am, 37 minutes beyond the allowed 1-hour time frame. -Medications scheduled for 8:00am were documented as being administered late on 2 other days, up to 23 minutes beyond the 1-hour time frame allowed. -Tramadol (a narcotic pain reliever) was scheduled to be administered 3 times a day at	D 364		

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D 364	Continued From page 72 8:00am, 2:00pm, and 8:00pm. -Tramadol scheduled for 8:00am on 07/25/19 was documented as administered at 9:37am, 37 minutes beyond the allowed 1-hour time frame. Based on observations, interviews, and record reviews, it was determined Resident #17 was not interviewable. k. Review of Resident #18's current FL-2 dated 02/21/19 revealed diagnoses included cognitive impairment, chronic obstructive pulmonary disease, iron deficiency anemia, hypertension, gastroesophageal reflux disease, insomnia, and muscle weakness. Review of Resident #18's July 2019 electronic medication administration record (e-MAR) revealed: -There were 3 medications scheduled to be administered once a day at 8:00am including Loratadine (for seasonal allergies); Omeprazole (for acid reflux); and Vitamin D3 (for Vitamin D deficiency). -Medications scheduled for 8:00am on 07/25/19 were documented as administered at 9:52am, 52 minutes beyond the allowed 1-hour time frame. -Medications scheduled for 8:00am were documented as being administered late on 9 other days, up to 53 minutes beyond the 1-hour time frame allowed. -There were 3 medications scheduled to be administered twice a day at 8:00am and 8:00pm including Coreg and Metoprolol (both for high blood pressure) and Ferrous Sulfate (for iron-deficiency anemia). -Medications scheduled for 8:00am on 07/25/19 were documented as administered at 9:52am, 52 minutes beyond the allowed 1-hour time frame. -Medications scheduled for 8:00am and 8:00pm	D 364		

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D 364	Continued From page 73 were documented as being administered late on 9 other occasions, up to 53 minutes beyond the 1-hour time frame allowed. -Hydrocodone/Acetaminophen (a narcotic pain reliever) was scheduled to be administered 3 times a day at 8:00am, 2:00pm, and 8:00pm. -Hydrocodone/Acetaminophen scheduled for 8:00am on 07/25/19 was documented as administered at 9:52am, 52 minutes beyond the allowed 1-hour time frame. -Hydrocodone/Acetaminophen was documented as being administered late on 6 other occasions, up to 40 minutes beyond the 1-hour time frame allowed. Interview with Resident #18 on 07/26/19 at 5:02pm revealed: -She got her morning medications between 9:30am and 10:00am. -When her acid reflux medication was late, it caused her "reflux to act up". -When her blood pressure medication was late it caused her to feel sluggish. -The resident had reported her medications being late but she could not recall when or who she reported it to. I. Review of Resident #19's current FL-2 dated 03/20/19 revealed diagnoses included dementia, dislocation of left hip, hypokalemia, gastroesophageal reflux disease, atrial fibrillation, hypertension, overactive bladder, congestive heart failure, and malignant neoplasm of the breast. Review of Resident #19's July 2019 electronic medication administration record (e-MAR) revealed: -Zyrtec (for seasonal allergies) was scheduled to be administered once a day at 7:00am.	D 364		

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D 364	Continued From page 74 -Zyrtec was administered late on 07/25/19 at 9:55am, 1 hour and 55 minutes beyond the allowed 1-hour time frame. -Zyrtec was administered late on 1 other day, 31 minutes beyond the allowed 1-hour time frame. -There were 6 medications scheduled to be administered once a day at 8:00am including Atorvastatin (for high cholesterol); Diltiazem (for heart/blood pressure); Metolazone (a diuretic for excess fluid that lower blood pressure); Lactulose and Senexon-S (laxatives); and Ocuvite (a vitamin supplement for eye health). -Medications scheduled for 8:00am on 07/25/19 were documented as administered at 9:55am, 55 minutes beyond the allowed 1-hour time frame. -There were 2 medications scheduled to be administered twice a day at 7:00am and 7:00pm including Potassium Chloride ER (for low potassium) and Ranitidine (for acid reflux). -Medications scheduled for 7:00am on 07/25/19 were documented as administered at 9:55am, 1 hour and 55 minutes beyond the allowed 1-hour time frame. -Medications scheduled for 7:00am and 7:00pm were documented as being administered late on 1 other occasion, 31 minutes beyond the 1-hour time frame allowed. -There were 2 medications scheduled to be administered 3 times a day at 8:00am, 2:00pm, and 8:00pm including Lorazepam (a narcotic for anxiety) and Acetaminophen (for pain/fever). -Medications scheduled for 8:00am on 07/25/19 were documented as administered at 9:55am, 55 minutes beyond the allowed 1-hour time frame. Interview with Resident #19 on 07/26/19 at 5:42pm revealed: -Her medications were occasionally late but not often. -She could not recall any particular times when	D 364		

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D 364	Continued From page 75 the medications were late. m. Review of Resident #20's current FL-2 dated 05/10/19 revealed diagnoses included dementia, hypertension, anxiety, hyperlipidemia, falls, chronic obstructive pulmonary disease, and history of breast cancer. Review of Resident #20's July 2019 electronic medication administration record (e-MAR) revealed: -There were 6 medications scheduled to be administered once a day at 8:00am including Anastrozole (for breast cancer); Lexapro (for depression); Lisinopril (for high blood pressure); Namenda (for Alzheimer's dementia); Simvastatin (for high cholesterol); and Aspirin (for prevention of heart disease). -Medications scheduled for 8:00am on 07/25/19 were documented as administered at 10:01am, 1 hour and 1 minute beyond the allowed 1-hour time frame. -Medications scheduled for 8:00am were documented as administered late on 6 other days, up to 1 hour 38 minutes beyond the allowed 1-hour time frame. -Gabapentin (for seizures, mood disorders, or nerve pain) was scheduled to be administered twice a day at 7:00am and 7:00pm. -Gabapentin was documented as administered at 10:01am on 07/25/19, 2 hours and 1 minute beyond the allowed 1-hour time frame. -Gabapentin was documented as being administered late on 16 other occasions, up to 2 hours and 38 minutes beyond the 1-hour time frame allowed. Based on observations, interviews, and record reviews, it was determined Resident #20 was not interviewable.	D 364		

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D 364	Continued From page 76 2. Review of Resident #3's current FL-2 dated 05/29/19 revealed: -Diagnoses included type II diabetes mellitus, autistic disorder, dysphagia and schizo-affective disorder. -There was documentation to see attached medication list. Review of a Physician's Order sheet dated 03/20/19 attached to the FL-2 dated 05/06/19 for Resident #3 revealed there was an order for Novolog sliding scale insulin (SSI) subcutaneous (SQ) before meals and at bedtime for finger stick blood sugar (FSBS) 141-180 give 2 units, 181-220 give 4 units, 220-260 give 6 units, 261-300 give 8 units, 301-340 give 10 units, 341-380 give 12 units, 381-420 give 14 units, 421-460 give 16 units, 461-500 give 18 units, 501 and greater give 20 units and notify primary care provider (PCP). Review of Resident #3's May 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog SSI SQ four times daily at 7:00am, 12:00pm, 6:00pm and 9:00pm. -There was documentation the Novolog SSI was administered at 10:42am on 05/07/19, at 10:17am on 05/11/19, at 9:15am on 05/12/19, at 10:16am on 05/21/19, at 8:52pm (for 6:00pm) on 05/22/19 and at 12:44am on 05/25/19. Review of Resident #3's June 2019 eMAR revealed: -There was an entry for Novolog SSI SQ four times daily at 7:00am, 12:00pm, 6:00pm and 9:00pm. -There was documentation the Novolog SSI was	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL004003	A. BUILDING: _____ B. WING _____	R 07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW TERRACE OF WADESBORO	123 ANSON HIGH SCHOOL ROAD WADESBORO, NC 28170

(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 364	Continued From page 77 administered at 9:08am on 06/07/19, at 9:03am on 06/08/29 and at 8:55am on 06/22/19. Review of Resident #3's June 2019 eMAR revealed: -There was an entry for Novolog SSI SQ four times daily at 7:00am, 12:00pm, 6:00pm and 9:00pm. -There was documentation the Novolog SSI was administered at 9:02am on 07/03/19 and 10:08am on 07/21/19. Interview with a medication aide (MA) on 07/25/19 at 10:48am revealed: -She could not remember the reason morning medications including Novolog SSI scheduled for 7:00am, were administered late on 11 occasions between 05/01/19 and 07/23/19. -On 05/07/19, Resident #3's 7:00am Novolog SSI was administered at 10:42am because the pharmacy was at the facility switching medication cards from the "bingo" cards to the multi-dose pack cards. Telephone interview with a second MA on 07/26/19 at 9:08am revealed: -Medications were administered late because all residents' medications were scheduled for the same administration time. -When medications times were not staggered, there was not enough time to administer medications to all residents within one before and one hour after the scheduled time. -The MAs told the former Resident Care Coordinator (RCC) about medications being late due to all medications being scheduled at the same time; the former RCC blamed the pharmacy and did not do anything about it. -There were six residents that received insulin in the morning; usually insulin was administered on	D 364		

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D 364	Continued From page 78 time because the MAs prioritized administering insulin. Interview with the Director of Resident Care (DRC) on 07/26/19 at 10:45am revealed: -He did not know medications were being administered 90 minutes to more then three hours late. -Staff expressed concern for medication times on 07/25/19; medications times should not have been at 7:00am when the shift was changing and staff had to complete controlled drug counts and give report. -Staff were expected to administer medications within one hour of scheduled time. Interview with the Administrator on 07/26/19 at 5:30pm revealed: -MAs were expected to administer medications within one hour before or one after the scheduled administration time. -Staff had not reported there were any problems with administering medications on time. -He had increased the number of staff on duty by one staff on each shift effective 07/01/19. -He watched MAs administer medications and counseled staff on any concerns. -He had not had the time since starting on 07/01/19 to complete reviews of eMARs for residents. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. The facility failed to administered medications within 1 hour before or after the scheduled administration time for 13 residents during the morning medication pass on 07/25/19 from 9:24am - 10:20am. At least 11 of the residents	D 364		

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D 364	Continued From page 79 had medications with multiple administration times that were administered too close together including but not limited to medications for depression; hyperthyroidism; high blood pressure; prevention of blood clots; Alzheimer's dementia; low potassium levels; mood disorders; nerve pain; psychosis; involuntary movements; chronic pain; anxiety; and acid reflux. Resident #3 had 11 doses of Novolog sliding scale insulin adminstered 90 minutes to more than 3 hours late between May and July 2019. The facility's failure to administer medications within one hour before or after the scheduled time was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/26/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 9, 2019.	D 364		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and	D 367	Director of Resident Care (DRC) reviewed physician orders verifying medication record matches Physician orders. Omnicare Pharmacy completed audit of medication records on 8/20/19 and 8/21/19. Pharmacist completed review on 8/21/19. Order Processing System (Bucket System) will be utilized daily to ensure orders are processed and transcriped accurately. ED, DRC and/or designee will review and approve Physician orders daily, correcting any orders transcribed incorrectly. ED, DRC and or designee will review Physcian orders weekly for 3 months to monitor for medication transciption errors. POC Date: 9/9/19	9/9/19

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D 364	Continued From page 79 had medications with multiple administration times that were administered too close together including but not limited to medications for depression; hyperthyroidism; high blood pressure; prevention of blood clots; Alzheimer's dementia; low potassium levels; mood disorders; nerve pain; psychosis; involuntary movements; chronic pain; anxiety; and acid reflux. Resident #3 had 11 doses of Novolog sliding scale insulin administered 90 minutes to more than 3 hours late between May and July 2019. The facility's failure to administer medications within one hour before or after the scheduled time was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/26/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 9, 2019.	D 364		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and	D 367	Director of Resident Care (DRC) reviewed physician orders verifying medication record matches Physician orders. Omnicare Pharmacy completed audit of medication records on 8/20/19 and 8/21/19. Pharmacist completed review on 8/21/19. DRC reviewed all physician orders related to insulin to ensure that the order is processed correctly and documentation of blood glucose and amount of insulin given are included in the administration of insulin. Order Processing System (Bucket System) will be utilized daily to ensure any new orders are processed and transcriped accurately. Medication Aides (MA) will accuretly document medication given or why not given, notifying MD as needed. ED, DRC and/or designee will review and approve Physician orders daily, correcting any orders transcribed incorrectly. ED, DRC and or designee will review Physician orders weekly for 3 months to monitor for medication transciption errors and to ensure medication documentation completed to include vitals, amount of insulin administered and documentation as to why medication not given if needed. POC Date: 9/9/19	9/9/19

LPN/ED 9/12/19

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D 367	Continued From page 80 documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure accurate documentation of the administration of medications including sliding scale insulin (Novolog), oral diabetes medication (Metformin) and allergy medications (Flonase) for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's current FL-2 dated 05/29/19 revealed: -Diagnoses included type II diabetes mellitus, autistic disorder, dysphagia and schizo-affective disorder. -There was documentation to see attached medication list. a. Review of a Physician's Order sheet dated 03/20/19 attached to the FL-2 dated 05/06/19 for Resident #3 revealed there was an order for Novolog sliding scale insulin (SSI) subcutaneous	D 367		

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D 367	Continued From page 81 (SQ) before meals and at bedtime for finger stick blood sugar (FSBS) 141-180 give 2 units, 181-220 give 4 units, 220-260 give 6 units, 261-300 give 8 units, 301-340 give 10 units, 341-380 give 12 units, 381-420 give 14 units, 421-460 give 16 units, 461-500 give 18 units, 501 and greater give 20 units and notify primary care provider (PCP). Review of Resident #3's May 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog sliding scale insulin (SSI) subcutaneously (SQ) four times daily for finger stick blood sugar (FSBS) results great than 141. -There was documentation of 55 opportunities to administer SSI; there was no documentation how much SSI was administered. Review of Resident #3's June 2019 eMAR revealed: -There was an entry for Novolog SSI SQ four times daily for FSBS results great than 141. -There was documentation of 56 opportunities to administer SSI; there was no documentation how much SSI was administered. Review of Resident #3's July 2019 eMAR revealed: -There was an entry for Novolog SSI SQ four times daily for FSBS results great than 141. -There was documentation of 54 opportunities to administer SSI; there was documentation of the amount of SSI administered for 2 of the 54 opportunities. Interview with a medication aide (MA) on 07/25/19 at 10:48am revealed MAs did not document how much SSI was administered on	D 367		

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D 367	Continued From page 82 the eMAR; the computer system only required the finger stick blood sugar (FSBS) result. Interview with a second medication aide (MA) on 07/25/19 at 11:09am revealed: -When administering sliding scale insulin (SSI), the computer system indicated how much insulin to give based on the finger stick blood sugar (FSBS) result that was entered. -MAs did not document the amount given each time they administered SSI. Telephone interview with the Front-End Manager at the facility's contracted pharmacy on 07/25/19 at 12:38pm revealed: -The pharmacy did not have a Novolog SSI order for Resident #3. -When the pharmacy entered SSI on the eMAR, they entered a place for documentation of the finger stick blood sugar (FSBS) result and the amount of insulin which was supposed to be given. -The facility staff had to enter the amount given in their computer system. Interview with the Director of Resident Care (DRC) on 07/26/19 at 10:45am revealed: -The Novolog sliding scale insulin (SSI) was not entered correctly on the electronic medication record (eMAR). -If the SSI had been entered correctly, the computer system would have automatically flagged how much insulin to give and a place to document how much was given by the MA. -The staff who approved the order was able to reconcile and change the order. b. Review of a hospital discharge summary dated 05/06/19 for Resident #3 revealed there was an order for Metformin 850mg three times daily.	D 367		

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D 367	Continued From page 83 Review of a Physician's Order sheet dated 07/22/19 for Resident #3 revealed there was an order for Metformin 1000mg twice daily. Upon request on 07/24/19, there was no order for Metformin 500mg twice daily. Review of Resident #3's May 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Metformin 500mg twice daily. -There was documentation Metformin 500mg was administered 05/01/19 at 7:30am and 05/06/19 at 7:30pm through 05/10/19 at 7:30pm. -There was an entry for Metformin 850mg three times daily. -There was documentation the Metformin 850mg was administered from 05/10/19 at 8:00am through 05/31/19 at 8:00pm except the following: -On 05/13/19 at 7:53am, 05/14/19 at 8:12am and 05/18/19 at 8:40am there was documentation the Metformin 850mg was not administered because it was a duplicate order. -On 05/17/19 at 7:17pm there was documentation the Metformin 850mg was not administered because it was discontinued. -On 05/18/19 at 7:00pm there was documentation the Metformin 850mg was not administered "due to condition". -On 05/25/19 at 1:06pm there was documentation the Metformin 850mg was not administered because the resident was at the emergency room. -From 05/29/19 at 8:42pm through 05/31/19 at 1:02pm there was documentation the Metformin 850mg was not administered because it was "ordered", and the facility was waiting on the pharmacy.	D 367		

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D 367	Continued From page 84 -There was an entry for Metformin 1000mg twice daily. -There was documentation the Metformin 1000mg was administered 05/01/19 at 7:30am and 05/06/19 at 7:30pm through 05/31/19 at 7:30pm except the following: -On 05/20/19 at 7:59am there was documentation the Metformin 1000mg was not administered because it was ordered. -On 05/20/19 at 6:28pm and on 05/21/19 at 7:54am and 6:29pm there was documentation the Metformin 1000mg was not administered because it was discontinued. -On 05/26/19 at 6:29pm and 05/27/19 at 7:10am there was documentation the Metformin 1000mg was not administered because it was a duplicate order. Review of Resident #3's June 2019 eMAR revealed: -There was an entry for Metformin 850mg three times daily. -There was documentation the Metformin 850mg was administered on 06/01/19 at 8:00pm, 06/02/19 at 8:00am and 8:00pm, 06/03/19 at 8:00am and 8:00pm, 06/10/at 8:00am and 06/11/19 at 8:00am. -There was an entry for Metformin 1000mg twice daily. -There was documentation the Metformin 1000mg was administered from 06/01/19 at 7:00am through 06/16/19 at 7:00am and from 06/24/19 at 7:00am through 06/30/19 at 7:00pm. Interview with a medication aide (MA) on 07/25/19 at 10:48am revealed: -She could not remember the details of what happened with the documentation of Metformin for Resident #3 on 05/20/19 and 05/21/19. -MAs were supposed to enter that medications	D 367		

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D 367	Continued From page 85 were not given and document a reason note whenever a medication was not available for administration. Interview with a second MA on 07/25/19 at 4:32pm revealed: -Normally the MAs were able to see on the computer screen notes entered for medications by the last MA who gave the medication such as "waiting for pharmacy," but the MA was supposed to check and make sure the medication had not come in before documenting the medication was not given. -She could not specifically remember what happened with the Metformin entries on the eMAR for Resident #3. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/25/19 at 12:07pm revealed: -The pharmacy dispensed 54 Metformin 850mg tablets on 11/20/18. -The pharmacy dispensed 28 Metformin 1000mg tablets on 04/23/19, 14 tablets on 06/19/19, 12 tablets on 06/19/19 and 56 tablets on 07/02/19. -Medication orders were entered on the eMAR by the order entry team at the pharmacy. -When medication dosages were increased or decreased, the old order was discontinued on the eMAR because there could not be more than one entry for the same medication. -She did not know what happened with Metformin 500mg, 850mg and 1000mg documented on Resident #3's May 2019 eMAR. Telephone interview with the Front-End Manager at the facility's contracted pharmacy on 07/25/19 at 12:38pm revealed the only active order for Metformin for Resident #3 was 1000mg twice daily.	D 367		

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D 367	Continued From page 86 Interview with the Director of Resident Care (DRC) on 07/26/19 at 10:45am revealed: -He expected MAs to notify him of issues like the multiple entries for Metformin on Resident #3's eMAR. -The former Resident Care Coordinator (RCC) and former Administrator would have been responsible for reconciling Resident #3's readmission orders and eMAR for errors or clarification needs. c. Review of a hospital discharge summary dated 05/06/19 for Resident #3 revealed there was an order for Flonase one spray in each nostril twice daily. Review of Resident #3's May 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Flonase one spray in each nostril twice daily. -There was documentation the Flonase had not arrived and the facility was waiting on the pharmacy from 05/06/19 through 05/12/19, except on 05/08/19 at 7:00am and 7:00pm, 05/09/19 at 7:00pm and 05/10/19 at 7:00am and 7:00pm. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/25/19 at 9:03am revealed: -The pharmacy received new and changed medication orders for Resident #3 from hospital discharge instructions dated 05/06/19 which were readmission orders. -There was an order for Flonase one spray each nostril twice daily. -The pharmacy first dispensed Flonase on 05/13/19 for Resident #3.	D 367		

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D 367	Continued From page 87 -The facility staff requested the order be placed on Resident #3's medication profile for the Flonase on 05/06/19 and did not request a fill until 05/13/19. Telephone interview with a medication aide (MA) on 07/26/19 at 9:08am revealed when a resident did not have medications in the facility, the MAs faxed the pharmacy for a refill request, documented the medication was not administered and document a reason such as waiting on pharmacy. Telephone interview with the Front-End Manager at the facility's contracted pharmacy on 07/25/19 at 12:38pm revealed: -The facility staff were able to make changes on the eMAR, but the changes did not come through on the pharmacy side of the system and were not able to be seen by pharmacy staff. -All medication orders should be sent to the pharmacy, so information seen on the computer screens matched at the pharmacy and the facility. -Resident #3 was re-admitted to the facility on 05/06/19, all orders prior to 05/06/19 would have been discontinued. Interview with the Director of Resident Care (DRC) on 07/26/19 at 10:45am revealed: -Staff were expected to document if medications were not available to administer for a resident. -The former Resident Care Coordinator (RCC) and former Administrator would have been responsible for reconciling Resident #3's readmission orders and eMAR for errors or clarification needs. -He reviewed eMARs daily for documentation and did random cart audits to monitor for compliance with medication administration. -Staff were expected to document medications	D 367		

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	HAL004003	A. BUILDING: _____ B. WING _____	R 07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW TERRACE OF WADESBORO	123 ANSON HIGH SCHOOL ROAD WADESBORO, NC 28170

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D 367	Continued From page 88 that were not given and the reason why. Interview with the Administrator on 07/26/19 at 5:30pm revealed: -If a medication was not in the facility, the MAs were expected to contact the pharmacy and notify the DRC. -If the MAs were not able to get a medication in the facility, then they were expected to contact the resident's PCP and document in the resident's progress note. -This process should have been followed with Resident #3's medications in May and June 2019. -The MAs were responsible for faxing medication refills to the pharmacy. -The MAs were expected to document on the eMAR how much SSI was administered each time. -He watched MAs administer medications and counseled staff on any concerns. -He had not had the time since starting on 07/01/19 to complete reviews of eMARs for residents. Attempted telephone interview with the former Resident Care Coordinator (RCC) on 07/25/19 at 11:37am was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and	D912		

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D912	Continued From page 89 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 health care, medication administration and management of facilities. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure health care referral and follow up to meet the acute health care needs of 3 of 6 sampled residents (Residents #1, #2, and #3) inlcuding falure to notify Resident #1's primary care provider of high blood presssure readings; Resident #2's provider, who ordered a psychiatric consult, related to the resident's anxiety; and Resident #3's provider, who ordered a valproic acid blood level, and a speech therapy consult to evaluate the resident's swallowing. [Refer to Tag 273 10A NCAC 13F.0902(b) Health Care (Type B Violation)] 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 6 residents (#6, #7, #8) observed during the medication passes including errors with insulins (#8), an oral antifungal for infection (#6), and a lubricant eye	D912	Residents will have the right to receive care and services which are adequate, appropriate, and in compliance with relevent federal and state laws and rules and regulations. Resident Rights training for staff initiated on 8/15/19 by County Monitor, Turquiose Bennett. ED and/or designee will monitor for ongoing compliance through observations and resident council meetings.	

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D912	Continued From page 90 drop (#7); and for 4 of 6 residents sampled (#1, #2, #3, #6) for record review including errors with insulin (#6), a blood pressure medication (#1), medications for anxiety and depression (#2); and multiple medication errors including medications for sleep/depression, high blood pressure, and diabetes for Resident #3. [Refer to Tag 358 10A NCAC 13F.1004(a) Medication Administration (Type A2 Violation)] 3. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered within one hour before or after the prescribed or scheduled times for 13 residents (#7, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20) during the morning medication pass on 07/25/19 resulting in several medications with multiple administration times being administered too close to the next scheduled administration times; and for 1 of 5 residents sampled (#3) whose rapid-acting insulin was administered late. [Refer to Tag 364 10A NCAC 13F.1004(g) Medication Administration (Type B Violation)] 4. Based on observations, interviews and record reviews, the Administrator failed to assure the overall management, operations and policies and procedures of the facility were developed and implemented to maintain substantial compliance with rules and statutes governing adult care homes as related to health care, medication administration and nutrition and food services. [Refer to Tag 980 G.S.131D-25 Implementation (Type A2 Violation)]	D912		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation	D980		

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D980	Continued From page 91 Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the Administrator failed to assure the overall management, operations and policies and procedures of the facility were developed and implemented to maintain substantial compliance with rules and statutes governing adult care homes as related to health care, medication administration and nutrition and food services. The findings are: PRACTICE STATEMENTS WILL BE ADDED AFTER QIC REVIEW 1. Based on observations, interviews, and record reviews, the facility failed to assure health care referral and follow up to meet the acute health care needs of 3 of 6 sampled residents (Residents #1, #2, and #3) inlcuding falure to notify Resident #1's primary care provider of high blood presssure readings; Resident #2's provider, who ordered a psychiatric consult, related to the resident's anxiety; and Resident #3's provider, who ordered a valproic acid blood level, and a speech therapy consult to evaluate the resident's swallowing. [Refer to Tag 273 10A NCAC 13F.0902(b) Health Care (Type B Violation)].	D980	ED, DRC along with Divisional Support Team will oversee all management of community to ensure complaince with state regulations and ensure resident safety, guidance and support. ED and/or DRC will be in the community 5 days a week, 8 hours daily to ensure compliance. ED, DRC and/or designee will monitor compliance in community to include but not limited to weekly audits of resident records, monitoring of medication administration times, medication pass audits and other processes in community to ensure compliance. Weekend Manager duty implemented within the community during off business hours to monitor for compliance, reporting issues to ED, DRC and or Divisional Support Team. POC Date: 8/25/19	8/25/19

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D980	Continued From page 92 2. Based on observations, interviews and record reviews, the facility failed to assure the kitchen and food storage areas were kept clean and free of contamination [Refer to Tag 282 10A NCAC 13F .0904(a)(1) Nutrition & Food Service]. 3. Based on observations, interviews and record reviews, the facility failed to assure 1 of 1 sampled resident (#3), who had a history of dysphagia, had diet orders clarified for consistency of food and liquids [Refer to Tag 307 10A NCAC 13F .0904(e)(1) Nutrition & Food Service]. 4. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 6 residents (#6, #7, #8) observed during the medication passes including errors with insulins (#8), an oral antifungal for infection (#6), and a lubricant eye drop (#7); and for 4 of 6 residents sampled (#1, #2, #3, #6) for record review including errors with insulin (#6), a blood pressure medication (#1), medications for anxiety and depression (#2); and multiple medication errors including medications for sleep/depression, high blood pressure, and diabetes for Resident #3. [Refer to Tag 358 10A NCAC 13F.1004(a) Medication Administration (Type A2 Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered within one hour before or after the prescribed or scheduled times for 13 residents (#7, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20) during the morning medication pass on 07/25/19 resulting in several medications with multiple administration times being administered too close to the next	D980		

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D980	Continued From page 93 scheduled administration times; and for 1 of 5 residents sampled (#3) whose rapid-acting insulin was administered late. [Refer to Tag 364 10A NCAC 13F.1004(g) Medication Administration (Type B Violation)]. 6. Based on observations, interviews and record reviews, the facility failed to assure accurate documentation of the administration of medications including sliding scale insulin (Novolog), oral diabetes medication (Metformin) and allergy medications (Flonase) for 1 of 5 sampled residents (#3) [Refer to Tag 367 10A NCAC 13F .1004(j) Medication Administration]. Confidential interview with a family member revealed: -There had been at least four different Administrators at the facility in 2019. -Family members would bring concerns to the Administrator and they would say they would take care of it, but nothing ever happened. Interview with a medication aide (MA) on 07/25/19 at 11:09am revealed: -The former Resident Care Coordinator (RCC) did not come out on the floor to monitor staff. -The former RCC did not arrive to work until 9:00am on week days. -MAs reported concerns first to the Supervisor and then the Resident Care Coordinator (RCC) which had become the Director of Resident Care (DRC) since 07/08/19. Telephone interview with the facility's contracted primary care provider (PCP) on 07/26/19 at 9:42am revealed there had been changes in the Administrator and RCC which resulted in things not getting done.	D980		

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D980	Continued From page 94 Interview with the Administrator on 07/26/19 at 5:30pm revealed: -He started as the Administrator on 07/01/19 and the former Administrator and former RCC were interim. -The facility staff, including him and the DRC, worked together as a team. -The personal care aides (PCAs) reported to the medication aide (MA)/Supervisor; the MA Supervisor reported to the DRC and Administrator. -He was out in the halls numerous times throughout the day monitoring staff perform job duties. -He was initially focused on resident records including making sure FL-2s and diet orders were up to date and in compliance. The Administrator failed to oversee the overall management of the facility and implementation of rules and regulations including health care and medication administration. The Administrator's failure resulted in Resident #1, experiencing continued depression and decline due to not having a psychiatric referral and not having an antidepressant (Zoloft) administered as ordered by the primary care provider (PCP); Resident #1 having elevated blood pressures while not receiving an antihypertensive medication (Losartan) as ordered by the PCP; Resident #3 not receiving multiple medications including an antidepressant (Trazadone), an antihypertensive (Lisinopril) and diabetic (Metformin) for three to six weeks; Resident #6 not receiving an antifungal (Fluconazole) for a chronic fungal infection; and 14 residents receiving morning medications including sliding scale insulin (Novolog) 90 minutes to more than three hours late. The Administrator's failure resulted in substantial risk of serious neglect and harm to the	D980		

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D980	Continued From page 95 residents and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/26/19 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 25, 2019.	D980		

Washington, Bynithia T

From: Meadowview Terrace of Wadesboro, ADM - Greer, Terry <mtow.adm@affinitylivinggroup.com>
Sent: Tuesday, September 03, 2019 4:30 PM
To: Washington, Bynithia T
Subject: [External] Plan of Correction
Attachments: Meadowview Terrace of Wadesboro POC Sept 2019.pdf

Please see attached document. I hope you're doing well. Please let me know that you received document.

Thanks

Terry Greer
Executive Director
Meadowview Terrace of Wadesboro
Office: (704) 994-9050 | **Mobile**: (910) 730-3588
Email: mtow.adm@affinitylivinggroup.com

Washington, Bynithia T

From: Meadowview Terrace of Wadesboro, ADM - Greer, Terry <mtow.adm@affinitylivinggroup.com>
Sent: Thursday, September 12, 2019 1:44 PM
To: Washington, Bynithia T
Subject: [External] Corrected POC
Attachments: Corrected POC page 80.pdf

Importance: High

Please review, let me know if I need to add more or if this is satisfactory.

Thank you

Terry Greer
Executive Director
Meadowview Terrace of Wadesboro
Office: (704) 994-9050 | **Mobile**: (910) 730-3588
Email: mtow.adm@affinitylivinggroup.com