Received via email on 06/21/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034098	A. BUILDING: _____ B. WING _____	R 05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 05/05/22 to 05/06/22.	{D 000}		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 of 5 sampled residents (#5) with a diagnosis of dementia and a history of behaviors including paranoia, agitation and anxiety. The findings are: Review of Resident #5's current FL2 dated 01/24/22 revealed: -Diagnoses included dementia and anxiety disorder. -Resident #5 was intermittently disoriented and was a wanderer. Review of Resident #5's mental health provider's (MHP) psychiatry progress note dated 03/09/22 revealed: -Resident #5 had a history of behaviors including paranoia and agitation and staff reported no changes. -Resident #5 had a history of anxiety, had a scheduled anti-anxiety medication, and an as needed anti-anxiety medication, and there were	{D 270}	Per facility policy any change in behavior should result in increased supervision (by placing resident(s) on 15 minute checks for 72 hours). Once a behavior/altercation/incident has been identified: PCA/CNA: Should immediately defuse situation, remove resident(s), increase supervision (by placing resident(s) on 15 min checks) for 72 hours. MA: Assess resident(s) i.e., ensure no injury to resident(s)/ vital signs will be obtained, complete behavior/incident report, gather statements, contact family/POA, contact physician/psych. RC: Gathers information and sends to county caseworker Admin: Reviews all documentation to ensure all policies were followed.	5·12·22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 6/21/22

Reviewed and Acknowledged Keisha Banks 06/24/22

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{D 270}	Continued From page 1 no changes recommended. Review of Resident #5's MHP's psychiatry progress note dated 04/06/22 revealed: -Resident #5 had a scheduled psychotropic medication prescribed for a history of behaviors including paranoia and agitation. -Resident #5 had a history of anxiety, had a scheduled anti-anxiety medication, and an as needed anti-anxiety medication. Review of the Resident #5's progress notes for April 2022 revealed: -There was no documentation of an incident on 04/26/22. -On 04/27/22, the Special Care Unit Coordinator (SCUC) documented Resident #5 was in an altercation with a resident, was redirected by staff, and then went down the 400 hall in the Special Care Unit (SCU) and started another verbal altercation with another resident. -Resident #5 was redirected again and then went to her room; she rested for the rest of the evening. -There was no documentation of any interventions nor increase in supervision. Review of Resident #5's Behavioral Incident Report dated 04/26/22 at 5:15pm revealed: -Resident #5 was involved in an incident that involved verbal and physical aggression on 04/26/22. -Resident #5 was arguing with two other residents and then decided to get physical with both residents. -A second shift staff member was present before or during the incident. Review of Resident #5's record revealed there was no documentation of interventions put in	{D 270}	Resident #5: Was assessed by psych doctor and facility followed psych recommendation. Facility will initiate shift change report for ALL staff i.e., PCA/CNA and MA to minimize miscommunication. Change shift report will include two hours round sign-off for all staff members providing care.	

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{D 270}	Continued From page 2 place by the facility nor any increase in supervision for Resident #5 after the incident on 04/26/22. Attempted telephone interview with the second shift staff member on 05/06/22 at 2:02pm was unsuccessful. The medication aide (MA) who completed the report on 04/26/22 was no longer employed at the facility. Observation of the SCU on 05/05/22 at 3:27pm revealed: -Resident #5 was standing inside the doorway of the family room in the SCU and there was a personal care aide (PCA) standing near her. -Resident #5 held her arm straight out to the side as residents entered the family room to try to block them from entering. -The PCA told Resident #5 she could not block residents from entering and asked her to put her arm down. -A resident entered the family room and Resident #5 had her arm out in attempt to block her from entering. -As the resident entered the family room, she pushed Resident #5's arm out of her way and Resident #5 hit the resident twice on her back. Interview with the PCA on 05/05/22 at 3:58pm revealed: -Resident #5 was physically aggressive with residents almost every other day. -He reported Resident #5 being physically aggressive with residents to the MA who worked on his shift, but he was not told to do anything differently for Resident #5. -He observed Resident #5 hit another resident today, but it was nothing compared to Resident	{D 270}		

Reviewed and Acknowledged 06/24/22

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{D 270}	Continued From page 3 #5's physical altercation with two other residents on 04/26/22. -The PCA was unable to complete the interview due to him needing to assist residents. Review of Resident #5's record revealed there was no documentation of interventions put in place by the facility nor any increase in supervision for Resident #5 after the incident on 05/05/22. Review of the SCU residents' 15-minute check logs revealed there were no 15-minute check logs for Resident #5. Interview with a PCA on 05/06/22 at 9:08am revealed: -Resident #5 just started having behaviors within the last 2 to 3 weeks. -She had been getting agitated easily. -She did not think Resident #5 was currently on 15-minute checks or had been on 15-minute checks due to her behaviors. Interview with a MA on 05/06/22 at 9:16am revealed: -She had not see Resident #5 be physically aggressive with other residents a lot. -Usually if she was agitated, she would go to her room and lay down. -She was not working when the incident occurred on 04/26/22, but whoever completed the behavior report for Resident #5 on that date should have also placed her on 15-minute checks for behaviors. -She did not know whether or not Resident #5 had been placed on 15-minute checks. Interview with a PCA on 05/06/22 at 9:24am revealed:	{D 270}		

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{D 270}	Continued From page 4 -She only knew of 1 physical altercation Resident #5 had with two other residents, but she did not know the details of the altercation. -She did not know if Resident #5 was put on 15-minute checks after the altercation with the two residents. Interview with the SCUC on 05/06/22 at 9:34am revealed: -She was not made aware of the incident that took place on 04/26/22 with Resident #5 and two other residents until a couple days later. -She had no further details than what was in the behavior report and the MA who wrote the report no longer worked at the facility. -After she became aware of the altercation with Resident #5 and the two other residents, she did not contact Resident #5's MHP. -The standard protocol was to place residents on a 15-minute checks for 72 hours for behaviors and falls. -Resident #5 was not placed on 15-minute checks after the physical altercation on 04/26/22. -The MA on duty on 04/26/22 should have started Resident #5 on 15-minute checks immediately after the incident occurred for 72 hours. -No one reported Resident #5 hitting another resident on yesterday on 05/05/22. -If she had known Resident #5 hit another resident on 05/05/22, she would have given Resident #5 an as needed medication for agitation if available, sent Resident #5 out to the hospital, followed up with Resident #5's MHP, and placed her on 15-minute checks. Interview with the Administrator on 05/06/22 at 12:54pm revealed: -She knew about the physical altercation between Resident #5 and two other residents on 04/26/22, but she did not know about Resident #5 hitting	{D 270}		

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{D 270}	Continued From page 5 another resident on 05/05/22. -She thought Resident #5 was placed on 15-minute checks after the incident on 04/26/22. -Anytime there was an incident between residents, the resident was automatically placed on 15-minute checks for 72 hours to monitor more closely. -She would have expected staff to contact Resident #5's mental health provider to see if there were any recommendations to redirect Resident #5 or any needs for changes in Resident #5's medications.	{D 270}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute healthcare needs for 2 of 5 sampled residents (#3, #5) related to a resident who had loosened leg wraps and whose toenails needed to be trimmed (#3) and a resident who had a diagnosis of dementia, a history of behaviors, and was in physical altercations with other residents (#5). The findings are:	{D 273}	Leg Wraps- Facility will implement round sheet (Q2hr) for PCA/CNA. MA will review at end of shift. If wraps are not intact as ordered the following steps will be made: 1- Home Health will be notified immediately. 2- MA will call/notify facility RN for proper placement, if HH is not available then immediately. 3- RN notifies RC. 4- RC communicates with Administrator. TED hose- Facility will contact the pharmacy to update the eMar to reflect that TED hose will be placed on and removed off as ordered.	5/9/22 5/9/22

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{D 273}	Continued From page 6 1. Review of Resident #3's current FL2 dated 09/21/21 revealed diagnoses included dementia, coronary artery disease, hyperlipidemia, and hypertension. a. Review of Resident #3's primary care provider's (PCP) encounter note dated 04/20/22 revealed: -The PCP saw Resident #3 on 04/20/22 at the request of facility staff for the evaluation and management of diagnoses including lymphedema (swelling in the arms or legs caused by a blockage in the lymphatic). -Resident #3 had a history of lymphedema, but he had been noncompliant with compression therapy. -Resident #3 was not willing to try compression wraps followed by thromboembolic deterrent (TED) hose. Review of a physician's order dated 04/20/22 revealed there was an order for home health skilled nursing for an unna boot (a compression bandage applied to the lower legs to treat venous insufficiencies) or wraps for 3 weeks then, before discontinuing wraps, measure for and apply TED hose on in the morning and off at bedtime. Observation of Resident #3 on 05/05/22 at 8:22am revealed: -Resident #3 had wraps on both lower extremities from his feet to mid-calf. -There was bunching that extended from below the ankle to the top of the wraps causing the wraps to have the appearance of slouch socks. -Resident #3 had swelling in both legs, but his right leg was more swollen than his left leg. Interview with Resident #3 on 05/05/22 at 8:26am reveled:	{D 273}	Toenails- Podiatry appointments are currently being utilized by outside services until a contract with Doctor's Making Housecalls is obtained. Facility will update current shower sheet to ensure all areas of the resident(s) body are being addressed. PCA/CNA will complete shower sheet on shower days. MA will review shower sheet prior to shift change and complete weekly skin review sheets and will communicate with RC of any concerns. If concerns arise the RC will schedule the appropriate appointment and communicate with Administrator if meads cannot be met. Regarding Resident #3 Home Health was notified and leg wraps were changed to TED hose. Appointment with outside podiatry was schedule for Resident #5. If any additional medical attention is needed. Provider will be notified by facility MA/RCC.	5/12/22

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{D 273}	Continued From page 7 -He had the wraps on his legs for a week or so due to swelling in his legs. -A nurse from outside of the facility came to wrap his legs. A second interview with Resident #3 on 05/05/22 at 11:37am revealed: -The nurse came to the facility to wrap his legs twice and each time the wraps fell down as he walked. -The nurse wrapped his legs tight, but not too tight. -He did not touch or move the wraps himself. -He had not told anyone at the facility his wraps had loosened, and no staff had looked at the wraps. Interview with a medication aide (MA) on 05/05/22 at 8:50am revealed: -She did not think Resident #3 had wraps on his legs and no one from home health came to the facility to wrap his legs. -She thought Resident #3 may have had wraps on his legs in the past, but not currently. Interview with a clinical coordinator from Resident #3's home health agency on 05/05/22 at 11:02am revealed: -Resident #3 was admitted to services due to the need for changing and removing nonsurgical dressing for edema on lower extremities. -There was an order dated 04/20/22 for home health skilled nursing service to provide unna boots or wraps for Resident #3 for 3 weeks then measure for TED hose. -Home health services started on 04/25/22 with a frequency of twice a week. -Resident #3's legs were wrapped on 04/25/22 and on 05/03/22 with the next visit scheduled for 05/07/22.	{D 273}	Per facility policy any change in behavior should result in increased supervision. Once a behavior/altercation has been identified Resident(s) involved will immediately be place on 15-minute checks by PCA/CNA. MA will document and inform RC. RC will review with the facility RN within 48 hours. Facility RN reviews all documents with physician/psych. RN will inform Administrator and a plan of correction will be put in place. Resident # 5 Was assessed by psych doctor and facility followed psych recommendation. Ongoing Inservice/Re-education for all staff regarding behaviors/altercations/incidents are to be held at monthly staff meeting by RN/Administration.	

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{D 273}	Continued From page 8 -On 04/25/22, Resident #3 had 2+ pitting edema on his bilateral extremities and positive petal pulse. -On 05/03/22, Resident #3's edema had improved to trace edema for his left lower extremity and 1+ for his right lower extremity. -The goal was for the wrap to be fitting on Resident #3's legs and not loose. -There was no documentation the facility called to notify the home health agency Resident #3's wraps were sagging on his legs. -If the facility had contacted home health, a nurse would have come back to rewrap his legs. -It was a standard practice for the home health nurse to discuss with facility staff that they could contact the home health agency 24/7 with any issues. Interview with a personal care aide (PCA) on 05/05/22 at 11:30am revealed: -She was not sure why Resident #3 had wraps on his legs. -Resident #3 did not need assistance with bathing or dressing so she had not checked or noticed any issues with his wraps. -If she had noticed issues with Resident #3's wraps, she would have told the MA on duty. Interview with a second PCA on 05/05/22 at 11:34am revealed: -She was working when the nurse from the home health agency came to wrap Resident #3's legs. -She has not seen Resident #3's leg wraps since the wraps were placed by the home health nurse. Interview with the Special Care Unit Coordinator (SCUC) on 05/05/22 at 3:42pm revealed: -She did not know Resident #3 had wraps on both of his legs. -Resident #3's leg wraps should not have been	{D 273}		

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{D 273}	Continued From page 9 bunched up around his legs. -The MA was responsible for notifying home health if there were issues with Resident #3's leg wraps. Interview with a second MA on 05/05/22 at 4:18pm revealed: -She did not know Resident #3 had wraps on his legs. -Resident #3 was independent with bathing and dressing, but PCAs should have checked Resident #3's skin, including wraps, on his bath days. -If there was a problem with Resident #3's wraps, the PCA should have documented it on the skin assessment form and told a MA. -The MAs were to report any issues with Resident #3's wraps to the SCUC who would contact the home health agency. Telephone interview with Resident #3's primary care physician (PCP) on 05/06/22 at 11:18am revealed: -He wrote an order for home health to wrap Resident #3's legs due to edema. -The goal was to get Resident #3's legs small enough so that he could wear TED hose. -He would have expected the facility to contact the home health agency if Resident #3's TED hose were sagging. Interview with the Administrator on 05/06/22 at 12:54pm revealed: -She did not know Resident #3 had leg wraps or that they were sagging. -She expected staff to assess Resident #3's leg wraps daily to ensure they were still in place. -If there were any issues with Resident #3's leg wraps, she expected staff to follow up with Resident #3's home health agency.	{D 273}		

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{D 273}	Continued From page 10 b. Review of Resident #3's shower/bath sheet for March, April, and May 2022 revealed: -There were shower sheets dated 03/02/22, 03/07/22, 03/14/22, 03/16/22, 03/21/22, 03/25/22, and 03/30/22; there was no documentation regarding Resident #3's toenails. -There were shower sheets dated 04/06/22, 04/08/22, 04/11/22, and 04/25/22; There was no documentation regarding Resident #3's toenails. -There was a shower sheet dated 05/02/22 and there was documentation Resident #3 had long toenails. Observation of Resident #3 on 05/05/22 at 3:48pm revealed: -Resident #3 was laying on his bed with his shoes off. -The toenails of both of Resident #3's feet were long, thick and about one-half inch long past the end of the toe. Interview with Resident #3 on 05/05/22 at 4:17pm revealed: -His toenails were long, thick, and needed to be trimmed. -He used to trim his own toenails, but it has been a while. -No one at the facility trimmed his toenails and a podiatrist had not trimmed his toenails in a while, but he did not know how long. -He would like to have his toenails trimmed. Interview with the Special Care Unit Coordinator (SCUC) on 05/05/22 at 3:49pm revealed: -She did not know Resident #3's toenails on both feet were long and needed to be trimmed. -The personal care aides (PCA) should have been looking at Resident #3's toenails on bath days, but she did not know often.	{D 273}		

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{D 273}	Continued From page 11 -She did not know when Resident #3 last got his toenails trimmed by a podiatrist. Interview with a PCA on 05/05/22 at 3:58pm revealed: -He noticed Resident #3's toenails were long on 04/18/22, but he did not tell anyone. -The PCAs and the MAs should be looking at the residents' toenails. -He did not know who was responsible for ensuring Resident #3's toenails were clipped by a podiatrist. Interview with a medication aide (MA) on 05/05/22 at 4:18pm revealed: -She did not know Resident #3's toenails were long and needed to be trimmed. -Unless a resident complained or unless staff saw residents with long toenails, they were not seen by podiatry. -Podiatry visited the facility every 3 to 4 months. -MAs and PCAs were not allowed to clip any residents' toenails. Interview with a PCA on 05/06/22 at 9:24am revealed: -Resident #3 was independent with bathing and dressing. -She assisted him by standing by the door when he took a bath. -She noticed, the week of 04/17/22, Resident #5's toenails were very long and told the MA working on her shift. -PCAs could not touch any resident's toenails to trim them. -She did not know who was responsible for contacting a podiatrist to trim Resident #3's toenails. Interview with the Medical Records Coordinator	{D 273}		

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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 273}	Continued From page 12 on 05/06/22 at 11:16am revealed: -She found documentation Resident #3 was seen by podiatry for foot care follow-up on 10/20/21. -There was no other documentation Resident #3 was seen by podiatry after 10/20/21. Interview with the Administrator on 05/06/22 at 12:54pm revealed: -Podiatry trimmed all residents' toenails when they visited the facility. -She did not know when the podiatrist was last in the facility, but it was usually every 3 months. -She did not know Resident #3's toenails were long and thick. -PCAs should assess residents' toenails on shower days and document that toenails needed to be trimmed. Attempted interview with the facility contracted podiatrist on 05/06/22 at 11:42am was unsuccessful. 2. Review of Resident #5's current FL2 dated 01/24/22 revealed: -Diagnoses included dementia without behavioral disturbance and anxiety disorder. -Resident #5 was intermittently disoriented and had a history of wandering. Review of Resident #5's care plan dated 01/12/22 revealed Resident #5 had a history of wandering, was currently receiving medications for mental illness/behavior and was currently being seen by a mental health provider. Review of Resident #5's mental health provider's (MHP) psychiatry progress note dated 03/09/22 revealed: -Resident #5 had a history of behaviors including paranoia and agitation.	{D 273}		

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{D 273}	Continued From page 13 -Staff reported no changes. -Resident #5 had a history of anxiety, had a scheduled anti-anxiety medication, and an as needed anti-anxiety medication, and there were no changes recommended. Review of Resident #5's MHP's psychiatry progress note dated 04/06/22 revealed: -Resident #5 had a scheduled psychotropic medication prescribed for a history of behaviors including paranoia and agitation. -Resident #5 had a history of anxiety, had a scheduled anti-anxiety medication, and an as needed anti-anxiety medication. -There were no new orders. Review of the Resident #5's progress notes for April and May 2022 revealed: -There was no documentation of an incident on 04/26/22. -On 04/27/22, the SCUC documented Resident #5 was in an altercation with a resident, was redirected by staff, and then went down the 400 hall in the SCU and started another verbal altercation. -Resident #5 was redirected again and then went to her room; she rested for the rest of the evening. Review of Resident #5's Behavioral Incident Report dated 04/26/22 at 5:15pm revealed: -Resident #5 was involved in an incident that involved verbal and physical aggression towards other residents on 04/26/22. -Resident #5 was arguing with two other resident and then decided to get physical with both residents. -A second shift personal care aide (PCA) was present before or during the incident.	{D 273}		

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{D 273}	Continued From page 14 Attempted telephone interview with the second PCA on 05/06/22 at 2:02pm was unsuccessful. The MA who completed the report on 04/26/22 was no longer employed at the facility. Observation of the Special Care Unit (SCU) on 05/05/22 at 3:27pm revealed: -Resident #5 was standing inside the doorway of the family room in the SCU and there was a personal care aide (PCA) standing near her. -Resident #5 held her arm straight out to the side as residents entered the family room to try to block them from entering. -The PCA told Resident #5 she could not block residents from entering and asked her to put her arm down. -A resident entered the family room and Resident #5 had her arm out in attempt to block her from entering. -As the resident entered the family room, she pushed Resident #5's arm out of her way and Resident #5 hit the resident twice on her back. -The PCA redirected Resident #5 away from the resident who was entering the room. Interview with the PCA on 05/05/22 at 3:58pm revealed: -Resident #5 was physically aggressive with residents almost every other day. -He reported Resident #5 being physically aggressive with residents to the MA who worked on his shift, but he was not told to do anything differently. -He observed Resident #5 hit another resident today, but it was nothing compared to Resident #5's physical altercation with two other residents on 04/26/22. -The PCA was unable to complete the interview due to him needing to assist residents.	{D 273}		

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{D 273}	Continued From page 15 Interview with a PCA on 05/06/22 at 9:08am revealed: -Resident #5 just started having behaviors within the last 2 to 3 weeks. -She became agitated easily around other residents. Interview with a second PCA on 05/06/22 at 9:24am revealed: -She had not been told to do anything differently for Resident #5. -Resident #5 bickered back and forth with other residents, but she had not seen her be physically aggressive. Interview with the Special Care Unit Coordinator (SCUC) on 05/06/22 at 9:34am revealed: -She did not notice a lot of behaviors with Resident #5. -Resident #5 had sundowning episodes and would get agitated, but she would try to diffuse the agitation when she saw it. -She was not made aware of the incident that took place on 04/26/22 with Resident #5 and two other residents until a couple days later. -She had no further details than what was in the behavior report and the medication aide who wrote the report no longer worked at the facility. -After she became aware of the altercation with Resident #5 and the two other residents, she did not contact Resident #5's MHP. -She was responsible for making contact with Resident #5's MHP, but she did not contact the MHP because she was new to the facility and still learning the processes. Telephone interview with Resident #5's primary care physician (PCP) on 05/06/22 at 11:18am revealed he was not familiar with Resident #5 or	{D 273}		

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{D 273}	Continued From page 16 the physical altercation that occurred on 04/26/22. Telephone interview with Resident #5's guardian on 05/06/22 at 12:41pm revealed: -She was not notified by the facility of any physical altercations involving Resident #5. -Resident #5 was currently being seen by a MHP. -She expected the facility to contact her as well as Resident #5's PCP (the facility contracted PCP) and MHP regarding the physical altercation. Interview with the Administrator on 05/06/22 at 12:54pm revealed: -She knew about the physical altercation between Resident #5 and two other residents on 04/26/22, but she did not know about Resident #5 hitting another resident on 05/05/22. -She would have expected a MA or the SCUC to contact Resident #5's MHP after the incidents to see if there were any recommendations to redirect Resident #5 or any needs for changes in Resident #5's medications. The facility failed to ensure referral and follow-up to meet health care needs for Resident #3 related to not notifying the home health provider of issues with leg wraps and not scheduling a podiatrist visit for trimming of toenails that were thick and about one-half inch long on both feet, and for Resident #5 related to not notifying the mental health provider of behaviors resulting in two incidents of physical altercations with residents within a two week period (#5). This failure was detrimental to the health, safety, and welfare of residents and constitutes an unabated Type B Violation. The facility provided a plan of correction in accordance with G.S. 131D-34 on 05/06/22 for this violation.	{D 273}		

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{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: TYPE B VIOLATION Based on observation, interview, and record reviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#6 and #8) observed during the morning and noon medication pass, including omission of a blood pressure medication (#6); and a medication for diabetes and depression (#8); and for 3 of 6 sampled residents (#2, #4 and #6) for record review including errors with medication used to treat elevated blood pressure, a medication used to treat high cholesterol, a medication used to treat depression, a medication used to manage behaviors, a medication to decrease inflammation, a medication for circulation and a supplement (#6); a medication used to treat and prevent constipation (#4); and a medication used to treat reflux and a medication used to treat a vitamin deficiency (#2). The findings are: 1. The medication error rate was 11% as evidenced by the observation of 3 errors out of 27	{D 358}	Per facility policy all Medication Administration staff will be reviewed monthly to ensure adherence to correct Medication Administration practices. Facility RN completed Inservice with all MAs regarding Medication Administration. Facility RN observed and checked off all MAs with Medication Pass Observation Form. MA will follow the five rights of Medication Administration and per facility policy number 6 right, right to refuse Medications, will be documented. RC will perform weekly cart audits to ensure compliance. Facility revised cart audit sheets to reflect accuracy and pharmacy dispositions. RC will perform weekly eMAR audits to ensure compliance.	5/13/22

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{D 358}	Continued From page 18 opportunities during the 8:00am medication pass on 05/05/22. a. Review of Resident #6's current FL-2 dated 06/24/21 revealed: -Diagnoses included vascular dementia, diabetes mellitus 2, hyperlipidemia, hypertension, anxiety, hypo-magnesium, depression, anemia, rheumatoid arthritis and allergic rhinitis. -There was an order for amlodipine (used to treat blood pressure) 10mg daily. Review of Resident #6's signed physician's orders dated 12/01/22 revealed an order for amlodipine 10mg daily. Observation of the medications administered during the medication pass on 05/05/22 at 8:00am revealed: -The medication aide (MA) prepared 5 pills for administration to Resident #6. -The MA prepared sertraline 100mg, haloperidol 1mg, loratadine 10mg, aspirin 81mg and magnesium oxide 400mg for administration to Resident #6. -The MA removed the 5 pills from individual bubble packs into a medication cup. -She placed the 5 pills in a small, clear bag and crushed them. -She poured the crushed medication into the medication cup and added two teaspoonfuls of apple sauce. -She administered the 5 crushed medications in applesauce to Resident #6 followed by a cup of water. -The MA did not prepare amlodipine 10mg for administration to Resident #6. Interview with the MA on 05/05/22 at 12:03pm revealed:	{D 358}		

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{D 358}	Continued From page 19 -She pulled medication from the medication cart, checked the medication three times against the eMAR, removed the medication into the medication cup and then administered the medication to Resident #6. -She gave 5 crushed pills to Resident #6 at the 8:00am medication pass. -She signed the eMAR for all the medications she administered. -She thought she gave Resident #6 her amlodipine as ordered. Review of Resident #6's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry for amlodipine 10mg 1 tablet daily to be administered at 8:00am. -There was documentation that amlodipine 10mg was administered at 8:00am on 05/05/22. A second interview with the MA on 05/05/22 at 12:08pm revealed she located the amlodipine 10mg in the overstock drawer. Observation of medication on hand on 05/05/22 at 12:07pm revealed: -There was a bubble pack of amlodipine 10mg in the overflow drawer. -The bubble pack had 30 of 30 amlodipine tablets remaining with a dispensed date of 04/10/22. Observation of Resident #6 on 05/06/22 at 9:21am revealed: -Resident #6 was lying in her bed. -The Special Care Unit Coordinator (SCUC) took Resident #6's blood pressure; the reading was 142/68. Telephone interview with a representative for the facility's contracted pharmacy on 05/05/22 at	{D 358}		

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{D 358}	Continued From page 20 1:45pm revealed: -Resident #6 had an order for amlodipine 10mg daily dated 08/18/21. -Amlodipine was used to treat elevated blood pressure. -The pharmacy dispensed 30 amlodipine 10mg tablets on 04/10/22. -The facility had not reordered amlodipine 10mg since 04/10/22. Based on eMAR documentation, medications dispensed and medications on hand between 04/10/22 to 05/05/22, there should have been 5 tablets of amlodipine available to be administered and there were 30 tablets remaining Interview with the Special Care Coordinator (SCC) on 05/05/22 at 12:25pm revealed: -The MAs should follow the six rights of medication administrations that was taught in the medication administration class. -The MA should compare the medication with the eMAR, once the medication was verified, the MA would place the medication into a medication cup, then click on the order in the eMAR for the medication and a green check would appear. -The green check indicated the medication was prepared for administration. -The MA should count the medications in the medication cup prior to administration and compare them to the green checks on the eMAR; the number for each should be the same. -Once the MA administered the medication, she would return to the eMAR and click on "given" and the MAs initials would automatically be signed onto the eMAR. -A medication could be signed on the eMAR as administered when it actually was not administered.	{D 358}		

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{D 358}	Continued From page 21 Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 05/05/22 at 2:24 was unsuccessful. Refer to the interview with the Administrator on 05/06/22 at 10:19am and 12:50pm. b. Review of Resident #8's current FL-2 dated 08/08/21 revealed: -Diagnoses included cognitive deficits, hypertension, diabetes mellitus 2, congestive heart failure, neuropathy and skin ulcer. -There was an order for Jardiance (used to lower blood sugar) 10mg daily. 1. Review of Resident #8's signed physician's orders dated 02/06/22 revealed an order for Jardiance 10mg daily. Observation of the medications administered during the medication pass on 05/05/22 at 8:00am revealed: -The medication aide (MA) prepared 10 pills for administration to Resident #8. -The MA prepared Tradjenta 5mg, gabapentin 300mg, losartan potassium 25mg, metoprolol 50mg, aspirin 81mg, folic acid 400mg, torsemide 200mg, vitamin B complex, amlodipine 10mg, and vitamin B-12 for administration to Resident #8. -The MA removed the 10 pills from individual bubble packs into a medication cup. -She administered the 10 pills to Resident #8 with a cup of water. -The MA did not prepare Jardiance 10mg for administration to Resident #8.	{D 358}		

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{D 358}	Continued From page 22 Review of Resident #8's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Jardiance 10mg 1 tablet daily to be administered 8:00am. -There was documentation that Jardiance 10mg was administered at 8:00am on 05/05/22. Interview with the MA on 05/05/22 at 12:06am revealed: -She did not give Resident # 8 her Jardiance as ordered because it was not available in the medication cart. -She signed the eMAR by accident. Observation of Resident #8's medication on hand on 05/05/22 at 12:07pm revealed: -There was a bubble pack of Jardiance 10mg with a dispense date of 04/10/22 for 15 tablets. -The bubble pack had 2 of 15 Jardiance tablets remaining in the bubble pack. A second interview with the MA on 05/05/22 at 12:08pm revealed: -There was a bubble pack with 2 of 30 Jardiance 10mg tablets available for administration to Resident #8. -She did not see Jardiance when she was looking for Resident #8's medication for administration. A second review of Resident #8's May 2022 eMAR on 05/05/22 revealed: -There was an order for fingerstick blood sugar checks (FSBS) before meals and at bedtime. -Resident #8's FSBS readings for May 2022 were 7:30am 124-455; 11:30am 378-539; 4:30pm 358-539 and 8:00pm 412-526. Interview with a representative from the facility's	{D 358}		

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{D 358}	Continued From page 23 contracted pharmacy on 05/05/22 at 1:48pm revealed: -Jardiance was used to lower blood sugar in people with diabetes. -The pharmacy dispensed a 2 week supply of 15 Jardiance tablets on 04/10/22. Telephone interview with the Primary Care Provider (PCP) on 05/05/22 at 3:43pm revealed resident #8 took Jardiance to help control her blood sugar. Interview with the Special Care Unit Coordinator (SCUC) on 05/05/22 at 12:25pm revealed: -The MAs should follow the six rights of medication administrations that was taught in the medication administration class. -The MA should compare the medication with the eMAR, once the medication was verified, the MA would place the medication into a medication cup, then click on the order in the eMAR for the medication and a green check would appear. -The green check indicates that the medication had been prepared for administration. -The MA should count the medications in the medication cup prior to administration and compare them to the green checks on the eMAR; the number for each should be the same. -Once the MA administered the medication, she would return to the eMAR and click on "given" and the MAs initials would automatically be signed onto the eMAR. -A medication could be signed on the eMAR as administered when it actually was not administered. Interview with the Administrator on 05/06/22 at 10:19am and 12:50pm revealed: -Observation of the medication administration pass was not being done at present but it would	{D 358}		

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{D 358}	Continued From page 24 be initiated. -The Special Care Unit Coordinator (SCUC) would be responsible for weekly medication cart audits.. -She was concerned that the MAs were not administering medications as ordered. -She was concerned that medications were being documented as administered when they were not. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Refer to the interview with the Administrator on 05/06/22 at 10:19am and 12:50pm. 2. Review of Resident #8's signed physician's orders dated 05/04/22 revealed an order for sertraline (used to treat depression) 25mg daily. Observation of the medications administered during the medication pass on 05/05/22 at 8:00am revealed: -The medication aide (MA) prepared 10 pills for administration to Resident #8. -The MA prepared Tradjenta 5mg, gabapentin 300mg, losartan potassium 25mg, metoprolol 50mg, aspirin 81mg, folic acid 400mg, torsemide 200mg, vitamin B complex, amlodipine 10mg, and vitamin B-12 for administration to Resident #8. -The MA removed the 10 pills from individual bubble packs into a medication cup. -She administered the 10 pills to Resident #8 with a cup of water. -The MA did not prepare sertraline 25mg for administration to Resident #8. Review of Resident #'s May 2022 electronic medication administration record (eMAR)	{D 358}		

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{D 358}	Continued From page 25 revealed: -There was an entry for sertraline 25mg 1 tablet daily to be administered at 8:00am. -There was no documentation sertraline 25mg was administered at 8:00am on 05/05/22. Interview with the MA on 05/05/22 at 12:13pm revealed: -Resident #8's sertraline 25mg was not available during the 8:00am medication pass. -Sertraline 25mg was a new order and the medication had not been delivered to the facility from the pharmacy. -New medication orders would take 12 to 24 hours to be delivered to the facility. Interview with a representative from the facility's contracted pharmacy on 05/05/22 at 1:48pm revealed: -The pharmacy received a new order for sertraline 25mg on 05/04/22. -The order was faxed to the pharmacy by the facility. -The pharmacy dispensed 30 sertraline 25mg tablets on 05/04/22. -The medication was delivered to the facility on the evening of 05/04/22 and was available for administration on the morning of 05/05/22. Observation of medication on hand on 05/05/22 at 12:07pm revealed: -There was a bubble pack of sertraline 25mg in the overflow drawer. -The bubble pack had 30 of 30 sertraline tablets remaining with a dispense date of 05/04/22. A second interview with the MA on 05/05/22 at 12:13pm revealed: -Resident #8's sertraline 25mg was in the overstock drawer of the medication cart.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034098	A. BUILDING: _____ B. WING _____	R 05/06/2022

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{D 358}	Continued From page 26 -New medications should be placed with the Resident's scheduled medications in the medication cart when it arrives to the facility, not the overstock drawer. Telephone interview with the Primary Care Provider (PCP) on 05/05/22 at 3:43pm revealed: -Resident #8 was ordered sertraline 25mg this week by the Mental Health Provider. -He expected the MAs to administer medications as ordered. Interview with the Special Care Unit Coordinator (SCUC) on 05/05/22 at 12:25pm revealed: -She or the Resident Care Coordinator (RCC) verified new orders. -Once an order was verified, it appeared on the eMAR. -The new orders were not verified until the medication was available for administration. -If the order was on the eMAR, the MA should have known the medication was in the facility for administration. -The MA should have spoken with her or telephoned the pharmacy when she could not locate the medication. -The pharmacy delivered new medications the same day if the new order was received in the pharmacy by 4:30pm. -New medications should be placed on the medication cart with the resident's scheduled medications, not in overstock. Interview with the Administrator on 05/06/22 at 10:19am and 12:50pm revealed: -When a medication is not available for administration, the MA needs to speak to the SCUC or call the pharmacy. -Observation of the medication administration pass was not being done at present but it would	{D 358}		

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{D 358}	Continued From page 27 be initiated. -She was concerned that the MAs were not administering medications as ordered. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with the Mental Health Provider on 05/06/22 at 11:00am was unsuccessful. Refer to the interview with the Administrator on 05/06/22 at 10:19am and 12:50pm. 2. Review of Resident #6's current FL-2 dated 06/24/21 revealed diagnoses included vascular dementia, diabetes mellitus 2, hyperlipidemia, hypertension, anxiety, hypo-magnesium, depression, anemia, rheumatoid arthritis and allergic rhinitis. a. Review of Resident #6's current FL-2 dated 06/24/21 revealed an order for amlodipine 10mg daily. Review of Resident #6's physician's orders dated 12/01/21 revealed an order for amlodipine 10mg daily. Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for amlodipine 10mg daily with a scheduled administration time of 8:00am. -There was documentation that amlodipine was administered daily at 8:00am from 02/01/22 to 02/28/22. -There was an entry to check blood pressure three times a week.	{D 358}		

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{D 358}	Continued From page 28 -There was documentation Resident #6's blood pressure was taken every other day. -The blood pressure readings ranged from 111/60-140/88. Review of Resident #6's March 2022 eMAR revealed: -There was an entry for amlodipine 10mg daily with a scheduled administration time of 8:00am. -There was documentation that amlodipine was administered daily at 8:00am from 03/01/22 to 03/31/22. -There was an entry to check blood pressure three times a week. -There was documentation Resident #6's blood pressure was taken every other day. -The blood pressure readings ranged from 92/77-148/75. Review of Resident #6's April 2022 eMAR revealed: -There was an entry for amlodipine 10mg daily with a scheduled administration time of 8:00am. -There was documentation that amlodipine was administered daily at 8:00am from 04/01/22 to 04/30/22. -There was an entry to check blood pressure three times a week. -There was documentation Resident #6's blood pressure was taken every other day. -The blood pressure readings ranged from 124/72-159/99. Review of Resident #6's May 2022 eMAR revealed: -There was an entry for amlodipine 10mg daily with a scheduled administration time of 8:00am. -There was documentation that amlodipine was administered daily at 8:00am from 05/01/22 to 05/05/22.	{D 358}		

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{D 358}	Continued From page 29 -There was an entry to check blood pressure three times a week. -There were blood pressure readings documented on 05/02/22 of 157/93 and on 05/04/22 of 144/74. Observation of Resident #6's medication on hand on 05/05/22 at 4:06pm revealed there was a bubble pack labeled amlodipine 10mg with 30 tablets. Telephone interview with a representative from the facility's contracted pharmacy on 05/05/22 at 1:45pm revealed: -Resident #6 had an order for amlodipine 10mg daily with an order date of 08/18/21. -Amlodipine was used to treat elevated blood pressure. -The pharmacy dispensed 30 tablets of amlodipine 10mg on 12/21/21. -The pharmacy dispensed 30 tablets of amlodipine 10mg on 03/02/22. -The pharmacy dispensed 30 tablets of amlodipine 10mg on 04/10/22. -The pharmacy did not dispense amlodipine 10mg in January 2022 or February 2022. Based on eMAR documentation, medications dispensed and medications on hand between 12/21/21-05/5/22, there would have been no amlodipine available to be administered from 01/02/22-03/01/22 and 04/02/22-04/09/22 when the medication was reordered, and from 04/10/22-05/05/22 based on documentation there should have been 5 tablets remaining and there were 30 tablets remaining. Interview with a medications aide (MA) on 05/06/22 at 9:25am revealed: -She did not know why Resident #6 had an entire	{D 358}		

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{D 358}	Continued From page 30 bubble pack of 30 amlodipine 10mg remaining on the medication cart unless she was hospitalized. -If Resident #6 had not left the facility then she was not receiving her medications as ordered. -There was a medication cart audit schedule posted for the medication cart to be audited weekly; the MAs were assigned specific days to audit the medication carts. -She did not look at the pharmacy dispense dates of medications and compare them to the number of pills remaining to see if the count was accurate as part of her audit. Interview with the Special Care Unit Coordinator (SCUC) on 05/06/22 at 09:07am revealed: -The pharmacy sent a month's supply of medication at a time. -There should be no extra pills after the 30-day cycle unless the resident was in the hospital or the medication was not administered. -No medications were brought into the facility from an outside pharmacy. -Resident #6's medications were not administered as ordered. -The MAs were expected to administer the medications as ordered by the PCP. -She was concerned that the residents were not getting their medication as ordered. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable. Attempted telephone interview with a second MA on 05/06/22 at 9:04am and 10:30am was unsuccessful. Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 05/05/22 at 2:24	{D 358}		

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{D 358}	Continued From page 31 was unsuccessful. Refer to the interview with the Administrator on 05/06/22 at 10:19am and 12:50pm. b. Review of Resident #6's current FL-2 dated 06/24/21 revealed an order for aspirin (used to promote circulation) 81mg daily. Review of Resident #6's physician's orders dated 12/01/21 revealed an order for aspirin 81mg daily. Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for aspirin 81mg daily with a scheduled administration time of 8:00am. -There was documentation that aspirin was administered daily at 8:00am from 02/01/22 to 02/28/22. Review of Resident #6's March 2022 eMAR revealed: -There was an entry for aspirin 81mg daily with a scheduled administration time of 8:00am. -There was documentation that aspirin was administered daily at 8:00am from 03/01/22 to 03/31/22. Review of Resident #6's April 2022 eMAR revealed: -There was an entry for aspirin 81mg daily with a scheduled administration time of 8:00am. -There was documentation that aspirin was administered daily at 8:00am from 04/01/22 to 04/30/22. Review of Resident #6's May 2022 eMAR revealed: -There was an entry for aspirin 81mg daily with a	{D 358}		

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{D 358}	Continued From page 32 scheduled administration time of 8:00am. -There was documentation that aspirin 81mg was administered daily at 8:00am from 05/01/22 to 05/05/22. Observation of Resident #6's medication on hand on 05/05/22 at 4:06pm revealed there was a bubble pack labeled aspirin with 27 tablets. Telephone interview with a representative from the facility's contracted pharmacy on 05/05/22 at 1:45pm revealed: -Resident #6 had an order for aspirin 81mg daily with an order date of 07/28/21. -The pharmacy dispensed 30 tablets of aspirin 81mg on 12/21/21. -The pharmacy dispensed 30 tablets of aspirin 81mg on 03/02/22. -The pharmacy dispensed 30 tablets of aspirin 81mg on 04/21/22. Based on eMAR documentation, medications dispensed and medications on hand between 12/21/21-05/5/22, there would have been no aspirin available to be administered from 01/02/22-03/01/22 and 04/02/22-04/20/22 when the medication was reordered, and from 04/21/22-05/05/22 based on documentation there should have been 15 tablets remaining and there were 27 tablets remaining. Interview with a medications aide (MA) on 05/06/22 at 9:25am revealed: -She did not know why Resident #6 had extra pills remaining in the medication cart unless she was hospitalized. -If Resident #6 had not left the facility then she was not receiving her medications as ordered. -There was a medication cart audit schedule posted for the medication cart to be audited	{D 358}		

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{D 358}	Continued From page 33 weekly; the MAs were scheduled to audit the medication cart. -She did not look at the pharmacy dispense dates of medications and compare them to the number of pills remaining to see if the count was accurate as part of her audit. Interview with the Special Care Unit Coordinator (SCUC) on 05/06/22 at 09:07am revealed: -The pharmacy sent a month's supply of medication at a time. -There should be no extra pills after the 30-day cycle unless the resident was in the hospital or the medication was not administered. -No medications were brought into the facility from an outside pharmacy. -Resident #6's medications were not administered as ordered. -The MAs were expected to administer the medications as ordered by the PCP. -She was concerned that the residents were not getting their medication as ordered. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable. Attempted telephone interview with a second MA on 05/06/22 at 9:04am and 10:30am was unsuccessful. Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 05/05/22 at 2:24 was unsuccessful. Refer to the interview with the Administrator on 05/06/22 at 10:19am and 12:50pm. c. Review of Resident #6's current FL-2 dated 06/24/21 revealed an order for magnesium oxide	{D 358}		

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{D 358}	Continued From page 34 (used as a supplement) 400mg twice daily. Review of Resident #6's physician's orders dated 12/01/21 revealed an order for magnesium oxide 400mg twice daily. Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for magnesium oxide 400mg twice daily with a scheduled administration time of 8:00am and 8:00pm -There was documentation that magnesium oxide was administered twice daily at 8:00am and 8:00pm from 02/01/22 to 02/28/22. Review of Resident #6's March 2022 eMAR revealed: -There was an entry for magnesium oxide 400mg twice daily with a scheduled administration time of 8:00am and 8:00pm -There was documentation that magnesium oxide was administered twice daily at 8:00am and 8:00pm from 03/01/22 to 03/31/22. Review of Resident #6's April 2022 eMAR revealed: -There was an entry for magnesium oxide 400mg twice daily with a scheduled administration time of 8:00am and 8:00pm -There was documentation that magnesium oxide was administered twice daily at 8:00am and 8:00pm from 04/01/22 to 04/30/22. Review of Resident #6's May 2022 eMAR revealed: -There was an entry for magnesium oxide 400mg twice daily with a scheduled administration time of 8:00am and 8:00pm -There was documentation that magnesium oxide	{D 358}		

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{D 358}	Continued From page 35 was administered twice daily at 8:00am and 8:00pm from 05/01/22 to 05/05/22. Observation of Resident #6's medication on hand on 05/05/22 at 4:05pm revealed there was a bubble pack labeled magnesium oxide 400mg with 59 tablets. Telephone interview with a representative from the facility's contracted pharmacy on 05/05/22 at 1:45pm revealed: -Resident #6 had an order for magnesium oxide 400mg twice daily with an order date of 08/18/21. -Magnesium oxide 400mg was used as a supplement. -The pharmacy dispensed 60 tablets of magnesium oxide 400mg on 02/02/22. -The pharmacy dispensed 60 tablets of magnesium oxide 400mg on 03/24/22. -The pharmacy dispensed 60 tablets of magnesium oxide 400mg on 04/21/22. Based on eMAR documentation, medications dispensed and medications on hand between 12/21/21-05/5/22, there would have been no magnesium oxide available to be administered from 03/05/22-03/23/22 when the medication was reordered, and from 04/24/22-05/05/22 based on documentation there should have been 49 tablets remaining and there were 59 tablets remaining. Interview with a medications aide (MA) on 05/06/22 at 9:25am revealed: -She did not know why Resident #6 had extra pills remaining in the medication cart unless she was hospitalized. -If Resident #6 had not left the facility then she was not receiving her medications as ordered. -There was a medication cart audit schedule posted for the medication cart to be audited	{D 358}		

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{D 358}	Continued From page 36 weekly; the MAs were scheduled to audit the medication care weekly. -She did not look at the pharmacy dispense dates of medications and compare them to the number of pills remaining to see if the count was accurate as part of her audit. Interview with the Special Care Unit Coordinator (SCUC) on 05/06/22 at 09:07am revealed: -The pharmacy sent a month's supply of medication at a time. -There should be no extra pills after the 30-day cycle unless the resident was in the hospital or the medication was not administered. -No medications were brought into the facility from an outside pharmacy. -Resident #6's medications were not administered as ordered. -The MAs were expected to administer the medications as ordered by the PCP. -She was concerned that the residents were not getting their medication as ordered. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable. Attempted telephone interview with a second MA on 05/06/22 at 9:04am and 10:30am was unsuccessful. Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 05/05/22 at 2:24 was unsuccessful. Refer to the interview with the Administrator on 05/06/22 at 10:19am and 12:50pm. d. Review of Resident #6's physician's orders dated 12/01/21 revealed an order for	{D 358}		

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{D 358}	Continued From page 37 methotrexate (used to decrease inflammation) 2.5mg, 7 tablets, weekly on Sunday. Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for methotrexate 2.5mg, 7 tablets, weekly on Sunday with a scheduled administration time of 9:00am. -There was documentation that 7 tablets of methotrexate were administered weekly on 02/06/22, 02/13/22, 02/20/22 and 02/27/22 at 9:00am. Review of Resident #6's March 2022 eMAR revealed: -There was an entry for methotrexate 2.5mg, 7 tablets, weekly on Sunday with a scheduled administration time of 9:00am. -There was documentation that 7 tablets of methotrexate were administered weekly on 03/06/22, 03/13/22, 03/20/22 and 03/27/22 at 9:00am. Review of Resident #6's April 2022 eMAR revealed: -There was an entry for methotrexate 2.5mg, 7 tablets, weekly on Sunday with a scheduled administration time of 9:00am. -There was documentation that 7 tablets of methotrexate were administered weekly on 02/06/22, 02/13/22, 02/20/22 and 02/27/22 at 9:00am. Review of Resident #6's May 2022 eMAR revealed: -There was an entry for methotrexate 2.5mg, 7 tablets, weekly on Sunday with a scheduled administration time of 9:00am. -There was documentation that 7 tablets of	{D 358}		

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{D 358}	Continued From page 38 methotrexate were administered on 05/01/22 at 9:00am. Observation of Resident #6's medication on hand on 05/05/22 at 4:06pm revealed there was a bubble pack labeled methotrexate 2.5mg with 59 tablets. Telephone interview with a representative from the facility's contracted pharmacy on 05/05/22 at 1:45pm revealed: -There was an order for Resident #6 for methotrexate 2.5mg, 7 tablets every week on Sunday, with an order date of 08/30/21. -Methotrexate was used for inflammation. -The pharmacy dispensed 28 tablets of methotrexate 2.5 mg on 11/07/21. -The pharmacy dispensed 28 tablets of methotrexate 2.5mg on 03/02/21. -The pharmacy dispensed 28 tablets of methotrexate 2.5mg on 04/10/22. Based on eMAR documentation, medications dispensed and medications on hand between 11/07/21-05/5/22, there would have been no methotrexate available to be administered from 12/05/21-03/05/22 and 03/28/22-04/09/22 when the medication was reordered, and from 04/10/22-05/05/22 based on documentation there should have been 0 tablets remaining and there were 13 tablets remaining. Interview with a medications aide (MA) on 05/06/22 at 9:25am revealed: -She did not know why Resident #6 had extra pills remaining in the medication cart unless she was hospitalized. -If Resident #6 had not left the facility then she was not receiving her medications as ordered. -There was a medication cart audit schedule	{D 358}		

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	HAL034098	A. BUILDING: _____ B. WING _____	R 05/06/2022

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{D 358}	Continued From page 39 posted for the medication cart to be audited weekly; the MAs were scheduled to audit the medication cart weekly. -She did not look at the pharmacy dispense dates of medications and compare them to the number of pills remaining to see if the count was accurate as part of her audit. Interview with the Special Care Unit Coordinator (SCUC) on 05/06/22 at 09:07am revealed: -The pharmacy sent a month's supply of medication at a time. -There should be no extra pills after the 30-day cycle unless the resident was in the hospital or the medication was not administered. -No medications were brought into the facility from an outside pharmacy. -Resident #6's medications were not administered as ordered. -The MAs were expected to administer the medications as ordered by the PCP. -She was concerned that the residents were not getting their medication as ordered. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with a second MA on 05/06/22 at 9:04am and 10:30am was unsuccessful. Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 05/05/22 at 2:24 was unsuccessful. Refer to the interview with the Administrator on 05/06/22 at 10:19am and 12:50pm. e. Review of Resident #6's physician's order	{D 358}		

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{D 358}	Continued From page 40 dated 12/01/21 revealed an order for haloperidol (used to treat behaviors) 1mg three times daily. Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for haloperidol 1mg three times daily with a scheduled administration time of 9:00am, 3:00pm and 9:00pm -There was documentation that haloperidol was administered three times daily at 9:00am, 3:00pm and 9:00pm from 02/01/22 to 02/28/22. Review of Resident #6's March 2022 eMAR revealed: -There was an entry for haloperidol 1mg three times daily with a scheduled administration time of 9:00am, 3:00pm and 9:00pm -There was documentation that haloperidol was administered three times daily at 9:00am, 3:00pm and 9:00pm from 03/01/22 to 03/31/22. Review of Resident #6's April 2022 eMAR revealed: -There was an entry for haloperidol 1mg three times daily with a scheduled administration time of 9:00am, 3:00pm and 9:00pm -There was documentation that haloperidol was administered three times daily at 9:00am, 3:00pm and 9:00pm from 04/01/22 to 04/30/22. Review of Resident #6's May 2022 eMAR revealed: -There was an entry for haloperidol 1mg three times daily with a scheduled administration time of 9:00am, 3:00pm and 9:00pm -There was documentation that haloperidol was administered three times daily at 9:00am, 3:00pm and 9:00pm from 05/01/22 to 05/05/22.	{D 358}		

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{D 358}	Continued From page 41 Observation of Resident #6's medication on hand on 05/05/22 at 4:05pm revealed there was a bubble pack labeled haloperidol 1mg with 56 tablets. Telephone interview with a representative from the facility's contracted pharmacy on 05/05/22 at 1:45pm revealed: -Resident #6 had an order for haloperidol 1mg three times daily with an order date of 08/25/21. -Haloperidol was used to manage behaviors. -The pharmacy dispensed 90 tablets of haloperidol 1mg on 12/12/21. -The pharmacy dispensed 90 tablets of haloperidol 1mg on 02/16/22. -The pharmacy dispensed 90 tablets of haloperidol1mg on 04/12/22. Based on eMAR documentation, medications dispensed and medications on hand between 12/12/21-05/5/22, there would have been no haloperidol 1mg available to be administered from 01/11/22-02/15/22 and 03/17/22-04/11/22 when the medication was reordered, and from 04/12/22-05/05/22 based on documentation there should have been 21 tablets remaining and there were 56 tablets remaining. Interview with a medications aide (MA) on 05/06/22 at 9:25am revealed: -She did not know why Resident #6 had extra pills remaining in the medication cart unless she was hospitalized. -If Resident #6 had not left the facility then she was not receiving her medications as ordered. -There was a medication cart audit schedule posted for the medication cart to be audited weekly; the MAs were scheduled to audit the medication cart weekly. -She did not look at the pharmacy dispense dates	{D 358}		

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{D 358}	Continued From page 42 of medications and compare them to the number of pills remaining to see if the count was accurate as part of her audit. Interview with the Special Care Unit Coordinator (SCUC) on 05/06/22 at 09:07am revealed: -The pharmacy sent a month's supply of medication at a time. -There should be no extra pills after the 30-day cycle unless the resident was in the hospital or the medication was not administered. -No medications were brought into the facility from an outside pharmacy. -Resident #6's medications were not administered as ordered. -The MAs were expected to administer the medications as ordered by the PCP. -She was concerned that the residents were not getting their medication as ordered. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with a second MA on 05/06/22 at 9:04am and 10:30am was unsuccessful. Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 05/05/22 at 2:24 was unsuccessful. Refer to the interview with the Administrator on 05/06/22 at 10:19am and 12:50pm. f. Review of Resident #6's physician's order dated 12/01/21 revealed an order for sertraline 25mg daily. Review of Resident #6's February 2022 electronic	{D 358}		

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{D 358}	Continued From page 43 medication administration record (eMAR) revealed: -There was an entry for sertraline 25mg daily with a scheduled administration time of 8:00am. -There was documentation that sertraline was administered daily at 8:00am from 02/01/22 to 02/28/22. Review of Resident #6's March 2022 eMAR revealed: -There was an entry for sertraline 25mg daily with a scheduled administration time of 8:00am. -There was documentation that sertraline was administered daily at 8:00am from 03/01/22 to 03/31/22. Review of Resident #6's April 2022 eMAR revealed: -There was an entry for sertraline 25mg daily with a scheduled administration time of 8:00am. -There was documentation that sertraline was administered daily at 8:00am from 04/01/22 to 04/30/22. Review of Resident #6's May 2022 eMAR revealed: -There was an entry for sertraline 25mg daily with a scheduled administration time of 8:00am. -There was documentation that sertraline was administered daily at 8:00am from 05/01/22 to 05/05/22. Observation of Resident #6's medication on hand on 05/05/22 at 4:05pm revealed there was a bubble pack labeled sertraline 25mg with 27 tablets. Telephone interview with a representative from the facility's contracted pharmacy on 05/05/22 at 1:45pm revealed:	{D 358}		

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{D 358}	Continued From page 44 -Resident #6 had an order for sertraline 25mg daily with an order date of 07/14/21. -Sertraline 25mg was used to treat depression. -The pharmacy dispensed 30 tablets of sertraline 25mg on 12/21/21. -The pharmacy dispensed 30 tablets of sertraline 25mg on 03/02/22. -The pharmacy dispensed 30 tablets of sertraline 25mg on 04/21/22. Based on eMAR documentation, medications dispensed and medications on hand between 12/21/21-05/5/22, there would have been no sertraline 25mg available to be administered from 01/21/22-03/01/22 and 04/02/22-04/20/22 when the medication was reordered, and from 04/21/22-05/05/22 based on documentation there should have been 15 tablets remaining and there were 27 tablets remaining. Interview with a medications aide (MA) on 05/06/22 at 9:25am revealed: -She did not know why Resident #6 had extra pills remaining in the medication cart unless she was hospitalized. -If Resident #6 had not left the facility then she was not receiving her medications as ordered. -There was a medication cart audit schedule posted for the medication cart to be audited weekly; the MAs were scheduled to audit the medication cart. -She did not look at the pharmacy dispense dates of medications and compare them to the number of pills remaining to see if the count was accurate as part of her audit. Interview with the Special Care Unit Coordinator (SCUC) on 05/06/22 at 09:07am revealed: -The pharmacy sent a month's supply of medication at a time.	{D 358}		

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{D 358}	Continued From page 45 -There should be no extra pills after the 30-day cycle unless the resident was in the hospital or the medication was not administered. -No medications were brought into the facility from an outside pharmacy. -Resident #6's medications were not administered as ordered. -The MAs were expected to administer the medications as ordered by the PCP. -She was concerned that the residents were not getting their medication as ordered. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with a second MA on 05/06/22 at 9:04am and 10:30am was unsuccessful. Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 05/05/22 at 2:24 was unsuccessful. Refer to the interview with the Administrator on 05/06/22 at 10:19am and 12:50pm. 3. Review of Resident #4's current FL-2 dated 05/19/21 revealed: -Diagnoses included dementia with psychosis, hypoglycemia, vitamin D deficiency, and schizophrenia. -There was an order for Miralax (used to treat constipation) to mix 17 grams in eight ounces of water daily. a. Review of Resident #4's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Miralax 17 grams (1	{D 358}		

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{D 358}	Continued From page 46 capful) in 8 ounces of liquid of choice with a scheduled administration time of 8:00am. -There was documentation Miralax was administered at 8:00am from 02/01/22-02/28/22. -There were no exceptions documented. Review of Resident #4's March 2022 eMAR revealed: -There was an entry for Miralax 17 grams (1 capful) in 8 ounces of water with a scheduled administration time of 8:00am. -There was documentation Miralax was administered at 8:00am from 03/02/01/22-03/31/22. -There were no exceptions documented. Review of Resident #4's April 2022 eMAR revealed: -There was an entry for Miralax 17 grams (1 capful) in 8 ounces of liquid of choice with a scheduled administration time of 8:00am. -There was documentation Miralax was administered at 8:00am from 04/01/22-04/30/22. -There were no exceptions documented. Review of Resident #4's May 2022 eMAR revealed: -There was an entry for Miralax 17 grams (1 capful) in 8 ounces of liquid of choice with a scheduled administration time of 8:00am. -There was documentation Miralax was administered at 8:00am from 05/01/22-05/05/22. -There were no exceptions documented Observation of Resident #4's medications on hand on 04/05/22 at 4:14pm revealed: -There was an opened bottle of Miralax dispensed on 01/22/22. -The bottle contained 510 grams of Miralax. -The bottle contained multiple doses of Miralax.	{D 358}		

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{D 358}	Continued From page 47 Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/06/22 at 8:18am revealed: -Resident #4 was dispensed a bottle of Miralax that contained 510 grams, a thirty-day supply, on 01/22/22. -Resident #4 was dispensed a bottle of Miralax that contained 238 grams, a fourteen-day supply, on 11/10/21 and 08/21/21. -There was no other dispensing of Miralax for Resident #4's. -Resident #4's Miralax was not automatically refilled and refills would need to be requested by the medication aide (MA). -Resident #4's Miralax was ordered to treat constipation. Attempted telephone interview with Resident #4's primary care provider (PCP) on 05/06/22 at 11:43am was unsuccessful. Interview with a medication aide (MA) on 05/06/22 at 8:47am revealed she administered Resident #4's Miralax when she worked. Interview with Resident #4 on 05/06/22 at 9:00am revealed: -He had a bowel movement (BM) "about three days ago." -He took water that looked milky some days, but not every day. -He had problems with constipation once in a while, but it was not an everyday thing. -Sometimes he had a hard time passing a BM. -He had not told anyone he was constipated, and no one had asked. Interview with the Special Care Unit Coordinator (SCUC) on 05/06/22 at 8:37am revealed:	{D 358}		

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{D 358}	Continued From page 48 -When a MA administered medications, she expected the MA to pull the medications from the medication cart for the resident, match the medication to the eMAR, make sure the medication was correct and administer the medication. -She had not completed a cart audit; she recently started working for the facility. -If a medication was scheduled, she would not expect the medication to be remaining in the cart if the medication was dispensed in January 2022. Interview with the Administrator on 05/06/22 at 11:01am revealed the pharmacy provided cart audit services. Attempted telephone interview with Resident #4's primary care provider (PCP) on 05/06/22 at 11:43am was unsuccessful. Refer to the interview with the Administrator on 05/06/22 at 10:19am and 12:50pm. 4. Review of Resident #2's current FL-2 dated 02/08/22 revealed diagnoses included gastroesophageal reflux disease (GERD), chronic obstructive pulmonary disease, and hypertension. a. Review of Resident #2's current FL-2 dated 02/08/22 revealed an order for Omeprazole 20mg once a day. (Omeprazole is used to treat GERD). Review of Resident #2's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Omeprazole 20mg with a scheduled administration time of 8:00am. -There was documentation Omeprazole was administered at 8:00am from 02/01/22-02/28/22. -There were 28 doses of Omeprazole	{D 358}		

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{D 358}	Continued From page 49 documented as administered; there were no exceptions documented. Review of Resident #2's March 2022 eMAR revealed: -There was an entry for Omeprazole 20mg with a scheduled administration time of 8:00am. -There was documentation Omeprazole was administered at 8:00am from 03/02/01/22-03/31/22. -There were 31 doses of Omeprazole documented as administered; there were no exceptions documented. Review of Resident #2's April 2022 eMAR revealed: -There was an entry for Omeprazole 20mg with a scheduled administration time of 8:00am. -There was documentation Omeprazole was administered at 8:00am from 04/01/22-04/30/22. -There were 30 doses of Omeprazole documented as administered; there were no exceptions documented. Review of Resident #2's May 2022 eMAR revealed: -There was an entry for Omeprazole 20mg with a scheduled administration time of 8:00am. -There was documentation Omeprazole was administered at 8:00am from 05/01/22-05/05/22. -There were 5 doses of Omeprazole documented as administered; there were no exceptions documented. Observation of Resident #2's medications on hand on 05/05/22 at 10:47am revealed: -There was a bubble pack labeled for Omeprazole 20mg. -Thirty tablets of Omeprazole 20mg were dispensed on 04/14/22.	{D 358}		

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{D 358}	Continued From page 50 -There were 16 of 30 tablets available to be administered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/05/22 at 1:49pm revealed: -Resident #2 was dispensed a 30-day supply of Omeprazole 20mg on 04/14/22, 03/12/22, and 02/16/22. -Resident #2's Omeprazole was not automatically refilled, and refills would need to be requested by the medication aide (MA). -Resident #2's Omeprazole was ordered to treat reflux. -Resident #2 could be affected if she missed one day of the Omeprazole depending on how severe her reflux was. Based on eMAR documentation, medication dispensing record, and medications on hand, Resident # 2's Omeprazole 20mg was not administered four times since the medication was dispensed on 04/14/22. Interview with Resident #2 on 05/05/22 at 9:04am revealed: -She was not administered her medication today. -She was supposed to take a pill "really early in the morning" and she had missed it for "quite a few days." -Her primary care provider had ordered the pill for her reflux. -She had been burping a lot and it hurt to burp. Observation of Resident #2 on 05/05/22 between 9:04am-9:15am revealed the resident holding her stomach, burping, and grimacing. Second interview with Resident #2 on 05/05/22 at 1:58pm revealed:	{D 358}		

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{D 358}	Continued From page 51 -She told the Resident Care Coordinator (RCC) the MA did not give her Omeprazole today, 05/05/22. -She had missed her Omeprazole a couple of days, that was why she was burping so bad. -If she missed one day taking her Omeprazole she would hurt in her stomach and burp a lot. Interview with the RCC on 05/06/22 at 9:36am revealed: -The third shift MA passed Resident #2's Omeprazole because it was scheduled for 6:30am. -If the third shift MA was running behind and not able to pass the medication, she would let the next shift MA know, so the medication could be administered. -She administered 7:00am medications yesterday, 05/05/22. -She did not administer Resident #2's Omeprazole because the MA had not reported to her that she was not able to administer the medication. -Resident #2 would usually tell someone if she missed a pill. -Resident #2 did not tell anyone she had missed her Omeprazole. Attempted telephone interview on 05/06/22 at 10:53am with the third shift MA who documented administering Resident #2's Omeprazole on 05/05/22 was unsuccessful. Telephone interview with another third shift MA on 05/06/22 at 10:54am revealed: -She had administered Resident #2's Omeprazole before when she worked. -She did not recall the last time she administered Resident #2's Omeprazole. -There had been 2-3 times when she was not	{D 358}		

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{D 358}	Continued From page 52 able to complete her morning medication pass and she would tell the first shift MA who was supposed to then administer the medication. Refer to the interview with the Administrator on 05/06/22 at 10:19am and 12:50pm. b. Review of Resident #2's current FL-2 dated 02/08/22 revealed an order for Vitamin D 50,000u capsule once a week. (Vitamin D is used to treat a vitamin deficiency). Review of Resident #2's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D 50,000u weekly with a scheduled administration time of 8:00am. -There was documentation Vitamin D was administered at 8:00am on 02/05/22, 02/12/22, 02/19/22, and 02/26/22. -There were 4 doses of Vitamin D documented as administered; there were no exceptions documented. Review of Resident #2's March 2022 eMAR revealed: - There was an entry for Vitamin D 50,000u with a scheduled administration time of 8:00am. -There was documentation Vitamin D was administered at 8:00am on 03/05/22, 03/12/22, 03/19/22, and 03/26/22. -There were 4 doses of Vitamin D documented as administered; there were no exceptions documented. Review of Resident #2's April 2022 eMAR revealed: -There was an entry for Vitamin D 50,000u with a scheduled administration time of 8:00am.	{D 358}		

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{D 358}	Continued From page 53 -There was documentation Vitamin D was administered at 8:00am on 04/02/22, 04/09/22, 04/16/22, 04/23/22, and 04/30/22. -There were 5 doses of Vitamin D documented as administered; there were no exceptions documented. Observation of Resident #2's medications on hand on 05/05/22 at 10:47am revealed: -There was a bubble pack labeled for Vitamin D 50,000u. -Four tablets of Vitamin D were dispensed on 04/01/22. -There were 2 of 4 tablets available to be administered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/05/22 at 1:49pm revealed: -Resident #2 was dispensed a 4-week supply of Vitamin D on 04/01/22 and 05/03/22. -Resident #2's Vitamin D was not automatically refilled, and refills would need to be requested by the medication aide (MA). -Resident #2's Vitamin D was not requested to be refilled in March 2022. Based on eMAR documentation, medication dispensing record, and medications on hand, Resident #2 missed 2 doses of her weekly Vitamin D 50,000u. Telephone interview with Resident #2's PCP on 05/05/22 at 4:22pm revealed: -He did not recall the reason Vitamin D 50,000u was prescribed for Resident #2, as he was not the original prescriber, but the medication was usually prescribed for someone who had a low Vitamin D level. -He did not know if Resident #2's Vitamin D level	{D 358}		

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{D 358}	Continued From page 54 was therapeutic or not. Interview with Resident #2 on 05/06/22 at 9:28am revealed: -She did not know all the medications she took. -She knew she took a little green pill (Vitamin D pill in the resident's bubble pack) but did not know how often she took it. -She did not know why she took Vitamin D but if her PCP wrote a prescription for it, he must have wanted her to take it. Interview with the RCC on 05/06/22 at 9:36am revealed: -Resident #2 received her Vitamin D once a week. -Resident #2 had not missed any doses of Vitamin D. Telephone interview with a MA on 05/06/22 at 10:23am revealed: -She had administered Resident #2's Vitamin D when she worked. -She did not know why there were extra Vitamin D tablets on hand. Refer to the interview with the Administrator on 05/06/22 at 10:19am and 12:50pm. Interview with the Administrator on 05/06/22 at 10:19am and 12:50pm revealed: -The MAs should be comparing the medications to the eMAR. -The MA should click on the eMAR once the medication has been verified. -If medications were not administered, there would be an exception noted on the eMAR. The facility failed to ensure medications were administered as ordered for 2-residents observed	{D 358}		

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{D 358}	Continued From page 55 during the medication pass including omission of a blood pressure medication for Resident #6 who had experienced blood pressure readings of 92/77 to 157/93 and Resident #8 who was not administered her medication for diabetes with blood sugar readings of 124-539 and a medication for depression; and 2 of 6 sampled residents for record review including Resident #2 who experienced painful symptoms of acid reflux and was not administered her reflux medication as ordered and who was not administered a supplement and Resident #6 who was not administered a medication to treat behaviors, inflammation, depression and circulation. The facility's failure to administer medication as ordered was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/06/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 20, 2022.	{D 358}		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by:	D 371	Inservice/Re-education was completed by facility RN. MA in question was placed in 15-hr retraining Medication Administration and Infection Control training.	5/13/22

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D 371	Continued From page 56 Based on observations and interview, the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA), who performed a fingerstick blood sugar (FSBS) and insulin injection with ungloved, bare hands; and failed to wash her hands with soap and water and before and after FSBS check and insulin administration. The findings are: Review of the facility's infection control policy revealed: -Standard precautions apply when contact may occur to any bodily fluid. -Gloves were worn when touching body fluids. -Gloves were removed and effective handwashing was to be completed after contact with bodily fluids. -Effective handwashing consisted of warm water, antibacterial soap, applying friction and vigorously rubbing all aspects of the hand including between the fingers and around the Fingernails for 20 seconds, rinse thoroughly, shake off excess water and dry hands thoroughly with a paper towel. Observation of the morning medication pass on 05/05/22 at 8:26am revealed: -The medication aide (MA) initiated preparing to check a FSBS by gathering a glucometer, a lancet, a glucose strip and an alcohol wipe. -The MA turned the glucometer on and placed the glucose strip in the meter. -The MA approached a resident, cleaned her fourth finger on her right hand, pricked the finger with the lancet and placed a drop of blood on the glucose strip. -The FSBS reading was 326. -The MA returned to the medication cart and used	D 371	Monthly Inservice/Re-education for all MA will be completed by facility RN/Administrator. Ongoing random spot-checks will be performed to ensure Infection Control safety.	

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D 371	Continued From page 57 hand sanitizer to clean her hands. -She retrieved the residents insulin pen, pen needle and an alcohol swab; she placed the needle on the insulin pen. -She administered the insulin as ordered to the resident. -She returned to the medication cart, placed the insulin pen in the top drawer of the medication cart, then sanitized her hands with hand sanitizer. -The MA did not don gloves while obtaining the FSBS or administration of the insulin to the resident. -The MA did not wash her hands as stated in the policy when coming in contact with bodily fluids may occur. Interview with a MA on 05/06/22 at 10:56am revealed: -She would don gloves before she retrieved the supplies for a FSBS. -She would obtain the FSBS and place the glucose strip in the red box on the medication cart. -She would clean the glucometer and place on the medication cart, then wash her hands. -She would retrieve the insulin pen and administer the medication. Interview with the Special Care Unit Coordinator (SCUC) on 05/06/22 at 8:09am revealed: -The MAs should wash their hands thoroughly before donning and doffing gloves. -Gloves should be worn when performing FSBS checks and administration of insulin. -The MAs were expected to wear gloves and wash their hands when appropriate. Interview with the Administrator on 05/06/22 at 10:00am revealed: -The MAs should wash their hands with soap and	D 371		

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D 371	Continued From page 58 water and don gloves before performing a FSBS check. -The MAs should wash their hand with soap and water once gloves were removed. -All staff have infection control training annually. -The MAs were expected to wear gloves and wash their hands when there was a potential for contact with bodily fluids.	D 371		
{D 612}	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to the residents during the global coronavirus (COVID-19) pandemic as	{D 612}	Facility has updated policy and procedure to reflect CDC guidelines and Health Department Regulations. Ongoing Inservice/Re-education will be completed by facility RN/Administrator at all staff meetings and will include a. source control measures for HCP. b. source control referred to the use of a well-fitting facemask to cover person's mouth and nose. C. fully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. All residents and staff will be evaluated daily for signs and symptoms. Facility Administrator will adhere to COVID-19 requirements, ensure staff are wearing masks and that the residents are being screened daily.	5/12/22

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{D 612}	Continued From page 59 related to the screening of residents and the use of facemasks by staff. The findings are: 1. Review of the CDC Interim Infection Prevention and Control Recommendations to prevent SARs-CoV-2 spread in Nursing Homes dated 02/22/22 revealed residents should be evaluated daily for symptoms of COVID-19 and actively monitor residents for fever. Review of the NC DHHS COVID-19 Post Acute Care Setting Infection Control Assessment and Response (ICAR) tool dated 10/2021 revealed the staff and residents should be actively screened daily for fever, signs, and symptoms of COVID-19. Review of the facility's Infection Control Protocol dated 05/01/17 revealed: -There was no date for the protocol related to COVID-19. -Staff were to monitor residents daily for signs of COVID-19 including temperature. Review of three residents' March 2022, April 2022, and May 2022 electronic medication administration records (eMARs) revealed there was no documentation of daily temperature checks. Interview with 6 residents on 05/25/22 and 05/06/22 revealed: -One resident had his temperature randomly checked, but "not every day." -Another resident could not recall the last time his temperature was checked. -A third resident had his temperature checked by his primary care provider (PCP) when he had an	{D 612}		

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{D 612}	Continued From page 60 appointment but not by the facility staff. -Two residents could not recall the last time their temperature was checked. -A sixth resident had her temperature checked "sometimes" but not often; she could not recall the last time her temperature was checked by staff. Interview with the Special Care Unit Coordinator (SCUC) on 05/06/22 at 9:34am revealed: -Residents' temperatures should be taken daily and documented on the eMARs. -She thought all resident temperatures were being taken daily. -There was no other place residents' temperatures were being documented if they were not documented on the eMAR. Interview with a MA on 05/06/22 at 10:16am revealed: -Resident temperatures were taken during her shift, but not all residents got their temperatures taken. -All residents had their temperatures taken when the pandemic first started. -She thought residents who were diagnosed with COVID-19 were the ones who were still getting their temperatures taken. -She did not know the last time residents had their temperatures taken or why all residents did not have their temperatures taken daily. Interview with the Administrator on 05/06/22 at 12:54pm revealed: -She was aware of the CDC recommendation to check residents' temperatures at least once daily. -She did not know all residents' temperatures were not being checked at least once daily. 2. Review of the CDC Interim Infection Prevention	{D 612}		

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{D 612}	Continued From page 61 and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic updated 02/02/22 revealed: -Source control measures were to be implemented for Health Care Personnel (HCP). -Source control referred to the use of well-fitting facemasks to cover a person's mouth and nose to prevent the spread of respiratory secretions when the person was breathing, talking, sneezing, or coughing. -Fully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. Review of the NC DHHS COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 02/10/22 revealed facilities, residents, families, and visitors were to adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure. Review of the facility's Infection Control Protocol dated 05/01/17 revealed: -Staff were to use personal protective equipment as part of the infection control practices. -Facemasks needed to be worn by all staff at all times. -Facemasks were to be put on before entering the building. -Facemasks were to be extended under the chin and both the mouth and nose should be protected. -Facemasks were not to be worn under the chin or stored in scrubs pockets between care of residents. -Facemask loops were to be secured by hooking the loops appropriately around the ears. Observation from the outside of the facilty prior to	{D 612}		

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{D 612}	Continued From page 62 entering the facility on 05/05/22 at 7:56am revealed: -Two staff were seen, through a window, standing in the the Special Care Unit (SCU) dining hall and residents were seated around them. -The two staff were not wearing facemasks. Observation of the nurse's station on 05/05/22 at 7:57am revealed a female staff without a facemask. Observation in the SCU on 05/05/22 between 8:04am and 8:47am revealed: -A medication aide (MA) was wearing a facemask that only covered her mouth. -The MA pulled her mask down below her chin three times to speak to residents and other staff. Observation of the nurses station in the assisted living unit on 05/05/22 between 10:51am and 5:10pm revealed the medical records personnel had her mask below her chin. Interview with 8 residents on 05/05/22 from 8:12am to 9:20am revealed: -One resident stated staff sometimes forgot to wear facemasks. -Another resident stated some staff wore facemasks, but not all staff. -A third resident stated staff did not wear facemasks. -A fourth resident stated staff did not wear facemasks. -A fifth resident stated staff did not wear facemasks every day, but if an outside agency was in the building, they all wore facemasks. -A sixth resident stated staff did not wear facemasks even though they were supposed to. -A seventh resident stated not all staff wore facemasks.	{D 612}		

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{D 612}	Continued From page 63 -An eighth resident stated some staff wore facemasks all the time, but not all. Confidential interviews with two staff revealed: -On 05/05/22, a staff told everyone to put face masks on but did not say why. -They always wore their facemask, so it did not matter to them. -No one had told them they had to wear a facemask every day. -There was staff that did not wear facemasks every day. Interview with the Resident Care Coordinator (RCC) on 05/06/22 at 9:58am revealed: -Staff had been instructed to wear a facemask from the time they entered the facility until they exited the facility. -Facemasks were located at the nurse's stations and staff knew where to get them. -She was not wearing her facemask while sitting at the nurse's station on the morning of 05/05/22, because she was eating at the nurse's station. -She did not know why another staff was not wearing a facemask. -If staff was caught without a facemask, they were directed to put one on. -She had not had to remind any staff to put a facemask on, but that was not to say other staff had not had to. Interview with a personal care aide (PCA) 05/05/22 at 1:48pm revealed: -All staff usually wore a facemask throughout their shift. -Staff occasionally pulled the facemask down below their nose to breath, but they always pulled it back up.(This is out of place- this is about monitoring residents)	{D 612}		

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{D 612}	Continued From page 64 Interview with a resident on 05/05/22 at 2:30pm revealed all staff were not wearing facemasks daily, but they all had on a facemask today. Observation of a personal care aide (PCA) on 05/06/22 at 8:10am revealed: -She was not wearing a face mask. -The SCC called the PCA into the medication room and gave her a mask. Interview with the PCA at 8:11am revealed: -She would place her mask on before she entered the front door. -She did not have a mask to don before she entered the building. -She forgot to get a mask after she came into the building and started work. -No one had spoken to her about a mask today on 05/06/22, until the RCC instructed her to don a mask. Interview with the Administrator on 05/06/22 at 3:08pm revealed: -Staff should wear their facemasks while in the facility. -If a staff was in a room by themselves, then they could take their facemask down. -Staff usually had their facemasks on when she was in the facility. -Facemasks should be worn to cover the nose and the mouth. -She sometimes had to remind staff to wear their facemasks to cover their nose.	{D 612}		
{D911}	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights:	{D911}		

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	HAL034098	A. BUILDING: _____ B. WING _____	R 05/06/2022

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{D911}	Continued From page 65 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all residents were treated with respect and dignity related to a staff (Staff E), personal care aide (PCA), yelling and being verbally disrespectful towards residents including Resident #7. The findings are: Review of Resident #7's current FL2 dated 04/13/22 revealed diagnoses included decubitus ulcer, right elbow pain, multiple falls, weakness of both arms, impaired mobility and activities of daily living, and deep vein thrombosis of the femoral vein of the left lower extremity. Observation of the hallway on 05/05/21 at 11:51am revealed yelling was heard coming from the dining hall, but it was indistinguishable. Observation of the dining hall on 05/05/21 at 11:52am revealed: -Residents were seated in the dining hall and beverages had been passed out. -A personal care aide (PCA), Staff E, was standing near a table with a trash can tilted towards Resident #7 who was sitting at a nearby table. -Staff E was yelling at a Resident #7, "Get the rotten milk out of the trash can then." -Resident #7 repeated several times, "I dare you to say that." -Staff E snatched milk cartons from the table where she was standing and angrily threw the	{D911}	Resident Rights should be held in the upmost regard, which is why we will do monthly Inservice (in-house). Inservice was completed by our facility RN. Our goal going forward is to obtain quarterly Resident Rights for staff and residents. We have currently scheduled Resident Rights with our local Ombudsman for Resident and still awaiting a date for staff. Staff E was reprimanded and placed on a two-week suspension. Administrator(s) educated Staff E prior to returning to work on Resident Rights, proper tone, and communication with residents.	5/9/22

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{D911}	Continued From page 66 cartons in the trash can. Interview with Resident #7 on 05/06/22 at 1:44pm revealed: -She was in the dining on hall on 05/05/22 and residents were being served beverages. -She had not received her milk yet and had asked for milk. -Staff E yelled her saying the milk was spoiled and if she wanted it then she could get it out of the trash can. -It made her feel degraded when Staff E yelled at her. -"The staff are mean." Interview with Staff E, on 05/05/22 at 1:48pm revealed: -The cartons of milk were rotten, and the residents would not give the milk to her. -The milk cartons were dated 05/09/22, but some of the residents complained it was rotten. -She was just trying to tell the residents to give her the milk because they were going to get sick. -She was not yelling; she had a loud voice because she was deaf in one of her ears. -No residents that she knew of had complained about her yelling at them. Observation of the hallway on 05/05/21 at 11:58am revealed: -A resident walked up to Staff E and told her she wanted her to be her witness so she could confront another resident. -Staff E walked with the resident to the other residents' room and stood in the doorway as the resident confronted the other resident, cursed at her, and accused her of stealing from her. -After the resident finished the confrontation, Staff E told the resident to go to tell the Administrator the other resident was stealing from her room.	{D911}		

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{D911}	Continued From page 67 Interview with a resident on 05/05/22 at 2:00pm revealed: -Staff E was a little disrespectful and hateful. -He heard Staff E say to a resident a few weeks ago, "If you can't do it yourself, then I'm not going to help you". -Staff E was disrespectful to him a few days ago in the dining hall and told him, "You need to sit down and shut your mouth." -It made him feel uneasy and he did not like it. -"They (staff) need to respect us." Interview with a second resident on 05/05/22 at 2:10pm revealed: -Staff E yelled at residents and ordered residents around. -Staff E treated residents like they were children and like they were stupid. -During lunch today, Staff E was taking residents' milk because she said it was spoiled. -She had tasted her milk and it was not spoiled; She told staff E her milk was not spoiled. -Staff E took her milk from the table and she tried to take it back from her; Staff E snatched the milk out of her hand, but she did give it back to her. -Staff E was "bossy and that she was in charge". -She went to the dining room to eat and expected it to be peaceful, but almost every day, Staff E and other staff yelled at residents about something. Interview with a third resident on 05/05/22 at 2:25pm revealed Staff E criticized residents and seemed to have gotten worse over the last few days. Interview with a fourth resident on 05/05/22 at 3:01pm revealed: -Staff E yelled at residents a lot, said rude things,	{D911}		

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{D911}	Continued From page 68 and gave residents a hard time -He heard Staff E yelling more in the dining hall. Interview with a fifth resident on 05/05/22 at 3:08pm revealed: -He went to the resident council meetings and residents usually complained about the staff. -One of the biggest complaints about staff was that they did not have patience and got mad at the least little thing. Interview with a sixth resident on 05/05/22 at 3:11pm revealed: -Some of the staff did not know how to speak to the residents. -They could tone it down. -Staff was confrontational to residents at times if the residents did not want to do something. Interview with a seventh resident on 05/05/22 at 3:32pm revealed: -Staff E yelled all the time and was very rude. -"I think she is a bully." -She heard Staff E ask a resident if she was 4 years old. -Staff E had not been at the facility that long, but she developed an attitude real fast and she was loud. Interview with the Resident Care Coordinator (RCC) on 05/05/22 at 4:32pm revealed no residents complained to her about staff being disrespectful or yelling at them. Interview with an eighth resident on 05/05/22 at 5:22pm revealed sometimes staff were not nice to residents. Interview with ninth resident on 05/05/22 at 5:25pm revealed:	{D911}		

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{D911}	Continued From page 69 -He had seen a personal care assistant (PCA) raise her voice at residents. -Sometimes staff would get mad at you when you asked them to do things. Interview with the Administrator on 05/06/22 at 12:54pm revealed: -Staff E usually spoke loudly and she could hear her in the hallways from her office. -She had not heard staff E speak inappropriately to any residents and no residents had ever complained to her about Staff E being rude or yelling. -She addressed any known residents' rights issues with staff immediately.	{D911}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care and medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure referral and	{D912}	Facility will strive to ensure that all Residents will receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	

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{D912}	Continued From page 70 follow-up to meet the routine and acute healthcare needs for 2 of 5 sampled residents (#3, #5) related to a resident who had loosened leg wraps and whose toenails needed to be trimmed (#3) and a resident who had a diagnosis of dementia, a history of behaviors, and was in physical altercations with other residents (#5). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Unabated Type B Violation)]. 2. Based on observation, interview, and record reviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#6 and #8) observed during the morning and noon medication pass, including omission of a blood pressure medication (#6); and a medication for diabetes and depression (#8); and for 3 of 6 sampled residents (#2, #4 and #6) for record review including errors with medication used to treat elevated blood pressure, a medication used to treat high cholesterol, a medication used to treat depression, a medication used to manage behaviors, a medication to decrease inflammation, a medication for circulation and a supplement (#6); a medication used to treat and prevent constipation (#4); and a medication used to treat reflux and a medication used to treat a vitamin deficiency (#2). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	{D912}		