STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY HOUSE OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

(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 an annual survey from 01/25/22-01/27/22.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 2 of 5 sampled residents (#1 and #3) related to referrals for a spine center and orthotics (#1) and an eye examination (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 09/01/21 revealed diagnoses included vertebral compression fracture, congestive heart failure, hypothyroidism, atrial fibrillation, depression, dementia, and hypertension. Review of Resident #1's hospital discharge summary dated 11/06/21 revealed: -There was an ambulatory referral for a spine center with instructions to schedule an appointment as soon as possible. -There was another ambulatory referral for prosthetics orthotics to schedule an appointment as soon as possible within 2 days. Review of Resident #1's November 2021, December 2021, and January 2022 progress notes revealed there was no documentation indicating Resident #1 had attended an appointment.	D 273		

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D 273	Continued From page 1 Review of Resident #1's record revealed there was no after visit summary from the spine center or prosthetics orthotics. Interview with Resident #1 on 01/27/22 at 11:09am revealed: -She had two falls since her admission to the facility. -She thought she had attended an appointment to see the orthopedic provider, but she did not know the date of the appointment. -Her family member transported her to the appointment. -She did not recall attending any other appointments. Telephone interview with a representative for the spine center on 01/26/22 at 3:55pm revealed -Resident #1 had an appointment on 11/19/21 but she was a "no show". -The appointment was not canceled on 11/19/21 and the documentation in the computer indicated no show. -Resident #1's appointment was not rescheduled. Telephone interview with a representative for the prosthetics orthotics clinic on 01/26/22 at 4:00pm revealed: -Resident #1 had a referral in the computer system but an appointment had not been made for her. -With outpatient referrals, either they called the facility to schedule an appointment or someone called on behalf of the resident to schedule an appointment. Telephone interview with Resident #1's Nurse Practitioner (NP) on 01/27/22 at 8:52am revealed: -When residents had referrals, she expected the	D 273		

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resident to attend an appointment for the referral.
-She thought Resident #1 had attended an appointment with an orthopedic provider.
-Staff told her that Resident #1 had attended an appointment.

Interview with a medication aide (MA) on 01/27/22 at 10:26am revealed:
-When residents returned from the hospital, the Resident Care Coordinator (RCC) reviewed the hospital discharge paperwork.
-The RCC was responsible for referrals and scheduling any appointments.

Interview with the RCC on 01/27/22 at 2:25pm revealed:
-She did not document in Resident #1's record that she called Resident #1's family member.
-She did not have any documentation for Resident #1's appointments.
-She thought Resident #1 attended an appointment for one of the referrals.
-She recalled speaking with Resident #1's family member to tell him to schedule the appointments.
-She did not have a system in place for ensuring residents attended the appointments for the referrals.
-She had not told Resident #1's NP that she had not attended the appointments, because she thought Resident #1 had attended one of the appointments.

Interview with the Administrator on 01/27/22 at 5:10pm revealed:
-She did not know that Resident #1 had not attended any appointments for referrals written in November 2021.
-The RCC was responsible for ensuring residents attended appointments for referrals.

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D 273	Continued From page 3 Attempted telephone interview with Resident #1's family member on 01/26/22 at 8:06am was unsuccessful. Refer to interviews with the RCC on 01/27/22 at 2:25pm and 3:48pm. Refer to interview with the Administrator on 01/27/22 at 5:10pm. 2. Review of Resident #3's current FL-2 dated 08/04/21 revealed diagnoses included diabetes and cognitive dysfunction. Review of Resident #3's after visit summaries from his primary care provider (PCP) appointments dated 09/21/21, 10/21/21, 11/16/21, 12/15/21, and 01/20/22 revealed: -There was a health maintenance summary with a list of recommended procedures. -A retinal eye examination was last completed 02/07/17. -The due date for a subsequent retinal eye examination was 02/07/18. Review of Resident #3's record revealed there was no documentation related to completion of a retinal eye examination. Telephone interview with Resident #3's responsible party on 01/27/22 at 8:25am revealed: -He accompanied Resident #3 to his PCP appointment last week. -The PCP told him to schedule Resident #3's retinal eye examination. -He thought Resident #3 had "something done with his eyes years ago." -Resident #3 may have had an eye examination two years ago.	D 273		

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D 273	Continued From page 4 Interview with the Resident Care Coordinator (RCC) on 01/27/22 at 3:48pm revealed: -She had not discussed scheduling the retinal eye examination with Resident #3's responsible party. -She did not follow-up with Resident #3's PCP about scheduling the eye examination. -The facility did not transport Resident #3 to his appointments, so she did not think she was responsible for scheduling his appointments. Interview with the Administrator on 01/27/22 at 5:10pm revealed she did not know if Resident #3 ever went out for his retinal eye examination. Telephone interview with Resident #3's PCP on 01/28/22 at 2:41pm revealed: -He did not expect Resident #3 to get a retinal eye examination during the global coronavirus (COVID-19) pandemic. -He spoke with Resident #3's responsible party last week about scheduling the eye examination. -He recommended annual eye examinations for Resident #3. Refer to interviews with the RCC on 01/27/22 at 2:25pm and 3:48pm. Refer to interview with the Administrator on 01/27/22 at 5:10pm. _____ Interviews with the RCC on 01/27/22 at 2:25pm and 3:48pm revealed: -She was responsible for reviewing the after visit summaries. -When a resident had a referral, she called their family member to tell them to schedule an appointment for the resident. -She called the family member to schedule the appointments for referrals because the family	D 273		

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D 273	Continued From page 5 members had to transport the resident to the appointment. -The facility provided transportation if a resident had a local appointment. -If the referral was for a provider in another town, the facility did not provide transportation. -She wrote the appointments on a desk calendar when family members told her the dates for residents' appointments. -She did not have the desk calendar from 2021. -She was responsible for ensuring residents attended appointments for referrals. -She did not know if it was her responsibility to schedule appointments for the residents. Interview with the Administrator on 01/27/22 at 5:10pm revealed: -The RCC was responsible for ensuring the residents' medical appointments were scheduled and attended. -The electronic medical record software had an appointment follow-up feature that was used by the RCC. -There was also a handwritten calendar of appointments posted in the medication room in the front hall. -She expected appointments to be documented on both the electronic calendar and the handwritten calendar. -She expected documentation related to referrals to be in the residents' records. -If a resident missed a referral appointment, she expected the resident's responsible party to be contacted and the PCP to be notified of the missed appointment.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care	D 276		

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(c) The facility shall assure documentation of the following in the resident's record:
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents (#4) related to an order for a urinalysis and culture.

The findings are:

Review of Resident #4's current FL-2 dated 02/11/21 revealed diagnoses included dementia and depression.

Review of Resident #4's primary care provider's (PCP) orders revealed there was an order dated 11/24/21 for a urinalysis and culture.

Review of Resident #4's record revealed there were no urinalysis and culture results.

Interview with the Resident Care Coordinator (RCC) on 01/27/22 at 3:48pm revealed:
-She could not find the results for the urinalysis that was ordered on 11/24/21 for Resident #4.
-Resident #4's PCP did not have results of the urinalysis.
-She did not think the urinalysis had been done.
-She was responsible for making sure orders were implemented.

Interview with the Administrator on 01/27/22 at 5:10pm revealed:

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D 276	Continued From page 7 -Every order ultimately went through the RCC's hands. -The RCC usually wrote the order on the board in the medication room or informed the MAs when a urine specimen needed to be collected. -There was no record of Resident #4's urinalysis being done. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure foods were free from contamination related to uncovered food being transported through hallways on an open cart and a food delivery cart that was soiled and not cleaned after use. The findings are: a. Observation of the lunch meal service on the locked unit on 01/25/22 at 12:10pm revealed: -There was a three-tiered wheeled cart with 16 uncovered plates of lemon bar desserts on the	D 283		

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D 283	Continued From page 8	D 283		

first and second tier of the cart.
-The distance the cart traveled from the kitchen with the uncovered desserts was 59 feet.

Observation of the breakfast meal service on 01/26/22 at 8:00am revealed:
-There was a three-tiered wheeled cart with 12 uncovered bowls of cold cereal on the second tier of the cart.
-The cart was used to transport food from the kitchen by traveling down two hallways to a second dining room located on the 100 hall.

Interview with the Kitchen Manager on 01/25/22 at 12:10pm revealed:
-All the food for the separate dining room located on the 100 hall was preplated in the kitchen and transported on an enclosed cart or an open cart.
-The food should have been covered before it was sent to the second dining room on the opened cart.
-The food sent on the enclosed cart was not covered.
-She knew the food should have been covered and she should have noticed the uncovered plates before they went to the second dining room.
-The plates should have been covered to keep germs in the air from contaminating the food.

Interview with the morning cook on 01/26/22 at 8:30am revealed:
-The bowls of cereal should have been covered.
-She forgot to cover them before sending them to the second dining room.
-She usually remembered to cover food before transporting it to the second dining room.

Interview with the Administrator on 01/27/22 at 7:40am revealed:

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D 283	Continued From page 9 -Everything placed on the food delivery carts should be covered to prevent contamination. -Plates of food should have been covered before leaving the kitchen; it was basic common sense. b. Observation of the food transportation cart on 01/26/22 at 2:00pm revealed: -There were two stacked and insulated containers used to transport hot plates of food from the kitchen to the second dining room on the 100 hall. -The food transportation containers were enclosed with toggle latches to secure the doors during transport. -There were used plates and cups on the top of the cart and food debris on the top. -The closures or locks on the food transportation containers had a thick yellow film that was sticky to the touch. -The handles on the food transportation containers had a thick yellow build up and were greasy to the touch. -The inside of the food transportation containers had grooves that supported pans that acted as shelves and held the plates of hot food. -The inside of the food transportation containers had an unpleasant odor when they were opened. -The pans inside the food containers had debris and dried liquids on them. Observation of the kitchen on 01/26/22 at 2:00pm revealed there was no cleaning schedule posted in the kitchen. Interview with the cook on 01/26/22 at 2:10pm revealed: -The food containers were used to transport open plates of hot food for the residents on the 100 hallway. -She did not wash and sanitize the containers after every meal.	D 283		

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-The food containers were used for every meal but were only cleaned about once a week.
-Dirty plates were stacked on the top of the food containers and not placed inside the containers.
-She had not been told to wash and sanitize the food containers more often than once a week.

Interview with the Dietary Manager on 01/26/22 at 2:12pm revealed:
-The food transport containers were used daily for hot plates of food for the dining room on the 100 hall.
-Multiple staff would touch the outside handles and latches to the food containers during the process of serving plates of food to the residents.
-She had not considered the outside of the food containers to be a frequently touched surface before.
-She knew frequently touched surfaces needed to be cleaned and sanitized after use.
-She did not want the plates of food to become contaminated by placing them inside the dirty food container.
-She did not think about cleaning the outside or the inside of the food containers more than once a week.
-She did see the build up and the debris on the inside and outside of the food containers.
-She would instruct the staff to wash and sanitize the inside and the outside of the food containers after every meal.

Interview with the Administrator on 01/27/22 at 7:40am revealed:
-She did a walk through the kitchen on a daily basis.
-She did not have an audit or a check off list of items she was looking for when she walked through the kitchen.
-She thought there was a cleaning assignment

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D 283	Continued From page 11 sheet posted somewhere in the kitchen. -She did not know if the food transportation containers were on the cleaning assignment sheet. -She considered the outside of the food containers to be a frequently touched surface and thought they were cleaned and sanitized after each meal service. -She had not looked at the food transportation containers. -She thought the inside of the food containers were washed and sanitized after every meal because they were used to transport food.	D 283		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to have matching therapeutic menus for guidance for staff for residents with orders for therapeutic diets. The findings are: Observation of the kitchen on 01/25/22 at 10:30am revealed: -There was a diet list and a week at a glance menu posted on a bulletin board near a food preparation table in the kitchen.	D 296		

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D 296	Continued From page 12 -The week at a glance menu was dated for the week of 01/23/22. -There were no diet menus in the kitchen. Observation of the kitchen on 01/26/22 at revealed there was no diet menu in the kitchen as a guide for the cook. Interview with the morning cook on 01/26/22 at 11:40am revealed: -She had never seen the diet menu. -She just knew mechanical soft diets got chopped food and the pureed diets got pureed food. -She usually worked as a medication aide (MA) but cooked in the kitchen when the facility needed some help. Interview with the Dietary Manager on 01/25/22 at 10:30am and 12:37pm revealed: -She had prepared the lunch meal for the day. -She had to substitute items on the lunch meal. -She did not have a diet menu, but she did have a diet list and she knew one resident was ordered a pureed diet. -She pureed the food that was on the week at a glance menu to serve to the resident that had a pureed food diet order. -There had been a diet menu in the kitchen on the bulletin board yesterday, 01/24/22, but she did not know where it went. -She was responsible for printing the week at a glance menus and the daily diet menus. -She had only been the Dietary Manager for a few days, so she did not know how to print the diet menus. -She thought the Resident Care Coordinator (RCC) could also print the diet menus. Interview with the RCC on 01/25/22 at 11:55am revealed:	D 296		

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D 296	Continued From page 13 -She was not responsible for printing the diet menus for the kitchen. -The Dietary Manager was responsible for printing the weekly menus and the diet menus. -The Dietary Manager was new to the position and may not have known how to print the diet menus. -She knew the diet menu included mechanical soft and pureed diets. -She was only responsible for updating the resident diet list. Interview with the Administrator on 01/26/22 at 2:45pm revealed: -The Dietary Manager printed the diet menu but she was new so she may not have learned how. -She could print the diet menu for the kitchen but she thought there was a book with the diet menus in the kitchen somewhere. -She had last seen the book with the diet menus when the previous Dietary Manager had them. -The previous Dietary Manager last worked on 12/25/21. -She did not know the kitchen staff was not using the diet menus as a guide for preparing meals. -The kitchen staff should have been using the diet menus or let someone know they could not locate them.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

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COVENTRY HOUSE OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews it was determined the facility failed to serve the correct therapeutic diet order for 1 of 2 residents (#2) who had an order for a pureed diet and an order for nectar thickened liquids.

The findings are:

Observation of the lunch meal on 01/25/22 from 12:18pm to 12:44pm revealed:
-The residents were served fried fish, beets, coleslaw, a lemon bar, water and a choice of iced tea or milk.
-Resident #2 was served fried fish that was a ground consistency that was not smooth or moist and was not a pureed consistency.
-He was served beets that were a ground consistency with chunks and not a smooth pureed consistency; he was served chopped coleslaw that was a regular consistency and not pureed.
-He was served thin liquids; he was served milk, water and iced tea.
-Resident #2 cleared his throat multiple times as he ate and drank.
-The personal care aide (PCA) asked him if he was "okay" after he coughed during the meal and after clearing his throat multiple times.
-Resident #2 ate 100 percent of his meal and drank 100 percent of his milk.

Observation of the breakfast meal on 01/26/22 from 8:07am to 8:36am revealed:
-The residents were served scrambled eggs, French toast sticks without syrup, a sausage link,

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whole grapes or canned slices of mandarin oranges, orange juice, water, milk and coffee.
-A PCA served Resident #2 a bowl with approximately one cup of canned slices of mandarin oranges.
-The mandarin orange slices were not pureed but were a regular consistency.
-Resident #2 ate approximately a quarter of the mandarin oranges and began to cough.
-The morning cook told the PCA to remove the bowl of oranges after Resident #2 began to cough.
-The cook gave Resident #2 a bowl of mandarin oranges that were chopped into small chunks and had a thin liquid in the bowl.
-Resident #2 was served scrambled eggs that were not pureed but were a regular consistency.
-He was served sausage and French toast that were added together and were a ground consistency and not pureed to a smooth consistency.
-He was served milk, coffee and orange juice that were thin liquids and not nectar thick.
-Resident #2 cleared his throat more than five times while he ate and after each time he drank from his beverages.
-He ate 100 percent of his meal and drank 100 percent of his orange juice and coffee.

Review of Resident #2's hospice visit notes dated from 03/21/21 to revealed:
-They were completed by a Registered Nurse (RN).
-On 03/21/21 he was admitted to hospice with a diagnoses of aspiration pneumonia and swallowing dysfunction.
-He had an order for thickened liquids and pureed foods.

-On 07/09/21 there was documentation Resident

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#2 tolerated his meal when he was served a pureed meal.
-On 10/26/21 the RN noted increased coughing while eating and drinking.
-On 01/14/22 there was a PRN (as needed) visit to recheck Resident #2's condition related to a fear of aspiration from 01/03/22 when he deviated from his ordered diet.

a. Review of Resident #2's current FL-2 dated 02/11/21 revealed diagnoses included depression, atrial fibrillation, congestive heart failure, benign prostatic hyperplasia, hypertension, history of transient ischemic attack, and stage three chronic kidney disease.

Review of Resident #2's physician signed diet order dated 04/15/21 revealed he was ordered a pureed diet.

Review of the diet list posted in the kitchen on 01/25/22 at 10:30am revealed Resident #2 was ordered a pureed diet; the diet list was not dated.

Interview with the personal care aide (PCA) on 01/26/22 at 11:40am revealed:
-She was not aware of a diet list.
-She did not know Resident #2 was on a pureed diet.
-She had served Resident #2 mandarin orange slices for lunch.
-She took the mandarin orange slices back to the kitchen after she was told by the cook that he could not have them.
-She was just helping out in the dining room because they kitchen was short staffed.

Interview with the morning cook on 01/26/22 at 11:40am revealed:
-She usually worked as a medication aide (MA),

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but she had been working as a cook to help out in the kitchen.
-She knew Resident #2 was ordered a pureed diet because his name was on the diet list for a pureed diet order and she had the list memorized.
-The PCA gave Resident #2 the whole mandarin orange slices because she did not know Resident #2 was ordered a pureed diet.
-She did puree a bowl of oranges after the PCA brought them back into the kitchen.
-Pureed food was supposed to be the consistency of baby food.
-She thought the mandarin oranges were pureed to the correct consistency.

Interview with the Dietary Manager on 01/25/22 at 12:37pm revealed:
-She knew Resident #2 was ordered a pureed diet because he was on the diet list.
-She prepared his food for his meals and pureed some items and made other items "mushy".
-She did not have a diet menu for a guide for that day.
-There were guidelines on how to correctly puree foods posted in the kitchen, but she could not find them.
-She knew pureed foods should be the consistency of baby food.
-She did not puree the coleslaw for Resident #2's lunch meal.
-Resident #2 could eat foods that were not a pureed consistency; he could eat foods that were "mashed" up.
-He could eat coleslaw; his family had said he could eat coleslaw.
-She had never seen Resident #2 have a problem eating coleslaw.
-She had been told by a MA that Resident #2's family did not want him to have a pureed diet because they wanted him to eat whatever he

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wanted with "what time he had left".
-Resident #2 was on a pureed diet due to esophagus issues.
-Resident #2 strangled when he ate.

Telephone interview with Resident #2's Power of Attorney (POA) on 01/26/22 at 10:24am revealed:
-Resident #2 did not care for a pureed diet but it was better for him to be on the pureed diet because Resident #2 would choke on a regular consistency.
-When Resident #2 ate a pureed diet, he did not choke but he did choke when he ate a regular consistency diet.
-Resident #2 had aspirated while on a regular consistency diet and had been admitted to the hospital with pneumonia about a year ago.
-It was better if Resident #2 was on a pureed diet.

Telephone interview with Resident #2's primary care provider (PCP) on 01/26/22 at 10:51am revealed:
-Resident #2 had esophagus disfunction and difficulty swallowing and was ordered a pureed diet.
-Resident #2 did not care for the pureed diet.
-He was referred to hospice care around May 2021 due to his aspiration risk.

Refer to telephone interview with Resident #2's Hospice Nurse (RN) on 01/27/22 at 9:45am.

b. Review of Resident #2's current FL-2 dated 02/11/21 revealed diagnoses included depression, atrial fibrillation, congestive heart failure, benign prostatic hyperplasia, hypertension, history of transient ischemic attack, and stage three chronic kidney disease.

Review of Resident #2's physician signed diet

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order dated 04/15/21 revealed he was ordered nectar thickened liquids.

Review of the diet list posted in the kitchen on 01/25/22 at 10:30am revealed Resident #2 was ordered nectar thickened liquids; the diet list was not dated.

Observation of the kitchen on 01/25/22 at 10:30am revealed there were no nectar thickened liquids or food thickener available for serving.

Interview with Resident #2 on 01/26/22 at 8:45am revealed:
-The staff thickened his water for him.
-He did not mind drinking some of his nectar thick liquids, but he did not like the taste of the nectar thickened water.
-He coughed quite often when he drank "thin beverages".
-He was not always served nectar thickened beverages and he could not remember when he was served thickened beverages.

Interview with the personal care aide (PCA) on 01/26/22 at 11:40am revealed:
-She was not aware of a diet list.
-She did not know Resident #2 was ordered thickened liquids; no one told her.
-She was just helping out in the dining room because the kitchen was short staffed.

Interview with the morning cook on 01/26/22 at 11:40am revealed Resident #2 was not ordered nectar thickened liquids because he would not drink them.

Interview with the Dietary Manager on 01/25/22 at 12:37pm revealed:
-She did not know if Resident #2 was ordered

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nectar thickened liquids or not.
-She thought the family had taken Resident #2 off of nectar thickened liquids a couple of weeks ago.
-He was listed on the diet list has having an order for nectar thick liquids, but she did not follow that because it needed to be updated since the family did not want him on thickened liquids.
-She had been told by a medication aide (MA) that Resident #2's family did not want him to have nectar thickened liquids because he would not drink them and they wanted him to drink whatever he wanted with "what time he had left".
-Resident #2 was ordered nectar thickened liquids at one time due to esophagus issues.
-Resident #2 strangled when he drank because he drank too fast.
-The kitchen did not provide nectar thickened liquids for residents; they used to thicken liquids in the kitchen but none of the residents were ordered thickened liquids anymore.

Telephone interview with Resident #2's Power of Attorney (POA) on 01/26/22 at 10:24am revealed:
-Resident #2 was ordered a thickened liquid because he would cough when he drank thin liquids.
-The kitchen staff thickened beverages for Resident #2.
-Resident #2 had esophagus damage for years and was ordered the thickened liquids by his physician.
-The only way Resident #2 did not cough while drinking beverages was if they were thickened liquids.

Telephone interview with Resident #2's primary care provider (PCP) on 01/26/22 at 10:51am revealed:
-Resident #2 had esophagus disfunction and

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difficulty swallowing and was ordered nectar thickened liquids.
-Resident #2 did not care for the nectar thickened liquids; sometimes he would agree to drink the nectar thickened liquid and sometimes he would not.
-He was referred to hospice care around May 2021 due to his aspiration risk.

Refer to telephone interview with Resident #2's Hospice Nurse (RN) on 01/27/22 at 9:45am.

Refer to interview with the Administrator on 01/27/21 at 7:40am revealed:

_____

Telephone interview with Resident #2's hospice Registered Nurse (RN) on 01/27/22 at 9:45am revealed:
-Resident #2 was ordered a thickened liquid and pureed diet because he had dysphagia and was at risk for aspiration.
-The last order was signed on 10/09/21.
-The family did not have any concerns with Resident #2's current diet orders because they were aware of his swallowing issues and his dysphagia.
-She expected the facility to follow Resident #2's current diet orders.

Interview with the Administrator on 01/27/21 at 7:40am revealed:
-She expected diet orders to be followed 100 percent by the kitchen staff because they were like medication orders from a physician.
-She was concerned Resident #2 could choke on his food when he ate if he was not served a pureed meal at the correct consistency.
-She thought the family did not want Resident #2 to have thickened liquids because he did not like them; she did not know who had told her the

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D 310	Continued From page 22 family did not want him on thickened liquids. -She was concerned Resident #2 could strangle and aspirate when he drank his liquids if he was not served the nectar thickened liquid as ordered. -The facility was ultimately responsible for Resident #2's care.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#3) related to medications used to treat diabetes and gastroesophageal reflux disease (GERD). The findings are: Review of Resident #3's current FL-2 dated 08/04/21 revealed diagnoses included cognitive dysfunction, diabetes, and GERD.	D 344		

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D 344	Continued From page 23 a. Review of Resident #3's current FL-2 dated 08/04/21 revealed there was an order for Lantus (a long-acting insulin used to treat diabetes) inject 8 units subcutaneously (sc) every evening. Review of Resident #3's physician's orders dated 10/19/21 revealed there was an order for Lantus inject 8 units sc every evening at 8:00pm. Review of a consultant pharmacist recommendation to physician dated 08/11/21 revealed: -The consultant pharmacist recommended increasing Resident #3's Lantus dose to 10 units every day. -Resident #3's primary care provider (PCP) documented he had seen Resident #3 recently, reviewed his blood sugar logs, and increased Resident #3's Lantus. -The PCP's signature on the recommendation was dated 09/16/21. Review of Resident #3's after visit summaries from appointments with his PCP on 10/21/21, 11/16/21, 12/15/21, and 01/20/22 revealed: -There was a list of Resident #3's current medications. -The entry for Lantus was inject 8 units sc nightly. -There was documentation Resident #3 may have been taking the medication "differently." Review of Resident #3's PCP's progress note dated 12/15/21 revealed: -There was a list of Resident #3's current medications. -The entry for Lantus was inject 8 units sc nightly. -There was documentation Resident #3 was taking Lantus ". . . differently: Inject 10 Units under the skin nightly."	D 344		

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Review of Resident #3's November 2021-January 2022 electronic medication administration records (eMAR) revealed:
-There was an entry for Lantus inject 8 units every evening scheduled for administration at 8:00pm.
-There were instructions to discard and reorder the insulin 28 days after opening.
-There was documentation Lantus 8 units was administered at 8:00pm from 11/01/21-01/24/22.

Observation of Resident #3's medication available for administration on 01/27/22 at 10:30am revealed:
-There was a 300-unit Lantus insulin pen with a label instructing to inject 8 units sc every evening.
-The label had a handwritten date of 11/04/21.

Interview with Resident #3 on 01/26/22 at 3:40pm revealed he did not know the amount of Lantus insulin ordered by his PCP.

Telephone interview with a nurse from Resident #3's PCP's office on 01/28/22 at 2:39pm revealed:
-Resident #3's current Lantus order was 10 units at bedtime.

Attempted telephone interview with a pharmacist from the facility's contracted pharmacy on 01/27/22 at 7:27am was unsuccessful.

Refer to interview with the Resident Care Coordinator (RCC) on 01/27/22 at 3:48pm.

Refer to interview with the Administrator on 01/27/22 at 5:10pm.

b. Review of Resident #3's current FL-2 dated 08/04/21 revealed there was an order for

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omeprazole (used to treat gastroesophageal reflux disease [GERD]) 40mg daily.

Review of Resident #3's physician's orders dated 10/19/21 revealed there was an order for omeprazole 40mg daily.

Review of a consultant pharmacist recommendation to physician dated 08/11/21 revealed:
-The consultant pharmacist recommended changing the administration time for Resident #3's daily omeprazole from 8:00pm to 15-30 minutes before a meal.
-Resident #3's primary care provider (PCP) documented he had seen Resident #3 recently, Resident #3 needed to continue omeprazole due to longstanding GERD, and the facility may adjust the administration time.
-The PCP's signature on the recommendation was dated 09/16/21.

Review of Resident #3's November 2021-January 2022 electronic medication administration records (eMAR) revealed:
-There was an entry for omeprazole 40mg scheduled for administration at 8:00pm.
-There was documentation omeprazole 40mg was administered at 8:00pm from 11/01/21-01/24/22.

Observation of Resident #3's medication available for administration on 01/27/22 at 10:30am revealed omeprazole 40mg was available in pre-sorted multi-pack containers.

Interview with Resident #3 on 01/26/22 at 3:40pm revealed:
-He did not know the name of the medication he received for GERD.

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D 344	Continued From page 26 -He had not been experiencing any heartburn or indigestion. Interview with the Administrator on 01/27/22 at 5:10pm revealed the administration time of Resident #3's omeprazole should have been changed after the facility received the recommendation form from the PCP. Telephone interview with Resident #3's PCP on 01/28/22 at 2:41pm revealed he had no concerns about the administration time of Resident #3's omeprazole. Attempted telephone interview with a pharmacist from the facility's contracted pharmacy on 01/27/22 at 7:27am was unsuccessful. Refer to interview with the Resident Care Coordinator (RCC) on 01/27/22 at 3:48pm. Refer to interview with the Administrator on 01/27/22 at 5:10pm. _____ Interview with the RCC on 01/27/22 at 3:48pm revealed: -The consultant pharmacist sent the recommendation form to the PCP for review. -She did not know who sent the form to the facility after the PCP addressed the recommendation. -She thought the pharmacy was responsible for making the changes based on the PCP's response to the recommendation. -She did not know if anyone had followed-up on the PCP's response to the recommendations. -She was not employed at the facility in September 2021. -The PCP's response should have been clarified by someone from the facility.	D 344		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 27 Interview with the Administrator on 01/27/22 at 5:10pm revealed: -The pharmacy emailed the recommendation form to the facility and the facility faxed the form to the PCP. -The PCP returned the form to the facility via fax. -The Resident Care Coordinator was responsible for reviewing the PCP's response on the recommendation form and faxing it to the pharmacy.	D 344		
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, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 4 residents (#6) related to a medication used to treat the symptoms of dementia and a vitamin supplement during the 8:00am medication pass on 01/26/22 and 3 of 5 sampled residents (#2, #3, #5) for a record review related to medications used to treat constipation and acid indigestion (#2), two medications used to treat diabetes (#3), and two medications used to treat chronic obstructive pulmonary disease (COPD) (#5). The findings are:	D 358		

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The medication error rate was 5.2% as evidenced by the observation of 2 errors out of 38 opportunities during the 8:00am medication pass on 01/26/22.

1. Review of Resident #6's current FL-2 dated 06/23/21 revealed diagnoses included Alzheimer's disease, hypertension, gastro-esophageal reflux disease, environmental allergies, asthma, hypothyroidism, fall risk, edema of lower extremities, hyperlipidemia, and type 2 diabetes mellitus.

a. Review of Resident 6's current FL-2 dated 06/23/21 revealed there was a medication order for ascorbic acid (vitamin C) 500mg (used to treat low levels of vitamin C) one tablet daily.

Review of Resident #6's six-month physician orders dated 10/27/21 revealed there was a medication order for ascorbic acid 500mg one tablet daily.

Observation of the at 8:00am medication pass on 01/26/22 at 8:51am revealed:
-The medication aide (MA) prepared Resident #6 medications using medications on the medication cart.
-She placed one tablet of ascorbic acid 1000mg tablet into the medication cup from an over the counter bottle of ascorbic acid.
-The bottle of ascorbic acid 1000mg tablets was labeled with Resident #6's name.
-There was no date to indicate the day the bottle was opened.
-Resident #6 was administered her medications at a table in the dining room.
-Resident #6 was administered one ascorbic acid 1000mg tablet.

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D 358	Continued From page 29 Review of Resident #6's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for ascorbic acid (vitamin C) 500mg one tablet daily, scheduled for 8:00am. -There was documentation of administration of ascorbic acid 500mg from 01/01/22 to 01/26/22 at 8:00am. Telephone interview with a representative at the facility contracted pharmacy on 01/26/22 at 4:32pm revealed: -There was an active order dated 10/27/21 for ascorbic acid 500mg for Resident #6. -Ascorbic acid was not dispensed for Resident #6. -There was a note in the computer system that indicated ascorbic acid was provided by Resident #6's family number. Telephone interview with Resident #6's Nurse Practitioner on 01/27/22 at 8:52am revealed she had not written the original order for Resident #6's ascorbic acid, but she had signed Resident #6's six-month physician orders dated 10/27/21. Interview with a MA on 01/26/22 at 3:22pm revealed: -She administered medications to Resident #6 on 01/26/22 for the 8:00am medication pass. -She administered ascorbic acid 1000mg to Resident #6, which was not the dose indicated on Resident #6's eMAR. -She did not notice Resident #6's bottle of ascorbic acid had 1000mg tablets. Interview with the Resident Care Coordinator (RCC) on 01/27/22 at 2:25pm revealed: -She thought Resident #6's family member	D 358		

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delivered ascorbic acid and gave it to a MA who did not check the dose.
-Family members usually gave the medications they delivered to her and she checked the dosage of the medications prior to placing them on the medication cart.
-She did not know Resident #6 was administered the wrong dose of ascorbic acid, until 01/26/22.
-She expected the MAs to notify her when the wrong dose of medication was delivered.

Interview with the Administrator on 01/27/22 at 5:10pm revealed:
-She did not know Resident #6 was receiving the wrong dose of ascorbic acid.
-She expected the MAs to read the eMAR and compare to the medication container to ensure they were administering the correct dose.
-The MAs were responsible for administering medications as ordered.

Based on observations, record reviews, and interviews it was determined that Resident #6 was not interviewable.

Attempted telephone interview with Resident #6's family member on 01/27/22 at 8:20am was unsuccessful.

Refer to the interview with the RCC on 01/27/22 at 2:25pm.

Refer to the interview with the Administrator on 01/27/22 at 5:10pm.

b. Review of Resident 6's current FL-2 dated 06/23/21 revealed there was a medication order for memantine 10mg (used to treat moderate to severe confusion related to Alzheimer's disease) one tablet daily.

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D 358	Continued From page 31 Review of Resident #6's six-month physician orders dated 10/27/21 revealed there was a medication order for memantine 10mg one tablet daily. Observation of the at 8:00am medication pass on 01/26/22 at 8:51am revealed: -The medication aide (MA) prepared Resident #6 medications using medications on the medication cart. -The MA looked throughout the area of the medication cart where Resident #6's medications were stored. -She did not locate any memantine for Resident #6. -Resident #6 was administered her other medications at a table in the dining room. Interview with the MA on 01/26/22 at 8:50 am revealed: -She could not locate Resident #6's memantine. -She thought the family member provided memantine for Resident #6 and she would call the family member later in her shift. -She planned to tell the Resident Care Coordinator (RCC) about the memantine to determine what the RCC wanted to do about the medication. Review of Resident #6's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for memantine 10mg one tablet daily, scheduled for 8:00am. -There was documentation of administration of memantine 10mg from 01/01/22 to 01/25/22 at 8:00am. -There was documentation on 01/26/22 at 8:00am that memantine 10mg was not available	D 358		

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and the MA was notifying Resident #6's family member.

Telephone interview with a representative at the facility contracted pharmacy on 01/26/22 at 4:32pm revealed:
-There was an active order dated 08/04/21 for memantine 10mg daily for Resident #6.
-Seven tablets of memantine were dispensed once for Resident #6 on 08/04/21.
-There were notes in the computer system that the facility had memantine on hand to administer to Resident #6 when she was admitted.
-Staff at the facility were supposed to notify the pharmacy when Resident #6 had used the memantine and needed to begin the cycle fill for memantine.
-The reason the facility was sent memantine for Resident #6 on 08/04/21 was because a request was made for the medication.
-Resident #6's memantine did not continue to be sent because it was not placed on the weekly cycle fill.
-No staff from the facility had notified the pharmacy to request the medication after 08/04/21.

Telephone interview with Resident #6's Nurse Practitioner on 01/27/22 at 8:52am revealed:
-She had not received any notification from staff at the facility that Resident #6 did not have memantine available for administration.
-She was not able to provide the dose of memantine Resident #6 was supposed to have administered because she was traveling.
-Memantine was used to treat the symptoms of Alzheimer's disease.
-If a resident did not receive memantine as ordered, the resident might have an increase of symptoms of Alzheimer's disease.

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D 358	Continued From page 33 Interview with a MA on 01/26/22 at 3:20pm revealed: -She had not told the RCC about the unavailability of Resident #6's memantine. -She last saw memantine for Resident #6 on 01/25/22 and it was in a bottle. -She thought Resident #6's family member provided memantine for her. Observation of a blue bottle of medication for Resident #6 on the Administrator's desk on 01/27/22 at 7:30am revealed: -There was a labeled pill bottle containing 22 white memantine tablets. -The bottle of memantine was dispensed on 05/13/21 by another pharmacy. Interview with the RCC on 01/27/22 at 2:25pm revealed: -There was a bottle of memantine for Resident #6 located in a box in the medication room. -Resident #6 was admitted with medications and staff used these medications first before requesting refills from the facility contracted pharmacy. -She thought Resident #6's bottle of memantine was removed on 01/24/22 by the MAs who completed the medication cart audit. -Resident #6's bottle of memantine was removed because the label indicated twice daily administration and the instructions did not match Resident #6's current order. -She did not know Resident #6's bottle of memantine was removed from the medication cart until 01/26/22. -Resident #6's bottle of memantine should have lasted for 180 days from 05/2021 if taken daily. -She expected the MAs to notify her if there was a medication not available to administer and call	D 358		

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the pharmacy.
-The MAs were expected to document that a medication was unavailable and the reason.

Interview with the Administrator on 01/27/22 at 5:10pm revealed:
-She did not know before 01/26/22 that Resident #6's memantine was not available on the medication cart.
-She thought the MAs who did the cart audit on 01/24/22 removed Resident #6's bottle of memantine.
-She expected the MAs to call pharmacy and notify the RCC if there was a medication not available for administration.
-The RCC and MAs were responsible for ensuring medications were administered as ordered.

Based on observations, record reviews, and interviews it was determined that Resident #6 was not interviewable.

Attempted telephone interview with Resident #6's family member on 01/26/22 at 8:20am was unsuccessful.

Refer to the interview with the RCC on 01/27/22 at 2:25pm.

Refer to the interview with the Administrator on 01/27/22 at 5:10pm.

2. Review of Resident #2's current FL-2 dated 02/11/21 revealed diagnoses included depression, congestive heart failure, atrial fibrillation, benign prostatic hyperplasia, hypertension, and stage 3 kidney disease.

a. Review of Resident #2's current FL-2 dated

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D 358	Continued From page 35 02/11/21 revealed there was a medication order for magnesium oxide 400mg (used to treat symptoms of too much stomach acid) one tablet twice daily. Review of Resident #2's physician orders dated 03/23/21 revealed there was a medication order for magnesium oxide 500mg twice daily. Review of Resident #2's six-month physician orders dated 10/27/21 revealed there was a medication order for magnesium oxide 500mg one tablet twice daily. Review of Resident #2's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for magnesium oxide 500mg twice daily, scheduled for 9:00am and 9:00pm. -There was documentation of administration of magnesium oxide 500mg from 11/01/21 to 11/30/21 at 9:00am and 9:00pm. Review of Resident #2's December 2021 eMAR revealed: -There was an entry for magnesium oxide 500mg twice daily with "family supplies" in parentheses, scheduled for 9:00am and 9:00pm. -There was documentation of administration of magnesium oxide 500mg from 12/01/21 to 12/31/21 at 9:00am and 9:00pm. Review of Resident #2's January 2022 eMAR revealed: -There was an entry for magnesium oxide 500mg twice daily with "family supplies" in parentheses, scheduled for 9:00am and 9:00pm. -There was documentation of administration of magnesium oxide 500mg from 01/01/22 to 01/25/22 at 9:00am and 9:00pm.	D 358		

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D 358	Continued From page 36 Observation of Resident #2's medications on hand on 01/26/22 at 4:11pm revealed there was no magnesium oxide available for administration. Telephone interview with Resident #2's family member on 01/27/22 at 8:24am revealed: -Resident #2 resided at the facility for the past 3 years. -He provided all over the counter (OTC) medications for Resident #2. -He received emails, phone calls, or text messages from the medication aides (MA), Resident Care Coordinator (RCC) or Administrator notifying him Resident #2 needed a certain medication. -The RCC or MAs were supposed to notify him before Resident #2 ran out of medications. -When notified in this manner, he had time to obtain and deliver the medications. -He last provided medications for Resident #2 before Christmas near Thanksgiving 2021. -He could not recall how many bottles of medication that he purchased. -No one had contacted him recently to supply OTC medications for Resident #2. Telephone interview with a representative at the facility contracted pharmacy on 01/26/22 at 4:32pm revealed: -Resident #2 had an active order dated 10/27/21 for magnesium oxide 500mg twice daily. -Magnesium oxide had never been dispensed for Resident #2. -There was documentation that Resident #2's family member supplied magnesium oxide for him. Telephone interview with Resident #2's Nurse Practitioner (NP) on 01/27/22 at 8:52am revealed:	D 358		

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-She thought hospice had ordered magnesium oxide for Resident #2.
-Staff had not told her that Resident #2 did not have magnesium oxide available for administration.

Interview with a MA on 01/27/22 at 10:26am revealed:
-When she administered medications and a medication was not available to administer, she notified the RCC.
-If the RCC had not received the medication, she documented that the medication was not available.
-After documenting the medication was not available, she reordered the medication.
-When a resident had a medication that was supplied by their family member, the MAs or the RCC notified them that more medication was needed.
-She thought she notified Resident #2's family member near the end of 2021, but she did not know the exact date.
-She requested that he bring more magnesium oxide for Resident #2.
-She did not document that she had notified Resident #2's family member to make the request.
-She thought Resident #2 had a small OTC container of magnesium oxide.
-She did not know Resident #2 did not have any magnesium oxide to administer.
-She had not contacted Resident #2's family member recently to request medications.
-The MAs were responsible for administering medications accurately.

Interview with the RCC on 01/27/22 at 2:25pm revealed:
-She did not know Resident #2 did not have any

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magnesium oxide tablets available for administration.
-She expected staff to not document administration of Resident #2's magnesium oxide if it was not available for administration.
-She expected the MAs to notify the family member if more medication was needed for a resident.
-She had not contacted Resident #2's family member recently to request medications.

Interview with the Administrator on 01/27/22 at 5:10pm revealed:
-She expected the MAs to document unavailable if there was a medication not available for administration.
-The MAs should call the pharmacy if there was a medication unavailable for administration.
-If the medication was reordered, she expected the MAs to write a note on the board in the medication room to make other MAs aware.
-If the family provided the medication, either the RCC or the MAs should notify the family member that more medication was needed.
-She did not know Resident #2 did not have any magnesium oxide available to administer.

Based on observations, record reviews, and interviews it was determined that Resident #2 was not interviewable.

Refer to the interview with the RCC on 01/27/22 at 2:25pm.

Refer to the interview with the Administrator on 01/27/22 at 5:10pm.

b. Review of Resident #2's six-month physician orders dated 10/27/21 revealed there was a medication order for Miralax 17 grams (used to

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treat occasional constipation) daily.

Review of Resident #2's November 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax 17 grams mix one capful to the indicated line in 4-8 ounces of fluid and take daily, scheduled for 9:00am.
- There was documentation of administration of Miralax from 11/01/21 to 11/30/21 at 9:00am.

Review of Resident #2's December 2021 eMAR revealed:
-There was an entry for Miralax 17 grams mix one capful to the indicated line in 4-8 ounces of fluid and take daily, scheduled for 9:00am.
- There was documentation of administration of Miralax from 12/01/21 to 12/31/21 at 9:00am.

Review of Resident #2's January 2022 eMAR revealed:
-There was an entry for Miralax 17 grams mix one capful to the indicated line in 4-8 ounces of fluid and take daily with "family supplies" in parentheses, scheduled for 9:00am.
- There was documentation of administration of Miralax from 01/01/22 to 01/25/22 at 9:00am.

Observation of Resident #2's medications on hand on 01/26/22 at 4:11pm revealed there was an empty Miralax container that was dispensed on 02/23/21.

Telephone interview with Resident #2's family member on 01/27/22 at 8:24am revealed:
-He did not recall the number of Miralax bottles he purchased for Resident #2.
-He thought he last provided Miralax for Resident #2 near Thanksgiving 2021.
-No one from the facility had contacted him

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recently concerning over the counter (OTC) medications for Resident #2.

Telephone interview with a representative at the facility contracted pharmacy on 01/26/22 at 4:32pm revealed:
-Resident #2 had an active order dated 10/27/21 for Miralax in the computer system.
-There was a note on Resident #2's computer profile indicating his family provided Miralax for him.

Telephone interview with Resident #2's Nurse Practitioner (NP) on 01/27/22 at 8:52am revealed Resident #2 had Miralax ordered for constipation.

Interview with a medication aide (MA) on 01/27/22 at 10:26am revealed:
-She did not know how long one container of Miralax would last if administered daily.
-She did not know Resident #2's Miralax container was empty.
-She had not notified Resident #2's family member to provide more Miralax.
-The MAs were not supposed to document administration of medications that were not administered.

Interview with the Resident Care Coordinator (RCC) on 01/27/22 at 2:25pm revealed:
-She did not know Resident #2 had an empty container of Miralax that was dispensed on 02/23/21.
-She did not know how long a container of Miralax would last if administered daily.
-She expected the MAs to notify a resident's family member or her if more medication was needed.
-She would notify family members via phone or text to make them aware more medication was

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needed.
-She had not contacted Resident #2's family member to request more Miralax.

Interview with the Administrator on 01/27/22 at 5:10pm revealed:
-She did not know Resident #2 had an empty container of Miralax on the medication cart.
-She expected the MAs to notify the family members or notify the RCC if more medication was needed.

Based on observations, record reviews, and interviews it was determined that Resident #2 was not interviewable.

Refer to the interview with the RCC on 01/27/22 at 2:25pm.

Refer to the interview with the Administrator on 01/27/22 at 5:10pm.
3. Review of Resident #3's current FL-2 dated 08/04/21 revealed diagnoses included cognitive dysfunction and diabetes.

a. Review of Resident #3's current FL-2 dated 08/04/21 revealed:
-There was an order for fingerstick blood sugar (FSBS) checks four times a day.
-There was an order for insulin aspart (a rapid-acting insulin used to treat diabetes) inject 8 units subcutaneously (sc) before lunch and dinner; hold if blood sugar is less than 150.

Review of Resident #3's physician's orders dated 10/19/21 revealed there was an order for insulin aspart inject 10 units sc before lunch and dinner; hold if blood sugar is less than 150.

Review of Resident #3's November 2021

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electronic medication administration record (eMAR) revealed:
-There was an entry for FSBS checks scheduled at 6:00am, 12:00pm, 5:00pm, and 8:00pm.
-There was an entry for insulin aspart inject 10 units sc 30 minutes before lunch and dinner (hold if blood sugar is less than 150).
-The frequency was listed as three times a day and insulin aspart was scheduled for administration at 8:00am, 12:00pm, and 5:00pm.
-There was documentation insulin aspart 10 units had been administered at 8:00am from 11/01/21-11/30/21, including one incident when Resident #3's blood sugar was 97.
-There was documentation insulin aspart 10 units had been administered at 12:00pm from 11/01/21-11/30/21, including four incidents when Resident #3's blood sugar ranged from 95-149.
-There was documentation insulin aspart 10 units had been administered at 5:00pm from 11/01/21-11/30/21, including seven incidents when Resident #3's blood sugar ranged from 109-144.

Review of Resident #3's December 2021 eMAR revealed:
-There was an entry for FSBS checks scheduled at 6:00am, 12:00pm, 5:00pm, and 8:00pm.
-There was an entry for insulin aspart inject 10 units sc 30 minutes before lunch and dinner (hold if blood sugar is less than 150).
-The frequency was listed as three times a day and insulin aspart was scheduled for administration at 8:00am, 12:00pm, and 5:00pm.
-There was documentation insulin aspart 10 units had been administered at 8:00am from 12/01/21-12/31/21, including 16 incidents when Resident #3's blood sugar ranged from 97-149.
-There was documentation insulin aspart 10 units had been administered at 12:00pm from

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12/01/21-12/31/21, including five incidents when Resident #3's blood sugar ranged from 74-138.
-There was documentation insulin aspart 10 units had been administered at 5:00pm from 12/01/21-12/31/21, including three incidents when Resident #3's blood sugar ranged from 95-148.

Review of Resident #3's January 2022 eMAR revealed:
-There was an entry for FSBS checks scheduled at 6:00am, 12:00pm, 5:00pm, and 8:00pm.
-There was an entry for insulin aspart inject 10 units sc 30 minutes before lunch and dinner (hold if blood sugar is less than 150).
-The frequency was listed as three times a day and insulin aspart was scheduled for administration at 8:00am, 12:00pm, and 5:00pm.
-There was documentation insulin aspart 10 units had been administered at 8:00am from 01/01/22-01/25/22, including ten incidents when Resident #3's blood sugar ranged from 132-149.
-There was documentation insulin aspart 10 units had been administered at 12:00pm from 01/01/22-01/24/22, including three incidents when Resident #3's blood sugar ranged from 139-144.
-There was documentation insulin aspart 10 units had been administered at 5:00pm from 01/01/22-01/24/22, including five incidents when Resident #3's blood sugar ranged from 83-127.

Observation of Resident #3's medications available for administration on 01/27/22 at 10:30am revealed there was a 300-unit insulin aspart pen with a handwritten label indicating the pen had been put into use on 01/25/22.

Interview with a first shift medication aide (MA) on 01/27/22 at 10:30am revealed:
-She did not know why the eMAR documentation indicated Resident #3's insulin was administered

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if it was supposed to be held based upon the results of the FSBS checks.
-She may have documented administering insulin aspart even if she did not administer it if she was distracted by a resident or something else when she was completing the eMAR documentation.
-She paid attention to the results of Resident #3's FSBS checks.
-The medication administration software indicated which residents were supposed to receive medication during each medication pass.
-She administered the medication as prompted by the software.
-She did not check her eMAR documentation at the end of the medication pass or at the end of the shift to make sure the documentation was accurate.
-The Resident Care Coordinator (RCC) was responsible for clarifying medication orders and checking the eMARs.
-She asked the RCC whenever she needed guidance about medications.
-She had not spoken with Resident #3's primary care provider (PCP) about the resident's medication orders.

Interview with Resident #3 on 01/27/22 at 11:48am revealed:
-He did not remember with certainty, but he thought he had received insulin before breakfast on the morning of 01/27/22.
-He did not know his insulin schedule.

Interview with another first shift MA on 01/27/22 at 2:37pm revealed:
-Resident #3had FSBS checks before meals.
-Resident #3 had orders to receive insulin before breakfast and lunch.
-She was usually good about documenting if Resident #3's insulin was not administered based

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on the FSBS checks results.
-She was "pretty sure" she was documenting "due to condition" if Resident #3's insulin was not administered because the eMAR had a record of the FSBS results.
-She noticed the discrepancy between the frequency and the instructions for administration of Resident #3's insulin aspart on the eMAR but had not talked with anyone about it.
-The RCC had not talked with her about Resident #3's insulin aspart administration.
-She did not know why there was no documentation of the times she did not administer insulin aspart to Resident #3.

Interview with a second shift MA on 01/27/22 at 3:23pm revealed:
-She knew Resident #3 was not to receive insulin aspart before dinner if the result of his FSBS check was less than 150.
-She clicked on "not given" and documented a reason for not administering Resident #3's insulin aspart if she did not administer it.
-She was not responsible for reviewing the eMARs.
-The RCC had never asked her about anything on the eMARs other than times she had administered medication late.
-She was not assigned medication cart audits, but she would perform a cart audit weekly.
-She did not know why there were no exception notes documented for the times she did not administer Resident #3's insulin aspart.
-Resident #3 did not receive insulin aspart when his FSBS result was below 150.
-The MAs might not have paid attention when they were documenting on the eMAR.

Interview with the RCC on 01/27/22 at 3:48pm revealed she had not noticed the discrepancy

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between the frequency and the instructions on the eMAR for Resident #3's insulin aspart.

Interview with the Administrator on 01/27/22 at 5:10pm revealed the discrepancy between the frequency and the instructions for administration of Resident #3's insulin aspart should have been caught on 10/19/21 when the order was verified in the eMAR system.

Telephone interview with a nurse at Resident #3's PCP's office on 01/28/22 at 2:39pm revealed the frequency of Resident #3's insulin aspart order was twice a day before lunch and dinner.

Telephone interview with Resident #3's PCP on 01/28/22 at 2:41pm revealed:
-He was pleased with Resident #3's most recent A1C level (a blood test indicating blood sugar control over the past three months).
-Resident #3's A1C level was 6.3% in December of 2021.

Attempted interview with a representative at the facility's contracted pharmacy on 01/27/22 at 7:27am was unsuccessful.

Refer to interview with the RCC on 01/27/22 at 2:25pm.

Refer to interview with the Administrator on 01/27/22 at 5:10pm.

b. Review of Resident #3's current FL-2 dated 08/04/21 revealed there was an order for Lantus (a long-acting insulin used to treat diabetes) inject 8 units subcutaneously (sc) every evening.

Review of Resident #3's primary care provider's (PCP) orders dated 10/19/21 revealed there was

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an order for Lantus inject 8 units sc every evening at 8:00pm.

Review of Resident #3's November 2021-January 2022 electronic medication administration records (eMAR) revealed:
-There was an entry for Lantus inject 8 units every evening scheduled for administration at 8:00pm.
-There were instructions to discard and reorder the insulin 28 days after opening.
-There was documentation Lantus 8 units was administered at 8:00pm from 11/01/21-01/24/22.

Observation of Resident #3's medication available for administration on 01/27/22 at 10:30am revealed:
-There was a 300-unit Lantus insulin pen with a label instructing to inject 8 units sc every evening.
-The label had a handwritten date of 11/04/21.

Interview with a first shift medication aide (MA) on 01/27/22 at 10:30am revealed:
-The handwritten date on the insulin label indicated the date the insulin pen was put into use.
-The insulin pen should have been disposed of after 30 days.
-She was not responsible for administering Lantus to Resident #3.
-The Resident Care Coordinator (RCC) or the second shift MA should have removed the out of date insulin from the medication cart.

Interview with a second shift MA on 01/27/22 at 3:23pm revealed:
-She administered Lantus to Resident #3 within the past week.
-She did not prime the insulin pen before administering the insulin to Resident #3.

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-She did not notice the date on the insulin label.
-She was not sure if there was any insulin remaining in the insulin pen.
-She did not know if Resident #3 was receiving any insulin at 8:00pm each evening if the insulin pen had been in use since 11/04/21.
-She did not know who was responsible for medication cart audits.

Interview with the RCC on 01/27/22 at 3:48pm revealed:
-Insulin was supposed to be disposed of within 28 days of opening.
-There were signs about medication expiration dates posted in the medication room.
-Two units of insulin were used for priming the insulin pen.
-Resident #3 was not getting any insulin out of the insulin pen that was on the medication cart.
-She was not sure if Resident #3 had any more Lantus available for administration.
-She did not know if the pharmacy automatically dispensed Resident #3's Lantus or if the Lantus needed to be requested by the facility.
-She should have noticed the insulin was out of date and disposed of it.

Interview with the Administrator on 01/27/22 at 5:10pm revealed:
-Insulin was supposed to be discarded 30 days after opening or by the expiration date.
-Resident #3's Lantus pen should not have been on the cart; it should have been in the trash.

Telephone interview with Resident #3's PCP on 01/28/22 at 2:41pm revealed he questioned whether Resident #3 was "even getting insulin" if the Lantus insulin pen was out of date.

Attempted telephone interview with a pharmacist

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from the facility's contracted pharmacy on 01/27/22 at 7:27am was unsuccessful.

Refer to interview with the RCC on 01/27/22 at 2:25pm.

Refer to interview with the Administrator on 01/27/22 at 5:10pm.

4. Review of Resident #5's current FL-2 dated 02/11/21 revealed diagnoses included Alzheimer's disease, dementia, and chronic obstructive pulmonary disease (COPD).

a. Review of Resident #5's current FL-2 dated 02/11/21 revealed an order for Spiriva (used to prevent bronchospasm caused by COPD) handheld inhaler 18 micrograms (mcg) inhale one capsule with two separate inhalations at night.

Review of Resident #5's signed physician's orders dated 10/27/21 revealed an order for Spiriva with handheld inhaler 18mcg, inhale one capsule with two separate inhalations at night.

Review of Resident #5's electronic medication administration record (eMAR) for November 2021 revealed:
-There was an entry for Spiriva with handheld inhaler 18mcg, inhale one capsule with two separate inhalations scheduled at 8:00pm.
-Spiriva was documented as administered 30 of 30 opportunities for November 2021.

Review of Resident #5's eMAR for December 2021 revealed:
-There was an entry for Spiriva with handheld inhaler 18mcg, inhale one capsule with two separate inhalations scheduled at 8:00pm.
-Spiriva was documented as administered 31 of

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D 358	Continued From page 50 31 opportunities for December 2021. Review of Resident #5's eMAR for January 2022 revealed: -There was an entry for Spiriva with handheld inhaler 18mcg, inhale one capsule with two separate inhalations scheduled at 8:00pm. -Spiriva was documented as administered 26 of 26 opportunities for January 2022. Observation of Resident #5's medications on hand on 01/26/22 at 3:30pm revealed: -Spiriva was dispensed on 11/23/21; 30 tablets were dispensed. -There were 22 tablets available for administration. Telephone interview with a representative at the facility contracted pharmacy on 01/26/22 at 3:49pm revealed: -There was an active order dated 02/11/21 for Spiriva with handheld inhaler 18 mcg, inhale one capsule with two separate inhalations nightly for Resident #5. -30 capsules of Spiriva 18mcg were dispensed on 10/03/21; a 30-day supply was dispensed. -30 capsules of Spiriva 18mcg were dispensed on 11/23/21; a 30-day supply was dispensed. -Spiriva 18mcg was not on a cycle fill and had to be ordered by the facility when needed. -Spiriva was used to treat COPD; an outcome of not administering Spiriva as ordered would be worsening of symptoms. Telephone interview with a medication aide (MA) on 01/27/22 at 12:01pm revealed: -She administered Resident #5 her medication at night. -Resident #5 had refused her medication in the past but it had been awhile, and she did not	D 358		

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refuse it often.
-She made sure Resident #5 inhaled her Spiriva when she administered it.
-She could not explain why there were still 22 capsules available for administering.

Telephone interview with Resident #5's primary care provider on 01/27/22 at 9:00am revealed:
-Resident #5 was ordered Spiriva for her COPD.
-Resident #5's COPD could become exacerbated if she was not administered the Spiriva as ordered.
-She expected the facility to follow medication orders.

Interview with the Resident Care Coordinator (RCC) on 01/27/22 at 3:13pm revealed:
-Inhalers expired 30 days after opening; if they were used correctly then they should run out before the 30 days after opening.
-If Resident #5 had 22 Spiriva capsules left after 30 days it was because it was not administered to her.
-Resident #5 had trouble inhaling but the capsules would have been used in an attempt to administer her the Spiriva.

Interview with the Administrator on 01/27/22 at 5:47pm revealed:
-She knew from the number of Spiriva capsules that were available that Resident #5 had not been administered her medication as ordered.
-Inhalers were not on a cycle fill and should have run out and been reordered before January 2022.
-The MAs knew not to document on the eMAR unless they had administered the medication.

Refer to the interview with the RCC on 01/27/22 at 2:25pm

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Refer to the interview with the Administrator on 01/27/22 at 5:10pm.

b. Review of Resident #5's current FL-2 dated 02/11/21 revealed an order for Symbicort inhaler (used to treat chronic obstructive pulmonary disease (COPD)) 80-4.5mcg, inhale two puffs twice daily.

Review of Resident #5's signed physician's orders dated 10/27/21 revealed an order for Symbicort inhaler 80-4.5mcg, inhale two puffs twice daily.

Review of Resident #5's electronic medication administration record (eMAR) for November 2021 revealed:
-There was an entry for Symbicort inhaler 80-4.5mcg, inhale two puffs twice daily scheduled at 8:00am and 8:00pm.
-Symbicort was documented as administered 30 of 30 opportunities for November 2021.

Review of Resident #5's eMAR for December 2021 revealed:
-There was an entry for Symbicort inhaler 80-4.5mcg, inhale two puffs twice daily scheduled at 8:00am and 8:00pm.
-Symbicort was documented as administered 31 of 31 opportunities for December 2021.

Review of Resident #5's eMAR for January 2022 revealed:
-There was an entry for Symbicort inhaler 80-4.5mcg, inhale two puffs twice daily scheduled at 8:00am and 8:00pm.
-Symbicort was documented as administered 26 of 26 opportunities for January 2022.

Observation of Resident #5's medications on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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hand on 01/26/22 at 3:30pm revealed:
-Symbicort was dispensed on 11/08/21.
-The counter indicated there were 105 doses available for administration.

Telephone interview with a representative at the facility contracted pharmacy on 01/26/22 at 3:49pm revealed:
-There was an active order dated 02/11/21 for Symbicort inhaler 80-4.5mcg, inhale two puffs twice daily for Resident #5.
-A 30-day supply of Symbicort 80-4.5mcg was dispensed on 07/12/21; 120 doses were dispensed.
-A 30-day supply of Symbicort 80-4.5mcg was dispensed on 11/08/21; 120 doses were dispensed.
-Resident #5's Symbicort 80-4.5mcg was not on a cycle fill and had to be ordered by the facility when needed.
-Symbicort 80-4.5mcg was used to treat COPD; an outcome of not administering Symbicort as ordered would be worsening of symptoms.

Interview with a medication aide (MA) on 01/27/22 at 11:00am revealed:
-Resident #5 did not always inhale her Symbicort; she pressed Resident #5's inhalers for her because she was not strong enough to press them herself.
-She administered Resident #5 her medications including her inhalers as ordered.
-She watched the counter on the Symbicort inhaler and reordered a replacement from the pharmacy when the counter was low.
-She could not explain why there were 105 doses available on the counter.
-She administered Resident #5's medication as ordered; she could not say what other MAs did.

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Telephone interview with a MA on 01/27/22 at 12:01pm revealed:
-She administered Resident #5 her medication in the morning and at night.
-Resident #5 had refused her medication in the past but it had been awhile, and she did not refuse it often.
-She made sure Resident #5 inhaled her Symbicort when she administered it.
-She did not pay attention to the counter on the inhaler when she administered the Symbicort to Resident #5.

Telephone interview with Resident #5's primary care provider on 01/27/22 at 9:00am revealed:
-Resident #5 was ordered Symbicort for her COPD.
-Resident #5's COPD could become exacerbated if she was not administered the Symbicort as ordered.
-She expected the facility to follow medication orders.

Interview with the Resident Care Coordinator (RCC) on 01/27/22 at 3:13pm revealed:
-Inhalers expired 30 days after opening; if they were used correctly then they should run out before the 30 days after opening.
-Resident #5's Symbicort should not have had a count of 105 doses left if it was dispensed in November 2021.
-The MAs were trained to look at the counter as they administered inhalers.
-She did not think Resident #5 was administered her inhaler as ordered due to the counter on the inhaler.

Interview with the Administrator on 01/27/22 at 5:47pm revealed:
-She knew from the number on the Symbicort

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D 358	Continued From page 55 counter that Resident #5 had not been administered her medication as ordered. -Inhalers were not on a cycle fill and the Symbicort should have run out and been reordered before January 2022. -The MAs knew not to document on the eMAR unless they had administered the medication. Refer to the interview with the RCC on 01/27/22 at 2:25pm Refer to the interview with the Administrator on 01/27/22 at 5:10pm. _____ Interview with the RCC on 01/27/22 at 2:25pm revealed: -She became the full-time RCC in October 2021. -Medication orders were sent to the pharmacy via electronic prescription from the physician, the NP, or via fax. -The pharmacy placed the medication orders into the eMAR system and she verified the medication orders once the medication was delivered. -When she verified a medication, she checked the name of the medication, dose, and time in the eMAR sytem, and allergies. -Once verified, she took the medication to the MAs to lock in the medication cart. -Over the counter medications were provided by the family members. -When residents were admitted, they might bring medications with them. -MAs used these medications first before the facility contracted pharmacy began dispensing medications for the resident. -She thought that this saved money for the residents and family members. -The facility received instructions to begin conducting medication cart audits and a form was provided.	D 358		

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D 358	Continued From page 56 -She had asked two MAs to complete the first medication cart audit on 01/24/22. -She was not able to locate the results of the medication cart audit forms from 01/24/22. -During the medication cart audit, the MAs were supposed to remove expired medications, any medications that did not match the ordered dose, and anything that was not listed on the orders. -The removed medications were placed in an expired medication box. -She expected the MAs to notify her if there was a medication dose that did not match the ordered dose. -She expected the MAs to notify the pharmacy and check the medication order. -She did not expect the MAs to document administration of an inaccurate dose of medication or a medication that was not available. -She and the MAs were responsible for administering medications as ordered. Interview with the Administrator on 01/27/22 at 5:10pm revealed: -Every order ultimately went through the RCC's hands. -The RCC was responsible for verifying medication orders in the electronic record. -She expected medications to be administered as ordered. -She expected the MAs to follow the MAR and verify the MAR matched the medication that was being administered. -She held the MAs responsible for medication administration. -Weekly cart audits began last week. -The entire cart was supposed to be audited. -The MAs on second and third shift were responsible for most of the cart audits. -Documentation of the administration of a	D 358		

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D 358	Continued From page 57 medication that was not given was falsification of records.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication aides were not pre-charting the administration of medication for 1 of 5 sampled residents (#3) related to the application of topical creams. The findings are: Review of Resident #3's current FL-2 dated 08/04/21 revealed diagnoses included cognitive dysfunction. a. Review of Resident #3's physician's orders dated 10/19/21 revealed there was an order for triamcinolone acetonide cream (Kenalog) (used to treat skin conditions) 0.1% apply to affected area daily. Review of Resident #3's electronic medication administration record (eMAR) for November 2021 revealed:	D 366		

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D 366	Continued From page 58 -There was an entry for Kenalog cream 0.1% apply topically to the affected area(s) daily scheduled for administration at 8:00am. -There was documentation Kenalog had been administered at 8:00am for 30 of 30 opportunities. Review of Resident #3's eMAR for December 2021 revealed: -There was an entry for Kenalog cream 0.1% apply topically to the affected area(s) daily scheduled for administration at 8:00am. -There was documentation Kenalog had been administered at 8:00am for 31 of 31 opportunities. Review of Resident #3's eMAR for January 2022 revealed: -There was an entry for Kenalog cream 0.1% apply topically to the affected area(s) daily scheduled for administration at 8:00am. -There was documentation Kenalog had been administered at 8:00am for 25 of 25 opportunities. Observation of Resident #3's medication available for administration on 01/27/22 at 10:30am revealed: -There were multiple creams with Resident #3's name on them. -There was one partially used 15-gram tube of Kenalog in a plastic bag. -The label on the plastic bag indicated the pharmacy had dispensed the Kenalog on 09/09/21. Review of Resident #3's eMAR for 01/27/22 revealed there was documentation Kenalog cream had been applied on 01/27/22 at 8:00am.	D 366		

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D 366	Continued From page 59 Interview with the first shift medication aide (MA) on 01/27/22 at 10:30am revealed she documented she had applied the Kenalog cream on Resident #3, but she had not actually done so. Refer to interview with the first shift MA on 01/27/22 at 10:30am. Refer to interview with the Resident Care Coordinator (RCC) on 01/27/22 at 3:48pm. Refer to interview with the Administrator on 01/27/22 at 5:10pm. Refer to interview with Resident #3's primary care provider (PCP) on 01/28/22 at 2:41pm. b. Review of Resident #3's primary care provder's (PCP) progress note dated 12/15/21 revealed: -There was a medication list. -Cetaphil cream (a moisturizer) was on the list with instructions to apply topically daily to all extremities. Review of Resident #3's eMAR for December 2021 revealed: -There was an entry for Cetaphil moisturizer cream apply topically to all extremities daily scheduled for administration at 8:00am. -There was documentation Cetaphil had been administered at 8:00am from 12/18/21-12/31/21. Review of Resident #3's eMAR for January 2022 revealed: -There was an entry for Cetaphil moisturizer cream apply topically to all extremities daily scheduled for administration at 8:00am. -There was documentation Cetaphil had been administered at 8:00am for 25 of 25 opportunities.	D 366		

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D 366	Continued From page 60 Observation of Resident #3's medication available for administration on 01/27/22 at 10:30am revealed: -There was one unused 16-ounce container of Cetaphil moisturizer. -The label on the container indicated the Cetaphil moisturizer was dispensed by the pharmacy on 12/16/21. Review of Resident #3's eMAR for 01/27/22 revealed there was documentation Cetaphil moisturizer had been applied on 01/27/22 at 8:00am. Interview with the first shift medication aide (MA) on 01/27/22 at 10:30am revealed she documented she had applied the Cetaphil moisturizer on Resident #3, but she had not actually done so. Refer to interview with the first shift MA on 01/27/22 at 10:30am. Refer to interview with the Resident Care Coordinator (RCC) on 01/27/22 at 3:48pm. Refer to interview with the Administrator on 01/27/22 at 5:10pm. Refer to interview with Resident #3's primary care provider (PCP) on 01/28/22 at 2:41pm. _____ Interview with the first shift MA on 01/27/22 at 10:30am revealed: -The hospice nurse applied Resident #3's creams sometimes. -The hospice nurse did not visit Resident #3 every day. -She did not want to interrupt Resident #3's	D 366		

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D 366	Continued From page 61 breakfast to apply cream on him. -She either wrote herself a note if she needed to apply cream to Resident #3 or she left the cream out as a reminder to apply it at a later time. -She had not applied any cream on Resident #3 during the morning medication pass. Interview with the Resident Care Coordinator (RCC) on 01/27/22 at 3:48pm revealed: -Creams were "a problem to get done." -She did not know how to help the MAs with getting creams applied on the residents. -If the MA would have asked for help applying a cream, she would have helped the MA. -If it was a "medication," she would feel different about it. Interview with the Administrator on 01/27/22 at 5:15pm revealed it was falsification of records to document the administration of a medication if it was not given. Interview with Resident #3's primary care provider (PCP) on 01/28/22 at 2:41pm revealed: -He did not know what the facility was doing related to the unused moisturizer. -Resident #3's skin appeared to be improving when he saw the resident last week.	D 366		
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	D 367		

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D 367	Continued From page 62 administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the accuracy of medication administration records for 1 of 5 sampled residents (#3) related to a medication used to treat diabetes. The findings are: Review of Resident #3's current FL-2 dated 08/04/21 revealed: -Diagnoses included cognitive dysfunction and diabetes. -There was an order for insulin aspart (a rapid-acting insulin used to treat diabetes) inject 8 units subcutaneously (sc) 30 mins before lunch and dinner; hold if blood sugar is less than 150. Review of Resident #3's subsequent physician orders dated 10/19/21 revealed there was an order for insulin aspart inject 10 units sc 30 mins before lunch and dinner; hold if blood sugar is less than 150.	D 367		

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Review of Resident #3's November 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for insulin aspart inject 10 units sc 30 minutes before lunch and dinner (hold if blood sugar is less than 150).
-The frequency was listed as three times a day and insulin aspart was scheduled for administration at 8:00am, 12:00pm, and 5:00pm.
-There was documentation insulin aspart 10 units had been administered at 8:00am, 12:00pm, and 5:00pm from 11/01/21-11/30/21.

Review of Resident #3's December 2021 eMAR revealed:
-There was an entry for insulin aspart inject 10 units sc 30 minutes before lunch and dinner (hold if blood sugar is less than 150).
-The frequency was listed as three times a day and insulin aspart was scheduled for administration at 8:00am, 12:00pm, and 5:00pm.
-There was documentation insulin aspart 10 units had been administered at 8:00am, 12:00pm, and 5:00pm from 12/01/21-12/31/21.

Review of Resident #3's January 2022 (eMAR) revealed:
-There was an entry for insulin aspart inject 10 units sc 30 minutes before lunch and dinner (hold if blood sugar is less than 150).
-The frequency was listed as three times a day and insulin aspart was scheduled for administration at 8:00am, 12:00pm, and 5:00pm.
-There was documentation insulin aspart 10 units had been administered at 8:00am, 12:00pm, and 5:00pm from 01/01/22-01/24/22.
-There was documentation insulin aspart 10 units had been administered at 8:00am on 01/25/22.

Observation of Resident #3's medications in the

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facility on 01/27/22 at 10:30am revealed there was a 300-unit insulin aspart pen with a label indicating the pen had been put into use on 01/25/22.

Attempted telephone interview with a representative from the facility's contracted pharmacy on 01/27/22 at 7:27am was unsuccessful.

Interview with Resident #3 on 01/27/22 at 11:48am revealed he did not know his insulin schedule.

Interview with a first shift medication aide (MA) on 01/26/22 at 3:10pm revealed:
-The medication administration software indicated which residents were supposed to receive medication during each medication pass.
-Pictures of the residents with medications to be administered would show up on the computer screen.
-If a resident's picture appeared on the screen, she administered the indicated medication.
-She administered Resident #3's medication as prompted by the computer system.
-The Resident Care Coordinator (RCC) was responsible for the accuracy of the eMARs.

Interview with the RCC on 01/27/22 at 3:48pm revealed:
-The pharmacy was responsible for creating the eMARs.
-She routinely sent orders to the pharmacy and went by "what the pharmacy prints."
-She emailed or faxed orders to the pharmacy.
-She approved the order on the eMAR after the medication was delivered to the facility.
-She sent the orders to the primary care provider (PCP) to review every six months.

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D 367	Continued From page 65 -She reviewed the eMARs when it was time for a new FL-2, when the six-month order review was due, and before a resident went to an off-site medical appointment. -She reviewed the eMARs daily to see if there were medications that were not administered or were administered late. -She had not noticed the discrepancy between the frequency and the instructions on the eMAR for Resident #3's insulin aspart. Interview with the Administrator on 01/27/22 at 5:10pm revealed: -She did not know how often the eMARs were reviewed for accuracy. -The discrepancy between the frequency and the instructions for administration of Resident #3's insulin aspart should have been caught on 10/19/21 when the order was verified in the eMAR system.	D 367		