STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068025	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE STRATFORD	405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey on July 19-21, 2022 with a desk review on July 22, 2022 and a telephone exit on July 22, 2022.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide personal care assistance with shaving to 1 of 3 sampled residents (#5). The findings are: Review of Resident #5 current FL-2 dated 03/13/22 revealed diagnoses included dementia without behavioral disturbances and bradycardia. Review of Resident #5 ' s signed care plan dated 01/31/22 revealed Resident #5 required limited assistance with shaving. Review of Resident #5 ' s resident registry dated 03/07/22 revealed Resident #5 required assistance with shaving. Review of Resident #5 ' s pre-admission checklist	D 269	The Stratford shall ensure that staff provides personal care to residents according to their care plans, and attend to any other personal care needs that they may be unable to attend to for themselves. Area Clinical Director (ACD) in-serviced all care staff on the correct procedure for shaving residents, and providing care of resident fingernails. ACD will continue to provide ongoing education with care staff related to shaving, nail care, and other personal care items as the needs arise; as well as training with new staff upon hire. Resident Care Manager (RCM) and Memory Care Manager (MCM) will update all "Who Am I" sheets to ensure all caregivers know what is needed to provide care for each resident, both in AL and MC. These sheets will be updated as the residents' needs change. They will be reviewed for accuracy when the resident's care plan is updated by the RCM/MCM. Care staff will be sure to round on residents at a minimum of every 2 hours, checking for any needs that may be voiced at that time. Executive Director (ED) or Designee will complete an inventory weekly of personal care items including soap, razors, and shaving cream to ensure adequate stock for staff to provide care for residents.	7/21/2022 9/5/2022 9/5/2022 9/5/2022 9/5/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Executive Director | TITLE | (X6) DATE: 09/01/22

Reviewed and acknowledged on 09/07/22 KG

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D 269	Continued From page 1 dated 03/07/22 revealed Resident #5 required assistance with grooming. Review of Resident #5's electronic documentation of activities of daily living (ADL) of July 2022 revealed: -There was documentation Resident #5 was to be shaved daily on Tuesday, Thursday and Saturday. -There was documentation Resident #5 was shaved every Tuesday, Thursday and Saturday of July 2022. -The most recent documentation of Resident #5 being shaved was on Tuesday, 07/19/22 at 10:56am. Observation of Resident #5 on 07/20/22 at 10:30am revealed: -He was ambulating in the Special Care Unit (SCU). -He had a scraggly beard, about 1/4 inch long. Interview with Resident #5 on 07/19/22 at 12:10pm revealed: -He had requested to be shaved yesterday, 07/18/22, but no one would shave him. -He requested a shave again today, 07/19/22, and was told by the personal care aide (PCA) he would be shaved after lunch. Interview with a PCA on 07/19/21 at 12:15pm revealed: -She would see that Resident #5 was shaved after lunch. -She did not shave male residents because she did not know how. -There were only a select few PCAs that shaved male residents. -Residents usually were shaved on their shower day.	D 269	Any care items noted to be low in inventory, will be reordered by the ED to ensure adequate supplies remain in stock. RCM/MCM will make unit rounds no less than twice daily to ensure personal care and supervision, including ensuring appropriate personal hygiene and grooming is occurring for all residents as required. ED will follow up with RCM/MCM in daily management meeting to ensure care and documentation of care is occurring as required. The team will also follow up on any voiced Resident concerns. ED will make facility rounds no less than twice daily to ensure personal care of residents is occurring appropriately, and that no resident concerns are voiced that may need follow up.	9/5/2022 9/5/2022 9/5/2022 9/5/2022

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D 269	Continued From page 2 -Resident #5 received his showers on Tuesday, Thursday and Saturday; he should have been shaved on Saturday, July 16th. Interview with a medication aide (MA) on 07/19/22 at 12:20pm revealed: -There were only a few PCAs that would shave the residents. -Some of the PCAs do not shave the residents. Interview with Resident #5 on 07/20/22 at 10:30am revealed: -He had his shower this morning but was not shaved. -He had requested to be shaved the past two days, but no one had shaved him. Interview with a second PCA on 07/20/22 at 11:15am and 1:15pm revealed: -Resident #5 received a shower three days a week; male residents should be shaved when they were showered. -The male residents were shaved about once a week. -Shaving supplies were not always available to shave the residents. -There were no razors or shaving cream available in the facility to shave the residents. -Resident #5's shower days were Tuesday, Thursday and Saturday -Resident #5 told me he wanted a shave today, but there were no supplies to shave him. -Resident #5 told me he wanted a shave on Monday, 07/18/22; she told him she would shave him when they had shaving supplies. -There have been no razors or shaving cream in the facility for one to two weeks. -She had told the Special Care Coordinator (SCC) that razors and shaving cream were needed to shave the residents.	D 269		

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D 269	Continued From page 3 -The shaving cream and razors where kept on the supply cart. -There were no shaving supplies on the supply cart today to shave the male residents. Observation of the supply cart on 07/20/22 at 1:15pm revealed there was no shaving cream or razors available to shave the male residents. Interview with a second MA on 07/20/22 at 4:30pm revealed. -There were a few men who would ask for a shave. -The male residents in the SCU would be shaved as needed or when requested. -Resident #5 would ask to be shaved. -The PCAs would ask the SCC/RCC for razors when the needed them. -She did not know there were no razors or shaving cream in the facility. Interview with a third PCA on 07/21/22 at 4:15pm revealed: -Resident's should be shaved on their shower day; each resident was showered three times a week. -Sometimes residents only received a shower and were not shaved due to staff shortage. -Shaving supplies were not always available to shave the residents. Telephone interview with a MA on 07/21/22 at 12:43pm revealed: -There were only a select few PCA's who would shave the residents. -One of the PCAs who could shave the residents recently quit. -Residents should be shaved on their shower days. -Resident #5's shower days were Tuesday,	D 269		

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D 269	Continued From page 4	D 269		

Thursday and Saturday.
-Only a few PCA's would shave the residents.
-The Staff did not always have supplies for shaving the residents.
-There were no shaving supplies available for Resident #5 to be shaved.
-She did not know the last time supplies were available for shaving of residents.
-The Staff reported to the SCC when shaving supplies were needed.
-She did not report to the SCC on 07/18/22 that shaving supplies were needed; she thought the PCA informed the SCC that shaving supplies were needed.

Interview with the Activities Director (AD) on 0720/22 at 1:15pm revealed:
-She would pick up shaving cream and razors at a local retail store when supplies were needed.
-She picked up razors about 2 to 3 weeks ago; she purchased 4 packs of razors, each pack contained 3 razors.
-She did not know there were no shaving supplies in the facility.
-No one had asked her to pick up shaving supplies.

Interview with the Supervisor on 07/20/22 at 4:14pm revealed:
-Residents should be shaved when they received their shower.
-Shaving supplies such as shaving cream and razors were supplied by the facility.
-She did not know if there were any shaving supplies in the facility.
-No one had told her they needed shaving supplies.
-The AD would pick up shaving supplies when needed.

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D 269	Continued From page 5 Interview with the SCC on 07/20/22 at 12:22pm revealed: -Male residents should be shaved on their shower days and as needed. -Shaving supplies, such as razors and shaving cream, were purchased from a local retail store. -The AD would pick up shaving supplies when needed. -No one had told her they were out of shaving supplies. -There were only a few PCAs that knew how to shave male residents. Interview with the Administrator on 07/21/22 at 6:35pm revealed: -Resident should be shaved on their shower day and as needed. -The facility would purchase shaving supplies from a local retail store when supplies were needed. -She did not know there were no shaving supplies in the facility until yesterday, 07/20/22. -The MA/PCA should alert the RCC/MCC so shaving supplies can be picked up at a local retail store before supplies are depleted. Attempted telephone interview with a PCA on 07/21/22 at 11:05am was unsuccessful.	D 269		
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	D 273	The Stratford shall ensure referral and follow-up to meet the routine and acute health care needs of residents. RCM in-serviced Med Techs on the importance of thoroughly reviewing discharge summaries when a resident returns from a hospital stay or ER visit to ensure that all orders have been carried out.	7/25/2022

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D 273	Continued From page 6 reviews, the facility failed to ensure health care referral and follow-up to meet the healthcare needs for 2 of 5 sampled residents (#1, #4) related to a resident who had an order for protective sleeves ordered for his arms and was not wearing the protective sleeves (#1) and a resident who had multiple orders for both a physical and occupational therapy that were not implemented until the resident contacted her provider and requested a fourth order (#4). 1. Review of Resident #1's current FL-2 dated 04/07/21 revealed a diagnosis of pneumonia. Review of a physician's order dated 06/15/22 revealed: -Hospice to provide Geri sleeves (a breathable protective sleeve used to provide comfortable protection for sensitive skin). -Put on bilateral upper extremities daily, take off for showers, and put on again. Observation of Resident #1 on 07/19/22 at various times between 8:30am-5:00pm revealed the resident was not wearing Geri sleeves. Observation of Resident #1 on 07/20/22 at various times between 8:30am-5:00pm revealed the resident was not wearing Geri sleeves. Observation of Resident #1 on 07/21/22 at various times between 8:30am-5:00pm revealed the resident was not wearing Geri sleeves. Review of Resident #1's electronic medication administration record (eMAR) from 06/17/22-06/30/22 revealed: -There was an entry to apply Geri sleeves, hospice to provide, put on bilateral upper extremities daily, take off for showers and put	D 273	RCM/MCM will re-inservice Med Techs on the importance of notifying the MD of missed doses of medications, as well as missed days of implementing treatments or any other ordered medical device. RCM/MCM will review any discharge summaries received thoroughly to ensure there are no missed orders, and also will ensure the PCP reviews these documents and signs for any resident returning from the hospital. RCM/MCM will in-service Med Techs on the appropriate and mandatory use of the facility's communication log as their shift reporting tool to ensure pertinent information is passed shift to shift. RCM/MCM will monitor order processing folders daily to ensure MD orders are processed appropriately. RCM/MCM will also use this process to ensure any ordered DME, treatments, skin protection devices, and referrals are carried out per MD orders. RCM/MCM will review the electronic facility activity documentation daily for any needed follow-up. This documentation will be reviewed with the ED during daily management meeting. RCM/MCM will complete a minimum of 2 chart audits weekly to ensure orders are accurate and have been carried out. Chart audits will be submitted to the ED upon completion for review.	9/5/2022 9/5/2022 9/5/2022 9/5/2022 9/5/2022 9/5/2022

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D 273	Continued From page 7 back on again. -The start date was 06/17/22 and the discontinue date was 06/20/22. -There was a scheduled administration time of 7:00am and 7:00pm. -There was an exception documented on 06/17/22 at 7:00am as waiting on hospice. -There was an exception documented on 06/17/22 at 7:00pm as no one came from hospice on second shift. -There was an exception documented on 06/18/22 at 7:00am as no one came from hospice. -There was an exception documented on 06/18/22 at 7:00pm as no one came from hospice on this shift. -There was an exception documented on 06/19/22 at 7:00am as no one came from hospice. -There was an exception documented on 06/19/22 at 7:00pm as have not seen hospice. -There was no other documentation on the eMAR. Review of Resident #1's eMAR from 07/01/22-07/19/22 revealed there was no entry for Geri sleeves. Review of Resident #1's progress notes from 06/01/22-07/19/22 revealed: -On 06/06/22, Resident #1 had a skin tear from scratching. -On 06/15/22, Resident #1's hospice nurse was notified of the order for Geri sleeves; the hospice nurse reported the Geri sleeves would be delivered tomorrow. -On 06/15/22, there was documentation an order was received for Resident #1's Geri sleeves to apply in the mornings, and take off for showers and bedtime.	D 273		

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D 273	Continued From page 8 -The order did not need clarification, was sent to the pharmacy on 06/15/22, approved on the eMAR, and had a start date of 06/17/22. -There was no other documentation related to the Geri sleeves. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/19/22 at 4:48pm revealed: -They received the orders for the Geri sleeves and the order was keyed in as special therapy with a note hospice to provide. -The facility would get an alert there was a new order that needed to be approved. -They had not received an order to discontinue Resident #1's Geri sleeves so it was an active order for them. Interview with Resident #1's private duty caregiver on 07/20/22 at 2:45pm revealed: -She had never seen staff ask Resident #1 about the Geri sleeves, but she did not work 24-7. -One day last week, the staff put a cream on Resident #1's arm because he was scratching and then covered the area with a dressing. -The next time she worked, the area was not covered. Telephone with another private duty caregiver on 07/21/22 at 11:18am revealed: -She had seen Resident #1 with the Geri sleeves on, but not lately. -She had seen him remove the Geri sleeve and refuse to put them back on. -She would let the facility staff know, and Resident #1 would put the Geri sleeve back on when the staff came in. -She did not recall the last time she saw Resident #1 wear the Geri sleeves. -The last time she worked, on Tuesday, 07/19/22,	D 273		

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D 273	Continued From page 9 she had asked about the Geri sleeves because Resident #1 was not wearing them. -The previous caregiver did not know where the Geri sleeves were and told her to check the soiled linens hamper. Interview with a medication aide (MA) on 07/20/22 at 1:11pm revealed: -Resident #1's Geri sleeves were on the medication cart. -Resident #1 did not like the Geri sleeves. -She cleaned any open areas on Resident #1's arm and covered the area in gauze. -There was no order to discontinue Resident #1's Geri sleeves, but the resident never wore them. -She did not recall if she told anyone Resident #1 refused to wear the Geri sleeves. Telephone interview with Resident #1's family member on 07/20/22 at 4:20pm revealed: -She knew there was an order for Resident #1's Geri sleeves but she thought the order was for as needed. -She had seen Resident #1 with some type of bandage on his arm. -She would expect the Geri sleeves to be applied if Resident #1 was scratching. Interview with a MA on 07/20/22 at 5:05pm revealed: -At one-point Resident #1 did not have the Geri sleeves, but then they were delivered. -She did not recall the date the Geri sleeves were delivered. -Resident #1 would let the Geri sleeves be applied, but he would take them off later. -Resident #1's Geri sleeves were not on the medication cart; she thought the Geri sleeves were in the resident's room. -Resident #1 would scratch his arm until it bled.	D 273		

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D 273	Continued From page 10 -She did not tell Resident #1's PCP the resident was not wearing the Geri sleeves. -She had not documented when she applied Resident #1's Geri sleeves because there was nowhere to document it. -She just knew Resident #1 had an order to wear the Geri sleeves. Interview with another MA on 07/21/22 at 11:41pm revealed: -She had never applied Resident #1's Geri sleeves. -She thought hospice was supposed to apply the Geri sleeves. -If they wanted the MAs to apply the Geri sleeves, they would have told the MAs to apply. -She had never applied Resident #1's Geri sleeves. -Resident #1's Geri sleeves were on the medication cart. Interview with the Special Care Coordinator on 07/20/22 at 4:21pm revealed: -Resident #1's family member had requested something for Resident #1's arm so he would not scratch it. -The hospice nurse said they would send Resident #1's Geri sleeves to the facility. -She thought it took a few days before the Geri sleeves were delivered but did not recall the date. -One of the MAs told her Resident #1 did not like the Geri sleeves when she asked if they had been delivered. -Resident #1's PCP asked about the Geri sleeves on 07/20/22 after doing an in room visit. -The Geri sleeves were in their original plastic bag on the medication cart. -The Geri sleeves did not look like they had been used. -She had not notified Resident #1's PCP the	D 273		

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D 273	Continued From page 11 resident had refused to wear the Geri sleeves because she did not know. -The Geri sleeves should have Interview with the Resident Care Coordinator on 07/21/22 at 5:37pm revealed: -She knew Resident #1 had an order for Geri sleeves. -She was not aware the order for the Geri sleeves was discontinued off the eMAR on 06/17/22. -The SCC received, and input orders and she then reviewed them. -She was not sure why the Geri sleeves order was no longer on the eMAR. Interview with the Administrator on 07/21/22 at 6:58pm revealed: -She did not know Resident #1 had an order for Geri sleeves. -She would expect Resident #1's Geri sleeves to be applied daily. -If Resident #1 refused the Geri sleeves, the MA should document the refusal and notify the PCP. -She was concerned Resident #1 did not get the treatment as prescribed. Interview with Resident #1 on 07/21/22 at 7:37pm revealed: -No one had put anything on his arms to stop him from scratching. -Sometimes he had a bandage on a sore. -He "probably would try it." Attempted telephone interview with Resident #1's hospice nurse on 07/20/22 at 4:52pm and 07/21/22 at 11:16am was unsuccessful. 2. Review of Resident #4's current FL-2 dated 04/13/22 revealed a diagnosis of major depressive disorder, dysphagia, hypothyroidism, and hypertension.	D 273		

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THE STRATFORD	405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516

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D 273	Continued From page 12 Review of Resident #4's Primary Care Provider's after-visit summary dated 04/18/22 revealed: -The reason for the visit was to establish a new patient. -Resident #4 was a good historian. -Resident #4 had cervical disc disease and gait disorder with a history of falls. -Resident #4 would be referred to physical therapy for strengthening. -To restore function PT/Occupational therapy (OT) would be ordered to evaluate and treat Resident #4's gait disorder secondary to osteoarthritis. -He felt Resident #4 would demonstrate improved function and quality of life with the implementation of PT/OT services. Review of a physician's order dated 05/04/22 revealed an order for PT/OT for cervical disc disease. Review of Resident #4's after-visit summary dated 05/27/22 revealed an order for PT/OT to evaluate and treat. Review of Resident #4's progress note dated 05/04/22 revealed: -The entry was recorded as a late entry on 05/25/22. -The entry was for a new order for PT/OT. -The order was received by the SCC. -There was no other documentation related to PT/OT. Interview with Resident #4 on 07/20/22 at 11:56am revealed: -She asked both the Resident Care Coordinator (RCC) and the Special Care Coordinator (SCC) about the PT orders.	D 273		

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D 273	Continued From page 13 -Both the RCC and SCC were sitting in the office together and the RCC said they would get it done. -She did not recall the date of the conversation. -At least three weeks later she still had not received any contact from anyone about the therapy. -The RCC told her she had called the home health agency about one and a half weeks ago and left a message. -She asked the RCC/SCC if she could call about PT/OT herself. -She reached out to her PCP and the next day the home health agency had the order for therapy. -She was having a lot of back pain and had to spend more time in bed than usual to get relief from the pain. Interview with a representative with the facility's contracted therapy provider on 07/20/22 at 12:39pm revealed: -He did not recognize Resident #4's name. -He looked through the folder he kept for orders and did not see an order for Resident #4 for PT/OT. -If he would not have been able to provide therapy for Resident #4, he would have kept a copy of the order and given the order back to the RCC/SCC. -He usually would also get an email about any new therapy orders. -Had an order been received Resident #4 would have been assessed for both PT/OT. Telephone interview with Resident #4's current primary care provider (PCP) on 07/21/22 at 8:50am revealed: -When she saw Resident #4 on 06/16/22, the resident was still having back pain and PT and OT were pending per the resident.	D 273		

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D 273	Continued From page 14 -Resident #4 told her she thought it was pending, so she did not do anything since she knew there was an active order. -On 06/24/22, Resident #4 reached out to her because PT/OT still had not started. -She made a referral to a named PT agency on 06/29/22 when she received the message from Resident #4. -Resident #4's PT was scheduled to begin on 07/25/22. -Had Resident #4 received the PT as ordered, the resident's back pain would have improved. -She did not write the orders for PT prior to 06/29/22, but she was aware the orders were written and expected the order to have been carried out. -She did not receive any notification the PT had not started until Resident #4 told her on 06/16/22 and again on 06/24/22. Interview with the SCC on 05/21/22 at 4:53pm revealed: -She recalled Resident #4 had an order for PT, and she gave the order to the facility's in-house therapy provider. -Orders were usually slid under the agency's door. -If the in-house therapy provider could not provide the therapy, the in-house provider would send the order to another agency. -The in-house agency did not provide anything in writing, communication was usually just verbal. -On 05/04/22, when another order came in, she would have slid it under the in-house provider's door again. -She recalled the PT order dated 05/27/22, but Resident #4 told her she was getting the therapy from an outside therapy agency and that the facility staff did not need to do anything. -When an outside agency provided services, they	D 273		

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D 273	Continued From page 15 would have signed in and she would talk to them about ancillary notes. -She did not think about the PT order again after Resident #4 told her she did not need to do anything. -They used a bucket system for the facility's contracted PCPs and probably should use the same system for outside providers so orders were not missed. Interview with the Administrator on 07/21/22 at 6:26pm revealed: -She was not aware Resident #4 had multiple PT orders that were not implemented. -The Care Managers (SCC/RCC) should have made sure the PT order was followed up on. -She was concerned the reason the PCP had ordered PT/OT was not addressed when the PT/OT was not started in a timely manner. Attempted telephone interview with Resident #4's previous PCP on 07/20/22 at 3:36pm and on 07/21/22 at 11:32am was unsuccessful.	D 273		
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:	D 276	The Stratford shall ensure documentation of written procedures, treatments or orders from a provider in the resident's record; as well as implementation of procedures, treatments, or orders. ACD re-inserviced all care staff on correct procedure for applying compression devices to legs, as well as Ted Hose, or any other compression type sock. ED/RCM/SCM will re-educate Med Techs on the importance of ensuring MD orders are carried out in a timely manner, including the collection of specimens used to rule out infection.	8/3/2022 9/5/2022

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D 276	Continued From page 16 Based on observation, interviews and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 5 sampled residents (#2 and #3) including obtaining a urine specimen for a urinalysis (#2) and donning and doffing tubigrips for a resident who had swelling of her ankles (#3). The findings are: 1. Review of Resident #3's current FL-2 dated 04/27/22 revealed diagnoses included dementia, ventricular fibrillation, hypertension, ventricular tachycardia, osteoarthritis, defibrillator, cardiac arrest and ataxic gait. Review of Resident #3's signed physician's order dated 06/15/22 revealed there was an order for tubigrips to bilateral lower legs, on in the morning and off at bedtime. Observation of Resident #3 on 07/19/21 at 9:56am revealed: -She had swelling in both ankles. -She was not wearing tubigrips. -There were no tubigrips located in her room. Review of Resident 3's June 2022 electronic medication administration record revealed: -There was an entry for tubigrip elastic bandage, put on in the morning and remove at bedtime. -There were exceptions documented on 06/16/22 - 06/19/22. -The exceptions were as follows; tubigrips will be delivered today on 06/16/22. Tubigrips not available on 06/17/22, measurement for tubigrips sent to pharmacy on 06/18/22 and tubigrips were discontinued on 06/19/22. Interview with a pharmacy technician at the	D 276	RCM/MCM will monitor order processing system daily to ensure appropriate and accurate use, as well as ensuring that all orders are processed correctly. RCM/MCM will review the electronic activity report for the facility daily for follow up from the previous day including progress notes and any incidents of concern for follow up. RCM/MCM will bring electonic activity report for the facility, as well as the EMAR compliance report to management meeting daily for review with ED to ensure any needed follow up is completed. RCM/MCM will complete a minimum of 2 chart audits per week to ensure charts are complete and there have been no missed orders. Chart audits are submitted to the ED upon completion for review.	9/5/2022 9/5/2022 9/5/2022 9/5/2022

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D 276	Continued From page 17 facility's contracted pharmacy on 07/21/22 at 11:08am revealed: -The pharmacy received an order for tubigrips on 06/15/22. -The order read, apply tubigrips to bilateral lower legs every morning and remove at bedtime. -The pharmacy was unable to fill the order immediately due to the tubigrips being on back order. -The facility was notified the tubigrips were on backorder by fax on 06/15/22 and 06/17/22. -The pharmacy was able to obtain medigrips and filled the order on 06/17/22. -Medigrips were similar to tubigrips but manufactured by a different company. -The medigrips were delivered to the facility on 06/17/22. -The pharmacy did not have a discontinue order for medigrips. Interview with a personal care aide (PCA) on 07/19/21 at 10:02am revealed: -She had not seen tubigrips in Resident #3's room. -No one had asked her to place tubigrips on Resident #3's lower legs and ankles. Interview with a second PCA on 07/21/22 at 4:00pm revealed: -She had not seen tubigrips in Resident #3's room. -Resident #3 did not have tubigrips on that had to be removed at bedtime. -She had never removed tubigrips from Resident #3's legs. Interview with a third PCA on 07/21/22 at 4:15pm revealed: -She had not seen tubigrips in Resident #3's room.	D 276		

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D 276	Continued From page 18 -She had never removed tubigrips from Resident #3's lower extremities. Interview with a medication aide (MA) on 07/19/21 at 12:20pm revealed: -The PCAs were responsible for donning and doffing tubigrips. -If Resident #3 had an order for tubigrips it would be on her eMAR so it could be documented when they were placed on her legs and when they were removed. -There was no entry on Resident #3's eMAR for tubigrips. -She did not recall Resident #3 having an order for tubigrips. -She did have a previous order for ted hose, but the order had been discontinued due to resident's refusal to wear. Interview with a second MA on 07/21/22 at 4:30pm revealed: -She was aware that Resident #3 had an order for tubigrips but the order was discontinued. -She did not know why the order was discontinued. -The Special Care Coordinator (SCC) would receive new orders and fax them to the pharmacy to be entered into the eMAR or the SCC would enter the new orders into the eMAR. -She had not seen Resident #3 wear tubigrips. Interview with Resident #3's Primary Care Provider (PCP) on 07/20/22 at 3:13pm revealed: -He ordered tubigrips for Resident #3 because she refused to wear Ted Hose. -Resident #3 had swelling of her lower extremities and he ordered the tubigrips to help with the swelling in her lower extremities and to improve circulation. -He was informed today, 07/21/22 that Resident	D 276		

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D 276	Continued From page 19 #3 was not wearing the tubigrips; he wrote an order today to discontinue the tubigrips. -He expected the staff to let him know Resident #3 was not wearing the tubigrips. Interview with the Supervisor on 07/20/22 at 4:14pm revealed: -She remembered Resident #3 having an order for tubigrips. -She had not seen Resident #3 wear tubigrips. -She did not recall the tubigrips being delivered from the pharmacy. Interview with the SCC on 07/20/22 at 1:34pm revealed: -Resident #3 had an order for tubigrips to lower extremities, on in the am and off at bedtime. -The tubigrips were delivered to the facility from the pharmacy. -Resident #3 refused to wear the tubigrips so they were discontinued. -She verbally discussed with the PCP Resident #3's refusal to wear the tubigrips and the PCP said it was fine to discontinue them. -She discontinued the order on the eMAR. -She did not get the order to discontinue the tubigrips in writing. -She obtained a written order to discontinue tubigrips from the PCP today, 07/20/22. Interview with the Administrator on 07/21/22 at 6:35pm revealed: -Tubigrips were ordered for swelling. -Resident #3 did have swelling of her ankles. -She expected the tubigrips to be applied and removed to Resident #3 as ordered. -If Resident #3 refused to wear the tubigrips, the MA should have documented refusal. -The tubigrips should not have been discontinued on the eMAR without a physician's written order.	D 276		

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D 276	Continued From page 20 -She was concerned Resident #3 did not get the prescribed treatment as ordered. 2. Review of Resident #2's current FL-2 dated 6/22/22 revealed diagnoses included frontal temporal dementia, glaucoma, prostate cancer and chronic kidney disease. Review of Resident #2's signed Primary Care Provider's (PCP) order dated 05/11/22 revealed an order to collect a urine specimen for a urinalysis (UA). Review of a signed PCP order dated 07/06/22 revealed an order to collect a urine specimen for a UA. Review of Resident #2's laboratory reports revealed there were no UA reports from 05/11/22 and 07/06/22 for review. Interview with a medication aide (MA) on 07/21/22 at 11:55am revealed: -The Special Care Coordinator (SCC) would let the medication aides (MA) know when a resident had an order for a UA. -The MAs would collect the urine specimen, send it to the laboratory and notify the SCC. -She did not document the collection of the urine specimen when she obtained one. -She would let the SCC know when she obtained the urine specimen or if she attempted to obtain the urine specimen. -She was not aware Resident #2 had an order for a UA and needed a urine specimen. Telephone interview with a second MA on 07/21/22 at 12:43pm revealed: -The SCC would notify the MA when a urine specimen was to be collected.	D 276		

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D 276	Continued From page 21 -She would notify the SCC when the urine specimen was collected or if she attempted to collect the urine specimen and was unsuccessful. -She was notified by the SCC that Resident #2 had an order for a UA and that a urine specimen was needed. -She was notified within the past few weeks of the need to collect a urine specimen on Resident #2. -She attempted to collect the urine specimen for the UA but was unsuccessful. -She informed the SCC that she was unsuccessful in obtaining the urine specimen. -She did not document the attempt to collect the urine specimen or her conversation with the SCC regarding her attempt to collect the urine specimen. -She did not know she needed to document the attempt to collect the urine specimen. -She did not recall anyone asking her to collect a urine specimen for a UA in May of 2022. Interview with a third MA on 07/21/22 at 4:20pm revealed: -The MAs were responsible for obtaining urine specimens. -The SCC would verbally communicate with the MAs when a urine specimen needed to be collected. -No one had asked her to obtain a urine specimen on Resident #2. Interview with the Special Care Coordinator (SCC) on 07/21/22 at 9:57am revealed: -When an order was written for collection of urine for a urinalysis, the MA that was working would be notified of the order and asked to collect the resident's urine. -The MAs collect the urine specimen. -Once the sample was collected, the MA would send the urine sample to the laboratory and notify	D 276		

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D 276	Continued From page 22	D 276		

management that the sample had been collected and sent to the laboratory.
-If the MA attempted to collect and was unsuccessful, the MA would report to the oncoming shift the need to collect the specimen.
-The MA working was notified to collect a urine specimen for a UA when the orders were written on 05/11/22 and 07/06/22.
-She did not recall what MA was working and who she spoke with about obtaining a urine specimen for Resident #2.
-She may have text the MA group Resident' #2's order for a UA.
-She knew one MA attempted to collect a urine specimen with the order dated 07/06/22 but was unsuccessful.
-The MA did not document the attempt to collect the urine sample; she verbally told the MCC.
-The MA was instructed to report to the MA working the on-coming shift to attempt to collect the urine specimen.
-The SCC did not follow up to see if the urine specimen was collected.

Interview with the Administrator on 07/21/22 at 6:35pm revealed:
-The SCC would notify the MA that a UA needed to be collected.
-The SCC should place the order in the "new order" folder.
-The order would stay there until the specimen was collected, then the order would be moved to another folder until the results were received.
-Once the urine specimen was obtained the MA would notify the SCC and document the urine specimen was obtained.
-There was a failure in the system we have in place to track new orders.
-When the physician ordered a UA, he would be looking for something specific.

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D 276	Continued From page 23 Attempted telephone interview with Resident #2's PCP on 07/21/22 at 9:30am and 2:30pm was unsuccessful.	D 276		
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 observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#2) who had an as needed order for a laxative with a duplicate as needed order that was scheduled resulting in the resident receiving daily doses of an as needed medication. The findings are: Review of Resident #2's current FL-2 dated 6/22/22 revealed diagnoses included frontal temporal dementia, glaucoma, prostate cancer and chronic kidney disease.	D 344	The Stratford shall ensure contact is made the resident's provider for verification or clarification of orders for medications and treatments as required. ED/RCM/MCM will in-service staff on the importance of following up with the PCP to clarify orders that are not clear or complete. Staff will also be in-serviced on the importance of notifying the RCM/MCM when there is any delay in getting a medication order clarified and assistance is needed. 9/5/2022 RCM/MCM will monitor order processing folders daily to ensure there are not medication orders awaiting clarification. If such orders are present, RCM/MCM will work to assist in expediting the process. 9/5/2022 RCM/MCM will ensure accuracy when approving orders, making sure to follow all directions given in the original physician's order. 9/5/2022 RCM/MCM will pull EMAR compliance reports daily to review for accuracy and compliance. The report will be reviewed and discussed with the ED during management meeting for 9/5/2022	

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D 344	Continued From page 24 Review of Resident #2's physician's order dated 06/22/22 revealed an order for milk of magnesia (MOM) (used to treat constipation) 30cc at bedtime as needed (PRN) for constipation. Review of Resident #2's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for MOM one dose PRN at bedtime today to be administered at 5:30pm. -There was documentation MOM was administered at 5:30pm on 06/28/22 - 06/30/22. -There was a second entry for MOM 30cc at bedtime PRN for constipation. Review of Resident #2's July 2022 eMAR revealed: -There was an entry for MOM one dose PRN at bedtime today to be administered at 5:30pm. -There was documentation MOM was administered at 5:30pm on 07/01/22 - 07/18/22. -There was an exception documented on 07/02/22; medication was not needed. -There was a second entry for MOM 30cc at bedtime PRN for constipation. Telephone interview with the pharmacy technician at the facilities contracted pharmacy on 07/19/22 at 4:11pm revealed: -The pharmacy had an order on Resident #2's profile order sheet for MOM 30cc at bedtime PRN. -They did not have an order for a scheduled dose of MOM. -The facility was able to enter and schedule standing orders for medications. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/20/22 at	D 344	follow up.	

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D 344	Continued From page 25 3:48pm revealed: -MOM was used for constipation. -It was usually ordered on a PRN basis. -Resident #2 could have some abdominal cramping or diarrhea if taking MOM daily. Interview with a medication aide (MA) on 07/20/22 at 11:25am revealed: -She did administer the MOM to Resident #2 as scheduled on the eMAR. -She saw it scheduled at 5:30 pm but did not notice the instructions were for PRN. Interview with a second MA on 07/20/22 at 4:30pm revealed: -She did administer the MOM to Resident #2 at 5:30pm because it was a scheduled medication. -She did not notice the instructions were entered as PRN. -Resident #2 did not have any diarrhea or abdominal discomfort. Interview with Resident #2's Primary Care Provider (PCP) on 07/20/22 at 3:13pm revealed: -He did not order MOM to be scheduled; it should only be administered on an as needed basis. -He did not know Resident #2 was receiving MOM daily. -Resident #2 could experience gastro-intestinal discomfort from receiving MOM daily. Interview with the Supervisor on 07/20/22 at 4:14pm revealed: -She had never administered MOM to Resident #2. -She would have clarified the MOM entry that was scheduled for 5:30pm with PRN instructions. -She expected the MAs to clarify any orders that were not clear.	D 344		

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D 344	Continued From page 26 Interview with the Resident Care Coordinator (RCC) on 07/19/21 at 4:43pm revealed: -The pharmacy usually entered medication orders on the eMAR. -If a new order did not show up on the eMAR, the RCC would enter the new order. -Sometimes the pharmacy would enter an order that the facility could not see. -If she could not see an order then she would enter the order manually. -All standing orders were entered by the RCC or Special Care Coordinator (SCC). Interview with the SCC on 07/20/22 at 1:34pm revealed: -Resident #2 was seen in the ED on 06/27/822. -She was informed resident #2 would be discharged from the facility and placed in a skilled facility. -Resident #2's medications were discontinued from the eMAR once the facility was notified of the discharge. -She received a phone call on 06/28/22 Resident #2 had returned to the facility and there were no orders in the eMAR. -She manually re-entered all the medications for Resident #2 after he returned to the facility. -She mistakenly entered two orders for the PRN MOM and scheduled one to be administered at 5:30pm. Interview with the Administrator on 07/21/22 at 6:35pm revealed: -The MAs should read the entry on the eMAR and compare it to the prescription label on the medication. -If the instructions entered on the eMAR were different from the instructions on the prescription label, the MA should notify the SCC and call the pharmacy.	D 344		

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D 344	Continued From page 27 -The pharmacy should be entering all information onto the eMAR. -The RCC and SCC verify the orders before the MA can administer the medication. -The RCC or SCC should have caught the discrepancy of the medication and called the pharmacy for clarification. -Medications that were ordered PRN were not to be scheduled at a specific time. -Resident #2 could have experienced gastro-intestinal discomfort by taking a PRN medication daily. -The MA should have called the pharmacy and spoke with the MCC regarding a PRN medication being scheduled.	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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 5 sampled residents (#1, #2, #4, and #5) related to two anti-itch medications and an eye drop (#1); a supplement and eye drops (#4); a non-steroidal, anti-inflammatory medication used to thin the	D 358	The Stratford shall ensure that the preparation and administration of medications and treatments by staff are according to provider orders which are kept in the resident's record, the facility's policies and procedures, and rule area .1004 (a). RCM/MCM notified PCPs of identified medication discrepancies related to Aspirin, Vitamin B12, and Milk of Magnesia. 7/20/22 ACD in-serviced Med Techs on the 6 Rights of Medication Administration, as well as the importance of reporting to the RCM/MCM if discrepancies on the MAR are noted. 7/21/22, 7/22/22, 7/23/22 ACD re-inserviced MCM on the importance of reviewing and clarifying discharge summaries on residents upon 7/21/22	

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D 358	Continued From page 28 blood (#2); and an antidepressant and a nasal spray (#5). The findings are: 1. Review of Resident #2's current FL-2 dated 06/22/22 revealed diagnoses included frontal temporal dementia, glaucoma, prostate cancer and chronic kidney disease. Review of Resident #2's physician's order dated 06/27/22 revealed there was an order for aspirin (a non-steroidal anti-inflammatory that can be used as a blood thinner) 81mg daily for 20 days. Review of Resident #2's Emergency Department (ED) discharge summary dated 06/28/22 revealed: -Resident #2 was seen in the ED for stroke-like symptoms. -Resident #2 was started on aspirin 81mg every morning for 20 days. Review of Resident #2's Primary Care Providers (PCP) visit not dated 06/29/22 revealed: -Resident #2 was seen for a follow up from his visit to the ED on 06/27/22. -Resident #2 was seen in the ED for stoke-like symptoms and facial droop; no facial droop was noted today, 06/29/22. -Resident #2 was started on aspirin 81mg every morning for 20 days. Review of Resident #2's physician's order dated 07/08/22 revealed there was an order for aspirin 81 mg daily. Review of Resident #2's June 2022 electronic medication administration record (eMAR) revealed:	D 358	the return from their hospital admission. RCC re-inserviced Med Techs on 6 rights of medication administration at med tech meeting. 7/25/22 ACD will complete random Med Tech observations during med passes to ensure at least 2 observations per month are completed. This will check compliance with giving meds correctly. 9/5/22 RCC/MCM will pull EMAR compliance reports daily and review for compliance and accuracy. This will be discussed with the ED during management meeting for any needed follow up. 9/5/22 Weekly cart audits will be completed by RCM/MCM/LSIC to check for the QA compliance of the medication cart. Follow up will be reviewed with the ED. 9/5/22 RCM/MCM will complete a minimum of 2 chart reviews weekly to audit for completion, accuracy, and medication compliance. Completed chart reviews will be submitted to the ED. 9/5/22	

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D 358	Continued From page 29 -There was an entry for aspirin 81mg every morning for 20 days with a scheduled administration time of 7:00am. -There was documentation that aspirin was administered every morning at 7:00am from 06/28/22 - 06/30/22. Review of Resident #2's eMAR for 07/01/22-07/16/22 revealed: -There was an entry for aspirin 81mg every morning for 20 days with a scheduled administration time of 7:00am. -There was documentation that aspirin was administered every morning at 7:00am from 07/01/22 - 07/8/22. -There was an entry that aspirin 81mg every morning for 20 days was discontinued on 07/08/22. -There was another entry dated 07/08/22 for aspirin 81mg daily with a scheduled administration time of 8:00am. -There was documentation that aspirin was administered daily at 8:00am from 07/09/22 - 07/16/22. -There was an entry that aspirin 81mg daily was discontinued on 07/16/22. Observation of Resident #2's medication on hand on 07/19/22 at 2:15pm revealed: -There was a bubble pack labeled aspirin 81mg dispensed on 06/27/22. -There were 20 tablets of aspirin dispensed on 06/27/22 to be administered every morning for 20 days. -There were 15 of 20 tablets of aspirin remaining in the bubble pack dispensed on 06/27/22. -There was a second bubble pack labeled aspirin 81mg dispensed on 07/08/22 with 11 tablets dispensed. -There were 8 of 11 tablets of aspirin remaining in	D 358		

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D 358	Continued From page 30 the bubble pack dispensed on 07/08/22. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 07/19/22 at 4:11pm revealed: -The pharmacy had an order dated 06/28/22 for aspirin 81 mg daily for 20 days. -The pharmacy dispensed 20 tablets of aspirin 81mg in a bubble pack on 06/27/22. -The pharmacy received a new order dated 07/08/22 for aspirin 81mg daily. -The pharmacy discontinued the order for aspirin 81mg daily for 20 days and entered the new order for aspirin 81mg daily. -The 11 doses of aspirin dispensed on 07/08/22 would have been enough doses to administer to Resident #2 until the pharmacy started placing the aspirin 81mg in the weekly multi-dose pack, starting 07/19/22. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/20/22 at 3:48pm revealed aspirin was used to thin the blood and prevent clotting in residents who were at risk for stroke. Interview with a medication aide (MA) on 07/20/22 at 11:25am revealed: -She had administered Resident #2 his aspirin 81mg from the bubble packs. -She did not know why there were extra tablets in the bubble pack than were documented on the eMAR. -The aspirin probably was not given from the bubble pack because the MAs thought the aspirin was in the multi-dose pack. Interview with another MA on 07/20/22 at 1:08pm revealed: -Resident #2 had an order for aspirin daily but it	D 358		

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D 358	Continued From page 31 was discontinued. -She had administered aspirin 81mg from the bubble packs to Resident #2. -She did not know why the aspirin was discontinued; she did not see the orders. -She did not know why there were extra tablets in the bubble pack; the pharmacy only sent enough tablets until the medication was placed in the multi-dose pack. -The orders were entered into the eMAR by the Special Care Coordinator (SCC), the Resident Care Coordinator (RCC) or the pharmacy. -She administered Resident #2's morning medications on 07/19/22. -There was an 81mg aspirin in Resident #2's multi-dose pack on the morning of 07/19/22; she removed the aspirin and destroyed it because it was not on the eMAR to be administered. -She did not know why the aspirin was in the multi-dose pack since it was discontinued from the eMAR. -She did not inform the SCC that the aspirin was in the multi-dose pack. -She did not realize the order for aspirin was still active and should be on the eMAR. -She would have no way of knowing the aspirin was still an active order; she did not see the resident's orders. Interview with Resident #2's PCP on 07/20/22 at 3:13pm revealed: -Resident #2 was started on aspirin when he presented to the ED with stroke like symptoms on 06/27/22. -The original order for aspirin was for 20 days but that order was discontinued and another order was written on 07/08/22 for aspirin 81mg daily. -He wanted Resident #2 to remain on aspirin until seen by the Neurologist which was scheduled for late August 2022.	D 358		

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D 358	Continued From page 32 -He was not aware that Resident #2 was not being administered aspirin daily as ordered. -Resident #2 was at risk for a stroke if he was not receiving aspirin as ordered. -He expected the staff to administer medications as ordered. Interview with the SCC on 07/20/22 at 12:25pm and 4:14pm revealed: -The facility used weekly multi-dose pack; the bubble packs were sent with enough medications until the medication could be dispensed in the multi-dose pack. -She would place her initials beside the bubble on the bubble pack when she administered a medication from the bubble pack. -She used the scanner when preparing medications for administration; each medication in the multi-dose pack would "light up" on the eMAR if it was in the multi-dose pack. -If the medication was on the eMAR and not in the multi-dose pack, the MA would get an alert that a medication was missing. -The alert that a medication was missing would prompt the MA to look for a bubble pack. -If the medication was in the multi-dose pack and not on the eMAR to be administered, the MA would get an alert to remove the medication from the multi-dose pack. -All MAs did not use the scanner; they manually click each medication off on the eMAR. -She did not know why there were extra aspirin tablets in the bubble pack related to how many had been documented as administered. -It appears the MAs were "clicking" medications were being administered when they were not, leading to extra tablets available for administration. -She was not sure why the second order for aspirin 81mg daily was discontinued since there	D 358		

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was no order to discontinue.
-Medications on the eMAR could be discontinued by the SCC, RCC or the pharmacy.

Interview with the Administrator on 07/21/22 at 6:35pm revealed:
-Resident #3's aspirin should have been administered as ordered.
-Resident #3 was ordered aspirin after being seen in the ED for stroke-like symptoms.
-Resident #3 may have more stroke-like symptoms if the aspirin was not administered as ordered.

Based on eMAR documentation, medications dispensed and medications on hand between 06/27/22 and 07/18/22, there should have been 10 tablets of aspirin available to be administered, but there were 23 tablets remaining in the bubble packs dispensed 06/27/22 and 07/08/22.

Refer to the interview with the Supervisor on 07/20/22 at 4:14pm.

Refer to the interview with the Special Care Coordinator on 07/20/22 at 12:25pm

Refer to the interview with the Administrator on 07/07/21 at 6:58pm.

2. Review of Resident #5's current FL-2 dated 03/13/22 revealed diagnoses included dementia without behavioral disturbances and bradycardia.

a. Review of Resident #5's physician's orders dated 07/11/22 revealed an order for bupropion (used for depression and mood) 100mg ½ tablet twice a day.

Review of Resident #5's Primary Care Providers

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D 358	Continued From page 34 (PCP) visit note dated 07/11/22 revealed: -The family reported increased depression and sleeping during the day. -Resident #5 had been sleeping more during the day; his affect appeared flatter. -The plan of action was to initiate bupropion 100mg ½ tablet twice a day. Review of Resident #5's electronic medication administration record (eMAR) for 07/13/22 - 07/18/22 revealed: -There was an entry for bupropion 100mg ½ tablet twice a day scheduled at 7:00am and 7:00pm. -There was documentation that bupropion was administered twice a day from 07/13/22 to 07/18/22. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 07/20/22 at 3:40pm revealed: -There was an order dated 07/12/22 for bupropion 100mg take ½ tablet twice a day. -The pharmacy dispensed a bubble pack with 14 one-half tablets on 07/12/22 with instructions to administer ½ tablet twice a day. -The medication in the bubble pack would provide enough medication for Resident #5 until the medication was placed in the multi-dose pack. -Bupropion would be placed in the multi-dose pack for administration starting on 07/19/22 with the morning dose. Observation of Resident #5's medication on hand on 07/20/22 at 10:30am revealed: -There was a bubble pack labeled bupropion 100mg tablets dispensed on 07/12/22. -There were 6 one-half tablets of bupropion remaining for administration.	D 358		

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D 358	Continued From page 35 Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/20/22 at 3:48pm revealed: -Bupropion was used to treat mood disorder and depression. -Resident #5's mood would not improve and he would continue to show signs of depression if the medication was not administered as ordered. Interview with a medication aide (MA) on 07/21/22 at 11:55am revealed: -Resident #5 was recently ordered bupropion twice a day. -The pharmacy would send a bubble pack of medication to be administered to Resident #5 until the medication was placed in the multi-dose pack. -She would scan Resident #5's multi-dose pack when administering his medications. -She would receive an electronic warning if the medication was not in the multi-dose pack. -She knew when she received the electronic warning that she had to look for the medication on the medication cart. -She had administered Resident #5's bupropion from the bubble pack. -She did not know why there were extra tablets in the bubble pack. Interview with the Special Care Coordinator (SCC) on 07/21/22 at 10:05am revealed: -Resident #5 had a new order for bupropion that was written by his PCP about a week ago. -Resident #5's PCP ordered bupropion for depression because Resident #5 had been sleeping a lot. -The pharmacy would send the medication in a bubble pack until the medication was placed in the multi-dose pack. -She did not know how many bupropion were	D 358		

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sent in the bubble pack or when the bupropion would be added to the multi-dose pack.
-The MA should scan the multi-dose pack; the eMAR would alert the MA with an electronic message if a medication was not in the multi-dose pack.
-If the MA received the electronic message that the medication was not in the multi-dose pack, the MA would look for a bubble pack.
-She did not know why there were extra bupropion in the bubble pack.

Interview with the Administrator on 07/21/22 at 6:35pm revealed:
-Resident #5 was ordered bupropion to treat depression.
-Resident #5 should have been administered his medication as ordered.

Based on eMAR documentation, medications dispensed and medications on hand between 07/13/22 and 07/18/22, there should have been 2 one-half tablets of bupropion available to be administered and there were 6 one-half tablets remaining in the bubble pack dispensed on 07/12/22.

Attempted telephone interview with Resident #5's PCP on 07/21/22 at 9:30am was unsuccessful.

Refer to the interview with the Supervisor on 07/20/22 at 4:14pm.

Refer to the interview with the Special Care Coordinator on 07/20/22 at 12:25pm

Refer to the interview with the Administrator on 07/07/21 at 6:58pm.

b. Review of Resident #5's physician's order

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THE STRATFORD	405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 37 dated 05/04/22 revealed an order for fluticasone (used for seasonal allergies) 50mcg 1 spray daily in each nostril for 14 days. Review of Resident #5's physician's order dated 05/18/22 revealed an order for fluticasone 50mcg 2 sprays in each nostril twice a day. Review of Resident #5's Primary Care Provider's (PCP) visit note dated 05/04/22 revealed: -Resident #5 complained of mild cough, right eye discomfort and a runny nose; symptoms likely allergy related. -Plan of treatment to start fluticasone 50mcg 1 spray in each nostril daily x 14 days for allergic rhinitis. Review of Resident #5's PCP visit note dated 05/11/22 revealed: -Resident #5 continued with allergic rhinitis. -Resident #5 continued to clear his throat but did not complain of a runny nose. -Resident #5 to continue the 14-day course of fluticasone nasal spray. Review of Resident #5's PCP visit note dated 05/18/22 revealed: -Resident #5 complained of right ear discomfort and throat pain; he denied a cough. -Resident #5 had post nasal drip. -Resident #5's symptoms were likely caused by allergic rhinitis. -Plan of treatment to increase fluticasone to 2 sprays twice daily. Review of Resident #5's PCP visit note dated 05/25/22 revealed Resident #5's allergy symptoms continued; Resident #5 was to continue the regimen of fluticasone nasal spray.	D 358		

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D 358	Continued From page 38 Review of Resident #5's PCP visit note dated 06/01/22 revealed Resident #5 was to continue with fluticasone 2 sprays in each nostril twice a day. Review of Resident #5's May 2022 electronic medication administration record (eMAR) revealed: There was an entry for fluticasone 50mcg instill 1 spray in each nostril daily at 8:00am. -There was documentation fluticasone was administered daily from 05/05/22 - 05/18/22. -There was an entry for fluticasone 50mcg instill 2 sprays in each nostril twice a day scheduled for 7:00am and 7:00pm. -There was documentation fluticasone was administered twice a day from 05/19/22 - 05/31/22. Review of Resident #5's June 2022 eMAR revealed: -There was an entry for fluticasone 50mcg instill 2 sprays in each nostril twice a day scheduled for 7:00am and 7:00pm. -There was documentation fluticasone was administered twice a day on 06/01/22. -There was an electronic entry that fluticasone was discontinued on 06/01/22. -There was no documentation that fluticasone was administered after 06/01/22. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 07/20/22 at 3:00pm revealed: -There was an order dated 05/18/22 for fluticasone 50mcg 2 sprays in each nostril twice a day. -Fluticasone nasal spray was dispensed on 05/04/22 and 05/27/22 with 120 sprays per bottle. -The order for fluticasone was still active; the	D 358		

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D 358	Continued From page 39 pharmacy had not received a discontinue order for fluticasone. -She did not know how fluticasone was discontinued from the eMAR. Observation of Resident #5's medication on hand on 07/20/22 at 10:30am revealed: -There was a bottle of fluticasone nasal spray dispensed on 05/27/22. -The bottle of fluticasone nasals spray had been opened, but it appeared greater than 3/4's full. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/20/22 at 3:48pm revealed: -Fluticasone was a nasal spray used for seasonal allergies. -Resident #5 could continue with symptoms of allergies if the fluticasone was not administered as ordered. Interview with Resident #5 on 07/21/22 at 9:30am and 5:09pm revealed: -He received a nasal spray for his allergies a few weeks ago. -He did not remember being administered his nasal spray recently. -He had a runny nose occasionally. -He denied his throat hurting. -He complained of itchy eyes at times. Interview with a MA on 07/21/22 at 11:55am revealed: -Resident #5 did not have an order for fluticasone. -Fluticasone was not on Resident #5's eMAR. -If Resident #5 had an order for fluticasone it would be on his eMAR. -She did not know Resident #5 had a current order for fluticasone.	D 358		

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D 358	Continued From page 40 -She would not know Resident #5 had an order for fluticasone since it was not on the eMAR. -She did not know Resident #5 had fluticasone on the cart. -Fluticasone was not on Resident #5's eMAR so she would not look for fluticasone on the medication cart. -She had not noticed any signs and symptoms, such as runny nose, itchy eyes or cough, in the past few weeks. Interview with a second MA on 07/21/22 at 12:43pm revealed: -Resident #5 received fluticasone for nasal congestion. -Resident #5 had nasal congestion about a month ago but she had not noticed any nasal congestion recently. -She thought it was ordered as an "as needed" medication. -She did not know fluticasone should be a scheduled medication; it was no longer on the eMAR. Interview with the Special Care Coordinator (SCC) on 07/21/22 at 10:05am and 4:44pm revealed: -She knew Resident #5 had an order for fluticasone nasal spray for 14 days. -Fluticasone was used for allergies. -She received a telephone call from a MA who verbalized the fluticasone was still on the eMAR for administration after the 14 days was completed. -She may have discontinued the fluticasone since the 14-day order was completed. -She did not realize she discontinued the most recent order for fluticasone. -She had not noticed Resident #5 with any symptoms of allergies in the past few weeks.	D 358		

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D 358	Continued From page 41 -She needed to pay closer attention when discontinuing orders. -The MAs needed to question why there was a medication on the medication cart and not on the eMAR. -The resident should be administered all medications that were ordered for him. Interview with the Administrator on 07/21/22 at 6:35pm revealed: -Resident #5 was ordered fluticasone nasal spray for his seasonal allergies. -Resident #5 should have received his medication as ordered. Attempted telephone interview with Resident #5's PCP on 07/21/22 at 9:30am was unsuccessful. Refer to the interview with the Supervisor on 07/20/22 at 4:14pm. Refer to the interview with the Special Care Coordinator on 07/20/22 at 12:25pm. Refer to the interview with the Administrator on 07/07/21 at 6:28pm. 3. Review of Resident #1's current FL-2 dated 04/07/21 revealed a diagnosis of pneumonia. a. Review of Resident #1's signed physician's orders dated 04/06/22 revealed: -There was an order to discontinue the current CeraVe (a moisturizing cream) and Triamcinolone (a cortisone cream used to treat skin conditions) order. -There was an order to start Triamcinolone 0.1%, mix sixteen ounces of Triamcinolone with a jar of CeraVe and apply twice daily to redness on bilateral upper arms.	D 358		

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D 358	Continued From page 42 Review of Resident #1's Primary Care Provider's (PCP) after visit summary dated 05/04/22 revealed: -Resident #1 was diagnosed with cellulitis (a bacterial skin infection) of the right upper arm and right leg; an antibiotic was ordered. -Resident #1 had eczema (a condition that causes the skin to be red and itchy) flare up likely due to the resident not receiving his CeraVe and Triamcinolone combination. -Orders to restart the CeraVe and Triamcinolone cream to affected areas were given. -Facility staff were to start working on the dispensing of CeraVe/Triamcinolone combination as soon as possible (ASAP). Review of Resident #1's PCP after visit summary dated 05/11/22 revealed: -Resident #1's cellulitis was improving. -The eczema was improving. -Restart the CeraVe/Triamcinolone combination ASAP; discussed with the Resident Care Coordinator (RCC). Review of Resident #1's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry for R-CeraVe CR/TAC 0.1% cream 1:1 topical with instructions to apply topically to redness to bilateral upper arms twice daily; the start date was 04/07/22 and the stop date was 05/06/22. -There was an exception documented on 05/01/22 at 7:00am as waiting on the pharmacy and 7:00pm as on order. -There was documentation on 05/02/22 the cream was applied at both 7:00am and 7:00pm. -There was an exception documented on 05/03/22 at 7:00am as waiting on the pharmacy;	D 358		

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at 7:00pm it was documented the cream was applied.
-There was an exception documented on 05/04/22 at 7:00am and 7:00pm as waiting on the pharmacy.
-There was an exception documented on 05/05/22 at 7:00am, as waiting on the orders.
-There was a second entry for R-CeraVe CR/TAC 0.5% ointment 1:1 topical with instructions to apply twice daily to bilateral upper arms and right leg with a start date of 05/05/22 and a stop date of 05/06/22.
-There was documentation the cream had been applied on 05/06/22 at 7:00am.
-There was a third entry for R-CeraVe CR/TAC 0.1% ointment 3:4 topical with instructions to apply twice daily to bilateral upper arms and right leg with a start date of 05/06/22; there was no stop date.
-There was documentation the ointment was applied at 8:00pm on 05/06/22 and at both 8:00am and 8:00pm from 05/07/22-05/31/22.

Observation of Resident #1's medication on hand on 07/09/22 at 2:39pm revealed:
-There was a tub of CeraVe/Triamcinolone cream with a dispense date of 05/06/22 and a handwritten date of 05/10/22.
-There was a second tub of CeraVe/Triamcinolone cream with a dispense date of 05/19/22 and a handwritten date of 06/19/22.

Interview with a medication aide (MA) on 07/19/22 at 2:39pm revealed:
-Handwritten dates on medication containers were when a medication was opened.
-She did not know why Resident #1 would have two tubs of CeraVe/Triamcinolone opened, but sometimes MAs would start using something

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when there was still medication available from the previous delivery.

Interview with another MA on 07/20/22 at 5:05pm revealed:
-Resident #1 had three different "creams" on the medication cart at one time.
-She recalled between 05/01/22-05/05/22, there was no cream on the medication cart for Resident #1.
-Resident #1 had multiple orders and there was a "big commotion" about the creams.
-One MA was saying this, and another MA was saying that and there were just too many hands dealing with getting the creams refilled.
-When the cream was getting low; whatever MA was working should have let someone in management know the medication needed to be reordered.
-She did not recall Resident #1's cream getting low; she only recalled when the creams were out.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 07/02/22 at 8:59am revealed:
-On 04/06/22, 240 grams of a compounded medication of CeraVe and Triamcinolone (R-CeraVe CR/TAC 0.1% ointment) were dispensed for a 15-day supply.
-There were no refills available on the order dated 04/06/22 and there was no documentation a refill had been requested.
-If a refill request had been sent in, they would have faxed the facility to let them know a new order was needed.
-On 05/05/22, a new order was received, and a 15-day supply of the CeraVe and Triamcinolone compound was dispensed.
-On 05/19/22, the CeraVe and Triamcinolone compound was dispensed again for a 15-day

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D 358	Continued From page 45 supply. -There have been no requests to refill the CeraVe and Triamcinolone compound since the 05/19/22 dispensing. -Resident #1 was on hospice and therefore he received a 15-day supply of medication each dispensing. -It was hard to know how long a tub of the compounded medication of CeraVe and Triamcinolone would last because it would depend on the size of the area it was being applied. Interview with Resident #1's PCP on 07/20/22 at 3:16pm revealed: -When he saw Resident #1 on 04/06/22, he noted the resident had a flare up of his eczema and had been "digging" at the rash. -He found out during the 04/06/22 visit, that Resident #1 was out of the medications used to treat his eczema. -He was not notified Resident #1 was out of the CeraVe/Triamcinolone cream and would have expected the staff to notify him if there was a problem with a refill. -If Resident #1 did not receive his CeraVe/Triamcinolone as ordered, he was at risk for another flare up of his eczema and possible cellulitis. -He saw Resident #1 today, 07/20/22, at the request of Resident #1's family member who had noted the resident had a reddened area and was concerned Resident #1 might have another eczema flare up. Telephone interview with Resident #1's family member on 07/20/22 at 4:20pm revealed: -She had asked the PCP to see Resident #1 when she saw Resident #1's right arm was red during her visit "this past weekend."	D 358		

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D 358	Continued From page 46 -She was concerned Resident #1 would scratch the red area and would get cellulitis again. Interview with the Special Care Coordinator (SCC) on 07/21/22 at 4:21pm revealed: -Resident #1's creams should be reordered, "well before getting low." -MAs were responsible for completing a refill sheet and scanning the sheet to her; she would then send the refill request to the pharmacy. -If the next day the medication was still not available, the MA should call the pharmacy to see why the medication was not delivered. -If there was a problem with why the medication had not been delivered, the MA should let her or the RCC know. -The MA may have made a note the medication needed to be reordered but did not let her know. -She did not know Resident #1's creams were out until she made rounds with Resident #1's PCP; when the PCP asked about the creams she would have looked and noted that it was not on the medication cart. -If she had known Resident #1 was out of his creams, she would have reordered the medication. Interview with the RCC on 07/21/22 at 5:37pm revealed: -She remembered there had been some issues with Resident #1's creams. -She did not remember the specifics, but when there were issues with medication, it should be documented in the resident's progress notes. -There was a time, about two months ago, when the facility was transitioning to electronic refills versus faxing because there had been an issue with the fax machine. -If Resident #1's CeraVe/Triamcinolone was not on the medication cart, she would have expected	D 358		

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D 358	Continued From page 47 the MA to notify her so the medication could have been ordered. Review of Resident #1's progress notes dated 04/01/22-05/05/22 revealed there was no documentation about Resident #1's CeraVe and Triamcinolone prescription. Interview with the Administrator on 07/21/22 at 6:58pm revealed she was not aware Resident #1 had an eczema flare-up because he had not been administered his medication that was ordered to treat eczema. Interview with Resident #1 on 07/21/22 at 7:37pm revealed: -If he did not get cream on his arms, his arms itched. -He thought the cream was applied to his arms every day. -He did not recall if he had missed any days having cream applied to his arms. Refer to the interview with the Supervisor on 07/20/22 at 4:14pm. Refer to the interview with the Special Care Coordinator on 07/20/22 at 12:25pm. Refer to the interview with the Administrator on 07/07/21 at 6:28pm. b. Review of Resident #1's signed physician's orders dated 04/06/22 revealed: -There was an order to discontinue current Tacrolimus (Tacrolimus topical is used on the skin to treat moderate to severe atopic dermatitis in patients who have received other medicines that have not worked well). -There was an order to start Tacrolimus 0.1%	D 358		

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D 358	Continued From page 48 apply twice daily to redness on bilateral upper arms. Review of Resident #1's Primary Care Provider's (PCP) after visit summary dated 05/04/22 revealed: -Resident #1 was diagnosed with cellulitis (a bacterial skin infection) of the right upper arm and right leg. -An antibiotic was ordered. -Resident #1 had eczema (a condition that causes the skin to be red and itchy) flare up likely due to the resident not receiving his Tacrolimus. -Insurance would no longer pay for the resident's Tacrolimus per the facility's Resident Care Coordinator (RCC) and prior authorization was started. Review of Resident #1's PCP after visit summary dated 05/11/22 revealed: -Resident #1's cellulitis was improving. -The eczema was improving. -Restart the CeraVe/Triamcinolone combination ASAP; discussed with the RCC. -Tacrolimus's prior authorization was pending. Review of Resident #1's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Tacrolimus ointment 0.1% apply topically to redness on both arms twice daily with a start date of 04/07/22 and a stop date of 05/07/22. -Tacrolimus was documented as applied at 8:00am on 05/01/22 and at 8:00pm there was an exception documented as on order. -There was an exception documented from 05/02/22-05/06/22 as on order and waiting on pharmacy. -There was no other entry for Tacrolimus.	D 358		

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D 358	Continued From page 49 Review of Resident #3's June 2022 and 07/01/22-07/22/22 eMAR revealed there was no entry for Tacrolimus ointment 0.1%. Observation of Resident #1's medication on hand on 07/09/22 at 2:39pm revealed there was no Tacrolimus ointment on hand. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/02/22 at 8:59am revealed: -Sixty grams of Tacrolimus were dispensed on 04/10/22 and 04/29/22. -Resident #1 was on hospice and therefore he received a 15-day supply of medication at each dispensing. -It was hard to know how long a tube of Tacrolimus would last because it would depend on the size of the area it was being applied. -There were no refills after 04/29/22 and there was no documentation a refill had been requested. Interview with a medication aide (MA) on 07/20/22 at 1:11pm revealed: -She recalled Resident #1 had a tube of Tacrolimus for a short period of time. -She thought the insurance did not approve for the Tacrolimus to be refilled. -She could not discontinue orders on the eMAR, only a manager could do that. -Managers were the Special Care Coordinator (SCC) and the RCC. -She only administered what "popped up" on the eMAR. -If Tacrolimus did not pop up, she did not administer it. Interview with Resident #1's PCP on 07/20/22 at	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE STRATFORD	405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 50 3:16pm revealed: -When he saw Resident #1 on 04/06/22, he noted the resident had a flare up of his eczema and had been "digging" at the rash. -He found out Resident #1 was out of his medications used to treat eczema. -He was not notified Resident #1 was out of the Tacrolimus and would have expected the staff to notify him if there was a problem with a refill. -If Resident #1 did not receive his Tacrolimus as ordered, he was at risk for another flare of his eczema and possible cellulitis. -He saw Resident #1 today, 07/20/22, at the request of Resident #1's family member who had noted the resident had a reddened area and was concerned Resident #1 might have another eczema flare up. Telephone interview with Resident #1's family member on 07/20/22 at 4:20pm revealed: -She had asked the PCP to see Resident #1 when she saw Resident #1's right arm was red during her visit "this past weekend." -She was concerned Resident #1 would scratch the red area and would get cellulitis again. Interview with the RCC on 07/21/22 at 5:37pm revealed: -She remembered there had been some issues with Resident #1's creams. -She did not remember the specifics, but when there were issues with medication, the issue should be documented in the resident's progress notes. -There was a time, about two months ago, when the facility was transitioning to electronic refills versus faxing because there had been an issue with the fax machine. -If Resident #1's Tacrolimus was not on the medication cart, she would have expected the MA	D 358		

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D 358	Continued From page 51 to notify her so the medication could have been ordered. Review of Resident #1's progress notes dated 04/01/22-05/05/22 revealed there was no documentation about Resident #1's Tacrolimus prescription. Interview with the SCC on 07/21/22 at 4:21pm revealed: -Resident #1's creams should be reordered, "well before getting low." -MAs were responsible for completing a refill sheet and scanning the refill sheet to her; she would then send it to the pharmacy. -If the next day the medication was still not available, the MA should call the pharmacy to see why the medication was not delivered. -If there was a problem with why the medication had not been delivered, the MA should let her or RCC know. -The MA may have made a note the medication needed to be reordered but did not let her know. -When she made rounds with Resident #1's PCP, the PCP asked about the creams and when she looked she noted that it was not on the medication cart. -If she had known Resident #1 was out of his creams, she would have reordered the medication. -She did not know why Resident #1's Tacrolimus had been discontinued on the eMAR. -It would have been her because she was the one who put in and took out orders, but she did not recall anything about the Tacrolimus. Interview with the Administrator on 07/21/22 at 6:58pm revealed she was not aware Resident #1 had an eczema flare-up because he had not been administered his medication that was ordered to	D 358		

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D 358	Continued From page 52 treat eczema. Interview with Resident #1 on 07/21/22 at 7:37pm revealed: -If he did not get cream on his arms, his arms itched. -He thought the cream was applied to his arms every day. -He did not recall if he had missed any days having cream applied to his arms. Refer to the interview with the Supervisor on 07/20/22 at 4:14pm. Refer to the interview with the Special Care Coordinator on 07/20/22 at 12:25pm. Refer to the interview with the Administrator on 07/07/21 at 6:28pm. c. Review of Resident #1's signed physician's orders dated 04/06/22 revealed there was an order for Refresh eye drops (used to treat dry eyes) and instill one drop in each eye twice a day. Review of Resident #1's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Refresh eye drops, instill one drop in each eye twice a day with a scheduled administration time of 7:00am and 7:00pm. -Refresh eye drops were documented as administered from 06/01/22-06/30/22. -There were 60 doses documented. Review of Resident #1's eMAR for 07/01/22-07/19/22 revealed: -There was an entry for Refresh eye drops, instill one drop in each eye twice a day with a	D 358		

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D 358	Continued From page 53 scheduled administration time of 7:00am and 7:00pm. -Refresh eye drops were documented as administered at 7:00am and 7:00pm from 07/01/22-07/18/22 and at 7:00am on 07/19/22. -There were 37 doses documented. Observation of Resident #1's medication on hand on 07/09/22 at 2:39pm revealed: -There was a box of thirty single-use containers of Refresh eye drops dispensed on 06/15/22. -There was a handwritten opened date of 06/20/22. -There were nineteen individual containers of Refresh eye drops inside the box. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/19/22 at 3:38pm revealed: -Resident #1's Refresh eye drops were dispensed on 05/05/22, 05/19/22, and 06/15/22. -Each dispensing was a 15-day supply. -The directions were to instill one drop in each eye twice daily. Second telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/21/22 at 9:26am revealed: -Resident #1's refresh eye drops were dispensed on 02/21/22 and 03/08/22 for a 15-day supply. -On 04/12/22, there was a request for a refill, and there were no refills on the prescription. -There was no dispensing for the Refresh eye drops between the dispensing on 03/08/22 and 05/05/22. Based on interviews, observations, and record review there should not been any Refresh eye drops available to be administered from the 06/15/22 dispensing,	D 358		

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D 358	Continued From page 54 Interview with a medication aide (MA) on 07/19/22 at 2:39pm revealed: -Handwritten dates on medication were when a medication was opened. -She did not know why there were more Refresh eye drops on hand than should be if the eye drops had been administered twice a day since 06/20/22. Interview with another MA on 07/20/22 at 1:11pm revealed: -She administered Resident #1's eye drops when she worked. -Resident #1 had never refused the Refresh eye drops when she worked. -She did not know why there were more Refresh eye drops on hand than there should have been, but she did remember there being two open boxes at one time. Interview with a third MA on 07/21/22 at 11:41pm revealed: -She had administered Resident #3's Refresh eye drops. -Resident #1 had never refused his eye drops. -She did not know why there were too many individual containers of eye drops available to be administered. " I just know I administer the eye drops when I am working, I cannot say what other people do." Interview with Resident #1's Primary Care Provider (PCP) on 07/20/22 at 3:16pm revealed: -Resident #1 was ordered Refresh eye drops for chronic dry eyes. -He had not been notified Resident #1 had missed being administered Refresh eye drops. -If Resident #1's Refresh eye drops were not administered as ordered, he could experience	D 358		

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D 358	Continued From page 55 irritation which could lead to conjunctivitis. -He expected his orders to be followed as written. Interview with the Special Care Coordinator (SCC) on 07/21/22 at 4:21pm revealed: -She was not aware Resident #1's Refresh eye drops had not been administered as ordered. -She expected Resident #1 to be administered the eye drops as ordered, "every dose, every time it was scheduled." Interview with the Administrator on 07/21/22 at 6:58pm revealed she was not aware Resident #1's Refresh eye drops had not been administered as ordered. Interview with Resident #1 on 07/21/22 at 7:37pm revealed: -He had dry eyes. -He used eye drops for his dry eyes. -He did not recall if he had missed any doses of his eye drops. -He did not know how many times a day he was supposed to get eye drops. Refer to the interview with the Supervisor on 07/20/22 at 4:14pm. Refer to the interview with the Special Care Coordinator on 07/20/22 at 12:25pm. Refer to the interview with the Administrator on 07/07/21 at 6:28pm. 4. Review of Resident #4's current FL-2 dated 04/13/22 revealed a diagnosis of major depressive disorder, dysphagia, hypothyroidism, and hypertension. a. Review of Resident #4's physician's orders	D 358		

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D 358	Continued From page 56 dated 06/16/22 revealed there was an order for Fish Oil (Omega-3 fatty acids-fish oil) 1200mg (used to lower triglyceride levels in the blood and to prevent dryness) four times a day. Review of Resident #3's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Fish Oil (Omega-3 fatty acids-fish oil) 1200mg with a scheduled administration time of 9:30am, 12:30pm, 4:30pm, and 8:30pm. -Fish Oil 200mg was documented as administered four times daily from 06/01/22-06/27/22. -There were exceptions documented from 06/28/22-06/30/22 with reason as waiting on the medication. Review of Resident #3's eMAR for 07/01/22-07/19/22 revealed: -There was an entry for Fish Oil (Omega-3 fatty acids-fish oil) 1200mg with a scheduled administration time of 9:30am, 12:30pm, 4:30pm, and 8:30pm. -There were exceptions documented from 07/01/22-07/11/22 with reason as waiting on the medication. -Fish Oil 200mg was documented as administered four times daily from 07/12/22-07/19/22. Review of Resident #4's progress note revealed: -There was an entry dated 05/04/22; the entry was recorded as a late entry on 05/25/22. -The new order was identified as Fish Oil. -There was another entry dated 05/05/22 the MA talked to the facility's contracted pharmacy and the Fish Oil would be sent out today, 05/05/22. -There were no other entries related to Resident	D 358		

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D 358	Continued From page 57 #4's Fish Oil tablets. Observation of Resident #4's medication on hand on 07/20/22 at 11:47am revealed: -There was a multi-dose package that contained Fish Oil 1200mg; there were four separate doses. -The package had a start date of 07/19/22 and the 07/19/22 doses had been administered. -The dose packages for 07/20/22 labeled the morning dose had been administered and Fish Oil was available in all the remaining packages. Interview with Resident #4 on 07/20/22 at 11:56am revealed: -She was out of her Fish Oil for a long time, a week to ten days at least. -The pharmacy would send a few Fish oil tablets out, then she would be without it again. -She thought the Fish Oil was on back order with the pharmacy. -She was taking the Fish Oil for dry eyes. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/21/22 at 9:28am revealed: -Resident #4's Fish Oil was dispensed on 05/04/22 for a 13-day supply to get the resident on cycle fill. -On 05/18/22, another 120 tablets were dispensed (30-day supply) on an emergency refill because they did not have a refill on the prescription. -When they obtained authorization for an emergency fill, the facility was notified. -They "usually" let the facility know if the pharmacy did not get a signed order, they cannot by law add the medication to the cycle fill medication. -They were only able to do a one-time emergency fill.	D 358		

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D 358	Continued From page 58 -On 07/0/22, signed physician's orders dated 06/16/22, which had Fish Oil listed as on of the medications, were sent to the pharmacy by the facility's Special Care Coordinator (SCC). Telephone interview with Resident #4's primary care provider (PCP) on 07/21/22 at 8:50am revealed: -Resident #4 was ordered Omega 3 for triglycerides, general joint pain, and lubrication in general. -She was not aware Resident #4 had not received her Omega3 as ordered. -She expected the medication to be administered as ordered. -Resident #4 would not benefit from the medication as it was intended if it was not administered. Telephone interview with a nurse for Resident #4' PCP on 07/21/22 at 3:12pm revealed: -She did not have any requests from the facility related to Resident #4's Omega 3. -On 06/29/22, the facility left her a voicemail, she attempted to return the call and left voicemail at the facility but did not receive a return call. Interview with a MA on 07/21/22 at 12:02pm revealed: -She recalled Resident #4 not having Fish Oil on the medication cart. -Resident #4 had called her PCP requesting a refill. -Resident #4 liked to call her PCP herself when she needed something. -When a resident was down to 7 pills remaining, they were supposed to let the Resident Care Coordinator (RCC) and/or the SCC know the medication needed to be ordered. -She remembered letting the RCC know Resident	D 358		

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D 358	Continued From page 59 #4 needed Fish Oil reordered but did not recall the date. Interview with the SCC on 05/21/22 at 4:53pm revealed: -She did not know Resident #4 was out of her Fish Oil for "that long." -When she found out Resident #4 was out of Fish Oil, she was told the resident needed a new prescription. -She did not recall the date, but she sent the signed PCP orders to the pharmacy when she was told the resident needed a new prescription. Interview with the RCC on 04/21/22 at 5:48pm revealed: -She did not recall Resident #4 being out of her Fish Oil medication. -If a resident went one day without medication, the MA was supposed to notify a manager. -When there were 10 tablets remaining on hand, she expected the MA to reorder. -When there were 5 tablets remaining on hand, and the reorder had not been delivered, she expected the MA to let a manager know. Interview with the Administrator on 07/21/22 at 6:26pm revealed: -She was not aware Resident #4 was not administered her Fish Oil. -She was concerned the resident did not receive the appropriately prescribed treatment. Refer to the interview with the Supervisor on 07/20/22 at 4:14pm. Refer to the interview with the Special Care Coordinator on 07/20/22 at 12:25pm. Refer to the interview with the Administrator on	D 358		

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D 358	Continued From page 60 07/07/21 at 6:28pm. b. Review of Resident #4's physician's orders dated 06/16/22 revealed there was an order for Refresh (eye lubricant) eye drops 0.5%, instill two drops in both eyes three times daily. Review of Resident #4's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Refresh eye drops 0.5% two drops in both eyes three times daily with a scheduled administration time of 9:30am, 1:30pm, and 7:30pm. -There were exceptions documented from 06/01/22-06/04/22 with reason as waiting on the medication. -Refresh eye drops were documented as administered at 9:20am and 1:30pm from 06/05/22-06/30/22. -There were exceptions documented for the 7:30pm administration from 06/06/22-06/10/22 with the reason as waiting on the pharmacy. -Refresh eye drops were documented as administered from 06/11/22-06/27/22, four times a day. -There were exceptions documented from 06/28/22-06/30/22 with reason as waiting on the pharmacy. -There were 16 total doses documented as not administered due to waiting on the pharmacy. Observation of Resident #4's medications on hand on 07/20/22 at 11:47am revealed a bottle of Refresh eye drops dispensed on 07/06/22. Interview with Resident #4 on 07/20/22 at 11:56am revealed: -She was out of her Refresh eye drops for "about a week a while back."	D 358		

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D 358	Continued From page 61 -She used Refresh for dry eyes. -Her eyes would have felt better had she not missed the eye drops. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/21/22 at 9:28am revealed: -On 05/04/22, a 23-day supply of Refresh eye drops were dispensed for Resident #4. -There were no refills on the medication. -On 07/06/22, a request for refill of the Refresh was received along with the signed physician's orders. -Refresh eye drops were dispensed on 07/06/22. -There was no documentation of request for refills between 05/04/22-07/05/22. Review of Resident #4's progress note revealed: -There was an entry dated 05/04/22; the entry was recorded as a late entry on 05/25/22. -The new order was identified as Refresh eye drops three times daily in both eyes. -There was an entry dated 05/05/22 the MA talked to the facility's contracted pharmacy and the Refresh eye drops would be sent out today, 05/05/22. -There were no other entries related to Resident #4's Refresh eye drops. Telephone interview with Resident #4's primary care provider (PCP) on 07/21/22 at 8:50am revealed: -Resident #4 was ordered Refresh eye drops because the resident had dry eyes. -She was not aware Resident #4 had not received her refresh eye drops as ordered. -She expected the medication to be administered as ordered. -Resident #4 could experience eye irritation if the Refresh eye drops were not administered.	D 358		

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D 358	Continued From page 62 Interview with a medication aide (MA) on 07/21/22 at 12:02pm revealed: -She recalled Resident #4 not having eye drops on the medication cart. -Resident #4 had called her PCP requesting a refill. -She remembered letting the Resident Care Coordinator (RCC) know Resident #4 needed eye drops reordered. Interview with the Special Care Coordinator (SCC) on 07/21/22 at 4:53pm revealed: -She was not aware Resident #4 went without her Refresh eye drops. -She expected the MA to let her know if after one day the MA was still "waiting" on the pharmacy for medication. -If the MA would have let her know Resident #3's Refresh had not been delivered, she would have found out why and the resident would not have gone without the eye drops for 4-5 days. Interview with the RCC on 07/21/22 at 5:48pm revealed: -She did not recall Resident #4 being out of Refresh eye drops. -If a resident went one day without medication, the MA was supposed to notify a manager. -Before resident #4 was out of the Refresh eye drops, the medication should have been reordered, based on the opened date on the bottle. Interview with the Administrator on 07/21/22 at 6:26pm revealed: -She was not aware Resident #4 was not administered her Refresh eye drops. -She was concerned the resident did not receive the appropriately prescribed treatment.	D 358		

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D 358	Continued From page 63 Refer to the interview with the Supervisor on 07/20/22 at 4:14pm. Refer to the interview with the Special Care Coordinator on 07/20/22 at 12:25pm. Refer to the interview with the Administrator on 07/07/21 at 6:28pm. _____ Interview with the Supervisor on 07/20/22 at 4:14pm revealed: -All medication aides (MA) were scheduled cart audits every Tuesday, Wednesday and Thursday. -The Special Care Coordinator (SCC) and The Resident Care Coordinator (RCC) would perform random cart audits. -Each MA would audit 3-4 residents every Tuesday, Wednesday and Thursday. -This schedule allowed for each medication cart to be audited each week. -The MAs were given a copy of the most current physician's order and compared the medication on the order sheet with the medications in the medication cart to ensure all medications ordered were available for administration. -The MAs would look for discontinued and expired medications and remove those from the medication cart. -The audits did not consist of comparing the number of pills remaining with the number of times there was documentation that the medication was administered. Interview with the SCC on 07/20/22 at 12:25pm revealed: -Medication cart audits were completed weekly, Tuesday through Thursday. -Each MA on each shift would audit 2 to 3 residents.	D 358		

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	HAL068025	A. BUILDING: _____ B. WING _____	07/22/2022

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D 358	Continued From page 64 -Once the audit were completed, the audit form was given to the supervisor and then to the SCC or RCC. -She did not recall receiving any completed medication cart audit forms the month of July 2022. -She was not sure if the medication cart audits were being done at this time. -Each MA was given a copy of the residents' physicians' orders sheets when performing a medication cart audit. -The MA would compare the orders with the medications on the medication cart; they looked for and removed, discontinued and expired medications. -The MA did not compare the number of tablets in the bubble packs to the number of times the medication was documented as administered. Interview with the Administrator on 07/21/21 at 6:58pm revealed: -She expected medications to be administered as ordered. -She was concerned if a medication was not administered as ordered, the residents may experience an exacerbation of whatever condition the medication was ordered to treat. -Any medication discrepancy should be caught during the medication cart audit which were completed on each resident weekly. -She was concerned the residents were not administered the medication as ordered. The facility failed to ensure medications were administered as ordered for 4 of 5 sampled residents for record review including a resident (#2) who was not administered his aspirin for stroke-like symptoms as ordered after returning from the Emergency Department, resulting in an increase risk of a cerebral vascular accident; and	D 358		

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D 358	Continued From page 65 a resident (#5) who was not administered his anti-depressant as ordered, which could lead to an increase in depression and was not administered a nasal spray as ordered, being at risk for an increase of allergy symptoms and a resident (#1) who went without multiple creams for five days that were ordered to treat eczema. The resident then experienced a flare up of his eczema, which resulted in him scratching the area and developing cellulitis which had to be treated with an antibiotic; a resident (#4) who had a history of dry eyes, skin, and vagina, was not administered her fish oil as ordered, as well as her eye drops, resulting in the resident being at risk for increased dryness; and a resident . The facility's failure to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/21/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 4, 2022.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered;	D 367	The Stratford shall ensure the resident's MAR is accurate for med administration. ACD re-inserviced MCM on the importance of reviewing and clarifying discharge summaries on residents upon the return from their hospital admission. 7/21/22 ED/RCM/MCM will in-service staff on 9/5/22	

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D 367	Continued From page 66 (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 electronic medication administration records (eMAR) were accurate for 1 of 5 sampled residents (#1, #4) including orders for a nutritional supplement and a cream that was self administered (#1). The findings are: Review of Resident #1's current FL-2 dated 04/07/21 revealed a diagnosis of pneumonia. a. Review of Resident #1's signed physician's orders dated 04/18/22 revealed there was an order for Vitamin B-12 1000mcg one tablet twice weekly. Review of Resident #1's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin B-12 take a tablet twice a week with scheduled administration days as Tuesday and Thursday at 7:00am. -The start date for the order was 01/13/22 and the	D 367	the importance of following up with the PCP to clarify orders that are not clear or complete. Also will in-service on the importance of notifying RCM/ MCM when there is any delay in getting a medication order clarified and assistance is needed. RCM/MCM will ensure accuracy when approving orders, making sure to follow all directions given in the original physician's order. 9/5/22 RCM/MCM will complete review of orders, referrals, discharge summaries, and/or FL2s upon return of residents from doctors visits and/or hospital stays on the same day the items are received to ensure orders are clear, clarifications are received, and there is follow up as appropriate. 9/5/22 RCM/MCM will run EMAR compliance reports daily and review for compliance of administration and accuracy. Report will be discussed in management meeting for ED review. 9/5/22	

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D 367	Continued From page 67 end date was 05/24/22. -There was documentation Vitamin B12 was administered on 05/03/22, 05/05/22, 05/10/22, 05/12/22, 05/17/22, and 05/19/22. -There was no other documentation Vitamin B12 had been administered or exceptions. Review of Resident #1's June 2022 eMAR revealed: -There was no entry for Vitamin B-12. -There was no documentation Vitamin B-12 had been administered. Review of Resident #1's eMAR dated 07/01/22-07/19/22 revealed: -There was no entry for Vitamin B-12. -There was no documentation Vitamin B-12 had been administered. Observation of Resident #1's medication on hand on 07/09/22 at 2:39pm revealed: -There was a punch card for Vitamin B12 with a dispense date of 06/23/22 with the directions to administer one tablet twice weekly. -There were 8 tablets dispensed and 5 tablets had been administered. Telephone interview with a representative with the facility's contracted pharmacy on 07/19/22 at 4:48pm revealed: -Resident #1's Vitamin B12 was still an active order, there was no order for the medication to be discontinued. -Resident #1 was a hospice patient, so all medications had to be requested for a refill. -Vitamin B12 was dispensed on 05/12/22, 05/24/22, and 06/23/22; 8 tablets were dispensed each time. Interview with a medication aide (MA) on	D 367		

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D 367	Continued From page 68 07/20/22 at 1:11pm revealed: -She could not discontinue orders in the eMAR; only the Resident Care Coordinator (RCC)or the Special Care Coordinator (SCC) could discontinue orders. -She administered medication based on what popped up on the eMAR to be administered at that time. -When she saw the medication that popped up, she would pull the medication from the drawer, pop the medication and administer it. -If Vitamin B12 was not on the eMAR then she did not administer the medication. -She did not recall if she had seen Resident #1's Vitamin B12 punch card on the medication cart or not. Interview with the SCC on 07/20/22 at 4:21pm revealed: -When orders come in, she or the RCC approved the orders in the eMAR. -She had approved the order for Resident #1's Vitamin B-12, but because specific days of the week needed to be set in the eMAR, and she did not set that, the two days per week, the order was not complete and therefore did not show up on Resident #1' eMAR. -She would have expected the MAs to have asked why the medication was on the medication cart and not on Resident #1's eMAR and she would have investigated why it was not on the eMAR. -She expected MAs to document when a medication was administered. Interview with the Administrator on 07/21/22 at 6:26pm revealed: -The MAs should not administer medication without using the six rights for medication administration (the right resident, medication,	D 367		

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dose, route, time, and documentation).
-If a medication was on the medication cart, and not on the eMAR, the MA should have contacted the pharmacy to see if the order was active and then talked to the RCC/SCC about why the medication was not on the eMAR.

Interview with Resident #1 on 07/21/22 at 7:37pm revealed he did not know what medication he took; he took whatever the MAs gave him.

b. Review of Resident #1's signed physician's orders dated 04/1822 revealed there was an order for Eucerin lotion to be applied to both arms and legs every day; may keep at bedside and self-administer.

Review of Resident #1's May 2022 electronic medication administration record (eMAR) revealed there was no entry for Eucerin; there was no documentation Eucerin had been applied.

Review of Resident #1's June 2022 eMAR revealed there was no entry for Eucerin; there was no documentation Eucerin had been applied.

Review of Resident #1's eMAR dated 07/01/22-07/19/22 revealed there was no entry for Eucerin; there was no documentation Eucerin had been applied.

Observation of Resident #1's room on 07/09/22 at 2:10:36am revealed there were multiple containers of lotion sitting on the resident's table beside his chair.

Interview with a medication aide (MA) on 07/20/22 t 1:11pm revealed:
-The Resident Care Coordinator (RCC)or the Special Care Coordinator (SCC)

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D 367	Continued From page 70 entered/approved orders. -If a resident had an order they could self-administer, the medication would be listed on the eMAR. -She had seen Eucerin in Resident #1's room. -She did not document if Resident #1 had used his Eucerin or not. -She would have made sure Resident #1 used his Eucerin had the medication been listed on the eMAR. Interview with the SCC on 07/20/22 at 4:21pm revealed: -She was not sure why Resident #1's Eucerin was not listed on the eMAR. -Medications/procedures that were self-administered should be listed on the eMAR so the staff could give reminders to ensure the medication was being administered. Interview with the Administrator on 07/21/22 at 6:26pm revealed: -She thought Resident #1's Eucerin cream probably should be listed on the eMAR so it could be monitored. -When the MA was completing her medication administration with Resident #1 she could make sure he had self-administered the Eucerin cream and documented it on the eMAR. Interview with Resident #1 on 07/21/22 at 7:37pm revealed he put lotion on his arms when they itched; he did not put lotion on his arms every day.	D 367		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in	D 465	The Stratford shall ensure that staff shall be present in the unit at all times in sufficient number to meet the needs of the residents.	

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D 465	Continued From page 71 sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure the minimum number of staff was present to meet the needs of residents residing in the Special Care Unit (SCU) for 9 of 9 shifts sampled from 07/05/22-07/18/22. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 77 beds including a special care unit (SCU) with a capacity of 33 beds. Confidential interviews with staff revealed: -One staff stated there were times when there was one medication aide (MA) and one personal care aide (PCA) staffed to cover the entire facility. -They need assistance "bad" because the residents were being neglected. -Another staff stated there was usually three staff in the facility on the third shift, a MA assigned to the assisted living (AL) and a MA and PCA assigned to the SCU. -Sometimes there may be one MA for the facility and two PCAs; one of the PCAs would cover the AL and the MA and a PCA would cover the SCU. -If the MA had to go to the AL, the PCA would go	D 465	ACD in-serviced all staff on Resident Rights, as well as the importance of their understanding that they are not to leave their shift until coverage arrives or a supervisor approves them to leave the shift acknowledging that adequate coverage to provide care has been organized. ED/LSIC re-inserviced staff on the attendance policy, call out policy, or anytime needing to miss work while following company policy and allowing the facility to be able to make arrangements for resident care. Schedule/Staffing sheets will be reviewed daily in management meeting by ED and Lead SIC to ensure appropriate staffing in the building. Open positions will also be discussed to ensure the facility is actively recruiting and hiring appropriately. ED will obtain a copy of the schedule weekly for the upcoming week from all department heads to ensure appropriate staffing throughout the community. Per call out policy staff will notify the LSIC at least 4 hours prior to start of the shift if they are unable to attend work.The LSIC will reach out to other care staff for assistance with coverage. If the LSIC is unable to find coverage, she will work said shift. If she is already working, the MCM would then be next in line to work the shift. The MCM	7/21/22 7/21/22 9/5/22 9/5/22 9/5/22

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D 465	Continued From page 72 to the SCU, to make sure there were two staff in the SCU. -A third staff stated they had worked with another PCA in the SCU and the only MA in the facility was in the AL. -A fourth staff stated when there was a MA in the SCU, the MA did not always assist with resident care. -Three residents in the SCU required two staff to assist with incontinence care. -There was one male resident in the SCU who required 1:1 care if he was awake during the third shift. -They had not seen anyone from Management working in the facility during the third shift when they were working. -Management included the Resident Care Coordinator (RCC), the SCU Coordinator, and the Administrator. -A fifth staff stated there were a lot of residents in the SCU who required assistance with changing incontinence briefs; the residents had to receive personal care multiple times during the night. -There was not enough staff to meet the needs of the residents in the SCU. -There was one time when the fifth worked in the SCU alone but did not recall the date. Interview with a PCA on 07/21/22 at 4:15pm revealed: -When the schedule was posted, the staff were asked to look at the schedule and sign up for extra shifts. -She had signed up to work third shift many times. -She had worked 112 hours, this pay period, not including today, 07/21/22, which was the last day of the pay period. Interview with another PCA on 07/21/22 at	D 465	would need to remember to punch in to alot her time to personal care services. When the MCM is working in personal care, the RCC would in turn provide management/ oversight over the Memory Care unit in her absence. ED will sign off on assignment sheets designating that they have been reviewed and approved.	9/5/22

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D 465	Continued From page 73 4:15pm revealed: -She always signed up for extra shifts because there were not enough staff. -She had worked 108 hours this pay period, not including today 07/21/22, which was the last day of the pay period. Interview with a MA on 07/21/22 at 2:47pm revealed: -There were a lot of residents who needed assistance with incontinence care on third shift in the SCU. -She was concerned if there was an emergency in the facility how would there be enough staff to do what needed to be done. -There was not enough staff to give showers and do the laundry. -The Special Care Coordinator (SCC) had come in at 5:00am before when they were short-staffed (she did not think it was in July 2022). -Right now, with the resident who required one to one care, the SCU needed four staff , one with the resident who required one to one care and three other staff to provide resident care. Interview with another MA on 07/21/22 at 5:10pm revealed: -She was the supervisor on 1st shift but worked second shift due to staff shortage. -She did the scheduling for the PCAs and MAs. -She would schedule for two weeks at a time. -The schedule was posted through 08/07/22. -Management told her how many personnel to staff for each shift. -She was instructed to staff 3 MAs and 5 PCAs for each shift when the facility was at capacity. -When the census was lower, she would staff with fewer personnel. -She would staff 2 MAs and 1 PCA on third shift; 1 MA for the assisted living and 1 MA and 1 PCA	D 465		

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for the SCU.
-There were not enough personnel to staff third shift appropriately.
-There should be at least 1 MA and 2 PCAs on third shift in the SCU.
-The management's names were not written on the schedule when they came in to work the floor.
-The ratio for staffing on third shift was 1 staff to 10 residents; with 28 residents there should be 3 personnel in the SCU.
-When she worked third shift, she usually worked in the SCU.
-If she was the only MA in the facility, she stayed in the SCU and sent a PCA to work AL.
-If a resident in AL needed medication, she would have the PCA from AL stay in the SCU, while she went out to administer medication in the AL.
-The facility needed three PCAs working, but they made it work.

Review of the facility's daily assignment sheet revealed the MA scheduled hours for third shift were 10:00pm-6:00am and the PCA scheduled hours for third shift were 11:00pm-7:00am.

Review of the Census Daily Detail Report dated 07/05/22 revealed there was a SCU census of 29 residents, which required 23.2 staff hours on third shift.

Review of the facility's daily assignment sheet for third shift dated 07/05/22 revealed:
-There was one PCA assigned to the SCU.
-There was one PCA assigned to the AL Unit.
-There was only one MA assigned to the facility for the SCU and AL units.

Review of the timecards for third shift dated 07/05/22-07/06/22 revealed:
-There was a total of 23.85 staff hours provided

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for the facility.
-It could not be determined how many of the 23.85 total staff hours worked were worked in the SCU on third shift.

Review of the Census Daily Detail Report dated 07/06/22 revealed there was a SCU census of 30 residents, which required 24 staff hours on third shift.

Review of the facility's daily assignment sheet for third shift dated 07/06/22 revealed:
-There was one PCA assigned to the SCU.
-There was one PCA assigned to the AL Unit.
-There was only one MA assigned to the facility for the SCU and AL units.

Review of the timecards for third shift dated 07/06/22-07/07/22 revealed:
-There was a total of 24.25 staff hours provided for the facility.
-It could not be determined how many of the 24.25 total staff hours worked were worked in the SCU on third shift.

Review of the Census Daily Detail Report dated 07/07/22 revealed there was a SCU census of 30 residents, which required 24 staff hours on third shift.

Review of the facility's daily assignment sheet for third shift dated 07/07/22 revealed:
-There was one PCA assigned to the SCU.
-There was one PCA assigned to the AL Unit.
-There was only one MA assigned to the facility for the SCU and AL units.

Review of the MA and PCA's timecards dated 07/07/22-07/08/22 revealed:
-There was a total of 23.36 staff hours provided

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	HAL068025	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE STRATFORD	405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516

(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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for the facility.
-It could not be determined how many of the 23.36 total staff hours worked were worked in the SCU on third shift.

Review of the Census Daily Detail Report dated 07/09/22 revealed there was a SCU census of 28 residents, which required 22.4 staff hours on third shift.

Review of the facility's daily assignment sheet for third shift dated 07/09/22 revealed:
-There was one PCA assigned to the SCU.
-There was one PCA assigned to the AL Unit.
-There was only one MA assigned to the facility for the SCU and AL units.

Review of the MA and PCA's timecards dated 07/09/22-07/10/22 revealed:
-There was a total of 23.40 staff hours provided for the facility.
-It could not be determined how many of the 23.40 total staff hours worked were worked in the SCU on third shift.

Review of the Census Daily Detail Report dated 07/10/22 revealed there was a SCU census of 28 residents, which required 22.4 staff hours on third shift.

Review of the facility's daily assignment sheet for third shift dated 07/10/22 revealed:
-There was one PCA assigned to the SCU.
-There was one PCA assigned to the AL Unit.
-There was only one MA assigned to the facility for the SCU and AL units.

Review of the MA and PCA's timecards dated 07/10/22-07/11/22 revealed:
There was a total of 16.26 staff hours provided

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for the facility.
-It could not be determined how many of the 16.26 total staff hours worked were worked in the SCU on third shift.

Review of the Census Daily Detail Report dated 07/13/22 revealed there was a SCU census of 28 residents, which required 22.4 staff hours on third shift.

Review of the facility's daily assignment sheet for third shift dated 07/13/22 revealed:
-There was one PCA assigned to the SCU.
-There was one PCA assigned to the AL Unit.
-There was only one MA assigned to the facility for the SCU and AL units.

Review of the MA and PCA's timecards dated 07/13/22-07/14/22 revealed:
-There was a total of 23.72 staff hours provided for the facility.
-It could not be determined how many of the 23.72 total staff hours worked were worked in the SCU on third shift.

Review of the Census Daily Detail Report dated 07/14/22 revealed there was a SCU census of 28 residents, which required 22.4 staff hours on third shift.

Review of the facility's daily assignment sheet for third shift dated 07/14/22 revealed:
-There was one PCA assigned to the SCU.
-There was one PCA assigned to the AL Unit.
-There was only one MA assigned to the facility for the SCU and AL units.

Review of the MA and PCA's timecards dated 07/14/22-07/15/22 revealed:
-There was a total of 24.4 staff hours provided for

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the facility.
-It could not be determined how many of the 24.4 total staff hours worked were worked in the SCU on third shift.

Review of the Census Daily Detail Report dated 07/16/22 revealed there was a SCU census of 28 residents, which required 22.4 staff hours on third shift.

Review of the facility's daily assignment sheet for third shift dated 07/16/22 revealed:
-There was one PCA assigned to the SCU.
-There was only one MA assigned to the facility for the SCU and AL units.
-There was no other staff listed on the assignment sheet.

Review of the MA and PCA's timecards dated 07/16/22-07/17/22 revealed:
-There was a total of 24.7 staff hours provided for the facility; 8.0 of the hours were the SCC's hours clocked in.
-It could not be determined how many of the 24.7 total staff hours worked were worked in the SCU on third shift.

Review of the Census Daily Detail Report dated 07/18/22 revealed there was a SCU census of 28 residents, which required 22.4 staff hours on third shift

Review of the facility's daily assignment sheet dated 07/18/22 revealed:
-There was one PCA assigned to the SCU.
-There was one PCA assigned to the AL Unit.
-There was only one MA assigned to the facility for the SCU and AL units.

Review of staff timecards dated

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D 465	Continued From page 79 07/18/22-07/19/22 revealed: -There was a total of 24.84 staff hours provided for the facility. -It could not be determined how many of the 24.84 total staff hours worked were worked in the SCU on third shift. Interview with the SCC on 07/21/22 at 10:28 and 5:15pm revealed: -Third shift was staffed with 1 MA and 1 PCA in the SCU. -The facility staff were trying to meet the state regulations for staffing in the SCU. -There should be 1 staff for every 10 residents in the SCU. -The facility staff were not meeting the state regulation at this time. -The facility staff always had two staff personnel in the SCU; staffing had never dropped to one in the SCU. -The RCC or SCC would work the floor when necessary to meet the needs of the residents. -Sometimes the first shift staff would come in an hour or two early to assist with resident care. -She would punch a card when she worked the floor. -There would be a punch card when she worked third shift. -She recalled one time when she worked, that she did not punch the clock when she went in at 4:00am. -She worked third shift on 07/15/22 or 07/16/22 because there were only 2 staff scheduled to work. -She only looked at the staffing schedule when the Supervisor told her she needed assistance. -She only worked the floor when the Supervisor told her she was needed. -She would sometimes not know until the next day the SCU only had two staff working the night	D 465		

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D 465	Continued From page 80 before. Interview with the Administrator on 07/21/22 at 7:43pm revealed: -The Care Managers (RCC and SCC) and the Supervisor handled staffing. -She had not been informed that there was not enough staff on third shift. -She was not aware there were nights when only two staff were in the facility on third shift. -There should be three care staff in the SCU and a MA and a PCA in the AL. -The SCU should be staffed nightly with 1 MA and 2 PCAs. -If there was an issue with staff coverage, she expected the RCC/SCC to assist with covering the floor. -No one had asked her to assist with resident care for the month of July 2022. -She would have worked had she known the facility was not adequately staffed. -If the facility was not adequately staffed, something could happen, because the staff would not be able to monitor everyone. -She was concerned that residents' needs were not being provided such as incontinent care as needed during night shift. The facility failed to ensure the minimum number of staff was present on third shift in the Special Care Unit (SCU) for 9 of 9 shifts sampled between 07/05/22-07/18/22. The facility's failure to provide enough staffing to meet the needs of the residents in the SCU was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/21/22 for this violation.	D 465		

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D 465	Continued From page 81 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 4, 2022.	D 465		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure all residents in the special care unit (SCU) were treated with respect and dignity when they took a male resident into another resident's room while providing incontinence care and assisting with showers. The findings are: Telephone interview with a personal care aide (PCA) on 07/21/22 at 1:49pm revealed: -There was a male resident who required 1:1 care. -When she was the only PCA in the SCU, she took the male resident with her everywhere she went because he could not be left alone. -She had taken the male resident with her to provide incontinence care to other residents. -She would get the male resident to sit on the toilet, while she gave residents showers. -It was unfair because the residents should have privacy and she should not have to take another resident with her. -The medication aides (MA), Resident Care	D911	The Stratford shall ensure that every resident is treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. RCM/MCM re-inserviced all Memory Care staff on the appropriate manner to carry out Resident #2 1:1 care. The education included understanding that staff assigned to Resident #2 were not to provide care to any other residents during that time. ACD in-serviced all staff on Resident Rights, and the importance of providing residents privacy. ED/LSIC review schedule/ staffing sheets to ensure that there is adequate staffing in the Memory Care Unit for 1:1 care of Resident #2 as well as staff to care for the remaining residents in the unit. This is discussed daily in management meeting. MCM will make rounds no less than twice daily to ensure assignments are being followed appropriately. ED will make rounds no less than twice daily to ensure appropriate 1:1	7/25/22 7/21/22 9/5/22 9/5/22 9/5/22

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D911	Continued From page 82 Coordinator (RCC), and SCU coordinator (SCC) were aware she took the male resident with her everywhere she went. Interview with a MA on 07/21/22 at 2:47pm revealed: -There was a male resident who had to have 1:1 supervision. -She had taken the male resident with her to do rounds, but she had never provided incontinence care while the male resident was with her. -She waited for the male resident to go to sleep, she would quickly change a resident, go back and check on the male resident and if he was not asleep, she would wait for him to go back to sleep so she could change another resident. -It was not fair to the residents to have to wait for personal care. Interview with the MA/Supervisor on 07/21/22 at 1:15pm revealed: -She worked third shift in the SCU most nights. -She would attempt to make her rounds when the male resident was sleeping. -She had to take Resident #2 with her at times when making rounds. -She had taken the male resident into other residents rooms when she provided incontinent care. -The male resident would sit on his rollator in other resident's rooms while she provided incontinent care. Interview with the SCC on 07/21/22 at 5:18pm revealed: -A male resident in the SCU required one on one supervision 24 hours a day. -The MA and the PCA would have to alternate supervising the male resident on third shift. -The Staff took the male resident with them into	D911	care is being provided.	

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D911	Continued From page 83 other resident's rooms during rounds and when incontinent care was being provided. -She thought the Administrator was aware of the male resident being taken into other resident's rooms while care was being given. -All residents required privacy during personal care for the staff. -The resident who was receiving incontinence care would not have privacy if another resident accompanied the staff. Interview with the RCC on 07/21/22 at 6:07pm revealed: -She worked as a MA once in the last 30-60 days. -She provided one-to-one care on the first shift for a resident in the SCU last Saturday, 07/16/22. -She had worked the third shift once in the last 30-days, but she did not recall when she worked. -She did not always punch in when she worked. -She was supposed to punch in, but she often forgot. -When she worked in the SCU it was her and a PCA. -She thought the requirement was 1:10 on the third shift, so should have been three staff for twenty-eight residents. Interview with the Administrator on 07/21/22 at 6:35pm revealed: -There was a male resident in the SCU who required one on one supervision during the day. -Staff should be communicating with the RCC and SCC that the male resident's condition had changed and that he required one on one. -She would have expected the staff to let the care managers (RCC and SCC) know the male resident's condition had changed and the male resident was not sleeping during the night and therefore would have required a sitter. -She was not aware the male resident was up at	D911		

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D911	Continued From page 84 night until it was brought to her attention today. -She did not know the male resident was entering other resident's room with the staff to provide personal care to other residents during third shift. -It was not appropriate for the male resident to be in another resident's room while personal care was being delivered to another resident because of resident rights and privacy.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration and special care unit staff. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 5 sampled residents (#1, #2, #4, and #5) related to two anti-itch medications and an eye drop (#1); a supplement and eye drops (#4); a non-steroidal, anti-inflammatory medication used to thin the blood (#2); and an antidepressant and a nasal spray (#5). [Refer to Tag D358, 10A NCAC 13F	D912	See above POC responses	

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D912	Continued From page 85 .1004(a) Medication Administration (Type B Violation)]. 2. Based on record reviews and interviews, the facility failed to ensure the minimum number of staff was present to meet the needs of residents residing in the Special Care Unit (SCU) for 9 of 9 shifts sampled from 07/05/22-07/18/22. [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staff (Type B Violation)].	D912		