Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092182	A. BUILDING: ______ B. WING ______	R 10/29/2021

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 October 28-29, 2021.	{D 000}	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
{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 reviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (Residents #1, #2 and #3) related to the administration of medications used to treat vitamin deficiency, dry nose, acid reflux, and an eye disease (Resident #1) and medications used to treat diabetes and fluid retention (Resident #3). The findings are: 1. Review of Resident #1's current FL-2 dated 10/27/21 revealed diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and hypertension. a. Review of Resident #1's current FL-2 dated 10/27/21 revealed a medication order for Preservision AREDS 2 (used to reduce the risk of progression of moderate macular degeneration) tab chew take one tablet twice daily with meals.	{D 358}	Upon reopening, Oliver House will maintain compliance by ensuring the preparation and administration of medications and treatments by staff according to MD orders; facility's policies and procedures; and State rules. RCC/SCC will run daily EMAR compliance reports to review for accuracy and medication administration compliance, as well as a daily review of any residents on sliding scale insulin to ensure all ordered medications are in the facility. This report will be discussed with the ED in management meeting daily for follow-up. RCC/SCC will run electronic activity report daily to review that medications have been administered accurately per MD orders, and any required follow-up has occurred. This will be reviewed daily with the ED. MAR to Medication cart audits will be completed weekly by Med Techs per Facility schedule and reviewed by the RCC/SCC to ensure follow-up has occurred as necessary. RCC/SCC will complete a weekly overall QA cart audit to verify the condition of the med cart, i.e. cleanliness, availability of meds, expired meds, discontinued meds, etc. Cart audits will be signed off by RCC/SCC and ED to verify completion.	12/13/21 12/13/21 12/13/21

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Deborah Lasa — TITLE: Executive Director — (X6) DATE: 12/14/21

Reviewed and Acknowledged-SS-12/17/21

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{D 358}	Continued From page 1 Review of Resident #1's previous physician orders revealed there was an order dated 07/27/21 for Preservision AREDS 2 softgel capsule take one capsule twice daily. Review of Resident #1's pharmacy dispense record revealed: -Preservision AREDS was dispensed on 07/27/21 and 08/05/21. -There were 42 capsules dispensed on 08/05/21. -There were no other dispense dates for Resident #1's Preservision AREDS. Review of Resident #1's facility dispense record from 08/27/21 to 10/29/21 revealed there were no dispensing dates for Resident #1's Preservision AREDS. Review of Resident #1's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Preservision AREDS 2 chew take one tablet twice daily with meals, scheduled for 7:30am, 8:00am, 4:30pm, and 5:00pm. -There was documentation of administration of Preservision AREDS 2 chew from 08/01/21 to 08/09/21 at 8:00am and 5:00pm. -There was documentation that Resident #1 was unavailable on 08/10/21 at 8:00am. -There was documentation of administration of Preservision AREDS 2 chew from 08/11/21 to 08/17/21 at 8:00am and 5:00pm. -There was documentation of administration of Preservision AREDS 2 chew on 08/18/21 at 7:30am and 4:30pm, 08/19/21 at 7:30am, 08/20/21 at 4:30pm, and from 08/21/21 to 08/25/21 at 7:30am and 4:30pm. -There was documentation of refusal on 08/19/21 at 4:30pm, and 08/20/21 at 7:30am.	{D 358}	RCC/SCC will complete a minimum of 2 chart reviews weekly to audit for completion, accuracy, and ensure there are no missed orders. Chart reviews will be submitted to the ED weekly upon completion for verification. ED/RCC/SCC reeducated Med Techs on the importance of following insulin orders; proper documentation; reasons to notify PCP; when to call the PCP for Out of Range Vital Signs; Refresher on notifying RCC/SCC when meds are out.	12/13/21 11/1/21

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-There was documentation that Resident #1 was out of the facility on 08/26/21 at 4:30pm.
-There was documentation of administration of Preservision AREDS 2 chew 08/26/21 at 7:30am, from 08/27/21 to 08/31/21 at 7:30am and 4:30pm.

Review of Resident #1's September 2021 eMAR revealed:
-There was an entry for Preservision AREDS 2 chew take one tablet twice daily with meals, scheduled for 7:30am, and 4:30pm.
-There was documentation of administration of Preservision AREDS 2 chew from 09/01/21 to 09/30/21 at 7:30am and 4:30pm.

Review of Resident #1's October 2021 eMAR revealed:
-There was an entry for Preservision AREDS 2 chew take one tablet twice daily with meals, scheduled for 7:30am, and 4:30pm.
-There was documentation of administration of Preservision AREDS 2 chew from 10/01/21 to 10/28/21 at 7:30am and 4:30pm.

Observation of Resident #1's medications on hand on 10/29/21 at 8:26am revealed there was no Preservision AREDS available for administration.

Interview with Resident #1 on 10/28/21 at 7:39am revealed she had recent problems with her medications, and she had only received two pills yesterday, on 10/27/21.

A second interview with Resident #1 on 10/29/21 at 1:20pm revealed:
-She did not like the taste of the Preservision AREDS 2.
-The medication aides (MA) began crushing the Preservision AREDS 2 and mixing it in

Office: 919-855-4590
Fax: 919-733-2579
Kim.Ruppel@dhhs.nc.gov

801 Biggs Drive, Brown Building
2708 Mail Service Center
Raleigh, NC 27699-2708

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applesauce.
-She thought she got it yesterday.
-She had not received any notifications in the mail from the pharmacy and no one at the facility had discussed any issues regarding the Preservision AREDS 2.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/29/21 at 9:27am revealed:
-There was an order dated 07/20/21 for Preservision AREDS 2 softgels.
-Preservision AREDS 2 softgels was dispensed on 07/20/21 and 08/05/21.
-The facility sent a refill request on 09/10/21.
-The pharmacy faxed a reply to the facility on 09/10/21 to notify them that a new order was needed for Resident #1's Preservision AREDS 2.
-The reason a new order was needed was thre were no more refills for Resident #1's Preservision AREDS 2.

Telephone interview with a representative at the facility's contracted pharmacy multi-dose packaging section on 10/29/21 at 10:01am revealed:
-Resident #1's Preservision AREDS 2 was last dispensed on 08/05/21 and forty-two tablets were sent.
-A refill request was sent from the facility on 09/09/21 and it was not refilled because of a billing issue.
-The billing department made a note that Resident #1's medical insurance did not cover this medication.
-The billing department indicated the reason was because Preservision AREDS 2 was an over the counter medication.
-The facility would have received two notifications, one from the billing department and

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another from the multi-dose packaging section.

Telephone interview with a representative at Resident #1's primary care physician (PCP) office on 10/29/21 at 10:29am revealed:
-Resident #1's PCP was no longer with the practice and her previous orders could not be viewed.
-The reason the orders could not be viewed was because the office had began using a different electronic medical records system.

Interview with a first shift medication aide (MA) on 10/29/21 at 12:00pm revealed:
-Resident #1 did not have any Preservision AREDS 2 on the medication cart.
-Resident #1's Preservision AREDS 2 used to be in her multi-dose package and then the pharmacy began sending it in a separate package.
-He did not know why the MAs were signing for Preservision AREDS 2 when the medication was not available.
-He did not recall the medication not being available after 09/09/21.
-When administering medications, the multi-dose package was scanned and the medications appeared on the computer screen.
-If there was a medication that was not included in the multi-dose package, the pharmacy was called, a refill request was completed, or the RCC was made aware.
-He waited 2 to 3 days for a medication to be delivered from the pharmacy before notifying the RCC.

Interview with the RCC on 10/29/21 at 3:14pm revealed:
-She expected the MAs to call the pharmacy if there was a medication that appeared on the eMAR but was unavailable for administration.

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-If the MA told her about the unavailable medication, then she would notify pharmacy and try to determine why it was not available for administration.
-She did not know Resident #1's Preservision AREDS 2 was not available for administration.
-She did not recall receiving an email from the pharmacy concerning Resident #1's Preservision AREDS 2.
-If there was an issue with billing for a medication, the pharmacy sent a notification that a medication was not covered by insurance.
-She did not recall receiving a notification concerning billing from the pharmacy for Resident #1's Preservision AREDS 2.
-If the issue was that it was not covered , the pharmacy sent the options available for the resident, such as having the PCP choosing another medication that was covered or discussing with resident concerning paying for the medication.

Interview with the Administrator on 10/29/21 at 5:37pm revealed she was not aware that Resident #1's Preservision AREDS 2 was last dispensed on 08/05/21 and was not available for administration.

Refer to interview with the RCC on 10/29/21 at 2:50pm.

Refer to interview with the Area Director of Clinical Services on 10/29/21 at 5:15pm.

Refer to interview with the Administrator on 10/29/21 at 5:39pm.

b. Review of Resident #1's current FL-2 dated 10/27/21 revealed a medication order for saline nasal spray (used to treat dry nose, allergies, or

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nasal congestion) administer one spray each nostril three times a day.

Review of Resident #1's previous FL-2 dated 01/28/21 revealed there was a medication order for saline nasal spray administer one spray into each nostril three times a day.

Review of Resident #1's pharmacy dispense record revealed one 44 milliliter bottle of saline nasal spray was dispensed on 07/26/21.

Review of Resident #1's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for saline nasal spray one spray into each nostril three times daily, scheduled at 8:00am, 10:00am, 2:00pm, 7:00pm, and 8:00pm.
-There was documentation of administration of saline nasal spray from 08/01/21 to 08/09/21 at 8:00am, 2:00pm and 8:00pm.
-There was documentation that Resident #1 was unavailable on 08/10/21 at 8:00am.
-There was documentation of administration of saline nasal spray on 08/10/21 at 2:00pm and 8:00pm, from 08/11/21 to 08/17/21 at 8:00am, 2:00pm, and 8:00pm.
-There was documentation of administration of saline nasal spray from 08/18/21 to 08/31/21 at 10:00am, 2:00pm, and 7:00pm.

Review of Resident #1's September 2021 eMAR revealed:
-There was an entry for saline nasal spray one spray into each nostril three times daily, scheduled at 10:00am, 2:00pm, and 7:00pm.
-There was documentation of administration of saline nasal spray from 09/01/21 to 09/17/21 at 10:00am, 2:00pm, and 7:00pm.

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-There was documentation that Resident #1's saline nasal spray was discontinued on 09/18/21 at 2:00pm.
-There was documentation of administration of saline nasal spray from 09/19/21 to 09/29/21 at 10:00am, 2:00pm, and 7:00pm.
-There was documentation of refusal by Resident #1 on 09/30/21 at 2:00pm.
-There was documentation of administration of saline nasal spray on 09/30/21 at 10.00am and 7:00pm.

Review of Resident #1's October 2021 eMAR revealed:
-There was an entry for saline nasal spray one spray into each nostril three times daily, scheduled at 10:00am, 2:00pm, and 7:00pm.
-There was documentation of administration of saline nasal spray from 10/01/21 to 10/05/21 at 10:00am, 2:00pm, and 7:00pm, on 10/07/21 at 10:00am, 2:00pm, and 7:00pm, and 10/08/21 at 10:00am and 2:00pm.
-There was documentation of administration of saline nasal spray from 10/09/21 to 10/16/21 at 10:00am, 2:00pm, and 7:00pm, on 10/17/21 at 10:00am and 2:00pm, and from 10/18/21 to 10/24/21 at 10:00am, 2:00pm, and 7:00pm.
-There was documentation of administration of saline nasal spray from 10/26/21 to 10/28/21 at 10:00am, 2:00pm, and 7:00pm.
-There was documentation of not administered on 10/06/21 at 10:00am, and 2:00pm.
-There was documentation of refusal on 10/06/21 at 7:00pm, 10/08/21 at 7:00pm, 10/17/21 at 7:00pm, 10/25/21 at 7:00pm, and 10/29/21 at 10:00am.

Observation of Resident #1's medications on hand on 10/29/21 at 8:26am revealed there was no bottle of saline nasal spray available for

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administration.

Interview with Resident #1 on 10/29/21 at 1:20pm revealed:
-She did have saline nasal spray but refused it most of the time.
-She did not have the bottle of saline nasal spray in her room.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/29/21 at 9:27am revealed:
-There was an order dated 07/16/21 for saline nasal spray one spray in each nostril three times a day.
-There were no refills on the order dated 07/16/21.
-Staff at the facility faxed a refill request on 09/10/21 and the pharmacy faxed that there were no more refills and a new prescription was needed.
-One 44 milliliter bottle of saline nasal spray was dispensed on 07/26/21.

Interview with a medication aide (MA) on 10/29/21 at 12:39pm revealed:
-He could not locate Resident #1's bottle of saline nasal spray.
-The last date that he saw Resident #1's saline nasal spray was 10/25/21.
-When a medication was not available for administration, he documented "on hold".
-However, there should be a hold order for the medication to document "on hold".

Interview with the Resident Care Coordinator (RCC) on 10/29/21 at 3:14pm revealed:
-She was not aware that Resident #1's saline nasal spray was not available for administration.
-She expected staff to request a refill when a

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medication was not available.
-If the MAs had any problems sending a refill request via fax, she could request a refill online.
-The MAs had to communicate with her if there were any difficulties obtaining a medication.
-She could not fix issues she did not know about for medications.

Interview with the Administrator on 10/29/21 at 5:37pm revealed she did not know Resident #1's saline nasal spray could not be located and was not administered.

Refer to interview with the RCC on 10/29/21 at 2:50pm.

Refer to interview with the Area Director of Clinical Services on 10/29/21 at 5:15pm.

Refer to interview with the Administrator on 10/29/21 at 5:39pm.

c. Review of Resident #1's current FL-2 dated 10/27/21 revealed a medication order for Daily-Vite 400 mcg (used to treat or to prevent vitamin deficiency) one tablet daily.

Review of Resident #1's physician orders revealed:
-There was a verbal order to discontinue Resident #1's daily vitamin signed by Resident #1's primary care provider (PCP) on 08/30/21.
-There was no hold order for Resident #1's Daily-vite.

Review of Resident #1's previous FL-2 dated 01/28/21 revealed there was an order for multivitamin with minerals take one tablet daily.

Review of Resident #1's pharmacy dispense

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record revealed twenty-eight tablets of Daily-Vite were dispensed on 09/09/21 and 09/30/21.

Review of Resident #1's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for multivitamin with minerals take one tablet daily, scheduled for 10:00am.
-There was documentation of administration of multivitamin with minerals from 08/01/21 to 08/29/21 at 10:00am.
-There was an entry for Daily-Vite 400 mcg tablet take one tablet daily, scheduled at 10:00am.
-There was documentation of administration of Daily-vite from 08/30/21 to 08/31/21 at 10:00am.

Review of Resident #1's September 2021 eMAR revealed:
-There was an entry for Daily-Vite 400 mcg tablet take one tablet daily, scheduled at 10:00am.
-There was documentation of administration of Daily-vite from 09/01/21 to 09/30/21 at 10:00am.

Review of Resident #1's October 2021 eMAR revealed:
-There was an entry for Daily-Vite 400 mcg tablet take one tablet daily, scheduled at 10:00am.
-There was documentation of administration of Daily-Vite from 10/01/21 to 10/26/21 at 10:00am, and 10/28/21 at 10:00am.
-There was documentation of not administered due "on hold" on 10/27/21 at 10:00am.

Observation of Resident #1's medications on hand on 10/29/21 at 8:26am revealed:
-There were Daily-Vite tablets available in Resident #1's weekly multi dose packet dated 10/28/21.
-There was a note written in green beside the picture of a Daily-Vite tablet that the medication

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was discontinued.
-There were handwritten instructions to remove the tablet from the multi-dose packet.

Interview with Resident #1 on 10/28/21 at 7:39am revealed she took a vitamin, but she did not receive it on 10/27/21.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/29/21 at 9:27am revealed:
-Resident #1 had an order dated 08/24/21 for Daily-Vite one tablet daily.
-There was no discontinue order for Daily-Vite on Resident #1's profile.
-Daily-Vite was keyed for multi-dose packaging and she could not view the dispense dates.

Telephone interview with a representative at the facility's pharmacy multi-dose packaging on 10/29/21 at 10:01am revealed:
-There was an active order for Resident #1's Daily-Vite and it was placed in the multi-dose packaging.
-There was no discontinue order in the system for Daily-Vite.
-Daily-vite was placed in the 10/28/21 multi-dose package for Resident #1.
-She was preparing Resident #1's multi-dose packages for 11/04/21 and Daily-Vite would be in the packages.

Interview with a first shift medication aide (MA) on 10/29/21 at 12:39pm revealed:
-He thought Resident #1's Daily-Vite was discontinued, but he did not know when it was discontinued.
-When a medication was discontinued, the Resident Care Coordinator (RCC) wrote discontinued on the multi-dose package beside

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the discontinued medication entry.
-The MAs were supposed to remove the medication from the multi-dose package before administering it to the resident.
-When a medication was discontinued and it still appeared on the eMAR, the MAs were supposed to document discontinued.
-He documented Resident #1's Daily-Vite as administered on the September 2021 and October 2021 for days that he worked.
-He did not know why he documented Resident #1's Daily-Vite as administered.
-The MAs were responsible for administering medications as ordered and documenting accurately on the resident eMARs.

Interview with the RCC on 10/29/21 at 3:14pm revealed:
-When a medication was discontinued, it took the multi-dose packaging system one to two deliveries before the medication was removed.
-She wrote discontinued beside the discontinued medication on the multi-dose package when it was not removed.
-She expected the MAs to document discontinued when a discontinued medication still appeared on the eMAR.
-She faxed discontinued orders to the pharmacy, and she removed the medication from the eMAR.
-She did not know the MAs continued to administer Daily-Vite to Resident #1.
-She did not know the pharmacy did not have Resident #1's discontinued order for Daily-Vite.

Interview with the Administrator on 10/29/21 at 5:37pm revealed:
-She expected discontinued medications to be removed from the medication cart.
-She did not know Resident #1 continued to receive Daily-Vite after it was discontinued.

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Refer to interview with the RCC on 10/29/21 at 2:50pm.

Refer to interview with the Area Director of Clinical Services on 10/29/21 at 5:15pm.

Refer to interview with the Administrator on 10/29/21 at 5:39pm.

d. Review of Resident #1's current FL-2 dated 10/27/21 revealed a medication order for omeprazole delayed release (DR) (used to treat gastro-esophageal reflux disease) 20mg one tablet at bedtime.

Review of Resident #1's previous FL-2 dated 01/28/21 revealed a medication order for omeprazole 20 mg capsule take one capsule daily.

Review of Resident #1's pharmacy dispense record revealed:
-Thirty tablets of omeprazole 20mg were dispensed on 09/24/21.
-There were no other dispense dates for omeprazole after 09/24/21.

Review of Resident #1's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for omeprazole 20mg take one capsule at bedtime, scheduled at 7:00pm.
-There was documentation of administration of omeprazole from 08/01/21 to 08/31/21 at 7:00pm.

Review of Resident #1's September 2021 eMAR revealed:
-There was an entry for omeprazole 20mg take one capsule at bedtime, scheduled at 7:00pm.

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-There was documentation of administration of omeprazole from 09/01/21 to 09/30/21 at 7:00pm.

Review of Resident #1's October 2021 eMAR revealed:
-There was an entry for omeprazole 20mg take one capsule at bedtime, scheduled at 7:00pm.
-There was documentation of administration of omeprazole from 10/01/21 to 10/28/21 at 7:00pm.

Observation of Resident #1's medications on hand on 10/29/21 at 8:26am revealed there was no omeprazole available for administration.

Interview with Resident #1 on 10/28/21 at 7:39am revealed
-She took a "stomach medication" that she did not receive on 10/27/21.
-She did not know if she had missed other medications at other times during the month of October.

A second interview with Resident #1 on 10/29/21 at 1:20pm revealed:
-She could not eat if she did not get her omeprazole.
-She thought she received the omeprazole last night on 10/28/21.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/29/21 at 9:27am revealed:
-There was an order dated 8/24/21 for omeprazole 20mg one capsule at bedtime.
-Thirty-tablet omeprazole 20mg was last dispensed on 09/24/21.
-Omeprazole was not a medication that was placed in multi-dose packages.
-Resident #1's omeprazole order had 11 refills.
-There were no refill requests for Resident #1's

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omeprazole from the facility.

Interview with a second shift medication aide (MA) on 10/29/21 at 2:51pm revealed:
-If there was a medication not available to administer, she told the Resident Care Coordinator (RCC) and tried to reorder the medication.
-She attempted to give the medication before the end of her shift if it was delivered from the pharmacy prior to the end of her shift.
-She could not recall administering Resident #1's omeprazole.

Interview with the RCC on 10/29/21 at 3:14pm revealed:
-She was not aware that Resident #1's omeprazole was last dispensed on 09/24/21.
-She did not know Resident #1 had not received any omeprazole from 10/25/21 to 10/28/21.
-She expected the MAs to document not given on the eMAR and the reason a medication was not given.

Interview with the Administrator on 10/29/21 at 5:37pm revealed she did not know Resident #1 did not have any omeprazole available for administration.

Refer to interview with the RCC on 10/29/21 at 2:50pm.

Refer to interview with the Area Director of Clinical Services on 10/29/21 at 5:15pm.

Refer to interview with the Administrator on 10/29/21 at 5:39pm.

2. Review of Resident #2's current FL-2 dated 08/17/21 revealed diagnoses included dementia,

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hypertension, hyperlipidemia, transient ischemia attacks, gout, pulmonary embolism, and cerebrovascular accident.

Review of Resident #2's physician orders provided by the facility revealed:
-There was an order dated 08/20/21 for vitamin D3 (used to treat vitamin D3 deficiency) 50mcg (2000 units) take one tablet daily.
-There was a discontinue order dated 10/28/21 for vitamin D 2000 units daily.

Review of Resident #2's cart audits for September 2021 revealed there was no vitamin D3 available on the medication cart on 09/07/21, 09/15/21, and 09/22/21.

Review of Resident #2's facility dispense record from 08/27/21 to 10/29/21 revealed there was no vitamin D3 dispensed.

Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for vitamin D3 50 mcg (2000 units) take one tablet daily, scheduled at 8:00am.
-There was documentation of administration of vitamin D3 from 08/21/21 to 08/31/21 at 8:00am.

Review of Resident #2's September 2021 eMAR revealed:
-There was an entry for vitamin D3 50 mcg (2000 units) take one tablet daily, scheduled at 8:00am.
-There was documentation of administration of vitamin D3 from 09/01/21 to 09/30/21 at 8:00am.

Review of Resident #2's October 2021 eMAR revealed:
-There was an entry for vitamin D3 50 mcg (2000 units) take one tablet daily, scheduled at 8:00am.

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-There was documentation of administration of vitamin D3 from 10/01/21 to 10/27/21 at 8:00am.

Observation of Resident #2's medications on hand on 10/29/21 at 8:19am revealed there was no vitamin D available for administration.

Telephone interview with a representative at Resident #2's primary care provider's (PCP) office on 10/29/21 at 12:59pm revealed:
-She thought that the previous provider ordered vitamin D3 for Resident #2.
-She was not able to locate the order in their electronic medical records because the office had recently switched to a new electronic records system.
-The SCC called on 10/28/21 requesting a copy of the vitamin D3 order for Resident #2 and she told the SCC that she could not locate it.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/29/21 at 9:27am revealed:
-Resident #2 had an order dated 08/19/21 for vitamin D3 2000 units daily that was keyed into the system for multi-dose packaging.
-She could not view the dispense dates for multi-dose packaging because it was a separate section of the pharmacy.
-There was no discontinue order for vitamin D3 on Resident #2's profile.

Telephone interview with a representative at the facility's contracted pharmacy multi-dose packaging section on 10/29/21 at 10:01am revealed:
-Vitamin D3 was not dispensed for Resident #2 because it was on back order.
-Resident #2's vitamin D3 was dispensed in the multi-dose packages.

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-The item number for Resident #2's vitamin D3 had been on back order for months.
-She sent the facility a monthly cycle fill report with notes about the residents' medications such as a new order was needed or out of stock.
-She would have sent a note concerning Resident #2's vitamin D3 when it was first out of stock to make staff at the facility aware.
-She did not have the exact date that she sent the facility a note but Resident #2's vitamin D3 had not been in stock for at least 3 months.
-The facility sent a refill request on 08/20/21 and the pharmacy told staff at the facility that it was on back order.
-There was also a new prescription sent on 08/19/21 from Resident #2's PCP.
-The pharmacy also let the facility know weekly that Resident #2's vitamin D3 was on back order because it was on the cycle fill request form.

Interview with a medication aide (MA) on 10/29/21 at 8:15am revealed:
-Resident #2 ran out of vitamin D3 on 10/28/21 and she informed the Special Care Coordinator (SCC).
-She thought the SCC called the pharmacy concerning Resident #2's vitamin D3.
-Resident #2's vitamin D3 was in an individual packet and was not in her multi-dose packaging.

Interview with the SCC on 10/29/21 at 12:48pm revealed:
-The pharmacy faxed or emailed the facility when there was an issue with a resident's medication.
-She received the multi-dose package delivery list, but she did not recall any notes concerning Resident #2's vitamin D3.
-There was an extra bottle of vitamin D3 in the overstock medication room and they used it for Resident #2's vitamin D3.

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{D 358}	Continued From page 19 -She did not know how many tablets of vitamin D3 were in the bottle, when the bottle began to be used for Resident #2, or who bought the bottle of vitamin D3. -She did not have the empty bottle and she did not have any receipts for Resident #2's vitamin D3. A second interview with the SCC on 10/29/21 at 4:31pm revealed: -She reviewed the cart audits for September 2021 and October 2021. -She could not find any cart audits for October 2021. -She thought Resident #2's September 2021 cart audits indicated no vitamin D3 was because they did not know the bottle of vitamin D3 was for Resident #2. -She held the MAs responsible for giving the medications as ordered. Interview with the Administrator on 10/29/21 at 5:37pm revealed she was not aware that Resident #2 did not have any vitamin D3 available to administer. Based on observations, record reviews, and interviews it was determined that Resident #2 was not interviewable. Refer to interview with the RCC on 10/29/21 at 2:50pm. Refer to interview with the Area Director of Clinical Services on 10/29/21 at 5:15pm. Refer to interview with the Administrator on 10/29/21 at 5:39pm. 3. Review of Resident #3's FL-2 dated 08/26/21	{D 358}		

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revealed diagnoses included high blood pressure, unspecified dementia, and coronary artery disease.

a. Review of Resident #3's FL-2 dated 08/26/21 revealed:
-There was an order for fingerstick blood sugar (FSBS) checks three times a day and at bedtime.
-There was an order for insulin aspart (Novolog) (a fast-acting insulin used to lower elevated blood sugar levels) inject subcutaneously (SQ) using a sliding scale three times a day and at bedtime.
-The minimum FSBS result for administering the sliding scale insulin (SSI) was 150.

Review of Resident #3's subsequent primary care provider's (PCP) order dated 08/31/21 revealed:
-There was an order for Novolog inject 5 units SQ with meals.
-There was an order to continue Resident #3's Novolog SSI before meals and at bedtime.
-There were instructions to add the 5 units of Novolog to the Novolog SSI amount at mealtimes.

Review of Resident #3's PCP's order dated 09/21/21 revealed there was an order for Novolog inject 10 units SQ at lunch.

Review of Resident #3's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog Inject 5 units SQ three times daily scheduled for administration at 8:00am, 12:00pm, and 5:00pm
-There was documentation Resident #3 did not receive Novolog on six opportunities between 09/02/21-09/20/21.
-Resident #3's FSBS results on those six opportunities ranged from 105-143.

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-There was documentation Novolog was not administered because Resident #3's FSBS results were below the parameters for administration.

Review of Resident #3's October 2021 eMAR revealed:
-There was an entry for Novolog inject 10 units SQ at lunch scheduled for administration at 12:00pm.
-There was documentation Resident #3 did not receive Novolog on four opportunities between 10/01/21-10/25/21.
-Resident #3's FSBS results on those four occasions ranged from 96-142.
-There was documentation Novolog was not administered because Resident #3's FSBS results were below the parameters for administration.

Interview with a first shift medication aide (MA) on 10/29/21 at 12:01pm revealed:
-He knew Resident #3 had orders for scheduled insulin and SSI.
-Novolog was a fast-acting insulin and was administered according to parameters.
-The Resident Care Coordinator (RCC) or another MA told him to use the parameters when administering fast-acting insulin.
-If the order did not say "do not hold," he used the parameters when he administered insulin.
-He did not administer the scheduled Novolog when Resident #3's FSBS results were below the parameters used for the SSI insulin.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/29/21 at 12:58pm revealed:
-There was a difference between scheduled insulin and SSI.

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{D 358}	Continued From page 22 -Scheduled insulin was to be administered at the ordered times. -SSI was given or not given based on the FSBS results and the ordered parameters for administration. Interview with Resident #3 on 10/29/21 at 1:28pm revealed he did not know the specifics of his insulin orders. Interview with the RCC on 10/29/21 at 2:50pm revealed: -Resident #3's scheduled Novolog insulin was to be administered independent of the SSI parameters. -The MAs should have known how to administer scheduled insulin. -The MAs had received training on diabetes care within the last six months. -She reviewed the eMARs whenever she had time, but eMARs with insulin orders should have been reviewed daily. -She did not remember the last time she reviewed Resident #3's eMARs. -The MAs needed to be reeducated on administering scheduled insulin. Interview with the Administrator on 10/29/21 at 5:39pm revealed: -The MAs knew Resident #3 was supposed to be administered the scheduled Novolog insulin at the ordered time independent of the parameters for the SSI. -Insulin was not to be held if it was written as a scheduled medication. -The information on administering scheduled insulin was communicated to the staff during the in-service training in August 2021. -The MA needed further individual training with the Area Director of Clinical Services.	{D 358}		

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-The RCC was responsible for the daily review of insulin administration.
-The RCC had not reported any concerns with insulin administration to her.

Attempted telephone interview with Resident #3's PCP on 10/29/21 at 1:58pm was unsuccessful.
Refer to the interview with the RCC on 10/29/21 at 2:50pm.

Refer to interview with the Area Director of Clinical Services on 10/29/21 at 5:15pm.

Refer to interview with the Administrator on 10/29/21 at 5:39pm.

b. Review of Resident #3's FL-2 dated 08/26/21 revealed there was an order to weigh the resident daily.

Review of Resident #3's subsequent primary care provider's (PCP) order dated 09/23/21 revealed there was an order for furosemide (used to treat fluid retention) 20mg take one tablet daily as needed if a daily weight gain of 3 pounds was noted.

Review of Resident #3's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for daily weights.
-There was an entry for furosemide 20mg take one tablet daily as needed for weight gain of 3 pounds or more in a day.
-There was documentation Resident #3 had a weight gain of 6 pounds in one day.
-There was no documentation Resident #3 received furosemide as ordered.

Review of Resident #3's October 2021 eMAR

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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 358}	Continued From page 24	{D 358}		

revealed:
-There was an entry for daily weights.
-There was an entry for furosemide 20mg take one tabletdaily as needed for weight gain of 3 pounds or more in a day.
-On two dates, there was documentation Resident #3 had a weight gain of 3 pounds in one day.
-There was documentation Resident #3 had a weight gain of 4 pounds in one day.
-There was no documentation Resident #3 received furosemide as ordered.

Observation of Resident #3's medication available for administration on 10/29/21 at 11:49am revealed:
-There were 27 of 30 furosemide 20mg tablets in a punch card.
-The label on the punch card indicated the pharmacy dispensed 30 furosemide 20mg tablets on 09/23/21.

Interview with the medication aide (MA) on 10/29/21 at 12:01pm revealed:
-He weighed Resident #3 daily.
-He was able to see the previous day's weight in the eMAR.
-He always let the Resident Care Coordinator (RCC) know if there was a gain or loss of at least two pounds.
-The RCC would call the PCP and then let the MA know if the PCP wanted the resident to take Furosemide.
-The furosemide was not given without notifying the PCP.
-He did not remember administering furosemide to Resident #3.

Interview with Resident #3 on 10/29/21 at 1:28pm revealed:

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{D 358}	Continued From page 25 -Staff did not tell him how much he weighed each day. -He did not know he had an order for a medication used to treat fluid retention. Interview with the RCC on 10/29/21 at 2:50pm revealed: -She expected the MA to administer the furosemide as ordered. -The MA should have administered the furosemide when Resident #3 had a weight gain of at least three pounds in one day. -The eMAR system had a tab listing all medications that were ordered to be administered as needed. -The MA should have known about Resident #3's furosemide order. -The MA was responsible for conducting weekly cart audits and should have been familiar with Resident #3's medication orders. -"Someone" knew Resident #3 had an order for furosemide and administered it without documenting on the eMAR. -She did not remember the last time she audited Resident #3's eMARs. Interview with the Administrator on 10/29/21 at 5:39pm revealed: -Resident #3 should have received the furosemide unless the PCP said not to administer it to him. -The MA was responsible for weighing Resident #3 and had access to the previous day's weight. -The MA was expected to follow the medication order. -"Someone" gave the furosemide but did not document it. -The MA needed further individual training with the Area Director of Clinical Services.	{D 358}		

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{D 358}	Continued From page 26	{D 358}		

Attempted telephone interview with Resident #3's PCP on 10/29/21 at 1:58pm was unsuccessful.

Refer to interview with the RCC on 10/29/21 at 2:50pm.

Refer to interview with the Area Director of Clinical Services on 10/29/21 at 5:15pm.

Refer to interview with the Administrator on 10/29/21 at 5:39pm.

____

Interview with the RCC on 10/29/21 at 2:50pm revealed the last time she reviewed an eMAR was at least two weeks ago.

Interview with the Area Director of Clinical Services on 10/29/21 at 5:15pm revealed:
-She provided medication administration in-service training to the MAs on 08/27/21.
-The training topics included counting narcotics, medication hold orders, taking vital signs, documentation, verbal orders, ordering medications from outside pharmacies, refused medications, and cart audits.
-She also observed the MAs while they were administering medication.
-The MAs were given all the information they needed to administer medications accurately.

Interview with the Administrator on 10/29/21 at 5:39pm revealed:
-She expected medications to be administered according to state rules and regulations and in accordance with the PCP's orders.
-The Area Director of Clinical Services provided additional training to the MAs on 08/27/21 and reviewed their skills.
-She did not review eMARs.
-She expected the RCC or Special Care

Division of Health Service Regulation

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{D 358}	Continued From page 27 Coordinator (SCC) to report any medication administration concerns to her. -The MA was responsible for the accurate administration of medications.	{D 358}		