DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL 060-116**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: **10/13/2022**

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Place of Southpark	**2101 Runnymede Lane Charlotte, NC 28209**

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)	COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 10/12/22 – 10/13/22.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 residents (#6, #7, #8) observed during the medication pass including errors with a medication for constipation (#6, #7)); a topical pain patch (#7); and a calcium supplement (#8); and for 1 of 5 sampled residents (#1) including errors with an antipsychotic, a medication to lower cholesterol, and two vitamin supplements (#1). The findings are: 1. The medication error rate was 14% as evidenced by 4 errors out of 27 opportunities during the 8:00am medication pass on 10/13/22. a. Review of Resident #6's current FL-2 dated 06/13/22	D 358		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

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)	COMPLETE DATE
D 358	Continued From page 1 revealed: -Diagnoses included atrial fibrillation, history of falling, iron deficiency, and back pain. -There was an order for Senna 8.6mg take 2 tablets once daily, hold for diarrhea. (Senna is a laxative used to treat and prevent constipation.) Observation of the 8:00am medication pass on 10/13/22 revealed: -The medication aide (MA) prepared and administered 1 tablet of Senna 8.6mg to Resident #6 at 8:07am. -The resident was administered 1 Senna 8.6mg tablet instead of 2 tablets as ordered. Review of Resident #6's October 2022 medication administration record (MAR) revealed: -There was an entry for Senna 8.6mg take 2 tablets every day, hold for diarrhea. -Senna was scheduled for administration at 8:00am. -Senna was documented as administered from 10/01/22 – 10/13/22. Observation of Resident #6's medications on hand on 10/13/22 at 11:50am revealed: -There was a supply of Senna 8.6mg tablets dispensed on 10/01/22 with instructions to take 2 tablets every day, hold for diarrhea. -There were 5 of 60 tablets remaining. Interview with the MA on 10/13/22 at 11:54am revealed: -She usually administered 2 Senna 8.6mg tablets to Resident #6. -She administered 1 Senna 8.6mg tablet to Resident #6 that morning (10/13/22) because she forgot to administer 2 tablets.	D 358		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

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)	COMPLETE DATE
D 358	Continued From page 2 -The resident had not complained of any issues with constipation or diarrhea. Interview with Resident #6 on 10/13/22 at 3:54pm revealed: -The resident was unsure which medications she received. -She had no current issues with constipation or diarrhea. Interview with the Director of Resident Care (DRC) on 10/13/22 at 12:20pm revealed: -The MAs should read and double check the MARs and the medication labels when administering medications. -Resident #6 should have received 2 Senna tablets instead of 1 tablet that morning on 10/13/22. Telephone interview with Resident #6's primary care provider (PCP) on 10/13/22 at 3:05pm revealed: -Resident #6 should have received 2 Senna tablets instead of 1 tablet. -The resident's bowels had been stable and she was not aware of any current issues with constipation. b. Review of Resident #7's current FL-2 dated 01/13/22 revealed: -Diagnoses included chronic diarrhea and cognitive deficits. -There was an order for Lidocaine 4% topical patch apply 1 patch to the left hip daily, remove after 12 hours. (Lidocaine is a topical patch used to treat pain.) Review of Resident #7's physician's orders dated 06/06/22 revealed: -There was an order for Lidocaine 4% patch apply topically once daily.	D 358		

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)	COMPLETE DATE
D 358	Continued From page 3 -The order did not specify where the patch should be applied. Review of Resident #7's physician's orders revealed no documentation the incomplete order for the Lidocaine 4% patch was clarified. Observation of the 8:00am medication pass on 10/13/22 revealed the medication aide (MA) applied 1 Lidocaine 4% patch to Resident #7's right lower back/hip area at 8:55am. Review of Resident #7's October 2022 medication administration record (MAR) revealed: -There was an entry for Lidocaine 4% patch apply topically once daily. -Lidocaine patch was scheduled to be applied at 8:00am and removed at 8:00pm. -Lidocaine patch was documented as administered from 10/01/22 – 10/13/22. Observation of Resident #7's medications on hand on 10/13/22 at 12:03pm revealed: -There was a box of Lidocaine 4% patches dispensed on 09/06/22. -The instructions on the label were to apply topically once daily. Interview with the MA on 10/13/22 at 12:02pm revealed: -She usually applied Resident #7's Lidocaine patch to either the resident's left or right hip because that was where the resident wanted the patch applied. -She had not noticed the instructions on the MAR and the medication label did not specify where the patch was to be applied.	D 358		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

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)	COMPLETE DATE
D 358	Continued From page 4 Interview with Resident #7 on 10/13/22 at 4:33pm revealed: -The MAs usually applied the Lidocaine patch to her right lower back. -She thought the patch helped a little with her pain. Interview with the Director of Resident Care (DRC) on 10/13/22 at 12:20pm revealed: -She had not noticed Resident #7's current order for the Lidocaine patch did not include a specific location for the patch to be applied. -The order should have been clarified. -The MAs should notify her or the Wellness Nurse if clarification was needed. -The MAs could also contact the provider for clarification of the order. -Orders for topical medications should include a specific location for administration. -The resident usually wanted the path applied to her right lower back/gluteal area. Telephone interview with Resident #7's primary care provider (PCP) on 10/13/22 at 3:05pm revealed: -The facility had not contacted her to clarify Resident #7's Lidocaine order. -Resident #7 had chronic back pain and used Lidocaine patches to treat the pain. -She would clarify the order today, 10/13/22. c. Review of Resident #7's physician's order dated 03/15/22 revealed an order for Metamucil powder take 1 scoop daily. (Metamucil is a fiber laxative that may be used to treat constipation or diarrhea.) Observation of the 8:00am medication pass on 10/13/22 revealed:	D 358		

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)	COMPLETE DATE
D 358	Continued From page 5 -The medication aide (MA) used a plastic disposable spoon and put Metamucil powder in a clear medication cup and filled the cup to the line marked for 15cc (3 teaspoons). -The MA mixed the Metamucil powder with a 5-ounce cup of water and administered it to Resident #7 at 8:54am. -The resident drank all of the water with the Metamucil. Observation of Resident #7's medications on hand on 10/13/22 at 12:04pm revealed: -There was one container of Metamucil dispensed on 09/29/22. -The instructions on the label were to take 1 scoop every day. -There was no pre-measured scoop in the container. -The serving size on the container was 2 teaspoons. Review of Resident #7's October 2022 medication administration record (MAR) revealed: -There was an entry for Metamucil powder take 1 scoop every day scheduled for 8:00am. -Metamucil was documented as administered from 10/01/22 – 10/13/22. Interview with the MA on 10/13/22 at 12:02pm revealed: -Resident #7's Metamucil container did not come with a pre-measured scoop. -Some of the Metamucil containers previously dispensed came with a pre-measured scoop. -She thought the pre-measured scoop held 3 teaspoons so that was why she measured the powder to the 15cc line (3 teaspoons). -She had not noticed the serving size on the label of the	D 358		

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)	COMPLETE DATE
D 358	Continued From page 6 Metamucil was 2 teaspoons. -The resident had a bowel movement with loose stool on 10/01/22 but no problems with diarrhea or constipation since then. Interview with Resident #7 on 10/13/22 at 4:33pm revealed: -She did not know if she received Metamucil every day. -She was sometimes a little constipated but not often. Interview with the Director of Resident Care (DRC) on 10/13/22 at 12:20pm revealed: -The Metamucil container usually had a scoop that the MAs should use to measure the proper amount to be administered. -If there was no scoop, the MAs should use the information on the label which usually indicated how much Metamucil powder was in one scoop. -She was not aware the current supply of Metamucil did not have a scoop. -The MAs should have notified her. Telephone interview with Resident #7's primary care provider (PCP) on 10/13/22 at 3:05pm revealed: -The MAs should measure and administer the correct dose of Metamucil to Resident #7. -Receiving too much Metamucil may cause the resident to have more bowel movements. d. Review of Resident #8's current FL-2 dated 05/17/22 revealed: -Diagnoses included osteoporosis. -There was an order for Calcium 1200mg daily. (Calcium is a supplement used to treat osteoporosis or thinning of the bones.)	D 358		

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)	COMPLETE DATE
D 358	Continued From page 7 Observation of the 8:00am medication pass on 10/13/22 revealed: -The medication aide (MA) administered one Calcium 600mg/Vitamin D 500IU) softgel to Resident #8 at 9:01am. -The MA did not administer 1200mg of Calcium as ordered. Observation of Resident #8's medications on hand on 10/13/22 at 9:05am revealed: -There was an over-the-counter (OTC) supply of Calcium with Vitamin D in the original manufacturer's container for Resident #7. -The manufacturer label on the front of the bottle had Calcium 1200mg/plus Vitamin D3 1000IU per serving. -The manufacturer label on the back of the bottle had 2 softgels were one serving size and 2 softgels contained 1200mg of Calcium and 1000IU of Vitamin D3. Review of Resident #8's October 2022 medication administration record (MAR) revealed: -There was an entry for Calcium 600mg take 2 tablets (1200mg) every day scheduled at 8:00am. -Calcium was documented as administered from 10/01/22 – 10/13/22. Interview with Resident #8 on 10/13/22 at 4:28pm revealed she thought she took Calcium and Vitamin D but she was not sure how much she received each day. Interview with the MA on 10/13/22 at 11:57am revealed: -The resident's family brought the resident's OTC medications to the facility. -She usually administered 1 softgel from the OTC Calcium bottle on hand.	D 358		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

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)	COMPLETE DATE
D 358	Continued From page 8 -She had not noticed on the label that the softgel also contained Vitamin D. -She had not noticed 2 softgels had 1200mg of Calcium instead of 1 softgel. Interview with the Director of Resident Care (DRC) on 10/13/22 at 12:20pm revealed: -Resident #8's family brought her OTC medications to the facility. -The MAs should have checked the OTC medications to make sure the medications brought matched the medications ordered by the provider. -The MAs were supposed to read the MARs and the medication labels when administering medications. -If something did not match, the MAs should stop and get clarification with the DRC or Wellness Nurse. Telephone interview with Resident #8's primary care provider (PCP) on 10/13/22 at 3:05pm revealed: -Resident #8 had an order and was also receiving Vitamin D 2000IU daily. -The resident did not need additional Vitamin D in her Calcium supplement. -The resident should receive the full dose of Calcium 1200mg as ordered. 2. Review of Resident #1's current FL-2 dated 07/08/22 revealed diagnoses included dementia and altered mental status. a. Review of Resident #1's physician's orders dated 08/08/22 revealed an order for Aripiprazole 5mg daily. (Aripiprazole is an antipsychotic.) Review of Resident #1's physician's order dated 08/17/22 revealed an order to discontinue Aripiprazole	D 358		

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)	COMPLETE DATE
D 358	Continued From page 9 5mg daily and start Aripiprazole 2mg daily. Review of Resident #1's physician's request dated 09/19/22 revealed a refill request for Aripiprazole 5mg daily signed by the facility's contracted primary care provider (PCP). Review of Resident #1's physician's order dated 09/27/22 revealed an order to discontinue Aripiprazole. Review of Resident #1's August 2022 medication administration record (MAR) revealed: -There was a preprinted entry for Aripiprazole 5mg daily. -There was documentation doses were administered daily 08/01/22 through 08/16/22 except on 08/13/22 (out of facility). -There was a handwritten entry for Aripiprazole 2mg daily. -There was documentation doses were administered 08/19/22 through 08/31/22. Review of Resident #1's September 2022 MAR revealed: -There was a preprinted entry for Aripiprazole 2mg daily. -There was documentation doses were administered daily 09/01/22 through 09/30/22. Review of Resident #1's October 2022 MAR revealed: -There was a preprinted entry for Aripiprazole 5mg daily. -There was documentation doses were administered 10/01/22 through 10/12/22. Telephone interview with a pharmacy technician from	D 358		

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)	COMPLETE DATE
D 358	Continued From page 10 the facility's contracted pharmacy on 10/13/22 at 4:02pm revealed: -The pharmacy received an order to change Resident #2's Aripiprazole from 5mg daily to 2mg daily on 08/17/22 and thirty 2mg tablets were dispensed on the same day. -The pharmacy received a refill request from the facility with the facility's contracted PCP signature for Aripiprazole 5mg daily on 09//19/22 and 30 tablets were dispensed the same day. -The pharmacy did not have an order to discontinue the Aripiprazole for Resident #2. Telephone interview with the facility's contracted PCP on 10/13/22 at 4:45pm revealed she was not concerned that Resident #1 received 5mg of Aripiprazole instead of 2mg from 09/19/22 through 10/12/22. Interview with the Wellness Nurse on 10/13/22 at 4:45pm revealed the medication aide (MA) made a mistake in recording the number of milligrams on the refill request for the Aripiprazole. The MA who made the fax refill request for Aripiprazole for Resident #1 on 09/19/22 was not available for interview on 10/13/22 after 4:45pm. b. Review of Resident #1's physician's orders dated 08/08/22 revealed an order for Atorvastatin 80mg daily. (Atorvastatin lowers cholesterol.) Review of Resident #1's physician's order dated 09/27/22 revealed an order to discontinue Atorvastatin.	D 358		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

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)	COMPLETE DATE
D 358	Continued From page 11 Review of Resident #1's August, September and October 2022 medication administration records (MARs) revealed: -There were preprinted entries for Atorvastatin 80mg daily. -There was documentation doses were administered 08/01/22 through 10/12/22. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/13/22 at 4:02pm revealed the pharmacy did not have an order to discontinue the Atorvastatin for Resident #2. Telephone interview with the facility's contracted primary care provider (PCP) on 10/13/22 at 4:45pm revealed she was not concerned that Atorvastatin was administered for an additional 15 days after being discontinued. c. Review of Resident #1's physician's orders dated 08/08/22 revealed an order for Vitamin D3 2,000 units daily. (Vitamin D is a supplement for Vitamin D deficiency.) Review of Resident #1's physician's order dated 09/27/22 revealed an order to discontinue Vitamin D3. Review of Resident #1's August, September and October 2022 medication administration records (MARs) revealed: -There were preprinted entries for Vitamin D3 2,000 units daily. -There was documentation doses were administered 08/01/22 through 10/12/22 except on 08/13/22 (out of facility).	D 358		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

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)	COMPLETE DATE
D 358	Continued From page 12 Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/13/22 at 4:02pm revealed the pharmacy did not have an order to discontinue the Vitamin D3 for Resident #2. Telephone interview with the facility's contracted primary care provider (PCP) on 10/13/22 at 4:45pm revealed she was not concerned that Vitamin D3 was administered for an additional 15 days after being discontinued. d. Review of Resident #1's physician's orders dated 08/08/22 revealed an order for Folic Acid 1mg daily. (Folic Acid is a Vitamin B supplement.) Review of Resident #1's physician's order dated 09/27/22 revealed an order to discontinue Folic Acid. Review of Resident #1's August, September and October 2022 medication administration records (MARs) revealed: -There were preprinted entries for Folic Acid 1mg daily. -There was documentation doses were administered 08/01/22 through 10/12/22 except on 08/13/22 (out of facility). Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/13/22 at 4:02pm revealed the pharmacy did not have an order to discontinue the Folic Acid for Resident #2. Telephone interview with the facility's contracted primary care provider (PCP) on 10/13/22 at 4:45pm revealed she was not concerned that Folic Acid was administered for an additional 15 days after being discontinued.	D 358		

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)	COMPLETE DATE
D 358	Continued From page 13 Telephone interview with Resident #1's family member on 10/13/22 at 3:44pm revealed: -She took Resident #1 to PCP appointment on 09/27/22. -She left the facility without the normal appointment folder due to being rushed. -She left the paperwork from the PCP with the receptionist or the Wellness Nurse. -She could not remember for certain. -The PCP discontinued the medications because Resident #1 was declining and no longer needed the medications. -The PCP was not concerned about any toxicity or side effects. Interview with the Wellness Nurse on 10/13/22 at 12:57pm revealed: -She found the orders dated 09/27/22 for Resident #2 on 10/12/22 when she was checking resident charts. -Normally, when family members took residents to outside providers, they brought a facility folder for the resident to the appointment and returned the folder and new orders. -The resident appointment folder was supposed to be returned to one of the medication aides (MAs). -Sometimes the folder might have been left with the receptionist who was usually good about notifying either the MA or her. -The MA was responsible for transcribing medication orders and faxing the orders to the pharmacy. -The MA was responsible for documenting the orders on a tracking sheet and she checked tracking sheet to follow up on all new orders. -The box was on the wall but due to construction at the facility, the box had been taken down.	D 358		

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)	COMPLETE DATE
D 358	Continued From page 14 Telephone interview with the facility's contracted PCP on 10/13/22 at 4:45pm revealed: -She became aware last week (10/06/22) Resident #1 had two PCP's: she and an outside PCP. -A family member continued taking Resident #1 to see her PCP from prior to admission. -The out of state Power of Attorney (POA) agreed to transfer Resident #1's care to her, the facility's contracted PCP. -Her initial visit with Resident #1 was shortly after the resident was admitted to the facility (07/11/22). -She made decisions for the resident based on her records. Interview with the Wellness Nurse on 10/13/22 at 4:45pm revealed: -The facility's contracted PCP was Resident #1's PCP. -The outside provider the family took the resident to was a geriatric neurology specialist. Interview with the Director of Resident Care (DRC) on 10/13/22 at 12:57pm revealed: -A family member took Resident #1 to the PCP visit on 09/27/22. -The family member must have given the after-visit forms and new orders to one of the personal care aides (PCAs) instead of the MA. -The orders were filed in Resident #1's chart without being transcribed on the MAR or faxed to the pharmacy. Attempted telephone interview with Resident #1's original PCP on 10/13/22 at 4:16pm was unsuccessful.	D 358		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

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)	COMPLETE DATE
D 406	Continued From page 15 10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure action was taken in response to the quarterly medication review for 1 of 2 sampled residents (#2) with recommendations to decrease the dosage of a medication that could cause sedation. The findings are: Review of Resident #2's current FL-2 dated 04/04/22 revealed diagnoses included chronic atrial fibrillation, pulmonary hypertension, vertigo, generalized weakness, pain and peripheral vascular disease. Review of Resident #2's Physician's Orders dated 06/06/22 revealed an order for meclizine 12.5mg twice daily. Review of Resident #2's quarterly medication reviews dated 05/26/22 and 08/28/22 revealed a recommendation to decrease the meclizine from twice daily to once daily at bedtime due to strong sedating properties and recommended limited use in older adults. Review of Resident #2's August, September and	D 406		

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)	COMPLETE DATE
D 406	Continued From page 16 October 2022 medication administration records (MARs) revealed: -There were preprinted entries for meclizine 12.5mg twice daily. -There was documentation doses were administered 08/01/22 through 10/12/22 except on 10/10/22 (at the hospital). Interview with Resident #2's primary care provider (PCP) on 10/13/22 at 3:05pm revealed: -She did not recall seeing the medication review recommendations dated 05/26/22 for Resident #2. -She last saw the resident on 09/12/22 and her visit note said to continue current regimen so she probably would not have changed any of the orders. -She was usually at the facility every Monday. -Normally, medication reviews were placed in her folder on each floor of the facility by staff. -She signed the medication review recommendations and placed signed forms in the folder for staff to fax to the pharmacy. -Sometimes she handed the signed forms to a medication aide (MA) if they were not busy. Interview with the Wellness Nurse on 10/13/22 at 4:54pm revealed: -She was responsible for following up on quarterly medication reviews. -She had not seen the pharmacy consultant's recommendations for the reviews done in May and August 2022 until 10/12/22. -She had been working often on the medication cart and providing direct care to residents. -The pharmacy consultant did not usually discuss the outcome of quarterly medication reviews with her. -The pharmacy consultant usually only came to her	D 406		

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)	COMPLETE DATE
D 406	Continued From page 17 with questions. -She did not know who at the facility the pharmacy consultant sent the quarterly medication review summary and recommendations to. Interview with the Director of Resident Care (DRC) on 10/13/22 at 5:07pm revealed: -The pharmacy consultant completed an exit process with her after each quarterly medication review. -The pharmacy consultation report and recommendations were emailed to her and the Wellness Nurse. -She or the Wellness Nurse placed the recommendations in the PCP's folder to be signed. -Signed recommendation forms were faxed back to the pharmacy. -She had not kept signed and faxed recommendations for residents. Interview with the Administrator on 10/13/22 at 5:07pm revealed she was responsible for ensuring the DRC and Wellness Nurse followed up on quarterly medication review recommendations. Attempted telephone interview with the facility's contracted pharmacy consultant on 10/13/22 at 4:25pm was unsuccessful.	D 406		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE