STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 and the Mecklenburg County Department of Social Services conducted an annual, follow-up, and complaint investigation survey 04/27/21-04/29/21.	D 000	Responses to the cited deficeincies do not constitute an admission or agreement by the facility of the facts alleged or conclusions, set forth in the statement of deficiencies, the plan of correction is prepared soley as a matter of compliance by the law.	
D 352	10A NCAC 13F .1003(a) Medication Labels 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed; (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date; (8) auxiliary statements as required of the medication; (9) the name, address, telephone number of the dispensing pharmacy; and (10) the name or initials of the dispensing pharmacist. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were properly labeled for 2 of 6 sampled residents (#4 and #6) as related to an insulin FlexPen (#4) and a medication to treat mood instability (#6).	D 352	10A NCAC 13F .1003 (a) Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantiy dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed;(7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date; (8) auxiliary statements as required of the medication; (9) the name,address, telephone number of the dispensing pharmacy; and (10) the name or initials or the dispensing pharmacist. Medications will be checked for accuracy of the labels to ensure that correct medications are secured with a correct label to ensure accuracy of the medications to be given. Any medications that is found to have an incorrect label will have a change order sticker appplied to the packaging if applicable If this is not possible then a brand new package of medication will be ordered from the contracted pharmacy. Med-Techs will be in-serviced on the proper use of the change order stickers and the placement on the packaging. All Medications will be marked with an expiration date an a open date as required. The process will reviewed by the MCM / Lead SIC and or ED for accuracy. The ADCS/DDCS will review monthly on the cart audit checks for 3 months to ensure compliance. Community will be in compliance by date of 07-15-2021	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 5/28/21

Reviewed and acknowledged SYR 06/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 352	Continued From page 1 The findings are: 1. Review of Resident #4's current FL2 dated 03/16/21 revealed: -Diagnoses included Type II Diabetes and right lower leg cellulitis. -There was an order for a Novolog FlexPen 100units/ml, administer 20 units three times a day before meals. Review of Resident #4's subsequent physician's order dated 04/14/21 revealed an order for the Novolog FlexPen 100units/ml, administer 23 units three times a day before meals. Observation of the medication pass on 04/27/21 at 11:40pm revealed: -The medication aide (MA) removed Resident #4's Novolog FlexPen from the pharmacy provided plastic pouch. -The pharmacy generated label affixed to the pouch revealed: Novolog FlexPen 100 units/ml, administer 20 units three times a day before meals. -There was no marking on the pharmacy pouch to indicate the order had changed. -The MA dialed the pen to 20 units and attempted to administer to the resident. -There was no other Novolog FlexPen on the medication cart. Interview with the MA on 04/27/21 at 12:05pm revealed: -She did not realize Resident #4's Novolog insulin order had been changed. -She had looked at the eMAR before administering the insulin, but the 23 units "did not register". -She went by the pharmacy label on the FlexPen plastic pouch.	D 352		

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D 352	Continued From page 2 -It was the responsibility of the MAs to remove the medication from the cart when there was an order change. -The facility's contracted pharmacy would send the new medication as soon as they received the order. -Pharmacy medications were delivered on second or third shift. -It was the MAs responsibility when new medications were delivered to the facility, to remove the previous medication and place the new medication on the cart. -The MAs on each shift do a cart audit daily for 2 or 3 residents daily. -She compared the label on the medication with the eMAR when she performed the cart audit. -When the cart audit was completed, she would submit her findings to the Director of Resident Care (DRC). -She had been very busy on the cart lately and was not sure if she had completed a cart audit for Resident #4's medications. -"This was an oversite on my part". Telephone interview with the facility's contracted pharmacist on 04/29/21 at 3:42pm revealed: -Resident #4's Novolog insulin order three times daily changed on 04/14/21 from 20 units to 23 units before each meal. -Seven Novolog FlexPens were sent to the facility on 04/14/21 for a 28 day supply of insulin. -The Novolog FlexPens labeled for 20 units three times daily before meals should have been returned and the new FlexPens with the most recent directions should be used for administration. -This was the policy the pharmacy and the facility had agreed upon. -Medication labels have to be "up to code" with the most current directions.	D 352		

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D 352	Continued From page 3 Telephone interview with the Director of Resident Care (DRC) on 04/29/21 at 9:25am revealed: -Resident #2's Novolog insulin order changed on 04/14/21, from 20 units to 23 units three times a day before meals. -The order was sent to the pharmacy and the medication was sent that evening on 04/14/21. -The MA who received the medication signed that it was in the building and should have placed it on the medication cart. -If the medication was the same, but the dosage changed, the previous medication should be removed and the new medication with the current dosage placed on the medication cart. -The discontinued medication should be returned to the pharmacy. -The facility did not use "direction change" stickers on medications that dosage or delivery time had changed. -If the MA who received the medication from the pharmacy courier did not remove the previous medication from the cart, every MA should be checking the eMAR entry with the pharmacy label, and should remove medications that do not match. -She reviewed the cart audit forms submitted to her, and conducted random cart audits, but she had not audited Resident #4's medications recently. Interview with the Administrator on 04/28/21 at 3:40pm revealed: -He had been the acting Administrator at the facility for the past 2 weeks. -He had not performed any cart audits to date. -Once a new order was prescribed and the medication was delivered to the facility, the previous medication should be removed from the medication cart and sent back to the pharmacy.	D 352		

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D 352	Continued From page 4 Based on observations, interview and record reviews it was determined Resident #4 was not interviewable. revealed: 2. Review of Resident #6's current FL2 dated 03/18/21 revealed diagnoses included dementia and schizophrenia. Review of a subsequent physician order dated 03/22/21 revealed: -There was an order for oxcarbazepine 150mg to be administered twice a day for 10 days, from 03/22/21 through 03/31/21. -There was an order for oxcarbazepine 300mg to be administered twice a day starting 04/01/21. Observation of Resident #6's medications on hand on 04/28/21 at 4:05pm revealed: -There was a blister pack labeled oxcarbazepine 150mg twice daily to be administered for 10 days, from 03/22/21 through 03/31/21. -There were 6 tablets remaining in the blister pack. -There was no additional oxcarbazepine available for administration in the facility. Telephone interview with the facility's contracted pharmacist on 04/29/21 at 3:42pm revealed: -The facility sent the order for oxcarbazepine 150mg to be administered twice a day for 10 days, from 03/22/21 through 03/31/21 and oxcarbazepine 300mg to be administered twice a day starting 04/01/21. -The pharmacy staff only keyed in the 10 day order for oxcarbazepine 150mg to be administered twice a day. -Due to that error, only 20 capsules of oxcarbazepine 150mg twice daily were sent to the facility.	D 352		

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D 352	Continued From page 5 -The order for oxcarbazepine 300mg twice daily was never filled and sent to the facility. -The facility did not contact the pharmacy staff requesting the oxcarbazepine 300mg twice daily to be filled. -The medication label should have listed the entire order from the physician: oxcarbazepine 150mg to be administered twice daily for 10 days, then oxcarbazepine 300mg to be administered twice daily. Telephone interview with the Director of Resident Care (DRC) on 04/29/21 at 9:25am revealed: -She had noticed the pharmacy had omitted the entry for Resident #6's order for oxcarbazepine 300mg twice daily, to begin on 04/01/21. -She manually entered oxcarbazepine 300mg twice daily, to be administered at 8:00am and 8:00pm, starting 04/01/21. -She did not notify the pharmacy of the error. -She did not know the label on the oxcarbazepine blister pack sent from the pharmacy only listed the order for 150mg twice a day for 10 days, from 03/22/21 through 03/31/21. -She did not know why the MAs had not caught this error during a cart audit. -Sometimes she performed random cart audits on the medication carts. -She did not remember doing a cart audit on Resident #6's medications since the oxcarbazepine order on 03/22/21. Telephone interview with Resident #6's mental health provider on 04/29/21 at 10:05pm revealed: -She had prescribed oxcarbazepine in a titrated dosage for Resident #6's agitation and mildly aggressive behaviors. -She did not know Resident #6 had not received the medication as prescribed. -She expected the facility to administer	D 352		

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D 352	Continued From page 6 medications as prescribed. Interview with the Administrator on 04/28/21 at 3:40pm revealed: -He did not know Resident #6 was not receiving oxcarbazepine as prescribed by her mental health provider. -He expected the MAs to follow the medication administration process and compare the eMAR entry to the label on the pharmacy generated blister pack. -He expected the MAs to clarify an order if there was a discrepancy between the label and the eMAR entry. -He expected the MAs to administer medications as prescribed and entered on the eMAR, and to clarify with the pharmacy or prescribing physician if needed. Based on observations, interview and record reviews it was determined Resident #6 was not interviewable.	D 352		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 358	10A NCAC 13F .1004 (a) Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescibing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. Monthly medication cart audits will be performed by the community MCM/Lead SIC along with the weekly cart audits performed weekly by the Med-Techs. Community Administrator will review both weekly and monthly audits to ensure compliance. Cycle fill audits will be completed by the Medication Aides and the oversight of the MCM prior to the new cart start of the cycle with the ED and the DDCS will have oversight as needed. All orders will be reveiwed by the MCM with assist from the ED and any orders that need clarifications will be addressed with the PCP immediately. Any orders that require a parameter will be reviewed by the MCM. The PCP will be notified of any outside range with instructions / recommendations to follow. Med-Techs will be inserviced on the Cart Audits. The correct way to do one. Med- Techs will also be in serviced on Cycle	

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D 358	Continued From page 7 reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies, for 3 of 4 residents (#4, #6 and #7) observed during the medication pass including errors with a medication to lower blood sugar (#4), a medication for bone loss (#6), and two creams ordered for skin irritation (#7); and for 2 of 5 residents sampled for record review (#5 and #6) regarding a mood stabilizer (#6) and an anti-anxiety medication (#5). The findings are: The medication error rate was 15% as evidenced by the observation of 4 errors out of 26 opportunities during the medication passes on 04/27/21 at 11:30am and on 04/28/21 at 8:00am. Review of the Clinical Standard Operating Procedures - Medication Management dated July 2020 revealed: -Medication Cart Audits: Cart Audits were completed to ensure medications were in the community and available for administration. -Medication cart audits require the following steps: Each medication aide (MA) on every shift had a designated number of residents to audit their medications. -The physician orders should be printed and compared to the medications on the cart. -Any expired medications were to be removed from the cart. -The MA should check for re-stocking of any medications. 1. Review of Resident #'4's current FL2 dated 03/16/21 revealed: -Diagnoses included dementia, Type II Diabetes, chronic obstructive pulmonary disease (COPD) and right lower leg cellulitis.	D 358	Fill the correct way to complete the process. Community will be in compliance by 07-15-2021.	

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D 358	Continued From page 8 -There was an order for a Novolog FlexPen 100units/ml, administer 20 units three times a day before meals. Review of Resident #4's subsequent physician's order dated 04/14/21 revealed an order for the Novolog FlexPen, administer 23 units three times a day before meals. Observation of the medication pass on 04/27/21 at 11:40pm revealed: -The morning medication aide (MA) on the 200 hall, removed Resident #4's Novolog FlexPen from the pharmacy provided plastic pouch. -The pharmacy generated label affixed to the pouch revealed: Novolog FlexPen 100units/ml, administer 20 units three times a day before meals. -The entry on the electronic medication administration record (eMAR) revealed: Novolog FlexPen, administer 23 units three times a day before meals. -The MA looked at the label on the pharmacy pouch. -There was no marking on the pharmacy pouch to indicate the order had changed. -The MA dialed the pen to 20 units and attempted to administer to the resident. -There was no other Novolog FlexPen on the medication cart. Interview with the MA on 04/27/21 at 12:05pm revealed: -She did not realize Resident #4's Novolog insulin order had been changed. -She had been administering 20 units of Novolog insulin to Resident #4 three times a day. -She had looked at the eMAR before administering the insulin, but the 23 units "did not register".	D 358		

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D 358	Continued From page 9 -She went by the pharmacy label on the FlexPen plastic pouch. -It was the responsibility of the MAs to remove the medication from the cart when there was an order change. -The facility's contracted pharmacy would send the new medication as soon as they received the order. -Pharmacy medications were delivered on second or third shift. -It was the MAs responsibility when new medications were delivered to the facility, to remove the previous medication and place the new medication on the cart. -The MAs on each shift do a cart audit daily for 2 or 3 residents. -She compared the label on the medication with the eMAR when she performed the cart audit. -When the cart audit was completed, she would submit their findings to the Director of Resident Care (DRC). -She had been very busy on the cart lately and was not sure if she had completed a cart audit for Resident #4's medications. -"This was an oversite on my part". -The DRC was not in the facility at this time. Attempted interview with a second MA on 04/29/21 at 11:32am was unsuccessful. Observation in the medication room on 04/27/21 at 3:15pm revealed: -There were 7 Flexpens for Resident #4 with pharmacy generated labels "Novolog Flexpen 100units/ml, administer 23 units three times a day before meals. -The label was dated 04/14/21. Review of Resident #4's April 2021 electronic medication administration record (eMAR), from	D 358		

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D 358	Continued From page 10 04/14/21 through 04/27/21 revealed: -There was an entry for a Novolog FlexPen, inject 23 units three times daily before meals, to be administered at 8:00am, 12:00pm and 5:00pm. -There was documentation Novolog 23 units had been administered three times daily from 04/14/21 through 04/27/21. -The Novolog FlexPen was documented as administered 39 of 39 possible opportunities. Telephone interview with the facility's contracted pharmacist on 04/29/21 at 3:42pm revealed: -Resident #4's Novolog insulin order three times daily changed on 04/14/21 from 20 units to 23 units before each meal. -Seven Novolog FlexPens were sent to the facility on 04/14/21 for a 28 day supply of insulin. -The Novolog FlexPens labeled for 20 units three times daily before meals should have been returned and the new FlexPens with the most recent directions should be used for administration. -This was the policy the pharmacy and the facility had agreed upon. -Medication labels have to be up to code with the most current directions. Telephone interview with the primary care physician (PCP) on 04/28/21 at 10:23am revealed: -She increased Resident #4's Novolog insulin from 20 units to 23 units due to an increase in her blood sugar readings. -The noon time dose of insulin would have an effect on the dinnertime fingerstick blood sugar (FSBS) readings. -She had noticed the FSBS at 5:00pm had been slightly higher the past 2 weeks.	D 358		

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D 358	Continued From page 11 Telephone interview with the Director of Resident Care (DRC) on 04/29/21 at 9:25am revealed: -Resident #2's Novolog insulin order changed on 04/14/21, from 20 units to 23 units three times a day before meals. -The order was sent to the pharmacy and the medication was sent that evening on 04/14/21. -The MA who received the medication signed that it was in the building and should have placed it on the medication cart. -If the medication was the same, but the dosage changed, the previous medication should be removed and the new medication with the current dosage placed on the medication cart. -The discontinued medication should be returned to the pharmacy. -The facility did not use "direction change" stickers on medications whose dosage had changed. -If the MA who received the medication from the pharmacy courier did not remove the previous medication from the cart, every MA should be checking the eMAR entry with the pharmacy label, and should remove medications that do not match. -She reviewed the cart audit forms submitted to her, and conducted random cart audits, but she had not audited Resident #4's medications recently. -She did not know Resident #4 had not received 23 units of Novolog insulin since the order changed on 04/14/21. Interview with the Administrator on 04/28/21 at 3:40pm revealed: -He had been the acting Administrator at the facility for the past 2 weeks. -He had not performed any cart audits to date. -He did not know Resident #4 had not been administered the proper insulin dosage since	D 358		

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D 358	Continued From page 12 04/14/21. -The process for administration of medications was to check the pharmacy generated label of the medication against the eMAR entry. -If there was a discrepancy, the MA should call the pharmacy or the physician to clarify. -Once a new order was prescribed and the medication was delivered to the facility, the previous medication was removed from the medication cart and sent back to the pharmacy. Based on observations, interview and record reviews it was determined Resident #4 was not interviewable. 2. Review of Resident #'6's current FL2 dated 03/18/21 revealed: -Diagnoses included dementia, schizophrenia, hypocalcemia and osteoporosis. -There was an order for calcium carbonate -vitamin D3, used to treat bone fragility. Observation of the 8:00am medication pass on 04/28/21 revealed: -The morning medication aide (MA) working in the 100 Hall prepared 8 oral medications for administration to Resident #6. -The MA looked at the electronic Medication Administration Record (eMAR) as she prepared medications, and could not find calcium carbonate-vitamin D 600-400 on the medication cart. -The MA made a notation to check the medication room after the administration of Resident #6's oral medications to determine if the calcium carbonate-vitamin D had been delivered. Observation of medications available for administration on 04/28/21 at 9:10am revealed calcium carbonate-vitamin D was not in the	D 358		

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D 358	Continued From page 13 overstock drawer in the medication room. Observation of the Re-order Binder which documented medications which had been faxed to the facility pharmacy for refill from 01/01/21 through 04/27/21 revealed there was no documentation Resident #6's calcium carbonate-vitamin D had been requested to be refilled. Review of Resident #6's April 2021 eMAR revealed: -There was an entry for calcium carbonate-vitamin D3 to be administered daily at 8:00am. -There was documentation calcium carbonate was administered daily from 04/01/21 through 04/27/21. Telephone interview with the facility's contracted pharmacist on 04/29/21 at 3:42pm revealed: -Resident #6 had an active order for calcium carbonate-vitamin D on her medication profile. -Calcium carbonate-vitamin D was not issued from the pharmacy in the weekly multi dose packaging. -The calcium carbonate-vitamin D refills had to be requested by the facility and were sent out in blister packs. -The last refill request from the facility was on 11/27/20 and 7 tablets were sent to the facility. -Prior to that, calcium carbonate-vitamin D was filled on 10/30/20, 09/04/20 and 07/15/20, all sent with 28 tablets in each blister pack. -If the calcium carbonate-vitamin D was administered as ordered, 12/04/20 would have been the refill date. Interview with the medication aide (MA) on 04/28/21 at 8:20am revealed: -She primarily worked third shift and did not	D 358		

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administer morning medications.
-She did not know how long the calcium carbonate-vitamin D had not been available for administration.
-She could check the documentation in the Medication Room showing which medications had been ordered recently.

Telephone interview with Resident #6's primary care physician (PCP) on 04/28/21 at 5:03pm revealed:
-Resident #6 was diagnosed with bone loss.
-He was treating her condition with Fosomax, a medication that alters bone formation, and calcium carbonate vitamin D to slow down the progression of her bone loss.
-Resident #6 required the calcium carbonate-vitamin D to work in conjunction with Fosomax for the best outcome.

Telephone interview with the Director of Resident Care (DRC) on 04/29/21 at 9:25am revealed:
-It was the responsibility of the MAs to audit the residents' medications on their assigned medication cart.
-Daily audits of medications for two or three residents should be performed.
-The MAs should print the physician's orders from the eMAR, and ensure the medications were on the medication cart with the correct labeling.
-It was the responsibility of the MAs to re-order medications as needed.
-The pharmacy re-order forms were in the Medication Room and were filed in the Re-order Binder when completed.
-The following day, if the medication had not arrived, the MA should contact the pharmacy and follow up on the re-order request.
-She did not know why the re-order process was not followed for Resident #6's calcium carbonate

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D 358	Continued From page 15 -vitamin D. -She did not know why the calcium carbonate - vitamin D was not identified during cart audits. -She performed random cart audits but did not recall if she had audited Resident #6's medications recently. Interview with the Administrator on 04/28/21 at 3:40pm revealed: -The MAs were responsible for performing cart audits on their assigned medication cart for 2 or three residents daily. -The MAs were responsible for re-ordering any medication that was not sent in the weekly multi dose packet, and removing any expired medications or medications whose dosage or directions had changed. -He had not performed any cart audits to date. -He did not know Resident #6's calcium carbonate-vitamin D had not been re-ordered since 11/27/20. Based on observations, interview and record reviews it was determined Resident #6 was not interviewable. 3. Review of Resident #7's current FL2 dated 07/25/20 revealed diagnoses included dementia, hyperlipidemia and anxiety disorder. a. Review of Resident #7's physician orders dated 03/18/21 revealed a physician order for Sarna Sensitive 1% lotion, to be applied topically to the chest, back and arms twice a day, (a medication used for skin irritation). Observation of the 8:00am medication pass on 04/28/21 at 8:20am-9:05am revealed; -The morning medication aide (MA) working in the 100 Hall prepared 4 oral medications for	D 358		

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D 358	Continued From page 16 administration to Resident #6. -She placed the medications in a medication cup and administered the medication with a cup of water. -The Sarna Lotion was not administered to Resident #7. Observation of medications available for administration revealed: -There was a bottle of Sarna Sensitive 1% Lotion for Resident #7 with a pharmacy generated label to administer twice daily to the chest, back and arms. -The bottle had approximately three quarters of the lotion remaining. Review of Resident #7's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Sarna Sensitive 1% Lotion to be administered twice daily at 8:00am and 8:00pm. -There was documentation Sarna Sensitive 1% Lotion was administered twice daily from 04/01/21 through 04/27/21. Interview with the MA on 04/28/21 at 9:45am revealed: -She worked third shift and did not administer morning medications. -She was distracted by Resident #7 during the preparation of medications. -She did not observe the eMAR entry for Sarna Sensitive 1% Lotion for Resident #7. -Resident #7 had not requested the Sarna Sensitive 1% Lotion during the administration of her medications. -She did not administer the Sarna Sensitive 1% Lotion to Resident #7 during the morning medication pass.	D 358		

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D 358	Continued From page 17 b. Review of Resident #7's physician orders dated 03/18/21 revealed a physician order for triamcinolone acetonide cream 1% apply topically to affected area twice daily, (a medication used to treat skin irritation). Observation of the 8:00am medication pass on 04/28/21 at 8:20am-9:05am revealed; -The morning MA working in the 100 Hall prepared 4 oral medications for administration to Resident #7. -The triamcinolone acetonide cream 1% was not administered to Resident #7. Observation of medications available for administration revealed: -Resident #7 had a tube of triamcinolone acetonide cream 1% with a pharmacy generated label to apply topically to affected area twice daily. -The tube was less than one quarter dispensed. Review of Resident #7's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for triamcinolone acetonide cream 1% to be administered twice daily at 8:00am and 8:00pm. -There was documentation triamcinolone cream was administered twice daily from 04/01/21 through 04/27/21. Interview with the MA on 04/28/21 at 9:45am revealed: -She did not observe the eMAR entry for triamcinolone acetonide cream 1% . -Resident #7 had not requested the triamcinolone acetonide cream during the administration of her medications. -She did not administer the triamcinolone cream	D 358		

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D 358	Continued From page 18 to Resident #7 during the morning medication pass. Based on observations, interview and record reviews it was determined Resident #7 was not interviewable. 4. Review of Resident #'6's current FL2 dated 03/18/21 revealed diagnoses included dementia and schizophrenia. Review of a subsequent physician order dated 03/22/21 revealed: -There was an order for oxcarbazepine 150mg to be administered twice a day for 10 days, from 03/22/21 through 03/31/21. -There was an order for oxcarbazepine 300mg to be administered twice a day starting 04/01/21. Review of the electronic medication administration record (eMAR) for March 2021 from 03/22/21 through 03/31/21 revealed: -There was an entry for oxcarbazepine 150mg twice daily for 10 days, to be administered at 8:00am and 8:00pm. -Oxcarbazepine 150mg was documented as administered at 8:00am and 8:00pm from 03/22/21 through 03/31/21. -Twenty doses of oxcarbazepine 150mg were documented as administered from 03/22/21 through 03/31/21. Review of the eMAR for April 2021 from 04/01/21 through 04/28/21 revealed: -There was an entry for oxcarbazepine 300mg twice daily, to be administered at 8:00am and 8:00pm. -Oxcarbazepine 300mg was documented as administered at 8:00am and 8:00pm from 04/01/21 through 04/27/21, and the 8:00am dose	D 358		

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D 358	Continued From page 19 on 04/28/21. -Fifty-five doses of oxcarbazepine 150mg were documented as administered from 04/01/21 through 04/28/21. Observation of Resident #6's medications on hand on 04/28/21 at 4:05pm revealed: -There was a blister pack labeled oxcarbazepine 150mg twice daily to be administered for 10 days. -There were 8 capsules remaining in the bubble pack. -There were no oxycarpazepine 300mg tablets available for administration in the facility. Telephone interview with the facility's contracted pharmacist on 04/29/21 at 3:42pm revealed: -The facility sent the order for oxcarbazepine 150mg to be administered twice a day for 10 days, from 03/22/21 through 03/31/21 and oxcarbazepine 300mg to be administered twice a day starting 04/01/21. -The pharmacy staff only keyed in the 10 day order for oxcarbazepine 150mg to be administered twice a day. -Due to that error, only 20 capsules of oxcarbazepine 150mg twice daily were sent to the facility. -If the facility keyed in the remainder of the order, oxcarbazepine 300mg twice daily, it would not show on the pharmacy side of the eMAR. -The facility had not requested oxcarbazepine 300mg twice daily, so no additional medication had been sent. Telephone interview with the Director of Resident Care (DRC) on 04/29/21 at 9:25am revealed: -She had noticed the pharmacy had omitted the entry for Resident #6's order for oxcarbazepine 300mg twice daily. -She manually entered oxcarbazepine 300mg	D 358		

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D 358	Continued From page 20 twice daily, to be administered at 8:00am and 8:00pm. -She did not notify the pharmacy of the error. -She did not know the pharmacy had not sent out the oxcarbazepine 300mg capsules for administration. -She did not know only 20 tablets of oxcarbazepine 150mg twice daily were sent from the pharmacy for the 10 day order. -She expected the MAs to follow the orders on the eMAR and clarify when needed. -She did not know why the MA had not contacted the pharmacy and request the oxcarbazepine 300mg capsules. -She did not know why there were 8 capsules left in the blister pack from the oxcarbazepine 150mg order. -She did not know why the MAs had not caught this error during a cart audit. -She did not remember doing a cart audit on Resident #6's medications since the oxcarbazepine order on 03/22/21. Telephone interview with Resident #6's mental health provider on 04/29/21 at 10:05pm revealed: -She had prescribed oxcarbazepine in a titrated dosage for Resident #6's agitation and mildly aggressive behaviors. -She had not seen any significant improvement in behaviors after her 04/27/21 visit with the resident and report from the staff. -Resident #6 was reported to be agitated at times, paranoid and verbally aggressive. -She did not know Resident #6 had not received the medication as prescribed, which did not assist her in assessing the medications effectiveness in treating her mental health. Interview with the Administrator on 04/28/21 at 3:40pm revealed:	D 358		

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D 358	Continued From page 21 -He did not know Resident #6 was not receiving oxcarbazepine as prescribed by her mental health provider. -He expected the MAs to follow the medication administration process and compare the eMAR entry to the label on the pharmacy generated blister pack. -He expected the MAs to clarify an order if there was a discrepancy between the label and the eMAR entry. -He expected the MAs to clarify with the pharmacy or prescribing physician if needed. Based on observations, interview and record reviews it was determined Resident #6 was not interviewable. 5. Review of Resident #5's FL-2 dated 02/24/21 revealed diagnoses included dementia, depression, epilepsy, cerebrovascular accident, muscle weakness, hypertension, hyperlipidemia, difficulty walking. Review of Resident #5's physician orders dated 02/24/21 revealed an order for Lorazepam 0.5mg (used to treat anxiety) one tablet daily 30 minutes before showers on Tuesday, Thursday, and Saturday. Review of Resident #5's March 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Lorazepam 0.5mg tablet with instructions to take one tablet daily 30 minutes before showers on Tuesday, Thursday, and Saturday. -There was documentation Lorazepam 0.5mg was administered to Resident #5 on 03/02/21, 03/06/21, 03/13/21, 03/20/21, and 03/27/21 with no exceptions.	D 358		

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D 358	Continued From page 22 -There were 7 out of 13 missed opportunities to administer Lorazepam 0.5mg from 03/01/21-03/31/21. Review of Resident #5's April 2021 eMAR revealed: -There was an entry for Lorazepam 0.5mg tablet with instructions to take one tablet daily 30 minutes before showers on Tuesday, Thursday, and Saturday. -There was documentation Lorazepam 0.5mg was administered to Resident #5 on 04/03/21, 04/10/21, 04/17/21, and 04/24/21 with no exceptions. -There were 7 out of 11 missed opportunities to administered Resident #5's Lorazepam 0.5mg from 04/01/21-04/25/21. Review of Resident #5's March 2021 electronic Care log revealed: -Resident #5 was scheduled to receive a shower every Tuesday, Thursday, and Saturday. -Resident #5's shower was completed every Tuesday, Thursday, and Saturday with no exceptions from 03/01/21-03/31/21. Review of Resident #5's April 2021 electronic Care log revealed: -Resident #5 was scheduled to receive a shower every Tuesday, Thursday, and Saturday. -Resident #5's shower was completed every Tuesday, Thursday, and Saturday with no exceptions from 04/01/21-04/25/21. Observation of Resident #5's medications on the medication cart on 04/26/21 at 3:30pm revealed: -There were 12 tablets of Lorazepam 0.5mg dispensed on 01/22/21 with one tablet remaining. -There were 12 tablets of Lorazepam 0.5mg dispensed on 04/06/21 with 12 tablets remaining	D 358		

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D 358	Continued From page 23 Interview with a first shift medication aide (MA) on 04/28/21 at 10:30am revealed: -Resident #5 had a physician's order for Lorazepam 0.5mg to be administered 30 minutes before showers. -Resident #5 was scheduled to receive showers every Tuesday, Thursday, Saturday and as needed. -She had administered Resident #5's Lorazepam 0.5mg on Saturday's before showers. -She did not recall administering Resident #5's Lorazepam 0.5mg on any other occasions. -She administered medications as they generated on the eMAR. -The Director Resident Care (DRC) was responsible for verifying and approving residents' new medication orders on the eMAR. -The eMAR automatically generates a reminder notification when a residents' medication was due for administration. Telephone interview with the facility's contracted pharmacy on 04/28/21 at 11:04am revealed: -The pharmacy received a physician order dated 01/22/21 and 04/06/21 for Resident #5 to be administered Lorazepam 0.5mg tablet by mouth daily 30 minutes daily before showers every Tuesday, Thursday, and Saturday. -There were 12 tablets of Lorazepam 0.5mg filled on 01/22/21 for Resident #5. -There were 12 tablets of Lorazepam 0.5mg filled on 04/06/21 for Resident #5. Telephone interview with Resident #5's physician on 04/28/21 at 10:50am revealed: -She ordered Lorazepam 0.5 one tablet on Tuesday, Thursday, and Saturday due to a history of agitation related to showers. -The facility notified her Resident #5's shower	D 358		

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D 358	Continued From page 24 schedule to be every Tuesday, Thursday, and Saturday. -She expected the facility to administer Resident #5's medications as ordered. -She did not know Resident #5 had not been receiving Lorazepam 0.5mg 30 minutes before his shower on Tuesday, Thursday, and Saturday. Telephone interview with Director of Resident Care (DRC) on 04/28/21 at 9:20am revealed: -She knew Resident #5 had an order for Lorazepam 0.5mg to be administered before showers. -Resident #5's order for Lorazepam .5mg was recognized as new order each time the medication required a refill. -Resident #5 received three showers each week in addition to any as needed showers. -When a resident's new medication order was verified and approved, the eMAR would generate a notification reminder for the MA to administer a resident's medication during a specified timeframe according to the physician's order instructions or changes made by the DRC. -She approved Resident #5's Lorazepam .5mg medication and had changed the frequency of administration to only every Saturday in error. Interview with the Divisional Vice President or Operations (DVPO) on 04/28/21 at 9:45am revealed: -MAs were responsible for administering residents' medications according the physician's orders. -The pharmacy was responsible for transcribing physician's orders in the eMAR. -The DRC was responsible for verifying the accuracy of the pharmacy's transcription of physician's orders in the eMAR before approving the order.	D 358		

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D 358	Continued From page 25 -Once a physician's order had been approved in the eMAR, a notification was generated in eMAR to remind the MA when a resident's medications were due for administration per shift. -The pharmacy would not be aware of which shift on Tuesday, Thursday, or Saturday that Resident #5 was scheduled to receive a shower. -The DRC was responsible for adjusting Resident #5's medication frequency to generate a notification for the MA to administer the medication on second shift. Interview with the Administrator on 04/29/21 at 12:26pm revealed: -He expected MAs to administer medications as ordered by the physician. -He expected the eMARs to be accurate. -The DRC was responsible for verifying the accuracy of new physician's orders that had been transcribed by the pharmacy on the eMARs. -The DRC was the primary person responsible for making changes to the eMAR system. -MAs were expected to review the eMAR and each medication label before administering a residents' medication.	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;	D 367	10A NCAC 13F .1004(j) 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 medication adminstered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medication 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 intials 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)	

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	HAL060125	A. BUILDING: _____ B. WING _____	04/29/2021

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D 367	Continued From page 26 (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 1 of 6 sampled residents (Resident #6) for the documentation of a mood stabilizer and a vitamin supplement. The findings are: Review of Resident #'6's current FL2 dated 03/18/21 revealed: -Diagnoses included dementia, schizophrenia, hypocalcemia and osteoporosis. -There was an order for calcium carbonate-vitamin D3, used to treat bone fragility. Review of Resident #6's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry for calcium carbonate-vitamin D3 to be administered daily at 8:00am. -There was documentation calcium carbonate was administered daily from 02/01/21 through 02/28/21.	D 367	Facility will ensure that all residents medication administration be accurate and will include the residents name, name of medication, strength and dosage, instructions for adminstering the medications, reason for the adminstration of medication for any PRN dosage, date and time of administration omission and or refusals, and the name or initials of the person administering the medication. Community will ensure these actions by monitoring of the EMAR on a daily routine by the MCM and will be followed by monitoring ofthe ED on a weekly routine X 3 months. Then MCM will continue to monitor on a daily/ weekly routine with the ED support as needed. The Med-Techs will a in-service on the Proper Steps of Med Adminstration. The community will be in compliance by 07-15-2021	

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D 367	Continued From page 27 Review of Resident #6's March 2021 eMAR revealed: -There was an entry for calcium carbonate-vitamin D3 to be administered daily at 8:00am. -There was documentation calcium carbonate was administered daily from 03/01/21 through 03/31/21. Review of Resident #6's April 2021 eMAR, from 04/01/21 through 04/27/21 revealed: -There was an entry for calcium carbonate-vitamin D3 to be administered daily at 8:00am. -There was documentation calcium carbonate was administered daily from 04/01/21 through 04/27/21. Observation of medications available for administration on 04/28/21 at 9:10am revealed calcium carbonate-vitamin D was not in the facility. Observation of the Re-Order Binder for a record of medications which had been faxed to the facility pharmacy for refill from January 01, 2021 through April 27, 2021 revealed there was no documentation Resident #6's calcium carbonate-vitamin D had been requested to be refilled. Telephone interview with the facility's contracted pharmacist on 04/29/21 at 3:42pm revealed: -Resident #6 had an active order for calcium carbonate-vitamin D on her medication profile. -Calcium carbonate-vitamin D was not issued from the pharmacy in the weekly multi dose packaging. -The calcium carbonate -vitamin D refills had to be requested by the facility and were sent out in	D 367		

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D 367	Continued From page 28	D 367		

blister packs.
-The last refill request from the facility was on 11/27/20 and 7 tablets were sent to the facility.
-Prior to that, calcium carbonate -vitamin D was filled on 10/30/20, 09/04/20 and 07/15/20, all sent with 28 tablets in each blister pack.

Interview with the medication aide (MA) on 04/28/21 at 8:20am revealed:
-She primarily worked third shift and did not administer morning medications.
-She did not know how long the calcium carbonate-vitamin D had not been available for administration.
-She did not document administration of the calcium carbonate-vitamin D and would contact the pharmacy for a refill.

Telephone interview with the Director of Resident Care (DRC) on 04/29/21 at 9:25am revealed:
-She did not know why the MAs were documenting calcium carbonate-vitamin D as administered when it was not in the building.
-She expected the MAs to document only those medications that were administered and order medications as needed.

Interview with the Administrator on 04/28/21 at 3:40pm revealed:
-The MAs should only document medications they administered as given.
-He did not know MAs had documented as administered a medication that was not in the facility.

b. Review of Resident #'6's current FL2 dated 03/18/21 revealed diagnoses included dementia and schizophrenia.

Review of a subsequent physician order dated

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D 367	Continued From page 29 03/22/21 revealed: -There was an order for oxcarbazepine 150mg to be administered twice a day for 10 days, from 03/22/21 through 03/31/21. -There was an order for oxcarbazepine 300mg to be administered twice a day starting 04/01/21. Review of the electronic medication administration record (eMAR) for March 2021 from 03/22/21 through 03/31/21 revealed: -There was an entry for oxcarbazepine 150mg twice daily for 10 days, to be administered at 8:00am and 8:00pm. -Oxcarbazepine 150mg was documented as administered at 8:00am and 8:00pm from 03/22/21 through 03/31/21. -Twenty doses of oxcarbazepine 150mg were documented as administered from 03/22/21 through 03/31/21. Review of the eMAR for April 2021 from 04/01/21 through 04/28/21 revealed: -There was an entry for oxcarbazepine 300mg twice daily, to be administered at 8:00am and 8:00pm. -Oxcarbazepine 300mg was documented as administered at 8:00am and 8:00pm from 04/01/21 through 04/27/21, and the 8:00am dose on 04/28/21. -Fifty-five doses of oxcarbazepine 150mg were documented as administered from 04/01/21 through 04/28/21. Observation of Resident #6's medications on hand on 04/28/21 at 4:05pm revealed: -There was a blister pack labeled oxcarbazepine 150mg twice daily to be administered for 10 days. -The fill date was 03/22/21. -There were 8 capsules remaining in the bubble pack.	D 367		

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D 367	Continued From page 30 -There was no blister pack of oxcarbazepine 300mg twice daily to start on 04/01/21. Telephone interview with the facility's contracted pharmacist on 04/29/21 at 3:42pm revealed: -The facility sent the order for oxcarbazepine 150mg to be administered twice a day for 10 days, from 03/22/21 through 03/31/21 and oxcarbazepine 300mg to be administered twice a day starting 04/01/21. -The pharmacy staff only keyed in the 10 day order for oxcarbazepine 150mg to be administered twice a day. -Due to that error, only 20 capsules of oxcarbazepine 150mg twice daily were sent to the facility. -The facility had not requested oxcarbazepine 300mg twice daily, so no additional medication had been sent. Telephone interview with the Director of Resident Care (DRC) on 04/29/21 at 9:25am revealed: -She did not know the pharmacy had not sent out the oxcarbazepine 300mg capsules for administration. -She did not know the MAs were documenting the oxcarbazepine 300mg as administered. -She did not know why the MAs had not caught this error during a medication cart audit. Interview with the Administrator on 04/28/21 at 3:40pm revealed: -He expected the MAs to document only those medications that were administered. -He did not know the MAs were documenting as administered a medication that had not been sent to the facility. Based on observations, interview and record reviews it was determined Resident #6 was not	D 367		

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D 367	Continued From page 31 interviewable.	D 367		