Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL100005	A. BUILDING: ______ B. WING ______	R **02/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEY HOUSE	**4 COOPER LANE** **BURNSVILLE, NC 28714**

(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 and the Yancey County Department of Social Services conducted a follow-up survey and complaint investigation on 02/07/23 through 02/08/23. The complaint investigation was initiated by the Yancey County Department of Social Services on 02/01/23.	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: FOLLOW-UP TO TYPE UNABATED B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 14 residents observed during the medication pass (Resident #6 and #7) and 1 of 5 sampled residents related to not administering an antipsychotic medication, a medication used to treat joint inflammation and a medication used to prevent constipation (Resident #1). The findings are:	D 358		

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The medication error rate was 6% as evidenced by the observation of 2 errors out of 33 opportunities during the 12:00pm medication pass on 02/07/23 and 8:00am medication pass on 02/08/23.

Review of the facility's policies and procedures for medication administration dated September 2021 revealed:
-A list of medications on the physician's orders will be faxed to the physician/provider for signature and date confirming review of all current medication orders.
-All orders are reviewed by the Resident Care Coordinator or Special Care Coordinator for accuracy and faxed to the facility's contracted pharmacy before being filed in a resident's record.
-If an order is incomplete or requires clarification, the Resident Care Coordinator or Special Care Coordinator will follow-up immediately with the provider.
-The facility will develop a schedule so that all resident's medication orders are checked on a weekly basis by completing a cart audit and making sure all medications are available by comparing to the resident's physician orders.
-The resident's prescribing physician/provider would be immediately notified of medication errors including missed doses and wrong doses administered.

1. Review of Resident #1's current FL2 dated 08/25/22 revealed:
-Diagnoses included vascular dementia, developmental delay, rheumatoid arthritis, depression, and anxiety.
-She was intermittently confused.

a. Review of Resident #1's current FL2 dated

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D 358	Continued From page 2 08/25/22 revealed an order for haloperidol (an antipsychotic medication used to treat depression and anxiety) 1mg take 1 tablet twice daily. Review of Resident #1's physician's order report dated 08/25/22 revealed an order for haloperidol 1mg take 1 tablet twice daily. Review of Resident #1's physician's orders revealed: -An order dated 12/29/22 for haloperidol 1mg twice daily at 12:00pm and 6:00pm. -An order dated 02/02/23 for haloperidol 1mg daily at 6:00pm for 2 weeks then discontinue haloperidol. Review of Resident #1's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for haloperidol 1mg take 1 tablet three times daily. -There was documentation haloperidol 1mg was administered three times daily at 6:00am, 12:00pm, and 6:00pm from 01/01/23 through 01/05/23. -There was no entry for haloperidol 1mg take 1 tablet twice daily at 12:00pm and 6:00pm. -There was no documentation haloperidol 1mg was administered from 01/06/23 through 01/31/23. Review of Resident #1's February 2023 eMAR revealed: -There was an entry for haloperidol 1mg take 1 tablet twice daily. -There was documentation haloperidol 1mg was administered twice daily at 12:00pm and 6:00pm on 02/01/23 and 02/02/23. -There was no entry for haloperidol 1mg take 1 tablet daily at 6:00pm for 2 weeks then	D 358		

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discontinue haloperidol.
-There was no documentation haloperidol 1mg was administered from 02/03/23 through 02/07/23.

Observation of Resident #1's medications on hand on 02/08/23 at 10:32am revealed:
-There was a multidose medication bubble pack labeled week 1 containing haloperidol 1mg with instructions to administer twice daily at mid-day and evening.
-Haloperidol 1mg was in 2 separate bubbles scheduled to be administered at 12:00pm and 6:00pm each day from 02/08/23 through 02/14/23.

Interview with a medication aide (MA) on 02/08/23 at 10:38am revealed:
-She did not know why haloperidol was not administered from 01/06/23 through 01/31/23.
-The multidose medication bubble packs were dispensed from the pharmacy on 02/07/23 for a one-week supply.
-She could not find an entry for haloperidol 1mg on Resident #1's February 2023 eMAR.
-She did not know why there was not a current entry for Resident #1's haloperidol on the February 2023 eMAR.
-She last administered haloperidol to Resident #1 on 02/02/23 at 12:00pm and 6:00pm.
-The Special Care Coordinator (SCC) was responsible for faxing all medication orders to the pharmacy, clarifying medication orders, and verifying the eMAR was accurate.
-The SCC would give the MAs a copy of the new medication orders to keep in a drawer on the medication cart so the MAs could reference the new order.
-She could not find any new medication orders or clarification orders in the drawer on the

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medication cart for Resident #1.

Interview with the SCC on 02/08/23 at 9:59am revealed:
-She did not know why Resident #1's haloperidol was not administered from 01/06/23 through 01/31/23.
-There was an order dated 12/29/22 to administer Resident #1 haloperidol 1mg twice daily at 12:00pm and 6:00pm.
-There was a current order dated 02/02/23 to administer Resident #1 haloperidol 1mg daily at 6:00pm.
-She did not know why Resident #1's haloperidol was not administered from 02/03/23 through 02/07/23.
-She was responsible for making sure all medications ordered for residents were accurate and matched the eMAR.
-She missed the order changes for haloperidol on 12/29/22 and 02/02/23 on Resident #1's eMAR.
-The facility's contracted pharmacy was responsible for entering all medication orders into the eMAR system and she approved the medication entries if the entries were accurate.
-She was responsible for contacting the primary care provider (PCP) and clarifying medication orders for residents and notify the PCP of missed doses of medications.
-She was responsible for completing weekly medication cart audits and comparing the medications on hand with the residents eMARs.
-She was responsible for auditing all the residents physician orders and comparing the orders to the eMARs to check for eMAR accuracy.
-She did not audit Resident #1's physician's orders or eMAR to check for accuracy because she was still auditing other resident records.

Telephone interview with a pharmacist from the

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facility's contracted pharmacy on 02/08/23 at 11:09am revealed:
-There was an order faxed by the facility to the pharmacy on 12/29/22 for Resident #1's haloperidol 1mg take 1 tablet twice daily.
-There was a problem with Resident #1's insurance paying for the haloperidol 1mg twice daily and was unable to be dispensed from 01/05/23 through 01/11/23.
-The pharmacy notified the facility with a telephone call and fax that Resident #1's haloperidol was unable to be dispensed and received "no response" from the facility .
-Resident #1's haloperidol 1mg take 1 tablet twice daily was dispensed by the pharmacy on 01/12/23 in multidose bubble packs and was available for administration from 01/12/23 through 02/01/23.
-Resident #1's order for haloperidol 1mg take 1 tablet daily at 6:00pm for 14 days then discontinue was faxed to the pharmacy on 02/02/23.
-Resident #1's multidose bubble pack was prepackaged before the haloperidol order was received on 02/02/23 and was dispensed as haloperidol 1mg take 1 tablet twice daily at 12:00pm and 6:00pm from 02/08/23 through 02/14/23.

Telephone interview with Resident #1's PCP on 02/08/23 at 2:18pm revealed:
-Resident #1 was ordered haloperidol for anxiety, depression, and for behaviors such as screaming and aggression towards staff and other residents.
-She had made several order changes for Resident #1's haloperidol.
-On 12/29/22, she changed Resident #1's haloperidol to 1mg twice daily.
-On 02/02/23, she changed Resident #1's haloperidol to 1mg daily for 2 weeks then discontinue the haloperidol.

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-She was not notified by the facility's staff of the missed doses of haloperidol for Resident #1 from 01/06/23 through 01/31/23 or she would not have ordered to administer haloperidol 1mg daily for 2 weeks on 02/02/23 before discontinuing the medication.
-She was tapering Resident #1's dosage of haloperidol before she discontinued it because haloperidol should not be stopped abruptly.
-Resident #1 could have experienced withdrawal symptoms from not being administered the haloperidol from 01/06/23 through 01/31/23 causing Resident #1 to be more withdrawn, decrease in appetite, not participate with activities of daily living, increased aggression, and increased anxiety.
-She had noticed a decline in Resident #1 physically and mentally over the past 3 months because Resident #1 had a decreased appetite with weight loss and appeared more withdrawn.
-She expected the facility to notify her of any missed medications or to clarify any medication orders.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Attempted telephone interview with Resident #1's responsible person on 02/08/23 at 2:35pm was unsuccessful.

Refer to the interview with the Administrator on 02/08/23 at 3:17pm.

b. Review of Resident #1's current FL2 dated 08/25/22 revealed an order for Xeljanz (a medication used to treat joint inflammation, pain, swelling, and stiffness associated with rheumatoid arthritis) 5mg take 1 tablet twice daily

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at 8:00am and 8:00pm.

Review of Resident #1's physician's order report dated 08/25/22 revealed an order for Xeljanz 5mg take 1 tablet daily at 8:00am.

Review of Resident #1's physician's orders revealed there were no orders since 08/25/22 to clarify if Xeljanz 5mg should have been administered daily or twice daily.

Review of Resident #1's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Xeljanz 5mg take 1 tablet daily at 8:00am.
-There was documentation Xeljanz 5mg was administered daily at 8:00am from 01/01/23 through 01/31/23 except on 01/27/23 with a comment Resident #1 was unavailable due to being gone from the facility.

Review of Resident #1's February 2023 eMAR revealed:
-There was an entry for Xeljanz 5mg take 1 tablet daily at 8:00am.
-There was documentation Xeljanz 5mg was administered daily at 8:00am from 02/01/23 through 02/07/23.

Observation of Resident #1's medications on hand on 02/08/23 at 10:32am revealed:
-There was a multidose medication bubble pack labeled week 1 containing Xeljanz 5mg with instructions to administer once daily at 8:00am.
-Xeljanz 5mg was in a single bubble pack scheduled to be administered at 8:00am daily from 02/08/23 through 02/14/23.

Interview with a medication aide (MA) on

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D 358	Continued From page 8 02/08/23 at 10:38am revealed: -The multidose medication bubble packs were dispensed from the pharmacy on 02/07/23 for a one-week supply. -Resident #1's Xeljanz 5mg was ordered to be administered daily. -The Special Care Coordinator (SCC) was responsible for faxing all medication orders to the pharmacy, clarifying medication orders, and making sure the eMAR was correct. -The SCC gave the MAs a copy of the new medication orders to keep on the medication cart in order to reference the new order. -She could not find any new medication orders or clarification orders on the medication cart for Resident #1. Interview with the SCC on 02/08/23 at 9:59am revealed: -She did not know Resident #1's Xeljanz was ordered twice daily at 8:00am and 8:00pm on the FL2 dated 08/25/22 and ordered once a day on the physician's order report dated 08/25/22. -She was responsible for contacting the primary care provider (PCP) and clarifying medication orders for residents. -She did not clarify the medication order for Resident #1's Xeljanz because she was not the SCC at the time the order was written. -She was responsible for making sure all current medication orders for residents matched the orders on the eMAR, but she had not reviewed all the resident records yet for accuracy. -She was responsible for completing weekly medication cart audits and completing eMAR audits by comparing physician's orders to the eMARs for accuracy. -She did not audit Resident #1's physician's orders or eMAR to check for accuracy because she was still auditing other resident records.	D 358		

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Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/08/23 at 11:09am revealed:
-The current FL2 for Resident #1 faxed to the pharmacy by the facility was dated 08/12/22.
-There was an order for Resident #1's Xeljanz 5mg take 1 tablet daily.
-The pharmacy did not receive a fax from the facility for an FL2 dated 08/25/22 for Resident #1.
-Resident #1's Xeljanz 5mg take 1 tablet daily was dispensed in a multidose bubble pack weekly with the last dispense date of 02/07/23 in quantity of 7 tablets.

Telephone interview with Resident #1's PCP on 02/08/23 at 2:18pm revealed:
-She ordered Xeljanz 5mg to be administered to Resident #1 twice daily for rheumatoid arthritis.
-The facility did not notify her there was another order dated the same day to administer Xeljanz 5mg daily to Resident #1.
-Resident #1 needed Xeljanz to be administered twice daily because of the rheumatoid arthritis which caused increased joint discomfort and limitations in bodily movement.
-She ordered Resident #1 a pain medication in December 2022 for increased pain of Resident #1's right hip due to arthritis and limited movement which could have been directly related to not receiving the Xeljanz twice a day.
-Resident #1 could experience increased joint discomfort, limitation of movement, increased pain, and become more withdrawn from not being administered Xeljanz twice a day.
-She expected the facility to call and clarify multiple or conflicting orders.

Based on observations, interviews, and record reviews it was determined Resident #1 was not

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interviewable.

Attempted telephone interview with Resident #1's responsible person on 02/08/23 at 2:35pm was unsuccessful.

Refer to the interview with the Administrator on 02/08/23 at 3:17pm.

c. Review of Resident #1's current FL2 dated 08/25/22 revealed an order for polyethylene glycol (a medication used to treat constipation) 17 grams daily.

Review of Resident #1's physician's order report dated 08/25/22 revealed there was no order for polyethylene glycol.

Review of Resident #1's physician's orders revealed there were no orders since 08/25/22 to clarify if polyethylene glycol should be administered.

Review of Resident #1's January 2023 electronic medication administration record (eMAR) revealed:
-There was no entry for polyethylene glycol 17 grams to be administered daily.
-There was no documentation polyethylene glycol was administered from 01/01/23 through 01/31/23.

Review of Resident #1's February 2023 eMAR revealed:
-There was no entry for polyethylene glycol 17 grams to be administered daily.
-There was no documentation polyethylene glycol was administered from 02/01/23 through 02/07/23.

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Observation of Resident #1's medications on hand on 02/08/23 at 10:32am revealed there was no polyethylene glycol available for administration.

Interview with a medication aide (MA) on 02/08/23 at 10:38am revealed:
-There was no polyethylene glycol available to administer to Resident #1.
-There was no order on the eMAR to administer polyethylene glycol to Resident #1.
-The Special Care Coordinator (SCC) was responsible for faxing all medication orders to the pharmacy, clarifying medication orders, and making sure the eMAR was correct.
-The SCC would give the MAs a copy of the new medication orders to keep on the medication cart to be able to reference the new order.
-She could not find any new medication orders or clarification orders on the medication cart for Resident #1's polyethylene glycol.

Interview with the SCC on 02/08/23 at 9:59am revealed:
-She did not know Resident #1 had an order for polyethylene glycol 17 grams daily.
-There was no entry for polyethylene glycol on Resident #1's eMAR.
-She could not find a discontinue order for Resident #1's polyethylene glycol.
-She was responsible for contacting the primary care provider (PCP) and clarifying medication orders for residents.
-She did not clarify the medication order for Resident #1's polyethylene glycol because she was not the SCC at the time the order was written.
-She was responsible for making sure all current medication orders for residents matched the orders on the eMAR, but she had not reviewed all

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the resident records yet for accuracy.
-She was responsible for completing weekly medication cart audits but did not know polyethylene glycol was ordered for Resident #1.
-She was responsible for making sure all current medication orders for residents matched the orders on the eMAR, but she had not reviewed all the resident records yet for accuracy.
-She was responsible for completing weekly medication cart audits and completing eMAR audits by comparing physician's orders to the eMARs for accuracy.
-She did not audit Resident #1's physician's orders or eMAR to check for accuracy because she was still auditing other resident records.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/08/23 at 11:09am revealed:
-The current FL2 for Resident #1 faxed to the pharmacy from the facility was dated 08/12/22 and there was no order for polyethylene glycol.
-The pharmacy did not receive a fax from the facility for an FL2 dated 08/25/22 for Resident #1.
-The pharmacy did not dispense polyethylene glycol for Resident #1.

Telephone interview with Resident #1's PCP on 02/08/23 at 2:18pm revealed:
-She ordered Resident #1 polyethylene glycol 17 grams daily to prevent constipation.
-The facility did not notify her of the missed doses of polyethylene glycol for Resident #1 during the month of January or February 2023.
-Resident #1 could have an increased risk of becoming constipated from not receiving the polyethylene glycol.
-She expected Resident #1's polyethylene glycol to be administered as ordered and notified of multiple missed doses.

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	HAL100005	A. BUILDING: ________ B. WING ________	R 02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEY HOUSE	**4 COOPER LANE BURNSVILLE, NC 28714**

(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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Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Attempted telephone interview with Resident #1's responsible person on 02/08/23 at 2:35pm was unsuccessful.

Refer to the interview with the Administrator on 02/08/23 at 3:17pm.

2. Review of Resident #6's current FL2 dated 01/19/23 revealed:
-Diagnoses included dementia, panic disorder, and anxiety.
-There was an order for memantine (a medication used to treat dementia) 10mg take 1 tablet twice daily.

Observation of the morning medication pass for Resident #6 on 02/08/23 at 8:29am revealed:
-The medication aide (MA) opened a bubble pack and put 2 medications into a medication cup for Resident #6.
-The medication included one tablet of memantine 5mg.
-The MA handed the medication cup to Resident #6 and watched the resident swallow the medications.

Review of Resident #6's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for memantine 5mg take 1 tablet twice daily.
-There was documentation memantine 5mg was administered twice daily from 01/01/23 through 01/31/23.

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Review of Resident #6's February 2023 eMAR revealed:
-There was an entry for memantine 5mg take 1 tablet twice daily.
-There was documentation memantine 5mg was administered twice daily from 02/01/23 through 02/07/23 and at 8:00am on 02/08/23.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/08/23 at 11:09am revealed:
-The order dated 07/01/22 for Resident #6's memantine 5mg take 1 tablet twice daily was the current order.
-The pharmacy did not receive a fax from the facility on 01/19/23 with an order for Resident #6's memantine 10mg take 1 tablet twice daily.
-Resident #6's memantine 5mg was last dispensed on 02/07/23 in a multidose bubble pack for a one week supply.

Interview with a medication aide (MA) on 02/08/23 at 10:38am revealed:
-She administered memantine 5mg to Resident #6 during the morning medication pass because that was the current order on Resident #6's eMAR.
-Resident #6's memantine 5mg tablet was dispensed by the pharmacy in a multidose bubble pack scheduled for twice daily.
-The Special Care Coordinator (SCC) was responsible for faxing all medication orders to the pharmacy, clarifying medication orders, and making sure the eMAR was correct.
-The SCC would give the MAs a copy of the new medication orders to keep on the medication cart to be able to reference the new order.
-She could not find any new medication orders or clarification orders on the medication cart for Resident #6's memantine.

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D 358	Continued From page 15 Interview with the SCC on 02/08/23 at 12:15pm: -She faxed Resident #6's FL2 dated 01/19/23 but did not have a confirmation the fax went through because the fax machine had not been printing faxed confirmations. -The pharmacy entered Resident #6's medications on the eMAR and she approved all the medications including the memantine 5mg because she did not realize the dosage was different. -She was responsible for checking all medications on the eMAR for accuracy after comparing the eMAR to medication orders. -She was still reviewing all the resident's records comparing the physician's orders to what was currently being administered and did not have a chance to review Resident #6's record yet. -She did not call the primary care provider (PCP) to clarify the dosage of memantine for Resident #6 because she did not know the order for memantine had changed. Telephone interview with Resident #6's PCP on 02/08/23 at 2:18pm revealed: -Resident #6 was ordered memantine because she had dementia. -On 01/19/23, she ordered an increased dose of Resident #6's memantine due to increased behaviors including panic attacks. -The facility did not notify her Resident #6 was being administered 5mg instead of the ordered 10mg of memantine. -Resident #6 was at risk of having increased confusion, increased anxiety, and panic attacks from receiving too low of dosage of memantine. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable.	D 358		

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Refer to the interview with the Administrator on 02/08/23 at 3:17pm.

3. Review of Resident #7's current FL2 dated 01/19/23 revealed:
-Diagnoses included Alzheimer's Disease, osteopenia, and history of a right ankle fracture.
-She was constantly disoriented.
-There was an order for calcium 500mg plus vitamin D (used to treat low blood calcium levels and assist with bone healing) take 1 tablet daily.

Observation of the morning medication pass for Resident #7 on 02/08/23 at 8:32am revealed:
-The medication aide (MA) opened a bubble pack and put 11 medications into a medication cup for Resident #7.
-The medication did not include calcium 500mg plus vitamin D.
-The MA handed the medication cup to Resident #7 and watched the resident swallow the medications.
-The MA proceeded to administer medications to other residents.

Review of Resident #7's January 2023 electronic medication administration record (eMAR) revealed there was no entry for calcium 500mg plus vitamin D on the eMAR.

Review of Resident #7's February 2023 eMAR revealed there was no entry for calcium 500mg plus vitamin D on the eMAR.

Interview with the Special Care Coordinator (SCC) on 02/08/23 at 12:15pm:
-She faxed Resident #7's FL2 dated 01/19/23 but did not have a confirmation the fax went through because the fax machine had not been printing

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D 358	Continued From page 17 faxed confirmations. -She did not why Resident #7's Physician's Order Report dated 01/19/23 did not have an order for calcium with vitamin D when the FL2 contained the order for calcium and was dated the same day (01/19/23). -The pharmacy entered Resident #7's medications on the eMAR and she approved all the medications because she did not realize Resident #7's calcium 500mg plus vitamin D was not on the eMAR. -She was responsible for checking all medications on the eMAR for accuracy after comparing the eMAR to the medications ordered. -She was still reviewing all the resident's records comparing the physician's orders to what was currently being administered and did not have a chance to review Resident #7's record yet. -She did not call the primary care provider (PCP) to clarify if calcium 500mg plus vitamin D should be administered to Resident #7 because she did not know the calcium with vitamin D was ordered. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 02/08/23 at 2:18pm revealed: -The pharmacy did not receive Resident #7's order for calcium 500mg plus vitamin D 1 tablet daily dated 01/19/23. -The pharmacy did not have a record of a discontinuation order for calcium for Resident #7 after 01/19/23. -The pharmacy did not dispense calcium 500mg plus vitamin D tablets for Resident #7 from 01/19/23 to current. Telephone interview with Resident #6's PCP on 02/08/23 at 2:43pm revealed: -Resident #7 sustained a right ankle fracture in November or December 2022.	D 358		

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D 358	Continued From page 18 -She ordered calcium 500mg plus vitamin D take 1 tablet daily for Resident #7 to aid in bone healing. -Resident #7 had osteopenia (bone loss caused by a condition that occurred when the body did not make new bone as quickly as it reabsorbed old bone) and needed the calcium with vitamin D supplement to help keep Resident #7's bone structure stronger. -The healing process of Resident #7's right ankle fracture could be hindered by not being administered the calcium plus vitamin D. Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable. Refer to the interview with the Administrator on 02/08/23 at 3:17pm. ______________________ Interview with the Administrator on 02/08/23 at 3:17pm revealed: -The SCC was responsible for contacting the PCP for medication clarification orders for residents. -The SCC was responsible for faxing the medication orders to the facility's contracted pharmacy, reviewing the eMAR for accuracy after comparing the eMAR to the physician's orders, and approving the medications in the eMAR system. -The SCC was responsible for weekly medication cart and eMAR audits. -Any new medication orders were kept in a folder in the SCC's office and once the medication was entered into the eMAR correctly, the order was filed in the resident's record. -She did not know of any residents that missed or received the wrong dosage of medications. -The SCC was responsible for contacting the	D 358		

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PCP when a resident missed multiple doses of a medication or received the wrong dosage of a medication.
-She expected staff to follow the facility's policies and procedures for medication administration which included clarifying orders or getting medications refilled by the pharmacy when unavailable and notifying the PCP.

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The facility's failure to ensure medications were administered as ordered resulted in Resident #1's antipsychotic medication being abruptly stopped without tapering, placing Resident #1 at risk for increased anxiety, increased aggression, and withdrawal symptoms, and being administered a medication used to treat inflammation associated with rheumatoid arthritis once daily instead of the ordered twice a day doseage, placing Resident #1 at risk for increased joint inflammation, pain, swelling and stiffness which could result in joint discomfort and limitation of movement and Resident #6 receiving a medication used to treat dementia one time daily instead of the ordered twice daily doseage which placed the resident at an increased risk of confusion, increased behaviors, and increased anxiety and panic attacks and Resident #7 not receiving a vitamin and mineral supplement to aid in bone healing, which could hinder a bone fracture from healing and keep the resident's bone structure strong. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 02/08/23.