STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	R-C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey and complaint investigation on February 18, 2020 - February 19, 2020.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the fact alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report. The Plan of Correction is prepared soley as a matter of compliance with State Law.	
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE A1 VIOLATION The Type A1 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#4) residing in a special care unit and based on assessed needs, resulting in a resident eloping from the facility without staff knowledge on 2 occasions. The findings are: Observation during the initial tour on 02/18/20 from 8:45am to 9:45am revealed the facilty was a	D 270	All magnetic exit doors are checked every shift by medication aide and checks are reviewed during morning meeting to ensure doors are secured and properly operating. In the event a door is found mechanically malfunctioning staff will secure and remain at the door until door is repaired. Additionally, Executive Director will be notified immediately.	4/3/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] EXEC, DOR — TITLE: ED — (X6) DATE: 3/23/2020

STATE FORM 6899 Q3IK11 If continuation sheet 1 of 22

* The Plan of Correction with Addendum was Reviewed and Accepted on 03/27/20, Refer to addendums On page 2 and 17 of this Statement of Deficiencies

[signature] (DH) 03/27/20

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D 270	Continued From page 1 free-standing special care unit (SCU). Review of Resident #4's current FL-2 dated 11/07/19 revealed: -The diagnoses included dementia, pain, history of fractured neck, and generalized weakness. -The recommended level of care was domiciliary and SCU. -Resident #4 was semi-ambulatory. -Resident #4 was constantly disoriented. Review of Resident #4's care plan dated 01/29/19 revealed: -Resident #4 was able to ambulate around the facility via wheelchair and interact with some of the other residents. -Resident #4 had wandering behavior. -Resident #4 was sometimes disoriented and forgetful. -Resident# 4 required hands on assist with activities of daily living including bathing, toileting, dressing, and mobility. Review of Resident #4's current Licensed Health Professional Support (LHPS) form dated 11/14/19 revealed: -The resident was alert and oriented to person and "pleasantly" confused. -Staff had reported the resident transferred independently and stand by assistance was required occasionally. -The resident self-propelled her wheelchair with occasional staff assistance. Review of Resident #4's progress notes revealed: -On 10/24/19 at 6:06pm, the resident was having behavior issues in the evenings "wanting to get out and go home" and wanting to call her parents to come and get her. The primary care provider (PCP) was notified.	D 270	D 270 (CONT) Any resident that has exit seeking behavior will be assessed by the primary care physician. Additionally, the resident will be referred to the psychiatry specialist for evaluation. The resident will be placed on increased supervision of 15/30 minute checks. All new hires will be trained on signs and symptoms of exit seeking behavior. D270 Addendum per telephone with Ms. Lisa Ashan 03/27/20: All Residents Supervision needs were reviewed by facility management at Risk meetings The Administrator Re-educated Staff regarding the facility's policy/procedures for Supervision Ongoing monitoring done by Daily review of residents' progress notes that are reviewed by facility management each morning. [signature] 03/27/20	

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D 270	Continued From page 2 -On 10/24/19 at 6:34pm, the resident's PCP gave an order to increase Ativan from 1 to 2 tablets and to send mental health an order to do an evaluation. (Ativan is a medication used to treat anxiety). -On 10/31/19 at 6:10 am, there was an edited entry created by the Executive Director (ED)/Administrator that a call was received at 2:08am "resident was exit seeking door at end of 200 hall"; the resident's wheelchair crossed over the threshold before staff redirected the resident back into the facility; the resident was placed on 15 minute checks and the ED went to the facility to verify the security of all exit doors. -On 10/31/19 at 1:49pm, the resident was still propelling herself around in the wheelchair trying to get to her parents. The resident continued to be on 15 minute checks. -On 11/02/19, at 4:02am, the resident got up at 3:30am stating she needed to leave to go get her children. The resident continued to state she needed to get to her car and was very anxious. After failed attempts to redirect the resident an as needed (PRN) Clonazepam was given at 4:00am. (Clonazepam is a medication used to treat anxiety and panic disorders). -On 11/02/19 at 2:37pm, the resident had a new order for a urinalysis. The urine sample was collected and sent to an outside laboratory. -On 11/03/19 at 8:02pm, the resident had mild behaviors, "nothing real major", and the resident had been trying to get out doors. -On 11/05/19 at 10:16am, staff continued to redirect the resident from exit seeking behavior by encouraging the resident to take part in daily activity of the day. -On 11/05/19, the residents urinalysis results were back and sent to the PCP who gave a verbal order for Bactrim one tablet twice daily for 7 days. (Bactrim is a medication used to treat	D 270		

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D 270	Continued From page 3 infection). -On 11/07/19 at 9:16 pm, the resident received a PRN due to her exit seeking behavior. -On 11/08/19 at 8:33pm, the resident received a PRN medication for behavior today, the resident was "upset" wanting to go home. The PRN was effective. -On 11/09/19 at 6:35am, the resident got up early and was a little confused. The resident did not know where her room was in order to go to the rest room. Review of Resident #4's record revealed there was no incident and accident report for the 10/31/19 elopement. Second review of Resident #4's progress notes revealed: -On 11/09/19 at 2:35 pm, there was an entry created by a medication aide (MA) the resident was taken to the facility's Monitoring Program this morning several times but the resident would not stay. The resident sat at the nurses station most of the day. "As gathering" residents for lunch, it was reported the resident had exited the building. The MA went out the activity room door and found Resident #4 lying in the grass of facility. Emergency Medical Services (EMS) was called and Resident #4 was sent to Emergency Room (ER). Review of the facility's Monitoring Program revealed: -The program included one staff (a personal care aide (PCA) or MA) assigned to at least one and no more than eight residents in a designated area. -The monitoring was assigned to these residents who were at high risk for falls, behaviors, or increased personal care needs.	D 270		

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D 270	Continued From page 4 -This would be based on care plans and assessments made by the LHPS nurse, protocols, Director of Resident Care, or ED/Administrator. -The goal was to provide a more one to one model with these residents requiring more frequent supervision or care. -The staff member assigned for the monitoring program would remain in place with these residents for the duration of the shift and would provide supervision as needed for the residents. -If a resident chose to leave the designated area, the floor staff would need to take the resident back to the floor or the residents' room and at that time the resident would be placed on 15 minute checks which would be completed by floor staff. Review of Resident #4's electronic Accident/Incident Report dated 11/09/19 revealed: -The time of the incident was 12:25 pm. -The location of the incident was outside on facility grounds. -There was no injury or pain noted. -The resident was taken to the ER. -Resident #4's family member was notified on 11/09/19 at 1:00 pm. -The PCP was notified on 11/09/19 at 12:45 pm. -The MA created the event on 11/09/19 at 3:26 pm. -The ED/Administrator closed the event on 11/10/19 at 11:46 am. Review of the EMS and Fire Report dated 11/09/19 revealed: -The call was received at 12:29 pm. -Resident #4 was fully dressed laying in the driveway entrance of the facility. -Staff relayed they did not know how she got out of the facility.	D 270		

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D 270	Continued From page 5 -Bystanders relayed Resident #4 fell out of the wheelchair but could not relay how she landed. -Resident #4 was fighting EMS while putting on the c-collar and being placed on a backboard. -Resident #4 relayed her neck and back hurt. -Staff relayed that Resident #4 always had back pain. -Resident #4 was alert to her name only. -Staff relayed this was Resident #4's baseline. -Resident #4's Injury/trauma was related to fall on hard surface. Review of an Emergency Department Encounter for Resident #4 dated 11/09/19 revealed: -The resident was seen for an unwitnessed fall. -In the history and physical information there was an entry the resident was "complaining of back pain achy constant worse with bending moving, nothing seems to make this better or worse...". EMS reported staff reported that the resident regularly complained of back pain prior to the fall. -The resident had a computed tomography (CT) scan of the brain and cervical spine which showed no abnormality and no fractures. (A CT scan is a diagnostic test using X-ray images taken from different angles around the body to show the bones, blood vessels and soft tissues inside the body). -The resident had a CT scan of the thoracic and lumbar spine which showed stable multiple thoracic and lumbar compressions deformities without any findings of a fracture. -The residents final impression was an accidental fall, lumbar strain and a head injury. Telephone interview with a MA on 02/19/2020 at 11:35am revealed: -She knew of a time when Resident #4 "got out" of the facility. -She did not know the date and was unsure of the	D 270		

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D 270	Continued From page 6 time when Resident #4 exited the facility. -She thought she was working and was about to leave. -She thought the time of day was close to 2:00pm or 3:00pm. -The resident slipped out of her wheelchair and was on the grass. -The resident never got to the paved road. -The resident got out through the back exit door to the activity room because there was defect in the door. -When Resident #4 exited the facility, that was the first time she knew of that the resident "got out" of the facility. -The facility placed a long pole with a flag on her wheelchair so the resident could be seen going from one end of the hall to the next. -The facility placed a "flappy thing like zip ties" on the wheels of the wheelchair so the resident could be heard when she rolled by staff. -The resident was placed in the Monitoring Program after she exited the facility. -She had seen Resident #4 go to the front door of the facility and push the door to see if it was unlocked and would look for her car outside. Interview with the Housekeeping Supervisor (HS) on 02/19/20 at 3:42 pm revealed: -The SCU exit door by the laundry room did not lock and the resident got out. -She was in the laundry room and heard a commotion. -Resident #4 was lying in the parking lot past the "big bush" but she could not see the resident. -A cook and a MA went outside to assist Resident #4. -She didn't know how long Resident #4 was lying outside. -She went through the door that was not locking and came to the end of the building then noticed	D 270		

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D 270	Continued From page 7 people around Resident #4. -Maintenance staff changed the lock that day around 1:00 pm because she was designated to stay at the door until it was fixed. -Administration was there and came outside. -Administration called Maintenance who came and changed the lock. -She did not recall the date. Interview with the Dining Services Manager on 02/19/20 at 3:50 pm revealed: -She was working the day Resident #4 eloped from the facility through the back door by the laundry room on 11/09/19. -The incident occurred around 12:30 pm as lunch was being served. -She heard chaos from the MAs as they were going outside. -She opened the kitchen door and observed Resident #4 lying in the grass. -Resident #4 was found by the service pole at the end of the parking area by the kitchen exit door. -She was not sure if the resident was on the side of the pole closest to the facility of close to the road. -She could not see the wheelchair but stated resident was always in a wheelchair. -She did not go out to the exact place where Resident #4 was found. -She estimated the distance from the facility to where Resident #4 was lying in the grass to be about 150 feet. -She went back inside to finish serving lunch. -Three staff members were outside with the resident. -The ED/Administrator came in shortly and stated there were issues with the back door. -The ED/Administrator put a sounding device and flags on the wheelchair following this incident.	D 270		

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D 270	Continued From page 8 Interview with the Resident Care Manager (RCM) on 02/19/20 at 3:05pm revealed: -Interventions were put in place the first time Resident #4 eloped on 10/31/19. -Door chimes were installed and Resident #4 was placed on 15-minute checks after 10/31/19. -She did not work the two times Resident #4 eloped on 10/31/19 and 11/09/19. -Resident #4 was placed on 15-minute checks and had a flag placed on her wheelchair as a visual aid for staff after the elopement on 11/09/19. -Resident #4 also had straws attached to wheelchair tires to generate noise in order to alert staff she was moving throughout the facility. Second interview with the RCM on 02/19/20 at 3:34pm revealed: -There were two incidences Resident #4 got out of the building. -She was not at the facility when it happened. -Lock checks were checked every shift by MAs after Resident #4 got out of the building on 11/09/19. -Somebody came out the same week or a few days before Resident #4 got out and checked the doors. -She was not sure how Resident #4 got out on 11/09/19 if the door locked. -There were no cameras in the facility. Interview with a MA on 02/19/20 at 3:53pm revealed: -Resident #4 was an exit seeker and would push on the doors at the facility. -She was completing her 15-minute checks when Resident #4 was noted to be out of the facility on 11/09/19. -Resident #4 had eloped from the facility and was found by a passerby laying on the ground on	D 270		

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D 270	Continued From page 9 11/09/19. -She saw Resident #4 on the ground with her wheelchair lying in the grass. -The ED/Administrator had to repair the door in which Resident #4 exited due to malfunction. -There was a gap between the door frame and the jam of the door, and the ED/Administrator had to get it repaired. -Resident #4 was transferred to a skilled nursing after the last elopement on 11/09/19. Interview with the Interim Care Manager (ICM) on 02/19/20 at 4:05pm revealed: -Resident #4 would go to the doors of the facility and pull on them. -Resident #4 had eloped twice from the facility, with the first time on 10/31/19. -On 11/09/19, while getting ready for the lunch meal a man came to the front door and said one of our residents got out. -She and other staff ran outside and Resident #4 was laying in the grass and the resident's wheelchair was there too. -She thought the people that saw Resident #4 outside called 911. -She called the ED/Administrator and the MA called the resident's family. -Resident #4 was not out "not long at all", and it could not have been more than 6-7 minutes. -She was not sure how Resident #4 got out. -She could not recall if Resident #4's wheelchair was turned over. -She could not recall the events from the elopement on 10/31/19 because she did not work that day. -The door was not locking and that was how Resident #4 got out. -Someone was responsible for standing at the defective door until it was repaired. -Staff would monitor the doors during shifts after	D 270		

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D 270	Continued From page 10 11/09/19 to ensure coverage of the defective door. -Resident #4 was on every 15 minute checks after 10/31/19 and things were placed on the wheels and a flag placed on the resident's wheelchair and these interventions remained in place on 11/09/19 when the resident got out. Interview with the Clinical Instructor (CI) on 02/19/20 at 4:38pm revealed: -Resident #4 resided on 200 hall which was located to the left of the nursing station. -Resident #4 could self-propel in her wheelchair, was independent with transfers from bed to wheelchair, independent with dressing, and required assistance of staff for bathing. -She had never witnessed Resident #4 display exit seeking behavior. -She was told on 11/01/19 by the ED/Administrator Resident #4 had gotten out of the building by the 200 hallway exit door on 10/31/19. -The ED/Admin told her that on 10/31/19 Resident #4 had crossed over the threshold of the door and staff had brought the resident back into the building. No one knew how the resident got out. -She was told by a medication aide (MA) working third shift on 10/31/19 that she saw Resident #4 outside the front door of the facility and let the resident in the building. -She did not remember when the MA told her Resident #4 was outside the front facility door. -The MA told her she had reported Resident #4 was outside the front facility door to the ED/Admin. -She did not discuss with the ED/Admin that the MA told her Resident #4 was outside the front facility door because she knew the ED/Admin was handling the investigation. -She thought it was better for her to remain	D 270		

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D 270	Continued From page 11 "neutral" and let the ED/Admin do the investigation. -She was not at the facility when Resident #4 got out of the facility on 11/09/19. -On 11/11/20 she performed staff training on exit seeking behavior and making sure doors were secured. Interview with the MA that created the entry in Resident #4's progress note on 11/09/19 at 2:35pm on 02/19/2020 at 4:10pm revealed: -She knew that Resident #4 had exited the facility right at lunch time during the 7:00am - 3:00pm shift (no date provided). -She thought the resident exited the facility through the activity room door. -The door "malfunctioned (lock wasn't working)". -The ED/Administrator came to the facility, put someone on the door to guard it until fixed. -Resident #4 was in the yard and was on the ground. -The resident used a wheelchair and would walk some. -The resident had gotten up and tried to walk. -She did not remember where in the yard the resident was found. -She could not give an estimate for the distance from the facility where Resident #4 was found. -She went to where Resident #4 was found and did not remember who else went to the resident. -She did not remember how facility staff found out Resident #4 was outside the facility. -Resident #4 had been exit-seeking before "on and off" but "not terribly". -The resident would go to the door. -The resident was on 30 minutes checks. -The resident checks were visual. -The resident checks were documented. -The resident was placed on every 15-minute checks after she "got out". -She had seen Resident #4 about 15 minutes	D 270		

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D 270	Continued From page 12 prior to the time the resident was found outside. -Resident #4 had not gone out of the facility prior to this occurrence, to her knowledge. -The resident was "occasionally" exit seeking. Telephone interview with Resident #4's family member on 02/19/20 at 4:12pm revealed: -The family member was called one time when Resident #4 got out of the facility and the resident was sent the the ER (no date provided). -The family member was told by facility staff that Resident #4 was out just a minute before staff got her back into the facilty, however later found out that the resident was out long enough to go around the facility to another door and had to knock on the door to get back in. -The family member found out later on there were two incidences of Resident #4 getting out of the SCU facility. -Resident #4 had multiple visits to the ER starting on 10/28/19 and the resident was moved from the facility to a higher level of care because of the residents decline. -The family member could not understand how Resident #4 was able to get out of a SCU facility that should have been secured to protect the resident's safety. Interview with the ED/Administrator on 02/19/20 at 3:10pm revealed: -Resident #4 had eloped from the facility two times on 10/31/19 and 11/09/19. -She came in when it was reported that Resident #4 eloped on 10/31/19 around 2:00am. -She was informed by staff that Resident #4 crossed the threshold of the door and they brought her back in on 10/31/19. -Resident #4 exited the facility through an exit door at the end of the 200 hall on 10/31/19. -There were no auditory alarms installed prior to	D 270		

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D 270	Continued From page 13 Resident #4 eloping on 10/31/19. -She had been informed of staff sleeping and she performed random checks at night to observe staff. -She periodically performed physical walk through's at random times to monitor staff. -She would enter through different doors during these random checks. -A MA had informed the Clinical Instructor (CI) that Resident #4 had gotten all the way of the facility and walked out the door. -After Resident #4's elopement on 10/31/19, she was placed on 15-minute checks and door chimes were installed. -Resident #4 had straws placed on her wheelchair to generate noise while moving throughout the facility and remained on 15-minute checks. -Resident #4 also had a flag placed on the back of her wheelchair as a visual aide for staff. -The flag on the back on the wheelchair would make a noise if Resident #4 crossed any doorway at the facility. -Resident #4 was able to elope due to a lock on the door had split and was defective on 11/09/19. -Resident #4 was seen by a passerby on the grass, he remained with Resident #4 until another person went to get staff on 11/09/19. -Staff had to stand at the door of the facility to ensure residents did not leave the building until the lock was repaired. -Resident #4 was transferred to skilled nursing after her last elopement. -The expectation was to keep residents safe and check on residents every 15 minutes. Second interview with ED/Administrator on 02/19/20 at 4:34pm revealed: -The initial report from staff indicated Resident #4 had crossed the doorway of the building and did	D 270		

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D 270	Continued From page 14 not get out of staffs' site on 10/31/19. -A few days later she found out Resident #4 got all the way out of the facility down the 200 halls and had exited the building and the resident knocked on the door to get back in. -Resident #4 was placed on 15-minute checks and door chimes were installed after the elopement on 10/31/19. -The 15-minute checks were done as a collaborative effort with staff. -New locks were installed at the defective door where Resident #4 exited on 10/31/19. -The lock checks were implemented after 10/31/19 and before 11/09/19. -She inspected the door the day Resident #4 eloped on 11/09/19 to find a lock had split on the door. -The door was not making connection to completely close and was pulling between two broken pieces of the door. -Resident #4 was on every 15 minute checks on 11/09/19, would not stay in the Monitoring Program and the resident sat near the nurses station. -Staff were responsible to document the every 15 minute checks with staff initials and a code indicating where the resident was located. -Resident #4 was checked at 12:15pm and at 12:25pm it was reported the resident was out the door. -A passerby saw Resident #4 standing behind her wheelchair and she fell to the ground. -The man passing by stayed with Resident #4 and the a family member of the man came to the facility door. -The man that found Resident #4 on 11/09/19 called EMS. Telephone interview with Resident #4's PCP on 02/19/20 at 2:49pm revealed:	D 270		

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D 270	Continued From page 15 -Resident #4 was wheelchair bound and was able to self propel herself in the wheelchair. -She was aware Resident #4 got out of the door of the facility and staff got the resident back in and thought the incident was a "fluke"occurrence. -She was contacted by staff on a second incident when Resident #4 was seen lying outside of the facility, however, did not have specifics because she did not have any documentation with her. -A SCU facility should have secured doors with a code to let everybody in and out of the secured facility. -Residents residing in a SCU have dementia and the residents ability for awareness of safety without staff would be a concern. The facility failed to provide adequate supervision for 1 out of 5 sampled residents who had wandering behaviors. The facility's failure to supervise Resident #4 resulted in the elopement of Resident #4 on 10/31/19 and 11/09/19. This non-compliance was detrimental to the health, safety, and welfare which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S.131D-34 on 02/19/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 4, 2020	D 270		
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,	D 358	Medication orders are processed throuth the order processing system. Med aides were re-inserviced on medication reconciliation upon return from hospitalization to include FL2 orders and hospital discharge records.	4/3/2020

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D 358	Continued From page 16 prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE A1 VIOLATION The Type A1 Violation is abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #1) for a medication used to stabilize mood. The findings are: Review of Resident #1's current FL-2 dated 02/11/20 revealed: -Diagnoses included dementia. -The resident was intermittently disoriented. -There was an order for Depakote ER 500mg every morning. (Depakote ER is a medication used to stabilize moods). -There was an order for Depakote ER 1000mg at the hour of sleep. Review of Resident #1's Assessment and Care Plan dated 11/18/19 revealed: -The resident was receiving medications for mental illness/behaviors. -The resident "sometimes" refused medications. -The resident was sometimes disoriented and forgetful, needing reminders. Review of Resident #1's February 2020 electronic medication administration record (eMAR)	D 358	D358 (cont) All reconciliations will be reviewed by Care Manager with oversight by the Executive Director to assure timely and accurate medication administration. Random chart audits will be completed to assure continued compliance. Newly hired med aides will be educated on medication reconciliation. D358 Addendum Per telephone with Lisa Ash on 03/27/20: Each Resident's medication orders have been reviewed during the At Risk Meetings. Medication reviews and Cart audits include review of the order, MARS (Medication Administration records) and the medications on hand. Medication Aides and Care Managers Perform medCart audits. [signature] RN 03/27/20	

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D 358	Continued From page 17 revealed: -There was a computer printed entry for Depakote 24hr, 500mg every morning with a scheduled administration time at 8:00am. -There was documentation Depakote 24hr 500mg was administered on 02/12/20 at 8:00am. -There was a discontinued date for Depakote 24hr 500mg dated 02/12/20 and an "x" documented daily from 02/13/20 - 02/18/20. Review of Resident #1's medications on hand on 02/18/20 at 11:23am revealed Depakote ER 500mg, one every morning and two every hour of sleep with a dispensing date of 02/11/20 and a quantity of 90 tablet with 79 tablets remaining. Review of a subsequent primary care provider's (PCP) order with a section labeled "current issue" for Resident #1 dated 02/19/20 revealed: -The resident did not receive the morning dose of Depakote 500mg from 02/13/20 - 02/19/20 due to a "pharmacy malfunction". -The resident had not had any behaviors or adverse reactions. -The resident had received the "PM dose of 1000mg". -A Depakote level was requested along with a request to hold the order for the morning dose of Depakote 500mg until the laboratory results were received. -Resident #1's PCP signed the request/order. Interview with the Executive Director (ED)/Administrator on 02/19/20 at 8:45am revealed: -Resident #1 was noncompliant with his medications. -Resident #1's PCP was contacted, and the resident was referred to an inpatient behavioral health hospital the first of February 2020 because	D 358		

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D 358	Continued From page 18 of the type of medications the resident was on and the facility did not want his behaviors to be exacerbated. -Resident #1's mood had been "more level" since returning back to the facility the first of February 2020. Interview with a medication aide (MA) on 02/19/20 at 4:45pm revealed: -Pharmacy staff would enter the order in "quickmar". -The Resident Care Manager (RCM) or the Interim Care Manager (ICM) would review and approve the orders. -Once approved, the order would flow over to the resident's eMAR. -The MAs would update each other at each shift change both verbally and with a 24-hour communication log kept in a binder at the nursing station of any new orders. Interview with the ICM on 02/19/20 at 3:13pm revealed: -Medication orders were faxed to the facility's contracted pharmacy provider. -The facility's contracted pharmacy provider was responsible for adding medications to the residents' eMAR system and the CMs and/or the ED/Administrator were responsible for approving the medications in the system by comparing the order to the new medication added to the eMAR then clicking on "approved" in the system. -She received Resident #1's new medications orders when the resident was discharged from the inpatient behavioral health unit on 02/11/19, she faxed the orders to the contracted pharmacy and approved Resident #1's medications added by the pharmacy by comparing a copy of the medication orders with the medications added to the eMAR.	D 358		

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D 358	Continued From page 19 -All of Resident #1's medications including Depakote 500 mg every morning was showing in the eMAR system. -She was not sure why Resident #1's Depakote ER 500mg every morning was discontinued. -Medication cart audits were done daily. -Resident #1's medications would have been reviewed in a cart audit this week. -She thought Resident #1's discontinuation of the morning dose of Depakote ER 500mg would have been recognized during the cart audit this week. Second interview with the ICM on 02/19/20 at 4:15pm revealed: -Mediation cart audits were performed once every shift on Mondays - Thursdays. -The MA for each shift would perform the medication cart audits. -The MA would compare the medications in the cart to the hard copy physician's order to ensure they matched. -The MA would then compare the hard copy physician's order to the medication order in the resident's electronic medication administration record (eMAR) on the medication carts laptop. -The MA would document on the hard copy physicians order how many days were left of the prefilled medications. -The MA's would turn in the hard copy physician's order to her for review after the cart audits were completed. -The prefilled multidose packs were automatically refilled every week. Second interview with the ED/Administrator on 02/19/20 at 4:34pm revealed: -Resident #1's medications were sent to the facility's contracted pharmacy provider. -The facility's contracted pharmacy provider	D 358		

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D 358	Continued From page 20 imported the orders. -The facility had to approve the orders added to the system by matching it with the order. -The ICM printed Resident #1's medication orders and checked the medications to assure the medications were in and added to the eMAR, then approved the morning and evening dose of Depakote. -Resident #1's Depakote ER 500mg did populate to the eMAR but on 02/12/20 the eMAR system showed the morning dose of Depakote 500mg was discontinued. -It was unknown why Resident #1's Depakote 500mg ER every morning was discontinued. -Resident #1's medications were not delivered as a multidose packaging and delivered from the pharmacy on punch cards. Telephone interview with Resident #1's PCP on 02/19/20 at 2:49pm revealed: -Resident #1 was seen by a mental health provider and was treated by inpatient behavioral health in February 2020. -Resident #1 took Depakote to keep his moods stable. -She was not aware of any behavioral issues Resident #1 had since the resident returned to the facility from the behavioral health unit.	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		

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D912	Continued From page 21 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure every resident had the right to receive care and services, which are adequate, appropriate, and in compliance with rules and regulations as related to supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#4) residing in a special care unit and based on assessed needs, resulting in a resident eloping from the facility without staff knowledge on 2 occasions. [Refer to Tag 270, 10A NCAC 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].	D912	Facility takes full responsibility and accountability to assure resident rights are upheld to the highest standard to include safety andcare and services. Staff were inserviced on resident rights on 3/6/2020. All new hires will receive education on resident rights.	