STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081047	A. BUILDING: _____ B. WING _____	04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CARE CENTER # 1	5023 US HIGHWAY 64 UNION MILLS, NC 28167

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 14, 2021.	C 000		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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: Based on observations, record reviews, and interviews, the facility failed to ensure the preparation and administration of medications, prescription and non-prescription, are in accordance with orders by a licensed prescribing practitioner for 2 of 3 sampled residents (Resident #2 and #3) with an order for a medication to treat gastroesophageal reflux disease (GERD) and a medication for increased pressure of the eyes (Resident #2) and medication used to treat high blood pressure and GERD (Resident #3). The findings are: 1.Review of Resident #2's current FL2 dated 07/13/20 revealed diagnoses included schizophrenia, gastroesophageal reflux disease (GERD), and chronic obstructive pulmonary disease (COPD).	C 330		

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C 330	Continued From page 1	C 330		

a. Review of Resident #2's current FL2 dated 07/13/20 revealed an order for Dexilant 60mg (used to treat GERD) before breakfast.

Review of Resident #2's signed physician orders dated 03/25/21 revealed there was an order for Dexilant 60mg before breakfast.

Review of Resident #2's February 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Dexilant 60mg before breakfast.
-The Dexilant was documented as administered from 02/01/21 to 02/28/21.

Review of Resident #2's March 2021 eMAR revealed:
-There was an entry for Dexilant 60mg before breakfast.
-The Dexilant was documented as administered from 03/01/21 to 03/31/21.

Review of Resident #2's April 2021 eMAR revealed:
-There was an entry for Dexilant 60mg before breakfast.
-The Dexilant was documented as administered from 04/01/21 to 04/14/21.

Observation of medications on hand for Resident #2 on 04/14/21 at 10:40am revealed there was no Dexilant 60mg available to administer to Resident #2.

Interview with the Supervisor-in-charge (SIC) on 04/14/21 at 10:40am revealed:
-Resident #2's Dexilant went up in price and the pharmacy did not send it.
-She marked the eMAR for the Dexilant as

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C 330	Continued From page 2	C 330		

administered without paying attention.
-She was not sure when she last administered the Dexilant.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 04/14/21 at 11:55am revealed:
-The pharmacy last dispensed Resident #2's Dexilant 60mg, 30 tablets, on 05/15/20.
-Resident #2's Dexilant's prior authorization for reimbursement was denied on 07/16/20 and the facility would have had to pay the full amount if it was dispensed.
-The pharmacy contacted the current SIC and was instructed to not send the medication and she would contact the Primary Care Provider (PCP).

Interview with Resident #2's PCP on 04/14/21 at 12:20pm revealed:
-There was no documentation in Resident #2's records the facility had contacted them regarding the Dexilant not being administered or regarding the prior authorization denial.
-The provider that usually saw Resident #2 had recently resigned and the last time she saw Resident #2 was on 04/05/21.

Interview with Resident #2 on 04/14/21 at 1:28pm revealed:
-He was not sure what medications he was given.
-He did not have any increased heartburn or GERD symptoms.

Refer to interview with the SIC on 04/14/21 at 10:40am.

b. Review of Resident #2's current FL2 dated 07/13/20 revealed an order for latanoprost eye drops, one drop in each eye at bedtime (used to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 330	Continued From page 3 treat high pressure in the eyes). Review of Resident #2's signed physician orders dated 03/25/21 revealed there was an order for latanoprost eye drops, one drop in each eye at bedtime. Review of Resident #2's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry for latanoprost eye drops, one drop in each eye at bedtime. -The latanoprost eye drops were documented as administered from 02/01/21 to 02/28/21, except for 02/08/21 when there was no documentation they were administered. Review of Resident #2's March 2021 eMAR revealed: -There was an entry for latanoprost eye drops, one drop in each eye at bedtime. -The latanoprost eye drops were documented as administered from 03/01/21 to 03/31/21 except for four instances they were not documented as administered, on 03/06/21, 03/14/21, 03/27/21, and 03/30/21. Review of Resident #2's April 2021 eMAR revealed: -There was an entry for latanoprost eye drops, one drop in each eye at bedtime. -The latanoprost eye drops were documented as administered from 04/01/21 to 04/13/21 except for two instances they were not documented as administered, on 04/02/21 and 04/05/21. Observation of medications on hand for Resident #2 on 04/14/21 at 10:40am revealed there was no latanoprost eye drops available to administer to Resident #2.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 330	Continued From page 4 Interview with the SIC on 04/14/21 at 10:40am revealed: -She marked the eMAR for the latanoprost eye drops as administered without paying attention. -She was not sure when she last administered the latanoprost eye drops. Telephone interview with a pharmacist with the facility's contracted pharmacy on 04/14/21 at 11:55am revealed: -The pharmacy last dispensed Resident #2's latanoprost eye drops on 04/23/19. -The facility had not contacted them to refill Resident #2's latanoprost eye drops since 04/23/19 until today. Interview with Resident #2's PCP on 04/14/21 at 12:20pm revealed: -Latanoprost was usually prescribed by an eye doctor. -He was unsure who had prescribed the latanoprost eye drops. -There was no documentation in Resident #2's records the facility had contacted them for orders for the latanoprost eye drops. Interview with Resident #2 on 04/14/21 at 1:28pm revealed: -He was not sure what medications he was given. -He saw the eye doctor about two months ago and had not received any prescriptions. Refer to interview with the SIC on 04/14/21 at 10:40am. 2. Review of Resident #3's current FL2 dated 10/24/20 revealed diagnoses included schizophrenia, dyspnea and obesity.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 330	Continued From page 5 a. Observation of Resident #3's medications on hand on 04/14/21 at 11:40am revealed: -There was a bottle of omeprazole 40mg tablets take 1 tablet daily. -The omeprazole was dispensed on 11/30/20, for a 3 month supply. -There were 36 tablets remaining in the bottle. Review of Resident #3's record on 04/14/21 revealed there was no physician's order for omeprazole 40mg daily. Review of Resident #3's February 2021 electronic medication administration record (eMAR) revealed: -There was no entry for omeprazole 40mg daily on the eMAR. -There was no documentation of administration of omeprazole 40mg from 02/01/21 to 02/28/21. Review of Resident #3's March 2021 eMAR revealed: -There was no entry for omeprazole 40mg daily on the MAR. -There was no documentation of administration of omeprazole 40mg from 03/01/21 to 03/31/21. Review of Resident #3's April 2021 eMAR revealed: -There was no entry for omeprazole 40mg daily on the eMAR. -There was no documentation of administration of omeprazole from 04/01/21 to 04/14/21. Interview with the pharmacist at the Veteran's Administration (VA) on 04/14/21 at 1:04pm revealed: -The pharmacy last dispensed Resident #3's omeprazole on 11/30/20 and 12/13/20, quantity 90 tablets.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 330	Continued From page 6 -The omeprazole was an active order for Resident #3. Interview with Resident #3 on 04/14/21 at 11:55am revealed: -He had been taking omeprazole for over 2 years. -He had never missed a dose of his omeprazole. Interview with the supervisor in charge (SIC) on 04/14/21 at 11:36am and 1:42pm revealed: -Resident #3's omeprazole was a longstanding order. -She had administered the omeprazole daily according to the directions on the medication bottle. -Resident #3's omeprazole was sent in the mail from the VA. -The omeprazole order was accidentally omitted on the current FL2 dated 10/24/20, so it was never sent to the pharmacy provider. -The omeprazole was not put on the medication profile with the facility's contracted pharmacy, so it was never entered on the eMAR. -The omeprazole had been documented on the paper MARs in the past, but she could not locate them. Refer to interview with the SIC on 04/14/21 at 10:40am. b. Observation of Resident #3's medications on hand on 04/14/21 at 11:40am revealed: -There was a bottle of lisinopril 10mg tablets take ½ tablet daily. -The lisinopril 10mg was dispensed last on 03/25/21. Review of Resident #3's record on 04/14/21 revealed there was no physician's order for lisinopril.	C 330		

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C 330	Continued From page 7 Review of Resident #3's February 2021 electronic medication administration record (eMAR) revealed: -There was no entry for lisinopril on the eMAR. -There was no documentation of administration of lisinopril from 02/01/21 to 02/28/21. Review of Resident #3's March 2021 eMAR revealed: -There was no entry for lisinopril on the MAR. -There was no documentation of administration of lisinopril from 03/01/21 to 03/31/21. Review of Resident #3's April 2021 eMAR revealed: -There was no entry for lisinopril on the eMAR. -There was no documentation of administration of lisinopril from 04/01/21 to 04/14/21. Interview with the pharmacist at the Veteran's Administration (VA) on 04/14/21 at 1:04pm revealed: -The pharmacy last dispensed Resident #3's lisinopril on 03/25/21. -The lisinopril was a current order for Resident #3. Interview with Resident #3 on 04/14/21 at 11:55am revealed: -He had been taking lisinopril for over 2 years. -He had never missed a dose of lisinopril. Interview with the SIC on 04/14/21 at 11:36am and 1:42pm revealed: -Resident #3's lisinopril was a longstanding order. -She had administered the lisinopril daily according to the directions on the medication bottle. -Resident #3's lisinopril was sent in the mail from	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 330	Continued From page 8 the VA. -The lisinopril order was accidentally omitted on the current FL2 on 10/24/20, so it was never sent to the pharmacy provider. -The lisinopril order was not put on the medication profile with the facility's contracted pharmacy, so it was never entered on the eMAR. -The lisinopril had been listed on the paper MARs in the past, but she could not locate them. Attempted telephone interview with Resident #3's primary care provider (PCP) on 04/14/21 at 12:20pm was unsuccessful. Refer to interview with the SIC on 04/14/21 at 10:40am. _____ Interview with the SIC on 04/14/21 at 10:40am revealed: -She was responsible for administering all medications to the residents. -She knew she was to compare the eMAR with the medications administered. -She was not comparing the eMAR to the medications on hand. -She was responsible for verifying the physician orders matched the medications on hand and the eMARs.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order;	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 342	Continued From page 9 (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of electronic medication administration records (eMARs) for 2 of 3 sampled residents (Resident #2 and #3). The findings are: 1. Review of Resident #2's current FL2 dated 07/13/20 revealed diagnoses included schizophrenia, gastroesophageal reflux disease (GERD), and chronic obstructive pulmonary disease (COPD). a. Review of Resident #2's current FL2 dated 07/13/20 revealed an order for Dexilant 60mg (used to treat GERD) before breakfast. Review of Resident #2's signed physician orders dated 03/25/21 revealed there was an order for Dexilant 60mg before breakfast.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 342	Continued From page 10 Review of Resident #2's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Dexilant 60mg before breakfast. -The Dexilant was documented as administered from 02/01/21 to 02/28/21. Review of Resident #2's March 2021 eMAR revealed: -There was an entry for Dexilant 60mg before breakfast. -The Dexilant was documented as administered from 03/01/21 to 03/31/21. Review of Resident #2's April 2021 eMAR revealed: -There was an entry for Dexilant 60mg before breakfast. -The Dexilant was documented as administered from 04/01/21 to 04/14/21. Observation of medications on hand for Resident #2 on 04/14/21 at 10:40am revealed there was no Dexilant 60mg available to administer to Resident #2. Interview with the SIC on 04/14/21 at 10:40am revealed: -Resident #2's Dexilant went up in price and the pharmacy did not send it. -She marked the eMAR for the Dexilant as administered without paying attention. -She was not sure when she last administered the Dexilant. Telephone interview with a pharmacist with the facility's contracted pharmacy on 04/14/21 at 11:55am revealed the pharmacy last dispensed	C 342		

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C 342	Continued From page 11 Resident #2's Dexilant 60mg, 30 tablets, on 05/15/20. b. Review of Resident #2's current FL2 dated 07/13/20 revealed an order for latanoprost eye drops, one drop in each eye at bedtime (used to treat high pressure in the eyes). Review of Resident #2's signed physician orders dated 03/25/21 revealed there was an order for latanoprost eye drops, one drop in each eye at bedtime. Review of Resident #2's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry for latanoprost eye drops, one drop in each eye at bedtime. -The latanoprost eye drops were documented as administered from 02/01/21 to 02/28/21, except for 02/08/21 when there was no documentation they were administered. Review of Resident #2's March 2021 eMAR revealed: -There was an entry for latanoprost eye drops, one drop in each eye at bedtime. -The latanoprost eye drops were documented as administered from 03/01/21 to 03/31/21 except for four instances they were not documented as administered, on 03/06/21, 03/14/21, 03/27/21, and 03/30/21. Review of Resident #2's April 2021 eMAR revealed: -There was an entry for latanoprost eye drops, one drop in each eye at bedtime. -The latanoprost eye drops were documented as administered from 04/01/21 to 04/13/21 except for two instances they were not documented as	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 342	Continued From page 12 administered, on 04/02/21 and 04/05/21. Observation of medications on hand for Resident #2 on 04/14/21 at 10:40am revealed there was no latanoprost eye drops available to administer to Resident #2. Interview with the SIC on 04/14/21 at 10:40am revealed: -She marked the eMAR for the latanoprost eye drops as administered without paying attention. -She was not sure when she last administered the latanoprost eye drops. Telephone interview with a pharmacist with the facility's contracted pharmacy on 04/14/21 at 11:55am revealed: -The pharmacy last dispensed Resident #2's latanoprost eye drops on 04/23/19. -The facility had not contacted them to refill Resident #2's latanoprost eye drops since 04/23/19 until today. 2. Review of Resident #3's current FL2 dated 10/24/20 revealed diagnoses included schizophrenia, dyspnea and obesity. a. Observation of Resident #3's medications on hand on 04/14/21 at 11:40am revealed: -There was a bottle of omeprazole 40mg tablets take 1 tablet daily. -The omeprazole was dispensed on 11/30/20, for a 3 month supply. -There were 36 tablets remaining in the bottle. Review of Resident #3's record on 04/14/21 revealed there was no physician's order for omeprazole 40mg daily. Review of Resident #3's February 2021 electronic	C 342		

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C 342	Continued From page 13	C 342		

medication administration record (eMAR) revealed:
-There was no entry for omeprazole 40mg daily on the eMAR.
-There was no documentation of administration of omeprazole 40mg from 02/01/21 to 02/28/21.

Review of Resident #3's March 2021 eMAR revealed:
-There was no entry for omeprazole 40mg daily on the MAR.
-There was no documentation of administration of omeprazole 40mg from 03/01/21 to 03/31/21.

Review of Resident #3's April 2021 eMAR revealed:
-There was no entry for omeprazole 40mg daily on the eMAR.
-There was no documentation of administration of omeprazole from 04/01/21 to 04/14/21.

Interview with the pharmacist at the Veteran's Administration (VA) on 04/14/21 at 1:04pm revealed:
-The pharmacy last dispensed Resident #3's omeprazole on 11/30/20 and 12/13/20, quantity 90 tablets.
-The omeprazole was an active order for Resident #3.

Interview with the supervisor in charge (SIC) on 04/14/21 at 11:36am and 1:42pm revealed:
-Resident #3's omeprazole was a longstanding order.
-She had administered the omeprazole daily according to the directions on the medication bottle.
-The omeprazole was not put on the medication profile with the facility's contracted pharmacy, so it was never entered on the eMAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081047	A. BUILDING: _____ B. WING _____	04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CARE CENTER # 1	5023 US HIGHWAY 64 UNION MILLS, NC 28167

(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
C 342	Continued From page 14 -The omeprazole had been documented on the paper MARs in the past, but she could not locate them. b. Observation of Resident #3's medications on hand on 04/14/21 at 11:40am revealed: -There was a bottle of lisinopril 10mg tablets take ½ tablet daily. -The lisinopril 10mg was dispensed last on 03/25/21. Review of Resident #3's record on 04/14/21 revealed there was no physician's order for lisinopril. Review of Resident #3's February 2021 electronic medication administration record (eMAR) revealed: -There was no entry for lisinopril on the eMAR. -There was no documentation of administration of lisinopril from 02/01/21 to 02/28/21. Review of Resident #3's March 2021 eMAR revealed: -There was no entry for lisinopril on the MAR. -There was no documentation of administration of lisinopril from 03/01/21 to 03/31/21. Review of Resident #3's April 2021 eMAR revealed: -There was no entry for lisinopril on the eMAR. -There was no documentation of administration of lisinopril from 04/01/21 to 04/14/21. Interview with the pharmacist at the Veteran's Administration (VA) on 04/14/21 at 1:04pm revealed: -The pharmacy last dispensed Resident #3's lisinopril on 03/25/21. -The lisinopril was a current order for Resident	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081047	A. BUILDING: _____ B. WING _____	04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CARE CENTER # 1	5023 US HIGHWAY 64 UNION MILLS, NC 28167

(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
C 342	Continued From page 15 #3. Interview with the SIC on 04/14/21 at 11:36am and 1:42pm revealed: -Resident #3's lisinopril was a longstanding order. -She had administered the lisinopril daily according to the directions on the medication bottle. -The lisinopril order was not put on the medication profile with the facility's contracted pharmacy, so it was never entered on the eMAR. -The lisinopril had been listed on the paper MARs in the past, but she could not locate them. Attempted telephone interview with Resident #3's primary care provider (PCP) on 04/14/21 at 12:20pm was unsuccessful.	C 342		