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NORTH POINTE	1195 PINEVIEW ROAD RANDLEMAN, NC 27317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on October 30-31, 2019.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 3 of 5 sampled residents (Resident #1, #2, and #3) related to a supplement, nasal spray, blood pressure, weights (#3), a laxative (#2), and leg wraps. The findings are: 1. Review of Resident #3's current FL2 dated 05/09/19 revealed diagnoses included acute hypoxic respiratory failure, congestive heart failure, hypertension, and Type 2 diabetes. a. Review of Resident #3's physician's order dated 06/11/19 revealed magnesium oxide (a medication used to treat decreased magnesium levels) 400 mg three times a day. Review of Resident #3's September 2019	D 273		

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electronic Medication Administration Record (eMAR) revealed:
-There was an entry for magnesium oxide 400 mg scheduled at 6:00 am, 12:00 pm, and 5:00 pm.
-Magnesium oxide 400 mg was not documented as administered for 9 of 90 opportunities from 09/01/19 through 09/30/19.
-Staff documented "resident refused medication" for 7 of the 9 missed doses.
-Staff documented "missed dose" for 2 of the 9 missed doses.

Review of Resident #3's October 2019 eMAR revealed:
-There was an entry for magnesium oxide 400 mg scheduled at 6:00 am, 12:00 pm, and 5:00 pm.
-Magnesium oxide 400 mg was not documented as administered for 26 of 89 opportunities from 10/01/19 through 10/29/19.
-Staff documented "resident refused medication" for 23 of the 26 missed doses.
-Staff documented "missed dose" for 3 of the 26 missed doses.

Review of Resident #3's progress notes revealed no documentation the primary care provider (PCP) was notified regarding magnesium oxide refusals and missed doses in September 2019 and October 2019.

Review of the facility's Medication Administration Policy revealed "Following three medication refusals, the MD will be contacted and the RCC made aware and documentation will be made in the resident chart".

Observation of medications on hand for Resident #3 on 10/31/19 at 4:00 pm revealed:

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-Magnesium oxide was available to be administered.
-There were 84 tablets of magnesium oxide dispensed on 10/18/19.
-There were 53 tablets of magnesium oxide remaining.

Interview with Resident #3 on 10/31/19 at 5:15 pm revealed:
-The staff administered all medications.
-She did not refuse magnesium oxide in September 2019 and October 2019.

Telephone interview with a representative from the facility's contracted pharmacy on 10/31/19 at 12:05 pm revealed there were 84 tablets of magnesium oxide dispensed on 07/19/19, 08/16/19, 09/13/19, and 10/11/19.

Telephone interview with a first shift medication aide (MA)/Supervisor on 10/31/19 at 1:05 pm revealed:
-She remembered Resident #3 refusing magnesium oxide in September 2019 and October 2019.
-She notified Resident #3's PCP regarding refusals (date unknown).
-She documented PCP notification in the progress notes.
-She did not know there was no documentation of PCP notification in the progress notes.

Interview with the Resident Care Coordinator (RCC) on 10/31/19 at 4:00 pm revealed:
-She did not know Resident #3 refused and missed magnesium oxide several times in September 2019 and October 2019.
-She expected staff to administer medications as ordered and notify her with consecutive refusals.
-No one was currently conducting eMAR audits to

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look for medication refusals.
-Staff were expected to notify the PCP regarding consecutive medication refusals.
-The MA/RCC was responsible for contacting the PCP.

Interview with the Administrator on 10/31/19 at 4:50 pm revealed:
-She did not know Resident #3 refused and missed magnesium oxide on several occasions in October 2019.
-The facility policy was to contact the PCP after 3 consecutive medication refusals.
-The RCC/MA was responsible for contacting the PCP regarding medication refusals.
-PCP notification should be documented on the eMAR and in the progress notes.
-The pharmacy could print a noncompliance report but she has not requested the report.
-The cooperate office had been conducting random eMAR audits.
-The last eMAR audit was completed on October 2, 2019.
-Cooperate had not informed her of medication refusals.

Interview with Resident #3's PCP on 10/31/19 at 4:47 pm revealed:
-She did not know Resident #3 was not administered magnesium oxide as ordered in September and October 2019.
-She expected the facility to notify her if medications are refused or missed.
-Magnesium oxide was prescribed because Resident #3 had decreased magnesium levels.
-If Resident #3 was not administered magnesium oxide as ordered it could result in decreased magnesium levels.
-Resident #3 was last seen by the PCP in October 2019.

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D 273	Continued From page 4 b. Review of Resident #3's physician's order dated 09/10/19 revealed deep sea nasal spray 0.65% solution (a medication used to treat dry or irritated nasal passages) one spray into each nostril twice daily. Review of Resident #3's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for deep sea nasal spray 0.65% solution, one spray into each nostril twice daily at 8:30 am and 8:30 pm. -Deep sea nasal spray was not documented as administered for 7 of 59 opportunities from 10/01/19 through 10/29/19. -Staff documented "resident refused medication" on the eMAR. Review of Resident #3's progress notes revealed no documentation the primary care provider (PCP) was notified regarding deep sea nasal spray refusals in October 2019. Review of the facility's Medication Administration Policy revealed "Following three medication refusals, the MD will be contacted and the RCC made aware and documentation will be made in the resident chart". Observation of medications on hand for Resident #3 on 10/31/19 at 4:00 pm revealed: -Deep sea nasal spray was available to be administered. -One bottle (44 ml) of deep sea nasal spray was last dispensed on 03/25/19. -The bottle was half full. Interview with Resident #3 on 10/31/19 at 5:15 pm revealed:	D 273		

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D 273	Continued From page 5 -The staff administered all medications. -She did not refuse deep sea nasal spray in October 2019. Interview with a representative from the facility's contracted pharmacy on 10/31/19 at 12:05 pm revealed deep sea nasal spray was last dispensed on 03/25/19 (44 ml bottle). Telephone interview with a first shift medication aide (MA)/Supervisor on 10/31/19 at 1:05 pm revealed: -She remembered Resident #3 refusing deep sea nasal spray in October 2019. -She notified Resident #3's PCP regarding refusals (date unknown). -She documented PCP notification in the progress notes. -She did not know there was no documentation of PCP notification in the progress notes. Interview with the Resident Care Coordinator (RCC) on 10/31/19 at 4:00 pm revealed: -She did not know Resident #3 refused deep sea nasal spray several times in October 2019. -She expected staff to administer medications as ordered and notify her with consecutive refusals. -No one was currently conducting eMAR audits to look for medication refusals. -Staff were expected to notify the PCP regarding consecutive medication refusals. -The MA/RCC was responsible for contacting the PCP and should document any PCP notification in the progress notes. Interview with the Administrator on 10/31/19 at 4:50 pm revealed: -She did not know Resident #3 refused deep sea nasal spray on several occasions in October 2019.	D 273		

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-The facility policy was to contact the PCP after 3 consecutive medication refusals.
-The RCC/MA was responsible for contacting the PCP regarding medication refusals.
-PCP notification should be documented on the eMAR and in the progress notes.
-The pharmacy could print a noncompliance report but she has not requested the report.
-The cooperate office had been conducting random eMAR audits.
-The last eMAR audit was completed on October 2, 2019.
-Cooperate had not informed her of medication refusals.

Interview with Resident #3's PCP on 10/31/19 at 4:47 pm revealed:
-She did not know Resident #3 was not administered deep sea nasal spray as ordered in September and October 2019.
-She expected the facility to notify her if medications were refused or missed.
-Deep sea nasal spray was prescribed because Resident #3 had complained of nasal congestion.
-If Resident #3 was not administered deep sea nasal spray as ordered she could experience increased nasal congestion.
-Resident #3 was last seen by the PCP in October 2019.

c. Review of Resident #3's physician's order dated 09/10/19 revealed blood pressures (BP) twice a day and notify the Primary Care Provider (PCP) if BP was greater than 150/90.

Review of Resident #3's September 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check blood pressure twice a day and notify PCP if BP greater than

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150/90 scheduled at 8:00 am and 8:00 pm.
-Staff documented Resident #3 refused BP for 4 of 60 opportunities from 09/01/19 through 09/30/19.
-BP ranged from 120-146/48-95.

Review of Resident #3's October 2019 eMAR revealed:
-There was an entry to check blood pressure twice a day and notify PCP if BP greater than 150/90 scheduled at 8:30 am and 8:30 pm .
-Staff documented Resident #3 refused BP for 7 of 59 opportunities from 09/01/19 through 09/30/19.
-BP ranged from 114-187/55-90.

Review of Resident #3's progress notes revealed no documentation the PCP was notified regarding BP refusals in September 2019 and October 2019.

Interview with Resident #3 on 10/31/19 at 5:15 pm revealed:
-Staff monitored her BP but she did not know how often.
-She did not remember refusing BP checks.

Telephone interview with a first shift medication aide (MA)/Supervisor on 10/31/19 at 1:05 pm revealed:
-The personal care aide (PCA) and MA could obtain BPs.
-The MA was responsible for documenting the BP on the eMAR.
-The MA was responsible for notifying the PCP regarding BP refusals.
-Resident #3 often refused BP checks.
-She did not remember if she notified the PCP.
-PCP notification would be documented in the progress notes.

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D 273	Continued From page 8 -She did not know there was no documentation of PCP notification in the progress notes. Interview with the Resident Care Coordinator (RCC) on 10/31/19 at 4:00 pm revealed: -She knew Resident #3 had an order for staff to obtain BP twice a day. -She did not know Resident #3 refused several BPs in September 2019 and October 2019. -The PCA and MA could obtain BP. -The MA was responsible for documenting BPs on the eMAR. -She expected staff to obtain BPs as ordered and notify her with consecutive refusals. -Staff were expected to notify the PCP regarding refusals. -The RCC or MA was responsible for PCP notification regarding consecutive BP refusals and should document any PCP notification in the progress notes. -If PCP notification was not documented she would assume contact was not made. -No one was currently conducting eMAR audits to look for BP refusals. Interview with the Administrator on 10/31/19 at 4:50 pm revealed: -The PCA or MA could obtain resident BPs but the MA was responsible for documenting the BP on the eMAR. -She did not know Resident #3 refused BPs in September 2019 and October 2019. -The facility policy was to contact the PCP after 3 consecutive BP refusals. -The RCC or MA was responsible for contacting the PCP regarding BP refusals. -PCP notification should be documented on the eMAR and in the progress notes. -The pharmacy could print a noncompliance report but she has not requested the report.	D 273		

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-The cooperate office had been conducting random eMAR audits.
-The last eMAR audit was completed on October 2, 2019.
-Cooperate had not informed her of medication refusals.

Interview with Resident #3's PCP on 10/31/19 at 4:47 pm revealed:
-She did not know Resident #3 refused BPs in September 2019 and October 2019.
-She expected the facility to notify her if a resident refused ordered BP checks.
-She ordered BPs twice a day because Resident #3 had increased BP in the past.
-Resident #3 was last seen by the PCP in October 2019 and her BP was stable.

d. Review of Resident #3's physician's order dated 09/10/19 revealed weekly weight and notify the Primary Care Provider (PCP) with a 5 pound (lb) weight (wt) gain or loss in one week.

Review of Resident #3's September 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check weekly wt and notify the PCP with a 5 lb wt gain or loss in one week scheduled once a week at 7:00 am.
-Staff documented "unable to take medication" or "patient refused medication" for 3 of 5 opportunities from 09/01/19 through 09/30/19.
-Resident #3's wt ranged from 109-110 lbs.

Review of Resident #3's October 2019 eMAR revealed:
-There was an entry to check weekly wt and notify the PCP with a 5 lb wt gain or loss in one week scheduled once a week at 7:00 am.
-Staff documented "patient refused medication"

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for 2 of 4 opportunities and staff did not document a wt for 2 of 4 opportunities from 10/01/19 through 10/30/19.
-There was no wt documented for October 2019.

Review of Resident #3's progress notes revealed no documentation the PCP was notified regarding wt refusals in September 2019 and October 2019.

Interview with Resident #3 on 10/31/19 at 5:15 pm revealed:
-Staff monitored her wt but she did not know how often.
-She did not remember refusing weights.

Telephone interview with a first shift medication aide (MA)/Supervisor on 10/31/19 at 1:05 pm revealed:
-The personal care aide (PCA) and MA could obtain resident wts.
-The MA was responsible for documenting the wt on the eMAR.
-The MA was responsible for notifying the PCP regarding wt refusals.
-Resident #3 refused wt checks several times a month.
-She did not remember if she notified the PCP of wt refusals.
-PCP notification would be documented in the progress notes.
-She did not know there was no documentation of PCP notification in the progress notes.

Interview with the Resident Care Coordinator (RCC) on 10/31/19 at 4:00 pm revealed:
-She knew Resident #3 had an order for staff to obtain weekly wts.
-She did not know Resident #3 refused several wts in September 2019 and October 2019.
-The PCA and MA could obtain wt.

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-The MA was responsible for documenting wts on the eMAR.
-She expected staff to obtain wts as ordered and notify her with consecutive refusals.
-Staff were expected to notify the PCP regarding refusals.
-The RCC or MA was responsible for PCP notification regarding consecutive wt refusals and should document any PCP notification in the progress notes.
-No one was currently conducting eMAR audits to look for wt refusals.

Interview with the Administrator on 10/31/19 at 4:50 pm revealed:
-The PCA or MA could obtain resident wts but the MA was responsible for documenting the wt on the eMAR.
-She did not know staff documented Resident #3 refused wts in September 2019 and October 2019.
-The facility policy was to contact the PCP after 3 consecutive wt refusals.
-The RCC or MA was responsible for contacting the PCP regarding wt refusals.
-PCP notification should be documented on the eMAR and in the progress notes.
-The pharmacy could print a noncompliance report but she has not requested the report.
-The cooperate office had been conducting random eMAR audits.
-The last eMAR audit was completed on October 2, 2019.
-Cooperate had not informed her of refusals.

Interview with Resident #3's PCP on 10/31/19 at 4:47 pm revealed:
-She did not know Resident #3 refused wts in September 2019 and October 2019.
-She expected the facility to notify her if a resident

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refused ordered wt checks.
-She ordered weekly wts because Resident #3 had weight loss.
-Resident #3 was last seen by the PCP in October 2019.

3. Review of Resident #2's current FL2 dated 07/30/19 revealed:
-Diagnoses included Alzheimer's dementia, anxiety, anemia, hypothyroidism, depression, hypertension, and gastrointestinal reflux.
-There was an order for lactulose 10 gram/15 ml give 30 ml twice daily (a medication used to treat constipation).

Review of Resident #2's September 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for lactulose 10gm/15 ml give 30 ml twice daily scheduled at 9:00 am and 9:00 pm.
-Lactulose was documented as not administered for 3 of 60 opportunities from 09/01/19 through 09/30/19.
-Doses missed were non-consecutive.
-Staff documented "resident refused medication" for 2 of 3 missed doses.

Review of Resident #2's October 2019 eMAR revealed:
-There was an entry for lactulose 10gm/15 ml give 30 ml twice daily scheduled at 9:00 am and 9:00 pm.
-Lactulose was documented as not administered for 12 of 60 opportunities from 10/01/19 through 10/29/19.
-Consecutive doses missed from 10/17/19 at 9:00 am, 10/17/19 at 9:00pm, and 10/18/19 at 9:00 am.
-Staff documented "resident refused medication"

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D 273	Continued From page 13 for 11 of 60 missed doses. Review of Resident #2's progress notes revealed no documentation the primary care provider (PCP) was notified regarding lactulose refusals in September 2019 and October 2019. Observation of medications on hand for Resident #2 on 10/31/19 at 4:46 pm revealed: -Lactulose was available to be administered. -There were 473 ml of lactulose dispensed on 10/22/19. -There were almost a full bottle of lactulose remaining. Interview with Resident #2's PCP on 10/31/19 at 9:33 am revealed: -She did not know Resident #2 refused lactulose in September and October 2019. -She expected the facility to notify her if medications were refused. -Several months back, Resident #2 refused medications and had to be re-evaluated by the psychiatric provider. -She had complied with her medication regiment after her medications were changed. Interview with Resident #2 on 10/31/19 at 1:00 pm revealed: -The staff administered all medications. -She did not know what medications she was taking. -She took her medications when the medication aide (MA) brought them to her. -She did not refuse lactulose in September 2019 and October 2019. Telephone interview with a representative from the facility's contracted pharmacy on 10/31/19 at	D 273		

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D 273	Continued From page 14 12:37 pm revealed there were 437 ml of lactulose dispensed on 10/22/19. Telephone interview with a first shift MA/Supervisor on 10/31/19 at 1:07 pm revealed: -She did not remember Resident #2 refusing lactulose in September 2019 and October 2019. -She would notify Resident #2's PCP regarding refusals if she refused medications 3 times in one week per the facility policy. -Resident #2 had only refused 2 or 3 times in October 2019, but the refusals had not been consecutive. -The MAs were responsible for documenting refusals in the progress notes. -She did not recall documenting any refusals in the progress notes for Resident #2. Interview with the Resident Care Coordinator (RCC) on 10/31/19 at 11:05 am revealed: -She did not know staff documented Resident #2 refused lactulose several times in September 2019 and October 2019. -She expected staff to administer medications as ordered and notify her with consecutive refusals. -No one was currently conducting eMAR audits to look for medication refusals. -Staff were expected to notify the PCP regarding 3 consecutive days of medication refusals per policy. -The MA/RCC was responsible for contacting the PCP of medication refusals. Interview with the Administrator on 10/31/19 at 11:27 am revealed: -She did not know Resident #2 refused lactulose several times in September 2019 and October 2019. -The facility policy was to contact the PCP after 3 consecutive medication refusals.	D 273		

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-The RCC/MA was responsible for contacting the PCP regarding medication refusals.
-If a PCP was notified, it would be documented in the progress notes.
-The cooperate office had been conducting random eMAR audits.
-The last eMAR audit was completed on 10/02/19.
-Cooperate had not informed her of medication refusals.

4. Review of Resident #1's current FL2 dated 01/0219 revealed diagnoses included acute kidney failure, dementia and hypertension.

Review of Resident #1's physician's orders revealed:
-There was an order dated 08/13/19 for leg wraps, apply to bilateral lower extremities, apply in the morning and remove at night.
-There was a six-month physician's order sheet dated 09/10/19 that included an order for leg wraps, apply to bilateral lower extremities, apply in the morning and remove at night.

Review of Resident #1's September 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for leg wraps, apply to bilateral lower extremities, apply in the morning and remove at night scheduled at 8:30am and 8:30pm daily.
-There was documentation Resident #1 refused leg wraps six times on 09/01/19, 09/02/19, 09/11/19, 09/20/19, 09/23/19 and 09/27/19.
-There was no documentation the resident's primary care physician (PCP) was notified regarding the resident refusing to wear the leg wraps.

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Review of Resident #1's October 2019 eMAR revealed:
-There was an entry for leg wraps, apply to bilateral lower extremities, apply in the morning and remove at night scheduled for at 8:30am and 8:30pm daily.
-There was documentation Resident #1 refused leg wraps nineteen times from 10/01/19 to 10/16/19 and 10/19/19 to 10/22/19.
-There was no documentation the resident's PCP was notified regarding the resident refusing to wear the leg wraps.

Review of Resident #1's record revealed the leg wraps were discontinued on 10/22/19 due home health treating wounds on the resident's leg.

Based on record review, observation and interviews with staff, it was determined Resident #1 was not interviewable.

Interview with Resident #1's PCP on 10/31/19 at 11:20am revealed:
-She ordered the leg wraps due to Resident #1's edema.
-Facility staff had not notified her that Resident #1 refused leg wraps.
-Had the staff made her aware she could have reassessed the resident's edema related to the leg wraps.
-Resident #1 was getting treatment to the great toe on her left foot, but that should not impede staff applying the leg wraps.
-She was in the facility weekly visiting residents; the staff should have informed her Resident #1 refused leg wraps.

Interview with a day shift medication aide (MA) on 10/31/19 at 11:36am revealed:
-The personal care aides (PCAs) on the 7pm to

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D 273	Continued From page 17 7am shift were responsible for applying and removing Resident #1's leg wraps. -The MA doing the medication pass checked Resident #1's leg wraps to ensure the leg wraps were on and applied correctly. -If the MA did not see the leg wraps on the resident, she was supposed to ask the resident to allow staff to put the leg wraps on her. -If the resident refused the leg wraps, the MA was to document the refusal on the eMAR. -The MA recalled several times (unable to recall specific dates) when Resident #1's leg wraps were not available because staff were unable to find the leg wraps, so she documented the resident refused the leg wraps. -It was the facility's policy after three refusals the MA was to notify the resident's PCP. -If Resident #1's PCP was notified there should be documentation in the resident's record. -Resident #1's PCP should have been notified regarding the resident's refusals, but she was unable to find document the PCP had been notified. Interview with the Administrator on 10/31/19 at 4:35pm revealed: -She was not aware Resident #1 refused leg wraps nineteen times in October 2019. -The MA should document if the resident refused the leg wraps or if they were not available. -The facility's policy was to contact the PCP after three consecutive refusals. -The Resident Care Coordinator (RCC) and MA was responsible for contacting the PCP regarding refusals. -The PCP notification should be documented on the eMAR and in the resident's progress notes.	D 273		

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D 280	Continued From page 18	D 280		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure a quarterly Licensed Health Professional Support (LHPS) evaluation was completed for 1 of 5 (Resident #5) sampled residents with LHPS tasks for oxygen, a nebulizer, and bipap machine. The findings are:	D 280		

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D 280	Continued From page 19 Review of Resident #5's current FL2 dated 11/16/18 revealed diagnoses included chronic obstructive pulmonary disease, essential hypertension, chronic pain syndrome, restlessness and agitation, major depressive disorder, difficulty walking, and dependent on supplemental oxygen. Review of Resident #5's record revealed there was no documentation of an LHPS evaluation. a. Review of Resident #5's current FL2 dated 11/16/18 revealed there was a physician order for continuous oxygen at 2 liters per minute (lpm) via nasal canula. Review of Resident #5's August, September, and October 2019 electronic Medication Administration Record (eMAR) revealed there was no entry for continuous oxygen 2 lpm. Observation of Resident #5's room on 10/31/19 at 4:30 pm revealed: -There was an oxygen concentrator at the bedside. -Resident #5 was not wearing oxygen. Interview with Resident #5 on 10/31/19 at 4:35 pm revealed: -She used oxygen 2 lpm via nasal canula at night only. -She did not experience shortness of breath during the day. -She managed all care related to oxygen and the concentrator. Refer to interview with the Resident Care Coordinator (RCC) on 10/31/19 at 4:00 pm.	D 280		

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D 280	Continued From page 20 Refer to interview with the Administrator on 10/31/19 at 4:50 pm. Refer to telephone interview with the contracted LHPS nurse on 10/31/19 at 5:38 pm. b. Review of Resident #5's current FL2 dated 11/16/18 revealed there was a physician order for Ipratropium Bromide and Albuterol Sulfate (a medication used to treat chronic obstructive pulmonary disease). 0.5-2.5 3mg/3ml, inhale orally via nebulizer three times a day. Review of Resident #5's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Ipratropium and Albuterol nebulizer solution, inhale 1 vial via nebulizer three times a day scheduled at 6:00 am, 12:00 pm, and 5:00 pm. -Staff documented the resident self-administered the Ipratropium and Albuterol 40 of 93 opportunities. Review of Resident #5's September 2019 eMAR revealed: -There was an entry for Ipratropium and Albuterol nebulizer solution, inhale 1 vial via nebulizer three times a day scheduled at 6:00 am, 12:00 pm, and 5:00 pm. -Staff documented the resident self-administered the Ipratropium and Albuterol 8 of 90 opportunities. Review of Resident #5's October 2019 eMAR revealed: -There was an entry for Ipratropium/Albuterol nebulizer solution, inhale 1 vial via nebulizer three times a day scheduled at 6:00 am, 12:00 pm, and 5:00 pm.	D 280		

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D 280	Continued From page 21 -Staff did not document the resident self-administered the Ipratropium/Albuterol. Observation of Resident #5's room on 10/31/19 at 4:30 pm revealed: -There was a nebulizer machine and Ipratropium and Albuterol located in the closet. -The Ipratropium and Albuterol was dispensed on 01/23/18 with 16 vials remaining. -The label had instructions to inhale 3 ml orally every 6 hours and inhale 3 ml orally every 2 hours as needed for shortness of breath. Telephone interview with a representative from the facility's contracted pharmacy on 10/31/19 at 12:05 pm revealed: -The current order was for Ipratropium Bromide and Albuterol Sulfate 0.5-2.5 3mg/3ml, inhale orally via nebulizer three times a day. -There was no order to self-administer. -There were 90 vials of Ipratropium/Albuterol last dispensed on 01/23/18. Interview with Resident #5 on 10/31/19 at 4:35 pm revealed: -She self-administered all duoneb treatments. -Staff did not administer Ipratropium and Albuterol. -She kept the duoneb in her room and administered once daily. -She managed all care related to the nebulizer. Refer to interview with the Resident Care Coordinator (RCC) on 10/31/19 at 4:00 pm. Refer to interview with the Administrator on 10/31/19 at 4:50 pm. Refer to telephone interview with the contracted LHPS nurse on 10/31/19 at 5:38 pm.	D 280		

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D 280	Continued From page 22 c. Review of Resident #5's physician's order dated 06/25/19 revealed bipap machine at bedtime. Review of Resident #5's August, September, and October 2019 electronic Medication Administration Record (eMAR) revealed there was no entry for bipap at bedtime. Observation of Resident #5's room on 10/31/19 at 4:30 pm revealed there was a bipap machine on the bedside table. Interview with Resident #5 on 10/31/19 at 4:35 pm revealed: -She used the bipap machine at night only. -She managed all care related to the bipap machine. Refer to interview with the Resident Care Coordinator (RCC) on 10/31/19 at 4:00 pm. Refer to interview with the Administrator on 10/31/19 at 4:50 pm. Refer to telephone interview with the contracted LHPS nurse on 10/31/19 at 5:38 pm. Interview with the Resident Care Coordinator (RCC) on 10/31/19 at 4:00 pm revealed: -She did not know what a Licensed Health Professional Support (LHPS) evaluation was until the previous week. -The Administrator was responsible for ensuring LHPS evaluations were completed. -She did not know Resident #5 did not have an LHPS evaluation completed. -She knew Resident #5 had orders for oxygen, nebulizer, and a bipap machine.	D 280		

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D 280	Continued From page 23 Interview with the Administrator on 10/31/19 at 4:50 pm revealed: -She was responsible for ensuring the residents were evaluated quarterly by a LHPS professional. -She did not know Resident #5 required an LHPS evaluation. -The contracted LHPS nurse completed all LHPS evaluations for the facility. -She did not know Resident #5 was ordered oxygen. -She knew Resident #5 had an order for a nebulizer and bipap. Telephone interview with the contracted LHPS nurse on 10/31/19 at 5:38 pm revealed: -She came to the facility once a month. -She completed an LHPS for residents according to a list provided by the Administrator. -She did not know Resident #5 required an LHPS evaluation. -Resident #5 was not on the list of residents requiring an LHPS evaluation.	D 280		
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	D 358		

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D 358	Continued From page 24 Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 5 sampled residents related to errors with administration of a blood thinner (#4). The findings are: Review of Resident #4's current FL2 dated 08/21/19 revealed: -Diagnoses included generalized weakness with encephalopathy and urinary tract infection. -There was an order for Coumadin 1 mg take 1 tablet daily along with 6 mg to equal 7 mg. -There was an order for Coumadin 6 mg take 1 tablet daily. Review of Resident #4's physician's orders dated 03/26/19 revealed: -There was an order for Coumadin 1 mg take 1 half tablet (0.5 mg) daily along with 5 mg to equal 5.5 mg. -There was an order for Coumadin 5 mg take 1 tablet daily along with half tablet of 1 mg (0.5 mg) to equal 5.5 mg. Review of Resident #4's August 2019 International Normalized Ratio (INR) lab results revealed: -INR results on 08/01/19 were 1.4 (Normal reference range was 2.0 to 3.0 for a therapeutic range for people taking Coumadin). -INR results on 08/05/19 were 1.8. -INR results on 08/13/19 were 5.2. -INR results on 08/15/19 were 2.3. -INR results on 08/16/19 were 2.8. -INR results on 08/20/19 were 1.1. -INR results on 08/23/19 were 1.1.	D 358		

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D 358	Continued From page 25 -INR results on 08/29/19 were 2.0. Review of Resident #4's August 2019 physician's orders revealed: -There was an order dated 08/01/19 for Coumadin 7 mg daily. -There was an order dated 08/06/19 to increase Coumadin to 7.5 mg daily. -There was an order dated 08/13/19 for to discontinue Coumadin and check INR on 08/15/19. -There was an order dated 08/15/19 for Coumadin 5 mg daily. -There was an order dated 08/20/19 to increase Coumadin to 6 mg daily. -There was an order dated 08/23/19 to continue Coumadin 6 mg daily. -There was an order dated 08/29/19 to increase Coumadin to 7 mg daily. Review of Resident #4's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Coumadin 1 mg daily (to be given with 6 mg to equal 7 mg) scheduled at 5:00 pm with an order date of 08/01/19 and there was no discontinue date. -There was an entry for Coumadin 6 mg daily (to be given with 1 mg to equal 7 mg) scheduled at 5:00 pm with an order date of 08/01/19 and a discontinue date of 08/06/19. -Coumadin was not documented as administered on 08/01/19 and 08/02/19; staff should have administered 7 mg of Coumadin. -There was an entry for Coumadin 7.5 mg daily scheduled at 5:00 pm with a start date of 08/06/19 and a discontinue date of 08/13/19. -On 08/06/19, Coumadin 1 mg (to be given with 6 mg to equal 7 mg) and 6 mg (to be given with 1 mg to equal 7 mg), totaling to 7 mg of Coumadin,	D 358		

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was documented as administered; staff should have administered 7.5 mg.
-From 08/07/19 through 08/12/19, Coumadin 7.5 mg and Coumadin 1 mg (to be given with 6 mg to equal 7 mg), totaling to 8.5 mg of Coumadin, was documented as administered; staff should have administered 7.5 mg of Coumadin.
-On 08/14/19, Coumadin 1 mg (to be given with 6 mg to equal 7 mg) was documented as administered and Coumadin should have been held per order dated 08/13/19.
-There was an entry for Coumadin 5 mg daily scheduled at 5:00 pm with an order date of 08/15/19 and a discontinue date of 08/20/19.
-On 08/15/19, Coumadin was not documented as administered and staff noted the "medication [was] on hold"; staff should have administered 5 mg of Coumadin.
-On 08/16/19, Coumadin 1 mg (to be given with 6 mg to equal 7 mg) was documented as administered and Coumadin 5 mg of was not documented as administered and staff noted the "patient [was] unable to take the medication"; staff should have administered 5 mg of Coumadin.
-From 08/17/19 through 08/19/19, Coumadin 5 mg and Coumadin 1 mg (to be given with 6 mg to equal 7 mg), totaling to 6 mg of Coumadin, was documented as administered; staff should have administered 5 mg of Coumadin.
-There was an entry for Coumadin 6 mg daily scheduled at 5:00 pm with a start date of 08/20/19 and a discontinue date of 09/19/19.
-On 08/20/19, Coumadin 1 mg (to be given with 6 mg to equal 7 mg) was documented as administered and staff should have administered 6 mg of Coumadin.
-From 08/21/19 to 08/28/19, Coumadin 6 mg and Coumadin 1 mg (to be given with 6 mg to equal 7 mg), totaling to 7 mg of Coumadin, was

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documented as administered; staff should have administered 6 mg of Coumadin.
-Coumadin was not documented as administered when it should have been administered on 08/01/19, 08/02/19, and 08/15/19.
-There were 3 doses of Coumadin missed in August 2019.
-There were 21 doses of Coumadin documented as administered to Resident #4 at a dose different than ordered in August 2019.

Review of Resident #4's September 2019 INR lab results revealed:
-INR results on 09/03/19 were 5.0.
-INR results on 09/05/19 were 2.8.
-INR results on 09/09/19 were 1.1.
-INR results on 09/11/19 were 0.9.
-INR results on 09/13/19 were 1.1.
-INR results on 09/16/19 were 1.1.
-INR results on 09/20/19 were 1.4.
-INR results on 09/23/19 were 2.2.
-INR results on 09/26/19 were 3.0.
-INR results on 09/30/19 were 5.0.

Review of Resident #4's physician's orders dated 09/10/19 revealed:
-There was an order for Coumadin 1 mg take 1 tablet daily along with 6 mg to equal 7 mg.
-There was an order for Coumadin 6 mg take 1 tablet daily.

Review of Resident #4's September 2019 physician's orders revealed:
-There was an order dated 09/03/19 to discontinue Coumadin and check INR on 09/05/19.
-There was an order dated 09/05/19 to start Coumadin 1 mg daily.
-There was an order dated 09/09/19 to increase Coumadin to 2 mg daily.

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D 358	Continued From page 28 -There was an order dated 09/11/19 to increase Coumadin to 4 mg daily. -There was an order dated 09/13/19 to increase Coumadin to 5 mg daily. -There was an order dated 09/16/19 to increase Coumadin to 6 mg daily. -There was an order dated 09/20/19 to increase Coumadin to 6.5 mg daily. -There was an order dated 09/23/19 to continue Coumadin 6.5 mg daily. -There was an order dated 09/24/19 for Coumadin 6 mg daily. -There was an order dated 09/26/19 for Coumadin 6 mg daily. -There was an order dated 09/30/19 to hold Coumadin and check INR on 10/03/19. Review of Resident #4's September 2019 eMAR revealed: -There was an entry for Coumadin 1 mg daily (to be given with 6 mg to equal 7 mg) scheduled at 5:00 pm with an order date of 08/01/19 and discontinue date of 09/11/19. -There was an entry for Coumadin 6 mg daily scheduled at 5:00 pm with an order date of 08/20/19 and discontinue date of 09/03/19. -On 09/04/19, Coumadin 1 mg (to be given with 6 mg to equal 7 mg) was documented as administered and Coumadin should have been held per order dated 09/03/19. -On 09/05/19, Coumadin 1 mg (to be given with 6 mg to equal 7 mg) was not documented as administered and staff noted the "patient [was] unable to take the medication"; staff should have administered 1 mg of Coumadin. -There was an entry for Coumadin 1 mg daily scheduled at 5:00 pm with an order date of 09/06/19 and a discontinue date of 09/09/19. -On 09/07/19, Coumadin 1 mg (to be given with 6 mg to equal 7 mg) and Coumadin 1 mg were not	D 358		

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documented as administered, and staff noted the "medication [was] on hold"; staff should have administered 1 mg of Coumadin.
-On 09/08/19, Coumadin 1 mg (to be given with 6 mg to equal 7 mg) and Coumadin 1 mg, totaling to 2 mg of Coumadin, were both documented as administered; staff should have administered 1 mg of Coumadin.
-There was an entry for Coumadin 2 mg daily scheduled at 5:00 pm with an order date of 09/09/19 and a discontinue date of 09/11/19.
-On 09/09/19, Coumadin 1 mg (to be given with 6 mg to equal 7 mg) was not documented as administered and staff noted the "order [was] discontinued"; staff should have administered 2 mg of Coumadin.
-On 09/10/19, Coumadin 1 mg (to be given with 6 mg to equal 7 mg) and Coumadin 2 mg, totaling to 3 mg of Coumadin, were both documented as administered; staff should have administered 2 mg of Coumadin.
-There was an entry for Coumadin 4 mg daily scheduled at 5:00 pm with an order date of 09/11/19 and a discontinue date of 09/11/19.
-On 09/11/19, Coumadin 1 mg (to be given with 6 mg to equal 7 mg) was documented as administered and staff should have administered 4 mg of Coumadin.
-There was no Coumadin documented as administered from 09/13/19 through 09/15/19 and staff should have administered 5 mg of Coumadin.
-From 09/16/19 through 09/19/19, Coumadin 5 mg was documented as administered and staff should have administered 6 mg of Coumadin.
-There was an entry for Coumadin 6 mg daily scheduled at 5:00 pm with an order date of 09/19/19 and no discontinue date.
-From 09/20/19 through 09/23/19, Coumadin 6 mg was documented as administered and staff

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should have administered 6.5 mg of Coumadin.
-Coumadin was not documented as administered when it should have been administered on 09/05/19, 09/07/19, 09/09/19, 09/13/19, 09/14/19, 09/15/19, 09/19/19.
-There were 7 out of 18 doses of Coumadin missed in September 2019.
-There were 11 doses of Coumadin documented as administered to Resident #4 at a dose different than ordered in September 2019.

Review of Resident #4's October 2019 INR lab results revealed:
-INR results on 10/03/19 were 1.3.
-INR results on 10/04/19 were 1.2.
-INR results on 10/08/19 were 1.6.
-INR results on 10/10/19 were 2.0.
-INR results on 10/14/19 were 1.9.

Review of Resident #4's October 2019 physician's orders revealed:
-There was an order dated 10/03/19 for Coumadin 4 mg daily.
-There was an order dated 10/08/19 to increase Coumadin to 5 mg daily.
-There was an order dated 10/10/19 to continue Coumadin 5 mg daily.
-There was an order dated 10/21/19 to continue Coumadin 5 mg daily.

Review of Resident #4's October 2019 eMAR revealed:
-There was an entry for Coumadin 4 mg daily scheduled at 5:00 pm with an order date of 10/03/19 and a discontinue date of 10/08/19.
-There was no Coumadin documented as administered to Resident #4 on 10/03/19 and staff should have administered 4 mg of Coumadin.
-There was an entry for Coumadin 5 mg daily

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scheduled at 5:00 pm with an order date of 10/08/19 and no discontinue date.
-There was no Coumadin documented as administered on 10/08/19 and 10/13/19 and staff should have administered 5 mg of Coumadin.
-Coumadin was not documented as administered when it should have been administered on 10/03/19, 10/08/19, and 10/13/19.
-There were 3 doses of Coumadin missed in October 2019.

Observation of Resident #4's medications on hand on 10/30/19 at 3:30 pm revealed there were 28 tablets of Coumadin 5 mg dispensed on 10/18/19 with 22 tablets remaining and available for administration.

Telephone interview with a representative from the contracted pharmacy on 10/30/19 at 4:34 pm revealed:
-Resident #4's medications were cycle filled every month.
-Cycle fill dates were different every month because cycle filled medications were dispensed every 28 days.
-The number of Coumadin tablets dispensed with new orders varied because the number dispensed would get Resident #4 to the next cycle fill date.
-The facility faxed Resident #4's Coumadin orders to the pharmacy.
-The pharmacy did not require Resident #4's INR lab results in order to dispense Coumadin.
-Orders faxed to the pharmacy would be delivered to the facility on the same day in the evening, and if an order was faxed past the delivery cut off time, the medications would be delivered the next day.
-The pharmacy delivered medications to the facility once a day.

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D 358	Continued From page 32 -The eMAR was pharmacy driven and the pharmacy added and discontinued medication orders on the eMAR. -The facility staff had the ability to add temporary orders on the eMAR. -She did not know if the facility added, changed, or discontinued orders on the eMAR and each facility would have their own policy on what they could modify on the eMAR. -Coumadin 5 mg daily was the current order for Resident #4. -On 10/16/19, 28 tablets of Coumadin 5 mg were dispensed. -On 10/08/19, 10 tablets of Coumadin 5 mg were dispensed. -On 10/03/19, 15 tablets of Coumadin 4 mg were dispensed. -On 09/19/19, 28 tablets of Coumadin 6 mg were dispensed. -On 09/13/19, 7 tablets of Coumadin 5 mg were dispensed. -On 09/11/19, 9 tablets of Coumadin 4 mg were dispensed. -On 09/09/19, 11 tablets of Coumadin 2 mg were dispensed. -On 09/06/19, 14 tablets of Coumadin 1mg were dispensed. -On 09/03/19, Coumadin was discontinued. -On 08/22/19, 28 tablets of Coumadin 6 mg were dispensed. -On 08/20/19, 3 tablets of Coumadin 6 mg were dispensed. -On 08/26/19, the pharmacy received another order for Coumadin 6 mg, but Coumadin 6 mg was the same dose on file. -On 08/15/19, 8 tablets of Coumadin 5 mg were dispensed. -On 08/13/19, Coumadin was discontinued. -On 08/06/19, 7 tablets of Coumadin 7.5 mg were dispensed.	D 358		

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D 358	Continued From page 33 -On 08/01/19, 22 tablets of Coumadin 6 mg and 15 tablets of 1 mg were dispensed to total the Coumadin 7 mg dose ordered. -There was not a 7 mg tablet for Coumadin and the combination of the 6 mg and 1 mg was the only way the dose was dispensed. Interview with the Resident Care Coordinator (RCC) on 10/31/19 at 8:50 am revealed: -Resident #4's INR labs were collected by a contracted Registered Nurse. -Resident #4's INR lab results were called to the provider and the provider either faxed a Coumadin order or verbalized an order over the telephone. -The Coumadin order was either called into the pharmacy or the order was faxed to the pharmacy. -She was now responsible for Resident #4's INR labs and for processing Resident #4's Coumadin orders. -The Administrator was responsible for processing Resident #4's Coumadin orders in August 2019, September 2019, and October 2019. Second interview with the Resident Care Coordinator (RCC) on 10/31/19 at 10:52 am revealed: -She was not aware Coumadin was not administered as ordered in August 2019, September 2019, and October 2019. -She did not have Resident #4's August 2019 eMAR to review because of technical difficulties because when they attempted to pull the eMAR, the administration record was blank. -She reviewed the September 2019 eMAR and October 2019 eMAR with the Administrator because the Administrator processed Resident #4's Coumadin orders at that time.	D 358		

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D 358	Continued From page 34 -On 09/07/19, Coumadin was held by staff because they did not know what to administer to Resident #4. -On 09/13/19, 09/14/15, and 09/15/19, Coumadin was held because the staff did not know what to administer to Resident #4 because Resident #4's INR was collected on 09/13/19 and staff did not know if the PCP changed the Coumadin order. -If the INR lab results were collected late on a Friday afternoon, the PCP may not respond with a Coumadin order. -Staff should have called the provider on call if they did not reach the PCP by telephone. -She did not know why staff did not follow up with the provider. -On 09/16/19, 09/17/19, and 09/18/19, the Administrator told the medication aide (MA) to give 1 mg with the 5 mg to total to the 6 mg Coumadin dose ordered for Resident #4. -The Administrator told the MA to document the administration of 1 mg plus the 5 mg dose of Coumadin in the comment section in the eMAR. -On 09/20/19, 09/21/19, and 09/23/19, the Administrator told the MA to give 0.5 mg with the 6 mg to total to the 6.5 mg Coumadin dose ordered for Resident #4. -The Administrator told the MA to document the administration of 0.5 mg plus the 6 mg dose of Coumadin in the comment section in the eMAR. -The Administrator had extra Coumadin tablets for Resident #4. -Resident #4's Coumadin was kept by the facility unless it was expired. -She did not know why Resident #4's Coumadin was not documented as administered on 10/03/19, 10/08/19, and 10/13/19. -If Coumadin was not documented on Resident #4's eMAR, then it was not administered. -There was no additional documentation outside of the eMAR for the administration of Resident	D 358		

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#4's Coumadin.
-Staff did not document Coumadin doses administered to Resident #4's August 2019, September 2019, and October 2019 in the comment section in the eMAR.
-The facility should have used the back-up pharmacy if Resident #4's Coumadin order was late.
-The RCC and Administrator were responsible for calling the PCP.
-The RCC was responsible for MAR audits.
-She did not audit Resident #4's MAR or record because she was new to the position.
-MAs should not have made the judgment to hold Resident #4's Coumadin.
-MAs were responsible for medication administration and documenting administration in the eMAR.
-She did not notice any bleeding or bruising with Resident #4 in October 2019.
-Resident #4 was not a resident that refused medications.
-Resident #4's PCP was not notified of Coumadin not being administered as ordered in August 2019, September 2019, and October 2019.

Interview with Resident #4 on 10/31/19 at 11:10 am revealed:
-She took Coumadin for a mechanical heart valve.
-She took Coumadin once a day.
-MAs administered her Coumadin.
-She did not remember missing a dose.

Telephone interview with Resident #4's PCP on 10/31/19 at 11:32 am revealed:
-Resident #4 was prescribed Coumadin for mitral valve replacement.
-She did not know Coumadin was not administered to Resident #4 for 3 doses in August

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2019, 7 doses in September 2019, and 3 doses in October 2019.
-She did not know Coumadin was not administered as ordered to Resident #4 for 21 doses in August 2019 and 11 doses in September 2019.
-Coumadin was a very important medication to monitor, and every time Coumadin was administered, medication aides should have verified the time Coumadin was administered and that the correct dose was administered.
-There were serious side effects if Coumadin was not administered correctly, and the risk for side effects was why she was checking Resident #4's INR so frequently when Resident #4 used to be checked once a month.
-She did not see any side effects, like bleeding with Resident #4.
-If Coumadin was administered more than the ordered dose, Resident #4 could have bleeding anywhere in the body.
-If Coumadin was administered below the ordered dose, Resident #4 could have a blood clot in the mitral valve.
-The frequency of Resident #4's INR lab test increased over the past two months because Resident #4's INR results were not stable.
-Her goal for Resident #4's INR was 2 to 3.5.
-She expected staff to administer Resident #4's Coumadin based on the handwritten and verbal orders in August 2019, September 2019, and October 2019.
-Coumadin orders were verbally given to the Administrator and the first shift supervisor.

Interview with the Administrator on 10/31/19 at 11:40 am revealed:
-If Resident #4's INR results were sent to the PCP late on a Friday, the PCP may not reply, and the Administrator would not get an order until late

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that evening or the next day.
-She was the only one that received Resident #4's Coumadin orders from Resident #4's PCP in August 2019, September 2019, and October 2019.
-She was the only one that processed Resident #4's Coumadin orders in August 2019, September 2019, and October 2019.
-If she needed clarification on Resident #4's Coumadin order, she verbally told medication aides (MAs) to hold Resident #4's Coumadin dose until she heard from the PCP.
-When she told MAs to hold Resident #4's Coumadin, she meant for the MA to hold Resident #4's Coumadin for thirty minutes until she got clarification from the PCP.
-When an order for Resident #4's Coumadin was sent to the pharmacy, the pharmacy would put the previous Coumadin order on hold in the eMAR in order to start the new Coumadin dose.
-The Coumadin order would need to be approved in the eMAR before the medication would be available for documentation in the eMAR.
-She was the only one to approve Resident #4's Coumadin orders in the eMAR in August 2019, September 2019, and October 2019.
-She would approve Resident #4's Coumadin order as soon as it was available on the eMAR, which was usually the next day.
-When Resident #4's Coumadin order changed, there were only two MAs working the cart at the time, and the Administrator would verbally tell the MAs the Coumadin order.
-She would not wait for the Resident #4's Coumadin order to be available in the eMAR; she would verbally tell the MAs to either hold Resident #4's Coumadin or administer the ordered dose that was not showing in the eMAR.
-She only needed to tell the MA working the cart at the time of the order change because Resident

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D 358	Continued From page 38 #4 received her Coumadin once daily and then the Coumadin order would be on the eMAR. -If Resident #4 was ordered Coumadin 5 mg, and a 5 mg tablet was not on hand, she would tell MAs to administer five 1 mg tablets. -The Administrator told the MA's to administer leftover Coumadin, totaling to the ordered dose, and document the dose administered in the comment section in the eMAR. -She did not know the MAs did not use the comment section in the eMAR to document different doses administered in August 2019, September 2019, and October 2019. -If the Coumadin order changed for Resident #4, and the order was not approved in the eMAR, the medication should never be held and should be administered at the current dose ordered by the PCP. -She kept Resident #4's extra Coumadin cards in case Resident #4 needed them and if Resident #4 had dose changes. -In August 2019 and September 2019, Resident #4's Coumadin orders were changing so frequently and Resident #4's INR results were "good" up until September 2019, and then Resident #4's "INR was being checked every other day." -She knew Coumadin was a blood thinner, but she did not know why Resident #4 was taking Coumadin. -She knew she needed to make sure Resident #4 took her Coumadin, and if Resident #4 did not receive her Coumadin as ordered, Resident #4's PCP should have been notified immediately. -MAs should contact Resident #4's PCP if Coumadin was not administered as ordered. -MAs were not allowed to hold Resident #4's Coumadin without an order. -The RCC was now responsible for Resident #4's INR and Coumadin.	D 358		

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D 358	Continued From page 39 -She did not audit Resident #4's record or eMAR. -Resident records and eMARs were audited randomly by a representative from corporate and she did not know the last time Resident #4's record and eMAR were audited. -She did not notice any health changes or bleeding with Resident #4 in August 2019, September 2019 and October 2019. -She expected MAs to document medication administration on the eMAR. Interview with a medication aide (MA) on 10/31/19 at 12:56 am revealed: -She administered medications to Resident #4. -She knew Resident #4 had frequent Coumadin order changes in August 2019, September 2019 and October 2019. -For a while, she would ask the Administrator for the exact dose of Coumadin to administer to Resident #4. -There was a lot of "back and forth" between the Administrator and the Primary Care Provider (PCP) and waiting on the PCP to change Resident #4's Coumadin dose. -She did not think she was told to administer a Coumadin dose different than what was on the eMAR. -In the past, Resident #4 was ordered 6 mg of Coumadin and she had administered six 1 mg tablets of Coumadin to total a 6 mg dose. -The Administrator instructed the MA to administer a combination of Coumadin doses to total to the ordered dose and document the dose administered in the comment section in the eMAR. -She did not know the exact dates when she administered a combination of Coumadin tablets, but it had been a few weeks. -She could not say if any MA ever documented the Coumadin dose administered to Resident #4	D 358		

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D 358	Continued From page 40	D 358		

in the comment section in the eMAR.
-The "comment section" was the same as the note section on the eMAR.
-She, as a MA, would not make the judgement to hold Resident #4's Coumadin without an order.
-She administered medications to Resident #4 based on the eMAR and based on instructions from the Administrator.
-If Coumadin was held, the MA would need to notify the PCP.
-She never held Resident #4's Coumadin unless she was told to do so by the Administrator.
-She documented in the eMAR she administered 1 mg of Coumadin to Resident #4 on 08/11/19 and 6 mg of Coumadin to Resident #4 on 08/22/19 and 08/29/19.
-She did not remember if she administered a different dose to Resident #4 on 08/11/19, 08/22/19, and 08/29/19 and she did not document a dose in the comment section in the eMAR.
-She knew it was critical for Resident #4 to receive her Coumadin because it was a blood thinner.
-She did not know why Resident #4 took Coumadin.
-If Resident #4's Coumadin was not documented in the eMAR, then it was not administered.
-She did not see any bleeding or bruising with Resident #4 in August 2019, September 2019, and October 2019.
-She never attended an in-service training on Coumadin.
-MAs did not approve orders on the eMAR.
-The RCC was responsible for auditing the eMARs.
-A representative from corporate also audited the eMARs and the last audit was two to three weeks ago.

Telephone interview with first shift supervisor on

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D 358	Continued From page 41 10/31/19 at 12:56 pm revealed: -She administered medications, processed medication orders, received medication orders, faxed orders to the pharmacy, and audited medication carts. -She worked directly with Resident #4 and she administered Resident #4's Coumadin. -She used the eMAR to know what medications to administer to Resident #4 and she would document medication administration on the eMAR. -If she ever had an issue with a medication, she would call the pharmacy first and then she would notify the RCC. -The PCP told her to hold Resident #4's Coumadin about a month and a half to two months ago. -The only time Resident #4's Coumadin was held was when there was an order from the Primary Care Provider (PCP). -She did not know Coumadin was not documented as administered for 3 doses in August 2019, 7 doses in September 2019, and 3 doses in October 2019. -She did not know Coumadin was not documented and administered as ordered for 21 doses in August 2019 and 11 doses in September 2019. -The Administrator told her to administer Resident #4's Coumadin using a combination of tablets to total the dose ordered; for example, six tablets of 1 mg to equal the ordered 6 mg of Coumadin. -The MAs did not administer a combination of tablets to Resident #4 "that often". -She did not know where the MAs should document the Coumadin doses administered to Resident #4. Third interview with the RCC on 10/31/19 at 4:30 pm revealed:	D 358		

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D 358	Continued From page 42 -MAs, supervisors, the RCC, and the Administrator sent medication orders to the pharmacy. -The RCC and the Administrator were the only staff that could approve Coumadin orders for Resident #4. -The first shift supervisor was responsible for Coumadin before the RCC started in October 2019. -When Resident #4 received a new order for Coumadin, the pharmacy would discontinue the previous Coumadin order and the new Coumadin had to be approved by the Administrator before it could be started; the new order took two days to start on the September 2019 eMAR. -On the September 2019 eMAR, Resident #4's Coumadin showed discontinued over two days when it should have taken one day to discontinue and for the new Coumadin order to start. -The Administrator, the RCC, and the MAs were responsible for ensuring Resident #4 received her Coumadin daily. Second interview with the Administrator on 10/31/19 at 4:35 pm revealed: -She was the only one that received Resident #4's Coumadin orders from the PCP. -The supervisor had the ability to approve medication orders in the eMAR. -The supervisors did not have anything to do with Resident #4's Coumadin orders. -The RCC was now responsible for Resident #4's INR and Coumadin orders. -If the Coumadin order changed and the pharmacy discontinued the previous order, the MA had no active order on the eMAR and the MAs did "not have anything to go off of." -Resident #4 was supposed to receive Coumadin every day unless she previously told the MAs to hold Resident #4's Coumadin.	D 358		

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D 358	Continued From page 43 -The pharmacy needed to put an active Coumadin order for the same day the previous dose was discontinued. -She solely relied on the pharmacy to modify the eMAR and she was now looking at having the RCC and the Administrator modify orders in the eMAR. The facility failed to assure medications were administered as ordered for Resident #4 resulting in errors of administration of Coumadin resulting in abnormal INR results; and could have resulted in bleeding anywhere in Resident #4's body and a blood clot. 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 for this violation in accordance with G.S. 131D-34 on 10/31/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 17, 2019.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of	D 375		

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D 375	Continued From page 44 prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 5 sampled residents (#5) had physicians' orders to self-administer a nebulizer. The findings are: Review of Resident #5's current FL2 dated 11/16/18 revealed: -The diagnoses included chronic obstructive pulmonary disease (COPD), essential hypertension, chronic pain syndrome, restlessness and agitation, major depressive disorder, difficulty walking, and dependent on supplemental oxygen. -An order for Ipratropium Bromide and Albuterol Sulfate (a medication used to treat COPD) 0.5-2.5 3mg/3ml, inhale orally via nebulizer three times a day. Review of Resident #5's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Ipratropium and Albuterol nebulizer solution, inhale 1 vial via nebulizer three times a day scheduled at 6:00 am, 12:00 pm, and 5:00 pm. -Staff documented the resident self-administered the Ipratropium/Albuterol 40 of 93 opportunities. Review of Resident #5's September 2019 eMAR revealed: -There was an entry for Ipratropium and Albuterol	D 375		

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nebulizer solution, inhale 1 vial via nebulizer three times a day scheduled at 6:00 am, 12:00 pm, and 5:00 pm.
-Staff documented the resident self-administered the Ipratropium/Albuterol 8 of 90 opportunities.

Review of Resident #5's October 2019 eMAR revealed:
-There was an entry for Ipratropium and Albuterol nebulizer solution, inhale 1 vial via nebulizer three times a day scheduled at 6:00 am, 12:00 pm, and 5:00 pm.
-Staff did not document the resident self-administered the Ipratropium/Albuterol from 10/01/19 through 10/30/19.

Review of Resident #5's record revealed no physician's order to self-administer Ipratropium and Albuterol or a self-administration assessment.

Observation of Resident #5's room on 10/31/19 at 4:30 pm revealed:
-There was a nebulizer machine and Ipratropium and Albuterol located in the closet.
-The Ipratropium and Albuterol was dispensed on 01/23/18 with 16 vials remaining
-The label had instructions to inhale 3 ml orally every 6 hours and inhale 3 ml orally every 2 hours as needed for shortness of breath.

Telephone interview with a representatve from the facility's contracted pharmacy on 10/31/19 at 12:05 pm revealed:
-The current order was for Ipratropium Bromide and Albuterol Sulfate 0.5-2.5 3mg/3ml, inhale orally via nebulizer three times a day.
-There was no order to self-administer.
-There were 90 vials of Ipratropium and Albuterol last dispensed on 01/23/18.

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D 375	Continued From page 46 Interview with Resident #5 on 10/31/19 at 4:35 pm revealed: -Staff did not administer Ipratropium and Albuterol three times a day. -She kept the Ipratropium and Albuterol in her room and administered once daily. Interview with a first shift medication aide (MA) on 10/31/19 at 12:50 pm revealed: -The Ipratropium and Albuterol was kept on the medication cart and the MA set up the nebulizer for Resident #5. -She did not know why the Ipratropium and Albuterol was not on the medication cart. -She set up the Ipratropium and Albuterol nebulizer and Resident #5 completed the treatment. Interview with a first shift MA/Supervisor on 10/31/19 at 1:05 pm revealed: -She observed Resident #5 self-administer the Ipratropium and Albuterol. -She did not know if Resident #5 had a self administer order. -She did not normally work on Resident #5's hall. Interview with the Resident Care Coordinator (RCC) on 10/31/19 at 4:00 pm revealed: -She knew Resident #5 was ordered a nebulizer treatment. -She did not know Resident #5 self-administered Ipratropium and Albuterol. -She thought the Ipratropium and Albuterol was on the medication cart. -She thought the MA set up the Ipratropium and Albuterol treatment for Resident #5. -She did not know if Resident #5 had an order to self-administer.	D 375		

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D 375	Continued From page 47 Interview with a second shift MA on 10/31/19 at 4:45 pm revealed: -She did not know why the Ipratropium and Albuterol was not on the medication cart. -She would re-order the Ipratropium and Albuterol. -She did not know the Ipratropium and Albuterol was in Resident #5's room. -Staff must have used the last dose of the Ipratropium and Albuterol on first shift. -She may have documented Resident #5 self-administered the Ipratropium and Albuterol because she set up the treatment, but the resident completed the treatment herself. -Before he documented the Ipratropium and Albuterol was administered she would ask Resident #5 if she had administered it. -She did not know if Resident #5 had a self-administer order. -She knew a self-administer order was required if Resident #5 was self-administering the nebulizer. Interview with the Administrator on 10/31/19 at 4:50 pm revealed: -She did not know Resident #5 was ordered a nebulizer. -She did not know who administered Resident #5 the Ipratropium and Albuterol. -She did not know Resident #5 kept the Ipratropium and Albuterol in her room. -She expected staff to administer all medications as ordered. -She did not know if Resident #5 had a self-administer order for Ipratropium and Albuterol. -She knew a self administer order was required. Telephone interview with Resident #5's Primary Care Provider (PCP) on 10/31/19 at 4:47 pm revealed:	D 375		

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D 375	Continued From page 48 -Resident #5 was last seen by the PCP on 10/29/19. -Resident #5 was prescribed Ipratropium and Albuterol for COPD. -She expected the staff to administer the Ipratropium and Albuterol. -She did not know Resident #5 was self-administering the Ipratropium and Albuterol. -If Resident #5 did not receive the Ipratropium and Albuterol as ordered she could experience a COPD exacerbation.	D 375		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services that were adequate, appropriate and in compliance with 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 assure medications were administered as ordered by the licensed	D912		

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D912	Continued From page 49 prescribing practitioner for 1 of 5 sampled residents related to errors with administration of a blood thinner (#4). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		