Received via electronic mail 07/28/22

PLAN OF CORRECTION for Follow Up Survey, completed June 29, 2022.

Spring Arbor of Thomasville
HAL-029-012
Davidson County

It is the policy and standard practice of Spring Arbor of Thomasville to comply with all North Carolina Adult Care rules and state regulations.

D 273 / 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.

Plan of Correction

Immediately following this survey, the Primary Care Provider (PCP) for Resident #3 was contacted to review this resident's medication refusals and to clarify orders.

An audit of eMARs for medication refusals for the past 30 days was conducted by the Resident Care Director and Assistant Resident Care Coordinator and PCPs contacted as needed.

Inservices were conducted with All Medication Aides to review Spring Arbor's policy on refusal of medications by any resident. This included communication to Supervisor or Resident Care Director (RCD), communication to Primary Care Provider, communication to family as needed, and appropriate documentation. Trainings were conducted by the RCD and the Regional Nurse on 6/30, 7/1, 7/6 & 7/15/22 to ensure All Medication Aides were in attendance.

Prevention of Re-occurrence:

Medication Aide trainings are held monthly by the RCD and Assistant Resident Care Coordinator, (ARCC) to review proper and safe medication administration practices and Spring Arbor policies.

Supervisors-in-Charge will use the Shift-to-Shift report as a communication alert to oncoming shift, RCD, ARCC, Cottage Care Coordinator (CCC) and Executive Director (ED) about medication refusals.

PLAN OF CORRECTION for Follow Up Survey, completed June 29, 2022.

Monitoring Responsibility & Frequency

It is the responsibility of the RCD, ARCC and/or designee to regularly review Shift-to-Shift communication about medication refusals and to audit Accuflo program for documented medication refusals weekly for 90days and then monthly on-going.

The Regional Nurse will randomly audit resident eMARs for medication refusals and appropriate actions and documentation during quarterly community visits.

Correction Completion Date: 7/15/2022

D 358 / 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.

Plan of Correction

Immediately following this survey, the Primary Care Physician for Resident #1 and the Primary Care Provider for Resident #3 were each contacted, to review and clarify specific medication orders.

A review was conducted of all PRN medication administration timeframes including Controlled Substances and documentation, and all warfarin orders were reviewed for completion including documentation to assure compliance.

Inservices were held for Medication Aides, reviewing medication administration safe practices, incorporating PRN orders, warfarin therapy, and complete documentation of medication administrations. This training was conducted by the Resident Care Director and Regional Nurse on 6/30/2022.

MAST LTC Pharmacist Kimberly Jones was immediately contacted following survey findings and a Coumadin Therapy In-Service for Medication Aides, RCD, ARCC and CCC was set up and conducted on 7/27/22.

PLAN OF CORRECTION for Follow Up Survey, completed June 29, 2022.

Prevention of Re-occurrence:

Weekly audit reports are reviewed in Accuflo program for all PRN medication usage by the RCD, ARCC or designee.

A revised system with preferred lab provider, MAKO to have lab portal results e-mailed to RCD, ARCC, CCC and/or designee.

Monitoring Responsibility & Frequency

It is the responsibility of the RCD, ARCC, CCC and/or designee to regularly review orders for all PRN administrations including Controlled Substances and to audit compliance with administration and documentation of their effectiveness in the eMAR. The RCD and/or ARCC will audit the Warfarin Log and the eMAR for timely lab work and compliance with orders.

The Regional Nurse will randomly audit resident eMARs for all PRN medication orders and orders for warfarin therapy and required lab work and to assure compliance with all administration and documentation during quarterly community visits and as needed

Correction Completion Date: 7/28/2022

D 366 / 10A NCAC 13F .1004 Medication Administration
(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited

Plan of Correction

Immediately following this survey, a room-by-room search was conducted, to assure that no untended medications were out and available in any resident apartment or common area.

Inservices were held for Medication Aides, to review proper medication administration procedures, including actual observation of resident taking medication before leaving the resident and before documenting administration. This re-education and training was conducted by the RCD and Regional Nurse on 6/30/2022.

PLAN OF CORRECTION for Follow Up Survey, completed June 29, 2022.

A Medication Aide Inservice was conducted on 7/21/2022, to emphasize with each medication Aide of our policy of "no untended medications" in the community, and to promptly report to the Supervisor or RCD/ARCC if loose and untended medications are observed in a resident's apartment or common area. An All Staff Inservice is scheduled for 8/04/2022 to reinforce this policy with each team member.

Prevention of Re-occurrence:

All team members who have reason to be in a resident's apartment are reminded regularly to keep alert for safety concerns, including any loose and untended medications, and to report these immediately to an SIC or other manager.

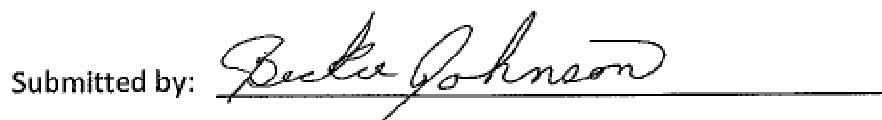
Medication Aide training is conducted monthly by the RCD and ARCC. Review of safe and proper medication administration practices is addressed, including Spring Arbor policies of no pre-pouring medications, and always staying with a resident until a medication has been observed to be taken.

Monitoring Responsibility & Frequency

The RCD, ARCC and/or ED will conduct random room checks each week, to assure that no medications are loose and untended in a resident's room.

The RCD and/or ARCC will regularly observe medication administration procedures with Medication Aides to assure that pre-pouring is not occurring.

Correction Completion Date: 7/28/2022

Submitted by:  Date: 7/28/2022

Beckie Johnson, Executive Director

Reviewed and acknowledged 07/29/22. SG

Received via electronic mail 07/28/22

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
	HAL029012	A. BUILDING: ______ B. WING ______	R 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THOMASVILLE	915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 06/28/22 through 06/29/22.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 3 sampled residents (#3) who had medication refusals for an eye drop solution and an inhaler. The findings are: Review of the facility's Medication Administration policy dated September 2020 revealed that if a resident refused a medication three times, the physician was to be notified. a. Review of Resident #3's current FL2 dated 05/12/22 revealed: -Diagnoses included asthma. -There was an order for Symbicort (an inhaled bronchodilator medication used to treat asthma) 2 puffs twice daily. Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Symbicort inhale 2 puffs twice daily scheduled at 8:00am and 8:00pm. -There was documentation Resident #3 refused	D 273		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Becky Johnson
TITLE — Exc. Director Spring Arbor Thomasville, NC
(X6) DATE — 7/28/22

Reviewed and acknowledged 07/29/22. SG.

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D 273	Continued From page 1 Symbicort 8 times from 04/01/22 through 04/30/22. Review of Resident #3's May 2022 eMAR revealed: -There was an entry for Symbicort inhale 2 puffs twice daily scheduled at 8:00am and 8:00pm. -There was documentation Resident #3 refused Symbicort 7 times from 05/01/22 through 05/31/22. Review of Resident #3's June 2022 eMAR revealed: -There was an entry for Symbicort inhale 2 puffs twice daily scheduled at 8:00am and 8:00pm. -There was documentation Resident #3 refused Symbicort 12 times from 06/01/22 through 06/28/22. Review of Resident #3's progress notes on 06/28/22 at 11:00am revealed there was no documentation the primary care provider (PCP) had been notified of Resident #3 refusing Symbicort more than 3 times. Interview with Resident #3 on 06/28/22 at 1:30pm revealed: -She used her Symbicort inhaler to help control her asthma. -She refused the Symbicort whenever she felt like she did not need it. Interview with a medication aide (MA) on 06/28/22 at 2:10pm revealed: -She documented Resident #3's Symbicort as refused 4 times in April 2022, 3 times in May 2022, and 5 times in June 2022. -She thought the facility's policy on medication refusal was to notify the PCP if a resident refused a medication for three consecutive days.	D 273		

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D 273	Continued From page 2 -The MA was responsible for notifying the Resident Care Director (RCD) or the Assistant Resident Care Director (ARCD) about refusals if the MA did not have time to complete the notification, and the RCD or ARCD would be responsible for notifying the PCP. -She had not notified the PCP about Resident #3 refusing Symbicort because she usually worked night shift when the PCP's office was closed. Interview with a second MA on 06/28/22 at 3:50pm revealed: -She had documented Resident #3's Symbicort as refused 3 times in June 2022. -She had not notified the PCP or the ARCD about Resident #3's Symbicort refusals. -She did not know what the facility's policy was on medication refusals. -She thought the MA was supposed to notify the ARCD if a resident frequently refused a medication, and the ARCD would notify the PCP. -She thought one of the other MAs had already notified the ARCD about the Symbicort refusals. Interview with the ARCD on 06/29/22 at 11:00am revealed: -She did not know Resident #3 had refused Symbicort 8 times in April 2022, 7 times in May 2022, and 12 times in June 2022. -She completed audits of the eMAR, but mostly to check that the orders on the eMAR matched the physician orders in the resident's record. -If a resident was refusing medication, the MA was responsible for letting either herself or the RCD know so that they could notify the PCP. Telephone interview with Resident #3's PCP on 06/29/22 at 11:30am revealed: -He prescribed Symbicort to Resident #3 to help control her asthma.	D 273		

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D 273	Continued From page 3 -He was not aware that she had been refusing Symbicort. -He would want to be notified about the Symbicort refusals once Resident #3 refused it more than a couple of times in a week. -Symbicort was a maintenance inhaler so refusing frequent doses of it could exacerbate her asthma symptoms and cause shortness of breath. Interview with the RCD on 06/29/22 at 11:50am revealed: -The facility's policy was to notify the PCP if a medication was refused three or more times. -Part of the training they did with MAs was how to send notifications to the PCP. -She tried to audit the eMARs once a month for all residents, and frequent medication refusals was one of the areas she reviewed. -She was not aware Resident #3 had refused Symbicort 8 times in April 2022, 7 times in May 2022, and 12 times in June 2022. Interview with the Administrator on 06/29/22 at 12:16pm revealed: -She was not aware Resident #3 had refused Symbicort 8 times in April 2022, 7 times in May 2022, and 12 times in June 2022. -She expected the MAs to notify the PCP if a resident refused 3 or more doses of a medication so that the order could be adjusted or discontinued, and to document the notification once complete. b. Review of Resident #3's physician's order dated 03/19/21 revealed an order for Cromolyn 4% (a medicated solution used to treat symptoms of the eye caused by allergies) eye drops instill 1 drop into the right eye four times daily.	D 273		

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D 273	Continued From page 4 Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Cromolyn 4% eye drops instill 1 drop into the right eye four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation Resident #3 refused Cromolyn 4% eye drops 7 times from 04/01/22 through 04/30/22. Review of Resident #3's May 2022 eMAR revealed: -There was an entry for Cromolyn 4% eye drops instill 1 drop into the right eye four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation Resident #3 refused Cromolyn 4% eye drops 18 times from 05/01/22 through 05/31/22. Review of Resident #3's June 2022 eMAR revealed: -There was an entry for Cromolyn 4% eye drops instill 1 drop into the right eye four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation Resident #3 refused Cromolyn 4% eye drops 35 times from 06/01/22 through 06/28/22. Review of Resident #3's progress notes on 06/28/22 at 11:00am revealed there was no documentation the primary care provider (PCP) had been notified of Resident #3 refusing Cromolyn 4% more than 3 times. Interview with Resident #3 on 06/28/22 at 1:30pm revealed: -She had the prescription for Cromolyn 4% eye	D 273		

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D 273	Continued From page 5 drops because her right eye was a prosthetic. -Since she received her eye drops several times daily, she refused it because she did not want to be bothered with it sometimes. Telephone interview with a representative from Resident #3's PCP's office on 06/29/22 at 2:40pm revealed: -Resident #3 was prescribed Cromolyn 4% eye drops to prevent allergy-type symptoms such as irritation due to her having a prosthetic eye. -The PCP had not been notified by the facility that Resident #3 had been refusing her eye drops. -The PCP expected the facility staff to notify their office if Resident #3 was refusing her Cromolyn 4% eye drops so that the ordered frequency could be adjusted. -Refusing to use the Cromolyn eye drops could result in irritation to the eye around the prosthetic. Interview with a medication aide (MA) on 06/28/22 at 2:10pm revealed: -She thought the facility's policy on medication refusal was to notify the PCP if a resident refused a medication for three consecutive days. -The MA was responsible for notifying the Resident Care Director (RCD) or the Assistant Resident Care Director (ARCD) about refusals if the MA did not have time to complete the notification herself, and the RCD or ARCD would be responsible for notifying the PCP. -She had documented Resident #3's Cromolyn 4% eye drops as refused 3 times in April 2022, 5 times in May 2022, and 6 times in June 2022. -She had not notified the PCP about Resident #3 refusing Cromolyn 4% eye drops because she usually worked night shift when the PCP's office was closed. -She had noticed Resident #3's Cromolyn eye drop refusals and had written a note for the day	D 273		

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D 273	Continued From page 6 shift MA a couple of weeks prior so that the day shift MA could notify the PCP. -She did not know if the PCP had been notified or not. Interview with a second MA on 06/28/22 at 3:50pm revealed: -She had documented Resident #3's Cromolyn 4% eye drops as refused 4 times in June 2022. -She had not notified the PCP or the ARCD about Resident #3's Cromolyn 4% eye drop refusals. -She did not know what the facility's policy was on medication refusals. -She thought the MA was supposed to notify the ARCD if a resident frequently refused a medication, and the ARCD would notify the PCP. Interview with the ARCD on 06/29/22 at 11:00am revealed: -She did not know Resident #3 had refused Cromolyn 4% eye drops 7 times in April 2022, 18 times in May 2022, and 35 times in June 2022. -She completed audits of the eMAR, but mostly to check that the orders on the eMAR matched the physician orders in the resident's record. -If a resident was refusing medication, the MA was responsible for letting either herself or the RCD know so that they could notify the PCP. Interview with the RCD on 06/29/22 at 11:50am revealed: -The facility's policy was to notify the PCP if a medication was refused three or more times. -Part of the training they did with MAs was how to send notifications to the PCP. -She tried to audit the eMARs once a month for all residents and frequent medication refusals was one of the areas she reviewed. -She did not know that Resident #3 had refused Cromolyn 4% eye drops 7 times in April 2022, 18	D 273		

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D 273	Continued From page 7 times in May 2022, and 35 times in June 2022. Interview with the Administrator on 06/29/22 at 12:16pm revealed: -She did not know Resident #3 had refused Cromolyn 4% eye drops 7 times in April 2022, 18 times in May 2022, and 35 times in June 2022. -She expected the MAs to notify the PCP if a resident refused 3 or more doses of a medication so that the order could be adjusted or discontinued, and to document the notification once completed.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to administer medication as ordered for 2 of 3 sampled residents (#3 and #1) with orders for an anti-anxiety medication (#3) and an anti-coagulation medication (#1). The findings are: 1. Review of Resident #3's current FL2 dated 05/12/22 revealed: -Diagnoses included depression and anxiety.	D 358		

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D 358	Continued From page 8	D 358		

-There was an order for lorazepam (a controlled substance used to treat anxiety) 0.5mg once daily as needed.

Review of Resident #3's physician order dated 03/17/22 revealed there was an order change lorazepam from 0.5mg twice daily scheduled to 0.5mg once daily as needed for anxiety.

Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg, take 1 tablet once daily as needed.
-There was documentation lorazepam was administered on 04/14/22 at 12:45pm.

Review of Resident #3's Controlled Substance Count Sheet (CSCS) for April 2022 revealed lorazepam 0.5mg was documented as administered 04/14/22 at 1:00pm and at 8:00pm.

Review of Resident #3's May 2022 eMAR revealed:
-There was an entry for lorazepam 0.5mg, take 1 tablet once daily as needed.
-There was documentation lorazepam was administered on 05/04/22 at 12:23am and at 12:18pm.
-There was documentation lorazepam was administered on 05/17/22 at 12:30pm and at 9:45pm.
-There was documentation lorazepam was administered on 05/19/22 at 1:56am and at 11:49am.

Review of Resident #3's CSCS for May 2022 revealed:
-Lorazepam 0.5mg was documented as administered on 05/04/22 at 12:24am and

Division of Health Service Regulation

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D 358	Continued From page 9 12:18am. -Lorazepam 0.5mg was documented as administered on 05/17/22 at 12:30am and 9:45pm. -Lorazepam 0.5mg was documented as administered on 05/19/22 at 2:00am and 11:50am. Review of Resident #3's June 2022 eMAR revealed: -There was an entry for lorazepam 0.5mg take 1 tablet once daily as needed. -There was documentation that lorazepam was administered on 06/27/22 at 3:50am and at 10:36pm. Review of Resident #3's CSCS for June 2022 revealed lorazepam 0.5mg was documented as administered 06/27/22 at 3:51am and 10:29pm. Interview with Resident #3 on 06/28/22 at 1:30pm revealed: -She took lorazepam as needed when she felt anxious. -She did not know how often she could take it, she relied on the staff to monitor that for her. -She never needed to take her lorazepam more than two times in a day. Interview with a medication aide (MA) on 06/28/22 at 2:10pm revealed: -Resident #3 was prescribed lorazepam daily as needed. -The eMAR displayed the last administration time for as needed medications. -She had administered lorazepam to Resident #3 on 05/17/22 at 9:45pm, which was the second dose administered that day. -She had not realized Resident #3 had already received her lorazepam once on 05/17/22, she	D 358		

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D 358	Continued From page 10 thought she must have overlooked the date and time of the last dose administered. Interview with a second MA on 06/28/22 at 3:50pm revealed: -She had administered lorazepam to Resident #3 on 06/27/22 because Resident #3 had asked her for it. -She knew Resident #3 had already received one dose that day already, but thought since the order was to take it daily as needed, she could administer it whenever Resident #3 requested it. -She did not know Resident #3's lorazepam order was to take it one time daily as needed. Telephone interview with Resident #3's primary care provider (PCP) on 06/29/22 at 10:00am revealed: -She had changed Resident #3's lorazepam order from twice daily scheduled to once daily as needed. -She had attempted a gradual dose reduction to prevent Resident #3 from building a tolerance to the lorazepam so that it would remain effective at treating her anxiety when she took it. -She had not been aware that Resident #3 had received lorazepam two times daily instead of once daily five times from April 2022 through June 2022. -She expected the MAs to administer lorazepam to Resident #3 as it was ordered, or to notify her if she was consistently requesting it more than once a day so that the order could be adjusted. Interview with the Assistant Resident Care Director (ARCD) on 06/29/22 at 11:00am revealed: -She was not aware Resident #3 had received lorazepam more than once per day five times since April 2022.	D 358		

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D 358	Continued From page 11 -She and the Resident Care Director (RCD) completed audits of the eMAR, but during those audits she mostly checked the orders for accuracy. -She did review how often residents used their as needed medications, but she counted how many times it was administered per month, not per day. -There was no set schedule for when she completed the audits, they were usually done as needed if a MA reported frequent requests for medication or frequent refusals of medication. Interview with the RCD on 06/29/22 at 11:50am revealed: -She tried to audit eMARs for all residents once per month but there was no set schedule for which resident's eMAR she was going to review on a certain day. -During her audits, she looked at blood pressure and blood sugar parameters, as needed medication use, or medications that had not been administered and the reason why. -She did not know Resident #3 had received lorazepam more than once per day five times since April 2022. Interview with the Administrator on 06/29/22 at 12:16pm revealed: -She was not aware Resident #3 had received lorazepam more than once per day five times since April 2022. -She expected the MAs to pass medications according to the written instructions on the eMAR. -If a medication was only ordered to be taken once daily as needed, it should never be administered more than once per day. -If Resident #3 requested to take lorazepam a second time in a day, the MA should have notified the PCP to request a one-time order allowing a second dose that day.	D 358		

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D 358	Continued From page 12 2. Review of Resident #1's current FL2 dated 03/16/22 revealed: -Diagnoses included alzheimer's disease with late onset, unspecified dementia without behaviors disturbance and atherosclerotic heart disease. -There was an order for Coumadin (a blood thinner) 10mg once daily. Review of Resident #1's signed physician's orders dated 04/28/22 revealed an order for Coumadin (warfarin is generic) 7.5mg on Tuesday, Thursday, Saturday and Sunday; take 5mg daily on Monday, Wednesday, and Friday. Review of Resident #1's subsequent physician's orders dated 04/29/22 for warfarin tablets revealed: -Resident #1's goal range for International Normalized Ratio (INR) (used to measure the clotting time for residents on blood thinner), was documented as "2.5 to 3.5" (normal INR reference range for someone not on Coumadin is 1.1). -The INR on 04/29/22 was 1.9. -Resident #1's dosage for warfarin was 7.5mg daily on 04/29/22, 04/30/22, 05/01/22, and 05/02/22 and recheck INR on 05/03/22. Review of Resident #1's physician's order dated 05/03/22 revealed an order for warfarin 7.5mg daily (6 days a week) except 5mg daily on Wednesday. Re-check INR on 05/10/22. Review of Resident #1's electronic medication administration record (eMAR) for May 2022 revealed: -There was an entry for warfarin 7.5mg daily except 5mg daily on Wednesday, beginning on 05/04/22.	D 358		

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D 358	Continued From page 13 -There was an entry for warfarin 5mg on Wednesday, beginning on 05/04/22. -There was no documentation for administration of warfarin 7.5mg on 05/03/22 . Review of Resident #1's warfarin orders dated 05/10/22 (INR=3.9), 05/17/22 (INR=3.2), 05/24/22 (INR=3.0) compared to the May 2022 eMAR revealed: -Warfarin was documented as administered as ordered for 7.5mg daily except on Wednesday give 5mg from 05/03/22 to 05/31/22. -There was an order to recheck INR on 06/01/22. Review of Resident #1's warfarin order dated 06/01/22 revealed: -The INR was documented as 3.2. -There was an order for warfarin 7.5mg daily (6 days a week) except 5mg daily on Wednesday. Re-check INR on 06/14/22. Review of Resident #1's warfarin order dated 06/14/22 revealed: -The INR was documented as 3.3. -There was an order for warfarin 7.5mg daily (6 days a week) except 5mg daily on Wednesday. Re-check INR on 06/28/22. Review of Resident #1's warfarin order dated 06/28/22 revealed: -The INR was documented as 3.4. -There was an order for warfarin 7.5mg daily (6 days a week) except 5mg daily on Wednesday. Review of Resident #1's eMAR for June 2022 revealed: -There was an entry for warfarin 7.5mg daily except 5mg daily on Wednesday, discontinued on 06/01/22. -There was an entry for warfarin 5mg on	D 358		

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Wednesday, discontinued on 06/01/22.
-There was an entry for warfarin 7.5mg daily except 5mg daily on Wednesday, beginning on 06/02/22.
-There was an entry for warfarin 5mg on Wednesday, beginning on 06/02/22.
-There was no documentation for administration of warfarin 5mg on 06/01/22 (Wednesday).
-There was no documentation for administration of warfarin 7.5mg on 06/14/22 (Thursday).

Observation of medication on hand for administration on 06/28/22 at 1:00pm revealed:
-There were 2 tablets of warfarin 5mg remaining for 2 warfarin 5mg tablets dispensed on 06/01/22 labeled for administration weekly on Wednesday.
-There was one warfarin 5mg tablet remaining for one warfarin 5mg dispensed on 06/14/22 label for administration weekly on Wednesday.

Interview with the Assistant Resident Care Director (ARCD) on 06/29/22 at 11:00am revealed:
-She and the Resident Care Director (RCD) completed audits of the eMAR, but during those audits she mostly checked the orders for accuracy.
-She reviewed the eMARs for missing doses.
-There was no set schedule for when she completed the audits, they were usually done as needed if a MA reported frequent requests for medication or frequent refusals of medication.

Interview with the RCD on 06/29/22 at 11:50am revealed:
-She tried to audit eMARs for all residents once per month, but there was no set schedule for which resident's eMAR she was going to review on a certain day.
-During her audits, she looked the accuracy and

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D 358	Continued From page 15 completeness of medication orders, not for missing administration. -She did not know Resident #1's warfarin was not administered as ordered for 3 doses from 05/03/22 to 06/28/22. -Missed doses of warfarin could change the effectiveness because it was a very narrow therapeutic dose range medication. Telephone interview with the Nurse Practitioner (NP) at Resident #1's warfarin clinic on 06/29/22 at 1:00pm revealed: -Resident #1's INR was checked by a home health agency and the results sent to the clinic on the day the INR was obtained. -The NP had discussed getting the INR results before lunch on the day the value was obtained to allow for time for her to review the INR results and send current warfarin orders to the facility's contracted pharmacy. -She expected the facility to administer Resident #1's warfarin daily including the day of the INR draw, unless instructed to hold the medication for elevated INR value outside the her goal range for INR of "2.5 to 3.5". -Not receiving warfarin as ordered would make maintaining therapeutic levels difficult. -There had not been any changes to Resident #1's warfarin doses over the last 2 months, but the range had been up and down slightly and most often reflected a missed dose. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/29/22 at 2:30pm revealed: -The pharmacy received warfarin orders for Resident #1 routinely by 3:00pm to 3:40pm on INR draw days. -The pharmacy entered new warfarin orders in the eMAR system as a pending order when	D 358		

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received.
-The facility would be responsible to accept the order for the new order to appear on the eMAR for medication aides (MA) to see for administration.
-The facility would be responsible to notify the pharmacy representatives if Resident #1 did not have a dose of warfarin to administer at 5:00pm on the day of the INR and new order.
-The pharmacy could coordinate receiving a dose from the facility's back-up pharmacy prior to the routinely delivery which occurred around 8:00pm to 9:00pm daily.

Interview with the Memory Care Coordinator (MCC) on 06/29/22 at 3:00pm revealed:
-She administered warfarin to Resident #1 on several occasions.
-The NP at Resident #1's warfarin clinic NP sometimes ordered just enough warfarin to last until the day the resident's INR was checked and the new order sent to the pharmacy.
-The 3 missed warfarin doses were all on the day the INR was drawn and because there was no medication to administer due to the dose scheduled at 5:00pm and the medications delivered at 8:00pm.
-If MA staff did not approve the new order prior to 5:00pm (scheduled dose), the order would not show to be administered by the MA until the following day.
-She would discuss changing the scheduled dose of warfarin to later in the evening after the contracted pharmacy delivery with the RCD.

Based on observations, interviews, and record review o 06/29/22, it was determined Resident #1 was not interviewable.

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D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a medication aide (MA) observed a resident taking their medication for 1 of 3 sampled residents (#3). The findings are: Review of the facility's Medication Administration policy dated September 2020 revealed: -Pre-pouring medication was not permitted. -Proper documentation of each medication was to be done at the time of administration. Review of Resident #2's current FL2 dated 05/12/22 revealed: -Diagnoses included rheumatoid arthritis (RA), hypertension, depression, anxiety, asthma, ulcerative colitis, and gastroesophageal reflux disease (GERD). -There was an order for esomeprazole (a medication used to treat acid reflux conditions such as GERD) 40mg daily. -There was an order for folic acid (a supplement	D 366		

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D 366	Continued From page 18 used to treat anemia) 1mg daily. -There was an order for meloxicam (a nonsteroidal anti-inflammatory medication used to treat RA) 15mg daily. -There was an order for propranolol (a beta-blocker used to treat high blood pressure) 80mg twice daily. -There was an order for sulfasalazine (an anti-inflammatory medication used to treat ulcerative colitis and RA) 500mg take 2 tablets three times daily. -There was an order for venlafaxine (an antidepressant medication) 150mg daily. Review of Resident #3's electronic medication administration record (eMAR) for June 2022 revealed: -There was an entry for esomeprazole 40mg daily scheduled at 8:00am. -There was an entry for folic acid 1mg daily scheduled at 8:00am. -There was an entry for meloxicam 15mg daily scheduled 8:00am. -There was an entry for propranolol 80mg twice daily scheduled at 8:00am and 8:00pm. -There was an entry for sulfasalazine 500mg, take 2 tablets three times daily scheduled 8:00am, 2:00pm, and 8:00pm. -There was an entry for venlafaxine 150mg daily scheduled at 8:00am. -Esomeprazole, folic acid, meloxicam, propranolol, sulfasalazine, and venlafaxine were documented as administered on 06/28/22 at 8:00am. Observation of Resident #3's eMAR on a staff computer on 06/28/22 at 3:45pm revealed the exact time her morning medications were documented as administered was at 7:57am on 06/28/22.	D 366		

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Observation of Resident #3's room on 06/28/22 at 9:14am revealed:
-Resident #3 was lying in her recliner chair covered up with a blanket.
-There was a bedside table next to her recliner chair with one cup of medication containing 5 tablets and 2 capsules on it and a cup of water.
-There were no staff present in the room.

Interview with Resident #3 on 06/28/22 at 9:15am revealed:
-Usually in the mornings, the medication aide (MA) would come to her room with her morning medications and let her know that they were dropping off her pills but did not always stay and watch her take them.
-She was familiar with the medications she took and the pills in the cup on her bedside table were her morning medications.

Interview with the MA on 06/28/22 at 9:17am revealed:
-She had not given Resident #3 her medication yet that morning.
-She thought that if there were pills in Resident #3's room it would have been her evening pills from the day prior.
-Sometimes the night shift MA started the morning medication pass if they had time so the pills could have been left by the MA who worked the night shift before she arrived that morning.
-She always watched each resident take their medications.
-She would destroy the medications that were in Resident #2's room and bring her morning medications.

Second interview with Resident #3 on 06/28/22 at 1:30pm revealed:

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D 366	Continued From page 20 -The pills that were in her room that morning had not been leftover from last night because she always took her medication when it was given to her, and the pills had not been there when she fell asleep last night. -She did not know who brought her the morning medication that day because she had been asleep in her chair and did not wake up when they were set on her bedside table. -The MA from that morning (06/28/22) went back to her room and asked her to take the pills that were on her bedside table, so she did. -The MA had not brought in a second set of morning medication or removed the medication that had been on her bedside table. Interview with a second MA on 06/28/22 at 3:50pm revealed: -She had worked night shift the previous night into the morning of 06/28/22. -She had not prepared Resident #3's morning medications. -She never left medications in a resident's room without watching them take the medication. Interview with the Assistant Resident Care Director (ARCD) on 06/29/22 at 11:00am revealed: -It was the facility's policy that MAs were not to pre-pour medications. -MAs were supposed to stand and watch each resident take their medications before leaving a resident's room to ensure the medications were swallowed. -MAs were not supposed to document medications as administered until they witnessed the resident taking the medications. -Resident #3 did not have an order to self-administer her medication and therefore was not exempt from these rules.	D 366		

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D 366	Continued From page 21 Interview with the Resident Care Director (RCD) on 06/29/22 at 11:50am revealed the medication administration policy that all the MAs were trained on included, they were to watch residents take their medications prior to documenting the medications as administered. Interview with the Administrator on 06/29/22 at 12:16am revealed: -The MAs knew that the facility policy included that before MAs prepared medications to administer, they were supposed to check with the resident and ensure the resident was ready to take their medications. -Once the MA knew the resident was ready for their medication, the MA was to prepare the medications, and witness them being taken by the resident. -Once the medications were taken by the resident, the MA was to document that the medications had been administered. -She had not been aware that medication had been left in Resident #3's room. -The MAs knew they were not supposed to leave medications in resident rooms. -She expected the MAs to follow the facility's medication administration policy.	D 366		