Jones, Marie A

From: Neal, Ronnie <ronnie.neal@carillonassistedliving.com>
Sent: Friday, November 15, 2019 10:59 AM
To: Jones, Marie A
Subject: [External] RE: Carillon Assisted Living of Knightdale 2019-10-16 SOD 38HO13
Attachments: Plan of Correction.pdf

Ms. Jones,

Please find attached our Plan of Correction for the follow-up survey on October 16, 2019. Thank you and have a great day.

Respectfully,

Ronnie Neal
Executive Director
PH: (919) 266-6676

From: Jones, Marie A [mailto:marie.jones@dhhs.nc.gov]
Sent: Friday, November 1, 2019 4:58 PM
To: Neal, Ronnie
Cc: Catherine Goldman; tworek, dai; Conley, Theresa L; dhsr.adultcare.email7
Subject: Carillon Assisted Living of Knightdale 2019-10-16 SOD 38HO13

Dear *Ms. Moriarty*:

Please find the Statement of Deficiencies and accompanying letter for the follow-up survey on October 16, 2019 attached to this e-mail. If the Statement of Deficiencies includes citations or violations for which a plan of correction is required, please read the attached letter carefully for instruction on completing the plan of correction. **PLEASE NOTE: WE WILL NOT ACCEPT A FAXED PLAN OF CORRECTION! We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is SIGNED AND DATED or it will not be accepted.** A response to the plan of correction will be sent ONLY if the plan of correction is not approved. Please retain a copy for your files.

The attached letter also contains information regarding your right to request an Informal Dispute Resolution (IDR) of any cited deficiencies or violations. For more information about the IDR process please visit our website at http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have any questions regarding the information provided in or attached to this email, please call me at(919) 817-4384. Please be aware that information sent via electronic mail is immediately available for release to the public. Therefore, the information contained in and attached to this e-mail is now public information.

Sincerely,

Marie A. Jones RN, BSN

Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

STAR RATING

If the Statement of Deficiencies attached to this email is a result of an annual, follow-up or complaint inspection a star rating certificate and worksheet will be issued within 45 days of the date of this email. If you would like to know more information about the NC Star Rated Certificate Program or view facility ratings, please visit the star rating website at http://www.ncdhhs.gov/dhsr/acls/star/index.html. If you have questions about this facility's star rating or the rating program in general, please send an email with your questions to the star rating customer service email address at DHSR.AdultCare.Star@dhhs.nc.gov

Marie A. Jones RN, BSN
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2708 Mail Service Center
Raleigh, NC 27699-2708

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
	HAL092166	A. BUILDING: _____ B. WING _____	R-C 10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

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{D 000}	Initial Comments The Adult Care Licensure Section and Wake County Human Services conducted a follow-up survey on October 15, 2019 to October 16, 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 and in accordance with the facility's policies for 2 of 5 residents (#6, #7) observed during the medication passes including errors with an antipsychotic (#6), two inhalers for breathing problems (#6), a vitamin D supplement (#6), a calcium with vitamin D supplement (#7), and a medication for overactive bladder (#7).	{D 358}	Plan: Carillon of Knightdale will assure medications are prepared and administered in accordance with prescribed orders. Medication Aids will receive additional training regarding appropriate technique for administration of medications, including proper use of inhalers, and recognizing expired medications. Monitoring System: The Executive Director, Resident Care Director, Resident Care Coordinator and/or Regional Nurse will randomly perform med pass reviews with Med Techs to review technique and assure compliances are maintained. Additional training will be provided as warranted.	11/30/19

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

[signature], Executive Director — 11-14-19

Reviewed and accepted
MAT 12/19/19

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{D 358}	Continued From page 1 The findings are: 1. The medication error rate was 19% as evidenced by the observation of 6 errors out of 31 opportunities during the 2:00pm medication pass on 10/15/19 and the 8:00am/9:00am medication passes on 10/16/19. a. Review of Resident #6's current FL-2 dated 08/13/19 revealed: -Diagnoses included Alzheimer's dementia without behavioral disturbance, accelerated hypertension, depression, hyperlipidemia, coronary artery disease, and chest pain. -There was an order for Breo Ellipta 100-25mcg dose inhaler, inhale 1 puff once daily. (Breo Ellipta is used to treat chronic obstructive pulmonary disease and asthma in adults.) -There was an order for Incruse Ellipta 62.5mcg dose inhaler, inhale 1 puff once daily. (Incruse Ellipta is used to treat chronic obstructive pulmonary disease.) [Breo Ellipta and Incruse Ellipta are dry powder inhalers used to deliver medications deep into the lungs. These types of inhalers are breath-activated requiring a deep, fast breath to release the medication from the device and into the lungs. According to the manufacturer, Breo Ellipta and Incruse Ellipta require the cover lids to be opened and slid all the way down until a "click" is heard. The "click" will release a dose into the chamber and decrease the counter by 1 number, indicating the inhaler is ready to use. Before using the inhaler, exhale fully, then close mouth around the mouthpiece and take 1 long, steady deep breath through the mouth. Hold breath in for 3 to 4 seconds then breathe out slowly and gently. Both inhalers expire 6 weeks after	{D 358}		

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{D 358}	Continued From page 2 opening.] Review of Resident #6's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Breo Ellipta 100-25mcg inhale 1 puff once daily with a scheduled administration time of 8:00am. -There was an entry for Incruse Ellipta 62.5mcg inhale 1 puff once daily with a scheduled administration time of 8:00am. Interview with the medication aide (MA) on duty in the special care unit (SCU) on 10/16/19 at 8:30am revealed: -She usually worked third shift but she was filling in for the first shift MA that morning (10/16/19). -Resident #6 had two inhalers she was going to receive that morning (10/16/19). -The first shift MA had told her that Resident #6 was not "breathing in" with the inhalers like she was supposed to do. -She did not know if the first shift MA had reported it to anyone else or notified the resident's primary care provider (PCP). Observation of the 8:00am/9:00am medication pass on 10/16/19 revealed: -At 8:34am, the MA opened the cover lid to Resident #6's Incruse Ellipta 62.5mcg inhaler. -The MA did not slide the cover lid all the way to the bottom of the device and no click was heard. -The counter on the Incruse inhaler remained on 10. -The MA did not have the resident to exhale prior to putting the mouthpiece in the resident's mouth. -The resident took a quick shallow breath in but did not hold her breath. -The MA did not instruct the resident to breath in deeply or hold her breath.	{D 358}		

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{D 358}	Continued From page 3 -The MA told the resident to do it again. -The resident took a second quick shallow breath in but did not hold her breath and she was not instructed by the MA. -The MA closed the cover lid on the Incruse Ellipta inhaler. -At 8:35am, the MA opened the cover lid to Resident #6's Breo Ellipta 100-25mcg inhaler. -The MA did not slide the cover lid all the way to the bottom of the device and no click was heard. -The counter on the Breo inhaler remained on 10. -The MA did not have the resident to exhale prior to putting the mouthpiece in the resident's mouth. -The resident took a quick shallow breath in and did not hold her breath. -The MA did not instruct the resident to breath in deeply or hold her breath. -The resident took a second quick shallow breath in but did not hold her breath and she was not instructed by the MA. -The MA closed the cover lid on the Breo Ellipta inhaler. Observation of Resident 6's inhalers on 10/16/19 at 8:40am revealed: -The Breo Ellipta and Incruse Ellipta inhalers were dispensed on 07/17/19, with a 30-day supply. -The counter on both inhalers remained at 10, the same as prior to the MA attempting to administer the inhalers. -There was a sticker on the box of each inhaler with a handwritten open date of 08/03/19 indicating the inhalers expired 6 weeks after opening. A second interview with the MA on duty in the SCU on 10/16/19 at 8:40am revealed: -The counter on the Breo Ellipta and Incruse Ellipta inhalers was on 10 for both inhalers before	{D 358}		

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{D 358}	Continued From page 4 she administered them to Resident #6 and they remained on 10 afterwards. -She was not aware she was supposed to pull the cover lid all the way down the side of the inhaler device until she heard a click. Observation during the medication pass on 10/16/19 at 8:42am revealed: -The MA opened the cover lid to the Breo Ellipta inhaler and pulled it all the way down until a click was heard. -The counter on the inhaler changed to 9. -The MA put the mouthpiece to Resident #6's mouth but the resident only inhaled slightly and did not appear to get a deep inhalation of the medication. -The MA did not instruct the resident to breath in deeply or hold her breath. -The MA put both inhalers back in the medication cart and did not attempt to administer them anymore. Observation and interview of Resident #6 on 10/16/19 at 8:48am revealed: -The resident had walked down the hall from the living room to her bedroom. -The resident sat on the side of her bed and was breathing short rapid breaths. -The resident stated she felt short of breath. -She could not answer questions about her medications, including her inhalers. A third interview with the MA on duty in the SCU on 10/16/19 at 12:29pm revealed: -She usually worked on third shift and did not normally administer morning medications. -She had never administered the Breo Ellipta or Incruse Ellipta inhalers to Resident #6. -She did not pull the cover lids of Resident #6's Breo Ellipta or Incruse Ellipta all the way down	{D 358}		

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{D 358}	Continued From page 5 that morning (10/16/19 at 8:34am and 8:35am) and she did not hear them click. -She asked the resident to do 2 puffs with each inhaler because the resident's breath was weak and the counter did not decline on either inhaler. -The counter on both inhalers stayed on 10 after the resident completed 2 puffs on each inhaler (on 10/16/19 at 8:34am and 8:35am). -Sometimes when she helped Resident #6 go to the bathroom on third shift, the resident would have shortness of breath. -She had never seen Resident #6 as short of breath as she was that morning on 10/16/19. -She did not notice the inhalers had expired when she administered them that morning (10/16/19). -The first shift MAs usually audited the carts and ordered the medications. Telephone interview with a second MA on 10/16/19 at 5:07pm revealed: -She usually worked first shift and administered morning medications to Resident #6, including the Breo Ellipta and Incruse Ellipta inhalers. -She usually slid the cover lid down and the counter would decline by 1 count. -She had no problems with the getting the counter on the inhaler to go down. -The resident usually inhaled a deep breath when she administered the inhalers. -She did not recall having or voicing any concerns to anyone about the way Resident #6 used the inhalers. -She had not noticed the inhalers had expired. -Resident #6 sometimes got short of breath when the resident walked down the hall. Interview with a third MA on 10/16/19 at 5:48pm revealed: -She had administered the inhalers to Resident #6 at times when she was working in the SCU as	{D 358}		

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{D 358}	Continued From page 6 a MA. -She would pull the cover lid all the way down and heard it click before she had the resident to inhale. -The counter would decline by 1 count after she opened the cover lid and heard the click. -Sometimes Resident #6 would inhale a full breath but sometimes the resident would only inhale a half breath depending on the resident's mood. -She had never seen Resident #6 short of breath. Review of Resident #6's pharmacy dispensing records dated 05/01/19 - 10/16/19 revealed: -There was 1 Breo Ellipta inhaler (30-day supply) dispensed on 05/07/19, 07/17/19, and 10/16/19. -There was 1 Incruse Ellipta inhaler (30-day supply) dispensed on 05/17/19, 07/17/19, and 10/16/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/16/19 at 4:18pm revealed: -The facility did not receive monthly cycle fills, so the facility staff had to reorder medications when needed for refills. -They dispensed one Breo Ellipta and one Incruse Ellipta inhaler on 07/17/19, which was a 30-day supply of each medication. -The pharmacy did not receive another refill request for either inhaler until today, 10/16/19. Interview with the Resident Care Coordinator (RCC) on 10/16/19 at 1:25pm revealed: -The MAs were trained on the proper use of inhalers by a registered nurse during medication training upon hire and the MAs should know how to use the inhalers. -The MAs had not reported any concerns with Resident #6's inhaler use.	{D 358}		

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{D 358}	Continued From page 7 -She and the MAs conducted cart audits weekly including identifying any expired medications. -She had not noticed Resident #6's inhalers had expired when she conducted weekly cart audits. -Resident #6's Breo Ellipta and Incruse Ellipta inhalers should have already been empty before they expired since the inhalers were opened on 08/03/19 and they were 30-day supplies. -She had not noticed Resident #6 having any shortness of breath. -She would contact Resident #6's PCP about the errors with the two inhalers. Interview with the Resident Care Director (RCD) on 10/16/19 at 1:25pm revealed: -The MAs had been trained on the proper use of inhalers during medication training upon hire. -The MAs had not reported any concerns with any resident's use of inhalers. -The MAs conducted cart audits weekly which should include identifying any expired medications. -Resident #6's Breo Ellipta and Incruse Ellipta inhalers should have already been empty since the inhalers were opened on 08/03/19 and they were 30-day supplies. Telephone interview with a nurse at Resident #6's PCP's office on 10/16/19 at 4:36pm revealed: -Resident #6's PCP was unavailable for interview. -Their office had not been notified of any concerns on Resident #6's use of the Breo Ellipta or Incruse Ellipta inhalers. -The resident should receive both inhalers once daily as ordered. -Not receiving the inhalers as ordered could contribute to the resident's shortness of breath. -They last saw the resident during a visit on 09/18/19 and she did not notice the resident having any shortness of breath at that time.	{D 358}		

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{D 358}	Continued From page 8 b. Review of Resident #6's physician's order dated 09/23/19 revealed there was an order for Risperidone 0.25mg twice daily before breakfast and at bedtime. (Risperidone is an antipsychotic.) Review of Resident #6's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Risperidone 0.25mg take 1 tablet twice a day before breakfast and at bedtime. -Risperidone was scheduled to be administered at 7:30am and 8:00pm. -Risperidone was documented as administered from 10/01/19 - 10/15/19. Observation of the 8:00am/9:00am medication pass on 10/16/19 revealed: -Resident #6 was in the dining room and had already finished eating breakfast. -The medication aide (MA) administered Risperidone 0.25mg to the resident at 8:35am after breakfast instead of before breakfast as ordered. Interview with the MA on 10/16/19 at 12:29pm revealed: -If a medication was ordered before breakfast, it should be administered before the resident has eaten. -She saw on the eMAR that Resident #6's Risperidone was ordered to be given before breakfast, but the resident had already eaten breakfast. -She was running behind with the morning medication pass because she usually worked on third shift and did not usually administer morning medications.	{D 358}		

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{D 358}	Continued From page 9 Interview with the Resident Care Coordinator (RCC) on 10/16/19 at 1:21pm revealed: -Breakfast was usually served at 8:00am. -Medications ordered before breakfast should be administered 30 minutes to 1 hour before the meal. -The MAs had been trained on when medications should be administered. Attempted telephone interview with Resident #6's primary care provider (PCP) on 10/16/19 at 4:36pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable. c. Review of Resident #6's current FL-2 dated 08/13/19 revealed there was an order for Vitamin D3 1000units 1 tablet every day. (Vitamin D is a supplement.) Review of Resident #6's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D3 1000units take 1 tablet every day with a scheduled administration time of 9:00am. -Vitamin D was documented as administered from 10/01/19 - 10/15/19. Interview with the medication aide (MA) on 10/16/19 at 8:31am revealed: -Resident #6 did not have any Vitamin D in the medication cart available for administration, including the back-up supply. -There was no empty bubble card for the Vitamin D in the medication cart so it had probably been reordered.	{D 358}		

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{D 358}	Continued From page 10 -She would let the Resident Care Coordinator (RCC) know about the Vitamin D. Observation of the 8:00am/9:00am medication pass on 10/16/19 revealed: -The MA prepared and administered morning medications to Resident #6 at 8:36 am. -The MA did not administer Vitamin D as ordered to Resident #6 because the medication was unavailable. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/16/19 at 4:17pm revealed: -Resident #6's Vitamin D was last dispensed on 08/30/19 with a 30-day supply. -The facility did not receive cycle fills and had to order medications by fax or through the eMAR. -The pharmacy received a faxed request to refill Vitamin D on 10/09/19. -She did not know why the refill request on 10/09/19 had not been dispensed. -The pharmacy did not receive another request to refill the Vitamin D until today (10/16/19). -A 30-day supply of Vitamin D would be delivered to the facility this evening. Review of Resident #6's pharmacy dispensing record for 05/01/19 - 10/16/19 revealed 30 tablets of Vitamin D3 1000 units were dispensed on 05/12/19, 06/13/19, 07/19/19, 08/30/19, and 10/16/19. A second interview with the MA on 10/16/19 at 12:29pm revealed: -The MAs were responsible for ordering medications. -She usually reordered medications after she administered the last pill in the bubble card.	{D 358}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 11 Interview with the RCC on 10/16/19 at 1:25pm revealed: -The MAs were responsible for ordering medications. -The MAs could either fax refill requests or reorder using the eMAR. -The MAs should reorder when there was a 14-day supply remaining. -If it was too soon to refill at that time, the pharmacy could send the medication as soon as the insurance would pay for it. -Resident #6's Vitamin D was ordered by fax request on 10/09/19. -She did not know why it was not received by the facility when ordered on 10/09/19. -If a medication was not received, the MAs should contact the pharmacy. -She reordered Resident #6's Vitamin D today (10/16/19.) Based on the observations, interviews, and record reviews, it was determined Resident #6 was not interviewable. Attempted telephone interview with Resident #6's primary care provider (PCP) on 10/16/19 at 4:36pm was unsuccessful. d. Review of Resident #7's current FL-2 dated 01/03/19 revealed: -Diagnoses included bursopathy, epilepsy, major depressive disorder, osteoporosis, edema, hypertension, insomnia, and impetigo. -There was an order for Trospium 20 mg twice daily before meals. (Trospium is used to treat overactive bladder.) Review of Resident #7's October 2019 electronic medication administration (eMAR) revealed: -There was an entry for Trospium 20mg take 1	{D 358}		

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	HAL092166	A. BUILDING: _____ B. WING _____	R-C 10/16/2019

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{D 358}	Continued From page 12 tablet twice a day before meals with scheduled administration times of 9:00am and 4:30pm. -Trospium was documented as administered from 10/01/19 - 10/15/19. Interview with the Resident Care Coordinator (RCC) on 10/16/19 at 10:45am revealed: -She was working as a medication aide and administering medications for residents on A Hall. -Breakfast was served in the dining room at 8:00am. -Resident #7 did not usually go to dining room for breakfast. -Resident #7 preferred to sleep late and eat snacks in her room for breakfast. Observation of the 8:00am/9:00am medication pass on 10/16/19 revealed: -Resident #7 was administered Trospium 20mg at 10:52am, 52 minutes beyond the allowed time frame. -Trospium was administered to the resident after breakfast instead of before breakfast as ordered. Interview with Resident #7 on 10/16/19 at 12:54pm revealed: -She preferred getting her morning medications later because she liked to sleep late and watch television. -She usually ate breakfast in her room in the mornings around 8:45am or 9:00am. -She ate a protein bar and drank milk that morning (10/16/19) for breakfast around 9:00am or 9:30am. A second interview with the RCC on 10/16/19 at 1:06pm revealed: -Resident #7 usually ate breakfast in her room. -There were times when Resident #7 did not eat breakfast.	{D 358}		

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{D 358}	Continued From page 13 -Resident #7 ate breakfast in her room that morning (10/16/19) around 9:00am or "a little after" 9:00am. -She was aware Resident #7's Trospium was supposed to be administered before meals. -Resident #7 liked to sleep late in the morning and she would not take her medications until late morning. -She attempted to contact the primary care provider (PCP) to get Resident #7's scheduled medication times changed a few months ago. -She had not attempted to reach the PCP since then and she had not documented her previous attempts to reach the PCP. Interview with a nurse at Resident #7's PCP's office on 10/16/19 at 4:51pm revealed: -She would let the PCP know about the error with Resident #7's Trospium. -Medications were expected to be administered as ordered by the PCP. e. Review of Resident #7's current FL-2 dated 01/03/19 revealed Calcium + Vitamin D3 600/200 1 tablet twice daily. (Calcium +Vitamin D3 is a supplement.) Review of Resident #6's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Calcium + Vitamin D3 600/200 take 1 tablet by mouth twice a day with scheduled administration times of 9:00am and 9:00pm. -Calcium + Vitamin D3 was documented as administered from 10/01/19 - 10/15/19. Observation of the 8:00am/9:00am medication pass on 10/16/19 revealed: -The Resident Care Coordinator (RCC) prepared	{D 358}		

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{D 358}	Continued From page 14 and administered 10 pills to Resident #7 at 10:52am. -The RCC had pulled the bubble card with Calcium + Vitamin D3 600/200 tablet from the medication cart during preparation but did not punch one into the medication cup. -Calcium + Vitamin D3 was not administered as ordered when the resident received her other morning medications. -Surveyor intervened and asked the RCC about the Calcium + Vitamin D3 tablet. -After counting the morning medications and checking the eMAR and bubble cards, the RCC realized she did not punch the Calcium + Vitamin D3 into the medication cup. -The RCC then prepared one Calcium + Vitamin D3 tablet and administered it to the resident at 10:58am. Interview with the RCC on 10/16/19 at 10:56am revealed: -She usually administered Resident #7's Calcium + Vitamin D3 with the resident's other morning medications. -She forgot to punch the Calcium + Vitamin D3 tablet into the medication cup when she prepared Resident #7's morning medications. Interview with a nurse at Resident #7's primary care provider's (PCP) office on 10/16/19 at 4:51pm revealed: -She would let the PCP know about the error with Resident #7's Calcium + Vitamin D3. -Medications were expected to be administered as ordered by the PCP. The facility failed to administer medications as ordered for 2 of 5 residents observed during the medication passes resulting in a 19% medication error rate with 6 errors out of 31 opportunities.	{D 358}		

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{D 358}	Continued From page 15 Resident #6 did not receive two inhalers as ordered during the medication pass observed due to the MA failing to use proper technique when preparing and administering the inhalers. Resident #6 was observed to have shortness of breath after failing to receive the inhalers as ordered on 10/16/19. Both inhalers the MA attempted to administer were expired. Resident #6's inhalers were dispensed twice from 05/01/9 - 10/15/19, with a 30-day supply each time. There was only a two-month supply of each inhaler dispensed for a 5-month time period. There was a 10-day supply of each inhaler remaining on 10/16/19 from the 30-day supplies that were opened on 08/03/19. Resident #6 did not receive inhalers for chronic obstructive pulmonary disease once daily as ordered and the resident had shortness of breath. The failure of the facility to administer medications as ordered 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 10/16/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 30, 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.	D912	Plan: The community will ensure residents' rights are upheld through compliance with relevant federal and state laws, and their corresponding rules and regulations. [Refer to Plan of Correction for tag D 358, 10A NCAC 13F .1004(a)].	11/30/19

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D912	Continued From page 16 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 as related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 5 residents (#6, #7) observed during the medication passes including errors with an antipsychotic (#6), two inhalers for breathing problems (#6), a vitamin D supplement (#6), a calcium with vitamin D supplement (#7), and a medication for overactive bladder (#7). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		