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
	hal-051065	A. BUILDING: ______ B. WING ______	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	**200 KELLIE DRIVE SMITHFIELD, NC 27577**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on July 6, 2022 - July 7, 2022.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#5) related to administration of medication used to treat constipation. The findings are: Review of Resident #5's current FL-2 dated 09/30/21 revealed: -Diagnoses included dementia and hyperlipidemia. -She was intermittently confused. -She was incontinent of bladder and bowel. Review of Resident #5's current care plan dated 09/30/21 revealed -She required total assistance with eating. -She required limited assistance with toileting, ambulation, bathing, dressing, grooming and transferring.	D 358		

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D 358	Continued From page 1 -She was ambulatory using a wheelchair. -She was occasionally incontinent of bowel and bladder. Review of a progress note from Resident #5's hospice primary care provider (PCP) dated 06/15/22 revealed: -There was an order to discontinue all medications except comfort medications. -The medications that were to be discontinued were as follows: Vitamin C, Aspirin, Citalopram, Docusate, Melatonin, Namenda, Midodrine, Omeprazole, Vitamin D3 and Zinc. -There was an order to increase the hospice nurse visits to twice a week starting 06/17/22. Review of Resident #5's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Docusate Sodium 100mg take 2 tabs (200mg) once a day with scheduled administration time at 9:00am. (Docusate Sodium is used to treat constipation.) -Docusate Sodium was documented as administered from 05/01/22 - 05/31/22. Review of Resident #5's June 2022 eMAR revealed: -There was an entry for Docusate Sodium 100mg take 2 tabs (200mg) once a day with scheduled administration time at 9:00am. -Docusate Sodium was documented as administered from 06/01/22 - 06/30/22. Review of Resident #5's July 2022 eMAR revealed: -There was an entry for Docusate Sodium 100mg take 2 tabs (200mg) once a day with scheduled administration time at 9:00am. -Docusate sodium was documented as	D 358		

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administered from 07/01/22 - 07/06/22.

Interview with the Resident Care Coordinator (RCC) on 07/07/22 at 11:55am revealed:
-She thought that she had discontinued all of Resident #5's medications except for the comfort medications.
-She was not aware that Resident #5 still had the docusate sodium on her eMAR.
-It was the responsibility of the RCC to update medications on the resident's eMAR and to notify the pharmacy of the updates via fax.

Interview with Resident #5's family member on 07/07/22 at 1:16pm revealed Resident #5 was only receiving medications to treat end of life symptoms and control pain.

Interview with the Executive Director on 07/07/22 at 12:28pm revealed it was the responsibility of the RCC to update the resident's eMAR and fax new orders to the pharmacy.

Telephone interview with Resident #5's primary care provider (PCP) on 07/07/22 at 1:48pm revealed:
-She was not aware that Resident #5 was still receiving Docusate Sodium daily.
-She thought that this medication was discontinued, as well as the other medications that were not end of life medications.
-This was a medication error and she expected the facility to have completed a medication error report and to have notified her of the error.
-Resident #5 had been having some occasional loose stools that could have been related to her still receiving the Docusate Sodium.

Attempted telephone interview with Resident #5's hospice nurse on 07/07/22 at 1:22pm was

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D 358	Continued From page 3 unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 1 of 5 sampled residents (#4) related to a medication administered to treat high blood pressure not	D 367		

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documented on the MAR.

The findings are:

Review of Resident #4's current FL-2 dated 05/18/22 revealed:
-Diagnoses included mild dementia, depression/anxiety, headaches, diabetes mellitus type 2, right carotid artery stenosis, and hypertension.
-There was no order for metoprolol tartrate (used to treat high blood pressure) 50mg tablet twice daily.

Review of Resident #4's physician orders for metoprolol tartrate revealed:
-On 11/17/21 there was an order for metoprolol tartrate 50mg tablet twice a day.
-On 04/14/22 there was an order to start metoprolol tartrate 50mg tablet every morning and metoprolol 25mg tablet at bedtime.
-On 04/20/22 there was an order for metoprolol tartrate 50mg two times a day.
-There were no additional physicians' orders for metoprolol tartrate for Resident #4.

Review of Resident #4's Primary Care Provider (PCP) visit note dated 04/28/22 revealed:
-The PCP visit note was electronically signed on 05/01/22.
-The PCP documented in the section for "Medications", a "stop date" of 04/29/22 for metoprolol tartrate 50mg tablet twice daily.
-There was no documented order in the section for "Orders" to discontinue the metoprolol tartrate 50mg tablet.
-There were no additional physicians' orders for metoprolol tartrate documented on the 04/28/22 PCP visit note.

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Review of subsequent electronically signed PCP visit notes for Resident #5 revealed:
-On 05/04/22 and 05/18/22, there was no documentation of metoprolol tartrate prescribed for Resident #5.
-On 06/01/22, there was an entry to the PCP visit note of "BP uncontrolled during visit. Denies chest pain, shortness of breath, or headache. Compensated with metroprolol. Patient has cardiology appointment on 07/18. Continue to check BP and HR."

Review of Resident #4's May 2022 electronic medication administration records (eMARs) revealed:
-There was no entry for metoprolol tartrate 50mg 1 tablet twice daily.
-There was no documentation for metoprolol tartrate 50mg 1 tablet daily being administered.

Review of Resident #4's June 2022 electronic medication administration records (eMARs) revealed:
-There was no entry for metoprolol tartrate 50mg 1 tablet twice daily.
-There was no documentation for metoprolol tartrate 50mg 1 tablet daily being administered.

Review of Resident #4's July 2022 electronic medication administration records (eMARs) revealed:
-There was no entry for metoprolol tartrate 50mg 1 tablet twice daily.
-There was no documentation for metoprolol tartrate 50mg 1 tablet daily being administered.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/07/22 at 12:44pm revealed:
-The most recent order for Resident:4's

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D 367	Continued From page 6 metoprolol tartrate was date 04/21/22 for metroprolol 50mg twice daily. -The pharmacy had dispensed the metroprolol tartrate 50mg since 04/21/22 for a seven-day supply weekly. -There was not a copy of the 05/18/22 physician orders sheet on file at the pharmacy. -The pharmacy entered new orders to the EMARs. -The facility was responsible for reviewing and accepting any orders that were entered to the EMARs. -She was not sure why the metoprolol tartrate order was not populating to Resident #4's EMAR but thought the order could have gone to a "failed folder" which facility staff were able to view and reconcile. -The medications were dispensed to the facility in multi-dose packaging. -She did not know if the medication aides (MAs) had been removing the metoprolol tartrate from the multi-dose packaging if it was not populating on the EMARs with instructions for administration. Observation on 07/07/22 at 1:05pm of Resident #4's medications on hand revealed: -Medications were supplied in multi-dose packaging. -Medications to be administered at 8:00am daily were supplied together in an 8:00am dosing package. -Medications to be administered at 8:00pm daily were supplied together in an 8:00pm dosing package. -Metoprolol Tartrate 50mg was included in the 8:00am and 8:00pm dosing package. Interview with a MA on 07/07/22 at 1:15pm revealed: -She administered medications according to the	D 367		

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instructions on the EMARs.
-She administered 8:00am medications to Resident #4 on 07/07/22.
-She did not discard any of the medications from Resident #4's 8:00am dosing package.
-She was not allowed to discard medications from the multi-dose packaging.
-"Normally" the multi-dose packaged medications matched the EMARs.

Interview with the Resident Care Coordinator (RCC) on 07/07/22 at 12:27pm revealed:
-She was not sure what happened that the metoprolol tartrate entry was not showing up on the EMARs with instructions for administration.
-She was not aware of any changes with administration of the metoprolol tartrate to Resident #5 since 04/20/22.
-Sometimes the pharmacy updated physician orders and the orders did not populate to the EMARs with instructions for administration.

Interview with the Executive Director (ED) on 07/07/22 at 2:58pm revealed:
-The RCC should be completing medication cart audits weekly.
-She expected staff to ensure medications on hand matched the medications on hand prescribed for administration.

Telephone interview with Resident #4's PCP on 07/07/22 at 3:15pm revealed:
-Resident #4 needed to be administered the metoprolol tartrate.
-The RCC notified her today (07/07/22) that the metoprolol tartrate 50mg twice daily was not being documented as administered.
-There could be a plan of care issue if the medication was not documented as administered such as an accurate assessment of blood

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D 367	Continued From page 8 pressure results. -Resident #4 should be going to see a cardiologist soon.	D 367		