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FORM APPROVED

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
	HAL049030	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT PLACE OF MOORESVILLE	128 BRAWLEY SCHOOL ROAD MOORESVILLE, NC 28117

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D 000	Initial Comments The Adult Care Licensure Section and the Iredell County Department of Social Services conducted an annual survey 07/12/22 - 07/13/22.	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 observations, interviews and record reviews the facility failed to notify the Primary Care Provider for 1 of 2 sampled residents (#5) related to refusal of compression stockings. The findings are: Review of Resident #5's current FL2 dated 04/19/22 revealed: -Diagnoses included dementia with behavioral disturbances. -There was an order for compression stockings to be applied every morning and removed at bedtime due to edema. Observation of Resident #5 on 07/13/22 at 1:58pm revealed: -He was not wearing the compression stockings that were in his dresser. -He became very upset when a Medication Aide (MA) asked him about his stockings, started cursing and told staff to leave his room. Telephone interview with Resident #5's family member on 07/13/22 at 9:45am revealed: -She was at the facility at least three times a	D 273	Wellness Director or designee will provide in-service to current medication aides on proper referral and follow up to Primary Care physician to communicate routine and accurate healthcare needs of residents Wellness Director will check monthly to ensure follow up is occurring. 8/31/2022	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Emily Paxton ED

Emily Paxton ED 8/12/2022

Reviewed & Acknowledged BH 08/15/22

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week to see him.
-His compression stockings were rarely on when she was there.

Review of Resident #5's July 2022 electronic Treatment Administration Record (eTAR) revealed:
-There was an entry for compression stockings to be applied every morning and removed at bedtime.
-There was documentation the compression stockings were applied at 8:00am 07/01/22 through 07/10/22 and removed at 7:00pm.
-There was documentation the compression stockings were not applied on 07/11/22, 07/12/ 22 or 07/13/22 due to resident refusal.
-There was documentation the compression stockings were removed at 8:00pm on 07/11/22 and 07/12/22.

Interview with a MA on 07/13/22 at 2:02 revealed:
-Resident #5 kept his compression stockings in his dresser drawer.
-She never put the compression stockings on Resident #5 because he always refused.

Interview with another MA on 07/13/22 at 2:10pm revealed Resident #5 refused to wear his compression stockings and became combative if she tried to put them on.

Telephone interview with the facility's contracted Physician's Assistant (PA) on 07/13/22 at 2:25pm revealed:
-Resident #5 needed to wear compression stockings to control peripheral edema.
-The staff at the facility never told her Resident #5 refused to wear his compression stockings.
-If he did not wear his compression stockings, and his edema worsened, he was at risk for leg

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D 273	Continued From page 2 wounds. -He may need more diuretics if his edema worsened due to compression stocking refusals. Interview with the Administrator on 07/13/22 at 2:35pm revealed: -She did not know Resident #5 refused to wear his compression stockings. -MAs were trained to document refusals and inform the PA of treatment refusals. -Based on observation and record review it was determined Resident #5 was not interviewanble.	D 273	Wellness Director or designee will provide in-service to current medication aides on proper referral and follow up to Primary Care Physician to communicate routine and accurate healthcare needs of residents . Wellness Director will check monthly to ensure follow up is occuring.	8/31/2022
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 2 of 7 sampled residents (#6 and #7) with orders for a vitamin supplement and a medication to treat stomach acid (#6) and a medication to lower high blood pressure (#7). The findings are: Review of the facility's Medication Administration	D 358	Wellness Director or designee will in-service Medication Aides to assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with physicians orders. Wellness Director to review weekly.	8/31/2022

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Policy and Procedure with a revised date of 08/17/21 revealed a medication aide (MA) will administer medications according to the orders given by the authorized practitioner.

1. Review of Resident #6's current FL2 dated 04/22/22 revealed:
-Diagnoses included severe malnutrition and gastroesophageal reflux disease.
-Medication order included vitamin B complex (supplement) 1 tablet daily, and pantoprazole (reduces stomach acid) 40mg daily.

Review of subsequent physician's orders revealed an order dated 06/21/22 to decrease pantoprazole to 20mg daily.

a. Observation during the morning medication administration pass on 07/13/22 revealed the medication aide (MA) administered pantoprazole 40mg to Resident #6 at 7:36am.

Review of Resident #6's electronic Medication Administration Record (eMAR) for 07/13/22 revealed there was an entry for pantoprazole 20mg daily with an administration time of 7:00am.

Observation of Resident #6's medications on hand on 07/13/22 at 8:35am revealed:
-There was one bubble pack labeled pantoprazole 40mg one tablet daily.
-Thirty tablets were dispensed on 05/13/22 and 12 tablets remained.
-There were no other bubble packs labeled pantoprazole.

Telephone interview with a representative with the facility's contracted pharmacy on 07/13/22 at 9:27am revealed:
-The pharmacy had received a faxed physician's

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order for pantoprazole 20mg daily on 06/21/22.
-The pharmacy had dispensed 30 tablets on 06/21/22.

Interview with the MA on 07/13/22 at 8:35am revealed:
-She had administered pantoprazole 40mg to Resident #6 because she had not looked closely at the dosage of pantoprazole on the bubble pack label.
-She had been trained to compare the bubble pack label with the eMAR.
-She did not know where Resident #6's bubble pack of pantoprazole 20mg was.

Interview with the Wellness Director on 07/13/22 at 10:10am revealed:
-The MAs had received training to compare the label on the medication to the eMAR.
-She did not know where Resident #6's bubble pack ofpantoprazole 20mg was.

b. Observation during the morning medication administration pass on 07/13/22 revealed the Medication Aide (MA) did not administer vitamin B complex to Resident #6.

Review of Resident #6's electronic Medication Administration Record (eMAR) for 07/01/22 - 07/13/22 revealed:
-There was an entry for vitamin B complex daily with an administration time of 8:00am.
-There was documentation the vitamin B complex had not been administered 07/03/22 - 07/10/22 and 07/13/22 and documentation the resident was not physically able to take.

Observation of Resident #6's medications on hand for administration on 07/13/22 at 8:35am revealed there was not a bubble pack labeled

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D 358	Continued From page 5 vitamin B complex. Interview with the MA on 07/13/22 at 8:35am revealed: -There was not any vitamin B complex to administer to Resident #6. -She had documented the resident was not physically able to take the vitamin B complex because she had been instructed to do so when medications were not available in the facility to administer. Telephone interview with a representative with the facility's contracted pharmacy on 07/13/22 at 9:27am revealed: -The pharmacy had received a faxed physician's order on 05/03/22 for vitamin B complex daily for Resident #6. -The pharmacy had dispensed 30 tablets on 05/03/22, 05/25/22, and on 07/07/22 which had been delivered to the facility on 07/12/22. Interview with the Wellness Director on 07/13/22 at 10:10am revealed: -The MAs should have notified her if they could not locate a medication that had been delivered by the pharmacy. -The MA should request a refill from the pharmacy before the medication runs out. Telephone interview with the facility's contracted Physician's Assistant (PA) on 07/13/22 at 10:53am revealed: -Resident #6 was prescribed the vitamin B complex due to a history of malnutrition. -Resident #6 needed her daily dose of the vitamin B complex. 2. Review of Resident #7's current FL2 dated 09/17/21 revealed diagnoses included Alzheimer's disease and dementia.	D 358		

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Review of physician's orders for Resident #7 dated 06/22/22 revealed:
-An order for hydralazine (used to treat high blood pressure) 25 mg tablet as needed if blood pressure (BP) above 170/100.
-Check BP twice a day for one week.

Review of subsequent physician's orders for Resident #7 dated 06/28/22 revealed:
-Continue with order for as needed hydralazine.
-Check BP once a day.

Review of Resident #7's Medication Administration Record (MAR) for July 2022 revealed:
-A BP reading on 07/11/22 at 7:00pm of 201/102.
-An order was listed for hydralazine 25mg tablet as needed if BP was above 170/100.
-There was no documentation on the MAR that hydralazine was administered on 07/11/22.

Telephone interview with a family member on 07/13/22 at 10:45am revealed:
-Resident #7 was having episodic increases in her blood pressure.
-The Physician Assistant (PA) had written an order for Resident #7 to be administered hydralazine 25mg if her BP was over 170/100.
-She was notified by the Medication Aide (MA) on 07/11/22 of Resident #7's elevated BP of 201/102.
-She asked the MA if the hydralazine had been given.
-The MA told her the hydralazine was not available to give to Resident #7 and would have to be ordered from the pharmacy.

Interview with the Special Care Coordinator (SCC) on 07/13/22 at 2:37pm revealed:

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D 358	Continued From page 7 -Resident #7's BP was high on occasion. -She was notified by the MA on 0711/22 that Resident #7's BP was 201/102. -She instructed the MA to check to see if there was an as needed medication ordered for Resident #7. -She was made aware that the as needed hydralazine was not available for administration. -On 07/12/22 she spoke with the Wellness Director who stated she had faxed the order to the pharmacy on 06/22/22. -She trained her staff to follow up with the pharmacy within 24 hours of sending an order or to put a note under her office door so she could follow up with the pharmacy. Telephone interview with the Primary Care Provider (PCP) on 07/13/22 at 3:00pm revealed: -She was not aware the hydrazaline had not been available for administration for Resident #7. -The facility should adminster medications per orders given. Interview with the Wellness Director on 07/13/22 at 3:09pm revealed: -Resident #7 had an elevated BP of 201/102 on 07/11/22. -There was an order for hydralazine to be administered in the event of Resident #7's BP being elevated over 170/100. -She had faxed the physician's order to the pharmacy on 06/22/22. -She did not follow up to verify the pharmacy had received the fax. -The hydralazine was not available to administer to Resident #7 when her BP was 201/102 on 07/11/22.	D 358	Wellness Director or designee will In-service Medication Aides to assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with physicians orders. Wellness Director to review weekly. 8/31/2022	

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D 363	Continued From page 8	D 363		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.	D 363	Wellness Director or designee will provide in-service to current medication aides to ensure all medications are properly labeled and protected from spillage and contamination. Cart audits to be performed ongoing to ensure compliance. 8/31/2022	

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to ensure medications prepared for administration in advance were identified by name and strength up to the point of administration and protected from contamination and spillage for 1 of 7 residents (Resident #4).

The findings are:

Review of Resident #4's current FL2 dated 12/19/21 revealed diagnoses included Alzheimer's disease and anxiety.

Review of physician's orders dated 05/03/22 revealed an order for Ativan (medication used to treat anxiety) 0.25mg tablet three times daily.

Observation of Resident #4's medication on hand on 07/12/22 at 4:14pm revealed a bubble pack of Ativan 0.25mg with 8 tablets remaining.

Review of the Controlled Substances (CS) log revealed the 8:00pm dosage of Ativan 0.25mg for 07/12/22 had already been administered.

Review of Resident #4's electronic Medication Administration Record (eMAR) for July 2022 revealed:
-There was an entry for Ativan 0.25mg tablet three times daily at 8:00am, 2:00pm and 8:00pm.
-The 8:00pm dose of Ativan for 07/12/22 was not documented as administered.

Interview with the Medication Aide (MA) on 07/12/22 at 4:16pm revealed she pre-poured Resident #4's Ativan 0.25mg tablet at 4:10pm because he was already in bed and would not be

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D 363	Continued From page 10 coming down to dinner. Observation of the medication cart on 07/12/22 at 4:16pm revealed: -In the top drawer of the medication cart, a clear, plastic medication cup with a small white pill that appeared to be one-half of a tablet was present. -She had not put the resident's name, the name of the medication, strength or time due on the medication cup. -She had not sealed the medication cup in the medication cart. -She knew that she should not have pre-poured his medication. Interview with the Special Care Coordinator (SCC) on 07/12/22 at 4:22pm revealed: -The MAs were not trained to pre-pour medications. -They can only give medications between an hour before they are scheduled up to an hour after they are scheduled for administration. -The MA should not have pre-poured Resident #4's 8:00pm dose of Ativan. -There was no identifying information written on the outside of hte cup about the resident or the medication. -The medication cup was left open on the cart, so it was at risk for contamination.	D 363	Wellness Director or designee will provide in-service to current medication aides to ensure all medications are properly labeled and protected from spillage and contamination. Cart Audits to be performed ongoing to ensure compliance. 8/31/2022	
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations.	D 364	Wellness Director or designee will provide in-service to current Medication aides on medications administered to residents within one hour before and one hour after the prescribed or scheduled time unless prescribed or scheduled time unless precluded by emergency situation. Wellness Director to review medication variance weekly. 8/31/22	

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure medications and treatments were administered one hour before or after the prescribed or scheduled times for 2 of 5 sampled residents (#2 and #1) resulting in medications with multiple administrations times being administered too late or too close to the next scheduled administration times (#2), diuretics used to treat edema being administered late (#1) and compression stockings used to decrease edema applied too late in the day (#1).

The findings are:

Review of the facility's Medication Administration Policy and Procedure with a revised date of 08/17/21 revealed the standard medication pass and treatment times is within one hour before or one hour after the scheduled administration time.

1. Review of Resident #2's current FL2 dated 04/20/22 revealed diagnoses included Parkinson's Disease (a disorder of the central nervous system that affects movement including tremors), and atrial fibrillation (irregular rapid heart rate).

Review of a signed physician's order dated 04/26/22 for Resident #2 revealed:
-There was an order for carbidopa-levodopa (helps to control movement) 150mg four times daily.
-There was an order for Eliquis (blood thinner) 5mg two times daily.

a. Review of Resident #2's electronic Medication Administration Record (eMAR) for 07/01/22 - 07/12/22 revealed:
-There was an entry for carbidopa-levodopa

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150mg four times daily with administration times of 5:00am, 9:00am, 1:00pm, and 8:00pm.
-There was documentation the carbidopa-levodopa 150mg had been administered on 07/01/22, 07/04/22 - 07/08/22 and 07/10/22 - 07/11/22 at 5:00am, 9:00am, 1:00pm, and 8:00pm, on 07/02/22 at 5:00am, 9:00am, and 1:00pm, on 07/03/22 at 9:00am, 1:00pm, and 8:00pm, on 07/09/22 at 9:00am, 1:00pm and 8:00pm, and on 07/12/22 at 5:00am and 9:00am.

Review of Resident #2's Medication Variance Report for 07/01/22 - 07/12/22 revealed:
-The carbidopa-levodopa that was scheduled to be administered at 9:00am was documented as administered at 10:54am on 07/02/22, at 11:30am on 07/03/22, at 10:51am 07/09/22, and at 2:27pm on 07/11/22.
-The carbidopa-levodopa that was scheduled to be administered at 5:00am was documented as administered at 7:13am on 07/05/22, at 7:03am on 07/06/22, and at 7:14am on 07/10/22.
-The carbidopa-levodopa that was scheduled to be administered at 1:00pm was documented as administered at 2:53pm on 07/04/22.

Telephone interview with the facility's contracted Physician's Assistant (PA) on 07/13/22 at 10:53am revealed:
-Resident #2 was prescribed the carbidopa-levodopa due to involuntary movements and tremors.
-The medication did not stay in the body long and needed to be given at the correct times to prevent the Resident from having an increase in tremors or involuntary movements.

Interview with Resident #2 on 07/13/22 at 1:27pm revealed the medications aides (MA) frequently

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administered his medications late.

Refer to the interview with a medication aide (MA) on 07/13/22 at 10:28am.

Refer to the interview with a second MA on 07/13/22 at 1:45pm.

Refer to the interview with the Wellness Director on 07/12/22 at 3:17pm.

Refer to the interview with the Wellness Director on 07/13/22 at 10:10am.

Refer to the interview with the Administrator on 07/13/22 at 10:45am.

b. Review of Resident #2's electronic Medication Administration Record (eMAR) for 07/01/22 - 07/12 22 revealed:
-There was an entry for Eliquis 5mg two times daily with administration times of 8:00am and 8:00pm.
-There was documentation the Eliquis 5mg had been administered on 07/01/22, 07/03/22 - 07/11/22 at 8:00am and 8:00pm, 07/02/22 at 8:00am, and 07/03/22 8:00pm.

Review of Resident #2's Medication Variance Report for 07/01/22 - 07/12/22 revealed:
-The Eliquis that was scheduled to be administered at 8:00am was administered on 07/02/22 at 10:52am, and on 07/12/22 at 9:59am.
-The Eliquis that was scheduled to be administered at 8:00pm was administered on 07/10/22 at 6:13pm.

Telephone interview with the facility's contracted Physician's Assistant (PA) on 07/13/22 at 10:53am revealed:

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-The Eliquis was prescribed for Resident #2 as a blood thinner to prevent blood clots.
-Not administering the Eliquis as prescribed could result in the blood becoming thicker.

Interview with Resident #2 on 07/13/22 at 1:27pm revealed the medication aides (MA) frequently administered his medications late.

Refer to the interview with a medication aide (MA) on 07/13/22 at 10:28am.

Refer to the interview with a second MA on 07/13/22 at 1:45pm.

Refer to the interview with the Wellness Director on 07/12/22 at 3:17pm.

Refer to the interview with the Wellness Director on 07/13/22 at 10:10am.

Refer to the interview with the Administrator on 07/13/22 at 10:45am.

2. Review of Resident #1 current FL2 dated 06/14/22 revealed:
-Diagnoses included coronary artery disease, pacemaker, lower extremity edema and varicose veins.
-There was an order for compression stockings to be applied each morning a removed each evening.
-There was an order for spironolactone (used to treat edema) 50mg daily.
-There was an order for torsemide (used to treat edema) 20mg daily.

Review of Resident #1 Resident Register revealed he was admitted on 06/13/22.

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a. Review of Resident #1's June 2022 electronic Treatment Administration Record (eTAR) revealed:
-There was an entry for compression stockings dated 06/14/22 to be applied daily at 8:00am.
-There was documentation the compression stockings were applied at 8:00am from 06/15/22 through 06/30/22.
-There was an entry for compression stockings to be removed daily at 8:00pm.
-There was documentation the compression stockings were removed at 8:00pm from 06/15/22 through 06/25/22 and 06/27/22 through 06/30/22.

Review of Resident #1's June 2022 treatment variance report revealed:
-The compression stockings that were scheduled to be applied at 8:00am were documented as applied at 10:32am on 06/18/22, 9:04am on 06/20/22. 9:28am on 06/21/22, 10:26am on 06/23/22, 10:49am on 06/24/22, 9:30am on 06/25/22, 10:47am on 06/26/22, 9:36am on 06/27/22, 11:17am on 06/28/22, 9:36am on 06/29/22 and 9:16am on 06/30/22.
-The compression stockings that were scheduled to be removed at 8:00pm were documented as removed at 6:09pm on 06/17/22, 5:09pm on 06/18/22, 6:50pm on 06/19/22, 6:50pm on 06/21/22, 6:32pm on 06/22/22 and 6:58pm on 06/27/22.

Review of Resident #1's July 2022 eTAR revealed:
-There was an entry for compression stockings to be applied daily at 8:00am from 07/01/22 through 07/07/22.
-There was an entry for compression stockings to be applied daily at 7:00am from 07/08/22 through 07/31/22.
-There was documentation the compression

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stockings were applied at 8:00am from 07/01/22 through 07/07/22.
-There was documentation the compression stockings were applied at 7:00am from 07/08/22 through 07/12/22.
-There was an entry for compression stockings to be removed daily at 8:00pm.
-There was documentation the compression stockings were removed at 8:00pm from 07/01/22 through 07/12/22.

Review of Resident #1's July 2022 treatment variance report revealed:
-The compression stockings that were scheduled to be applied at 8:00am were documented as applied at 10:27am on 07/01/22, 10:41am on 07/02/22, 11:29am on 07/03/22, 10:14am on 07/04/22, 9:38am on 07/05/2 and, 9:53am on 07/07/22.
-The compression stockings that were scheduled to be applied at 7:00am were documented as applied at 9:05am on 07/08/22, 9:14am on 07/10/22 and 9:38am on 07/11/22.
-The compression stockings that were scheduled to be removed at 8:00pm were documented as removed at 6:51pm on 07/09/22, 6:59pm on 07/10/22 and 6:43pm on 07/11/22.

Interview with Resident #1 on 07/12/22 at 9:30am revealed:
-His compression stockings were frequently put on late.
-The stockings made his legs feel better and he preferred them be on before he walked to the dining room for breakfast each morning.

Interview with Resident #1's family member on 07/12/22 at 9:30am revealed:
-Resident #1 moved into the facility about a month ago and the family member visited at least

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4 times a week.
-The compression stockings were rarely on when the family member came to visit.
-The family member usually had to request that the compression stockings be put on Resident #1.
-Resident #1 told the family member his legs felt better when he wore his compression stockings and he wished they were put on earlier in the day.

Observation of Resident #1 on 07/12/22 at 9:48am revealed:
-He was sitting in his recliner and had socks and slippers on but no compression stockings.
-A Medication Aide (MA) entered the room to administer medications, noticed the compression stockings were not on so she retrieved them from the dresser drawer and applied them to Resident #1's legs.

Interview with the MA on 07/12/22 at 9:50am revealed:
-When she administered Resident #1's morning medications she put the compression stockings on him, if they had not already been applied by the third shift MA.
-The compression stockings were scheduled to be applied at 8:00am but third shift sometimes put them on before they left at 7:30am.

Interview with the facility's contracted Physician Assistant (PA) on 07/12/22 at 3:07pm revealed:
-Resident #1 had orders for compression stockings to treat edema.
-If he did not wear his compression stockings his edema could get worse resulting in wounds, problems with mobility and with his history of coronary artery disease and pacemaker, the edema could overwork his heart.

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Interview with the Wellness Director on 07/12/22 at 3:17pm revealed:
-A family member contacted her last week to inform her that the compression stockings were not being applied early in the morning.
-She changed the eTAR morning application time from 8:00am to 7:00am to ensure they would be put on before Resident #1 walked to the dining room for breakfast.
-The compression stockings should be applied by the third shift MA before they leave at 7:30am or by the first shift MA when they first started their shift.

Refer to the interview with a medication aide (MA) on 07/13/22 at 10:28am.

Refer to the interview with a second MA on 07/13/22 at 1:45pm.

Refer to the interview with the Director of Nursing (DON) on 07/12/22 at 3:17pm.

Refer to the interview with the DON on 07/13/22 at 10:10am.

Refer to the interview with the Administrator on 07/13/22 at 10:45am.

b. Review of Resident #1's July 2022 electronic Medication administration Record (eMAR) revealed:
-There was an entry for spironolactone 50mg to be administered at 8:00am.
-There was documentation spironolactone 50mg was administered at 8:00am from 07/01/22 through 07/12/22.

Review of Resident #1's July 2022 medication variance report revealed the spironolactone 50mg

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that was scheduled to be administered at 8:00am was administered at 10:27am on 07/01/22, at 10:41 on 07/02/22, at 11:29am on 07/03/22, at 10:14am on 07/04/22, at 9:38am on 07/05/22, at 9:53am on 07/07/22, at 9:05am on 07/08/22, at 9:55am on 07/09/22, at 9:14am on 07/10/22, at 9:38am on 07/11/22 and at 9:55am 07/12/22.

Interview with Resident #1 on 07/12/22 at 9:30am revealed:
-He was usually in the dining room at 8:00am and unavailable when his medications were scheduled to be administered, so he usually received them late.
-Last night he was incontinent in the middle of the night and needed help changing his clothes.

Observation of Resident #1 on 07/12/22 at 9:48am revealed he was sitting in his recliner when the Medication Aide (MA) entered his room to administer his medications.

Interview with the MA on 07/12/22 at 9:48am revealed medications were being administered late because she was working by herself there was not another MA to help her

Interview with the facility's contracted Physician Assistant (PA) on 07/12/22 at 3:07pm revealed:
-Resident #1 had spironolactone ordered in the morning to treat his edema.
-If he took the medication too late in the day it could make him urinate too much late into the night.

Refer to the interview with a medication aide (MA) on 07/13/22 at 10:28am.

Refer to the interview with a second MA on 07/13/22 at 1:45pm.

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Refer to the interview with the Wellness Director on 07/12/22 at 3:17pm.

Refer to the interview with the Wellness Director on 07/13/22 at 10:10am.

Refer to the interview with the Administrator on 07/13/22 at 10:45am.

c. Review of Resident #1's July 2022 electronic Medication administration Record (eMAR) revealed:
-There was an entry for torsemide 20mg to be administered at 8:00am.
-There was documentation torsemide 20mg was administered at 8:00am from 07/01/22 through 07/12/22.

Review of Resident #1's July 2022 medication variance report revealed the torsemide 20mg that was scheduled to be administered at 8:00am was administered at 10:27am on 07/01/22, at 10:41 on 07/02/22, at 11:29am on 07/03/22, at 10:14am on 07/04/22, at 9:38am on 07/05/22, at 9:53am on 07/07/22, at 9:05am on 07/08/22, at 9:55am on 07/09/22, at 9:14am on 07/10/22, at 9:38am on 07/11/22 and at 9:55am 07/12/22.

Interview with Resident #1 on 07/12/22 at 9:30am revealed:
-Last night he was incontinent in the middle of the night and needed help changing his clothes.
-He was usually in the dining room at 8:00am and unavailable when his medications were scheduled to be administered, so he usually received them late.

Observation of Resident #1 on 07/12/22 at 9:48am revealed he was sitting in his recliner

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when the Medication Aide (MA) entered his room to administer his medications.

Interview with the MA on 07/12/22 at 9:48am revealed medications were being administered late because she was working by herself there was not another MA to help her

Interview with the facility's contracted Physician Assistant (PA) on 07/12/22 at 3:07pm revealed:
-Resident #1 had torsemide ordered in the morning to treat his edema.
-If he took the medication too late in the day it could make him urinate too much late into the night.

Refer to the interview with a medication aide (MA) on 07/13/22 at 10:28am.

Refer to the interview with a second MA on 07/13/22 at 1:45pm.

Refer to the interview with the Wellness Director on 07/12/22 at 3:17pm.

Refer to the interview with the Wellness Director on 07/13/22 at 10:10am.

Refer to the interview with the Administrator on 07/13/22 at 10:45am.

Interview with a medication aide (MA) on 07/13/22 at 10:28am revealed:
-It was difficult for one MA to administer all the morning medications in a timely manner.
-There were two medication carts in the assisted living and usually only one MA scheduled.
-She had voiced her concerns to the Director of Nursing (DON) but nothing had changed.

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Interview with a second MA on 07/13/22 at 1:45pm revealed:
-Sometimes she would get "behind" during her medication pass.
-Sometimes the previous shift was still administering medications when she was scheduled to administer medications and she would start her medication pass late.
-There were over 30 residents to administer medications to and it was difficult to administer them timely.
-She had informed the Wellness Director, the Special Care Coordinator (SCC), and the Administrator of her concerns.

Interview with the Wellness Director on 07/12/22 at 3:17pm revealed:
-The facility changed from using paper Medication Administration Records (MAR) and Treatment Administration Records (TAR) to electronic versions in December 2021 or early January 2022.
-When they used paper MARs and TARs the facility policy allowed a 4-hour window to administer medications and do treatments which was 2 hours before the scheduled time or 2 hours after the scheduled time.
-Now that the facility was using electronic MARs they were limited to a 2 hours window; 1 hour before and 1 hour after.
-It has taken the MAs some time to get used to the stricter timeframe.

Interview with the Wellness Director on 07/13/22 at 10:10am revealed:
-The MAs were trained to administer medications within one hour before and one hour after the scheduled administration times.
-She did not know why the medications were being administered too early or too late.

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D 364	Continued From page 23 Interview with the Administrator on 07/13/22 at 10:45am revealed: -She was not aware medications were not being administered within one hour before or after scheduled times. -Staff knew to administer the medications within the scheduled timeframes.	D 364	Wellness Director or designee will provide in-service to current Medication Aides on medications administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situation. Wellness Director to review medication variance weekly.	8/31/2022
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, interviews and record reviews the facility failed to ensure the accuracy of the electronic Treatment Administration Record	D 367	Wellness Director or designee will audit all Medication Administration records to ensure record is accurate per guidelines. Will continue to monitor MAR monthly.	8/31/2022

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(eTAR) for 2 of 5 sampled residents (#1 and #5) related to compression stockings administration.

The findings are:

1. Review of Resident #1's current FL2 dated 06/19/22 revealed:
-Diagnoses included varicose veins in lower extremities, cardiac pacemaker, coronary artery disease and lower extremity edema
-There was an order for compression stockings to be put on lower extremities in the morning and removed in the evening.

Review of Resident #1's resident register revealed he was admitted to the facility on 06/13/22.

Observation on 07/12/22 at 9:48am revealed a Medication Aide (MA) put compression stockings on Resident #1 after she administered his medications.

Review of Resident #1's eTAR revealed:
-There was documentation a third shift MA put compression stockings on Resident #1 on 06/27/22 at 9:36am.
-There was documentation a third shift MA put compression stockings on Resident #1 on 07/08/22 at 9:05am.
-There was documentation a third shift MA put compression stockings on Resident #1 on 07/11/22 at 9:38am.
-There was documentation a third shift MA put compression stockings on Resident #1 on 07/12/22 at 7:30am.

Interview with a third shift MA on 07/12/22 at 3:48pm revealed:
-She worked third shift as a MA and usually left

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	HAL049030	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT PLACE OF MOORESVILLE	128 BRAWLEY SCHOOL ROAD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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the facility between 7:30-8:00am.
-She never put compression stockings on Resident #1 and never documented that she did.
-She forgot to sign out of the computer when she left work on 07/12/22.
-She sometimes forgot to sign out of the computer before she left work.

Interview with a MA on 07/13/22 at 8:30am revealed:
-She worked first shift as a MA.
-When she started working each day, she had to sign on to the computer in order to document administration of medications or treatments.
-If the third shift MA failed to sign out of the computer, she had to sign that MA out before she could sign in and start documenting administration of treatments.
-Sometimes she would start documenting treatment administration under the third shift MA's initials before she realized what she was doing.
-When that happened the eTAR documentation was inaccurate.
-When she attempted to document that she put compression stockings on Resident #1 on 07/12/22 the treatment had already been documented as administered at 7:30am by the third shift MA.

Interview with another MA on 07/13/22 at 1:15pm revealed:
-Frequently when she started work and attempted to sign into the computer the third shift MA was still logged into the computer and had forgotten to sign out before she left work.
-She occasionally would start documenting treatment administrations under the third shift MA's initials before she realized what she was doing.
-When that happened the eTAR documentation

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was inaccurate.

Interview with the Administrator on 07/12/22 at 3:40pm and 07/13/22 at 2:35pm revealed:
-She was not aware the eTAR documentation was inaccurate.
-MAs had been trained how to use the computer and should not document using someone else's initials.

2. Review of Resident #5's current FL2 dated 04/19/22 revealed:
-Diagnoses included dementia with behavioral disturbances.
-There was an order for compression stockings to be applied every morning and removed at bedtime due to edema.

Review of Resident #5's May 2022 electronic Treatment Administration Record (eTAR) revealed:
-There was an entry for compression stockings to be applied every morning and removed at bedtime.
-There was documentation the compression stockings were applied 05/01/22 through 05/31/22 for 31 of 31 opportunities.
-There was documentation the compression stockings were removed 05/01/22 through 05/31/22 for 31 of 31 opportunities.

Review of Resident #5's June 2022 eTAR revealed:
-There was an entry for compression stockings to be applied every morning and removed at bedtime.
-There was documentation the compression stockings were applied 06/01/22 through 06/30/22 for 30 of 30 opportunities.
-There was documentation the compression

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stockings were removed 06/01/22 through 06/30/22 for 30 of 30 opportunities.

Review of Resident #5's July 2022 eTAR revealed:
-There was an entry for compression stockings to be applied every morning and removed at bedtime.
-There was documentation the compression stockings were applied 07/01/22 through 07/10/22 for 10 of 13 opportunities.
-There was documentation the compression stockings were not applied on 07/11/22, 07/12/22 or 07/13/22 due to resident refusal.
-There was documentation the compression stockings were removed 07/01/22 through 07/12/22 for 12 of 12 opportunities.

Interview with a Medication Aide (MA) on 07/13/22 at 2:02 revealed:
-Resident #5 always refused to wear his compression stockings.
-When she documented on the eTAR and attempted to document refusals, it was difficult to do.
-She attempted to, but could not explain, why it was difficult to document refusals.

Interview with another MA on 07/13/22 at 2:10pm revealed:
-Resident #5 refused to wear his compression stockings and became combative if you tried.
-She documented the refusal on 07/12/22.
-She did not know why someone would document on 07/011/12 and 07/12/22 that they were removed if they were never put on.
-Documenting refusals on the eTAR was difficult and she did not know how to explain the process of documenting refusals on the eTAR.
-She thought MAs failed to document refusals

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D 367	Continued From page 28 because everyone was trained differently and it was difficult to save the documentation on the eTAR when you signed out. Interview with the Administrator on 07/12/22 at 3:40pm and 07/13/22 at 2:35pm revealed: -She was not aware the eTAR documentation was inaccurate or difficult to do. -MAs had been trained how to use the computer and should not document administration if a treatment was refused.	D 367	Wellness Director or designee will audit all Medication Administration Records to ensure record is accurate per guidelines Will continue to monitor MAR monthly	8/31/2022

Emily Baxter, ED 8/12/2022
Emily Baxter ED