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
	HAL097015	A. BUILDING: ______ B. WING ______	08/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE GLEN MANOR	240 INDEPENDENCE AVENUE NORTH WILKESBORO, NC 28659

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D 000	Initial Comments The Adult Care Licensure Section and the Wilkes County Department of Social Services conducted an annual survey on August 28-29, 2019, with an exit conference via telephone on August 30, 2019.	D 000		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents observed during the medication pass who was administered an iron supplement which had been discontinued (Resident #4) and 5 of 5 sampled residents related to not receiving fast acting	D 358		

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insulin and an iron supplement as ordered (Resident #4), not receiving a fast acting insulin and a medication to lower cholesterol as ordered (Resident #3), not receiving a medication to treat enlarged prostate, a stool softener, a multivitamin, aspirin, a medication used to supplement thyroid hormone, a blood pressure medication and a medication to treat depression (Resident #5), continuing to receive a nasal spray for allergies, a sleeping aid and an anti-anxiety medication (Resident #2), and not receiving a laxative as ordered (Resident #1).

The findings are:

1. Review of Resident #4's current FL2 dated 07/10/19 revealed a diagnosis of insulin dependent type two diabetes mellitus.

a. Review of Resident #4's current FL2 dated 07/10/19 revealed:
-A physician's order for Humalog insulin (used to treat high blood sugar) 100unit/ml, inject 5 units subcutaneously after meals at 8am, 12pm and 5pm.
-A physician's order to obtain finger stick blood sugar (FSBS) three times daily before meals at 7am, 11am, and 4pm.

Review of Resident #4's physician's orders revealed an order dated 07/28/19 for Humalog U-100 Kwikpen insulin 100unit/ml, inject 5 units subcutaneously before breakfast, lunch and dinner.

Review of Resident #4's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Humalog insulin 100unit/ml, inject 5 units subcutaneously after

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meals at 8am, 12pm and 5pm documented as administered three times daily from 07/09/19 at 8pm to 07/26/19 at 5pm.
-There was an entry for Humalog insulin 100unit/ml, inject 5 units subcutaneously after meals at 8am, 12pm and 5pm documented as not administered on 7/27/19 at 8am, 7/27/19 at 12pm, 07/28/19 at 8am, and 7/28/19 at 12pm due to medication "on order".
-There was an entry for Humalog insulin 100unit/ml, inject 5 units subcutaneously after meals at 8am, 12pm and 5pm documented as administered on 07/27/19 at 5pm, when it was previously documented the medication was not available.
-There was an entry for Humalog insulin 100unit/ml, inject 5 units subcutaneously after meals at 8am, 12pm and 5pm documented as administered three times daily from 07/28/19 at 5pm to 07/31/19 at 5pm.
-There were 5 of 67 opportunities when Humalog 5 units was not administered due to the medication being on order.
-The FSBS on 07/27/19 was 268 at 7am, 360 at 11am and 461 at 4pm.
-The FSBS on 07/28/19 was 265 at 7am, 339 at 11am and 364 at 4pm.
-The FSBS on 07/29/19 was 305 at 7am, 262 at 11am and 327 at 4pm.
-The FSBS on 07/30/19 was 222 at 7am, 385 at 11am and 508 at 4pm.

Observation on 08/29/19 at 12:05pm of medications on hand in the special care unit (SCU) for Resident #4 revealed:
-A Humalog Kwikpen 100unit/ml, inject 5 units three times daily with meals.
-The Humalog Kwikpen was dispensed on 08/13/19 and had been marked as opened on 08/16/19.

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-There were 11 refills remaining.

Interview on 08/29/19 at 12:20pm with Resident #4's Physician Assistant (PA) revealed:
-She did not recall being notified by the facility of the 5 missed doses of Humalog insulin 5 units from 07/27/19 to 07/28/19.
-She expected the Humalog insulin 5 units to be administered right after meals were eaten.
-She had only been notified of the high FSBS in July 2019.
-She would expect to see high FSBS results if the doses were missed.

Telephone interview on 08/29/19 at 2:09pm with Resident #4's guardian revealed he was not aware of the 5 missed doses of Humalog insulin 5 units after meals from 07/27/19 to 07/28/19.

Interview on 08/29/19 at 2:40pm with a medication aide (MA) revealed:
-The Humalog insulin was not administered from 7/27/19 at 8am to 7/28/19 at 12pm because it was on order according to the eMAR.
-Her initials were documented as the MA who administered the insulin on 07/27/19 at 5pm, but the insulin was not available to administer.

Review of Resident #4's record revealed:
-There were hemoglobin A1C results of 9.8 on 07/15/19 and 7.9 on 05/01/19.
-The normal range for hemoglobin A1C was 4.0-6.0.

Interview on 08/29/19 at 2:50pm with the Administrator revealed:
-The Resident Care Director (RCD) was responsible to complete record audits monthly.
-She was not aware of the five missed doses of Humalog insulin for Resident #4.

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Telephone interview on 08/29/19 at 3:31pm with a representative from the facility's contracted pharmacy revealed:
-On 07/28/19, three Humalog kwikpens (20 day supply) were dispensed to the facility for Resident #4.
-On 08/13/19, three Humalog kwikpens (20 day supply) were dispensed to the facility for Resident #4.

Interview on 08/29/19 at 5:15pm with the Resident Care Coordinator (RCC) in the special care unit (SCU) revealed:
-She was not aware of the 5 missed doses of Humalog insulin 5 units after meals from 07/27/19 at 8am to 07/28/19 at 5pm.
-The MAs were responsible for notifying her when a resident was out of medications, but she had not been notified.
-She completed eMAR audits weekly by comparing the medications on hand to the entries in the eMAR.
-The PA was not notified of the missed doses of Humalog insulin.

b. Observation of the 8:00am medication pass on 08/29/19 revealed:
-At 8:00am, the morning medication aide (MA) prepared 10 medications for administration to Resident #4.
-The MA removed a Ferrex 150mg tablet from the resident's blister pack and placed it in a medication cup.
-The MA administered the whole tablet (Ferrex 150mg) to Resident #4.

Review of Resident #4's current FL2 dated 07/10/19 revealed there was an order for Ferrex (used to treat iron deficiency) 150mg twice daily.

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D 358	Continued From page 5 Review of Resident #4's subsequent physician's orders revealed an order dated 08/07/19 for Ferrex 150mg daily. Review of Resident #4's August 2019 electronic Medical Record (eMAR) on 08/29/19 at 8:00 revealed an entry for Ferrex 150mg every day documented as administered at 8:00am every day 08/01/19 - 08/29/19. Review of Resident #4's record revealed an order dated 08/14/19 to discontinue Ferrex 150mg every day. Interview on 08/29/19 at 9:50am with the MA revealed: -She did not know the Ferrex 150mg every day was discontinued. -The eMAR did not reflect the order as discontinued. -The MAs were responsible for faxing the orders to the pharmacy so the order could be discontinued in the eMAR. Interview on 08/29/19 at 11:58am with Resident #5's PA revealed: -She did not know Resident #4 continued to get the Ferrex 150mg every day after it was discontinued on 08/14/19. -Resident #4 took the Ferrex after a hospitalization on 07/15/19 and the HGB was 9.2 (normal value 12.0-16.0). -Resident #4 did not require the Ferrex anymore. Interview on 08/30/19 at 10:55am with the facility's contracted pharmacy revealed there was no order faxed over to discontinue Resident #4's Ferrex 150mg every day.	D 358		

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Refer to interview on 08/29/19 at 8:12am with a medication aide (MA).

Refer to interview on 08/29/19 at 9:50am with the Resident Care Coordinator (RCC) in the special care unit (SCU).

Refer to interview on 08/29/19 at 11:20am with the Resident Care Director (RCD).

Refer to interview on 08/29/19 at 2:22pm with the Administrator.

2. Review of Resident #3's current FL2 dated 05/15/19 revealed diagnoses included hypertension, major depressive disorder, atrial fibrillation, diabetes with neuropathy and cerebral infarction.

a. Review of Resident #3's current FL2 dated 05/15/19 revealed an order for Novolog (a rapid acting insulin used in the treatment of diabetics) Flexpen 10 units before each meal if blood sugar is greater than 200.

Review of Resident #3's July 2019 electronic Medication Administration Record (eMAR) revealed there was an entry for Novolog Flexpen 10 units documented as not administered with a blood sugar greater than 200, 07/05/19 at 7:00am, 07/04/19 and 07/13/19 at 12:00pm, 07/18/19, 07/22/19, and 07/26/19 at 5:00pm.

Review of Resident #3's August 2019 eMAR revealed there was an entry for Novolog Flexpen 10 units documented as not administered with a blood sugar greater than 200, 08/13/19 and 08/14/19 at 7:00am, and 08/17/19 at 5:00pm.

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Telephone interview on 08/30/19 at 10:55am with a representative from the facility's contracted pharmacy revealed:
-On 02/27/19, an order for Novolog Flexpen inject 10 units before meals if the blood sugar was greater than 200 and three, 9ml Flexpen (a 9-month supply) were dispensed to the facility.
-There were no reorders of the Flexpen.

Observation on 05/01/19 at 12:00pm of medications on hand for administration for Resident #3 revealed there were 2 of 3 Novolog Flexpen available for Resident #3 to use.

Interview on 08/29/19 at 11:58am with Resident #5's Physician revealed:
-She was not aware the Novolog Flexpen 10 units for Resident #3 were not administered as ordered with the blood sugars greater than 200.
-Resident #5 was seen earlier this morning, 08/29/19 and was not displaying any issues or had any complaints.
-She ordered the Novolog because of the high blood sugars with Resident #3.
-Resident #3's last HgbA1C (a blood test to measure an average blood sugars over 3 months) was completed on 08/14/19 and was 7.8 (normal 4.8-5.6).
-After review of Resident #3's blood sugars after each failure to administer the Novolog Flexpen, the blood sugars were not elevated she and expected the facility to administer the medications as ordered.

Interview on 08/29/19 at 8:12am with a medication aide (MA) revealed:
-Resident #3's blood sugars were not greater than 200 with her.
-The Resident Care Coordinator (RCC) and the Resident Care Director (RCD) were responsible

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for weekly eMAR audits and checked for medications that were not administered as ordered.

Interview on 08/29/19 at 9:50am with the RCC revealed:
-She and the RCD were responsible for weekly eMAR audits and checked for medications that were not administered as ordered, omissions and refusals.
-The last eMAR audit was preformed by her on the Special Care Unit (SCU) 08/01/19 for July 2019 eMARs.
-The RCD was responsible for the Assisted Living (AL) side.
-Resident #3 was on the AL side.

b. Review of Resident #3's current FL2 dated 05/15/19 revealed an order for atorvastatin (a medication used to lower bad cholesterol and raise the good cholesterol) 20mg every day.

Review of Resident #3's July 2019 electronic Medication Administration Record (eMAR) revealed there was an entry for atorvastatin 20mg every day documented as administered 07/01/19 - 07/31/19 at 8:00pm every day.

Review of Resident #3's August 2019 eMAR revealed:
-The atorvastatin 20mg every day was documented as administered 08/01/19 - 08/02/19, 08/11/19, 08/15/19 -08/27/19 at 8:00pm.
-The atorvastatin 20mg every day was documented as not administered and on order, 08/03/19 - 08/10/19, 08/12/19 - 08/14/19 at 8:00pm.
-The atorvastatin 20mg every day was not documented and left blank 08/28/19 - 08/31/19 at

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8:00pm every day.

Telephone interview on 08/30/19 at 10:55am with a representative from the facility's contracted pharmacy revealed:
-On 06/29/19, an order for atorvastatin 20mg every day and 30 tablets were dispensed to the facility.
-The 30 tablets dispensed on 06/29/19 were to start on 06/29/19 and would have run out on 07/29/19.
-On 08/14/19, 15 tablets of atorvastatin 20mg every day were dispensed to the facility.
-The 15 tablets dispensed on 08/14/19 were to start on 08/14/19 and would have run out on 08/28/19.
-The atorvastatin 20mg was on a cycle and would have been reordered every 30 days but the facility did not reorder the medication every 30 days.

Based on the review of the July and August 2019 eMARs and the interview with the facility's contracted pharmacy, staff documented the administration of 60 doses of the atorvastatin from 06/29/19 - 08/28/19 but only had 45 doses to administer.

Interview on 08/29/19 at 8:12am with a medication aide (MA) revealed:
-She did not know why the atorvastatin was not reordered.
-The Resident Care Coordinator (RCC) and the Resident Care Director (RCD) were responsible for weekly eMAR audits and checked for medications that were not administered as ordered.

Interview on 08/29/19 at 9:50am with the RCC revealed:
-She and the RCD were responsible for weekly

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eMAR audits and checked for medications that were not administered as ordered, holes and refusals.
-The last eMAR audit was preformed by her on the SCU 08/01/19 for July 2019 eMARs.
-The RCD was responsible for the Assisted Living (AL) side.
-Resident #3 was on the AL side.

Interview on 08/29/19 at 11:58am with Resident #3's Physician revealed:
-Resident #3 was on the atorvastatin along with Coumadin to help prevent strokes but no concerns because the Coumadin was most important.
-The atorvastatin should have been administered as ordered.

Refer to interview on 08/29/19 at 8:12am with a medication aide (MA).

Refer to interview on 08/29/19 at 9:50am with the Resident Care Coordinator (RCC) in the special care unit (SCU).

Refer to interview on 08/29/19 at 11:20am with the Resident Care Director (RCD).

Refer to interview on 08/29/19 at 2:22pm with the Administrator.

3. Review of Resident #5's current FL2 dated 05/08/19 revealed diagnoses included essential hypertension, major depressive disorder, polyneuropathy, peptic ulcer with perforation.

a. Review of Resident #5's current FL2 dated 05/08/19 revealed an order for tamsulosin (a medication used to treat the symptoms of an enlarged prostate) 0.4mg every night.

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Review of Resident #5's July 2019 electronic Medication Administration Record (eMAR) revealed there was an entry for tamsulosin 0.4mg every night documented as administered 07/01/19 - 07/31/19 at 8:00pm, every night.

Review of Resident #5's August 2019 eMAR revealed there was an entry for tamsulosin 0.4mg every night documented as administered 08/01/19 - 08/28/19 at 9:00pm, every night except 08/28/19- 08/31/19 when it was documented as blank.

Observation on 05/01/19 at 12:00pm of medications on hand for administration for Resident #5 revealed there was a bubble pack for tamsulosin 0.4mg every night with a dispense date of 08/14/19, with a quantity of 30, with 15 tablets remaining.

Telephone interview on 08/30/19 at 10:55am with a representative from the facility's contracted pharmacy revealed:
-On 05/13/19 30 tablets tamsulosin 0.4mg every day and were dispensed to the facility.
-The 30 tablets dispensed on 05/13/19 were to start on 05/14/19 and would have run out on 06/11/19.
-On 08/14/19 30 tablets for tamsulosin 0.4mg were dispensed to the facility.
-The 30 tablets dispensed on 08/14/19 were to start on 08/15/19 and would have run out on 09/12/19.
-The tamsulosin was on a cycle and would have been reordered every 30 days but the facility did not reorder the medication every 30 days.

Based on the review of the July and August 2019 eMAR's and the interview with the facility's

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contracted pharmacy, staff documented the administration of 74 doses of the tamsulosin 0.4mg from 07/01/19 - 09/12/19 but only had 30 doses to administer.

Interview on 08/29/19 at 11:58am with Resident #5's Physician revealed:
-She was not aware the tamsulosin 0.4mg every night was not administered as ordered.
-Resident #5 was seen earlier this morning, 08/29/19 and was not displaying any issues or had any complaints.
-She ordered the tamsulosin 0.4mg every night for Resident #5's enlarged prostrate.
-She did not have a concern since Resident #5 missed just a few doses.
-She and expected the facility to administer the medications as ordered.

b. Review of Resident #5's current FL2 dated 05/08/19 revealed an order for docusate sodium (a medication used as a stool softener) 100mg two times a day.

Review of Resident #5's July 2019 eMAR revealed there was an entry for docusate sodium 100mg two times a day documented as administered 07/01/19 - 07/31/19 at 8:00am and 8:00pm, every day.

Review of Resident #5's August 2019 eMAR revealed there was an entry for docusate sodium 100mg two times a day documented as administered 08/01/19 at 9:00am and 9:00pm - 08/27/19 at 9:00am, every day except 08/28/19 at 9:00pm - 08/31/19 at 9:00pm when it was left blank.

Observation on 05/01/19 at 12:00pm of medications on hand for administration for

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Resident #5 revealed there was a bubble pack for docusate sodium 100mg two times a day, with a dispense date of 08/14/19 with a quantity of 60 with 1 remaining.

Telephone interview on 08/30/19 at 10:55am with a representative from the facility's contracted pharmacy revealed:
-On 07/05/19 60 tablets of docusate sodium 100mg two times a day and were dispensed to the facility.
-The 60 tablets dispensed on 07/05/19 were to start on 07/07/19 and would have run out on 08/05/19.
-On 08/14/19 50 tablets docusate sodium 100mg two times a day and were dispensed to the facility.
-The 50 tablets dispensed on 08/14/19 were to start on 08/15/19 and would have run out on 09/04/19.
-The docusate sodium was on a cycle and would have been reordered every 30 days but the facility did not reorder the medication every 30 days.

Based on the review of the July and August 2019 eMAR's and the interview with the facility's contracted pharmacy, staff documented the administration of 120 doses of the docusate sodium 100mg two times a day from 07/07/19 - 09/04/19 but the facility staff only had 110 doses to administer.

Interview on 08/29/19 at 11:58am with Resident #5's Physician revealed:
-She was not aware the docusate sodium 100mg two times a day was not administered as ordered.
-Resident #5 was seen earlier this morning, 08/29/19 and was not displaying any issues or had any complaints.
-She ordered the docusate sodium 100mg two

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times a day to keep Resident #5's bowels regular.
-She did not have a concern since Resident #5 missed just a few doses.
-She and expected the facility to administer the medications as ordered.

c. Review of Resident #5's current FL2 dated 05/08/19 revealed an order for lisinopril (a medication used to lower blood pressure) 5mg, take ½ tablet every day.

Review of Resident #5's July 2019 eMAR revealed:
-There was an entry for lisinopril 5mg, take ½ tablet every day was documented as administered 07/01/19 - 07/16/19 at 8:00am, every day.
-The lisinopril 5mg, take ½ tablet every day was documented as administered 07/17/19 - 07/31/19 at 9:00am, every day.

Review of Resident #5's August 2019 eMAR revealed:
-The lisinopril 5mg, take ½ tablet every day was documented as administered 08/01/19 - 08/28/19 at 9:00am, every day.
-The lisinopril 5mg, take ½ tablet every day was left as blank 08/29/19 - 08/31/19 at 9:00am.

Observation on 05/01/19 at 12:00pm of medications on hand for administration for Resident #5 revealed there was a bubble pack for lisinopril 5mg, take ½ tablet every day, with a dispense date of 08/14/19 with a quantity of 15 with ½ tablets remaining.

Telephone interview on 08/30/19 at 10:55am with a representative from the facility's contracted pharmacy revealed:
-On 07/10/19 15 tablets of lisinopril 5mg, take ½

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tablet every day were dispensed to the facility.
-The 15 tablets dispensed on 07/10/19 were to start on 07/12/19 and would have run out on 08/09/19.
-On 08/11/19 15 tablets lisinopril 5mg, take ½ tablet every day and were dispensed to the facility.
-The 15 tablets dispensed on 08/11/19 were to start on 08/13/19 and would have run out on 09/11/19.
-The lisinopril was on a cycle and would have been reordered every 30 days but the facility did not reorder the medication every 30 days.

Based on the review of the July and August 2019 eMAR's and the interview with the facility's contracted pharmacy, staff documented the administration of 34 doses of the lisinopril 5mg, take ½ tablet every day from 07/12/19 - 09/11/19 but the facility staff only had 30 doses to administer.

Interview on 08/29/19 at 11:58am with Resident #5's Physician revealed:
-She was not aware the lisinopril 5mg, take ½ tablet every day was not administered as ordered.
-Resident #5 was seen earlier this morning, 08/29/19 and was not displaying any issues or had any complaints and the blood pressures documented were fine.
-She ordered the lisinopril 5mg, take ½ tablet every day to keep Resident #5's blood pressures down.
-She did have concerns that Resident #5 missed at least 15 doses in a row that could increase the chances of heart attack or stroke.
-She and expected the facility to administer the medications as ordered.

d. Review of Resident #5's current FL2 dated

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05/08/19 revealed an order for levothyroxine (a medication used to treat underactive thyroid) 125mcg every day.

Review of Resident #5's July 2019 eMAR revealed:
-There was an entry for levothyroxine 125mcg every day was documented as administered 07/01/19 - 07/15/19 at 8:00am, every day.
-The levothyroxine 125mcg every day was documented as administered 07/16/19 - 07/31/19 at 6:00am, every day.

Review of Resident #5's August 2019 eMAR revealed:
-There was an entry for levothyroxine 125mcg every day was documented as administered 08/01/19 - 08/17/19 at 6:00am, every day.
-The levothyroxine 125mcg every day was documented as not administered, and on order 08/18/19 - 08/31/19 at 6:00am.

Observation on 05/01/19 at 12:00pm of medications on hand for administration for Resident #5 revealed there was not a bubble pack for levothyroxine 125mcg every day located on the medication cart or in the facility.

Telephone interview on 08/30/19 at 10:55am with a representative from the facility's contracted pharmacy revealed:
-On 07/10/19 15 tablets of levothyroxine 125mcg every day and were dispensed to the facility.
-The 15 tablets dispensed on 07/10/19 were to start on 07/12/19 and would have run out on 08/09/19.
-On 08/11/19 15 tablets of levothyroxine 125mcg every day and were dispensed to the facility.
-The 15 tablets dispensed on 08/11/19 were to start on 08/13/19 and would have run out on

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09/11/19.
-The levothyroxine was on a cycle and would have been reordered every 30 days but the facility did not reorder the medication every 30 days.

Based on the review of the July and August 2019 eMAR's and the interview with the facility's contracted pharmacy, staff documented the administration of 34 doses of the levothyroxine 125mcg every day from 07/12/19 - 09/11/19 but the facility staff only had 30 doses to administer.

Interview on 08/29/19 at 11:58am with Resident #5's Physician revealed:
-She was not aware the levothyroxine 125mcg every day was not administered as ordered.
-Resident #5 was seen earlier this morning, 08/29/19 and was not displaying any issues or had any complaints.
-She ordered the levothyroxine 125mcg every day to keep Resident #5's the thyroid under control.
-She did not have concerns that Resident #5 missed a few doses.
-She and expected the facility to administer the medications as ordered.

e. Review of Resident #5's current FL2 dated 05/08/19 revealed an order for metoprolol (a medication used to lower blood pressure) 25mg every day.

Review of Resident #5's July 2019 eMAR revealed:
-There was an entry for metoprolol 25mg every day was documented as administered 07/01/19 - 07/15/19 at 8:00am every day.
-The metoprolol 25mg every day was documented as administered 07/16/19 - 07/31/19 at 9:00am every day.

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Review of Resident #5's August 2019 eMAR revealed:
-There was an entry for metoprolol 25mg every day was documented as administered 08/01/19 - 08/09/19, 08/11/19 and 08/13/19 - 08/28/19 at 9:00am.
-There was an entry for metoprolol 25mg every day as documented as not administered, and on order 08/10/19 and 08/12/19 at 9:00am.

Observation on 05/01/19 at 12:00pm of medications on hand for administration for Resident #5 revealed there was a bubble pack for metoprolol 25mg every day with a dispense date of 08/11/19, with a quantity of 30 with 13 remaining.

Telephone on 08/30/19 at 10:55am interview with a representative from the facility's contracted pharmacy revealed:
-On 07/10/19 30 tablets of metoprolol 25mg every day and were dispensed to the facility.
-The 30 tablets dispensed on 07/10/19 were to start on 07/12/19 and would have run out on 08/09/19.
-On 08/11/19 30 tablets of metoprolol 25mg every day and were dispensed to the facility.
-The 30 tablets dispensed on 08/11/19 were to start on 08/13/19 and would have run out on 09/11/19.

Based on the review of the July and August 2019 eMAR's and the interview with the facility's contracted pharmacy, staff documented the administration of 63 doses of the metoprolol 25mg every day from 07/12/19 - 09/11/19 but the facility staff only had 60 doses to administer.

Interview on 08/29/19 at 11:58am with Resident #5's Physician revealed:

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-She was not aware the metoprolol 25mg every day was not administered as ordered.
-Resident #5 was seen earlier this morning, 08/29/19 and was not displaying any issues or had any complaints.
-She ordered the metoprolol 25mg every day to keep Resident #5's blood pressure under control.
-She did have concerns that Resident #5 missed a few doses that could increase the chances of heart attack or stroke.
-She and expected the facility to administer the medications as ordered.

f. Review of Resident #5's current FL2 dated 05/08/19 revealed an order for Certa-vite (a multivitamin) 0.4mg every day.

Review of Resident #5's July 2019 eMAR revealed:
-There was an entry for Certa-vite 0.4mg every day was documented as administered 07/01/19 - 07/15/19 at 8:00am, every day.
-The Certa-vite 0.4mg every day was documented as administered 07/16/19 - 07/31/19 at 9:00am, every day.

Review of Resident #5's August 2019 eMAR revealed:
-There was an entry for Certa-vite 0.4mg every day was documented as administered 08/01/19 - 08/28/19 at 9:00am, every day.
-There was an entry for Certa-vite 0.4mg every day was left as blank 08/29/19 - 08/31/19 at 9:00am, every day.

Observation on 05/01/19 at 12:00pm of medications on hand for administration for Resident #5 revealed there was a bubble pack for Certa-vite 0.4mg every day with a dispense date of 08/17/19, with a quantity of 30 with 12

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remaining.

Telephone interview on 08/30/19 at 10:55am with a representative from the facility's contracted pharmacy revealed:
-On 07/05/19 30 tablets of Certa-vite 0.4mg every day and were dispensed to the facility.
-The 30 tablets dispensed on 07/05/19 were to start on 07/08/19 and would have run out on 08/07/19.
-On 08/17/19 22 tablets of Certa-vite 0.4mg every day and were dispensed to the facility.
-The 22 tablets dispensed on 08/17/19 were to start on 08/18/19 and would have run out on 09/07/19.

Based on the review of the July and August 2019 eMAR's and the interview with the facility's contracted pharmacy, staff documented the administration of 61 doses of the Certa-vite 0.4mg every day from 07/08/19 - 09/07/19 but the facility staff only had 52 doses to administer.

Interview on 08/29/19 at 11:58am with Resident #5's Physician revealed:
-She was not aware the Certa-vite 0.4mg every day was not administered as ordered.
-Resident #5 was seen earlier this morning, 08/29/19 and was not displaying any issues or had any complaints.
-She ordered the Certa-vite 0.4mg every day as a vitamin replacement.
-She did not have concerns that Resident #5 missed a few doses.
-She and expected the facility to administer the medications as ordered.

g. Review of Resident #5's current FL2 dated 05/08/19 revealed an order for aspirin (a medication used to keep the blood thin) 325mg

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every day.

Review of Resident #5's July 2019 eMAR revealed:
-There was an entry for aspirin 325mg every day was documented as administered 07/01/19 - 07/15/19 at 8:00am, every day.
-The aspirin 325mg every day was documented as administered 07/16/19 - 07/31/19 at 9:00am, every day.

Review of Resident #5's August 2019 eMAR revealed:
-There was an entry for aspirin 325mg every day was documented as administered 08/01/19 - 08/08/19, 08/10/19 - 08/11/19, and 08/14/19 at 9:00am, every day.
-The aspirin 325mg every day was documented as not administered and on order 08/09/19, 08/12/19 - 08/13/19 and 08/17/19 - 08/28/19 at 9:00am every day.
-The aspirin 325mg every day was left as blank 08/29/19 - 08/31/19 at 9:00am every day.

Observation on 05/01/19 at 12:00pm of medications on hand for administration for Resident #5 revealed there was a bubble pack for aspirin 325mg every day with a dispense date of 08/17/19, with a quantity of 30 with 10 remaining.

Telephone interview on 08/30/19 at 10:55am with a representative from the facility's contracted pharmacy revealed:
-On 07/05/19 30 tablets of aspirin 325mg every day and were dispensed to the facility.
-The 30 tablets dispensed on 07/05/19 were to start on 07/08/19 and would have run out on 08/07/19.
-On 08/17/19 22 tablets of aspirin 325mg every day and were dispensed to the facility.

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-The 22 tablets dispensed on 08/17/19 were to start on 08/18/19 and would have run out on 09/07/19.

Based on the review of the July and August 2019 eMAR's and the interview with the facility's contracted pharmacy, staff documented the administration of 61 doses of aspirin 325mg every day from 07/08/19 - 09/07/19 but the facility staff only had 52 doses to administer.

Interview on 08/29/19 at 11:58am with Resident #5's Physician revealed:
-She was not aware the aspirin 325mg every day was not administered as ordered.
-Resident #5 was seen earlier this morning, 08/29/19 and was not displaying any issues or had any complaints.
-She ordered the aspirin 325mg every day to decrease the chances of a heart attack or stroke.
-She did have some concerns that Resident #5 missed 9 doses that could increase the chances of heart attack or stroke.
-She and expected the facility to administer the medications as ordered.

h. Review of Resident #5's current FL2 dated 05/08/19 revealed an order for venlafaxine (a medication use to treat major depression) 75mg two times a day.

Review of Resident #5's July 2019 eMAR revealed an order transcribed as venlafaxine 75mg two times a day was documented as administered 07/01/19 - 07/31/19 at 8:00am and 8:00pm, two times a day.

Review of Resident #5's August 2019 eMAR revealed:
-There was an entry for venlafaxine 75mg two

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times a day was documented as administered 08/01/19 - 08/07/19 at 9:00am and 9:00pm, on 08/08/19 at 9:00am, 08/11/19 at 9:00am and 9:00pm and 08/14/19 at 9:00am
-The venlafaxine 75mg two times a day was documented as not administered 08/08/19 at 9:00pm, 08/09/19 - 08/10/19 and 08/12/19 - 08/13/19 at 9:00am and 9:00pm, 08/14/19 at 9:00pm, 08/15/19 - 08/16/19 at 9:00am and 9:00pm.
-The venlafaxine 75mg two times a day was left as blank 08/28/19 at 9:00pm - 08/31/19 at 9:00am and 9:00pm.

Observation on 05/01/19 at 12:00pm of medications on hand for administration for Resident #5 revealed there was a bubble pack for venlafaxine 75mg two times a day with a dispense date of 08/14/19, with a quantity of 50 with 5 remaining.

Telephone interview on 08/30/19 at 10:55am with a representative from the facility's contracted pharmacy revealed:
-On 06/06/19 60 tablets of venlafaxine 75mg two times a day and were dispensed to the facility.
-The 60 tablets dispensed on 06/06/19 were to start on 06/09/19 and would have run out on 07/08/19.
-On 07/08/19 60 tablets of venlafaxine 75mg two times a day and were dispensed to the facility.
-The 60 tablets dispensed on 07/08/19 were to start on 07/08/19 and would have run out on 08/07/19.
-On 08/14/19 50 tablets of venlafaxine 75mg two times a day and were dispensed to the facility.
-The 60 tablets dispensed on 08/14/19 were to start on 08/14/19 and would have run out on 09/07/19.

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Based on the review of the July and August 2019 eMAR's and the interview with the facility's contracted pharmacy, staff documented the administration of 180 doses of the venlafaxine 75mg two times a day from 06/09/19 - 09/07/19 but the facility staff only had 170 doses to administer.

Interview on 08/29/19 at 11:58am with Resident #5's Physician revealed:
-She was not aware the venlafaxine 75mg two times a day was not administered as ordered.
-Resident #5 was seen earlier this morning, 08/29/19 and was not displaying any issues or had any complaints.
-She ordered the venlafaxine 75mg two times a day for Resident #5's depression.
-She did not have concerns that Resident #5 missed the 10 doses since Resident #5 received at least 1 dose a day in most cases.
-She and expected the facility to administer the medications as ordered.

Refer to interview on 08/29/19 at 8:12am with a medication aide (MA).

Refer to interview on 08/29/19 at 9:50am with the Resident Care Coordinator (RCC) in the special care unit (SCU).

Refer to interview on 08/29/19 at 11:20am with the Resident Care Director (RCD).

Refer to interview on 08/29/19 at 2:22pm with the Administrator.

4. Review of Resident #2's current FL2 dated 06/19/19 revealed diagnoses included general anxiety disorder, adjustment disorder, essential hypertension, and cerebellar ataxia with defective

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ROSE GLEN MANOR	240 INDEPENDENCE AVENUE NORTH WILKESBORO, NC 28659

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DNA repair.

a. Resident #2's current FL2 dated 06/19/19 revealed a medication order for fluticasone spray (used to treat allergies) 50mcg, instill 2 sprays into each nostril every day.

Review of Resident #2's current medication list from her cardiologist dated 08/20/19 revealed:
-"Always use your most recent med list".
-The medication list did not list the fluticasone spray 50mcg.
-The facility Provider had signed the current medication list.

Review of Resident #2's August 2019 electronic Medication Administration Record (eMAR) revealed she had been administered the fluticasone spray 50mcg at 9:00am from 08/20/19 through 08/28/19.

Observation on 08/28/19 at 10am of Resident #2's medications on hand revealed she had the fluticasone spray available for administration.

Further review of Resident #2's record did not reveal any subsequent orders for the fluticasone spray.

Interview on 08/30/19 at 10:45am with Resident #2's Physician revealed:
-Resident #2 saw a cardiologist outside of the facility and they might not have known what medications she was on.
-There were no risks of Resident #2 continuing the fluticasone spray.
-Resident #2 had allergies and that is was why she takes the fluticasone spray.

b. Resident #2's current FL2 dated 06/19/19

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revealed a medication order for melatonin (used to treat insomnia) tablet 5mg, take one tablet at bedtime.

Review of Resident #2's current medication list from her cardiologist dated 08/20/19 revealed:
-"Always use your most recent med list".
-The medication list did not list the melatonin tablet 5mg.
-The facility Provider had signed the current medication list.

Review of Resident #2's August 2019 electronic Medication Administration Record (eMAR) revealed she had been administered the melatonin tablet 5mg at 9:00pm from 08/20/19 through 08/27/19.

Observation on 08/28/19 at 10am of Resident #2's medications on hand revealed she had the melatonin tablets available for administration.

Further review of Resident #2's record did not reveal any subsequent orders for the melatonin.

Interview on 08/30/19 at 10:45am with Resident #2's Physician revealed:
-Resident #2 saw a cardiologist outside of the facility and they might not have known what medications she was on.
-There were no risks of Resident #2 continuing the melatonin.
-Resident #2 used the melatonin to help with her sleep.

c. Resident #2's current FL2 dated 06/19/19 revealed a medication order for lorazepam (used to treat anxiety) 1mg, take one tablet at bedtime.

Review of Resident #2's current medication list

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from her cardiologist dated 08/20/19 revealed:
-"Always use your most recent med list".
-The medication list did not include the the lorazepam 1mg as a current medication.
-The facility Provider had signed the current medication list.

Review of Resident #2's August 2019 electronic Medication Administration Record (eMAR) revealed she had been administered the lorazepam 1mg at 9:00pm from 08/20/19 through 08/27/19.

Observation on 08/28/19 at 10am of Resident #2's medications on hand revealed she had 26 tablets of lorazepam 1mg available for administration.

Further review of Resident #2's record did not reveal any subsequent orders for the lorazepam.

Interview on 08/30/19 at 10:45am with Resident #2's Physician revealed:
-Resident #2 saw a cardiologist outside of the facility and they might not have known what medications she was on.
-There were no risks of Resident #2 continuing the lorazepam.
-Resident #2 has anxiety and that is why she takes the lorazepam.

Interview on 08/29/19 at 10:00am with the Resident Care Director (RCD) revealed:
-When Resident #2 went to her cardiologist, a copy of her most current medication administration record (MAR) was sent with her.
-She was not aware that when a new medication list was signed by the physician superseded all previous orders.
-She did not check the documentation from

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doctor or hospital visits when residents returned for new orders.

Attempted telephone interview on 08/30/19 at 3:45pm with Resident #2's cardiologist was unsuccessful.

Refer to interview on 08/29/19 at 8:12am with a medication aide (MA).

Refer to interview on 08/29/19 at 9:50am with the Resident Care Coordinator (RCC) in the special care unit (SCU).

Refer to interview on 08/29/19 at 11:20am with the Resident Care Director (RCD).

Refer to interview on 08/29/19 at 2:22pm with the Administrator.

5. Review of Resident #1's current FL2 dated 06/19/19 revealed:
-Diagnoses included chronic congestive heart failure (CHF), atrial fibrillation, hypertension and anxiety disorder.
-There was an order for Senexon-S (sennosides-docusate sodium) tablet 8.6-50mg, take one tablet every evening at 4:00pm.
-There was an order for Senna tablet 8.6mg take one tablet twice a day at 9:00am and 9:00pm.

Review of a Physician's order dated 07/23/19 revealed:
-A telephone order to discontinue senna due to diarrhea.
-The telephone order had been obtained by the Resident Care Director (RCD).
-The provider had signed the order on 07/23/19.

Review of Resident #1's July 2019 electronic

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Medication Administration Record (eMAR) revealed:
-There was an entry for Senexon-S (sennosides-docusate sodium) 8.6-50mg at 4:00pm was documented as administered from 07/01/19 through 07/23/19 at 4:00pm.
-There was an entry for Senexon-S (sennosides-docusate sodium) 8.6-50mg at 4:00pm had been discontinued on 07/24/19 and not administered through 07/31/19.
-There was an entry for senna 8.6mg at 9:00am and 9:00pm was documented administered from 07/01/19 through 07/24/19 at 9:00am.
-There was an entry for senna 8.6mg had been discontinued on 07/24/19 and had not been administered from 07/24/19 through 07/31/19 at 9:00pm.

Review of Resident #1's August 2019 eMAR revealed:
-There was no entry for the Senexon-S (sennosides-docusate sodium) 8.6-50mg at 4:00pm.
-There was no entry for the Senna 8.6mg at 9:00am and 9:00pm.

Interview on 08/29/19 at 10:00am with the RCD revealed:
-She knew that the provider meant to discontinue both the Senexon-S and the Senna.
-Resident #1 had complained of diarrhea.
-She had removed both the Senexon-S and the Senna from the eMAR's.

Interview on 08/29/19 at 9:45am with Resident #1 revealed:
-She did have diarrhea sometimes.
-She had some problems with constipation over the past several weeks.
-She had not told anyone.

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Telephone interview with the facility's contracted pharmacy on 08/29/19 at 11:00am revealed:
-They had received a discontinuation order for the Senexon-S 8.6-50mg on 07/24/19.
-They still had an active order for the Senna 8.6mg which was last dispensed on 06/28/19 for 60 tablets.
-The Senna 8.6mg was scheduled to be dispensed on 09/04/19.

Telephone interview with Resident #1's Physician on 08/30/19 at 10:45am revealed:
-She did want one of the medications discontinued because she did not need to be on both medications for constipation.
-She did feel that Resident #1 needed to be on at least one medication for constipation.

Refer to interview on 08/29/19 at 8:12am with a medication aide (MA).

Refer to interview on 08/29/19 at 9:50am with the Resident Care Coordinator (RCC) in the special care unit (SCU).

Refer to interview on 08/29/19 at 11:20am with the Resident Care Director (RCD).

Refer to interview on 08/29/19 at 2:22pm with the Administrator.

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Interview on 08/29/19 at 8:12am with a medication aide (MA) revealed:
-All medications that were documented as "on order" should have been documented as such.
-She only documented a medication as "on order" if the medication was not on the medication cart or in the facility.

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-The medication cart audit was done on a weekly basis by medication aides.
-The medication cart audits were completed to see if medications were missing, out of date or needed to be reordered.
-All the audits were kept in a notebook at the Nurses desk.
-The last medication cart audit was done on 08/27/19 by another MA.
-When a medication was out the MA was to call the pharmacy and check on the issue.
-The MAs were responsible for letting the Resident Care Coordinator (RCC) and the Resident Care Director (RCD) know about the issues with the missing medications after notifying the pharmacy.
-The RCC and RCD were responsible for checking to make sure the medication issues were resolved.
-The RCD was responsible for eMAR audits monthly and checked for medications that were not administered because of missing medications or refusals.

Interview on 08/29/19 at 9:50am with the Resident Care Coordinator (RCC) in the special care unit (SCU) revealed:
-The MAs were responsible for notifying the pharmacy and the RCD when a medication was missing or needed to be reordered.
-The MAs were responsible for weekly medication cart audits to check for out dated medications, missing medications and the need to reorder a medication.
-She checked all medication cart audits after they were completed by the MAs weekly in the SCU.
-She resolved any issues with the medication cart audits in the SCU.
-The RCD was responsible to check behind the MAs medication cart audit on the Assisted Living

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(AL) side on a weekly basis.
-She and the RCD were responsible for weekly eMAR audits and checked for medications that were not administered because of missing medications or refusals and omissions.

Interview on 08/29/19 at 11:20am with the Resident Care Director (RCD) revealed:
-The MAs were to call the pharmacy if a medication was missing and the physician if necessary.
-The MAs were to notify her the next day if the pharmacy did not fix the issue.
-The MAs were responsible for medication cart audits on a weekly basis and to notify the pharmacy and physician if a problem was found.
-The MAs were to fill out a medication cart audit sheet stating they checked the dates on all of the bubble packs, pulled all of the out of date or discontinued medications and were to reorder what was missing.
-The MAs were responsible for placing the medication cart audit sheets in the notebook in her office.
-She did not review the medication cart audit notebook at all.
-The last medication cart audit was completed on 07/19/19 for 06/16/19 - 07/16/19.
-She did not perform medication cart and eMAR audits because the MAs were "totally" responsible for them.
-She did not check behind the MAs at all.
-There was no way she could have known about the missing medications or mediations that were not administered unless the MAs "told me about it".
-The MAs had not notified her of missing medications or medications that were not administered.

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Interview on 08/29/19 at 2:22pm with the Administrator revealed:
-The MAs were responsible for weekly medication cart audits and notifying the pharmacy, physician, RCC and RCD of any issues
-The RCC and RCD were responsible for checking the MAs medication cart audits on a weekly basis.
-The RCD was responsible for keeping track of the final checks of all the medication cart audits.
-The RCC and the RCD were responsible for weekly eMAR audits to check for omissions, medications not administered and incorrect orders.
-She was not aware the medication cart audits were not reviewed by the RCD on a weekly basis or the eMAR audits were not being done.

The facility failed to administer medications as ordered, which resulted in Resident #4 not receiving Humalog insulin (used to prevent high blood sugars), Resident #3 not receiving Novolog insulin (used to prevent high blood sugars), and atorvastatin (used to prevent stroke) as ordered, Resident #5 not receiving lisinopril (used to treat high blood pressure), levothyroxine (used to treat underactive thyroid), metoprolol (used to treat high blood pressure), aspirin (a blood thinner), and venlafaxine (used to treat depression) as ordered. This failure 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 August 29, 2019 for this violation.

THE CORRECTION DATE FOR THE TYPE B

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D 358	Continued From page 34 VIOLATION SHALL NOT EXCEED OCTOBER 13, 2019.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents observed during the medication pass who was administered an iron supplement which had been discontinued (Resident #4) and 5 of 5 sampled residents related to not receiving fast acting insulin and an iron supplement as ordered (Resident #4), not receiving a fast acting insulin and a medication to lower cholesterol as ordered (Resident #3), not receiving a medication to treat enlarged prostate, a stool softener, a	D912		

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D912	Continued From page 35 multivitamin, aspirin, a medication used to supplement thyroid hormone, a blood pressure medication and a medication to treat depression (Resident #5), continuing to receive a nasal spray for allergies, a sleeping aid and an anti-anxiety medication (Resident #2), and not receiving a laxative as ordered (Resident #1). [Refer to Tag 0358 10A NCAC 13F .1004(a)(1)(2) Medication Administration (Type B Violation)].	D912		