STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092182	A. BUILDING: _____ B. WING _____	R-C 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVER HOUSE	4230 WENDELL BOULEVARD WENDELL, NC 27591

(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 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on August 17-19, 2021.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A2 VIOLATION The Type A2 violation was abated. Non-compliance continues. Based on interviews, and record reviews the facility failed to ensure referral and follow up for 1 of 5 (#3) sampled residents who did not have a scheduled appointment made for restoratives after receiving a referral from the resident's Dentist in July 2021. The findings are: Review of Resident #3's current FL-2 dated 04/06/21 revealed diagnoses included Alzheimer's disease, bipolar disorder, acute respiratory failure, and type 2 diabetes mellitus Review of Resident #3's dental visit dated 07/27/21 revealed: -Resident #3 had a periodic oral evaluation. -Resident #3 had decay in teeth #20, #21, and #22. -Resident #3 was referred for restorations due to the dental decay. Review of a facility fax cover sheet to an oral and	{D 273}		

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{D 273}	Continued From page 1	{D 273}		

facial surgical office revealed:
-There was documentation that 11 pages were faxed to the oral and facial surgical office's fax number on 08/09/21.
-The documents were from the Special Care Coordinator (SCC).
-There was no fax verification stamp on the document.
-There was another fax cover sheet dated 07/28/21 and 30 pages were documented as faxed to the same oral and facial surgical office's fax number.

Interview with Resident #3 on 08/18/21 at 11:42am revealed:
-He saw the Dentist and he thought he had his teeth cleaned.
-He thought the Dentist wanted him to have fillings for some of his teeth.

Interview with a medication aide (MA) on 08/18/21 at 12:15pm revealed residents' referrals and appointments were managed by the Resident Care Coordinator (RCC) and the SCC.

Telephone interview with a representative at the oral and facial surgery office on 08/18/21 at 9:31am revealed:
-Resident #3 did not have any pending appointments.
-She was not able to view any faxed documents.
-There were no recent referrals on Resident #3's profile.
-The last time Resident #3 was seen at the office was in 2015.

Interview with the SCC on 08/19/21 at 9:26am revealed:
-She knew about Resident #3's dental referral for restoratives.

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{D 273}	Continued From page 2 -She spoke with the RCC when choosing an oral and facial surgery office to send the referral for Resident #3. -The oral and facial surgery office was a provider the RCC had used in the past for dental referrals. -Resident #3's Dentist did not specify where or who the referral should be sent. -On 07/28/21, she faxed Resident #3's and other residents' dental referrals . -She faxed Resident #3's dental referral, medication list and face sheet to the oral and facial surgery office on 07/28/21 and 08/09/21. -She used the same process of making an appointment for referrals as she used at her previous job. -The RCC called the oral and facial surgery office the week after the first fax, 08/02/21 to 08/06/21, and on Monday 8/16/21. -She did not call because she was awaiting a call back from the oral and facial surgery office after sending Resident #3's dental referral via fax. -An appointment had not been made for Resident #3 because, she had not received a call from the oral and facial surgery office. -She was responsible for ensuring Resident #3's appointment was made in a timely manner. Interview with the RCC on 08/19/21 at 9:01am and 2:40pm revealed: -She chose the oral and facial surgery office to send the referrals for dental work, because she had utilized the office previously for other residents. -She called the oral and facial surgery office on 08/16/21 and left her contact information with a representative who stated someone would call her back. -She had not received a call back from the office as of 08/19/21. -The SCC was responsible for making the	{D 273}		

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{D 273}	Continued From page 3 appointments and referrals for the SCU residents. Interview with the SCC on 08/19/21 at 2:28pm revealed: -She spoke with a representative at the oral and facial surgery office. -The representative told her that they did not do restoratives. -She had to send Resident #3's referral to another oral and facial surgery office on 08/19/21. -She and the RCC located the new oral surgery office by completing an online search to determine if the office performed restoratives. Interview with the Administrator on 08/19/21 at 3:25pm revealed: -She expected referrals to be managed by the RCC and SCC. -She expected appointments to be made within 2-3 days of the referral. -She was told about Resident #3's referral for restoratives on 08/18/21. -She thought the RCC called last week to contact the oral and facial surgery office about an appointment for Resident #3. -The RCC and SCC were responsible for ensuring appointments for referrals were made in a timely manner.	{D 273}		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this	{D 276}		

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{D 276}	Continued From page 4 Rule. This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION The Type B violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to implement orders for 1 of 5 sampled residents (#3) with an order for urinalysis. The findings are: Review of Resident #3's current FL-2 dated 04/06/21 revealed: -Diagnoses included Alzheimer's disease, bipolar disorder, acute respiratory failure, and type 2 diabetes mellitus. -Resident #3 had an internal catheter. Review of Resident #3's primary care provider orders dated 08/03/21 revealed there was an order for a urinalysis with reflex to culture and a note that home health was supposed to obtain the urine sample. Review of Resident #3's lab results revealed there were no lab results for a urinalysis from 08/04/21 to 08/19/21. Observation of Resident #3 in his room on the Special Care Unit (SCU) on 08/17/21 at 10:00am revealed he had tubing and drainage bag for a catheter. Interview with Resident #3 on 08/18/21 at 11:42am revealed: -The Home Health nurse visited him every week	{D 276}		

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{D 276}	Continued From page 5	{D 276}		

because he had a catheter.
-He thought the Home Health nurse changed his catheter every month.
-He wanted his catheter removed but he had to speak with his Urologist.

Telephone interview with Resident #3's Home Health nurse on 08/18/21 at 9:20am revealed:
-He visited the facility twice a week and his last visit to the facility was 08/17/21.
-He saw Resident #3 every Friday and his last visit with Resident #3 was 08/13/21.
-He completed an assessment for Resident #3 on every other Friday and he changed Resident #3's Foley catheter on the alternating Friday.
-He was at the facility on 08/17/21 and he was not made aware that Resident #3 needed a urine specimen for a urinalysis.
-He had not collected any urine from Resident #3's catheter on or after 08/03/21.
-The staff at the facility usually called him when a urine sample was needed for a resident or told him while he was onsite at the facility.

Interview with a SCU medication aide (MA) on 08/18/21 at 12:15pm revealed:
-When the primary care provider (PCP) ordered a urinalysis, the Special Care Coordinator (SCC) told staff which resident needed a urine specimen.
-A swab or a toilet hat was used to collect the urine specimen.
-Once the specimen was collected staff notified the RCC or SCC so that they could call the laboratory company to pick up the specimen.
-There was a black refrigerator on the Assisted Living side of the facility for specimen storage.
-Staff did not collect urine specimens from Foley catheters.

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{D 276}	Continued From page 6 Interview with the SCC on 08/19/21 at 9:26am revealed: -She knew Resident #3 had an order for a urinalysis, but she did not remember seeing the written order. -She recalled Resident #3's PCP leaving her office on 08/03/21 and she thought Resident #3's PCP told the Home Health nurse about the urinalysis order. -She thought she also told the Home Health nurse about Resident #3's urinalysis on 08/03/21. -She did not have a process in place to ensure urinalysis were completed or to ensure the urine specimen was sent. -She usually told staff when a urinalysis was needed for a resident and staff told her when the urine was collected. -She or the RCC notified the laboratory company after the urine specimen was collected to arrange pick up of the specimen. -She contacted the Home Health nurse on 08/19/21 to make him aware of Resident #3's order for a urinalysis. -She was responsible for ensuring residents' urine specimens were collected and sent to the laboratory. Interview with the Administrator on 08/19/21 at 3:25pm revealed: -She expected all lab orders for urinalysis to be collected by staff and sent to the laboratory. -The RCC or SCC notified the laboratory company when a urine specimen was ready for pick up. -The RCC and SCC were responsible for ensuring residents' urine specimens were collected for laboratory orders and sent to the laboratory. Attempted telephone interview with Resident #3's	{D 276}		

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{D 276}	Continued From page 7 PCP on 08/18/21 at 4:25pm was unsuccessful.	{D 276}		
{D 287}	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to ensure residents received a napkin and non-disposable place setting consisting of at least a knife, fork, and spoon for use during meals. The findings are: Review of staff meeting sign-in sheets on 08/19/21 revealed: -There was a dietary in-service provided by the Administrator on 04/07/21. -There were staff meetings on 05/21/21, 05/26/21, and 06/22/21 that including dietary reviews and regulations on the agendas. Review of a meal cart check-off form on 08/19/21 revealed: -The left column was titled "Initials" and had	{D 287}		

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{D 287}	Continued From page 8	{D 287}		

spaces for dietary staff initials that corresponded to the rows in the center column.
-The center column was titled "Items" and listed silverware: spoon, fork, and knife, napkin, and other items to be provided with meals.
-The right column was titled "Check" and had spaces that corresponded to the rows in the center column.
-There was a signature line for the Dietary Aide (DA).
-There was a signature approval line for the Dietary Manager (DM).

Observation in the kitchen on 08/19/21 at 10:14am revealed there was a large box containing disposable napkins on the bottom shelf of the food preparation area.

Interview with a resident in the AL unit on 08/17/21 at 10:58am revealed:
-She routinely ate meals in her room.
-A full set of utensils was provided "sometimes" depending on which staff was on duty.
-Sometimes she was provided with only a spoon or a fork with her meals.
-She was given only a plastic spoon "the other day" to eat meat, cabbage, and carrots.
-She used her other hand to help move the food onto the spoon.
-She did not ask staff for a knife or fork because she had been a resident of the facility for several years and had gotten "used to going with the flow."
-She would get up and get a paper towel from the dispenser in her bathroom when she was not provided with a napkin.

Interview with a second resident in the AL unit on 08/17/21 at 9:23am revealed:
-Residents were provided with napkins during

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{D 287}	Continued From page 9	{D 287}		

meals "sometimes."
-Three days ago, on 08/14/21, she was not provided with a napkin during the lunch meal.
-She used a "wet wipe" when she returned to her room after the meal.

Interview with a third resident in the AL unit on 08/17/21 at 9:36am revealed:
-He ate his meals in the dining room.
-The residents were given napkins "sometimes."
-Sometime last week, he was not provided with a napkin and instead used a piece of toilet tissue that he had in his pocket.

Interview with a fourth resident in the AL unit on 08/17/21 at 9:46am revealed:
-She did not always receive a napkin during meal service.
-"Every once in a while, it gets hectic and they might forget" to provide the residents with a napkin.

Review of the lunch menu dated 08/17/21 posted in the kitchen revealed cornmeal breaded catfish, delicious rice, collard greens, fresh biscuit, peaches, and beverage of choice was to be served.

Observations of the special care unit (SCU) during lunch service on 08/17/21 from 11:36am-11:48am revealed:
-There were twelve residents seated in the dining room.
-Staff served the lunch plates to the residents.
-The residents received a fork, knife, and spoon; no napkins were provided with the utensils.
-Staff served beverages to the residents.
-There was a resident eating the catfish with her hands; she brushed off the food particles with her other hand.

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{D 287}	Continued From page 10 -Napkins were provided to all the residents at 11:48am. Observation of an assisted living (AL) resident on 08/17/21 at 12:05pm revealed: -The resident was served his lunch meal in his room. -He received a napkin and a plastic fork with his lunch plate. Observation of a second AL resident 08/17/21 at 12:06pm revealed: -The resident was served her lunch meal in her room. -She received a napkin and a plastic fork with her lunch tray. Observation of two other AL residents on 08/17/21 at 12:07pm revealed: -The residents who were served lunch in their room. -Both residents received a napkin and plastic fork with their lunch plate. Observation of the SCU during dinner service on 08/17/21 from 4:57pm-5:12pm revealed: -There were nine residents seated in the dining room. -The residents were served sandwiches, mixed vegetables, pickle slices, and ice cream. -The residents were given a full set of non-disposable utensils. -The residents were not provided with a napkin. -A resident in a wheelchair asked a PCA for a napkin at 5:00pm. -The PCA said she would "look for" a napkin. -The resident was licking her fingers at 5:10pm. -The resident was wheeled out of the dining room at 5:12pm. -The resident had not been provided with a	{D 287}		

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{D 287}	Continued From page 11 napkin. Review of the dinner meal cart check-off form for the special care unit (SCU) dated 08/17/21 revealed: -The left column was marked with a DA's initials. -The right column had marks corresponding to the rows for silverware: spoon, fork, knife, and napkin. -It was signed by the DA and the cook on duty. Interview with a personal care aide (PCA) on the AL unit on 08/18/21 at 2:46pm revealed: -The PCAs were responsible for providing a complete set of non-disposable utensils and a napkin to the residents who ate in their rooms. -Sometimes there was not enough silverware to provide to the residents. -She "didn't realize" she had not provided a full set of non-disposable utensils to a resident on the AL unit on 08/17/21. -She gave the residents "whatever they (dietary staff) provide." Interview with a second PCA on 08/18/21 at 4:37pm revealed: -Residents were provided with a complete set of non-disposable utensils. -Residents were "usually" provided with napkins; it depended on who was assisting with the meal. -She did not know why napkins were not provided on the meal cart for dinner in the SCU on 08/17/21. -She did not find any napkins in the metal food transport cart. -There should have been napkins on the metal food transport cart. -She was more concerned with the residents being provided with their food before it got cold instead of looking for napkins.	{D 287}		

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{D 287}	Continued From page 12 Interview with the Dietary Manager (DM) on 08/19/21 at 9:47am revealed: -The PCAs were responsible for getting metal utensils from the buffet area in the dining room and providing them to the residents. -If the PCAs were providing plastic utensils to the residents, it was without his knowledge. -There were orange bins containing plastic utensils in the kitchen. -The plastic utensils were used for the residents' snacks. -The Administrator informed staff during a meeting in April 2021 to provide a complete set of metal utensils and a napkin with all meals. -The Administrator created a check-off list to be completed before meals and snacks were served to the residents. -The DA was responsible for filling out the check-off sheet. -The cook on duty was responsible for "looking at the meal cart" and signing the form for each meal and snack for the AL and the SCU. -The check-off forms were provided to the Administrator each day. -Napkins were supposed to be on the meal cart. -It was the responsibility of the PCA to provide residents with a complete set of non-disposable utensils and napkins. -The PCAs were supposed to give a full set of non-disposable eating utensils to residents who were eating in their rooms. -He did not know where the "breakdown" occurred. Interview with a DA on 08/19/21 at 10:03am and 10:50am revealed: -He assembled the SCU dinner cart contents on 08/17/21. -He did not put napkins on the dinner cart.	{D 287}		

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{D 287}	Continued From page 13 -He marked on the meal check-off form that he had placed napkins on the cart for the dinner meal on 08/17/21 without putting napkins on cart. -He did not remember if the cook on duty reviewed the contents of the meal cart before it left the kitchen. -A PCA came into the kitchen on 08/17/21 during the dinner meal and asked for napkins. -He gave her enough napkins for the residents. -He did not know why the resident who had asked for a napkin did not receive one. Interview with the Administrator on 08/19/21 at 11:10am and 3:37pm revealed: -She provided a dietary in-service in April 2021. -Each monthly staff meeting included a dietary refresher. -She expected staff to provide the residents with a complete set of non-disposable utensils with each meal. -Residents who ate meals in their rooms should also get a complete set of non-disposable utensils with each meal. -Plastic utensils were supposed to be used only when there was a virus affecting the residents in the facility or if the power was out and the dishwasher was not working. -Dietary staff was responsible for placing a complete set of non-disposable eating utensils in plastic "sleeves." -Napkins were not placed in the sleeves. -The cook on duty was supposed to verify the contents on the meal cart and sign the meal cart check-off form. -She observed lunch and dinner service in the AL unit on 08/18/21. -She did not have any concerns about the lunch and dinner service on 08/18/21. -She needed to retrain staff about providing the residents with silverware.	{D 287}		

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{D 287}	Continued From page 14 -The beverage cart should have contained napkins. -Sometimes napkins were placed in the large metal cart with the plates. -The residents should always ask for what they need. -The resident's request for a napkin should have been followed-up right away.	{D 287}		
{D 306}	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure water was served with meals to all residents. The findings are: Review of staff meeting sign-in sheets on 08/19/21 revealed: -There was a dietary in-service provided by the Administrator on 04/07/21. -There were staff meetings on 05/21/21, 05/26/21, and 06/22/21 that including dietary reviews and regulations on the agendas. Review of a meal cart check-off form on 08/19/21 revealed:	{D 306}		

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{D 306}	Continued From page 15 -The left column was titled "Initials" and had spaces for dietary staff initials that corresponded to the rows in the center column. -The center column was titled "Items" and listed tea, coffee, coffee creamer and sugar, ice, milk, juice, water, nutritional shakes, thickened tea, thickened water, any other thickening drink and other items to be provided with meals. -The right column was titled "Check" and had spaces that corresponded to the rows in the center column. -There was a signature line for the Dietary Aide (DA). -There was a signature approval line for the Dietary Manager (DM). Review of the lunch menu dated 08/17/21 posted in the kitchen revealed beverage of choice was to be served with the meal. Interview with an assisted living (AL) resident on 08/17/21 at 9:23am revealed: -Water was not routinely served during meals. -The PCAs asked the residents if they wanted a particular beverage before serving it. -She wanted to "automatically" be served water with her meals. -There were times she had not been served water when she wanted it. -She was not served water last week; she requested water and the personal care aide (PCA) gave her a glass of water. Interview with a second AL unit resident on 08/17/21 at 9:46am revealed she was not routinely served water. Interview with a third AL resident on 08/17/21 at 11:05am revealed: -His meals were served in the dining room.	{D 306}		

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{D 306}	Continued From page 16 -Water was not routinely served. -The facility staff would ask him if he wanted water. -Water was only served when requested. Interview with the cook on duty on 08/17/21 at 11:13am revealed all residents were served water with their meals. Observation of a resident who was served lunch in her room in the AL unit on 08/17/21 at 12:06pm revealed: -She was not served water. -She was asked if she wanted tea. Observations of the SCU dining room during dinner service on 08/17/21 from 4:57pm-5:12pm revealed: -There were nine residents in the dining room. -Four residents were served water. Observation of the AL dining room on 08/17/21 at 5:10pm revealed: -There were 12 residents who had glasses of water served to them. -There were 10 residents who did not have water served to them, but these residents had glasses of iced tea. Interview with an AL resident on 08/18/21 at 8:20am revealed: -The resident asked staff for water for dinner on 08/17/21. -The resident did not receive water for dinner on 08/17/21 as requested. Interview with the Dietary Manager (DM) on 08/19/21 at 9:47am revealed: -The DA was responsible for filling out the check-off sheet.	{D 306}		

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{D 306}	Continued From page 17 -The cook on duty was responsible for "looking at the meal cart" and signing the form for each meal and snack for the AL and the SCU. -A gallon of water was always provided on the meal cart. -The residents were supposed to routinely be served water with every meal. -The PCAs were responsible for serving water to every resident. -All staff were informed of this requirement in a meeting in April 2021. -He did not know where the "breakdown" occurred. Interview with a DA on 08/19/21 at 10:03am revealed: -He always put water on the beverage carts. -The PCAs were responsible for serving water to the residents. Interview with the Administrator on 08/19/21 at 11:10am and 3:37pm revealed: -She provided a dietary in-service in April 2021. -Each monthly staff meeting included a dietary refresher. -She expected staff to provide water to the residents with every meal. -Residents who ate in their rooms should have also been served water with every meal. -She observed lunch and dinner service in the AL unit on 08/18/21. -She did not have any concerns about the lunch and dinner service on 08/18/21.	{D 306}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	{D 358}		

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{D 358}	Continued From page 18	{D 358}		

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:
FOLLOW UP TO TYPE B VIOLATION

Based on these findings, the previous Type B Violation was not abated.

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 4 of 5 sampled residents (#1,#3, #4 and #5) including errors with medications used to treat hyperglycemia and benign prostatic hyperplasia (#5), depression (#1 and #4), constipation (#4) and moderate to severe confusion (#3).

The findings are:

1. Review of Resident #5's FL2 dated 07/06/21 revealed diagnosis of diabetes mellitus, neuropathy, peripheral artery disease, coronary artery disease and benign prostatic hyperplasia.

a. Review of Resident #5's physician orders dated 06/17/21 revealed:
-There was an order for Novolog, (a rapid acting insulin used to lower blood sugar) administer three times daily with meals per sliding scale insulin (SSI); 150 - 200 administer 3 units; 210 - 250 administer 6 units;
251 - 300 administer 9 units; 301 - 350 administer 12 units; 351 - 400 administer 15 units.

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{D 358}	Continued From page 19 -There was an order for Novolog Flexpen administer 8 units with each meal in addition to SSI; 0 - 199 administer 0 units; 200 - 250 administer 4 units; 251- 300 administer 6 units; 301 - 350 administer 8 units; 350 or greater administer 10 units. Review of Resident #5's hospital discharge summary dated 07/06/21 revealed: -Resident #5 was hospitalized from 07/04/21 to 07/06/21 with diagnosis of sick sinus syndrome. -There was an order for Novolog Insulin 8 units three times a day with meals plus SSI. -There was no order for SSI. Review of Resident #5's lab results dated 05/18/21 revealed a hemoglobin A1C of 9.2. (Hemoglobin A1C measures the average blood sugar levels over the previous 3 months. The normal A1C level is below 5.7%). Review of Resident #5's electronic medications administration record (eMAR) for June 2021 revealed: -There was an entry for Novolog administer three times daily with meals per SSI; 150 - 200 administer 3 units; 210 - 250 administer 6 units; 251 - 300 administer 9 units; 301 - 350 administer 12 units; 351 - 400 administer 15 units. -Insulin aspart was scheduled for administration at 7:30am, 11:45am, and 5:00pm. -There were nine opportunities where the amount of insulin was not administered as ordered. -On 06/02/21 at 11:45am, there was documentation of a blood sugar reading of 422 with 15 units of insulin administered. -On 06/03/21 at 7:30am, there was documentation of blood sugar reading of 204 with 3 units of insulin administered.	{D 358}		

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{D 358}	Continued From page 20 -On 06/03/21 at 5:00pm, there was documentation of blood sugar reading of 474 with 15 units of insulin administered. -On 06/10/21 at 5:00pm, there was documentation of blood sugar reading of 273 with 6 units of insulin administered. -There was an entry for Novolog Flexpen U-100 from 06/04/21 to 06/30/21 to administer 8 units with each meal in addition to SSI; 0 - 199 administer 0 units; 200 - 250 administer 4 units; 251- 300 administer 6 units; 301 - 350 administer 8 units; 350 or greater administer 10 units. -Novolog Flexpen was scheduled for administration at 7:00am, 11:30am, 4:30pm. -There were twenty occasions where the amount of insulin was not administered as ordered. -On 06/12/21 at 11:30am, there was documentation of blood sugar reading of 146 with 0 units of insulin administered. -On 06/16/21 at 7:00am, there was documentation of blood sugar reading of 161 with 0 units of insulin administered. -On 06/17/21 at 11:30am, there was documentation of blood sugar reading of 152 with 0 units of insulin administered. Review of Resident #5's eMAR from 07/01/21 to 07/4/21 revealed: -There was an entry for insulin aspart U-100 administer three times daily with meals per SSI; 150 - 200 administer 3 units; 210 - 250 administer 6 units; 251 - 300 administer 9 units; 301 - 350 administer 12 units; 351 - 400 administer 15 units. -Insulin aspart was scheduled for administration at 7:00am, 11:30am, 4:30pm. -On 07/02/21 at 7:30am, there was documentation of blood sugar reading 255 with 6 units of insulin administered. -On 07/2/21 at 11:45am, there was	{D 358}		

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{D 358}	Continued From page 21	{D 358}		

documentation of blood sugar reading of 312 with 6 units of insulin administered.
-On 07/03/21 at 5:00pm, there was documentation of blood sugar reading of 363 with 10 units of insulin administered.
-There was an entry for Novolog Flexpen U-100 from 07/01/21 to 07/4/21 to administer 8 units with each meal in addition to SSI; 0 - 199 administer 0 units; 200 - 250 administer 4 units; 251- 300 administer 6 units; 301 - 350 administer 8 units; 350 or greater administer 10 units.
-Novolog Flexpen was scheduled for administration
-On 07/02/21 at 4:30pm, there was documentation of blood sugar reading of 160 with 0 units of insulin administered.
-On 07/03/21 at 7:00am, there was documentation of blood sugar reading of 120 with 0 units of insulin administered.
-On 07/04/21 at 11:30am, there was documentation of blood sugar reading of 178 with 0 units of insulin administered.

Review of Resident #5's eMAR from 07/07/21 to 07/31/21 revealed:
-There was an entry for insulin aspart U-100 administer three times daily with meals per SSI; 150 - 200 administer 3 units; 210 - 250 administer 6 units; 251 - 300 administer 9 units; 301 - 350 administer 12 units; 351 - 400 administer 15 units.
-Insulin aspart was scheduled for administration at 7:30am, 11:45am, and 5:00pm.
-There were twelve opportunities where the amount of insulin was not administered per the ordered sliding scale.
-On 07/07/21 at 11:45am, there was documentation of blood sugar reading of 435 with 15 units of insulin administered.
-On 07/10/21 at 7:30am, there was

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{D 358}	Continued From page 22	{D 358}		

documentation of blood sugar reading of 411 with 15 units of insulin administered.
-On 07/10/21 at 7:30am, there was documentation of blood sugar reading of 162 with 0 units of insulin administered.
-On 07/19/21 at 11:45am, there was documentation of blood sugar reading of 195 with no documentation of insulin administered.
-There was an entry for Novolog Flexpen U-100 from 07/01/21 to 07/21/21 to administer 8 units with each meal in addition to SSI; 0 - 199 administer 0 units; 200 - 250 administer 4 units; 251- 300 administer 6 units; 301 - 350 administer 8 units; 350 or greater administer 10 units.
-Novolog Flexpen was scheduled for administration at 7:00am, 11:30am, 4:30pm.
-There were twenty opportunities where the amount of insulin was not administered per the order.
-On 07/07/21 at 4:30pm, there was documentation of blood sugar readings of 169 with 0 units of insulin administered.
-On 07/08/21 at 4:30pm, there was documentation of blood sugar readings of 177 with 0 units of insulin administered.
-On 07/11/21 at 7:00am, there was documentation of blood sugar readings of 175 with 0 units of insulin administered.
-There was a second entry for Novolog Flexpen U-100 from 07/21/21 to 07/31/21 to administer 8 units with meals in addition to SSI; 200 - 250 administer 4 units; 251 - 300 administer 6 units; 301 - 350 administer 8 units; 350 or greater administer 10 units.
-Novolog Flexpen was scheduled for administration at 7:00am, 11:30am, 4:30pm.
-On 07/22/21 at 11:45am, there was documentation of blood sugar reading 224 with 6 units of insulin administered.
-On 07/26/21 at 11:45am, there was

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{D 358}	Continued From page 23 documentation of blood sugar reading 232 with 6 units of insulin administered. Review of Resident #5's eMAR for August 2021 revealed: -There was an entry for insulin aspart U-100 administer three times daily with meals per SSI; 150 - 200 administer 3 units; 210 - 250 administer 6 units; 251 - 300 administer 9 units; 301 - 350 administer 12 units; 351 - 400 administer 15 units. -Insulin aspart was scheduled for administration at 7:30am, 11:45am, and 5:00pm. -There were seven occasions where the amount of insulin was not administered per the ordered sliding scale. -On 08/02/21 at 7:30am, there was documentation of blood sugar reading of 429 with 15 units of insulin administered. -On 08/02/21 at 5:00pm, there was documentation of blood sugar reading of 270 with 6 units of insulin administered. -On 08/04/21 at 11:45am, there was documentation of blood sugar reading of 186 with no documentation of insulin administered. -There was an entry for Novolog Flexpen U-100 from 08/01/21 to 08/12/21 to administer 8 units with meals in addition to SSI; 200 - 250 administer 4 units; 251 - 300 administer 6 units; 301 - 350 administer 8 units; 350 or greater administer 10 units. -Novolog Flexpen was scheduled for administration at 7:00am, 11:30am, 4:30pm. -On 08/05/21 at 7:30am, there was documentation of blood sugar reading 291 with 10 units of insulin administered. -On 08/06/21 at 11:45am, there was documentation of blood sugar reading 246 with 12 units of insulin administered. -On 08/07/21 at 7:30am, there was	{D 358}		

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{D 358}	Continued From page 24 documentation of blood sugar reading 324 with 6 units of insulin administered. Interview with a medication aide (MA) on 08/18/21 at 3:20pm revealed: -She called the Primary Care Provider (PCP) for blood sugars greater than 400. -She documented on a progress note that the PCP had been contacted and any new orders received. -She did not call the PCP on 08/02/21 for a blood sugar of 429 but administered 15 units of insulin. -She did not know why she gave 15 units on 08/02/21 without calling the PCP. -She had not noticed until today, 08/18/21, that there was no insulin order for blood sugar readings of 201 - 209. -She did not know why she chose to administer 6 units of insulin on 07/22/21 at 5:00pm for a blood sugar reading of 209. -She did not know why she chose to administer 3 units of insulin on 07/23/21 at 5:00pm for a blood sugar reading of 209. -She would let the Resident Care Coordinator (RCC) know that there was no insulin order for blood sugar readings of 201-209. Interview with a second MA on 08/19/21 at 10:40am revealed: -She had noticed there were two different SSI orders on the eMAR. -She used the first SSI order that "popped up" on the eMAR. -She had not reported the two SSI orders on the eMAR to the RCC. -She had not noticed there was no insulin order for blood sugar ranges between 201-209. Interview with a third MA on 08/18/21 at 11:40am revealed:	{D 358}		

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-She had noticed there were two SSI orders on the eMAR.
-She had told the RCC "a while ago" about the two SSI orders.
-She did not know why she had administered 15 units of insulin on 08/11/21 at 7:30am for a blood sugar of 350 when the order was for 12 units.
-She did not know why she had administered 9 units of insulin on 08/11/21 at 5:00pm for a blood sugar of 357 when the order was for 15 units.
-She notified the RCC or PCP for blood sugars greater than 400.
-She administered 15 units of insulin on 06/12/21 at 7:30am for blood sugar reading of 447 because there was no order for blood sugar readings greater than 400.
-She did not notify the RCC or PCP of the blood sugar of 447 on 06/12/21.
-She knew there was no order for a blood sugar greater than 400.
-She documented on the eMAR and progress notes when new orders were received for blood sugars greater than 400.

Interview with a fourth MA on 08/18/21 at 2:40pm revealed:
-She had noticed there was insulin order for blood sugar ranges 201-209.
-She thought she had notified the RCC that there was no order for blood sugar ranges 201-209.
-She administered 15 units for blood sugars over 400.
-She spoke to the PCP about blood sugars greater than 400.

Interview with the RCC on 8/18/21 at 2:45pm revealed:
-The MAs let the RCC know if blood sugar readings were above 400.
-She notified the PCP regarding blood sugars

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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
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greater than 400.
-The MA should document when they notify the RCC or PCP.
-She wrote a telephone order and would have the PCP sign when the PCP returned to the facility.
-She verbally relayed any medication changes to the MAs.
-She documented on progress notes any communication with the PCP and new orders.

Interview with Director of Clinical Services on 08/19/21 at 9:55am revealed:
-The RCC was responsible for auditing the eMARs.
-She was unaware of any order discrepancies.
-The MAs were expected to follow the orders as written.
-The MAs were expected to report any discrepancies to the RCC.
-The MAs should administer medications as ordered.
-Resident #5 could become hypoglycemia (low blood sugar) or hyperglycemic (high blood sugar) if insulin was not administered correctly.
-Elevated blood sugars would cause damage to the kidneys, heart and eyes.
-The MA should notify the PCP of blood sugar readings greater than 400.
-The MA should document the new order in the progress notes and on the eMAR.
-The RCC or MA should fax all new orders to the pharmacy.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 08/19/21 at 8:45am revealed:
-She did not know there were two different SSI orders.
-She would expect to be notified to clarify which SSI range to use.

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-She did not know there was no insulin order for blood sugar readings of 201-209.
-She would have expected to be notified by the MA or RCC regarding a clarification order for blood sugar readings between 201-209.
-The facility notified her by phone or text to report needs for the residents, including order clarifications.
-She could not recall the last time the facility contacted her regarding a blood sugar reading greater than 400 for Resident #5.

Interview with the Administrator on 08/19/21 at 9:20am and at 3:28pm revealed:
-She was unaware that Resident #5 had multiple SSI orders.
-The MA should notify the RCC or PCP if there was a discrepancy.
-The MA or RCC could text or call the PCP 24 hours a day.
-The MAs could not decide which SSI order to administer.

Refer to the interview with the Administrator on 08/19/21 at 3:37pm.

b. Review of Resident #5's physician orders dated 06/17/21 revealed an order for tamsulosin (used to treat symptoms of an enlarged prostate) 0.4mg two capsules every evening.

Review of Resident #5's hospital discharge summary dated 07/06/21 revealed:
-Resident #5 was hospitalized from 07/04/21 to 07/06/21 which included diagnosis of sick sinus syndrome.
-There was an order for tamsulosin 0.4mg twice a day.

Review of Resident #5's electronic medication

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administration record (eMAR) from 07/07/21 to 07/14/21 revealed:
-There was an entry for tamsulosin 0.4mg one capsule every evening at 5:00pm
-There was documentation Tamsulosin was administered every evening at 5:00pm from 07/07/21 to 07/14/21.

Review of Resident #5's eMAR from 07/15/21 to 07/31/21 revealed:
-There was an entry for tamsulosin 0.4mg one capsule twice a day at 8:00am and 5:00pm.
-There was documentation of tamsulosin administered every morning and evening at 8:00am and 5:00pm.

Review of Resident #5's August 2021 eMAR revealed:
-There was an entry for tamsulosin 0.4mg one capsule twice a day at 8:00am and 5:00pm.
-There was documentation of tamsulosin administered every morning and evening at 8:00am and 5:00pm.

Observation of Resident #5's medications on hand on 08/17/21 at 2:45pm revealed:
-Resident #5's medication was dispensed in multi-dose packs.
-There was no Tamsulosin capsule in the 8:00am multi-dose packs.
-There were two tamsulosin 0.4mg capsules in the 5:00pm multi-dose packs.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 08/18/21 at 11:25am revealed:
-The pharmacy had a physician's order signed 06/17/21 for tamsulosin two every evening.
-The facility was responsible for faxing new orders to the pharmacy.

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{D 358}	Continued From page 29 -The pharmacy had not received discharge orders dated 07/06/21 from the facility. -The pharmacy was not aware of Resident #5's hospitalization with change in order for tamsulosin. -The tamsulosin medication had been packaged in the multi-dose packs two in the evening since 06/17/21. Telephone interview with Resident #5's Primary Care Provider (PCP) on 08/19/21 at 8:45am revealed: -Resident #5 was taking tamsulosin for benign prostatic hyperplasia. -Tamsulosin could be given one twice a day or two every evening. -She was not concerned regarding the frequency of tamsulosin. -The order for tamsulosin twice a day had been written when Resident #5 was discharged from the hospital. -She was unaware of the frequency change in tamsulosin until today, 08/19/21. Interview with a MA on 08/17/21 at 4:20pm revealed: -She compared the medication in multi-dosing pack to the eMAR. -She scanned the medication in the multi-dose pack in the eMAR. -She removed medication from the multi-dose pack and placed in the plastic medication cup. -She administered the medication to the resident. -She documented on the eMAR after medications were given. -She had noticed there were two tamsulosin capsules in the multi-blister pack for 5:00pm about "a week ago". -She had told the RCC about the discrepancy about "a week ago".	{D 358}		

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{D 358}	Continued From page 30 -She had been destroying one capsule of tamsulosin from the multi-blister pack for 5:00pm administration for "about a week". Interview with a second MA on 08/18/21 at 11:40am revealed: -She would remove the multi-dose pack from the medication cart. -She would scan the medication in the multi-dose pack in the eMAR. -All the medications in the multi-dose pack would show up on the eMAR screen. -She would "pop" medications into the medication cup. -She would administer the medications to the resident. -She would click on the "complete" button verifying medications were administered. -She would scan the eMAR for any other medication orders where the medication was not in the multi-dose pack. -She had not noticed the tamsulosin was not in the multi-dose pack for 8:00am. Interview with a third MA on 08/18/21 at 12:15pm revealed: -He would verify the medication in the multi-dose pack with the order on the eMAR. -He would remove the medication from the multi-dose pack and place the medication in medication cup. -He would administer the medication to the resident. -He would document on the eMAR the medication had been administered. -He had noticed about a "week ago" that tamsulosin was not in the morning multi-dose pack. -He thought he had told the RCC about the discrepancy about "a week ago".	{D 358}		

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{D 358}	Continued From page 31 -He did not know why he continued to document that the tamsulosin was given once he realized the medication was not in the morning multi-dose pack for 8:00am. -He realized that he needed to pay closer attention when comparing medication with orders on the eMAR. Interview with fourth MA on 08/19/21 at 10:40pm revealed: -She verified the medication with order on the eMAR. -She scanned the medication in multi-dose pack into eMAR. -She popped the medication into a medication cup. -If the medications had been changed or discontinued an alert would "pop up" on the eMAR screen. -She would administer the medications. -She would document on the eMAR that medications were administered. -If the medication was not in the multi-dose pack the order would not pop up on the eMAR. -She had not noticed that there was no tamsulosin in the multi-pack for the 8:00am dose. -She would have let the RCC know that the medication was not in the multi-dose pack had she noticed it was not there. -She had signed the eMAR that tamsulosin had been administered at 8:00am by mistake. Interview with RCC on 08/17/21 at 4:28pm revealed: -She was responsible for faxing orders to the pharmacy. -The pharmacy would enter the new order into the eMAR. -The entered order "popped" up on the computer screen for approval.	{D 358}		

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-She was responsible for approving the order.
-She would verify the medication was in the facility upon approval of the order.
-She and MA would make sure the medication and administration time was correct.
-The pharmacy updated the eMAR with new orders after hospitalization.
-The pharmacy should send the medications in multi-dose packs as ordered.

Interview with RCC on 08/18/21 at 12:00pm revealed:
-She could not recall if the hospital discharge summary was faxed to the pharmacy.
-She could not recall approving the order for tamsulosin twice a day.
-She was responsible for faxing hospital discharge orders to the pharmacy.
-She was responsible for monthly medication administration audits.

Interview with RCC on 08/19/2021 at 11:23am revealed:
-The MA would scan the medications in the multi-dose pack and the orders for all medications in the multi-dose pack would "pop up" on the eMAR screen.
-If the medication was not in the scanned multi-dose pack the order would not "pop-up".
-The MA would scan through the eMAR for any orders that did not "pop-up" when the multi-dose pack was scanned.
-The MA would click "complete" on the eMAR once medications had been administered.
-When the MA clicked "complete" all medications would be documented as administered.
-The tamsulosin that was ordered at 8:00am would not have scanned to the eMAR since it was not in the multi-dose pack for 8:00am.
-The tamsulosin would be documented as

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administered once the MA clicked "complete" on the eMAR.
-The tamsulosin that was ordered at 5:00pm would scan to the eMAR since it was in the multi-dose pack for 5:00pm.
-The tamsulosin would be documented as administered once the MA clicked "complete' on the eMAR.
-The staff should read the orders and compare medication with the order.
-The MA should report all discrepancies to the RCC to be corrected.
-The RCC had not been made aware of the discrepancy with tamsulosin.

Interview with the Administrator on 08/19/21 at 9:20am and at 3:28pm revealed:
-She was unaware of the discrepancy in the order for tamsulosin.
-The MA should notify the RCC or PCP if there was a discrepancy.
-The MA or RCC could text or call the PCP 24 hours a day.
-The MA should be comparing the order on the eMAR with the medication on the medicine cart.
-The benefit of the scanner for the eMAR was that it would alert the staff if the medication had been changed or discontinued.
-The RCC would send new orders to the pharmacy.
-The RCC would verify the order when it "popped-up" on the eMAR.
-The RCC would verify the medication was in the facility.
-The tamsulosin would not scan if it was not in the multi-dose pack.
-The MAs did not scan through the eMAR orders to verify all medications were being administered.
-The MAs did not read the orders.

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{D 358}	Continued From page 34 Refer to the interview with the Administrator on 08/19/21 at 3:37pm. 2. Review of Resident #1's current FL-2 dated 06/08/21 revealed: -Diagnoses included essential high blood pressure. -There was an order for sertraline (used to treat depression) 25mg take one tablet at bedtime. Review of Resident #1's subsequent orders dated 08/12/21 revealed: -There was an order to discontinue sertraline 50mg at bedtime. -There was an order for sertraline 50mg take 1½ tablets (75mg) at bedtime. Review of Resident #1's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry for sertraline 50mg take one tablet at bedtime scheduled for administration at 8:00pm. -There was documentation sertraline 50mg had been administered from 08/01/21-08/15/21. -There was an entry for sertraline 50mg take 1½ tablets (75mg) at bedtime scheduled for administration at 8:00pm. -There was documentation sertraline 75mg had been administered on 08/16/21. Observation of Resident #1's medication available for administration on 08/18/21 at 12:00pm revealed: -There was a blister pack labeled 1 of 2 containing 14 of 14 half tablets of sertraline 50mg that was dispensed by the pharmacy on 08/12/21. -The instructions on the label read take 1.5 tablets (75mg) at bedtime. -There was a second blister pack labeled 2 of 2	{D 358}		

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{D 358}	Continued From page 35 containing 13 of 13 whole tablets of sertraline 50mg tablets that were dispensed by the pharmacy on 08/12/21. -The instructions on the label read take 1.5 tablets (75mg) at bedtime. -There was a multi-pack containing Resident #1's bedtime medications for administration on 08/18/21 that included one sertraline 50mg tablet. -There was a multi-pack containing Resident #1's bedtime medications for administration from 08/19/21-08/25/21 that included one sertraline 50mg tablet in each pack. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/19/21 at 8:48am revealed: -There was an order written on 08/12/21 to discontinue sertraline 50mg. -There was an order written on 08/12/21 for sertraline take 75mg at bedtime. -The pharmacy dispensed a total of 20 sertraline 50mg tablets on 08/12/21. -The sertraline tablets were delivered to the facility on 08/13/21 at 3:00pm. -The Resident Care Coordinator (RCC) signed for the delivery of Resident #1's sertraline 50mg on 08/13/21. -The sertraline was available for administration at bedtime on 08/13/21. -Resident #1's previous sertraline order was for 50mg at bedtime. -When the multi-pack containing the sertraline 50mg tablet was scanned by the medication aide (MA) at the time of administration, the eMAR software would indicate the sertraline 50mg had been discontinued. -The MA would be prompted by the eMAR software to administer the correct dose of sertraline to Resident #1.	{D 358}		

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{D 358}	Continued From page 36 Interview with a MA on 08/18/21 at 4:05pm revealed: -She scanned Resident #1's multi-pack when she administered Resident #1's bedtime medications on 08/16/21. -The eMAR software did not indicate there had been a change to Resident #1's sertraline order. -The scanner did not always work. -She administered the medication contained in Resident #1's bedtime multi-pack on 08/16/21. -She did not know who placed the blister packs containing the sertraline with Resident #1's other medications in the medication cart. -She did not look at the blister packs containing the sertraline when she administered Resident #1's bedtime medication on 08/16/21. -She audited Resident #1's medications on 08/12/21 or 08/16/21 and did not see the blister packs of sertraline among Resident #1's medication. -The order for Resident #1's sertraline was not on the eMAR when she completed the audit. Interview with a second MA on 08/18/21 at 4:10pm revealed: -She administered Resident #1's bedtime medication contained in the multi-pack from 08/12/21-08/15/21. -She disregarded the sertraline tablets in the blister packs. -She scanned Resident #1's multi-pack before administering Resident #1's bedtime medications on 08/12/21-08/15/21. -No alert came up on the eMAR program indicating Resident #1's sertraline order had been changed. -The scanner did not always work. Interviews with the Resident Care Coordinator (RCC) on 08/18/21 at 4:18pm and 4:45pm	{D 358}		

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{D 358}	Continued From page 37 revealed: -She signed for the delivery of Resident #1's sertraline blister packs on 08/13/21 at 3:05pm. -She placed Resident #1's sertraline blister packs with Resident #1's medication in the medication cart. -She expected the MA to check the medication orders and the medication three times before administering any medication to a resident. -The scanner provided a "fourth check" for medication administration accuracy. -She expected the MA to scan the medication before administration and be prompted by the eMAR program that Resident #1's sertraline order had changed. -The eMAR program indicated if a medication had been discontinued, changed, scheduled to be administered at another time or if the wrong resident had been selected to have medication administered. -No one had reported any malfunctions of the scanner to her. Interview with the Administrator on 08/19/21 at 3:37pm revealed: -She expected the MA to read the medication orders and carry out the orders as written. -When an order was changed, the MA was expected note the change on the 24-hour report so the incoming MA would be informed of the new order. -All medications with a bar code were expected to be scanned. -The scanner would alert the MA to medication changes. -She had not received any reports about the scanner malfunctioning. -The MAs did not scan the medication or did not read the order on the eMAR before administering Resident #1's sertraline.	{D 358}		

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{D 358}	Continued From page 38 Based on observations and interviews, it was determined Resident #1 was not interviewable. Attempted interview with Resident #1's PCP on 08/19/21 at 8:43am was unsuccessful. Refer to the interview with the Administrator on 08/19/21 at 3:37pm. 3. Review of Resident #4's current FL-2 dated 05/11/21 revealed: -Diagnoses included dementia, gastroesophageal reflux disease (GERD), high blood pressure, seizures, fecal impaction of colon, and acute kidney failure. -There was an order for polyethylene glycol (Miralax) (used to treat constipation) 17 grams (G) take 17G mixed with eight ounces of water daily. Review of a hospital After Visit Summary for Resident #4 dated 06/01/21 revealed: -Resident #1 was seen in the emergency department (ED) on 06/01/21 for leg pain. -There was a list of Resident #4's medications. -Miralax 17G take 17G two times daily was on the medication list. Review of a hospital After Visit Summary for Resident #4 dated 08/03/21 revealed: -Resident #1 was seen in the ED on 08/03/21 for constipation. -There was a list of Resident #4's medications. -Miralax 17G take 17G two times daily was on the medication list. Review of Resident #4's June 2021 electronic medication administration record (eMAR) revealed:	{D 358}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 39 -There was an entry for Miralax take 17G mixed with eight ounces of water daily scheduled for administration at 8:00am and 7:00pm. -There was documentation Miralax was administered 59 of 60 opportunities in June 2021. -There was documentation Miralax was not administered 1 of 60 opportunities because Resident #1 was out of the facility. Review of Resident #4's August 2021 eMAR on 08/17/21 revealed: -There was an entry for Miralax take 17G mixed with eight ounces of water daily scheduled for administration at 8:00am and 7:00pm. -There was documentation Miralax was administered 26 of 33 opportunities. -There was documentation Miralax was not administered 6 of 33 opportunities because it was a duplicate order. -There was documentation Miralax was not administered 1 of 33 opportunities because Resident #4 was not available. -There was a second entry for Miralax take 17G mixed with eight ounces of water daily scheduled for administration at 8:00am. -There was documentation Miralax was administered 13 of 13 opportunities in August 2021. -There were seven occurrences in which the medication aide (MA) had documented administration of Miralax at 8:00am in both Miralax entries. Observation of Resident #4's medication available for administration on 08/19/21 at 10:25am revealed: -There was one open box of Miralax labeled 1 of 3 containing 11 of 14 packets of once-daily doses that was dispensed by the pharmacy on 08/04/21. -The instructions on the label read mix one	{D 358}		

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{D 358}	Continued From page 40 packet in fluid and take every day with eight ounces of water. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/19/21 at 8:48am revealed: -The last signed PCP orders for Resident #1 received by the pharmacy were dated 09/29/20. -The pharmacy did not have a copy of Resident #1's FL-2 dated 05/11/21. -The pharmacy had two Miralax orders on Resident #4's profile (active prescriptions). -There was a previous order for Miralax twice a day from November 2020 after Resident #4 returned from the hospital. -There was an order from January 2021 for Miralax daily. -The PCP did not discontinue the duplicate scheduled orders or change one of the orders to be used on an as needed basis. -Facility staff were able to edit the eMAR without the pharmacy being able to see or edit the eMAR. -Facility staff were "autonomous" related to entering orders on the eMAR. -The pharmacy dispensed 30 doses of Miralax for Resident #4 on 08/04/21. -The pharmacy received a "clarification order" for Resident #4's Miralax on 08/18/21. -The clarification order was for Miralax 17G take one packet daily. Interview with a MA on 08/18/21 at 10:25am revealed: -The Special Care Coordinator (SCC) was responsible for entering orders on the eMAR. -The SCC was responsible for cart audits. -She did not know how often the SCC conducted cart audits. -She administered Resident #1's Miralax from a bottle this morning.	{D 358}		

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{D 358}	Continued From page 41 -She could not find Resident #1's Miralax bottle. -She could not access the eMAR to view the medication administration information from this morning. Interview with the SCC on 08/18/21 at 10:55am revealed: -She and the MA were responsible for conducting the medication cart audits. -She conducted the medication cart audit weekly. -When she conducted the audit, she reviewed the current orders, reviewed the medication on the cart, and removed expired or discontinued medications. -She audited the medication cart last week. Interview with the Resident Care Coordinator (RCC) on 08/18/21 at 11:28am revealed: -She and the SCC were responsible for the residents' FL-2s and medication orders. -After a resident returned from a hospital visit, the discharge medications were reviewed by the PCP. Interview with a MA who was formerly the SCC on 08/18/21 at 12:08pm revealed: -When a resident returned from a hospital visit, the RCC or SCC was responsible for clarifying any medication order discrepancies with the PCP. -Resident #4 had been to the hospital "a couple times." -He was not the SCC when Resident #4 went to the ED on 06/01/21 or 08/04/21. Interview with a second MA on 08/19/21 at 10:20am revealed: -She administered another resident's Miralax to Resident #4. -The other resident's Miralax was in a bottle. -The other resident's Miralax had been	{D 358}		

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{D 358}	Continued From page 42	{D 358}		

discontinued.
-She "didn't want to waste" the discontinued Miralax so she administered it to Resident #4.

Interview with a third MA on 08/19/21 at 11:24am revealed:
-The MAs were responsible for cart audits from Monday-Thursday.
-Each MA was assigned residents based on the shift they were assigned to work.
-She administered Miralax to Resident #4 on second shift.

Interview with the RCC on 08/19/21 at 2:40pm revealed:
-The pharmacy's eMAR system and the facility's eMAR system were independent of each other.
-She was responsible for the accuracy of the residents' orders before the SCC was hired in mid-June 2021.

Interview with the Administrator on 08/19/21 at 3:37pm revealed:
-The After Visit Summaries were supposed to be reviewed by the RCC or the SCC.
-Any order discrepancies were supposed to be clarified by the PCP.
-The discrepancy in Resident #4's Miralax order should have been caught during the cart audit or during the medication administration.
-She expected Resident #4 to receive his medication as ordered.
-She tried to complete medication audits on two residents each week.

Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.

Attempted interview with Resident #4's PCP on

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{D 358}	Continued From page 43 08/18/21 at 8:43am was unsuccessful. Refer to the interview with the Administrator on 08/19/21 at 3:37pm. 4. Review of Resident #3's current FL-2 dated 04/06/21 revealed diagnoses included Alzheimer's disease, bipolar disorder, acute respiratory failure, and type 2 diabetes mellitus. a. Review of Resident #3's current FL-2 dated 04/06/21 revealed there was an order for memantine 10mg (used to treat moderate to severe Alzheimer's disease) take one tablet daily at 6:00pm. Review of Resident #3's subsequent orders revealed there was an order dated 07/20/21 for memantine 10mg take one tablet daily at 6:00pm. Review of Resident #3's June 2021 electronic medication administration record (eMAR) revealed: -There was an entry for memantine 10mg take one tablet daily at 6:00pm. -There was documentation of administration of memantine 10mg from 06/01/21 to 06/30/21 at 6:00pm. Review of Resident #3's July 2021 eMAR revealed: -There was an entry for memantine 10mg take one tablet daily at 6:00pm. -There was documentation of administration of memantine 10mg from 07/01/21 to 07/08/21, from 07/11/21 to 07/19/21, and 07/21/21 to 07/31/21 at 6:00pm. -There was documentation of "reordered" for 07/09/21, 07/10/21, and 07/20/21.	{D 358}		

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{D 358}	Continued From page 44 Review of Resident #3's August 2021 eMAR revealed: -There was an entry for memantine 10mg take one tablet daily at 6:00pm. -There was documentation of administration of memantine 10mg from 08/01/21 to 08/16/21 at 6:00pm. Review of Resident #3's pharmacy dispense records from May 2021 to August 2021 revealed memantine 10mg was dispensed on 05/03/21, 05/10/21, 05/14/21, 05/21/21, 05/28/21, 06/04/21, 07/10/21, 07/20/21, 07/23/21, 07/30/21, and 08/06/21. Observation of Resident #3's medications on hand on 08/18/21 at 10:50am revealed: -There were no memantine 10mg tablets in the new multi-dose pack dated 08/19/21. -There was a multi-dose pack dispensed on 08/12/21 with one tablet remaining of memantine 10mg. Telephone interview with a representative at the facility contracted pharmacy on 08/18/21 at 3:48pm revealed: -There was an active order for Resident #3's memantine 10mg but it was not dispensed for the 08/19/21 delivery because there were no refills. -A refill request was not sent from the pharmacy and a refill order for Resident 3's memantine was not sent to the pharmacy. -The pharmacy dispensed Resident #3's memantine 10mg in the multi-dose pack which provided a 7-day supply of medication. -Memantine 10mg was dispensed on 06/03/21, 06/10/21, 07/20/21, 07/29/21, 08/05/21, and 08/12/21. -She did not have any dispense dates between 06/10/21 to 07/20/21.	{D 358}		

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{D 358}	Continued From page 45 -An order was received on 07/20/21 for Resident #3's memantine 10mg one tablet daily. -Eight tablets of memantine 10mg were dispensed on 07/20/21 and the eight tablets provided enough tablets until the next weekly multi-dose pack dispense date. -She did not see a dispense date of 07/10/21 on Resident #3's profile for memantine. Telephone interview with a second shift medication aide (MA) on 08/18/21 at 5:10pm revealed: -If she saw that a medication was missing from the medication cart, her first action was to reorder it. -However, there were times that she reordered medications for days in a row, but the medication was never delivered. -She told the Special Care Coordinator (SCC) when this occurred. -The reason why Resident #3's memantine was not delivered could be a new order was needed, or there were no refills. -She recalled Resident #3's memantine was an issue because he did not have any memantine to administer and she reordered it. -She did not work everyday so she might reorder it on one day and then the next day might be her day off. -She did not know what occurred when she was not at work with Resident #3's memantine in June and July 2021. -She did not know who completed Resident #3's medication cart audit for July 2021. -She recalled that the pharmacy sent only a few tablets of memantine in July 2021, when it was finally sent to the facility. -Whoever completed Resident #3's cart audit, was supposed to reorder his memantine if it was not on the medication cart or in the medication	{D 358}		

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{D 358}	Continued From page 46 room. Telephone interview with a pharmacist on 08/19/21 at 7:49am revealed: -If a resident missed consecutive doses of memantine there would be a gradual increase in symptoms related to Alzheimer's disease such as confusion, memory loss. -The resident's signs and symptoms of Alzheimer's disease would begin to present. Interview with the SCC on 08/19/21 at 9:26am revealed: -She began working at the facility on 06/15/21. -She expected the MAs to complete cart audit to determine the amount of medication remaining on the medication cart for each resident. -Each resident had a cart audit completed for their medications weekly. -The MAs were expected to reorder the medication if needed. -If a medication needed a new prescription, she texted the PCP. -She was not aware that Resident #3 did not have memantine dispensed between 06/10/21 and 07/10/21. -She did not know who completed Resident #3's cart audit for that time period. -She had to locate Resident #3's cart audits for that time period to determine what might have happened concerning the dispensing of Resident #3's memantine. Interview with the Administrator on 08/19/21 at 3:25pm revealed: -She was not aware that Resident #3 did not have memantine dispensed between 06/10/21 and 07/10/21. -She expected the MAs to notify the SCC so that she could determine why the medication was not	{D 358}		

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{D 358}	Continued From page 47 delivered to the facility. -The MAs should not document that a medication was administered if it was not available to administer. Attempted telephone interview with Resident #3's PCP on 08/18/21 at 4:25pm was unsuccessful. Refer to the interview with the Administrator on 08/19/21 at 3:37pm. b. Review of Resident #3's current FL-2 dated 04/06/21 revealed there was an order for mirtazapine 7.5 mg (used to treat major depressive disorder) take one tablet at bedtime. Review of Resident #3's subsequent psychiatric providers orders revealed: -There was an order dated 05/11/21 to discontinue mirtazapine 7.5 mg and start mirtazapine 15 mg one tablet at bedtime. -There was an order dated 07/15/21 to discontinue mirtazapine 15mg and start mirtazapine 30mg one tablet at bedtime. -There was an order dated 07/29/21 to discontinue mirtazapine 30mg. Review of Resident #3's July 2021 eMAR revealed: -There was an entry for mirtazapine 15mg take at bedtime for insomnia/depression, scheduled for 7:00pm. -There was documentation of administration of mirtazapine 15mg from 07/01/21 to 07/14/21, and from 07/17/21 to 07/20/21 at 7:00pm. -There was documentation on 07/15/21 that mirtazapine 15mg was reordered because it was not in the bubble package. -There was documentation on 07/16/21 that the milligrams were "off".	{D 358}		

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{D 358}	Continued From page 48 -There was an entry for mirtazapine 30mg take one tablet at bedtime, scheduled for 8:00pm. -There was documentation of administration of mirtazapine 30mg from 07/19/21 to 07/31/21 at 8:00pm. Review of Resident #3's August 2021 eMAR revealed: -There was an entry for mirtazapine 30mg take one tablet at bedtime, scheduled for 8:00pm. -There was documentation of administration of mirtazapine 30mg from 08/01/21 to 08/11/21 at 8:00pm. -There was documentation that mirtazapine was discontinued on 08/12/21. Review of Resident #3's pharmacy dispense records from May 2021 to August 2021 revealed mirtazapine 30mg was dispensed on 07/16/21, 07/23/21, and 07/30/21. Observation of Resident #3's medications on hand on 08/18/21 at 10:50am revealed there were no mirtazapine available for administration. Telephone interview with a pharmacist at the facility contracted pharmacy on 08/18/21 at 2:15pm revealed: -Resident #3's mirtazapine 30mg was discontinued on 07/29/21. -There were 12 tablets of mirtazapine 30mg dispensed on 07/16/21 and 14 tablets of mirtazapine 30mg dispensed on 07/29/21 for Resident #3. -There was an adequate amount of mirtazapine 30mg tablets to continue administering the medication for 14 doses beyond 07/29/21. Telephone interview with a second shift medication aide (MA) on 08/18/21 at 5:10pm	{D 358}		

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revealed:
-She administered medications to Resident #3 during the evening shift.
-When a medication was discontinued, the SCC told staff most of the time.
-The SCC may have forgotten to tell staff when a medication was discontinued.
-She administered the medications that appeared on the eMAR screen for any resident.
-The SCC had to remove medications that were discontinued from the eMAR system, otherwise the medication continued to appear in the eMAR system.

Interview with the Special Care Coordinator (SCC) on 08/19/21 at 9:26am revealed:
-She faxed discontinue orders to the pharmacy and then she discontinued the medication from the eMAR system.
-She told the MAs when a medication was discontinued, to include second shift because she worked late hours.
-She recalled Resident #3's discontinue order for mirtazapine 30mg.
-She planned to discontinue Resident #3's mirtazapine 30mg when his Besom (used to treat insomnia) arrived from the pharmacy.
-She kept asking the MAs if Resident #3's Belsomra had arrived but she was told no.
-She discovered Resident #3's Belsomra was a controlled medication and was locked in the narcotics box of the medication cart.
-She did not know how many days the MAs looked for Resident #3's Belsomra on the medication cart.
-She did not know Resident #3 was receiving both mirtazapine and Belsomra.
-She and the Resident Care Coordinator (RCC) had to verify medications for them to appear on the eMAR system unless the pharmacy imported

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{D 358}	Continued From page 50	{D 358}		

the order.
-She verified Resident #3's Belsomra on 08/02/21 and she discontinued Resident #3's mirtazapine on 08/12/21 in the eMAR system.
-This error was her fault because she did not know she needed to see the medication first before verifying it in the eMAR system.

Interview with the Administrator on 08/19/21 at 3:25pm revealed she was not aware that Resident #3 continued to receive mirtazapine 30mg after it was discontinued on 07/29/21 until 08/11/21.

Attempted telephone interview with Resident #3's PCP on 08/18/21 at 4:25pm was unsuccessful.

Refer to the interview with the Administrator on 08/19/21 at 3:37pm.

Interview with the Administrator on 08/19/21 at 3:47pm revealed:
-The RCC was responsible for faxing orders to the pharmacy and entering new orders into the eMAR.
-She expected the MA to read the medication orders and carry out the orders as written.
-The MA was expected to administer medications as directed on the eMAR.
-The orders on the eMARs were the current orders.

The failure of the facility to administer medications as ordered for 4 of 5 sampled residents (#1, #3, #4, and #5) which resulted in Resident #5 not receiving insulin according to the sliding scale insulin and scheduled insulin orders from 06/17/21 to 08/19/21 resulting in fingerstick blood sugars greater than 400 and a HgA1C level

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{D 358}	Continued From page 51 increased to 9.2, and his tamsulosin which was not administered as ordered from 07/06/21 to 08/17/21. The facility's failure was detrimental to the health and safety of the residents and constitutes a Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/18/21 for this violation.	{D 358}		
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, record reviews, and interviews, the facility failed to ensure the	D 367		

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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
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accuracy of the electronic medication administration record (eMAR) for 2 of 5 sampled residents (#2 and #4) related to documentation of the administration of a moisturizer and a topical medication (#4) and a medication for depression, panic attacks, obsessive compulsive disorder and anxiety ordered to for daily administration (#2).

The findings are:

1. Review of Resident #4's current FL-2 dated 05/11/21 revealed diagnoses included dementia, Lennox-Gastaut syndrome (a severe form of epilepsy), gastroesophageal reflux disease (GERD), high blood pressure, seizures, bradycardia (abnormally slow heart action), impaction of colon, and acute kidney failure.

a. Review of Resident #4's current FL-2 dated 05/11/21 revealed:
-Signed physician's orders were attached to the FL-2.
-There was an electronic entry for hydrocortisone (used to treat dermatitis) 1% apply topically to forehead and nose every day.
-There was a handwritten entry to discontinue the hydrocortisone dated 05/11/21.

Review of Resident #4's subsequent physician orders revealed there was an order dated 05/11/21 to discontinue hydrocortisone 1%.

Review of a hospital After Visit Summary for Resident #4 dated 06/01/21 revealed:
-Resident #1 was seen in the emergency department (ED) on 06/01/21 for leg pain.
-There was a list of Resident #4's medications.
-Hydrocortisone 1% cream apply topically to forehead and nose everyday was on Resident #4's medication list.

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D 367	Continued From page 53 Review of a hospital After Visit Summary for Resident #4 dated 08/03/21 revealed: -Resident #1 was seen in the ED on 08/03/21 for constipation. -There was a list of Resident #4's medications. -Hydrocortisone 1% cream apply topically to forehead and nose everyday was on Resident #4's medication list. Review of Resident #4's June 2021 electronic medication administration record (eMAR) revealed: -There was an entry for hydrocortisone cream 1% apply topically to forehead and nose daily scheduled for administration at 8:00am. -There was documentation hydrocortisone was applied 30 of 30 opportunities in June 2021. Review of Resident #4's July 2021 eMAR revealed: -There was an entry for hydrocortisone cream 1% apply topically to forehead and nose daily scheduled for administration at 8:00am. -There was documentation hydrocortisone was applied 31 of 31 opportunities in June 2021. Review of Resident #4's August 2021 eMAR on 08/17/21 revealed: -There was an entry for hydrocortisone cream 1% apply topically to forehead and nose daily scheduled for administration at 8:00am. -There was documentation hydrocortisone was applied 17 of 17 opportunities in June 2021. Observation of Resident #4's medication on 08/18/21 at 10:25am revealed there was no hydrocortisone cream 1% available for administration.	D 367		

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Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/19/21 at 8:48am revealed:
-Resident #4 did not have a current order for hydrocortisone cream 1%.
-On 05/13/21, the pharmacy received a discontinue order for hydrocortisone cream 1% that was dated 05/11/21.
-On 07/19/21, a refill request for the hydrocortisone cream was sent to the pharmacy via fax.
-The pharmacy informed the facility there was not an order for hydrocortisone cream.
-Pharmacy staff were not able to enter information on a resident's eMAR without "approval" from facility staff.
-Facility staff responsible for the eMAR could accept or deny pharmacy notifications of orders.
-Pharmacy staff were not able to remotely view the facility eMAR.

Interview with the Special Care Coordinator (SCC) on 08/18/21 at 10:55am revealed:
-The eMAR on her computer indicated Resident #4's hydrocortisone cream 1% was an active order.
-She did not have a discontinue order for Resident #4's hydrocortisone cream.
-She needed to check with the Resident Care Coordinator (RCC) about Resident #4's hydrocortisone cream order.
-She audited the medication cart last week and Resident #4's hydrocortisone cream was on the cart.
-She compared the primary care provider's (PCP) orders to the medications on the cart when she conducted her audit.

Interview with the Administrator on 08/19/21 at 3:37pm revealed:

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-She expected Resident #4 to receive his medication as ordered.
-She tried to complete medication audits on two residents each week.
-The RCC and SCC were responsible for the accuracy of the eMARs.

Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.

b. Review of Resident #4's current FL-2 dated 05/11/21 revealed:
-Signed physician's orders were attached to the FL-2.
-There was an electronic entry for minerin lotion apply to skin three times weekly after showers.

Review of a hospital After Visit Summary for Resident #4 dated 06/01/21 revealed:
-Resident #1 was seen in the emergency department (ED) on 06/01/21 for leg pain.
-There was a list of Resident #4's medications.
-Minerin lotion was not on Resident #4's medication list.

Review of a hospital After Visit Summary for Resident #4 dated 08/03/21 revealed:
-Resident #1 was seen in the ED on 08/03/21 for constipation.
-There was a list of Resident #4's medications.
-Minerin lotion was not on Resident #4's medication list.

Review of Resident #4's June 202-August 2021 electronic medication administration records (eMARs) revealed there were no entries for minerin lotion.

Observation of Resident #4's medication on

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D 367	Continued From page 56 08/18/21 at 10:25am revealed: -There was a 16-ounce container of minerin lotion that had been dispensed by the pharmacy on 07/02/21. -The container had been opened and the lotion had been used. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/19/21 at 8:48am revealed: -Resident #4 had a current order for minerin lotion. -He did not know the reason Resident #4's minerin lotion was not showing up on the eMAR. -The pharmacy did not have access to the facility's eMARs. -The facility's eMAR was "autonomous" from the pharmacy's eMAR. Interview with a Medication Aide (MA) on 08/18/21 at 10:25am and at 2:50pm revealed: -Resident #4 was receiving minerin lotion before he went to the hospital. -After Resident #4's hospital visit, the minerin lotion was not showing up on the eMAR. -The Resident Care Coordinator (RCC) and Special Care Coordinator (SCC) were responsible for entering the orders on the eMARs. -She applied minerin lotion on Resident #4 daily because his skin was so dry. -She applied it on Resident #4 today, 08/18/21 Interview with the SCC on 08/18/21 at 10:55am revealed she would have to ask the RCC about Resident #4's minerin lotion entry and why it was not showing up on the eMAR. Interview with the RCC on 08/19/21 at 2:40pm revealed:	D 367		

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-The eMAR on her computer was different from the eMAR on the MA's computer.
-The eMAR on her computer had an entry for Resident #4's minerin lotion.
-The minerin lotion entry was not showing up on the MA's eMAR because the order did not include the specific days the minerin lotion was supposed to be applied.
-The minerin lotion appeared on the eMAR as an "imported" order from the pharmacy which means the pharmacy "brings over," or rekeyed, the order to the facility's eMAR system.
-Resident #4's previous minerin lotion order showed up on the eMAR because specific days were indicated in the order.
-The pharmacy's eMAR software was incapable of communicating with the facility's eMAR software.
-The RCC and SCC used their computers when completing the medication cart audits and did not know the minerin lotion was not showing up on the eMAR on the MA's computer.
-No one had reported to her that Resident #4's minerin lotion was not showing up on the MA's eMAR.

Interview with the Administrator on 08/19/21 at 3:37pm revealed:
-The RCC and SCC reviewed the eMARs for imported orders.
-Imported orders showed up on the MA's screens at all hours.
-The MAs informed the RCC and/or SCC when imported orders came in so the orders could be corrected by the RCC and/or SCC.
-The RCC and SCC were responsible for the accuracy of the eMARs.

Interview with the facility's Area Director of Operations on 08/19/21 at 4:05pm revealed:

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-There was a "glitch" in the eMAR system related to the pharmacy's ability to import orders.
-The facility preferred to be able to approve orders rather than have the pharmacy import orders to the eMAR.
-She was in contact with a representative from the eMAR software company to resolve the situation.
-The "glitch" in the system had been present for two years.

2. Review of Resident #2's current FL-2 dated revealed:
-Diagnoses included dementia, hypertension, hyperlipidemia, transient ischemic attacks, gout, coronary vascular accident, and pulmonary embolism.
-There was no medication order for Paxil (used to treat anxiety, depression, panic attacks, and obsessive compulsive disorder).

Review of Resident #2's primary care provider (PCP) orders dated 02/16/21 revealed:
-There was an order for Paxil 10mg take one tablet at bedtime with two refills.
-The prescribed quantity was thirty tablets.

Review of Resident #2's six-month physician orders dated 02/23/21 revealed there was an order for Paxil 10mg take one tablet at bedtime.

Review of Resident #2's pharmacy dispense records from May 2021 to August 2021 revealed:
-Paxil 10 mg was dispensed on 05/03/21, 05/10/21, 05/14/21, and 05/21/21.
-There were no other dispense dates for June 2021, July 2021, and August 2021.

Review of Resident #2's June 2021 electronic medication administration record (eMAR)

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revealed:
-There was an entry for Paxil 10mg take one tablet at bedtime, scheduled for 7:00pm.
-There was documentation of administration of Paxil 10mg from 06/01/21 to 06/17/21, from 06/19/21 to 06/28/21, and 06/30/21 at 7:00pm.
-On 06/18/21 and 06/29/21, there was documentation that Paxil 10mg was "on hold".

Review of Resident #2's July 2021 eMAR revealed:
-There was an entry for Paxil 10mg take one tablet at bedtime, scheduled for 7:00pm.
-There was documentation of administration of Paxil 10mg from 07/01/21 to 07/31/21 at 7:00pm.

Review of Resident #2's August 2021 eMAR revealed:
-There was an entry for Paxil 10mg take one tablet at bedtime, scheduled for 7:00pm.
-There was documentation of administration of Paxil 10mg from 08/01/21 to 08/16/21 at 7:00pm.

Observation of Resident #2's medication on hand on 08/18/21 at 10:46am revealed there were no Paxil 10mg tablets available for administration.

Telephone interview with a pharmacist at the facility contracted pharmacy on 08/18/21 at 2:15pm revealed:
-Resident #2 had a verbal order telephoned in by her primary care provider (PCP) on 04/15/21 for Paxil 10mg one tablet at bedtime.
-There were no refills provided with this type of order and the order was for a 30-day supply.
-There were no other refill orders for Resident #2's Paxil and it was last dispensed May 2021.
-Resident #2's Paxil was packaged in the multi-dose packages which provided a seven-day supply of medication.

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-There was no Paxil 10mg dispensed for Resident #2 in June 2021, July 2021 and August 2021.
-A refill request was sent to the facility, but he did not see any documentation that the refill request was signed by Resident #2's PCP.

Telephone interview with a medication aide on 08/18/21 at 5:10pm revealed:
-She administered medications to Resident #2 on the evening shift.
-She did not recall administering Paxil 10mg to Resident #2.
-If she signed that she administered a medication that was not available on the medication cart it was because she was distracted due to the resident activity on the Special Care Unit (SCU).
-The residents on the SCU had to be monitored and if she saw a resident needed immediate attention, she provided care first.
-Once she returned to the medication pass, she might click off every medication that appeared on the eMAR system for a resident, forgetting that there was an issue with one of the medications.
-She did cart audits for the SCU during the evening shift.
-The SCC assigned cart audits for each MA.
-She printed the resident's physician orders to check against the resident's medications available on the medication cart.
-She wrote the number of medications remaining on the medication cart for each medication and if a medication was not available, she reordered it.
-She gave the completed cart audit to the SCC.

Interview with the Special Care Coordinator (SCC) on 08/19/21 at 9:26am revealed:
-She began working at the facility in June 2021.
-She was still learning processes within the facility.

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D 367	Continued From page 61 -She expected staff to notify her and the pharmacy if there was a medication that appeared on the eMAR system but was not available to administer. -She did not expect staff to click on an unavailable medication as administered. -She did not know Resident #2's Paxil 10mg was documented as administered for June 2021, July 2021, and August 2021 when Paxil 10mg was not available to administer on the SCU medication cart. -She expected MAs to document on the cart audits if a medication was unavailable to administer and reorder the medication. -If the reordered medication was not delivered by the next day, she expected the MAs to notify her so that she could determine the reason. Interview with the Administrator on 08/19/21 at 3:25pm revealed: -She expected the MAs to reorder medications when there were 8 tablets remaining on the medication cart. -She expected MAs not to document administration of a medication that was not available to administer. -She was told about Resident #2's Paxil documented as administered but not available on the medication cart on 08/19/21. -The MAs and the SCC were responsible for ensuring the eMARs were accurate. Based on observations, record reviews, and interviews, it was determined Resident #2 was not interviewable.	D 367		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	{D912}		

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{D912}	Continued From page 62 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 resident received care and services which are adequate, appropriate, and in compliance with relevant federal and State laws, rules, and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 4 of 5 sampled residents (#1,#3, #4 and #5) including errors with medications used to treat hyperglycemia and benign prostatic hyperplasia (#5), depression (#1 and #4), constipation (#4) and moderate to severe confusion (#3) [Refer to Tag 0358, 10A NCAC 13F .1004 (a) Medication Administration (Unabated Type B Violation)].	{D912}		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless	D935		

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D935	Continued From page 63 that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (C) who administered medications had completed the 5, 10, or 15-hour medication administration training course and passed the medication test	D935		

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D935	Continued From page 64 within 60 days of the medication clinical skills competency validation. The findings are: Review of Staff C's, medication aide's (MA) personnel record revealed: -Staff C was hired on 04/45/16. -There was documentation of a Medication Clinical Skills Competency Validation dated 04/22/21 and 05/05/21. -There was no documentation that Staff C had passed the written MA exam. -There was no documentation Staff C completed the 5-hour, 10-hour or 15-hour medication administration training course. Review of a Special Care Unit (SCU) resident's July and August 2021 electronic medication administration record (eMAR) revealed Staff C documented the administration of medications 4 days in July 2021 and 2 days in August 2021. Interview with Staff C on 08/19/21 at 2:02pm revealed: -She had worked at the facility for six years as a housekeeper, personal care aide (PCA) and medication aide. -She administered medications in the SCU yesterday afternoon, on 08/18/21. -She thought she received the 5, 10, or 15-hour medication aide training a few months ago in June or July 2021, but she was not sure. -She thought she was able to continue being a MA for 8 weeks or 90 days after completing the medication clinical skills competency validation. -She had not taken the MA test because the website for signing up for the medication test was not operating in April 2021 and May 2021. -She tried signing up for the MA test in another	D935		

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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
D935	Continued From page 65	D935		

county but there was no availability.
-She left her information on 08/09/21 for a representative to contact her in order to sign up for the MA test.

Telephone interview with the Business Office Manager (BOM) on 08/19/21 at 5:02pm revealed:
-She assisted staff with the computer training for MAs.
-Once MAs completed the computerized training, she contacted the LHPS nurse for the next step of training.
-She told the Administrator and the Resident Care Coordinator (RCC) when staff were nearing the end of their 60-day window after completing the medication clinical skills competency validation.
-She thought she told the RCC that Staff C was near the end of her 60-day time limit since completing the medication clinical skills competency validation.

Interview with the RCC on 08/19/21 at 2:58pm revealed:
-She completed the assignment sheets for the Assisted Living (AL) and Special Care Unit (SCU).
-She had scheduled Staff C to work since 07/05/21, 3 times in AL and 2 times in the SCU.
-She did not know Staff C worked beyond the 60-day limit from the completion date of her medication clinical skills competency validation.
-Once a MA had completed the 5, 10, or 15-hour training and medication clinical skills competency validation, the BOM told her so that she could schedule them to work as a MA.
-The BOM told her when a MA should be removed from the schedule due to lack of training, but the BOM did not tell her about Staff C.
-The BOM was at home due to a family illness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092182	A. BUILDING: _____ B. WING _____	R-C 08/19/2021

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D935	Continued From page 66 Interview with the Administrator on 08/19/21 at 12:45pm revealed: -She and the BOM were responsible for ensuring all personnel records were complete. -She was not able to locate Staff C's 5, 10, or 15-hour training certificate, but the LHPS nurse told her Staff C competed the training course. -She did not know Staff C worked in the SCU as a MA beyond the 60-day limit of her medication clinical skills competency validation prior to 08/19/21. -The BOM was responsible for ensuring MAs completed the required training for MAs and informing the RCC and herself when something was not completed. -She would now be responsible for ensuring MAs completed the required training, 5, 10, or 15-hour course and completion of the MA test prior to scheduling them to work in AL or the SCU.	D935		