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	HAL092215	A. BUILDING: _____ B. WING _____	04/30/2021

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CADENCE GARNER	200 MINGLEWOOD DRIVE GARNER, NC 27529

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on 04/27/21 - 04/30/21.	D 000		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed	D 188	The facility will provide staff for the required hours according to census. Staffing sheets will be reviewed by the RSD or designee daily to make certain appropriate staffing levels to meet the needs of the residents. The RSD/ED will review weekly assignment sheets monitor for compliance for four (4) weeks. BOD will audit timecard reports weekly for four (4) weeks to capture all documented hours worked. All corrective measures will be implemented by 6/14/21. Continued monitoring of compliance will be conducted through QA audits, compliance trends and patterns.	

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

Robin Tabor, Executive Director 5/28/21
Reviewed + Accepted Dina B Nelson 05/28/21

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D 188	Continued From page 1 by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the required staffing hours for the assisted living with a census of 19 to 20 were met for 6 of 15 shifts sampled from 03/23/21 - 04/05/21. The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed for a capacity of 84 beds including a special care unit (SCU) with a capacity of 48 beds. Review of the facility's resident census report dated 03/23/21 revealed there was an assisted living (AL) census of 20 residents, which required 16 staff hours on second shift. Review of the employee time cards dated 03/23/21 revealed there was a total of 7 staff hours provided on second shift in the AL unit with a shortage of 9 hours. Review of the facility's resident census report dated 04/02/21 revealed there was an AL census of 20 residents, which required 16 staff hours on first shift. Review of the employee time cards dated 04/02/21 revealed there was a total of 11 hours	D 188		

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D 188	Continued From page 2 and 41 minutes staff hours provided on first shift in the AL unit with a shortage of 4 hours and 19 minutes. Review of the facility's resident census report dated 04/03/21 revealed there was an AL census of 20 residents, which required 16 staff hours on first and second shift. Review of the employee time cards dated 04/03/21 revealed: -There was a total of 11 hours and 30 minutes staff hours provided on first shift in the AL unit with a shortage of 4 hours and 30 minutes. -There was a total of 11 hours and 30 minutes staff hours provided on second shift in the AL unit with a shortage of 4 hours and 30 minutes. Review of the facility's resident census report dated 04/04/21 revealed there was an AL census of 19 residents, which required 8 staff hours on third shift. Review of the employee time cards dated 04/04/21 revealed there was a total of 4 hours of staff hours provided on third shift in the AL unit with a shortage of 4 hours. Review of the facility's resident census report dated 04/05/21 revealed there was an AL census of 19 residents, which required 16 staff hours on second shift. Review of the employee time cards dated 04/04/21 revealed there was a total of 8 hours and 15 minutes staff hours provided on second shift in the AL unit with a shortage of 7 hours and 45 minutes. Interview with a resident on 04/27/21 at 9:45am	D 188		

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D 188	Continued From page 3 revealed: -The facility was short staffed and they needed more help, especially on second and third shifts. -Sometimes the resident had to sit in the dining room and wait for food for 15 minutes or longer and sometimes the food was cold when it was received because there was not enough staff to pass out the food. -For the evening meal, there was only one staff person to serve the residents and it took "forever" to serve all the residents in the dining room. -There was not enough staff in the evenings because the resident could not get anyone to answer the call bell after 7:00pm. -The resident had to go down the hall in the evenings to find staff if the resident needed something. -Sometimes the resident could not find any staff on the AL side of the facility and had to go the SCU to find staff. Interview with a personal care aide (PCA) on 04/27/21 at 10:25am revealed: -She normally worked first shift and would stay until around 6:30pm to help with second shift. -Most of the time she was the only PCA on the AL halls (Hall A and Hall D). -About once a week there would be a second PCA on the AL to help with resident care. -The medication aide (MA) would help when she could but she was usually passing medications for the whole facility on AL and in the SCU. Interview with a MA on 04/27/21 at 10:45am revealed: -There are no residents that required two-person assistance on the AL unit, so there was usually one PCA. -There was one resident who transferred easier with two people but could be transferred with one	D 188		

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D 188	Continued From page 4 staff if needed. -She passed the medications for residents on the AL side and in the SCU when there was only one MA for the facility. -The Memory Care Manager (MCM) and the Resident Services Director (RSD) would assist with half of the morning medication pass on the SCU during the week. Telephone interview with a second MA on 04/30/21 at 8:06am revealed: -Staff clocked out for their breaks. -She was the only MA in the facility on night shift most of the time. -She split her time 50% on AL side and 50% on the SCU. Interview with the RSD on 04/30/21 at 3:58pm revealed: -The MCM was responsible for making the schedule for the facility. -If there was a call out, staff called into the MCM or RSD. -The MCM and RSD called alternative staff to find shift coverage or one of them would cover the staffing need. -The facility was using a staffing company to provide additional PCAs. -There were 3 MAs for the facility. -The MCM and RSD would assist with the medication pass on SCU when there was only one MA working. Interview with the facility's primary care provider (PCP) on 04/29/21 at 1:33pm revealed: -She received complaints from residents that there was a delay in getting their call bells answered because the facility was short staffed. -She received complaints from residents that there was a delay in receiving their medication	D 188		

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D 188	Continued From page 5 when they requested. -Residents reported the delay in receiving requested medication was mainly on 3rd shift.	D 188		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure timely notification of the physician for 1 of 6 sampled residents who was restrained to her wheelchair for an unknown period of time (#7.) The findings are: Review of the facility's Restraint Policy dated 06/15/20 revealed: -The staff should observe and respect the personal rights of all residents including being free from physical and chemical restraints. -Residents should be free of physical obstruction of movement. -Physical obstruction of movement includes but not limited to being personally involved or having used a material item for: blocking a resident's pathway; restricting a resident from the freedom to wander or get out of bed or chair; prevention of a resident's movement to and from one area; and restraining or blocking a resident in a sitting or lying position. -Restraints shall not be used for discipline of any kind for any residents. -Restraints shall not be used for convenience of	D 273	The facility will provide timely referral and follow up to meet the routine and acute healthcare needs of the residents to include documented timely notification to PCP and families. The RSD or designee will review shift reports daily to maintain timely, documented healthcare follow up. The ED/RSD will review electronic charting weekly for four (4) weeks for compliance. All corrective measures will be implemented by 6/14/21. Continued monitoring of compliance will be conducted through QA audits, compliance trends and patterns.	

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D 273	Continued From page 6 staff or facility at any time. -Any observation of above by a staff member should be immediately reported to their supervisor. Review of the facility's Elder Abuse, Neglect and Exploitation Policy dated 06/15/20 revealed: -Resident abuse, neglect, and exploitation are prohibited. -Should any resident experience abuse or when abuse is suspected, staff and volunteers are required to immediately provide notification to persons/agencies as described in this policy. -All Care Partners received in-service training on elder abuse, incidence, signs and symptoms of abuse, and reporting requirements during initial orientation; this training shall be repeated per state regulations. -All staff and volunteers are "mandated reporters." -If any Community staff member or volunteer has observed, suspects, has knowledge of, or is told by a resident or other staff member, of an incident which appears to be any form of abuse, the incident will be immediately reported to the Resident Services Director (RSD); If the RSD is not available, the incident will be reported to the Administrator; in all cases the Administrator will be informed as soon as possible. -Upon the notice of reported, observed, suspected or at imminent risk of any form of abuse: immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is conducted; a thorough investigation will be conducted by the RSD or the Administrator; the resident is interviewed and responses documented; witnesses or other persons may need to be interviewed as part of the investigation process; the RSD arranges for medical	D 273		

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D 273	Continued From page 7 evaluation of the resident as necessary; the family/responsible party is notified immediately of the incident; the resident's primary care physician (PCP) is notified immediately as necessary. -Reporting of any suspected, alleged, or witnessed abuse will be completed according to state reporting requirements. -The facility shall immediately notify the county department of social services and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. -The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register. -Any staff member willfully participating in this abuse will be terminated. Review of Resident #7's current FL-2 dated 10/30/20 revealed: -Diagnoses included left hip fracture, non-operable, bifrontal subarachnoid hemorrhage (AH), advanced dementia, hypertension, hypothyroidism, osteoarthritis and frequent falls. -She was constantly disoriented. -She was non-ambulatory and required total care with personal care assistance. Review of Resident #7's care plan dated 04/28/21 revealed: -She required limited assistance with ambulation/locomotion. -She was independent with transfers. Review of an Incident Report for Resident #7 dated 02/09/21 at 3:45pm revealed: -The incident occurred in Resident #7's room. -The staff observed Resident #7 to be restrained to her wheelchair by a long-sleeved shirt. -Resident #7 had no visible bruises or injuries	D 273		

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D 273	Continued From page 8 and vital signs were obtained. -Resident #7 had no loss of consciousness and normal range of motion. -The Memory Care Manager (MCM) was notified on 02/09/21 at 3:45pm. -Resident #7's primary care physician (PCP) was notified on 02/09/21 at 4:30pm. -Resident #7's family member was notified on 02/09/21 at 8:20pm. -Resident #7 was not sent to the hospital. -The staff were to continue to monitor Resident #7 for any changes. -Resident #7 was seen by her PCP; there was no date or time documented for when the PCP visit occurred. Review of a witness statement dated 02/09/21 revealed: -The author of the statement was a personal care assistant (PCA) that was scheduled to work 3:00pm-11:00pm shift on 02/09/21. -She went to Resident #7's room to look for her and noticed that the room door was locked. -She unlocked the room door and observed Resident #7 tied to the wheelchair around her waist with some pants. Review of a second witness statement revealed: -The witness statement was not dated. -The author of the witness statement was the former Administrator. -He was notified by a second shift PCA that Resident #7 was tied to her wheelchair in her room. -He went into Resident #7's room and observed her to be tied to her chair with a navy blue, long sleeved t-shirt. -The shirt was around Resident #7's upper body and the wheelchair and was tied behind her and Resident #7 was unable to get up from the chair.	D 273		

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D 273	Continued From page 9 -Resident #7 was able to move her arms freely. -The staff untied the shirt and assessed Resident #7 for injuries. -There were no apparent injuries. -There were no changes in Resident #7's mental status and she was responsive as normal. Review of a Health Care Personal Registry (HCPR) 5-Working Day Report dated 02/19/21 revealed: -There was an allegation of resident abuse related to Resident #7 that occurred on 02/09/21 at 3:45pm. -On 02/09/21 around 3:40pm, Resident #7 was discovered in her room by a PCA tied to her wheelchair with a long sleeve t-shirt. -The t-shirt was around Resident #7's upper body and the wheelchair and was tied behind her. -Resident #7 was able to move her arms freely but was not able to get up from the chair freely. -The t-shirt was immediately untied and there were no apparent injuries. -Resident #7's PCP was notified by the supervisor. -The former Administrator notified Resident #7's family member. -There were two 1st shift staff that were contacted and placed on suspension pending the investigation. -One staff stated she last saw Resident #7 on 02/09/21 around 1:00pm in the common area. -The former Administrator attempted to contact the second staff via telephone several times but was not successful. -The second staff responded to the former Administrator via electronic mail (email) and stated that "it wasn't done intentional, it was for her safety cuz she can't fall again." -There were 2 staff for 9 memory care residents on the memory care unit; there was a readily	D 273		

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D 273	Continued From page 10 available supervisor; there were other PCAs that could have been notified if additional assistance was needed. -Resident #7 was seen by her PCP on 02/11/21 and 02/18/21. -Resident #7's PCP performed a "thorough examination" with no findings of injury. -The former Administrator followed up with Resident #7's family member and informed him of the findings and conclusion of the investigation. Review of a physician's visit note for Resident #7 dated 02/18/21 revealed: -Resident #7 was seen by her PCP on 02/18/21 due to being restrained by staff. -The incident occurred on 02/09/21. -Resident #7 was thoroughly examined by PCP with no injuries noted. -The PCP documented she was not made aware of the 02/09/21 incident until 02/16/21 and was therefore not aware when she saw Resident #7 on 02/11/21. Interview with a PCA on 04/30/21 at 2:31pm revealed: -She worked on the Memory Care Unit (MCU) on 02/09/21 on the 7:00am-3:00pm shift. -She last saw Resident #7 at the nurses' station after lunch at about 1:00pm on 02/09/21. -On 02/09/21, she heard another staff say she was going to tie Resident #7 up while she was sitting at the nurses' station but thought the other staff said it jokingly. -She was made aware of Resident #7 being restrained by the former Administrator on 02/09/21 at about 7:00pm. -She discussed the above events with the former Administrator and was suspended pending investigation results. -She returned to work about 1 week later and was	D 273		

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D 273	Continued From page 11 reeducated on restraints and reporting abuse. Interview with Resident #7's PCP on 04/29/21 at 1:33pm revealed: -On 02/11/21, she was in the facility and followed up with Resident #7 related to abnormal blood pressure and heart rate. -She was not aware of the incident that occurred with Resident #7 on 02/09/21. -On 02/16/21, she was notified, by telephone, of the incident that occurred with Resident #7 on 02/09/21. -She was informed on 02/16/21 that Resident #7 had a sheet tied around her hands restraining her to the wheelchair and there were no injuries sustained. -She was not sure how long Resident #7 was restrained. -She was not sure what staff member notified her of that incident. -She was informed that the incident was investigated and that the accused person was terminated. -On 02/18/21, she was in the facility and followed up with Resident #7 related to the incident that occurred on 02/09/21 and there were no injuries noted. -There was not a restraint order for Resident #7. -There had never been a restraint order for Resident #7. -She was aware that Resident #7 attempted to stand up from her wheelchair unassisted at times but was not aware of any other behaviors. -She was concerned with the facility's delay to notify her of the 02/09/21 incident. -She expected to have been notified immediately of the incident that occurred with Resident #7 on 02/09/21. -Restraints were considered abuse and neglect and should be reported to the Administrator, the	D 273		

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D 273	Continued From page 12 PCP and the family member immediately. -She addressed her concerns with the management staff however she could not remember who the management staff were or when she addressed the concerns. Telephone interview with Resident #7's family member on 04/30/21 at 11:10am revealed: -Resident #7 had resided at the facility for about 3 years. -He was notified of Resident #7 being restrained to her wheelchair by her shirt. Based on observations, record reviews and interviews it was determined that Resident #7 was not interviewable. Attempted interview with the former Administrator on 04/30/21 at 10:24am was not successful. Attempted interview with the former personal care assistant (PCA) 04/30/21 at 10:30am was not successful.	D 273		
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:	D 358	The facility will administer medications as ordered and in accordance within the guidelines of NC state regulations. Medication Aides were re-trained by RSD utilizing the NC 15 Hour Medication Curriculum on 5/6/21.. Medication administration audits will be completed weekly by RSD/RCC for four (4) weeks to identify any training needed and to monitor for compliance. Multidisciplinary review and audits of MAR/ Charts/Med Carts by Pharmacy was conducted on 5/26/21.	

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	HAL092215	A. BUILDING: _____ B. WING _____	04/30/2021

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CADENCE GARNER	200 MINGLEWOOD DRIVE GARNER, NC 27529

(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 13 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 4 residents (#7, #8) observed during the medication passes including errors with medications for treatment of allergy symptoms, hemorrhoids, and dry eyes (#8), and an extended release pain medication that was crushed (#7); and for 3 of 7 residents sampled (#4, #5, #6) for record review including errors with insulin (#4), an antidepressant (#5), a medication for prevention of heart disease (#5), and narcotic pain medications (#5, #6). The findings are: 1. The medication error rate was 13% as evidenced by the observation of 4 errors out of 30 opportunities during the 8:00am/9:00am medication passes on 04/28/21. a. Review of Resident #8's current FL-2 dated 12/22/20 revealed diagnoses included frontal-temporal dementia, hemorrhoids, gastroesophageal reflux disease, seasonal allergies, lower back pain and left knee pain. Review of Resident #8's physician's orders dated 03/11/21 revealed an order for Ipratropium spray 0.03%, instill 2 sprays into each nostril twice a day. (Ipratropium is used to treat allergy symptoms.) Observation of the morning medication pass on 04/28/21 at 8:09am revealed: -The medication aide (MA) handed Resident #8 her Ipratropium nasal spray without providing her instructions for administration.	D 358	Quarterly onsite reviews will be conducted by the pharmacy according to NC State Regulations. Executive Director will be immediately notified if onsite reviews cannot be conducted. Scanner devises will be implemented by 6/14/21 with staff education by RSD/RGC for accurate documentation of medication administration. All corrective measures will be implemented by 6/14/21. Continued monitoring of compliance will be conducted through QA audits, compliance trends and patterns.	

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D 358	Continued From page 14 -Resident #8 administered 2 sprays in the right nostril and 1 spray in the left nostril instead of 2 sprays in each nostril as ordered. -The MA did not offer instruction or attempt to remind the resident of the second spray needed in the left nostril. Review of Resident #8's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Ipratropium spray 0.03%, instill 2 sprays into each nostril twice a day. -Ipratropium spray 0.03% was scheduled for administration twice a day at 8:00am and 8:00pm -Ipratropium spray 0.03% was documented as administered twice a day from 04/01/21 to 04/27/21 and at 8:00am on 04/28/21. Interview with Resident #8 on 04/28/21 at 8:13am revealed: -She used the Ipratropium nasal spray to help with her allergies. -If she did not take the Ipratropium spray as ordered she would get a runny nose or nose bleed. -She always held and sprayed the nasal spray herself and "usually" did 2 sprays in each nostril. Interview with the MA on 04/28/21 at 1:00pm revealed: -Resident #8 wanted to administer the nasal spray herself. -Resident #8 would not let staff administer her nasal spray. -She thought Resident #8 was supposed to get 1 to 2 sprays of Ipratropium in each nostril. -She thought the resident sprayed 2 times in each nostril during the morning medication pass (04/28/21). -After reviewing the eMAR during the interview,	D 358		

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D 358	Continued From page 15 the MA then stated the resident should get 2 sprays in each nostril. Interview with the Resident Services Director (RSD) on 04/28/21 at 2:05pm revealed: -She expected residents to receive their medications as ordered. -She was not aware that Resident #8 only received half of the Ipratropium spray 0.03% ordered for the left nostril. -She expected staff to instruct the resident if they did not administer the correct dose. Interview with the Administrator on 04/28/21 at 2:05pm revealed she expected residents to receive their medications as ordered. Interview with Resident #8's primary care provider (PCP) on 04/29/21 at 1:33pm revealed: -She expected medications to be administered as ordered. -She was not aware that Resident #8 only received 1 spray of the Ipratropium spray 0.03% in her left nostril during the medication pass on 04/28/21, when the order was for 2 sprays in both nostrils. -Resident #8 was at risk for increased seasonal allergy symptoms if she did not receive the full dose ordered. b. Review of Resident #8's physician's orders dated 03/11/21 revealed an order for Preparation H cream, apply rectally 4 times a day. (Preparation H is a medication used to treat hemorrhoids.) Review of Resident #8's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Preparation H cream,	D 358		

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D 358	Continued From page 16 apply topically rectally 4 times a day. -Preparation H cream was scheduled to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm. Observation of the 8:00am medication pass on 04/28/21 at 8:10am revealed Preparation H cream was not administered or offered to Resident #8 when she received her other morning medications at 8:10am. Interview with the medication aide (MA) on 04/28/21 at 8:12am revealed Resident #8 was scheduled to receive no additional medications that morning. A second review of Resident #8's April 2021 eMAR on 04/28/21 at 12:10pm revealed Preparation H cream was documented as administered on 04/28/21 at 8:00am. Interview with the MA on 04/28/21 at 1:00pm revealed: -Resident #8 usually applied the Preparation H cream herself. -The resident requested the cream first thing in the morning around 7:15am. -She placed the cream in a medication cup for the resident to use. -She had already given Resident #8 her Preparation H cream before the morning medication pass. -She thought the resident had an order to apply the cream herself. Observation of Resident #8's medication on hand on 04/28/21 at 1:00pm revealed there was a 0.9 ounce tube of Preparation H cream with a handwritten open date of "12/13/20".	D 358		

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D 358	Continued From page 17 Interview with Resident #8 on 04/28/21 at 4:36pm revealed: -Staff brought the cream to her room once a day, in a plastic medication cup at 7:25pm. -She only used the Preparation H cream at bedtime. -She did not receive any Preparation H cream yet today (04/28/21). -The hemorrhoids continued to cause rectal bleeding and pain. Interview with the Resident Services Director (RSD) on 04/28/21 at 2:05pm revealed: -Medications should be administered as ordered. -She was not aware that Resident #8 did not receive her Preparation H cream as ordered that morning (04/28/21). -She was not aware the resident only received Preparation H cream daily instead of 4 times a day, as ordered. Interview with the Administrator on 04/28/21 at 2:05pm revealed she expected residents to receive their medications as ordered. Interview with Resident #8's primary care provider (PCP) on 04/29/21 at 1:33pm revealed: -She expected Resident #8's Preparation H cream to be administered as ordered. -She expected to be notified if medication was not being administered as ordered. -She was not notified that Resident #8 only received her Preparation H cream once daily. -If Resident #8 did not receive her Preparation H cream as ordered she may experience a "flare up" in hemorrhoids. c. Review of Resident #8's physician's orders dated 03/11/21 revealed an order for Restasis 0.05%, instill one drop in each eye every 12	D 358		

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D 358	Continued From page 18 hours. (Restasis is a medication used to treat dry eyes. Restasis is packaged in single-use vials because it does not contain preservatives. According to the manufacturer, one vial should be used each time and immediately discarded after each use.) Review of Resident #8's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Restasis 0.05%, instill one drop in each eye every 12 hours. -Restasis 0.05% was scheduled to be administered at 8:00am and 8:00pm. Observation of the 8:00am medication pass on 04/28/21 at 8:10am revealed: -The medication aide (MA) handed Resident #8 one single-use plastic vial of Restasis 0.05% eye drops. -Resident #8 took the unopened Restasis 0.05% vial to her room. -The MA did not attempt to administer the eye drops to the resident. A second review of Resident #8's April 2021 eMAR on 04/28/21 at 12:10pm revealed Restasis 0.05% was documented as administered on 04/28/21 at 8:00am. Observation of Resident #8's room on 04/28/21 at 8:13am revealed: -There was an opened, empty plastic vial of Restasis 0.05% in her trash can. -There was an unopened, plastic Restasis 0.05% vial on the resident's bedside table. Interview with Resident #8 on 04/28/21 at 8:13am revealed: -The empty Restasis vial in the trash can was the	D 358		

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D 358	Continued From page 19 supply she received yesterday. -She would use the unopened vial multiple times throughout the day. Observation of Resident #8's room on 04/28/21 at 4:36pm revealed the unopened, plastic Restasis 0.05% vial was still on the resident's bedside table. Interview with a MA on 04/28/21 at 1:00pm revealed: -Resident #8 would not allow staff to instill her Restasis drops in her eyes. -The resident would usually use her eye drops at the medication cart. -Resident #8 used the Restasis eye drops one drop in each eye, twice. -Resident #8 used the same vial both times. -She was not aware the Restasis vials were single-use vials and should be discarded after each use. Interview with the Resident Services Director (RSD) on 04/28/21 at 2:05pm revealed: -Medications should be administered as ordered. -She was not aware Resident #8 was using the single-use Restasis vial multiple times throughout the day. -She was concerned that there would be a risk for infection when using the Restasis eye drops throughout the day. Interview with the Administrator on 04/28/21 at 2:05pm revealed she expected residents to receive their medications as ordered. Interview with Resident #8's primary care provider (PCP) on 04/29/21 at 1:33pm revealed: -She expected Resident #8's Restasis eye drops to be administered as ordered.	D 358		

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D 358	Continued From page 20 -She would be concerned with contamination if Resident #8 was using the single-use vial throughout the day. -She was not aware that Resident #8 was using the single-use Restasis eye drops throughout the day. d. Review of Resident #7's current FL-2 dated 10/30/20 revealed diagnoses included left hip fracture, bifrontal subarachnoid hemorrhage, advanced dementia, hypertension, hypothyroidism, osteoarthritis, and frequent falls. Review of Resident #7's physician's orders dated 03/11/21 revealed an order for Arthritis Pain 650mg tabs, take 2 tablets (1300mg) by mouth twice a day *DO NOT CRUSH*. (Arthritis Pain is an extended release medication used to treat arthritic pain.) Review of Resident #7's standing orders dated 04/01/21 revealed: -There was an order for may crush meds and/or place in applesauce/pudding, or juice if not contraindicated by pharmacy. -Refer to DO NOT CRUSH (DNC) list. Observation of the 8:00am medication pass on 04/28/21 revealed: -The Memory Care Manager (MCM) prepared morning medications for Resident #7 at 8:50am, including two Arthritis Pain 650mg tablets. -Resident #7 spit the medications back out at 8:54am. -The MCM then crushed all of Resident #7's oral medications including the two Arthritis Pain 650mg tablets, mixed them in butterscotch pudding and administered them to the resident at 9:00am. -Resident #7 spit 3 to 4 small pieces of tablets out	D 358		

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D 358	Continued From page 21 at 9:01am. Observation of Resident #7's medications on hand on 04/28/21 at 1:36pm revealed: -There was a supply of Arthritis Pain 650mg tablets dispensed on 03/24/21. -There was an auxiliary label with "don't chew or crush- swallow whole" on the medication label. Review of Resident #7's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for 8-hour Arthritis tablet 650mg, take 2 tablets (1300mg) by mouth twice a day**Do Not Crush**. -The 8-hour Arthritis 650mg tablets were documented as administered on 04/28/21 at 8:00am. Review of the facility's DNC medication list revealed Tylenol 8 hour was included on the list as a medication that should not be crushed due to it being time release formulation. (Arthritis Pain 650mg is a generic brand of Tylenol 8 hour Arthritis.) Interview with the MCM on 04/28/21 at 1:35pm revealed: -If a medication could not be crushed it would say that on the eMAR. -She "overlooked" the do not crush instructions on the eMAR this morning (04/28/21). -This morning was the first time that she had to crush Resident #7's medications. -She was not aware there was a DNC list in the 'Cart Notebook' stored on top of the medication cart. Interview with the Resident Services Director (RSD) on 04/28/21 at 2:05pm revealed:	D 358		

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D 358	Continued From page 22 -She administered Resident #7's morning medication yesterday (04/27/21). -Resident #7 was not able to swallow her medications yesterday. -She crushed all of her oral medication except the two Arthritis Pain 650mg tablets because it was listed on the eMAR and labeled not to crush. -Staff should refer to the eMAR, label, and DNC list for medications that could not be crushed. Interview with the Administrator on 04/28/21 at 2:05pm revealed: -She expected residents to receive their medications as ordered. -She expected staff to refer to the eMAR, label and DNC list for medications that could not be crushed. Interview with Resident #7's primary care provider (PCP) on 04/29/21 at 1:33pm revealed: -She was made aware today (04/29/21) that Resident #7 had difficulty swallowing medications. -She was concerned that she was not immediately notified that Resident #7 was having difficulty swallowing her medications. -Resident #7's Arthritis Pain 650mg tablets should not have been crushed because the medication would not be released properly. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. 2. Review of Resident #4's current FL-2 dated 10/08/20 revealed diagnoses included dementia, type 2 diabetes mellitus, hypertension, hyperlipidemia, carotid stenosis, and chronic kidney disease - stage 3.	D 358		

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D 358	Continued From page 23 Review of Resident #4's physician's order dated 01/13/21 revealed an order to start Novolog insulin, inject 6 units with breakfast, lunch, and dinner. (Novolog is rapid-acting insulin used to lower blood sugar.) Review of Resident #4's physician's order dated 01/30/21 revealed an order to hold Novolog insulin for 3 days. Review of Resident #4's January 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog insulin, inject 6 units 3 times a day with meals scheduled at 8:00am, 12:00pm, and 5:00pm. -Novolog 6 units with meals was documented as administered 3 times a day from 8:00am on 01/14/21 through 5:00pm on 01/31/21. -There was no entry on the eMAR to hold Novolog insulin as ordered on 01/30/21 and no Novolog was documented as held. -The resident's blood sugar was checked twice a day at 7:30am and 4:30pm. -The resident's blood sugar ranged from 89 - 328 from 01/01/21 - 01/31/21. -The resident's blood sugar ranged from 89 - 226 from 01/30/21 - 01/31/21 when the Novolog was administered but should have been held. Review of Resident #4's February 2021 eMAR revealed: -There was an entry for Novolog insulin, inject 6 units 3 times a day with meals scheduled at 8:00am, 12:00pm, and 5:00pm. -Novolog 6 units with meals was documented as administered 3 times a day from 02/01/21 - 02/28/21. -There was no entry on the eMAR to hold Novolog insulin as ordered on 01/30/21 and no	D 358		

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D 358	Continued From page 24 Novolog was documented as held. -The resident's blood sugar was checked twice a day at 7:30am and 4:30pm. -The resident's blood sugar ranged from 68 - 282 from 02/01/21 - 02/28/21. -The resident's blood sugar was 169 and 201 on 02/01/21 when the Novolog was administered but should have been held. Interview with a medication aide (MA) on 04/30/21 at 11:49am revealed: -She did not recall Resident #4's Novolog being on hold at any time. -If the Novolog had been put on hold, it would not have come up on the eMAR for staff to administer it. -Medication orders were entered into the eMAR system by pharmacy staff. Interview with the Memory Care Manager (MCM) on 04/30/21 at 10:15am revealed: -The pharmacy usually entered orders into the eMAR system, including hold orders, and the facility approved the orders. -She or the Administrator, the Resident Services Director (RSD), or and Supervisor could approve orders in the eMAR system. -She did not recall Resident #4 having an order to hold Novolog insulin. -The order should have been sent to the pharmacy and entered and approved in the eMAR system. -She did not know if the Novolog insulin was held but it should have been held as ordered. Telephone interview with the Manager of Operations at the facility's contracted pharmacy on 04/30/21 at 11:58am revealed: -The pharmacy did not receive Resident #4's order dated 01/30/21 to hold Novolog insulin for 3	D 358		

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D 358	Continued From page 25 days. -The pharmacy staff usually entered medication orders, including hold orders, into the eMAR system. -The order to hold Novolog insulin was not entered into the eMAR system because the pharmacy never received the order. Interview with Resident #4's primary care provider (PCP) on 04/29/21 at 1:33pm revealed: -The order dated 01/30/21 to hold Novolog insulin was written by one of her on-call colleagues. -Their office received some lab results on 01/29/21 indicating Resident #4's blood glucose was 49 so that prompted the on-call provider to write the order to hold Novolog for 3 days on 01/30/21. -She was not aware the resident's Novolog insulin was not held as ordered on 01/30/21 for 3 days. -She expected the resident's Novolog insulin to be held as ordered. -Not holding the insulin, put the resident at risk for hypoglycemia (low blood sugar) including symptoms of confusion, dizziness, and lightheadedness which could put the resident at risk for falls. Interview with Resident #4 on 04/27/21 at 10:28am revealed: -He thought the MAs checked his blood sugar twice a day and he received insulin but he could not recall how often. -His blood sugar usually "runs alright". 3. Review of Resident #6's current FL-2 dated 04/28/21 revealed diagnoses included dyspnea, hypertension, osteoarthritis, history of pulmonary embolism, chronic kidney disease - stage 4, and hypothyroidism.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092215	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE GARNER	200 MINGLEWOOD DRIVE GARNER, NC 27529

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D 358	Continued From page 26 Review of Resident #6's physician's order dated 08/21/20 revealed an order for Tramadol 50mg 1 tablet 2 to 3 times a day as needed (prn) for pain. Review of Resident #6's clarification order dated 09/21/20 revealed the order should be Tramadol 50mg 1 tablet 3 times a day prn pain. Review of Resident #6's physician's order dated 02/03/21 revealed an order for Tramadol 50mg 1 tablet 2 to 3 times daily prn pain. Review of Resident #6's physician's order dated 02/11/21 revealed: -There was an order to discontinue Tramadol 50mg 1 tablet 2 to 3 times daily prn pain. -There was an order to start Tramadol 50mg 3 times a day. Review of Resident #6's physician's order dated 03/03/21 revealed an order for Tramadol 50mg 1 tablet 3 times daily prn pain. Review of Resident #6's physician's order dated 03/13/21 revealed: -There was an order to discontinue Tramadol 50mg 1 tablet 3 times daily prn pain. -There was an order to start Tramadol 50mg 3 times daily scheduled. Review of Resident #6's physician's order dated 03/18/21 revealed an order to continue Tramadol 50mg 1 tablet 3 times daily scheduled. Review of Resident #6's physician's order dated 04/22/21 revealed an order for Tramadol 50mg 1 tablet 3 times daily. Review of Resident #6's pharmacy dispensing records dated 01/01/21 - 04/29/21 revealed:	D 358		

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D 358	Continued From page 27 -There were 75 Tramadol 50mg tablets dispensed on 01/02/21. -There were 75 Tramadol 50mg tablets dispensed on 02/03/21. -There were 90 Tramadol 50mg tablets dispensed on 03/03/21. -There were 90 Tramadol 50mg tablets dispensed on 03/15/21. -There were 90 Tramadol 50mg tablets dispensed on 04/22/21. Review of Resident #6's progress notes revealed: -On 03/01/21 at 5:35pm, the resident's primary care provider's (PCP) office was called for a new prescription for Tramadol 50mg. -On 03/03/21 at 4:44pm, the pharmacy was called concerning the resident's Tramadol 50mg; the hard copy prescription was sent to the pharmacy that morning and Tramadol would be in the tote tonight. Review of Resident #6's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Tramadol 50mg 1 tablet 2 to 3 times a day prn pain. -The date "written" documented on the eMAR for the prn Tramadol was 02/03/21 and the stop date was 02/11/21. -There was 1 dose of prn Tramadol 50mg documented as administered on 02/05/21 at 2:11pm. -There was an entry for Tramadol 50mg 1 tablet 3 times a day scheduled for 8:00am, 2:00pm, and 8:00pm. -The date "written" documented on the eMAR was 02/11/21. -There was no Tramadol documented as administered on 02/11/21 at 8:00am or 2:00pm. -The first dose was documented on 02/11/21 at	D 358		

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D 358	Continued From page 28 8:00pm. -Tramadol was not documented as administered on 02/13/21 at 8:00am due to the medication being unavailable, "awaiting pharmacy". -There were 49 doses of scheduled Tramadol 50mg tablets documented as administered from 02/11/21 - 02/28/21. -There was a total of 50 Tramadol 50mg tablets documented as administered on the eMAR from 02/01/21 - 02/28/21. Review of Resident #6's controlled substance (CS) logs for Tramadol for February 2021 revealed: -There were 17 prn doses of Tramadol 50mg documented as administered from 02/12/21 - 02/28/21, after the prn order was discontinued on 2/11/21. -There was no scheduled Tramadol documented as administered on 02/11/21 at 8:00am or 2:00pm. -There was no Tramadol 50mg documented as administered on the CS log on 02/13/21 at 8:00am (and none documented on the eMAR due to medication being unavailable). -There was a total of 89 Tramadol 50mg tablets documented as administered on the CS log from 02/01/21 - 02/28/21. Review of Resident #6's March 2021 eMAR revealed: -There was an entry for Tramadol 50mg 1 tablet 3 times a day scheduled for 8:00am, 2:00pm, and 8:00pm. -The date "written" documented on the eMAR for this scheduled Tramadol was 02/11/21 and the stop date was 03/03/21. -The scheduled Tramadol 50mg was documented as administered 6 times from 03/01/21 at 8:00am through 03/02/21 at 8:00pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 29 -The 8:00am dose of Tramadol 50mg for 03/03/21 was not documented as administered due to waiting on hard copy prescription to be sent to the pharmacy. -There was a second entry for Tramadol 50mg 1 tablet 3 times a day prn pain. -The date "written" documented on the eMAR for the prn Tramadol was 03/03/21 and the stop date was 03/15/21. -There were no prn doses of Tramadol 50mg documented as administered in March 2021. -There was a third entry for Tramadol 50mg 1 tablet 3 times a day scheduled for 8:00am, 2:00pm, and 8:00pm. -The date "written" documented for the third entry of Tramadol 50mg was 03/13/21 and there was no stop date listed. -There was no scheduled Tramadol documented as administered from 03/13/21 at 8:00am - 03/15/21 at 2:00pm. -The first dose was documented on 03/15/21 at 8:00pm. -There were 49 doses of scheduled Tramadol 50mg tablets documented as administered from 03/15/21 - 03/31/21. -There was a total of 55 Tramadol 50mg tablets documented as administered on the eMAR from 03/01/21 - 03/31/21. Review of Resident #6's CS logs for Tramadol for March 2021 revealed: -There were 2 prn doses of Tramadol 50mg documented as administered at 1:00am on 03/01/21 and 03/03/21, after an order for prn Tramadol was discontinued on 02/11/21. -Tramadol was not documented as administered on 03/03/21 at 8:00am (and none documented on the eMAR due to medication being unavailable). -There were 17 scheduled doses of Tramadol	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 30 50mg documented as administered from 03/04/21 - 03/13/21 after the order changed to prn on 03/03/21. -There was no scheduled Tramadol documented as administered from 03/13/21 at 8:00am - 03/14/21 at 8:00pm. -There were 14 prn doses of Tramadol 50mg documented as administered from 03/14/21 - 03/31/21 after an order for prn Tramadol was discontinued on 03/13/21. -There was a total of 96 Tramadol 50mg tablets documented as administered on the CS log from 03/01/21 - 03/31/21. Review of Resident #6's April 2021 eMAR revealed: -There was an entry for Tramadol 50mg 1 tablet 3 times a day scheduled for 8:00am, 2:00pm, and 8:00pm. -The date "written" documented on the eMAR for the scheduled Tramadol was 03/13/21 and there was no stop date listed. -There were 89 doses of scheduled Tramadol 50mg tablets documented as administered from 04/01/21 - 04/30/21 at 2:00pm. Review of Resident #6's CS logs for Tramadol for April 2021 revealed: -There were 27 prn doses of Tramadol 50mg documented as administered from 04/01/21 - 04/30/21, after an order for prn Tramadol was discontinued on 03/13/21. -There was a total of 118 Tramadol 50mg tablets documented as administered on the CS log from 04/01/21 - 04/30/21. Observation of Resident #6's medications on hand on 04/30/21 at 11:20am revealed there was a total of 63 Tramadol 50mg tablets on hand.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 31 Review of Resident #6's medication orders, eMARs, CS logs, and medications on hand revealed: -There were 345 Tramadol 50mg tablets dispensed from 02/03/21 - 04/30/21. -There were 298 Tramadol 50mg tablets documented as administered from 02/03/21 - 04/30/21 on the CS logs. -There were only 194 Tramadol 50mg tablets documented as administered from 02/03/21 - 04/30/21 on the eMARs. -There was a total of 104 Tramadol 50mg tablets documented as administered on the CS logs that was not documented on the eMARs. -There were 75 prn doses of Tramadol 50mg documented as administered on the CS log and declined from the count when the prn order had been discontinued and no prn should have been administered. Interview with a medication aide (MA) on 04/29/21 at 8:06am revealed: -Resident #6 had run out of her Tramadol before (could not recall date). -The resident had gotten down to 3 pills so she requested a refill but it did not come in. -She was off that weekend so when she came back on that Monday, the resident was out of Tramadol. -She told the Memory Care Manager (MCM) and checked the computer which noted the resident needed a new hard copy prescription. -They had to get a new hard script for Tramadol from the primary care provider (PCP). -The resident was out of Tramadol for about 2 days but the resident did not complain of pain when she was out of the Tramadol to her knowledge. -When she worked on night shift, the resident would get a scheduled Tramadol at 8:00pm and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092216	A. BUILDING: _____ B. WING _____	04/30/2021

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D 358	Continued From page 32 around 1:00am or 2:00am, the resident would press her call light and ask for a prn Tramadol. -She was not aware Resident #6's prn Tramadol order had been discontinued. Interview with the Memory Care Manager (MCM) on 04/30/21 at 10:15am revealed: -The only reason the facility would run out of a medication would be if they were waiting for a hard copy prescription to be sent by the PCP to the pharmacy. -The MAs should contact the PCP for a hard script 7 to 8 days before the resident ran out of a medication. -She did not recall Resident #6 being out of Tramadol. -The MAs were supposed to document the administration of the Tramadol on the CS log and eMAR. -She was not aware the MAs continued to administer prn Tramadol after it was discontinued. -The MAs should administer the Tramadol as ordered. Telephone interview with the Manager of Operations at the facility's contracted pharmacy on 04/30/21 at 11:58am revealed: -The pharmacy usually notified the facility and provider when a hard copy prescription was needed to refill a controlled substance. -The facility was also supposed to notify the provider when a hard copy prescription was needed. -The pharmacy received a hard copy prescription for Resident #6's Tramadol on 03/03/21 and a new supply was sent to the facility that same day, 03/03/21. -The pharmacy entered orders into the eMAR system and the facility staff had to approve the	D 358		

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D 358	Continued From page 33 orders in the eMAR system. Interview with the Resident Services Director (RSD) on 04/30/21 at 3:58pm revealed: -The MAs were supposed to document on the CS log and the eMAR when a CS was administered. -If Resident #6's prn Tramadol was not listed on the eMAR, the MAs should not have administered it. -If the facility needed a new hard copy prescription, the pharmacy was supposed to notify the facility. -The facility and the pharmacy would let the PCP know and the PCP would send a new electronic prescription to the pharmacy and a copy to the facility. Interviews with Resident #6's PCP on 04/29/21 at 1:33pm and 4:11pm revealed: -Resident #6's Tramadol order had gone back and forth between prn and scheduled. -She was not aware Resident #6 had missed any doses of Tramadol but she would expect to be notified of any missed doses. -If a hard copy prescription was needed the facility had access to contact her 24 hours a day if needed. -Resident #6 had chronic bilateral knee pain and she was concerned if Resident #6 missed doses of Tramadol, the resident would have breakthrough pain. -Resident #6's prn Tramadol was last discontinued on 03/13/21 so the resident should not have received any prn Tramadol since it was discontinued on 03/13/21. -Continuing to administered prn Tramadol after it was discontinued put the resident at risk for oversedation. Interviews with Resident #6 on 04/27/21 at	D 358		

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D 358	Continued From page 34 9:45am and 04/30/21 at 3:37pm revealed: -The facility had run out of her medications, including her pain medication. -She usually received Tramadol 4 times a day at 8:00am, 2:00pm, 8:00pm, and 2:00am. -She had been getting Tramadol that way for about a year. -She took Tramadol for pain in her knees and hips. -Her pain level would get to 3 or 4 on a scale of 1 to 10 when she did not receive the Tramadol. 4. Review of Resident #5's current FL-2 dated 10/08/20 revealed diagnoses included dementia, cognitive dysfunction with behavioral disturbances, social or emotional deficit, osteoporosis, bone fracture, and asthma. Review of Resident #5's facility house orders dated 09/24/20 revealed: -Oral medications may be crushed and/or placed in applesauce, pudding, or juice if not contraindicated by pharmacy. -Refer to Do Not Crush List. -Do not crush "Timed Release" medication. -These house orders were checked off by her primary care provider (PCP) and signed. Review of Resident #5's facility standing orders dated 04/01/21 revealed: -May Crush Meds - May crush meds and/or placed in applesauce, pudding, or juice if not contraindicated by pharmacy. -Refer to Do Not Crush List. -These house orders were signed by a second PCP. Review of a form of Medications Not To Be Crushed List located on the Assisted Living (AL) medication cart on 04/28/21 at 1:48pm revealed:	D 358		

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D 358	Continued From page 35 -There were 4 pages of the form and listed as SIDE ONE, SIDE TWO, SIDE THREE and SIDE FOUR. -Each page was divided into alphabetized medications into two separate columns. -Each of the columns were divided into 4 sub-columns. -The four sub-columns were identified with Generic Names for medications, Brand Names for medications, Dosage forms, and a numbered guide for the reason the medication should not be crushed. -On SIDE FOUR of the form was a numeric guide listed for numbers 1-19 describing the reasons the medication should not be crushed. Interview with a medication aide (MA) on 04/30/21 at 8:06am revealed: -She worked third shift and administered medications for both the AL and special care unit (SCU) residents. -Resident #5 had trouble swallowing her medications. -She had put a message in the progress notes about Resident #5 having trouble swallowing. -She had documented it about 3 weeks ago. -She had notified the Resident Services Director (RSD) about it again last week. -She had been crushing Resident #5's medications since she first noticed the problem with her swallowing. -She said certain medications "popped" up on the computer as Do Not Crush. -She did not remember which ones cannot be crushed. -She crushed all of Resident #5's medications. -There was one gel capsule that she did not crush but would let it dissolve in the pudding/applesauce. -There were some mornings she would	D 358		

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D 358	Continued From page 36 administer the morning medications. -The mornings she worked were on the weekends. -She had worked on 04/11/21 04/12/21 04/24/21 and 04/25/21 and administered Resident #5's 8:00am medications. Review of Resident #5's April 2021 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Aspirin (a pain reliever used to treat mild to moderate pain) tab 81mg EC with directions to take 1 tablet by mouth once daily "DO NOT CRUSH". -There was an electronic entry for Duloxetine (used to treat depression and chronic muscle or bone pain) cap 60mg with directions to take 1 tablet by mouth oncedaily "DO NOT CRUSH". -There was an electronic entry for Oxycontin (a narcotic used to treat severe ongoing pain) tab 10mg with directions to take 1 tablet by mouth every 12 hours "DO NOT CRUSH". -There were 24 entries initialed from 04/02/21 to 04/26/21 as being administered at 8:00pm (by the MA interviewed who stated she "crushed all medications for Resident #5"). Review of a form of Medications Not To Be Crushed List located on the AL medication cart on 04/28/21 at 1:48pm revealed: -Aspirin EC was listed and the reason given was #1- Enteric Coated. -Duloxetine was listed and the reason given was #1- Enteric Coated. -Oxycontin was listed and the reason given was #2- Timed Release. Telephone interview with a second MA on 04/30/21 at 10:22am revealed: -Resident #5 took her medications without having	D 358		

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D 358	Continued From page 37 to crush them. -She talked to Resident #5, took her time, offered plenty of water to help get the medications down and she would take them. -It came up on the computer if the medication was not to be crushed. -If it said Do Not Crush, then you do not crush the medication. -There was a list on each of the medication carts for medications that cannot be crushed. -There was a notation on the medication package as well that said **DO NOT CRUSH**. Interview with a third MA on 04/30/21 at 1:55pm revealed: -She had not had to crush any of Resident #5's medications. -She gave Resident #5 one medication at a time. -Resident #5 had one medication that was bigger than the other medications. -That medication was a little harder for Resident #5 to swallow, but she got it down if she had enough water to drink. -She gave Resident #5 two cups of water when she administered her 8:00am medications. Interview with a personal care aide (PCA) on 04/30/21 at 3:35pm revealed: -Resident #5 ate well without any problems swallowing that she had seen. -She had been in Resident #5's room when the MA administered medications. -The MA gave Resident #5 one pill at a time with water after each pill. -She had never seen any MA who gave Resident #5 her medications that were crushed. Interview with Resident #5's PCP on 04/30/21 at 4:00pm revealed: -She was not aware that all of Resident #5's	D 358		

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	HAL092215	A. BUILDING: _____ B. WING _____	04/30/2021

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CADENCE GARNER	200 MINGLEWOOD DRIVE GARNER, NC 27529

(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 38 medications were being crushed. -She was very concerned about medications being crushed that should not be crushed. -Crushing the Oxycontin could possibly cause an overdose considering the resident's age and weight since the medication was timed-released. -Time released medications were used to release a small amount of the medication into the patient's system over a long period of time. -The Oxycontin was ordered every 12 hours since it was time-released. -She had signed the facility house orders for crushing medications unless there was a contraindication. -Duloxetine, Aspirin EC, and Oxycontin should not be crushed. Interview with the Administrator on 04/30/21 at 4:35pm revealed: -She was very concerned about all the MAs and all the issues they were having. -She was bringing in nurses from an agency to administer medications. -She was going to have all the MAs retrained and checked off on their skills before allowing them to administer medications again. -She expected the MAs to follow the directions on the eMARs, medication labels, and the Do Not Crush Lists. Interview with Resident #5's power of attorney (POA) on 04/30/21 at 2:17pm revealed: -She knew Resident #5's dementia was getting worse. -The family had decided to have Resident #5 moved to the SCU. -She was unaware of any problems with Resident #5 taking her medications. Based on observations, record reviews and	D 358		

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D 358	Continued From page 39 Interviews, it was determined Resident #5 was not interviewable. The facility failed to ensure medications were administered as ordered for 2 residents observed during the medication pass and for 3 residents sampled. The facility crushed medications that were time-released and on the facility's Do Not Crush list for 2 residents, including Resident #5's extended-released narcotic pain reliever which put the resident at risk of overdose due to the medication being released immediately instead of over a period of time. Resident #8 did not receive her Preparation H cream as ordered placing the resident at risk of worsening bleeding and pain. The facility failed to hold Resident #4's rapid-acting insulin for three days after the resident's blood glucose on labwork was 49, placing the resident at further risk of hypoglycemic episodes. Resident #6 received scheduled and prn Tramadol after the prn order had been discontinued putting the resident at risk for oversedation. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 14, 2021.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 366	See next page.	

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D 366	Continued From page 40 (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure medication aides observed residents taking their medication for 5 of 5 residents sampled (#1, #6, #8, #9, #10) including one resident during the medication pass (#8) on 04/28/21. The findings are: 1. Review of Resident #8's current FL-2 dated 12/22/20 revealed diagnoses included frontal-temporal dementia, hemorrhoids, gastroesophageal reflux disease, seasonal allergies, lower back pain and left knee pain. Review of Resident #8's Care Plan (Service Plan Detail) signed by her primary care provider (PCP) on 01/28/21 revealed: -Resident #8 required total assistance with medication management. -Resident was not able to take medications without assistance. Review of Resident #8's physician's orders dated 03/11/21 revealed: -Acidophilus Probiotic, take 1 capsule daily. (Acidophilus Probiotic is used to help restore the	D 366	The facility will administer medications as ordered and in accordance within the guidelines of NC state regulations. Medication aides were re-trained utilizing the NC 15 Hour Medication Curriculum on 5/6/21. Medication Administration audits will be completed weekly by RSD/RCC for four (4) weeks to identify any additional training needed and to monitor for compliance. Multidisciplinary review and audits of MAR/Charts/Med Carts by pharmacy was conducted on 5/26/21. Quarterly onsite reviews will be conducted by the pharmacy according to NC state regulations. Executive Director will be immediately notified if onsite reviews cannot be conducted. Scanner devised will be implemented by 6/14/21 with staff education by RSD/RCC for accurate documentation of medication administration. All corrective measures will be implemented by 6/14/21. Continued monitoring of compliance will be conducted through QA audits, compliance trends and patterns.	

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D 366	Continued From page 41 normal balance of intestinal bacteria.) -Arthritis Pain 650mg tablet, take 1 tablet twice a day. (Arthritis Pain is used to treat arthritic pain.) -Centrum Mature tablet Women 50+, take 1 tablet daily. (Centrum Mature is a multivitamin.) -Docusate Sodium 100mg capsule, take 1 capsule once daily. (Docusate Sodium is a stool softener.) -Fish Oil 1000mg, take 1 capsule once daily. (Fish oil is a supplement used to prevent heart disease.) -Fluvoxamine 25mg tablet, take 1 tablet twice a day. (Fluvoxamine is used to treat the symptoms of obsessive-compulsive disorder.) -Icy Hot Advance Relief 7.5% patch, apply 1 patch topically to the left knee. (Icy Hot is used to treat pain.) -Ipratropium spray 0.03%, instill 2 sprays into each nostril twice a day. (Ipratropium is used to treat allergy symptoms.) -Loratadine 10mg tablet, take 1 tablet once daily. (Loratadine is used to treat allergy symptoms.) -Memantine 10mg tablet, take 1 tablet twice daily. (Memantine is used to treat symptoms of dementia.) -Omeprazole 40mg capsule, take 1 capsule every morning 30 minutes before meal. (Omeprazole is used to treat gastroesophageal reflux disease.) -Restasis 0.05%, instill 1 drop in each eye every 12 hours. (Restasis is used to treat dry eyes.) -Salonpas Plus Lidocaine 4% patch, apply 1 patch topically once a day for 12 hours, then remove (12-hours off, 12 hours on) to lower back. (Salonpas is used to treat pain.) Review of Resident #8's physician's order dated 03/23/21 revealed Fluvoxamine was increased from 25mg to 50mg. Review of Resident #8's April 2021 electronic	D 366		

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D 366	Continued From page 42 medication administration record (eMAR) revealed: -There was an entry for Acidophilus Probiotic, take 1 capsule daily scheduled for administration at 8:00am. -There was an entry for Arthritis Pain 650mg tablet, take 1 tablet twice a day scheduled for administration at 8:00am and 8:00pm. -There was an entry for Centrum Mature tablet Women 50+, take 1 tablet daily scheduled for administration at 8:00am. -There was an entry for Docusate Sodium 100mg capsule, take 1 capsule once daily scheduled for administration at 8:00am. -There was an entry for Fish Oil 1000mg, take 1 capsule once daily scheduled for administration at 8:00am. -There was an entry for Fluvoxamine 50mg tablet, take 1 tablet twice a day scheduled for administration at 8:00am and 8:00pm. -There was an entry for Icy Hot Advance Relief 7.5% patch, apply 1 patch topically to the left knee scheduled for application at 8:00am. -There was an entry for Ipratropium spray 0.03%, instill 2 sprays into each nostril twice a day scheduled for administration at 8:00am and 8:00pm. -There was an entry for Loratadine 10mg tablet, take 1 tablet once daily scheduled for administration at 8:00am. -There was an entry for Memantine 10mg tablet, take 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for Omeprazole 40mg capsule, take 1 capsule every morning 30 minutes before meal scheduled for administration at 7:30am. -There was an entry for Restasis 0.05%, instill 1 drop in each eye every 12 hours scheduled for administration at 8:00am and 8:00pm.	D 366		

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D 366	Continued From page 43 -There was an entry Salonpas Plus Lidocaine 4% patch apply 1 patch topically once a day for 12 hours to lower back then remove, scheduled for application at 8:00am and removal at 8:00pm. Observation of the morning medication pass on 04/28/21 at 8:10am revealed: -The medication aide (MA) placed an Arthritis Pain tablet 650mg, an Acidophilus Probiotic capsule, a Centrum Mature tablet, a Docusate Sodium capsule, a Fish Oil capsule, a Fluvoxamine 50mg tablet, a Loratadine 10mg tablet, a Memantine 10mg tablet and an Omeprazole 40mg capsule in a clear plastic medication cup and handed it to Resident #8. (There were 9 pills in the plastic medication cup.) -The MA handed Resident #8 a Salonpas Plus Lidocaine 4% patch. -The MA handed Resident #8 an Icy Hot Advance Relief 7.5% patch. -The MA handed Resident #8 a single-use Restasis 0.05% vial. -Resident #8 took the medication cup with the 9 pills, the 2 patches, and the eye drops down the hall to her room. -The MA did not attempt to administer the medications to the resident or observe the resident take the medications. Observation of Resident #8 in her room on 04/28/21 at 8:13am revealed: -There was an empty plastic medication cup in the trash can next to the door. -Resident #8 placed the Salonpas Plus Lidocaine 4% patch on her lower back. -Resident #8 placed the Icy Hot Advance Relief 7.5% patch on her left knee. -There was an unopened Restasis 0.05% single-use vial on her bedside table. -There was no staff present in Resident #8's	D 366		

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D 366	Continued From page 44 room. Interview with Resident #8 on 04/28/21 at 8:13am revealed: -Staff did not stay with her and observe her take her medications. -She placed her patches on herself. -She put her eye drops in her eyes herself throughout the day. Review of Resident #8's record revealed a physician note dated 02/25/21 that stated "Patient cannot self-administer medications". Second interview with Resident #8 on 04/28/21 at 4:36pm revealed: -She left the Salonpas and Icy Hot Patch on all day and throughout the night. -She took off the patches in the morning before her shower at 6:15am. Interview with the MA on 04/28/21 at 1:00pm revealed: -Resident #8 normally swallowed her oral medications while standing at the medication cart. -The resident usually took the patches and the eye drops to her room because the resident would not allow staff to put on the patches or administer the eyedrops. -She was not sure if Resident #8 had a self-administer order for any of her medications. -If a resident did not have an order to self-administer medications then the MAs were expected to observe the resident take their medications. Interview with the Resident Services Director (RSD) on 04/28/21 at 1:35pm revealed: -She expected staff to observe residents take their medications.	D 366		

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D 366	Continued From page 45 -If staff did not watch residents take their medications there was no way to know for sure if they took it. -The MAs should observe Resident #8 take her medications because the resident had dementia. Interview with the Administrator on 04/28/21 at 1:35pm revealed she expected staff to observe residents take their medications, including Resident #8 because she had dementia. Interview with Resident #8's primary care provider (PCP) on 04/29/21 at 1:33pm revealed: -She expected staff to observe residents taking all of their medications. -She was concerned that staff was not observing Resident #8 taking her prescribed medications based on her mental health history and severe obsessive-compulsive disorder. -There were multiple orders in place to ensure Resident #8 was not administering her own medications. -It was important for staff to administer and observe Resident #8 take her medication to ensure she was receiving all her medications and using her patches correctly. Refer to the interview with the Resident Services Director (RSD) on 04/28/21 at 2:05pm. Refer to the interview with the Administrator on 04/28/21 at 2:05pm. Refer to confidential staff interview. 2. Review of Resident #1's FL-2 dated 04/21/21 revealed: -Diagnoses included type 2 diabetes, congestive heart failure, hypertension, history of pulmonary embolism, and chronic kidney disease.	D 366		

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D 366	Continued From page 46 -There was an order for Eliquis 2.5mg twice a day. (Eliquis is used to prevent blood clots.) -There was an order for Lantus 15 units every evening. (Lantus is used to treat diabetes). -There was an order for Senna Plus 8.6-50mg every evening. (Senna Plus is a laxative used to treat constipation). Interview with Resident #1 on 04/27/21 at 10:30am revealed: -The medication aides (MA) did not always watch him swallow his medications. -The MAs set his night time medications down on his bedside table, turned around and left before he took his medications. -It was usually in the evening when his medication was left on his bedside table. Review of Resident #1's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Eliquis 2.5mg, take one tablet by mouth twice a day. -Eliquis was scheduled for administration at 8:00am and 8:00pm. -There was an entry for Lantus 15 units subcutaneous every evening. -Lantus 15 units was scheduled for administration at 8:00pm. -There was an entry for Senna Plus 8.6-50mg tablet, take one by mouth every night. -Senna Plus 8.6-50mg was scheduled for administration at 8:00pm. Telephone interview with the Memory Care Manager (MCM) on 04/30/21 at 10:16am revealed: -She was aware of an incident when a family member found medication that was left by MAs in Resident #1's room about a month ago.	D 366		

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D 366	Continued From page 47 -The family member made the former Resident Services Director (RSD) aware about a month ago when she found a Lantus insulin pen in Resident #1's room. Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/29/21 at 9:40am was unsuccessful. Refer to the interview with the Resident Services Director (RSD) on 04/28/21 at 2:05pm. Refer to the interview with the Administrator on 04/28/21 at 2:05pm. Refer to confidential staff interview. 3. Review of Resident #9's FL-2 dated 04/14/21 revealed: -Diagnoses included metastatic breast cancer to spine, renal carcinoma, hypertension, mild hypothyroidism, chronic back pain, gastroesophageal reflux disease, and history of frequent falls. -There was an order for Duloxetine 30mg daily. (Duloxetine is used to treat depression.) -There was an order for Gabapentin 600mg at bedtime. (Gabapentin is used to treat neuropathic pain.) -There was an order for Levothyroxine 25mcg daily. (Levothyroxine is used to treat hypothyroidism.) -There was an order for Lisinopril 20mg daily. (Lisinopril is used to treat high blood pressure.) -There was an order for Magnesium Oxide 400mg daily. (Magnesium Oxide is used for magnesium replacement.) -There was an order for Mega Red Krill Oil capsule daily. (Mega Red Krill Oil is used as a supplement.)	D 366		

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D 366	Continued From page 48 -There was an order for Sodium Chloride 1GM twice a day. (Sodium Chloride is used for Sodium replacement.) -There was an order for Super B Complex Tablet daily. (Super B Complex is a multivitamin.) -There was an order for Vitamin B12 1000mcg daily. (Vitamin B12 is used for vitamin replacement therapy.) -There was an order for Vitamin D3 2000u daily. (Vitamin D3 is used for vitamin replacement therapy.) Review of Resident #9's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Duloxetine 30mg daily. - Duloxetine 30mg was scheduled for administration at 8:00am. -There was an entry for Gabapentin 600mg at bedtime. -Gabapentin 600mg was scheduled for administration at 8:00pm. -There was an entry for Levothyroxine 25mcg daily. -Levothyroxine 25mcg was scheduled for administration at 6:30am. -There was an entry for Lisinopril 20mg daily. -Lisinopril 20mg was scheduled for administration at 8:00am. -There was an entry for Magnesium Oxide 400mg daily. -Magnesium Oxide 400mg was scheduled for administration at 8:00am. -There was an entry for Mega Red Krill Oil capsule daily. -Mega Red Krill Oil was scheduled for administration at 8:00am. -There was an entry for Sodium Chloride 1GM twice a day. -Sodium Chloride 1GM was scheduled for	D 366		

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D 366	Continued From page 49 administration at 8:00am and 8:00pm. -There was an entry for Super B Complex Tablet daily. -Super B Complex Tablet was scheduled for administration at 8:00am. -There was an entry for Vitamin B12 1000mcg daily. -Vitamin B12 was scheduled for administration at 8:00am. -There was an entry for Vitamin D3 2000u daily. -Vitamin D3 was scheduled for administration at 8:00am. Interview with Resident #9 on 04/27/21 at 10:15am revealed: -The medication aides (MAs) would sometimes leave her medications in her room if she was out for a meal or activity. -The MAs would not always observe her swallow her medications. Interview with a MA on 04/28/21 at 1:00pm revealed: -She sometimes left Resident #9's medications in her room. -Resident #9 was oriented and she would leave her medications for her in her room after breakfast. Attempted telephone interview with Resident #9's primary care provider (PCP) on 04/30/21 at 11:31am was unsuccessful. Refer to the interview with the Resident Services Director (RSD) on 04/28/21 at 2:05pm. Refer to the interview with the Administrator on 04/28/21 at 2:05pm. Refer to confidential staff interview.	D 366		

Division of Health Service Regulation

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D 366	Continued From page 50 4. Review of Resident #6's current FL-2 dated 04/28/21 revealed: -Diagnoses included dyspnea, hypertension, osteoarthritis, history of pulmonary embolism, chronic kidney disease - stage 4, and hypothyroidism. Interview with Resident #6 on 04/27/21 at 9:45am revealed: -This morning (04/27/21) the MA handed her medications to her in a medication cup when she left the dining room. -The resident took the medications to her room and she took the medications after she got back to her room. -The MA did not observe her take her morning medications on 04/27/21. -Some of the other MAs also let her take her medications to her room or sometimes the MAs would just leave the medications in a cup in her room and the resident would take the medications later with no one observing her. -If she was in the dining room and a MA asked if she wanted her medications she told them she would take the medications after she had food on her stomach, so the MAs would leave the medications in her room. Second interview with Resident #6 on 04/30/21 at 3:37pm revealed: -The MA left her medications again this morning (04/30/21) in her room and she took them after breakfast with no one observing her. -At night, the MAs would leave her night pills, including Tramadol and Tylenol at her bedside and she would take the Tramadol between 1:00am and 2:00am and the Tylenol at 5:30am when she got up.	D 366		

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D 366	Continued From page 51 Review of Resident #6's physician's order dated 03/09/21 revealed: -There was an order for Famotidine 20mg daily. (Famotidine is for acid reflux.) -There was an order for Febuxostat 40mg daily. (Febuxostat is used to treat gout.) -There was an order for Gabapentin 100mg 2 capsules 3 times a day. (Gabapentin is used to treat nerve pain.) -There was an order for Levothyroxine 125mcg 1 tablet every morning before breakfast. (Levothyroxine is for hypothyroidism.) -There was an order for Metoprolol Succinate 50mg ER once daily. (Metoprolol Succinate lowers blood pressure.) -There was an order for Torsemide 10mg once daily. (Torsemide is a diuretic.) -There was an order for Vitamin B12 100mcg ½ tablet daily. (Vitamin B12 is a supplement.) -There was an order for Tylenol 500mg 2 tablets every 4 hours as needed for headache or minor pain. (Tylenol is for pain.) Review of Resident #6's physician's order dated 03/11/21 revealed an order to start Ropinirole 0.25mg at bedtime. (Ropinirole is used to treat Parkinson's disease.) Review of Resident #6's physician's order dated 03/13/21 revealed: -There was an order to discontinue Tramadol 50mg 1 tablet 3 times daily as needed for pain. -There was an order to start Tramadol 50mg 3 times daily scheduled. Review of Resident #6's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Famotidine 20mg daily at 4:00pm.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092215	A. BUILDING: _____ B. WING _____	04/30/2021

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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 366	Continued From page 52 -There was an entry for Febuxostat 40mg daily at 8:30am. --There was an entry for Gabapentin 100mg 2 capsules 3 times a day at 8:30am, 2:00pm, and 8:00pm. -There was an entry for Levothyroxine 125mcg 1 tablet every morning before breakfast at 6:30am. -There was an entry for Metoprolol Succinate 50mg ER once daily at 8:30am. -There was an entry for Ropinirole 0.25mg at bedtime at 8:00pm. -There was an entry for Torsemide 10mg once daily at 8:00am. -There was an entry for Tramadol 50mg 1 tablet 3 times a day at 8:00am, 2:00pm, and 8:00pm. -There was an entry for Vitamin B12 100mcg ½ tablet daily at 8:00am. -There was an entry for Tylenol 500mg 2 tablets every 4 hours as needed for headache or minor pain. Interview with Resident #6's primary care provider (PCP) on 04/29/21 at 1:33pm revealed Resident #6 was alert and oriented but she expected staff to follow proper procedures and observe the resident take her medications. Refer to the interview with the Resident Services Director (RSD) on 04/28/21 at 2:05pm. Refer to the interview with the Administrator on 04/28/21 at 2:05pm. Refer to confidential staff interview. 5. Review of Resident #10's current FL-2 dated 06/09/20 revealed: -Diagnoses included mild cognitive impairment, essential hypertension, major depression, hyperlipidemia, neurogenic bladder,	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 366	Continued From page 53 non-traumatic intracerebral hemorrhage, urinary incontinence, and malignant neoplasm of the breast. -The resident was intermittently disoriented. Review of Resident #10's service plan detail signed by the primary care provider (PCP) on 01/28/21 revealed: -The resident's diagnoses included dementia without behavioral disturbance. -The resident was able to communicate effectively and make needs known. -The resident was oriented to person, place, and time. -The resident's medications would be stored in a locked med cart located in the med room. Interview with Resident #10 on 04/27/21 at 10:14am revealed: -The MAs did not always watch her take her medications. -Last night (04/26/21), the MA left her night medications in a cup sitting on a tray in her room. -She took the medications when she got ready to take them before she went to bed and no one observed her take the medications. -It was not unusual for the MAs to leave the medications in her room for her to take without anyone observing her. Review of Resident #10's physician's orders dated 03/11/21 revealed: -There was an order for Acidophilus Probiotic 1 capsule once daily. (Acidophilus Probiotic is used to restore the balance of intestinal bacteria.) -There was an order for Amlodipine 5mg 1 tablet daily. (Amlodipine lowers blood pressure.) -There was an order for Budesonide 3mg 2 capsules once daily. (Budesonide is a corticosteroid used to treat inflammation of the	D 366		

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
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D 366	Continued From page 54 intestines.) -There was an order for Bupropion XL 300mg 1 tablet every morning. (Bupropion XL is an antidepressant.) -There was an order for Folic Acid 400mcg 1 tablet daily. (Folic Acid is a vitamin supplement.) -There was an order for Melatonin 10mg 1 tablet at bedtime. (Melatonin is used to treat insomnia.) -There was an order for Myrbetriq 25mg 1 tablet daily. (Myrbetriq is for overactive bladder.) -There was an order for Omeprazole 40mg 1 capsule every morning 30 minutes before morning meal. (Omeprazole is for acid reflux.) -There was an order for Oxybutynin 15mg ER 1 tablet at bedtime. (Oxybutynin ER is for overactive bladder.) -There was an order for Trazodone 50mg 1 tablet at bedtime. (Trazodone is an antidepressant and may also be used for insomnia.) -There was an order for Venlafaxine 150mg ER 1 capsule daily. (Venlafaxine ER is an antidepressant.) -There was an order for Vitamin B12 1000mcg 1 tablet once daily. (Vitamin B12 is a vitamin supplement.) -There was an order for Vitamin E 400units 1 capsule once daily. (Vitamin E is a vitamin supplement.) Review of Resident #10's physician's order dated 03/30/21 revealed an order for Famotidine 20mg 1 tablet at bedtime for 28 days. (Famotidine is for heartburn/acid reflux.) Review of Resident #10's physician's order dated 04/06/21 revealed an order for Docusate Sodium 100mg 1 capsule at bedtime on Mondays, Wednesdays, and Fridays. (Docusate Sodium is a stool softener.)	D 366		

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D 366	Continued From page 55 Review of Resident #10's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Acidophilus Probiotic 1 capsule once daily scheduled at 8:00am. -There was an entry for Amlodipine 5mg 1 tablet daily scheduled at 8:00am. -There was an entry for Budesonide 3mg 2 capsules once daily scheduled at 8:00am. -There was an entry for Bupropion XL 300mg 1 tablet every morning scheduled at 8:00am. -There was an entry for Docusate Sodium 100mg 1 capsule at bedtime on Mondays, Wednesdays, and Fridays scheduled on those days at 8:00pm. -There was an entry for Famotidine 20mg 1 tablet at bedtime for 28 days scheduled at 8:00pm. -There was an entry for Folic Acid 400mcg 1 tablet daily scheduled at 8:00am. -There was an entry for Melatonin 10mg 1 tablet at bedtime scheduled at 8:00pm. -There was an entry for Myrbetriq 25mg 1 tablet daily scheduled at 8:00am. -There was an entry for Omeprazole 40mg 1 capsule every morning 30 minutes before morning meal scheduled at 7:30am. -There was an entry for Oxybutynin 15mg ER 1 tablet at bedtime scheduled at 8:00pm. -There was an entry for Trazodone 50mg 1 tablet at bedtime scheduled at 8:00pm. -There was an entry for Venlafaxine 150mg ER 1 capsule daily scheduled at 8:00am. -There was an entry for Vitamin B12 1000mcg 1 tablet once daily scheduled at 8:00am. -There was an entry for Vitamin E 400units 1 capsule once daily scheduled at 8:00am. Interview with Resident #10's primary care provider (PCP) on 04/29/21 at 1:33pm revealed: -She was concerned that the MAs were not observing Resident #10 take her medications.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 366	Continued From page 56 -Resident #10 took psychiatric medications for mood stabilization and it was important for staff to make sure the resident took those medications to prevent mood or behavior issues. Refer to the interview with the Resident Services Director (RSD) on 04/28/21 at 2:05pm. Refer to the interview with the Administrator on 04/28/21 at 2:05pm. Refer to confidential staff interview. Interview with the Resident Services Director (RSD) on 04/28/21 at 2:05pm revealed: -She was aware the MAs were not always observing resident's take their medications because a resident's family member had brought it to management's attention about a month ago. -She spoke with all 3 current MAs at that time and discussed the rule requiring MAs to observe residents take their medications. -She expected staff to observe residents take their medications. Interview with the Administrator on 04/28/21 at 2:05pm revealed -She was aware of a problem with the MAs not observing resident's take their medications because a resident's family member had brought it to management's attention a couple of weeks ago. -The RSD had a meeting with the MAs to remind them to observe residents take their medications. -She expected staff to observe residents take their medications. Confidential staff interview revealed medications had been left in residents' room at night for residents to take on their own without the MAs	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092216	A. BUILDING: _____ B. WING _____	04/30/2021

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D 366	Continued From page 57 observing the residents take the medications. (no resident or staff names were provided). The facility failed to ensure medication aides observed residents taking their medications for 5 of 5 residents sampled. During the medication pass on 04/28/21, the MA prepared and gave 9 oral medications, 2 topical pain patches, and an eye drop vial to Resident #8, who was diagnosed with dementia, and allowed the resident to take the medications to her room without the MA observing the resident take any of the medications. Resident #1's evening / night time medications were left on his bedside table by MAs which included a blood thinner, a laxative, and an insulin pen which was found in the resident's room by a family member about a month ago. Resident #9 received multiple medications, including medications for depression, nerve pain and hypothyroidism that were left in her room after breakfast without the MA observing the resident take it. Resident #6's narcotic pain reliever was left at her bedside at night and she would take it when she woke up around 1:00am or 2:00am with no MAs observing her take it. Resident #10 who had a diagnoses of cognitive impairment had medications left in her room in a cup on a tray at times and she would take them without MAs observing her. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/28/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 14, 2021.	D 366		

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D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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; (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, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 7 of 7 residents sampled (#1, #2, #3, #4, #5, #6, #7) related to multiple omissions for multiple medications for each resident with no reasons for the omissions documented. The findings are: 1. Review of Resident #4's current FL-2 dated 10/08/20 revealed:	D 367	The facility will monitor MARS are accurate and free of omissions. Medication aides were re-trained by RSD utilizing NC 15 Hour Medication Curriculum on 5/6/21. Cycle fill will be established by pharmacy to assist with monitoring medication administration. Scanner will be implemented with staff education by June 14th. Dashboard reviewed by RSD/RCC while onside for proper recording of medications in the event of system being offline. QuickMar contacted and updates completed for each med cart station on 5/15/21 to provide most current software.	

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D 367	Continued From page 59 -Diagnoses included dementia, type 2 diabetes mellitus, hypertension, hyperlipidemia, carotid stenosis, and chronic kidney disease - stage 3. -There was an order for Calcium 600mg twice a day. (Calcium is a supplement used to protect bone strength.) -There was an order for Cimetidine 200mg twice a day. (Cimetidine is for heartburn/acid reflux.) -There was an order for Donepezil 10mg 1 tablet nightly. (Donepezil is for Alzheimer's dementia.). -There was an order for Eliquis 2.5mg twice a day. (Eliquis is an anticoagulant used to prevent and treat blood clots.) -There was an order for Fish Oil 1,000mg 2 capsules twice a day. (Fish Oil is used to lower triglycerides.) -There was an order for Lantus insulin, 30 units at bedtime. (Lantus is long-acting insulin used to lower blood sugar.) -There was an order for Magnesium Oxide 400mg twice a day. (Magnesium Oxide is used to treat low magnesium levels.) -There was an order for Namenda 10mg twice daily. (Namenda is for Alzheimer's dementia.) -There was an order for Remeron 15mg 1 ½ tablets at bedtime. (Remeron is an antidepressant.) -There was an order for Senna 8.6mg 2 tablets at bedtime. (Senna is a laxative.) Review of Resident #4's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Calcium 600mg twice a day scheduled for 8:00am and 8:00pm. -There was an entry for Cimetidine 200mg twice a day scheduled for 8:00am and 8:00pm. -There was an entry for Donepezil 10mg 1 tablet nightly scheduled for 8:00pm. -There was an entry for Eliquis 2.5mg twice a day	D 367		

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D 367	Continued From page 60 scheduled for 8:00am and 8:00pm. -There was an entry for Fish Oil 1,000mg 2 capsules twice a day scheduled for 8:00am and 8:00pm. -There was an entry for Lantus insulin, 30 units at bedtime scheduled for 8:00pm. -There was an entry for Magnesium Oxide 400mg twice a day scheduled for 8:00am and 8:00pm. -There was an entry for Namenda 10mg twice daily scheduled for 8:00am and 8:00pm. -There was an entry for Remeron 15mg 1 ½ tablets at bedtime scheduled for 8:00pm. -There was an entry for Senna 8.6mg 2 tablets at bedtime scheduled for 8:00pm. -Documentation for Calcium, Cimetidine, Donepezil, Eliquis, Fish Oil, Lantus, Magnesium Oxide, Namenda, Remeron, and Senna was blank on 02/10/21 and 02/12/21 at 8:00pm with no reason for the omissions. Review of Resident #4's March 2021 eMAR revealed: -There was an entry for Calcium 600mg twice a day scheduled for 8:00am and 8:00pm. -There was an entry for Cimetidine 200mg twice a day scheduled for 8:00am and 8:00pm. -There was an entry for Donepezil 10mg 1 tablet nightly scheduled for 8:00pm. -There was an entry for Eliquis 2.5mg twice a day scheduled for 8:00am and 8:00pm. -There was an entry for Fish Oil 1,000mg 2 capsules twice a day scheduled for 8:00am and 8:00pm. -There was an entry for Lantus insulin, 30 units at bedtime scheduled for 8:00pm. -There was an entry for Magnesium Oxide 400mg twice a day scheduled for 8:00am and 8:00pm. -There was an entry for Namenda 10mg twice daily scheduled for 8:00am and 8:00pm. -There was an entry for Remeron 15mg 1 ½	D 367		

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D 367	Continued From page 61 tablets at bedtime scheduled for 8:00pm. -There was an entry for Senna 8.6mg 2 tablets at bedtime scheduled for 8:00pm. -Documentation for Calcium, Cimetidine, Donepezil, Eliquis, Fish Oil, Lantus, Magnesium Oxide, Namenda, Remeron, and Senna was blank on 03/12/21 at 8:00pm with no reason for the omissions. Interview with a medication aide (MA) on 04/30/21 at 11:49am revealed: -She did not know why there were omissions on Resident #4's eMARs. -The MA's initials should be documented on the eMARs when medications were administered. -If a medication was not administered, the MA's initials should be circled and a reason should be documented in the comments on the eMARs. -Resident #4 usually took his medications with no problems. Refer to the telephone interview with a medication aide (MA) on 04/30/21 at 8:06am. Refer to the telephone interview with the Memory Care Manager (MCM) on 04/30/21 at 10:16am. Refer to the interview with the Resident Services Director (RSD) on 04/30/21 at 9:50am. Refer to the interview with the Administrator on 04/28/21 at 7:55am. 2. Review of Resident #6's current FL-2 dated 04/28/21 revealed diagnoses included dyspnea, hypertension, osteoarthritis, history of pulmonary embolism, chronic kidney disease - stage 4, and hypothyroidism. Review of Resident #6's physician's order dated	D 367		

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D 367	Continued From page 62 03/09/21 revealed: -There was an order for Gabapentin 100mg 2 capsules 3 times a day. (Gabapentin is used to treat nerve pain.) -There was an order for Levothyroxine 125mcg 1 tablet every morning before breakfast. (Levothyroxine is for hypothyroidism.) Review of Resident #6's physician's order dated 02/11/21 revealed: -There was an order to discontinue Tramadol 50mg 1 tablet 2 to 3 times daily prn pain. -There was an order to start Tramadol 50mg 3 times a day. Review of Resident #6's physician's order dated 03/13/21 revealed: -There was an order to discontinue Tramadol 50mg 1 tablet 3 times daily as needed for pain. -There was an order to start Tramadol 50mg 3 times daily scheduled. Review of Resident #6's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Gabapentin 100mg 2 capsules 3 times a day scheduled for 8:30am, 2:00pm, and 8:00pm. -Documentation for Gabapentin was blank on 02/10/21 and 02/12/21 at 8:00pm and on 02/17/21 at 2:00pm with no reason for the omissions. -There was an entry for Levothyroxine 125mcg 1 tablet every morning before breakfast on an empty stomach scheduled for 6:30am. -Documentation for Levothyroxine was blank on 02/07/21 with no reason for the omission. -There was an entry for Tramadol 50mg 1 tablet 3 times a day scheduled for 8:00am, 2:00pm, and 8:00pm.	D 367		

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
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D 367	Continued From page 63 -Documentation for Tramadol was blank on 02/12/21 at 8:00pm and on 02/17/21 at 2:00pm with no reason for the omissions. Review of Resident #6's March 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Gabapentin 100mg 2 capsules 3 times a day scheduled for 8:30am, 2:00pm, and 8:00pm. -Documentation for Gabapentin was blank on 03/12/21 at 8:00pm with no reason for the omission. Refer to the telephone interview with a medication aide (MA) on 04/30/21 at 8:06am. Refer to the telephone interview with the Memory Care Manager (MCM) on 04/30/21 at 10:16am. Refer to the interview with the Resident Services Director (RSD) on 04/30/21 at 9:50am. Refer to the interview with the Administrator on 04/28/21 at 7:55am. 3. Review of Resident #3's current FL-2 dated 06/04/20 revealed: -Diagnoses included dementia, hypothyroidism, hyperlipidemia, major depressive disorder, and muscle weakness. -There was an order for Aspirin 81mg 1 tablet by mouth once daily. (Aspirin may be used to prevent heart disease.) -There was an order for Cranberry 400 mg by mouth twice daily. (Cranberry is used for reducing the risk of bladder infections.). -There was an order for Aricept 10mg by mouth at bedtime. (Aricept is used to treat confusion/dementia.)	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092215	A. BUILDING: _____ B. WING _____	04/30/2021

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D 367	Continued From page 64 -There was an order for Lactinex 1 tablet by mouth once daily. (Lactinex help restore the normal balance of bacteria in the stomach /intestines.) -There was an order for Lovastatin 10mg by mouth at bedtime (Lovastatin is used to treat high cholesterol.) -There was an order for Synthroid 50mcg by mouth once daily. (Synthroid is used to treat an underactive thyroid.) -There was an order for Vitamin B-12 500mg 2 tablets by mouth daily. (Vitamin B-12 is used to treat Vitamin B-12 deficiency.) -There was an order for Namenda 10mg by mouth once daily. (Namenda is used to treat moderate to severe confusion/dementia.) -There was an order for Remeron 15 mg by mouth at bedtime. (Remeron is used to treat depression.) -There was an order for Macrobid 100 mg by mouth at bedtime. (Macrobid is used to treat bladder infections.) Review of Resident #3's February electronic medication administration record (eMAR) revealed: -There was an electronic entry for Synthroid 50mcg by mouth once daily scheduled at 6:30am. -There was an electronic entry for Aspirin 81mg chew 1 tablet once daily scheduled at 8:00am. -There was an electronic entry Vitamin B-12 500mg 2 tablets by mouth daily scheduled at 8:00am. -There was an electronic entry for Lactinex 1 tablet by mouth once daily scheduled at 8:00am. -There was an electronic entry for Namenda 10mg by mouth once daily scheduled at 8:00am. -There was an electronic entry for Cranberry 400 mg twice daily scheduled at 8:00am and 8:00pm. -There was an electronic entry for Aricept 10mg	D 367		

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D 367	Continued From page 65 at bedtime scheduled at 8:00pm. -There was an electronic entry for Lovastatin 10mg by mouth at bedtime scheduled at 8:00pm. -There was an electronic entry for Remeron 15 mg by mouth at bedtime scheduled at 8:00pm. -There was an electronic entry for Macrobid 100 mg by mouth at bedtime scheduled at 8:00pm. -Documentation for Aspirin, Vitamin B-12, Lactinex, Cranberry, and Namenda was blank for each medication on 02/01/21 at 8:00am with no reasons for the omissions documented. -Documentation for Synthroid was blank on 02/07/21 and 02/08/21 with no reasons for the omissions documented. -Documentation for Cranberry, Aricept, Lovastatin, Remeron, and Macrobid was blank on 02/12/21 at 8:00pm with no reasons for the omissions documented. Review of Resident #3's March 2021 eMAR revealed: -There was an electronic entry for Cranberry 400 mg twice daily scheduled at 8:00am and 8:00pm. -There was an electronic entry for Aricept 10mg at bedtime scheduled at 8:00pm. -There was an electronic entry for Lovastatin 10mg by mouth at bedtime scheduled at 8:00pm. -There was an electronic entry for Remeron 15 mg by mouth at bedtime scheduled at 8:00pm. -There was an electronic entry for Macrobid 100 mg by mouth at bedtime scheduled at 8:00pm. -Documentation for Cranberry, Aricept, Lovastatin, Remeron, and Macrobid was blank on 03/27/21 at 8:00pm with no reasons for the omissions documented. Review of Resident #3's April 2021 eMAR revealed: -There was an electronic entry for Macrobid 100 mg by mouth at bedtime scheduled at 8:00pm.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 66 -Documentation for Macrobid was circled on 04/03/21 and 04/04/21 at 8:00pm with the reason being waiting on pharmacy documented. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. Refer to the telephone interview with a medication aide (MA) on 04/30/21 at 8:06am. Refer to the telephone interview with the Memory Care Manager (MCM) on 04/30/21 at 10:16am. Refer to the interview with the Resident Services Director (RSD) on 04/30/21 at 9:50am. Refer to the interview with the Administrator on 04/28/21 at 7:55am. 4. Review of Resident #5's current FL-2 dated 10/08/20 revealed: -Diagnoses included dementia, cognitive dysfunction with behavioral disturbances, social or emotional deficit, osteoporosis, bone fracture, and asthma. -There was an order for Tylenol 325 mg three times daily. (Tylenol is a pain reliever/fever reducer or used to treat mild to moderate pain.) -There was an order for Aspirin 81mg 1 tablet by mouth once daily. (Aspirin may be used to prevent heart disease or used to treat mild to moderate pain.) -There was an order for Cymbalta 60 mg by mouth once daily. (Cymbalta is used to treat major depressive disorder or neuropathic pain.) -There was an order for Oxycodone tab 10mg with directions to take 1 tablet by mouth every 12 hours (Oxycodone is a narcotic used to treat severe ongoing pain.)	D 367		

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D 367	Continued From page 67 -There was an order for Cimetidine 200mg by mouth daily before breakfast. (Cimetidine is used to treat ulcers and acid reflux.) -There was an order for Voltaren gel 1% apply 4 gm to lower back 4 times a day. (Voltaren gel is used to treat arthritis pain.) -There was an order for Aspercreme patch apply one patch daily. (Aspercreme patch is used to treat joint and muscle pain.) -There was an order for Colace daily (Colace is used to soften stool to aid in bowel movements.) -There was an order for Singulair 10 mg one by mouth at bedtime. (Singulair is used in the maintenance treatment of asthma.) -There was an order for Oys-Shell one by mouth daily. (Oys-Shell is used to treat or prevent low blood calcium levels.) -There was an order for Poly-powder mix 34 gms in 8 oz of liquid once daily. (Poly-Powder is used to relieve constipation and softens stools.) -There was an order for Senna 2 tablets by mouth at bedtime. (Senna is used to treat constipation.) -There was an order for Prep H Crème provide externally to affected area twice daily. (Prep H Crème is used to treat hemorrhoids.) Review of Resident #5's February 2021 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Oxycontin tab 10mg with directions to take 1 tablet by mouth every 12 hours scheduled at 8:00am and 8:00pm. -There was an electronic entry for Tylenol 325 mg three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was an electronic entry for Voltaren gel 1% apply 4 gm to lower back 4 times a day scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was an electronic entry for Aspercreme	D 367		

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D 367	Continued From page 68 patch apply one patch daily scheduled at 8:00am and 8:00pm. -There was an electronic entry for Colace daily scheduled at 8:00am and 8:00pm. -There was an electronic entry for Singulair 10 mg one by mouth at bedtime scheduled at 8:00am and 8:00pm. -There was an electronic entry for Senna 2 tablets by mouth at bedtime scheduled at 8:00pm. -There was an electronic entry for Prep H 1% Crème provide externally to affected area twice daily scheduled at 8:00am and 8:00pm. -Documentation for Senna, Prep H, Oxycontin, Tylenol, Voltaren, Aspercreme, Colace, and Singulair was blank on 02/10/21 and 02/12/21 at 8:00pm with no reasons for the omissions documented. -Documentation for Voltaren gel was blank on 02/12/21 at 4:00pm with no reasons for the omissions documented. -Documentation for Tylenol was blank on 02/17/21 at 4:00pm with no reasons for the omissions documented. Review of Resident #5's March 2021 eMAR revealed: -There was an electronic entry for Oxycontin tab 10mg with directions to take 1 tablet by mouth every 12 hours scheduled at 8:00am and 8:00pm. -There was an electronic entry for Tylenol 325 mg three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was an electronic entry for Voltaren gel 1% apply 4 gm to lower back 4 times a day scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was an electronic entry for Aspercreme patch apply one patch daily scheduled at 8:00am and 8:00pm.	D 367		

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D 367	Continued From page 69 -There was an electronic entry for Colace daily scheduled at 8:00am and 8:00pm. -There was an electronic entry for Singulair 10 mg one by mouth at bedtime scheduled at 8:00am and 8:00pm. -There was an electronic entry for Senna 2 tablets by mouth at bedtime scheduled at 8:00pm. -Documentation for Senna, Oxycontin, Tylenol, Voltaren, Aspercreme, Colace, and Singulair was blank on 03/12/21 at 8:00pm with no reasons for the omissions documented. Review of Resident #5's April 2021 eMAR revealed the only omissions of any medications for Resident #5 was documented when the resident was out of the facility on 04/19/21. Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable. Refer to the telephone interview with a medication aide (MA) on 04/30/21 at 8:06am. Refer to the telephone interview with the Memory Care Manager (MCM) on 04/30/21 at 10:16am. Refer to the interview with the Resident Services Director (RSD) on 04/30/21 at 9:50am. Refer to the interview with the Administrator on 04/28/21 at 7:55am. 5. Review of Resident #2's current FL-2 dated 01/14/20 revealed: -Diagnoses included bipolar disorder, hypertension (HTN), hypothyroidism, chronic pain, history of asthma, atrial fibrillation, gastroesophageal reflux disease (GERD),	D 367		

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D 367	Continued From page 70 constipation, bilateral lower extremity edema and history of deep tissue injury. -There was an order for Biofreeze 4% gel apply topically to bilateral hips twice a day. (Biofreeze is a topical medication used to treat minor aches and pains of the muscles and joints.) -There was an order for Certavite 1 tablet once a day. (Certavite is a combination of vitamins and minerals used to prevent or treat vitamin deficiency.) -There was an order for Docusate Sodium 100mg capsule one capsule at bedtime. (Docusate Sodium is a stool softener used to prevent constipation.) -There was an order for Gabapentin 300mg one capsule twice a day. (Gabapentin is an anticonvulsant used to treat nerve pain.) -There was an order for Levothyroxine 112mcg one tablet once a day. (Levothyroxine is used to treat hypothyroidism.) -There was an order for Lithium 300mg one capsule every other day. (Lithium is a mood stabilizer used to treat bipolar disorder.) -There was an order for Metoprolol Succinate 25mg ER one tablet every day. (Metoprolol is a medication used to treat high blood pressure.) -There was an order for Polyethylene Glycol Powder 17 grams once a day. (Polyethylene Glycol is a laxative used to treat occasional constipation.) -There was an order for Xarelto 20mg once a day with the evening meal. (Xarelto is a blood thinner used to treat and prevent blood clots.) -There was an order for Trazodone 150mg 1 ½ tablets (225mg) at bedtime. (Trazodone is an antidepressant used to treat depression, anxiety and insomnia.) -There was an order for Vitamin B-12 1000mcg 1 tablet once a day. (Vitamin B-12 is a water-soluble vitamin that helps produce red	D 367		

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D 367	Continued From page 71 blood cells.) -There was an order for Wixela Inhaler 100-50mcg 1 puff twice a day. (Wixela is used to control and prevent wheezing and shortness of breath.) Review of signed physician's orders for Resident #2 dated 03/11/21 revealed: -There was an order for Arthritis Pain 650mg 2 tablets twice a day. (Arthritis pain is used to treat minor aches and pains and reduce fevers.) -There was an order for Biofreeze 4% gel administered topically to bilateral hips, bilateral shoulders and back twice a day. -There was an order for Cetaphil liquid cleanser to face twice a day. (Cetaphil is a mild, non-irritating cleanser.) -There was an order for Melatonin 5mg one tablet in the evening. (Melatonin is used to treat insomnia.) -There was an order for Oxybutynin 5mg one tablet twice a day. (Oxybutynin is a medication used to treat overactive bladder.) -There was an order for Pantoprazole 40mg one tablet once a day. (Pantoprazole is a proton pump inhibitor used to treat GERD.) -There was an order for Simethicone 80mg 1 tablet twice a day. (Simethicone is an anti-foaming agent used to treat the symptoms of gas.) -There was an order for Thrombo-Embolus Deterrent (TED) Hoses to be applied every morning and removed every evening. -There was an order for Visine eye drops 1 drop in each eye twice a day. (Visine is an eye decongestant used to treat eye redness.) Review of Resident #2's February 2021 electronic medication administration record (eMAR) revealed:	D 367		

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D 367	Continued From page 72 -There was an entry for Arthritis Acetaminophen 650mg ER 2 tablets twice daily scheduled at 8:00am and 8:00pm. -Documentation for Arthritis Acetaminophen was blank on 02/01/21 for the 8:00am dose, 02/10/21 for the 8:00pm dose and 02/12/21 for the 8:00pm dose with no reason for the omissions documented. -There was an entry for Biofreeze 4% gel topically to bilateral hips twice daily scheduled at 8:00am and 8:00pm. -Documentation for Biofreeze was blank on 02/01/21 for the 8:00am dose, 02/10/21 for the 8:00pm dose and 02/12/21 for the 8:00pm dose with no reason for the omissions documented. -There was an entry for Certavite 1 tablet once a day scheduled at 8:00am. -Documentation for Certavite was blank on 02/01/21 for the 8:00am dose with no reason for the omission documented. -There was an entry for Docusate Sodium 100mg 1 capsule at bedtime scheduled at 8:00pm. -Documentation for Docusate Sodium was blank on 02/10/21 for the 8:00pm dose and 02/12/21 for the 8:00pm dose with no reason for the omissions documented. -There was an entry for Gabapentin 300mg 1 capsule twice a day scheduled at 8:00am and 8:00pm. -Documentation for Gabapentin was blank on 02/01/21 for the 8:00am dose, 02/10/21 for the 8:00pm dose and 02/12/21 for the 8:00pm dose with no reason for the omissions documented. -There was an entry for Levothyroxine 112mcg 1 tablet once a day scheduled at 6:30am. -Documentation for Levothyroxine was blank on 02/07/21 and 02/08/21 with no reason for the omissions documented. -There was an entry for Lithium 300mg 1 capsule every other day scheduled at 8:00am.	D 367		

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D 367	Continued From page 73 -Documentation for Lithium was blank on 02/01/21 with no reason for the omissions documented. -There was an entry for Melatonin 5mg 1 tablet every evening scheduled at 8:00pm. -Documentation for Melatonin was blank on 02/10/21 and 02/12/21 with no reason for the omissions documented. -There was an entry for Metoprolol Succinate 25mg ER 1 tablet once a day scheduled at 8:00am. -Documentation for Metoprolol was blank on 02/01/21 with no reason for the omission documented. -There was an entry for Oxybutynin 5mg twice a day scheduled at 8:00am and 8:00pm. -Documentation for Oxybutynin was blank on 02/01/21 for the 8:00am dose, 02/10/21 for the 8:00pm dose and 02/12/21 for the 8:00pm dose with no reason for the omissions documented. -There was an entry for Pantoprazole 40mg once a day scheduled at 8:00am. -Documentation for Pantoprazole was blank on 02/01/21 with no reason for the omission documented. -There was an entry for Polyethylene Glycol Powder 17 grams once a day scheduled at 8:00am. -Documentation for Polyethylene Glycol was blank on 02/01/21 with no reason for the omission documented. -There was an entry for Simethicone 80mg twice a day scheduled at 8:00am and 8:00pm. -Documentation for Simethicone was blank on 02/01/21 for the 8:00am dose, 02/10/21 for the 8:00pm dose and 02/12/21 for the 8:00pm dose with no reason for the omissions documented. -There was an entry for TED Hoses to be applied every morning and removed every evening scheduled at 8:00am and 8:00pm.	D 367		

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D 367	Continued From page 74 -Documentation for TED Hoses was blank on 02/01/21 for the 8:00am administration time, 02/10/21 for the 8:00pm administration time and 02/12/21 for the 8:00pm administration time with no reason for the omissions documented. -There was an entry for Trazodone 150mg 1 ½ tablets (225mg) scheduled at 8:00pm. -Documentation for Trazodone was blank on 02/10/21 and 02/12/21 with no reason for the omissions documented. -There was an entry for Visine eye drops 1 drop to each eye twice a day scheduled at 8:00am and 8:00pm. -Documentation for Visine was blank on 02/01/21 for the 8:00am dose, 02/10/21 for the 8:00pm dose and 02/12/21 for the 8:00pm dose with no reason for the omissions documented. -There was an entry for Vitamin B-12 SUB 1000mcg 1 tablet once a day scheduled at 8:00am. -Documentation for Vitamin B-12 was blank on 02/01/21 with no reason for the omission documented. -There was an entry for Wixela Inhaler 100-50mcg 1 puff twice a day scheduled at 8:00am and 8:00pm. -Documentation for Wixela was blank on 02/01/21 for the 8:00am dose, 02/10/21 for the 8:00pm dose and 02/12/21 for the 8:00pm dose with no reason for the omissions documented. -There was an entry for Xarelto 20mg 1 tablet once a day scheduled at 5:00pm. -Documentation for Xarelto was blank on 02/12/21 with no reason for the omission documented. Review of Resident #2's April 2021 eMAR revealed: -There was an entry for Xarelto 20mg 1 tablet once a day scheduled at 5:00pm.	D 367		

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D 367	Continued From page 75 -Documentation for Xarelto was blank on 04/17/21 with no reason for the omission documented. Based on observations, record reviews and interviews it was determined that Resident #2 was not available for interview. Refer to the telephone interview with a medication aide (MA) on 04/30/21 at 8:06am. Refer to the telephone interview with the Memory Care Manger (MCM) on 04/30/21 at 10:16am. Refer to the interview with the Resident Services Director (RSD) on 04/30/21 at 9:50am. Refer to the interview with the Administrator on 04/28/21 at 7:55am. 6. Review of Resident #7's current FL-2 dated 10/30/20 revealed diagnoses included left hip fracture, non-operable, bifrontal subarachnoid hemorrhage, advanced dementia, hypertension (HTN), hypothyroidism, osteoarthritis and frequent falls. Review of signed physician's orders for Resident #7 dated 03/11/21 revealed: -There was an order for Arthritis Pain 650mg 2 tablets twice a day. (Arthritis pain is used to treat minor aches and pains and reduce fevers.) -There was an order for Ensure 1 bottle three times a day to be provided by the family. (Ensure is a nutritional supplement.) -There was an order for Escitalopram 5mg once daily. (Escitalopram is an antidepressant used to treat depression and anxiety.) -There was an order for Levothyroxine 75mcg one tablet once a day. (Levothyroxine is used to	D 367		

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	HAL092215	A. BUILDING: _____ B. WING _____	04/30/2021

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D 367	Continued From page 76 treat hypothyroidism.) -There was an order for Mirtazapine 15mg 1 tablet at bedtime. (Mirtazapine is used to treat depression.) Review of Resident #7's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Arthritis Acetaminophen 650mg 2 tablets twice daily scheduled at 8:00am and 8:00pm. -Documentation for Arthritis Acetaminophen was blank on 02/01/21 for the 8:00am dose, 02/10/21 for the 8:00pm dose and 02/12/21 for the 8:00pm dose with no reason for the omissions documented. -There was an entry for Ensure 1 bottle three times a day to be provided by the family scheduled at 8:00am, 2:00pm and 8:00pm. -Documentation for Ensure was blank on 02/01/21 at 8:00am and 2:00pm, on 02/10/21 at 8:00pm, 02/12/21 at 2:00pm and 8:00pm, and 02/24/21 at 2:00pm with no reason for the omissions documented. -There was an entry for Escitalopram 5mg once a day scheduled at 8:00am. -Documentation for Escitalopram was blank on 02/01/21 with no reason for the omission documented. -There was an entry for Levothyroxine 75mcg 1 tablet once daily scheduled at 8:00am. -Documentation for Levothyroxine was blank on 02/01/21 with no reason for the omission documented. -There was an entry for Mirtazapine 15mg 1 tablet scheduled at 8:00pm. -Documentation for Mirtazapine was blank on 02/10/21 and 02/12/21 with no reason for the omissions documented.	D 367		

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D 367	Continued From page 77 Review of Resident #7's March 2021 eMAR revealed: -There was an entry for Ensure 1 bottle three times a day to be provided by the family scheduled at 8:00am, 2:00pm and 8:00pm. -On 03/07/21 at 8:00pm, Ensure was documented as not administered due to resident refusal. -Documentation for Ensure was blank on 03/20/21 at 2:00pm with no reason for the omission documented. Review of Resident #7's April 2021 eMAR revealed: -There was an entry for Ensure 1 bottle three times a day to be provided by the family scheduled at 8:00am, 2:00pm and 8:00pm. -Documentation for Ensure was blank on 04/27/21 at 8:00am with no reason for the omission documented. Interview with the Memory Care Manager (MCM) on 04/29/21 at 11:43am revealed: -Resident #7 received Ensure three times a day and the supplement was provided by her family. -Resident #7 was out of Ensure and she would notify Resident #7's family. -She was unsure how long Resident #7 was out of Ensure. Based on observations, record reviews and interviews it was determined that Resident #7 was not interviewable. Refer to the telephone interview with a medication aide (MA) on 04/30/21 at 8:06am. Refer to the telephone interview with the Memory Care Manger (MCM) on 04/30/21 at 10:16am.	D 367		

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D 367	Continued From page 78 Refer to the interview with the Resident Services Director (RSD) on 04/30/21 at 9:50am. Refer to the interview with the Administrator on 04/28/21 at 7:55am. 7. Review of Resident #1's FL-2 dated 04/21/21 revealed: -Diagnoses included type 2 diabetes, congestive heart failure, hypertension, history of pulmonary embolism, and chronic kidney disease. -There was an order for Eliquis 2.5mg twice a day. (Eliquis is used to prevent blood clots.) -There was an order for Lotrel 10-20mg once daily. (Lotrel is used to treat high blood pressure.) -There was an order for Lasix 40mg daily. (Lasix is used as a diuretic.) -There was an order for Lantus 35 units every morning. (Lantus is used to treat diabetes.) -There was an order for Lantus 15 units every evening. Review of Resident #1's physician's orders dated 10/20/21 revealed: -There was an order for Atorvastatin 80mg every evening. (Atorvastatin is used to treat high cholesterol.) -There was an order for Senna Plus 8.6-50mg every evening. (Senna Plus is a laxative used to treat constipation.) Review of Resident #1's February 2021 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Eliquis 2.5mg twice a day scheduled at 8:00am and 8:00pm. -There was an electronic entry for Lantus 15 units every evening scheduled at 8:00pm. -There was an electronic entry for Atorvastatin 80mg every evening scheduled at 8:00pm.	D 367		

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D 367	Continued From page 79 -There was an electronic entry for Senna Plus 8.6-50mg every evening scheduled at 8:00pm. -Documentation for Eliquis, Lantus, Atorvastatin, and Senna Plus was blank for each medication on 02/08/21 and 02/12/21 at 8:00pm with no reasons for the omissions documented. Review of Resident #1's March 2021 eMAR revealed: -There was an electronic entry for Eliquis 2.5mg twice a day scheduled at 8:00am and 8:00pm. -There was an electronic entry for Lotrel 10-20mg once daily scheduled at 8:00am. -There was an electronic entry for Lasix 40mg daily scheduled at 8:00am. -There was an electronic entry for Lantus 35 units every morning scheduled at 8:00am. -Documentation for Eliquis, Lotrel, Lasix and Lantus was blank for each medication on 03/18/21 at 8:00pm with no reasons for the omissions documented. Refer to the telephone interview with a medication aide (MA) on 04/30/21 at 8:06am. Refer to the telephone interview with the Memory Care Manager (MCM) on 04/30/21 at 10:16am. Refer to the interview with the Resident Services Director (RSD) on 04/30/21 at 9:50am. Refer to the interview with the Administrator on 04/28/21 at 7:55am. Telephone interview with a medication aide (MA) on 04/30/21 at 8:06am revealed: -The only reason there was a blank on the eMAR was when then computer was offline. -The eMAR system went offline once every 2 weeks.	D 367		

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	HAL092215	A. BUILDING: _____ B. WING _____	04/30/2021

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D 367	Continued From page 80 -The Resident Services Director (RSD) approached her about 2 weeks ago when the nighttime medications did not document, and it was on an evening that the system was 'offline'. Telephone interview with the Memory Care Manager (MCM) on 04/30/21 at 10:16am revealed: -The eMAR would show blanks when there was a 'glitch' in the computer or if it was 'offline'. -The eMAR system was offline at least 4 times a week and it occurred on all shifts. -Management was aware of the frequency of the eMAR system being offline. Interview with the RSD on 04/30/21 at 9:50am revealed: -There was no reason for blanks or omissions on the eMARs to her knowledge. -She checked the eMAR dashboard every morning to ensure there are no medications without documentation. -She was in communication with the pharmacy and the corporation about the frequency of 'offline' periods. -She provided the MAs with re-education about entering exceptions onto the eMAR. Interview with the Administrator on 04/28/21 at 7:55am revealed when the eMAR was 'offline' and the MAs signed off on the medications as administered the system would update to show documentation when it went back online.	D 367		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription	D 378	See next page	

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D 378	Continued From page 81 medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure medications were under locked security related to numerous medications being left unsecured on top of the medication cart; and the medication cart being left unlocked and unattended by the medication aide (MA) staff for 14 minutes in the Special Care Unit (SCU). The findings are: Observation of the SCU in the hallway near the nurse's station on 04/30/21 at 9:30am revealed: -The medication cart was on the right side of the hall located between the nurse's station and the dining room wall of the SCU. -There were more than 5 medications unsecured on top of the medication cart to allow for the count of medications on hand to be done. -There were "bubble' packs of medications, creams, lotions, prescription bottles and over the counter bottles of medications noted on top of the medication cart. -Arthritis Acetaminophen 650mg ER was on top of the medication cart. -Biofreeze 4% gel was on top of the medication cart. -Certavite was on top of the medication cart. -Docusate Sodium 100mg was on top of the medication cart.	D 378	Medication aides were re-trained by RSD utilizing the NC 15 Hour Medication Curriculum on 5/6/21. to include securing medications. All corrective measures will be implemented by 6/14/21. Continued monitoring of compliance will be conducted through QA audits, compliance trends and patterns. RSD/RCC will complete daily observations for four (4) weeks to monitor that medications are secured.	

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D 378	Continued From page 82 -Gabapentin 300mg was on top of the medication cart. -Levothyroxine 125mcg was on top of the medication cart. -Lithium 150mg and 300mg were on top of the medication cart. -Melatonin 5mg was on top of the medication cart. -Metoprolol Succinate 25mg ER was on top of the medication cart. -Oxybutynin 5mg was on top of the medication cart. -Pantoprazole 40mg was on top of the medication cart. -Polyethylene Glycol Powder 17grams was on top of the medication cart. -Simethicone 80mg was on top of the medication cart. -Trazodone 150mg was on top of the medication cart. -Visine eye drops was on top of the medication cart. -Vitamin B-12 SUB 1000mcg was on top of the medication cart. -Wixela inhaler 100-50mcg was on top of the medication cart. -Xarelto 20mg was on top of the medication cart. -Documentation for Xarelto was blank on 02/12/21 with no reason for the omission documented. -The drawers on the medication cart opened when pulled and closed freely without locking. -The medication aide (MA) walked off from the cart leaving it unattended by facility staff for 14 minutes before returning. -There were residents present in the living room and one noted to come to the nurse's station near the medication cart. Observation of the MA on the SCU on 04/30/21	D 378		

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D 378	Continued From page 83 from 9:30am-10:06am revealed: -The MA was in the hallway after walking away from the medication cart. -The MA walked into the resident living room with her back to the medication cart. -The MA walked down the hallway to a resident room located on the right side of the hall near the exit door. -The MA returned up to the resident living room to assist the primary care provider assess a resident. -The MA returned to the medication cart and began putting up the medications from the top of the medication cart and began to place other lotions, creams and drops on top of the medication cart to allow for the count of medications on hand to be completed. -The MA returned to the medication cart and put the medications from the top of the medication cart back in the drawers. Interview with Administrator on 04/29/21 at 10:55am revealed: -Medication carts were to remain locked when unattended by facility staff. -She had to remove the MA from the administering medications per facility protocol. Interview with the MA on 04/29/21 at 10:45am revealed: -She walked off from the medication cart to assist a resident in the living room who requested assistance. -She said the cart was visible. -She had gone down the hallway to help another resident and the medication cart was not visible from that area. -She was taught to lock the cart and take the keys with her. -She did not think about the medication cart as	D 378		

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D 378	Continued From page 84 being left unattended since the surveyors were present and counting the medications	D 378		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records of controlled substances for 1 of 3 residents sampled (#6) for a controlled substance used for moderate to severe pain. The findings are: Review of Resident #6's current FL-2 dated 04/28/21 revealed diagnoses included dyspnea, hypertension, osteoarthritis, history of pulmonary embolism, chronic kidney disease - stage 4, and hypothyroidism. Review of Resident #6's physician's order dated 08/21/20 revealed an order for Tramadol 50mg 1 tablet 2 to 3 times a day as needed (prn) for pain. Review of Resident #6's clarification order dated 09/21/20 revealed the order should be Tramadol 50mg 1 tablet 3 times a day prn pain.	D 392	The facility will secure controlled substance records in order for accessibility as requested for review. Medication Aides were re-trained by RSD utilizing the NC 15 Hour Medication Curriculum on 5/6/21 to include proper documentation of PRN medications. Med Cart audits to be conducted and all orders to be reviewed by the PCP to confirm controlled substance orders are accurate and necessary. Multidisciplinary review and audits of MAR/Charts/Med Carts by Pharmacy was conducted on 5/26/21. Quarterly onsite reviews will be conducted by the pharmacy according to NC State Regulations. Executive Director will be immediately notified if onsite reviews cannot be conducted. ED/RSD will review pharmacy reports for confirmation onsite review was conducted and recommendations have received follow up.	

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	HAL092215	A. BUILDING: _____ B. WING _____	04/30/2021

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D 392	Continued From page 85 Review of Resident #6's physician's order dated 02/03/21 revealed an order for Tramadol 50mg 1 tablet 2 to 3 times daily prn pain. Review of Resident #6's physician's order dated 02/11/21 revealed: -There was an order to discontinue Tramadol 50mg 1 tablet 2 to 3 times daily prn pain. -There was an order to start Tramadol 50mg 3 times a day. Review of Resident #6's physician's order dated 03/03/21 revealed an order for Tramadol 50mg 1 tablet 3 times daily prn pain. Review of Resident #6's physician's order dated 03/13/21 revealed: -There was an order to discontinue Tramadol 50mg 1 tablet 3 times daily prn pain. -There was an order to start Tramadol 50mg 3 times daily scheduled. Review of Resident #6's physician's order dated 03/18/21 revealed an order to continue Tramadol 50mg 1 tablet 3 times daily scheduled. Review of Resident #6's physician's order dated 04/22/21 revealed an order for Tramadol 50mg 1 tablet 3 times daily. Review of Resident #6's pharmacy dispensing records dated 01/01/21 - 04/29/21 revealed: -There were 75 Tramadol 50mg tablets dispensed on 01/02/21. -There were 75 Tramadol 50mg tablets dispensed on 02/03/21. -There were 90 Tramadol 50mg tablets dispensed on 03/03/21. -There were 90 Tramadol 50mg tablets dispensed on 03/15/21.	D 392		

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D 392	Continued From page 86 -There were 90 Tramadol 50mg tablets dispensed on 04/22/21. Review of Resident #6's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Tramadol 50mg 1 tablet 2 to 3 times a day prn pain. -The date written on the eMAR for the prn Tramadol was 02/03/21 and the stop date was 02/11/21. -There was 1 dose of prn Tramadol 50mg documented as administered on 02/05/21 at 2:11pm. -No other doses of prn Tramadol were documented as administered in February 2021. -There was an entry for Tramadol 50mg 1 tablet 3 times a day scheduled for 8:00am, 2:00pm, and 8:00pm. -The date written noted on the eMAR was 02/11/21. -The first dose was documented on 02/11/21 at 8:00pm. -There were 49 doses of scheduled Tramadol 50mg tablets documented as administered from 02/11/21 - 02/28/21. -There was a total of 50 Tramadol 50mg tablets documented as administered from 02/01/21 - 02/28/21. Review of Resident #6's controlled substance (CS) logs for Tramadol for February 2021 revealed: -Tramadol 50mg was documented as administered on 02/11/21 at 2:00pm, 02/12/21 at 8:00pm, and 02/17/21 at 2:00pm on the CS log but it was not documented as administered on the eMAR for those 3 occasions. -There were 20 prn Tramadol doses documented on the CS logs from 02/01/21 - 02/28/21 but only	D 392		

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D 392	Continued From page 87 1 prn dose was documented on the eMAR from 02/01/21 - 02/28/21. -There was a total of 89 Tramadol 50mg tablets documented as administered on the CS log from 02/01/21 - 02/28/21 but only 50 Tramadol 50mg tablets were documented as administered on the eMAR. -The CS logs did not accurately reconcile with the February 2021 eMAR. Review of Resident #6's March 2021 eMAR revealed: -There was an entry for Tramadol 50mg 1 tablet 3 times a day prn pain. -The date written on the eMAR for the prn Tramadol was 03/03/21 and the stop date was 03/15/21. -There was no prn doses of Tramadol 50mg documented as administered in March 2021. -There was an entry for Tramadol 50mg 1 tablet 3 times a day scheduled for 8:00am, 2:00pm, and 8:00pm. -The date written noted on the eMAR for this scheduled Tramadol was 02/11/21 and the stop date was 03/03/21. -Tramadol 50mg was documented as administered 6 times from 03/01/21 at 8:00am through 03/02/21 at 8:00pm. -The 8:00am dose of Tramadol 50mg for 03/03/21 was not documented as administered due to waiting on hard script to be sent to the pharmacy. -There was a second entry for Tramadol 50mg 1 tablet 3 times a day scheduled for 8:00am, 2:00pm, and 8:00pm. -The date written for the second entry of Tramadol 50mg was 03/13/21 and there was no stop date listed. -The first dose was documented on 03/15/21 at 8:00pm.	D 392		

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	HAL092215	A. BUILDING: _____ B. WING _____	04/30/2021

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CADENCE GARNER	200 MINGLEWOOD DRIVE GARNER, NC 27529

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D 392	Continued From page 88 -There were 49 doses of scheduled Tramadol 50mg tablets documented as administered from 03/15/21 - 03/31/21. -There was a total of 55 Tramadol 50mg tablets documented as administered from 03/01/21 - 03/31/21. Review of Resident #6's CS logs for Tramadol for March 2021 revealed: -There were 26 prn doses of Tramadol 50mg documented as administered from 03/01/21 - 03/31/21 on the CS log but no prn doses of Tramadol were documented as administered on the eMAR from 03/01/21 - 03/31/21. -There were 70 scheduled doses of Tramadol 50mg documented as administered from 03/01/21 - 03/31/21 but only 55 scheduled doses were documented as administered on the eMAR from 03/01/21 - 03/31/21. -There was a total of 96 Tramadol 50mg tablets documented as administered on the CS log from 03/01/21 - 03/31/21 but only 55 doses were documented on the eMAR from 03/01/21 - 03/31/21. -The CS logs did not accurately reconcile with the March 2021 eMAR. Review of Resident #6's April 2021 eMAR revealed: -There was an entry for Tramadol 50mg 1 tablet 3 times a day scheduled for 8:00am, 2:00pm, and 8:00pm. -The date written on the eMAR for the scheduled Tramadol was 03/13/21 and there was no stop date listed. -There were 89 doses of scheduled Tramadol 50mg tablets documented as administered from 04/01/21 - 04/30/21 at 2:00pm. -There was no entry on the eMAR for any prn Tramadol orders so no prn Tramadol was	D 392		

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D 392	Continued From page 89 documented as administered in April 2021. -There was a total of 89 Tramadol 50mg tablets documented as administered from 04/01/21 - 04/30/21. Review of Resident #6's CS logs for Tramadol for April 2021 revealed: -There were 27 prn doses of Tramadol 50mg documented as administered from 04/01/21 - 04/30/21 on the CS log but prn doses were documented as administered on the eMAR from 04/01/21 - 04/30/21. -There were 91 scheduled doses of Tramadol 50mg documented as administered from 04/01/21 - 04/30/21 but only 89 scheduled doses were documented as administered on the eMAR from 04/01/21 - 04/30/21. -There was a total of 118 Tramadol 50mg tablets documented as administered on the CS log from 04/01/21 - 04/30/21 but only 89 doses were documented on the eMAR from 04/01/21 - 04/30/21. -The CS logs did not accurately reconcile with the April 2021 eMAR. -There was a total balance of 63 tablets remaining after the last dose documented on 04/30/21. Observation of Resident #6's medications on hand on 04/30/21 at 11:20am revealed there was a total of 63 Tramadol 50mg tablets on hand. Review of Resident #6's medication orders, eMARs, CS logs, pharmacy dispensing records, and medications on hand revealed: -There were 345 Tramadol 50mg tablets dispensed from 02/03/21 - 04/30/21. -There were 298 Tramadol 50mg tablets documented as administered from 02/03/21 - 04/30/21 on the CS logs.	D 392		

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D 392	Continued From page 90 -There were only 194 Tramadol 50mg tablets documented as administered from 02/03/21 - 04/30/21 on the eMARs. -There was a total of 104 Tramadol 50mg tablets documented as administered on the CS logs that was not documented on the eMARs. -The CS logs did not accurately reconcile with the eMARs. Interview with a medication aide (MA) on 04/29/21 at 8:06am revealed: -When she worked on night shift, Resident #6 would get a scheduled Tramadol at 8:00pm and around 1:00am or 2:00am, the resident would press her call light and ask for a prn Tramadol. -She usually documented the administration of the Tramadol on the CS log and the eMAR. -She could not explain why prn doses of Tramadol were documented on the CS log but not on the eMAR. Interview with the Memory Care Manager (MCM) on 04/30/21 at 10:15am revealed: -The MAs were supposed to document the administration of the Tramadol on the CS log and eMAR. -The only system she was aware of to check the CS logs for accuracy was the MAs did CS counts each shift and there had not been any discrepancies with the count on hand to her knowledge. -She thought the Resident Services Director (RSD) checked the eMARs and CS logs but she was not sure. Interview with the RSD on 04/30/21 at 3:58pm revealed: -The MAs were supposed to document on the CS log and the eMAR when a CS was administered. -If there was a discrepancy with the CS logs, the	D 392		

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D 392	Continued From page 91 MAs were supposed to notify the RSD or the MCM. Interview with Resident #6 on 04/30/21 at 3:37pm revealed: -She usually received Tramadol 4 times a day at 8:00am, 2:00pm, 8:00pm, and 2:00am. -She had been getting Tramadol that way for about a year. -She took Tramadol for pain in her knees and hips.	D 392		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate	D 400	Multidisciplinary team from pharmacy conducted a MAR/Chart/Med Cart audit on 5/26/21. All quarterly pharmacy reviews will be completed onsite. ED/RSD/RCC will review quarterly reports.	

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D 400	Continued From page 92 prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to have medication reviews completed on-site as required for 7 of 7 residents sampled (#1, #2, #3, #4, #5, #6, #7) resulting in failure to identify medication related problems for the residents. The findings are: Review of the most current quarterly medication review reports dated 03/20/21 revealed there was a statement printed at the top of each page, "In light of the COVID-19 outbreak and subsequent on-site visit restrictions, compliance with 10A NCAC 13G .1009 was met using all available virtual resources". 1. Review of Resident #4's current FL-2 dated 10/08/20 revealed diagnoses included dementia, type 2 diabetes mellitus, hypertension, hyperlipidemia, carotid stenosis, and chronic kidney disease - stage 3. Review of Resident #4's most current medication review dated 03/20/21 revealed: -The pharmacist noted the resident's blood pressure and blood sugars were mostly within normal limits.	D 400		

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D 400	Continued From page 93 -The pharmacist noted the resident's Novolog insulin ordered changed on 01/13/21 to 6 units 3 times a day with meals. -The pharmacist did not identify and document the order to hold Novolog insulin for 3 days on 01/30/21 was not implemented and the resident continued to receive Novolog insulin 3 times a day from 01/30/21 - 02/01/21 without any doses being held as ordered. Telephone interview with the Consultant Pharmacist on 04/30/21 at 3:15pm revealed she did not identify the error with Resident #4's Novolog insulin not being held because the pharmacy did not have a copy of that order on file and she did not have access to look at the resident's paper record at the facility. Refer to interview with the Memory Care Manager (MCM) on 04/30/21 at 10:15am. Refer to telephone interview with the Manager of Operations at the facility's contracted pharmacy on 04/30/21 at 11:58am. Refer to telephone interview with the Consultant Pharmacist on 04/30/21 at 3:15pm. Refer to interview with the Resident Services Director (RSD) on 04/30/21 at 3:58pm. Refer to interview with the Administrator on 04/30/21 at 9:30am. 2. Review of Resident #6's current FL-2 dated 04/28/21 revealed diagnoses included dyspnea, hypertension, osteoarthritis, history of pulmonary embolism, chronic kidney disease - stage 4, and hypothyroidism.	D 400		

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D 400	Continued From page 94 Review of Resident #6's most current medication review dated 03/19/21 revealed: -The pharmacist noted the resident's blood pressure was within normal limits. -The pharmacist noted the resident's Tramadol order changed on 03/03/21 to discontinue scheduled Tramadol and start Tramadol 50mg 3 times a day as needed for pain. -The pharmacist noted another change in the Tramadol order dated 03/13/21 to discontinue prn Tramadol and start scheduled Tramadol 50mg 3 times a day. -The pharmacist did not identify and document the Tramadol was not administered as ordered according to the eMARs and controlled substance logs based on the order changes she noted for March 2021. Telephone interview with the Consultant Pharmacist on 04/30/21 at 3:15pm revealed she did not identify discrepancies with Resident #6's Tramadol because she did not have access to review the controlled substance logs. Refer to interview with the Memory Care Manager (MCM) on 04/30/21 at 10:15am. Refer to telephone interview with the Manager of Operations at the facility's contracted pharmacy on 04/30/21 at 11:58am. Refer to telephone interview with the Consultant Pharmacist on 04/30/21 at 3:15pm. Refer to interview with the Resident Services Director (RSD) on 04/30/21 at 3:58pm. Refer to interview with the Administrator on 04/30/21 at 9:30am.	D 400		

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D 400	Continued From page 95 3. Review of Resident #1's FL-2 dated 04/21/21 revealed diagnoses included type 2 diabetes, congestive heart failure, hypertension, history of pulmonary embolism, and chronic kidney disease. Resident #1's Resident Register revealed an admission on 02/16/19. Review of Resident #1's medication reviews revealed: -The last on-site medication review was completed on 12/18/19 by a pharmacist with the contracted pharmacy. -There was documentation of a quarterly medication review completed 03/20/21 that was completed remotely. Refer to interview with the Memory Care Manager (MCM) on 04/30/21 at 10:15am. Refer to telephone interview with the Manager of Operations at the facility's contracted pharmacy on 04/30/21 at 11:58am. Refer to telephone interview with the Consultant Pharmacist on 04/30/21 at 3:15pm. Refer to interview with the Resident Services Director (RSD) on 04/30/21 at 3:58pm. Refer to interview with the Administrator on 04/30/21 at 9:30am. 4. Review of Resident #3's current FL-2 dated 06/04/20 revealed diagnoses included dementia, hypothyroidism, hyperlipidemia, major depressive disorder, and muscle weakness. Resident #3's Resident Register revealed an	D 400		

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D 400	Continued From page 96 admission on 02/15/19. Review of Resident #3's medication reviews revealed: -The last on-site medication review was completed on 12/18/19 by a pharmacist with the contracted pharmacy. -There was a quarterly medication review for 03/20/21. -This review was not done on-site. Refer to interview with the Memory Care Manager (MCM) on 04/30/21 at 10:15am. Refer to telephone interview with the Manager of Operations at the facility's contracted pharmacy on 04/30/21 at 11:58am. Refer to telephone interview with the Consultant Pharmacist on 04/30/21 at 3:15pm. Refer to interview with the Resident Services Director (RSD) on 04/30/21 at 3:58pm. Refer to interview with the Administrator on 04/30/21 at 9:30am. 5. Review of Resident #5's current FL-2 dated 10/08/20 revealed diagnoses included dementia, cognitive dysfunction with behavioral disturbances, social or emotional deficit, osteoporosis, bone fracture, and asthma. Resident #5's Resident Register revealed an admission on 07/26/19. Review of Resident #5's medication reviews revealed: -The last on-site medication review was completed on 12/18/19 by a pharmacist with the	D 400		

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D 400	Continued From page 97 contracted pharmacy. -There was a quarterly medication review for 03/20/21. -This review was not done on-site. Refer to interview with the Memory Care Manager (MCM) on 04/30/21 at 10:15am. Refer to telephone interview with the Manager of Operations at the facility's contracted pharmacy on 04/30/21 at 11:58am. Refer to telephone interview with the Consultant Pharmacist on 04/30/21 at 3:15pm. Refer to interview with the Resident Services Director (RSD) on 04/30/21 at 3:58pm. Refer to interview with the Administrator on 04/30/21 at 9:30am. 6. Review of Resident #2's current FL-2 dated 01/14/20 revealed diagnoses included bipolar disorder, hypertension (HTN), hypothyroidism, chronic pain, history of asthma, atrial fibrillation, gastroesophageal reflux disease (GERD), constipation, bilateral lower extremity edema and history of deep tissue injury. Review of Resident #2's Resident Register revealed an admission date on 08/05/20. Review of Resident #2's medication reviews revealed there was a quarterly medication review dated 03/21/21 that was completed remotely. Refer to interview with the Memory Care Manager (MCM) on 04/30/21 at 10:15am. Refer to telephone interview with the Manager of	D 400		

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D 400	Continued From page 98 Operations at the facility's contracted pharmacy on 04/30/21 at 11:58am. Refer to telephone interview with the Consultant Pharmacist on 04/30/21 at 3:15pm. Refer to interview with the Resident Services Director (RSD) on 04/30/21 at 3:58pm. Refer to interview with the Administrator on 04/30/21 at 9:30am. 7. Review of Resident #7's current FL-2 dated 10/30/20 revealed diagnoses included left hip fracture, non-operable, bifrontal subarachnoid hemorrhage (AH), advanced dementia, hypertension, hypothyroidism, osteoarthritis and frequent falls. Review of Resident #7's Resident Register revealed an admission date on 05/03/18. Review of Resident #7's medication reviews revealed there was a quarterly medication review dated 03/21/21 that was completed remotely. Refer to interview with the Memory Care Manager (MCM) on 04/30/21 at 10:15am. Refer to telephone interview with the Manager of Operations at the facility's contracted pharmacy on 04/30/21 at 11:58am. Refer to telephone interview with the Consultant Pharmacist on 04/30/21 at 3:15pm. Refer to interview with the Resident Services Director (RSD) on 04/30/21 at 3:58pm. Refer to interview with the Administrator on	D 400		

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D 400	Continued From page 99 04/30/21 at 9:30am. Interview with the Memory Care Manager (MCM) on 04/30/21 at 10:15am revealed: -Prior to the COVID-19 pandemic, the consultant pharmacist always came on-site to the facility to do the medication reviews. -She could not recall when outside providers were allowed to come back to the facility. -The facility did not have any positive COVID-19 cases in March 2021. -She did not recall emailing the Consultant Pharmacist and instructing her to do the medication reviews remotely in March 2021. -She thought the previous Administrator may have told the Consultant Pharmacist to do the medication reviews remotely. Telephone interview with the Manager of Operations at the facility's contracted pharmacy on 04/30/21 at 11:58am revealed: -Some facilities requested the pharmacy consultants to do the medication reviews remotely during the COVID-19 pandemic. -The Consultant Pharmacists were doing on-site reviews during the COVID-19 pandemic but if a facility requested the reviews to be done remotely, the pharmacy would abide by the facility's wishes. -This facility wanted the pharmacy to do the medication reviews remotely. -For reviews done remotely, the Consultant Pharmacist had access to eMARs and any orders on file in the pharmacy's electronic system. Telephone interview with the Consultant Pharmacist on 04/30/21 at 3:15pm revealed: -She reached out to the facility prior to doing the medication reviews in March 2021. -She emailed the MCM and asked if they wanted	D 400		

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D 400	Continued From page 100 an on-site review or if they wanted her to do the medication reviews remotely. -The MCM replied and instructed her to do the medication reviews remotely. -When she did medication reviews remotely, she had access to and reviewed the eMARs and she could see any electronic orders on file at the pharmacy. -She did not have access to and could not review the residents' records in the facility. -She did not have access to and could not check medications on hand or controlled substance logs. Interview with the Resident Services Director (RSD) on 04/30/21 at 3:58pm revealed: -The medication reviews should have been done on-site at the facility. -The facility did not have any positive COVID-19 cases in March 2021 and the last COVID-19 cases were in December 2020. Interview with the Administrator on 04/30/21 at 9:30am revealed: -She had only worked at the facility about 2 weeks so she was not aware the medication reviews had not been done on-site in March 2021. -She found email correspondence dated 03/09/21 between the MCM and the Consultant Pharmacist. -The Consultant Pharmacist asked the MCM if she wanted the medication reviews done on-site or remotely. -The MCM instructed the Consultant Pharmacist to do the medication reviews remotely for March 2021. -There were no residents in the facility with COVID-19 in March 2021 and the medication reviews should have been done on-site.	D 400		

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D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the required staffing hours for the Special Care Unit (SCU) with a census of 20 - 21 were met for 5 of 15 shifts sampled from 03/23/21 - 04/05/21. The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed for a capacity of 84 beds including a SCU with a capacity of 48 beds. Review of the facility's resident census report dated 03/23/21 revealed there was a SCU census of 20 residents, which required 20 staff hours on first and second shift and 16 staff hours on third shift. Review of the employee time cards dated 03/23/21 revealed there was a total of 10 hours and 38 minutes staff hours provided on third shift in the SCU with a shortage of 5 hours and 22 minutes.	D 465	The facility will provide staff for the required hours according to census. Staffing sheets will be reviewed by the RSD or designee daily to make certain appropriate staffing levels to meet the needs of the residents. The ED/RSD will review weekly assignment sheets to monitor for compliance for four (4) weeks. BOD will audit timecard reports weekly for four (4) weeks to capture all documented hours worked. All corrective measures will be implemented by 6/14/21. Continued monitoring of compliance will be through QA audits, compliance trends and patterns.	

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D 465	Continued From page 102 Review of the facility's resident census report dated 04/03/21 revealed there was a SCU census of 21 residents, which required 21 staff hours on first and second shift and 16.8 staff hours on third shift. Review of the employee time cards dated 04/03/21 revealed there was a total of 17 staff hours provided on first shift in the SCU with a shortage of 4 hours. Review of the employee time cards dated 04/03/21 revealed there was a total of 17 staff hours provided on second shift in the SCU with a shortage of 4 hours. Review of the facility's resident census report dated 04/05/21 revealed there was a SCU census of 20 residents, which required 20 staff hours on first and second shift and 16 staff hours on third shift. Review of the employee time cards dated 04/05/21 revealed there was a total of 18 staff hours provided on second shift in the SCU with a shortage of 2 hours. Review of the employee time cards dated 04/05/21 revealed there was a total of 10 hours and 17 minutes staff hours provided on third shift in the SCU with a shortage of 5 hours and 43 minutes. Telephone interview with a resident's family member on 04/30/21 at 11:10am revealed: -The facility had a high turnover rate and were often short staffed. -The family member was at the facility for a visit on Easter Sunday (04/04/21) and noted that the	D 465		

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D 465	Continued From page 103 facility was short staffed. -There was 1 staff serving lunch in the SCU and it took a while for all residents to be served. Interview with a medication aide (MA) on 04/27/21 at 10:45am revealed: -She would pass the medications for residents on the assisted living (AL) side and in the SCU when there was only one MA for the facility. -The Memory Care Manager (MCM) and the Resident Services Director (RSD) would assist with half of the morning medication pass on the SCU during the week. Telephone interview with a second MA on 04/30/21 at 8:06am revealed: -Staff clocked out for their breaks. -She was the only MA in the facility on night shift most of the time. -She split her time 50% on SCU and 50% on the AL side. Review of the facility's schedule with the Business Office Manager (BOM) on 04/30/21 at 12:40pm revealed: -If staff missed a punch, they completed an exception form and she would enter their time into the system. -Once their time was entered into the system, it appeared on their time card. -There was no additional staff to report on the dates requested. Telephone interview with the MCM on 04/30/21 at 10:16am: -She would assist with half of the morning medication pass on the SCU when there was only one MA scheduled. -On average 75% of her time was used to provide resident care services and 25% of the time was	D 465		

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D 465	Continued From page 104 administrative duties. Interview with the RSD on 04/30/21 at 3:58pm revealed: -The MCM was responsible for making the schedule for the facility. -If there was a call out, staff called into the MCM or RSD. -The MCM and RSD called alternative staff to find shift coverage or one of them would cover the staffing need. -The facility was using a staffing company to provide additional PCAs. -There were 3 MAs for the facility. -The MCM and RSD would assist with the medication pass on SCU when there was only one MA working.	D 465		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer	D912	Medication aides were re-trained by RSD utilizing the NC 15 Hour Medication Curriculum on 5/6/21 to include proper documentation of PRN medications. Multidisciplinary review and audits of MAR/ Charts/Med Carts by Pharmacy was conducted on 5/26/21. Quarterly onsite reviews will be conducted by the pharmacy according to NC State Regulations. Scanner devices will be implemented by 6/14/21 with staff education by RSD/RCC for accurate documentation of medication administration. Medication Administration audits will be completed weekly by RSD/RCC for four (4) weeks to identify any additional training needed and to monitor for compliance.	

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D912	Continued From page 105 medications as ordered and in accordance with the facility's policies for 2 of 4 residents (#7, #8) observed during the medication passes including errors with medications for treatment of allergy symptoms, hemorrhoids, and dry eyes (#8), and an extended release pain medication that was crushed (#7); and for 3 of 7 residents sampled (#4, #5, #6) for record review including errors with insulin (#4), an antidepressant (#5), a medication for prevention of heart disease (#5), and narcotic pain medications (#5, #6). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure medication aides observed residents taking their medication for 5 of 5 residents sampled (#1, #6, #8, #9, #10) including one resident during the medication pass (#8) on 04/28/21. [Refer to Tag D366, 10A NCAC 13F .1004(i) Medication Administration (Type B Violation)].	D912	Weekly interviews will be conducted by ED/RSD/RCC for four (4) weeks to address concerns and make certain residents are being observed when administered medications. All corrective measures will be implemented by 6/14/21. Continued monitoring of compliance will be conducted through QA audits, compliance trends and patterns.	
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure Resident #7 was free of mental and physical abuse and neglect as related to the resident being restrained by being tied in her wheelchair with an article clothing and locked in her room for and undetermined amount of time on 02/09/21.	D914	The community will provide a safe environment free of mental and physical abuse, neglect and exploitation. Staff were re-educated on the facility restraint policy by RSD. ED/RSD or designee will make daily observations to identify practices that may be considered restraints. Corrective measures will be implemented by 5/28/21 and will be monitored by daily observations.	

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D914	Continued From page 106 The findings are: Based on observations, record reviews, and interviews the facility failed to ensure that a physical restraint was used in circumstances in which the resident had medical symptoms that warranted the use of restraints, used only with a written order from a physician for 1 of 6 sampled residents (#7). [Refer to Tag D915, G.S. 131D-21(5) Declaration of Residents' Rights (Type A2 Violation)].	D914		
D915	G.S. 131D-21(5) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 5. Except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews the facility failed to ensure that a physical restraint was used in circumstances in which the resident had medical symptoms that warranted the use of restraints, used only with a written order from a physician for 1 of 6 sampled residents (#7). The findings are: Review of the facility's Restraint Policy dated 06/15/20 revealed: -The staff should observe and respect the personal rights of all residents including being	D915	The community will safeguard to make certain they are free from what may be considered a restraint. Education to be provided by Physical Therapy Agency regarding appropriate positioning of residents by 5/28/21. All corrective measures will be implemented by 5/28/21. Continued monitoring of compliance will be conducted through QA audits, compliance trends and patterns.	

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D915	Continued From page 107 free from physical and chemical restraints. -Residents should be free of physical obstruction of movement. -Physical obstruction of movement includes but not limited to being personally involved or having used a material item for: blocking a resident's pathway; restricting a resident from the freedom to wander or get out of bed or chair; prevention of a resident's movement to and from one area; and restraining or blocking a resident in a sitting or lying position. -Restraints shall not be used for discipline of any kind for any residents. -Restraints shall not be used for convenience of staff or facility at any time. -Any observation of above by a staff member should be immediately reported to their supervisor. Review of the facility's Elder Abuse, Neglect and Exploitation Policy dated 06/15/20 revealed: -Resident abuse, neglect, and exploitation are prohibited. -Should any resident experience abuse or when abuse is suspected, staff and volunteers are required to immediately provide notification to persons/agencies as described in this policy. -All Care Partners received in-service training on elder abuse, incidence, signs and symptoms of abuse, and reporting requirements during initial orientation; this training shall be repeated per state regulations. -All staff and volunteers are "mandated reporters." -If any Community staff member or volunteer has observed, suspects, has knowledge of, or is told by a resident or other staff member, of an incident which appears to be any form of abuse, the incident will be immediately reported to the Resident Services Director (RSD); if the RSD is	D915		

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D915	Continued From page 108 not available, the incident will be reported to the Administrator; in all cases the Administrator will be informed as soon as possible. -Upon the notice of reported, observed, suspected or at imminent risk of any form of abuse: immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is conducted; a thorough investigation will be conducted by the RSD or the Administrator; the resident is interviewed and responses documented; witnesses or other persons may need to be interviewed as part of the investigation process; the RSD arranges for medical evaluation of the resident as necessary; the family/responsible party is notified immediately of the incident; the resident's primary care physician (PCP) is notified immediately as necessary. -Reporting of any suspected, alleged, or witnessed abuse will be completed according to state reporting requirements. -The facility shall immediately notify the county department of social services and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. -The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register. -Any staff member willfully participating in this abuse will be terminated. Review of Resident #7's current FL-2 dated 10/30/20 revealed: -Diagnoses included left hip fracture, non-operable, bifrontal subarachnoid hemorrhage (AH), advanced dementia, hypertension, hypothyroidism, osteoarthritis and frequent falls. -She was constantly disoriented. -She was non-ambulatory and required total care	D915		

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D915	Continued From page 109 with personal care assistance. Review of Resident #7's care plan dated 04/28/21 revealed: -She required limited assistance with ambulation/locomotion. -She was independent with transfers. Review of an Incident Report for Resident #7 dated 02/09/21 revealed: -There was an incident that occurred on 02/09/21 at 3:45pm in Resident #7's room. -The staff observed Resident #7 restrained to her wheelchair by a long-sleeved shirt. -Resident #7 had no visible bruises or injuries and vital signs were obtained. -Resident #7 had no loss of consciousness and normal range of motion. -The Memory Care Manager (MCM) was notified on 02/09/21 at 3:45pm. -Resident #7's primary care physician (PCP) was notified on 02/09/21 at 4:30pm. -Resident #7's family member was notified on 02/09/21 at 8:20pm. -Resident #7 was not sent to the hospital. -The staff were to continue to monitor Resident #7 for any changes. Review of a witness statement dated 02/09/21 revealed: -The author of the statement was a personal care assistant (PCA) that was scheduled to work 3:00pm-11:00pm shift on 02/09/21. -She went to Resident #7's room to look for her and noticed that the room door was locked. -She unlocked the room door and observed Resident #7 tied to the wheelchair around her waist with some pants. Review of a second witness statement revealed:	D915		

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D915	Continued From page 110 -The witness statement was not dated. -The author of the witness statement was the former Administrator. -He was notified by a second shift PCA that Resident #7 was tied to her wheelchair in her room. -He went into Resident #7's room and observed her to be tied to her chair with a navy blue, long sleeved t-shirt. -The shirt was around Resident #7's upper body and the wheelchair and was tied behind her and Resident #7 was unable to get up from the chair. -Resident #7 was able to move her arms freely. -The staff untied the shirt and assessed Resident #7 for injuries. -There were no apparent injuries. -There were no changes in Resident #7's mental status and she was responsive as normal. Review of a Health Care Personnel Registry (HCPR) 24-hour Initial Report dated 02/10/21 revealed: -Report was completed by the former Administrator on 02/10/21. -Resident #7 was found restrained to her wheelchair with her long-sleeved top with no apparent injury. -The incident occurred on 02/09/21 at 3:40pm. -There was nothing selected under the "Allegation/Incident Type" portion of the report. -There was one staff member named as an accused individual. -There was no serious bodily injury. -The incident was not reported to law enforcement. Interview with a Regional Long-Term Care Ombudsman on 04/29/21 at 3:38pm revealed: -She completed a training with facility staff on 03/24/21 and discussed different types of	D915		

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D915	Continued From page 111 chemical and physical restraints. -She educated the staff on residents' right to be free from chemical and physical restraints. Interview with a PCA on 04/30/21 at 2:31pm revealed: -She worked on the memory care unit on 02/09/21 on the 7:00am-3:00pm shift. -She last saw Resident #7 at the nurses' station after lunch at about 1:00pm on 02/09/21. -She did hear another staff say she was going to tie Resident #7 up while she was sitting at the nurses' station but felt the other staff member said it jokingly. -She did not report what the staff said because she thought it was a joke. -She was made aware of Resident #7 being restrained by the former Administrator on 02/09/21 at about 7:00pm. -She discussed the above events with the former Administrator and was suspended pending investigation results. -She returned to work about 1 week later and was reeducated on restraints and reporting abuse. Interview with Resident #7's PCP on 04/29/21 at 1:33pm revealed: -On 02/11/21, she was in the facility and followed up with Resident #7 related to abnormal blood pressure and heart rate. -She was not aware of the incident that occurred with Resident #7 on 02/09/21. -On 02/16/21, she was notified, by telephone, of the incident that occurred with Resident #7 on 02/09/21. -She was informed on 02/16/21 that Resident #7 had a sheet tied around her hands restraining her to the wheelchair and there were no injuries sustained. -She was not sure how long Resident #7 was	D915		

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D915	Continued From page 112 restrained. -She was not sure what staff member notified her of that incident. -She was informed that the incident was investigated and that the accused person was terminated. -On 02/18/21, she was in the facility and followed up with Resident #7 related to the incident that occurred on 02/09/21 and there were no injuries noted. -There was not a restraint order for Resident #7. -There had never been an order to retrain Resident #7. -She was aware that Resident #7 attempted to stand up from her wheelchair unassisted at times but was not aware of any other behaviors. -Restraints were considered abuse and neglect and should be reported to the Administrator, the PCP and the family member immediately. -She addressed her concerns with the management staff however she could not remember who the management staff were or when she addressed the concerns. Based on observations, record reviews and interviews it was determined that Resident #7 was not interviewable. Attempted interview with the former Administrator on 04/30/21 at 10:24am was not successful. Attempted interview with a former personal care assistant (PCA) 04/30/21 at 10:30am was not successful. Attempted interview with a former medication aide (MA) on 04/30/21 at 10:36am was not successful. The facility failed to assure 1 of 6 residents was	D915		

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D915	Continued From page 113 free from a physical restraint which resulted in Resident #7 being physically restrained to her wheelchair by staff on 02/09/21. Resident #7 was observed by another staff to be behind a locked door, restrained to her wheelchair by an article of clothing for an undetermined amount of time; the primary care physician (PCP) was not made aware of the incident until 02/16/21 and assessed Resident #7 for injuries on 02/18/21. The facility's failure to assure Resident #7 was free from restraint resulted in serious neglect and constitutes a Type A2 violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/29/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 28, 2021.	D915		