STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SOMERSET COURT AT UNIVERSITY PLACE	1635 EAST 5TH STREET WINSTON SALEM, NC 27101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey on 12/01/21 and 12/02/21.	{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 1 of 5 sampled residents (#4) related to not informing a resident's physician when weights were unable to be obtained because the scale was broken. The findings are: Review of Resident #4's current FL2 dated 11/15/21 revealed: -Diagnoses included congestive heart failure, morbid obesity, hypertension, hyperlipidemia, anxiety and depression. -There was an order for daily weights at 7am and contact the physician if there was greater than a 5-pound weight gain in 24 hours. Interview with Resident #4 on 12/01/21 at 9:43am revealed: -Her legs were wrapped twice weekly by home health because she had lymphedema. -She took medication to help the swelling. -The swelling was controlled right now, and her legs were not weeping when home health changed the wraps on Monday. Interview with Resident #4 on 12/01/21 at 3:20pm	{D 273}		

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{D 273}	Continued From page 1 revealed: -The facility scale broke on 11/23/21 and the staff knew it was broken. -She thought the scale only needed a battery. -She went to the spa room each day and obtained her weight but that had not occurred since the scale broke. Review of Resident #4's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for daily weights. -There was documentation that a daily weight was not taken from 11/23/21 through 11/30/21 because the scale was broken. -There was no documentation the physician was informed of the broken scale or that the weight was unable to be taken. Review of Resident #4's December 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for daily weights. -There was documentation that a daily weight was not taken on 12/01/21 but no reason was given why it was not taken. -There was no documentation the physician was informed of the broken scale or that the weight was able to be taken. Interview with the Administrator on 12/01/21 at 3:30pm revealed: -She was told on 11/30/21 that the scale needed new batteries, so she purchased them and put them in the maintenance employee's office. -She was not aware daily weights had not been taken on Resident #4 since 11/23/21. -She thought the physician had been informed that weights had not been taken since that is what the order instructs.	{D 273}		

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{D 273}	Continued From page 2 Interview with the Resident Care Coordinator (RCC) on 12/01/21 at 3:47pm revealed: -Resident #4 had weights taken daily on the scale in the spa room or on a scale that was in another resident's room. -The spa scale was broken so she assumed weights were being taken on the other scale. -If she had known weights were not being taken, she would have informed the physician. Telephone interview with Resident #4's physician on 12/02/21 at 12:57pm revealed: -Resident #4 had an order for daily weights due to cardiomyopathy (deterioration of the heart muscle) which causes fluid overload. -Monitoring Resident #4's daily weight was one parameter she used to monitor the fluid overload. -She expected staff to inform her of the broken scale that prevented daily weights from being obtained. -If Resident #4 started gaining too much weight she would need a medication prescribed to reduce the fluid associated with cardiomyopathy.	{D 273}		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by:	D 358		

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D 358	Continued From page 3 Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered to 1 of 5 sampled residents (#4) related to a medication used to treat depression, a medication used to control heart rhythms and a medication to maintain gut health. The findings are: Review of the facility's Medication Policy revealed: -When a medication provided in a multi-dose pack was discontinued a change or discontinue sticker was placed beside the medication name. -When time to administer medication from the multi-dose pack the MA and a witness will identify the discontinued medication and remove it from the multi-dose pack and document using the destruction form. -The facility received a cycle fill preview report monthly from the pharmacy. -The care coordinator reviewed and noted any changes, discharges and returns to the pharmacy. -The facility ensured that residents always had all current orders in the facility. -The facility developed a schedule so that all resident's medication orders were checked on a weekly basis by completing a cart audit. -Staff checked to see that all medications were available using a copy of the physician order. Review of Resident #4's current FL2 dated 11/15/21 revealed diagnoses included congestive heart failure, morbid obesity, hypertension, hyperlipidemia, anxiety and depression. a. Review of Resident #4's record revealed there was an order dated 11/15/21 to increase doxepin	D 358		

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D 358	Continued From page 4 (to treat depression) from 75mg to100mg daily at bedtime. Review of Resident #4's November 2021electronic Medication Administration Record (eMAR) revealed: -There was an electronic entry for doxepin 75mg at bedtime. -There was documentation doxepin 75mg was administered daily from 11/01/21-11/30/21. -There was an electronic entry for doxepin 100mg at bedtime. -Doxepin 75mg and doxepin 100mg were both documented as administered 11/16/21-11/23/21 and 11/26/21-11/30/21. -There was documentation doxepin 100mg was not administered on 11/24/21 because they were waiting on verification. -There was documentation doxepin 100mg was not administered on 11/25/21 but a reason was not documented. Observation of Resident #4's medications available for administration on 12/01/21 at 1:48pm revealed: -There were 7 Doxepin 100mg available for administration. -The Doxepin 100mg were packaged in multi-dose packaging on 11/27/21 and delivered to the facility with a start date of 12/02/21. Interview with the Resident Care Coordinator (RCC) on 12/01/21 at 2:04pm revealed: -Doxepin 75mg was increased to 100mg a few weeks ago. -She did not think Resident #4 received Doxepin 75mg after it was increased to 100mg because she thought the pharmacy stopped sending the Doxepin 75mg capsules. -Medication cart audits were conducted weekly	D 358		

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D 358	Continued From page 5 and the dose change should have been documented on the multi-dose package. Telephone interview with the facility's contract pharmacy on 12/01/21 at 2:51pm revealed: -On 11/15/21 the pharmacy received a faxed order from Resident #4's Primary Care Provider (PCP) for Doxepin to be increased from 75mg to 100mg at bedtime. -The facility received medications weekly in multi-dose packs. -The pharmacy had already filled and dispensed the multi-dose pack containing the doxepin 75mg to start Thursday 11/18/21, so they dispensed 7 doxepine 100mg capsules in a separate bubble pack. -The doxepin 100mg were dispensed in the weekly multi-dose packs from then on. Interview with the Administrator on 12/02/21 at 9:47am revealed: -She expected MAs to read the MAR and administer medications properly. -She was not aware both doxepin 75mg and 100mg were documented as administered after the dose was increased to 100mg. Telephone interview with Resident #4's Primary Care Provider (PCP) on 12/02/21 at 12:57pm revealed: -Resident #4's doxepin dose was increased from 75mg to 100mg for depression. -The maximum dose of doxepin was 150mg per day and if she received 175mg per day for 7 days as the eMAR indicated she could experience hypertension, edema, tachycardia, increased sleepiness or become weak and lethargic. -Doxepin was a medication that if consumed in excessive amounts could cause fatal arrythmias or other serious effects.	D 358		

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D 358	Continued From page 6 -She was very concerned that Resident #4 received 175mg of doxepin for 7 days. Refer to telephone interview with a representative from the facility's contract pharmacy on 12/01/21 at 2:51pm. Refer to Interview with the Administrator on 12/02/21 at 9:47am. Refer to Interview with the facility's regional nurse on 12/02/21 at 9:55am. Refer to Interview with the RCC on 12/02/21 at 10:25am. b. Review of Resident #4's record revealed there was an FL2 dated 11/15/21 with an order for amiodarone 100mg daily. Review of Resident #4's November 2021electronic Medication Administration Record (eMAR) revealed: -There was an entry for amiodarone 100mg daily (used to regulate heart rhythms). -There was documentation amiodarone 100mg was administered for 28 of 30 opportunities. -There was documentation amiodarone 100mg was not administered on 11/04/21 and 11/07/21but a reason was not documented. Review of Resident #4's December 2021eMAR revealed: -There was an entry for amiodarone 100mg daily. -There was documentation amiodarone 100mg was administered for 1 of 1 opportunity. Observation of medication available for administration on 12/01/21 at 1:48pm revealed there was no amiodarone 100mg available for	D 358		

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D 358	Continued From page 7 administration. Review of the pharmacy refill order forms dated 10/12/21, 10/16/21 and 11/07/21 revealed amiodarone 100mg was documented as one of the medications the facility needed to have refilled. Interview with a Medication Aide (MA) on 12/01/21 at 1:48pm revealed the MA who was on the cart was responsible for reordering a medication if they noticed it was getting low. Telephone interview with a representative from the facility's contract pharmacy on 12/02/21 at 8:49am revealed: -The last FL2 sent to the pharmacy was dated 06/18/21. -The pharmacy never received a physician's order update along with an FL2 dated 11/15/21. -They received an order for a 30-day supply of amiodarone 100mg from a hospital discharge in September 2021. -Seven amiodarone 100mg were dispensed on 09/17/21, 09/24/21, 10/01/21 and 10/08/21. -The pharmacy requested a refill prescription from the facility but never received one. Interview with the Resident Care Coordinator (RCC) on 12/02/21 at 9:10am revealed: -The MAR documented administration so the amiodarone had to have been available for administration. -Amiodarone 100mg was not available now because a MA discovered it on the weekly medication cart audit on 12/01/21 and placed on the pharmacy refill order, but it did not come in today (12/02/21) because it was spelled incorrectly. -She thought amiodarone was an active order	D 358		

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D 358	Continued From page 8	D 358		

and she did not know why it was not coming in the multi-dose packs.
-She did not know the pharmacy had requested a refill order.

Interview with the Administrator on 12/02/21 at 9:47am revealed:
-She did not know why the amiodarone 100mg was included on the pharmacy refill 3 times and not investigated.
-She did not know Resident #4's amiodarone was not being administered.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 12/02/21 at 12:57pm revealed:
-Resident #4 received amiodarone to prevent arrythmias and not taking it could cause Resident #4 to have atrial fibrillation.
-She was not contacted by the pharmacy for a refill prescription.

Refer to telephone interview with a representative from the facility's contract pharmacy on 12/01/21 at 2:51pm.

Refer to Interview with the Administrator on 12/02/21 at 9:47am.

Refer to Interview with the facility's regional nurse on 12/02/21 at 9:55am.

Refer to Interview with the RCC on 12/02/21 at 10:25am.

c. Review of Resident #4's record revealed there was an FL2 dated 11/15/21 with an order for a probiotic formula, 1 billion cell-250mg daily at 8:00am (to maintain gut health).

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Review of Resident #4's November 2021electronic Medication Administration Record (eMAR) revealed:
-There was an entry for probiotic formula, 1 billion cell-250mg daily at 8:00am.
-There was documentation probiotic formula, 1 billion cell-250mg daily at 8:00am was administered 29 of 30 opportunities.
-There was documentation probiotic formula, 1 billion cell-250mg daily at 8:00am was not administered on 11/04/21.

Review of Resident #4's December 2021 eMAR revealed:
-There was an entry for probiotic formula, 1 billion cell-250mg daily at 8:00am.
-There was documentation probiotic formula, 1 billion cell-250mg daily at 8:00am was administered 1 of 1 opportunity.

Observation of medication available for administration on 12/01/21 at 1:48pm revealed probiotic formula, 1 billion cell-250mg was not available for administration.

Review of the pharmacy refill order forms dated 10/12/21, 10/16/21 and 11/07/21 revealed the probiotic was not documented as one of the medications the facility needed to have refilled.

Interview with a Medication Aide on 12/01/21 at 1:48pm revealed the probiotic was not available for administration because the last dose was administered, a refill was submitted to the pharmacy and they were awaiting on the delivery.

Telephone interview with a representative from the facility's contract pharmacy on 12/02/21 at 8:49am revealed:
-The last FL2 sent to the pharmacy was dated

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D 358	Continued From page 10 06/18/21. -The pharmacy never received a physician's order update along with an FL2 dated 11/15/21. -The pharmacy last dispensed an emergency supply of 23 probiotics in August 2021 because they were waiting on a refill order which they never received from the facility. -The probiotics were dispensed 7 per week in multi-dose packs. Interview with the Resident Care Coordinator (RCC) on 12/02/21 at 9:10am revealed: -Resident #4's probiotic was an active order. -If there was no probiotic available to administer it was probably scheduled to be delivered from pharmacy today (12/02/21) because it was documented as administered on 12/01/21 on the MAR. -She did not remember receiving a refill request from the pharmacy. Interview with the Administrator on 12/02/21 at 9:47am revealed she was unaware Resident #4's probiotic was not being administered. Refer to Telephone interview with a representative from the facility's contract pharmacy on 12/01/21 at 2:51pm. Refer to Interview with the Administrator on 12/02/21 at 9:47am. Refer to Interview with the facility's regional nurse on 12/02/21 at 9:55am. Refer to Interview with the RCC on 12/02/21 at 10:25am. _____ Telephone interview with a representative from the facility's contract pharmacy on 12/01/21 at	D 358		

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D 358	Continued From page 11 2:51pm revealed: -The facility's medications were delivered each Wednesday in multi-dose packs. Interview with the Administrator on 12/02/21 at 9:47am revealed: -She did not know why Resident #4's FL2 dated 11/15/21 was not faxed to the pharmacy. -She expected the MA to administer medications as ordered. -Medication cart audits were conducted weekly after medications were delivered from the pharmacy. -The RCC and the lead Medication Aide (MA) were responsible for conducting the medication cart audits. -When medication cart audits were conducted the medications were confirmed with a matching order and any missing medications were requested from the pharmacy. -Any MA could contact the pharmacy for a medication that needed to be refilled. -If a medication was not administered the MA wrote the reason on the eMAR. -The RCC did not provide her with the cart audit paperwork but told her they were being completed. Interview with the facility's regional nurse on 12/02/21 at 9:55am revealed medication cart audits were assigned to a MA and the paperwork was given to the RCC who was responsible for ordering any missing medications and fix any problems found. Interview with the RCC on 12/02/21 at 10:25am revealed: -The computer alerted the MA when a medication was scheduled to be administered. -Once a medication was administered, the MA	D 358		

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D 358	Continued From page 12 documented on the e-MAR. -The MA who was working on Wednesday mornings was responsible for conducting the medication cart audit. -The MA cross referenced the medications and compared them to the physician's orders. -If a medication was missing, the MAs were responsible for completing an order request and refill form and sending it to the pharmacy. -The lead MA was responsible for reviewing the medication cart audit paperwork. -The pharmacy called the facility if they needed clarifications or order renewals. -Any pharmacy requests needing a physician signature were placed in the Primary Care Providers facility mailbox. -She did not know why the pharmacy did not have a copy of Resident #4's FL2 dated 11/15/21. -She thought she electronically scanned the FL2 to the pharmacy but could not locate a confirmation.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration;	D 367		

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D 367	Continued From page 13 (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the accuracy of the electronic Medication Administration Record (eMAR) for 1 of 5 sampled residents (Resident #4). Review of Resident #4's current FL2 dated 11/15/21 revealed: -Diagnoses included congestive heart failure, morbid obesity, hypertension, hyperlipidemia, anxiety and depression. -There was an order to increase doxepin (used to treat depression) from 75mg to100mg daily at bedtime. -There was an order for amiodarone (used to maintain heart rhythm) 100mg daily. -There was an order for a probiotic formula, (used to maintain gut health) 1 billion-250 cell/mg daily at 8:00am. -There was an order for furosemide (used to remove excess fluids) 80mg daily. Review of Resident #4's November 2021 eMAR revealed: -There was an electronic entry for doxepin 75mg at bedtime. -There was documentation doxepin 75mg was administered daily from 11/01/21 through 11/30/21. -There was an electronic entry for doxepin 100mg	D 367		

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	HAL034100	A. BUILDING: _____ B. WING _____	R 12/02/2021

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D 367	Continued From page 14 at bedtime. -There was documentation doxepin 100mg was administered 11/16/21 through 11/23/21 and 11/26/21 through 11/30/21. -There was an entry for amiodarone 100mg daily. -There was documentation amiodarone 100mg was administered for 28 of 30 opportunities. -There was an entry for probiotic formula, 1 billion-250 cell/mg daily at 8:00am. -There was documentation probiotic formula, 1 billion cells-250mg daily at 8:00am was administered 29 of 30 opportunities. -There was an electronic entry for furosemide 80mg daily with a start date of 09/01/21 and a stop date of 12/01/21. -There was documentation furosemide 80mg daily was administered 11/1/21 through 11/03/21 and 11/05/21. -There was an electronic entry for furosemide 80mg daily at 8am with a start date of 11/15/21 and no stop date. -There was documentation furosemide 80mg at 8am was administered on 11/18/21, 11/21/21, 11/22/21, 11/23/21, 11/25/21, 11/26/21 and 11/30/21. -There was an electronic entry for furosemide 80mg twice a day with a start date of 11/09/21 and no stop date. -There was documentation furosemide 80mg twice a day was administered from 11/09/21 through 11/30/21. Review of Resident #4's December 2021 eMAR revealed: -There was an electronic entry for doxepin 75mg at bedtime. -There was documentation doxepin 75mg was administered 12/01/21. -There was an entry for amiodarone 100mg daily. -There was documentation amiodarone 100mg	D 367		

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D 367	Continued From page 15	D 367		

was administered 12/01/21.
-There was an entry for a probiotic formula, 1 billion cells-250mg daily at 8:00am.
-There was documentation probiotic formula, 1 billion cells-250mg daily at 8:00am was administered 12/01/21.
-There was an electronic entry for furosemide 80mg daily at 8am with a start date of 11/15/21 and no stop date.
-There was documentation furosemide 80mg at 8am was administered 12/01/21.
-There was an electronic entry for furosemide 80mg twice a day with a start date of 11/09/21 and no stop date.
-There was documentation furosemide 80mg twice a day was administered at 8am on 12/01/21.

Observation of medication available for administration on 12/01/21 at 1:48pm revealed:
-Doxepin 75mg was not available for administration.
-Amiodarone 100mg was not available for administration.
-A probiotic formula, 1 billion-250250 cell/mg was not available for administration.
-Furosemide 80mg once daily was available for administration.

Review of the pharmacy refill order forms dated 10/12/21, 10/16/21 and 11/07/21 revealed:
-Amiodarone 100mg was documented as one of the medications the facility needed to have refilled.
-The probiotic was not documented as one of the medications the facility needed to have refilled.

Telephone interview with a representative from the facility's contract pharmacy on 12/01/21 at 2:51pm and 12/02/21 at 8:49am revealed:

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D 367	Continued From page 16 -The most recent FL2 they had on file was dated 06/18/21. -The pharmacy never received a physician's order update along with an FL2 dated 11/15/21. -The pharmacy received a fax order from Resident #4's Primary Care Provider (PCP) on 11/15/21 for Doxepin to be increased from 75mg to 100mg at bedtime. -The pharmacy had already filled the multi-dose pack to start Thursday 11/18/21, so they dispensed 7 capsules in a separate bubble pack. -The doxepin 100mg were dispensed in the multi-dose packs from then on. -They received an order for a 30-day supply of amiodarone 100mg from a hospital discharge in September 2021. -Seven amiodarone 100mg were dispensed on 09/17/21, 09/24/21, 10/01/21 and 10/08/21. -The pharmacy requested a refill prescription for amiodarone from the facility but never received one. -The pharmacy last dispensed an emergency supply of 23 probiotics in August 2021 because they were waiting on a refill order which they never received from the facility. -The pharmacy never received an order for furosemide 80mg twice a day. -The only furosemide order on file was for once daily. Interview with a Medication Aide (MA) on 12/07/21 at 1:48pm. -She was not sure why the furosemide 80mg twice a day was on the MAR if it was not documented that way on the multi dose pack. -The last probiotic was administered yesterday so it was reordered, and they were awaiting delivery from the pharmacy. Interview with the Resident Care Coordinator	D 367		

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D 367	Continued From page 17 (RCC) on 12/01/21 at 2:04pm and 12/02/21 at 9:10am revealed: -The doxepin 75mg was documented as being administered in error because she knew the doxepin 75mg was no longer delivered from the pharmacy after the doxepin 100mg was ordered. -She did not know why a MA would document administration of doxepin, amiodarone, a probiotic or furosemide if the medication was not available. Interview with the RCC on 12/02/21 at 10:25am revealed: -She did not know why the pharmacy did not have a copy of Resident #4's FL2 dated 11/15/21. -She thought she electronically scanned the FL2 to the pharmacy. -The computer alerted the MA when a medication was scheduled to be administered. -Once a medication was administered, the MA documented on the e-MAR. -The MA who was working on Wednesday morning was responsible for conducting the medication cart audit. -The MA matched the medications on the eMAR and the medications available for administration to the physician's orders. -If a medication was missing, they were responsible for completing an order request and sending it to the pharmacy. -The lead MA was responsible for reviewing the medication cart audit paperwork and confirming the pharmacy refill request forms were completed and faxed. -Medications needing to be refilled were sent to the pharmacy using an electronic scan. Interview with the Administrator on 12/02/21 at 9:47am revealed: -She did not know why Resident #4's FL2 dated	D 367		

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D 367	Continued From page 18 11/15/21 was not faxed to the pharmacy. -She expected the MA to document on the eMAR correctly. -Medication cart audits were conducted weekly and the errors should have been caught at that time.	D 367		