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CADENCE SENIOR LIVING AT MINT HILL	5601 MARGARET WALLACE ROAD MATTHEWS, NC 28105

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D 000	Initial Comments The Adult Care Licensure Section conducted a State involved complaint investigation and a COVID-19 Infection Control Survey with an onsite visit on 01/06/21, a desk review survey on 01/07/21 to 01/08/21, and 01/11/21, with a telephone exit on 01/12/21.	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 interviews, observations, and record reviews the facility failed to ensure physician notification for 2 of 5 sampled residents (Residents #1 and #3) regarding missing a medication to treat macular degeneration (Resident #1) and not following up with a physician's order to increase the scheduling of a medication to treat gout from once a day to twice a day (Resident #3). The findings are: 1. Review of Resident #1's current FL2 dated 09/16/20 revealed diagnoses included macular degeneration, dementia, history of hypertension, multinodular goiter. Review of Resident #1's physician's order dated 10/14/20 revealed: -Resident #1 received a Avatatin injection given in both eyes to treat macular degeneration. -There was an order to begin Preservision Areds	D 273		

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vitamins (a medication used to slow progression of age-related macular degeneration), one capsule twice daily.

Review of Resident #1's November 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Preservision Areds one capsule twice daily at 8:00am and 8:00pm.
-There was documentation that "family provides" medication.
-There were 11 doses documented as not administered due to "waiting on family to provide" from 11/25/20-11/30/20.

Review of Resident #1's December 2020 eMAR revealed:
-There was an entry for Preservision Areds one capsule twice daily at 8:00am and 8:00pm.
-There was documentation that "family provides" medication.
-There were 12 doses documented as not administered due to "waiting on family to provide" and "med not available" from 12/20/20-12/30/20.

Review of Resident #1's January 2021 eMAR revealed:
-There was an entry for Preservision Areds one capsule twice daily at 8:00am and 8:00pm.
-There was documentation that "family provides" medication.
-There were 5 doses documented as not administered due to "waiting on family to provide" and "med not available" from 01/01/21-01/05/21.

Review of Resident #1's progress notes revealed:
-There was no documentation Resident #1's family was contacted regarding Preservision Areds medication.
-There was no documentation Resident #1's

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Ophthalmologist was notified that the Preservision Areds were not available and the resident missed doses.

Observation of Resident #1's medications available for administration on 01/11/21 at 1:30pm revealed there was one 90 capsule unopened bottle of Preservision Areds.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/07/21 at 12:20pm revealed:
-The pharmacy had an order for Preservision Areds capsules twice daily dated 10/19/20.
-There was note on the order that the family would provide the medication.
-The pharmacy had not dispensed Preservision Areds, however would dispense if the facility requested the medication.
-There was no request received from the facility to dispense Preservision Areds from 10/19/20-01/07/21.

Telephone interview with a medication aide (MA) on 01/07/21 at 10:00am revealed:
-She worked 2nd shift.
-She documented on 11/29/20, 12/21/20-12/25/20, 12/26/20, 12/27/20-12/30/20, 01/01/21-01/02/21, and 01/04/21-01/05/21 that the Preservision Areds were not administered because the medication was not available.
-She thought the first shift staff reached out to the family member to bring the Preservision Areds into the facility to be administered.
-She had not personally contacted the family member about the medication not being available in the facility.
-She had not contacted the pharmacy to get the Preservision Areds into the facility.
-She had not contacted the physician to notify the

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resident missed doses of the Preservision Areds medication.
-If the family provided medication for a resident, MAs were responsible for contacting the family 48 hours before of running out of medication.
-If the family could not be reached, MAs could contact the pharmacy to get the medication in the facility.
-She did not know who was supposed to contact the physician to notify of missed doses of mediations.
-She had not contacted the physician to notify of missed doses.
-She had not notified the Resident Care Coordinator (RCC) or Resident Services Director (RSD) of missed doses or that Preservision Areds were not available for administration.
-She thought the first shift staff notified the RCC and RSD.

Interview with the RCC/MA on 01/07/21 at 12:10pm revealed:
-She assisted the RSD, however also served as a MA when needed.
-She documented on the eMAR during 11/24/20, 11/25/20, 11/27/20-11/29/20 that the Preservision medication was not administered because it was not available "waiting on family to provide".
-She contacted the family to bring Preservision Areds into the facility because it was unavailable.
-She did not know the date she contacted the family, however knew that the family member had surgery and was unable to bring the medication in the facility.
-MAs were supposed to contact the pharmacy if the family was unable to bring the medication into the facility.
-She called the pharmacy and waited for them to get into contact with the family.
-She did not know the date the pharmacy was

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contacted.
-She informed the eye doctor during the month eye injections in November 2020, that the Preservision was not administered because it was unavailable, and he instructed her to contact the pharmacy, so they could deliver the medication.
-She had not spoken to the eye doctor about missed doses in December 2020 or January 2021 because she did not know it was not administered.
-After 3 days of missed doses, MAs were supposed to contact the physician to notify.

Interview with the RSD on 01/11/21 at 10:45am revealed:
-When a resident's family provided medications, the MAs were responsible for contacting the family to bring the medications into the facility 2 weeks prior to running out.
-If the family did not bring the medication into the facility, the pharmacy should be contacted before the last pill was dispensed to get the medication in the facility.
-The physician also needed to be contacted after 3 missed doses of a medication.
-She did not know Resident #1 missed Preservision Areds medication because it was not available.
-No staff told her they were waiting on Resident #1's family to bring the medication into the facility.
-She was supposed to be notified so that she could follow-up with the physician and family.

Interview with the nurse for Resident #1's Opthalmologist on 01/07/21 at 4:43pm revealed:
-Resident #1 was prescribed Preservision Areds to treat macular degeneration.
-The Preservision Areds worked along with eye injections to improve macular degeneration.

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-The physician was not notified for missed doses of Preservision Areds.
-He would want to the notified to update Resident #1's treatment plan.

Interview with the Executive Director on 01/12/21 at 9:08am revealed:
-She expected family's who brought in medications to be contacted when the resident was down to a week supply of medication.
-The MAs, RCC, and RSD were responsible to call the family to get the medication in the facility.
-If the family did not bring the medication into the facility, she expected the MAs to contact the pharmacy to get the medication into the facility.
-She expected the communication with family and the physician to be documented.
-She also expected the RSD to contact the physician to notify of missed doses immediately to determine next steps.

2. Review of Resident #3's current FL2 dated 08/25/20 revealed:
-Diagnoses included dementia, chronic obstructive pulmonary disease and atrial fibrillation.
-There was an order for Allopurinol, (a medication used to prevent gout), 100mg once a day.

Review of Resident #3's Resident Register dated 08/25/20 revealed an admission date of 08/25/20.

Review of Resident #3's December 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Allopurinol 100mg, one tablet daily at 8:00am.
-There was documentation Allopurinol was administered once daily from 12/01/20 through 12/31/20.

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D 273	Continued From page 6 Review of Resident #3's January 2021 eMAR, from 01/01/21 through 01/11/21, revealed: -There was an entry for Allopurinol 100mg one tablet daily at 8:00am. -There was documentation Allopurinol was administered once daily from 01/01/21 through 01/11/21. Observation of Resident #3's medications available for administration on 01/11/21 at 1:30pm revealed Resident #3 had a bottle of Allopurinol 100mg, with a pharmacy generated label dated 11/12/20, take 2 tablets (200mg) daily, with 73 tablets remaining. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/08/21 at 10:36am revealed: -Resident #3 was on a "profile only", her medications were not provided by the pharmacy. -Resident #3's most current order for Allopurinol was 100mg daily, received from the FL2 dated 08/25/20. -The previous order dated July of 2019 was Allopurinol 100mg, two tablets daily, from a previous physician. Telephone interview with the Power of Attorney (POA) on 01/11/21 at 10:34am revealed: -Resident #3 was on a leave of absence (LOA) from the facility, and she received the medication administration record (MAR) to administer Resident #3's medications. -She observed the eMAR entry for Allopurinol 100mg once daily was different from the pharmacy generated label on the medication bottle, Allopurinol 100mg two tablets daily. -She sent an email to the primary care physician (PCP) on 12/25/20 requesting the order for	D 273		

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Allopurinol be changed to 100mg twice a day.
-She was concerned at the lower dose Resident #3 may have an exacerbation of gout.
-The PCP responded on 12/30/20 via email Allopurinol 100mg could be changed from daily to twice a day.

Telephone interview with the PCP on 01/11/21 at 12:48pm revealed:
-Resident #3's POA was very proactive in her care, and corresponded with the PCP frequently by email.
-She received several emails from the POA around the holidays.
-At the request of the POA she changed the Allopurinol 100mg from once daily to twice daily.
-The PCP forwarded this email, and the previous communications regarding the medications, to the Memory Care Director (MCD) on 12/30/20 and let her know the Allopurinol could be changed and added to Resident #3's medication profile.
-Resident #3 did not verbalize or exhibit any health changes that indicated she might be experiencing a gout flare up.
-She had been on the current dosage since she was admitted to the facility in August of 2020.
-She expected the facility staff to have followed up in a more timely manner with the change in orders for Resident #3.

Telephone interview with the MCM on 01/11/21 at 11:10am revealed:
-She had received an email thread that was forwarded to her from the provider on 12/30/20.
-She did not see the provider's order to change the Allopurinol 100mg from once daily to twice a day. "I just missed it."
-If she had read that portion of the email thread she would have sent an order clarification request to the provider for the Allopurinol 100mg to be

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changed to twice a day.
-Resident #3 received a 3 month supply of Allopurinol by mail from an outside provider.
-The medication bottle had a pharmacy generated label with Resident #3's name and the directions for administration, and was placed on the medication cart.
-She was responsible for the weekly cart audits.
-She performed the most recent cart audit the week of 01/02/21.
-The process she followed during a cart audit was verifying the medications entered on the eMAR were on the cart and the quantity remaining.
-She did not check the labels with the eMAR entry for accuracy.
-She verbally communicated to the MAs to follow the eMAR entry and not the label on the medication bottle if there was a discrepancy between the two.
-The facility provided "direction change" stickers that could be affixed to a medication bottle and were located on the medication carts.
-She did not know why she had not placed a sticker on the bottle when she was completing the cart audit.
-She did not know why she had not sent a copy of the FL2 orders, and any subsequent changed orders, to the outside pharmacy.

Interview with the Resident Services Director (RSD) on 01/11/21 at 4:10pm revealed:
-Orders were faxed to the physician within 24 hours for clarification and a signature.
-Orders received should be written on a telephone order form or order request clarification form.
-If she did not receive a response from the physician in 24-48 hours, she would contact the physician's office and follow up.
-She was not aware of the email correspondence

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D 273	Continued From page 9 between the POA and the PCP, and then forwarded to the MCD. -She would have expected the MCD to follow up with an order request clarification sent to the physician within 24-48 hours. -The facility did not take email correspondence as an order. -She reviewed medication orders on the eMAR, once they were entered by the pharmacy staff, within 24 hours and again within 48 hours. -She compared the signed physician orders with the eMAR entry. -Cart audits should be conducted weekly. -The MCM and Resident Care Coordinator (RCC) were responsible for performing the cart audits. -At this time she did not review the cart audits when they were completed. -She would expect the MCM and the RCC to compare the pharmacy label with the entry on the eMAR for accuracy. -The PCP should be contacted if there was a discrepancy with the medication label and the eMAR if additional clarification was needed. Interview with the Executive Director on 01/12/21 at 9:08am revealed: -She did not know there was an email correspondence forwarded to the MCM that included an order change -It was not the facility's policy to take physician orders through the email. -Orders should be sent to the facility through fax correspondence. -All orders should be followed up with the physician for clarification and/or a signature and sent to the pharmacy within 24-48 hours.	D 273		