STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HUNTER HILL SENIOR LIVING	891 NOELL LANE ROCKY MOUNT, NC 27804

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 08/17/22 to 08/18/22.	{D 000}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure orders were implemented for 1 of 5 sampled residents (#3) including errors for the use of a warm compress on his eye. The findings are: Review of Resident #3's current FL-2 dated 02/25/22 revealed: -Diagnoses included diabetes Type II, left side hemiplegia and history of a stroke. -There was no information documented for orientation status. Review of Resident #3's current care plan dated 02/09/22 revealed he had limited vision and required glasses to read. Review of Resident #3's physician's orders dated 07/21/22 revealed:	D 276		

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D 276	Continued From page 1 -There was an order for warm compresses to be applied for 10 minutes, four times daily, to his left eye for 1 week. -There was documentation the previous Clinical Director (CD) ensured the order was on the electronic medication administration record (eMAR) on 07/25/22. Review of Resident #3's eMAR for July 2022 revealed there was no entry for warm compresses to be applied for 10 minutes, four times daily to his left eye. Observation of Resident #3 on 08/18/22 at 10:40am revealed there was no redness, swelling or tearing of his left eye. Interview with Resident #3 on 08/18/22 at 10:40am revealed: -He was seen by an eye doctor 1-2 months prior because his left eye was irritated. -He had never had a warm compress applied and did not know if they had been ordered. -He did not know if it would have helped but he was no longer having eye irritation. Telephone interview with Resident #3's ophthalmologist on 08/18/22 at 2:40pm revealed: -Resident #3 was ordered warm compression for chelation in the left eye to reduce swelling and pain. (a chelation is a lump that forms on an oil gland of the eye lid.) -The warm compression could prevent cellulitis which could result in Resident #3 requiring hospitalization for intravenous antibiotic treatment. -Prolonged swelling and irritation could also result in scar tissue that could lead to an in-office surgical procedure to remove the hardened lump.	D 276		

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D 276	Continued From page 2 Interview with a medication aide (MA) on 08/18/22 revealed: -She worked all shifts, as needed, and had not seen an order for warm compresses to be applied to Resident #3's left eye. -She had never applied a warm compress to Resident #3's eye. Interview with the Resident Care Director (RCD) on 08/18/22 at 3:23 revealed: -She was not aware of the order for warm compresses to be applied for 10 minutes, four times daily, to his left eye for 1 week for Resident #3. -The previous CD was responsible for ensuring orders were carried out until she left employment the previous week but she did not know what the process had been for following up on pending orders. -She should not have documented the warm compresses were on the eMAR if they were not. Interview with the Administrator on 08/18/22 at 3:58pm revealed: -She was not aware of the order for warm compresses to be applied for 10 minutes, four times daily, to his left eye for 1 week. -Physician's orders were faxed to the pharmacy by the MA or CD when the PCP wrote an order or the provider would send the order directly to the pharmacy. -Once the pharmacy received the order, the entry usually appeared on the eMAR within the hour. -It was the CD's responsibility to ensure new orders were sent to the pharmacy prior to her departure from employment the previous week. -It was the CD's responsibility to approve new orders once the pharmacy entered them onto the eMAR and document that she had done that on the bottom of the order.	D 276		

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D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure clarification of a medication order for 1 of 5 sampled residents (#5) related to a medication used for anxiety. The findings are: Review of Resident #5's current FL-2 dated 05/25/22 revealed diagnoses included hypertension, cerebral infarction, muscle weakness, abnormal gait and mobility, and fracture of neck of femur from subsequent closed fracture. Review of Resident #5's Resident Register revealed an admission date of 05/10/22. Review of a physician's order request dated 07/22/22 revealed: -The facility submitted an order request to	D 344		

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Resident' #5's primary care provider (PCP) on 07/22/22 regarding Lorazepam. (Lorazepam was a medication used for anxiety).
-There was an order to continue Lorazepam 0.5mg 1 tablet three times a day for Resident #5.
-The PCP requested the resident be seen by the mental health provider .
-The request was signed by the Resident Care Coordinator (RCC) and the PCP.

Review of of a medication renewal response by Resident #5's PCP dated 07/26/22 revealed an order for Lorazepam 0.5mg 1 tablet three times a day (Hold for sedation).

Review of Resident #5's mental health provider medication order dated 07/26/22 revealed an order for Lorazepam 1mg one tablet daily, 0.5mg 1 tablet at 2:00pm and 0.5mg 1 tablet at bedtime for agitation.

Review of Resident #5's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet three times a day.
-There was documentation Lorazepam 0.5mg 1 tablet was administered at 7:00am, 1:00pm, and 7:00pm except on 07/26/22 due to resident refusal, from 07/26/ 22 to 07/31/22.

Review of Resident #5's August 2022 eMAR revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet three times a day.
-There was documentation Lorazepam 0.5mg 1 tablet was administered at 7:00am, 1:00pm except 08/04/22 due to resident refusal and 7:00pm, from 08/01/22 to 08/17/22.
-There was documentation Lorazepam 0.5mg 1

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tablet was administered at 7:00am on 08/18/22.

Telephone interview with the facility's contracted pharmacist on 08/08/22 at 11:30am revealed:
-The pharmacist received a medication order prescribed by Resident #5's PCP on 07/26/22 for Lorazepam 0.5mg 1 tablet three times a day.
-The pharmacist received a medication order prescribed by Resident #5's mental health provider on 07/26/22 for Lorazepam for 1mg one tablet daily, 0.5mg 1 tablet at 2:00pm, and 0.5 mg 1 tablet at bedtime for anxiety.
-The pharmacist dispensed Lorazepam 0.5mg 1 tablet three times daily as ordered by Resident #5's PCP.
-The PCP managed all medication regimen for the resident.
-There was no documentation that the pharmacist contacted the facility or the PCP for medication clarification.

Interview with the medication aide (MA) on 08/18/22 at 2:40pm revealed:
-Medication orders were sent by the prescriber to the facility or to the pharmacist.
-The Clinical Director (CD) usually checked the order for accuracy and faxed it to the pharmacist.
-Clarification of a medication order was usually done by the CD..
-The facility should have contacted the PCP for clarification regarding the Lorazepam order for Resident #5.

Interview with the Resident Care Director (RCD) on 08/18/22 at 3:30 revealed:
-The Lorazepam medication orders from the PCP for 0.5mg 1 tablet three times day and the mental health provider for 1mg one tablet daily and 0.5mg tablet at 2:00 pm, and 0.5 mg 1 tablet at bedtime were faxed to the pharmacist on the

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same day by the CD. (07/26/22)
-The PCP's order was received by the pharmacist after the mental health provider's order was received and entered into the system.
-The system "kicked out" the order from the mental health provider when the order from the PCP was entered into the system.
-It was the responsibility of the CD to ensure medication orders were clarified and accurate before faxing the order to the pharmacist.
-It was important Resident #5 received the medication his PCP preferred.

Interview with the Administrator on 08/18/22 at 3:55pm revealed:
-The medication orders for Lorazepam prescribed by the PCP for 0.5mg 1 tablet three times a day and the mental health provider for 1mg one tablet daily and 0.5mg 1 tablet at 2:00 pm, and 0.5 mg 1 tablet at bedtime were faxed to the pharmacist on the same day by the CD. (07/26/22).
-She was not aware at the time two different Lorazepam medication orders were faxed to the facility's contracted pharmacist on 07/26/22.
-It was the CD's responsibility to review medication orders for accuracy before faxing the order to the pharmacist to be dispensed.
-It was the CD's responsibility to request clarification from the PCP regarding the two Lorazepam orders.
-The facility should have contacted the PCP to get clarification on which Lorazepam order was to be dispensed for Resident #5.
-She did not know why the CD did not catch the error and request clarification from the PCP.

Telephone interview with Resident #5's PCP on 08/18/22 at 12:03pm revealed:
-She prescribed Lorazepam 0.5mg 1 tablet three times a day for Resident #5 until the resident was

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D 344	Continued From page 7 evaluated by the mental health provider and a treatment plan implemented. -She was not aware or notified that the mental health provider prescribed Lorazepam 1mg one tablet daily, 0.5mg 1 tablet at 2:00pm, and 0.5mg 1 tablet at bedtime for anxiety. -She did not receive a clarification request from the pharmacist or the facility regarding the two Lorazepam orders. -She expected to be notified by the pharmacist or the facility to receive clarification regarding the Lorazepam orders. -She expected Resident #5 to receive the medication as ordered by the mental health provider for Lorazepam 1mg one tablet daily, 0.5 mg 1 tablet at 2:00pm, 0.5mg 1 tablet at bedtime. Attempted telephone interview with Resident #5's mental health provider on 08/18/22 at 12:15pm was unsuccessful.	D 344		
{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: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation was abated. Non-compliance continues.	{D 358}		

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{D 358}	Continued From page 8 Based on interviews and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#3) including a medication used to treat nerve pain. The findings are: Review of Resident #3's current FL-2 dated 02/25/22 revealed: -Diagnoses included diabetes Type II, left side hemiplegia and Gout. -There was no information documented for orientation status. -There was an order for Gabapentin 100mg to be administered twice daily at 7:00am and 1:00pm. (Gabapentin is a medication used to relieve pain associated with conditions that affect the nervous system.) -There was an order for Gabapentin 100mg capsule, 2 capsules to be administered each evening at 7:00pm. Review of Resident #3's physician order dated 07/01/22 revealed there was an order for Gabapentin 100mg to administer 2 capsules three times daily. Review of Resident #3's physician order dated 07/08/22 revealed there was an order for Gabapentin 200mg to be administered three times daily. Review of Resident #3's electronic medication administration record (eMAR) for July 2022 revealed: -There was a computerized entry for Gabapentin 100mg, 1 tablet, to be administered twice daily at 7:00am and 1:00pm. -There was a computerized entry for Gabapentin	{D 358}		

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{D 358}	Continued From page 9 100mg, 2 capsules (for a total of 200mg) to be administered each evening at 7:00pm. -There was documentation that Gabapentin 100mg, 1 tablet, was administered each day at 7:00am and 1:00pm from 07/01/22 through 07/11/22. -There was documentation that Gabapentin 100mg, 1 tablet, was administered at 7:00am on 07/12/22. -There was documentation that Gabapentin 100mg, 2 capsules, was administered each evening at 7:00pm from 07/01/22 through 07/11/22. -There was documentation that Gabapentin 100mg, 2 capsules, was administered three times daily beginning at 1:00pm on 07/12/22. Interview with Resident #3's primary care provider (PCP)on 08/18/22 at 12:12pm revealed: -Resident #3 was prescribed Gabapentin to treat pain he was experiencing from chronic diabetes that was not controlled by the previous dosage. -She expected Resident #3 to begin receiving the Gabapentin 200mg three times each day within 24 hours of the order being written. Interview with the medication aide (MA) on 08/18/22 at 2:57pm revealed: -She found Resident #3's physician's order for Gabapentin 200mg, three times daily, dated 07/01/22 in the the "pending order box" that was located in the medication room on 07/05/22. -The order written on 07/01/22 was a clear order but she thought the PCP may have made a mistake on the dose that was ordered. -She sent Resident #3's PCP an order clarification request on 07/05/22 which was signed by the PCP on 07/08/22. -She did not know why an order written on 07/01/22 was still pending on 07/05/22.	{D 358}		

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{D 358}	Continued From page 10 -She did not know why Resident #3 did not begin receiving Gabapentin 200mg three times daily until 1:00pm on 07/12/22. -It should not have taken Resident #3 more that seventy-two hours to begin receiving his Gabapentin 200mg, three times daily, even if a clarification was needed. -Medications were entered onto the eMAR by the pharmacy when the order was sent. -Medications were delivered by the pharmacy overnight and usually available for administration the following day. -MAs were responsible for checking the "pending orders box" daily to ensure orders were carried out. -The facility's Clinical Director (CD) had been responsible for following up on pending orders until she left employment the previous week. Interview with the Resident Care Director (RCD) on 08/18/22 at 3:23pm revealed: -Resident #3's order for Gabapentin 200mg three times daily was clear and should have been on the eMAR and administration began within twenty four hours of receiving the order. -She did not know why a clear order written on 07/01/22 was not started until 07/12/22. -The previous CD was responsible for ensuring orders were carried out until she left employment the previous week but she did not know what the process had been for following up on pending orders. Interview with the Administrator on 08/18/22 at 3:58pm revealed: -She was not aware that Resident #3's physician order for Gabapentin 200mg three times daily written on 07/01/22 was not started until 07/12/22. -She did not know it took over a week for Resident #3 to begin receiving the increased	{D 358}		

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{D 358}	Continued From page 11 dose. -Physician's orders were faxed to the pharmacy by the MA or CD when the PCP wrote an order or the provider would send the order directly to the pharmacy. -It was the CD's responsibility to approve new orders once the pharmacy entered them onto the eMAR and document that she had done that on the bottom of the order. -Once the pharmacy received the order, the entry usually appeared on the eMAR within the hour and the medication was received in the facility that same night and was available for administration the following day. -The CD checked "pending order box" twice weekly to ensure orders were carried out.	{D 358}		