STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-079106	A. BUILDING: _____ B. WING _____	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKINGHAM	2605 SWALLOW ROAD REIDSVILLE, NC 27320

(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 initial survey on 01/25/23 and 01/26/23.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or conclusions, set forth in the statement of deficiencies, the plan of correction is prepared solely as a matter of compliance with the law.	
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 by a licensed prescribing practitioner for 1 of 2 residents (#4) including an error with an antipsychotic medication. The findings are: Review of the facility's policy on a discontinued order in multidose packaging revealed: -If a medication in multidose packing was discontinued the community would place a change of direction/discontinued sticker on the multidose packaging beside the medication name. -When it was time to administer the medication from the multidose packaging the medication aide (MA) would review the order and identify the discontinued medication. -The medication would be removed from the multidose packaging following proper infection	D 358	10A NCAC 13F .1004(a) Medication Administration RCC contacted PCP on 1/26/23 to clarify order and Pharmacy was contacted on 1/26/23 to correct order. Scanners were installed on 2/1/23 to correctly pickup orders from the EMAR in Matix to the to the medication in bubble packs. RCC & ED held a Med Aide meeting on 1/26/23 to educate on the importance of clarifying orders before approving in the matrix medication administration system. Facility will ensure that all orders are administered as ordered by a licensed prescribing practitioner. RCC and/or ED will review all orders for accruing before they are approved in Matrix EMAR and ensure that the medication is in the facility correctly to begin, administration by all med-aides. ED and/or designee will review weekly to ensure new orders have been entered correctly and have the correct documentation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3/8/23

Reviewed and Acknowledged K.M. 03/09/23

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D 358	Continued From page 1 control procedure. 1. Review of Resident #4's current FL2 dated 11/08/22 revealed: -Diagnoses included dementia, hypertension, and depression. -There was an order for quetiapine 25mg (a medication used to treat behaviors associated with dementia) take one tablet twice a day. Review of a signed physician's order dated 01/09/23 revealed that there was an order to discontinue quetiapine 25mg twice a day and an order to start quetiapine extended release (XR) 150mg take one tablet at bedtime. Observation of medication administration on 01/26/23 at 8:04am revealed: -The medication aide (MA) took Resident #4's medication card out of the medication cart. -The MA put all of Resident #4's scheduled medication into a cup. -The MA administered 9 tablets to Resident #4, including quetiapine 25mg. Review of Resident #4's January 2023 electronic Medication Administration Record (eMAR) from 01/01/23 to 01/26/23 revealed: -There was an entry for quetiapine 25mg take 1 tablet twice a day with scheduled administration times of 8:00am and 8:00pm. -Quetiapine 25mg was documented as administered from 01/01/23 to 01/16/23. -The entry for quetiapine 25mg was discontinued on the eMAR on 01/16/23 at 8:00am. -There was an entry for quetiapine XR 150mg with a scheduled administration time at 8:00pm. -Quetiapine XR 150mg was documented as administered from 01/11/23 to 01/25/23.	D 358		

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D 358	Continued From page 2 Observation of Resident #4's medications on hand on 01/26/23 at 10:56am revealed: -There was a weekly medication bubble pack with a medication label for quetiapine 25mg take one tablet twice a day. -There was not a change of direction or discontinued sticker on the medication bubble pack for quetiapine 25mg. -There was a weekly medication bubble pack with 1 of 14 quetiapine 25mg tablets remaining that was dispensed on 01/17/23 for administration dates of 01/19/23 to 01/26/23. -There was a weekly medication bubble pack with 1 of 7 quetiapine XR 150mg tablets remaining that was dispensed on 01/17/23 for administration dates of 01/19/23 to 01/26/23. Based on record review and the medications on hand, there should not have been any quetiapine 25mg tablets on the medication cart. There was 1 quetiapine 25mg tablet remaining which indicated that Resident #4 was still being administered the discontinued order of quetiapine 25mg tablets twice daily for 10 days after the discontinuation date in addition to the ordered dose of quetiapine XR 150mg at bedtime. Interview with the MA observed during the morning medication administration on 01/26/23 at 2:35pm revealed: -She was aware that Resident #4's quetiapine 25mg twice daily order was discontinued. -She was not aware that Resident #4's discontinued quetiapine 25mg twice daily order was dispensed in the weekly medication bubble pack and was still being administered to Resident #4 since the order was discontinued on 01/09/23. -Her normal process for administering medications was to compare the medication order labels on the weekly medication card	D 358		

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D 358	Continued From page 3 bubble pack to the orders on the eMAR. -MAs were responsible to administer medications as ordered. Telephone interview with Resident #4's mental health provider (MHP) on 01/26/23 at 2:28pm revealed: -She discontinued Resident #4's order for quetiapine 25mg twice daily on 01/09/23. -She was not aware that staff was still administering the discontinued order of quetiapine 25mg to Resident #4. -She would not have expected Resident #4 to experience any side effects because of the quetiapine, but possible side effects of the medication included increased sedation. -She expected staff to administer medications as ordered. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 01/26/23 at 2:05pm revealed: -The pharmacy discontinued Resident #4's order for quetiapine 25mg on 01/16/23. -She thought the weekly medication bubble pack that was dispensed to the facility on 01/17/23 was packaged prior to the discontinuation of Resident #4's order for quetiapine 25mg. -She thought the pharmacy dispensed medications 3 or 4 days prior to the weekly bubble pack start date. -The weekly medication bubble pack dispensed to the facility on 01/17/23 was scheduled to be administered from 01/19/23 to 01/26/23. -Quetiapine 25mg was dispensed to the facility on 01/17/23 for a quantity of 14 tablets which was a one-week supply. -Quetiapine 150mg XR was dispensed to the facility on 01/17/23 for a quantity of 7 tablets which was a one-week supply.	D 358		

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D 358	Continued From page 4 -She would not have expected Resident #4 to have any side effects from being administered both the discontinued order of quetiapine 25mg twice daily and the ordered dosage of quetiapine XR 150mg at bedtime. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable. Interview with the Supervisor on 01/26/23 at 2:55pm revealed: -She was not aware Resident #4's discontinued order of quetiapine 25mg twice daily was still in the weekly medication bubble pack and being administered to Resident #4. -MAs were responsible to administer medications as ordered. -She completed a medication cart audit weekly on Wednesdays where she compared medications on the medication cart to the medication orders on the eMAR. Interview with the Resident Care Coordinator (RCC) on 01/26/23 at 3:15pm revealed: -She was not aware Resident #4's discontinued order of quetiapine 25mg was still being administered to Resident #4. -MAs were responsible to administer medications as ordered. -She thought the Supervisor did a medication cart audit weekly on Wednesdays where she compared medications on the medication cart to the medication orders on the eMAR. Interview with the Executive Director (ED) on 01/26/23 at 3:40pm revealed: -She was not aware Resident #4's discontinued order of quetiapine 25mg twice daily was still being administered to Resident #4.	D 358		

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D 358	Continued From page 5 -MAs were responsible to administer medications as ordered.	D 358		