STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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 Section conducted a follow-up survey on September 26 - 28, 2023.	D 000		
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 reviews, the facility failed to ensure referral and follow-up for 1 of 5 sampled residents (#2) related to failure to notify a prescriber of missed doses of a blood pressure medication and an eye lubricant that was ordered after eye surgery. The findings are: Review of Resident #2's current FL2 dated 06/27/23 revealed diagnoses included blindness of both eyes, and a history of carotid stenosis. a. Review of an after-visit report from Resident #2's ophthalmologist dated 07/28/23 revealed: -Resident #2 had cataract surgery on her left eye on 07/28/23. -There was an order for Systane eye drops (used to treat dry eyes) instill one drop into the left eye four times daily for three months post-operative in surgical eye. Review of Resident #2's July 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Systane eye drops instill 1 drop into left eye three to four times daily post op in surgical eye for three months scheduled at	D 273		

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8:00am, 12:00pm, 4:00pm and 8:00pm.
-The Systane eye drops were documented as administered starting on 07/29/23 at 8:00am.
-There was documentation Systane eye drops were administered nine of twelve opportunities from 07/29/23 to 07/31/23.

Review of Resident #2's August 2023 eMAR revealed:
-There was an entry for Systane eye drops instill 1 drop into left eye three to four times daily post op in surgical eye for three months scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation Systane eye drops were administered four times daily from 08/01/23 to 08/31/23.

Review of Resident #2's September 2023 eMAR dated from 09/01/23 to 09/26/23 revealed:
-There was an entry for Systane eye drops instill 1 drop into left eye three to four times daily post op in surgical eye for three months scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation Systane eye drops were administered four times daily from 09/01/23 to 09/14/23.
-There was documentation Systane eye drops were administered 19 of 45 opportunities from 09/15/23 to 09/26/23.
-There was an administration exception documented as, "physically not able to take-medication not in" 25 times from 09/15/23 to 09/26/23.

Review of Resident #2's electronic progress notes from 07/01/23 to 09/26/23 revealed there was no documentation of notification to the provider about an issue with refilling the Systane eye drops or missed doses.

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D 273	Continued From page 2 Observation of Resident #2's medication on hand on 09/26/23 at 2:04pm revealed there were no Systane eye drops available for administration. Observation of Resident #2 on 09/28/23 from 8:09am to 8:12am revealed she rubbed her left eye four times with the heal of her left hand. Telephone interview with the pharmacist from the facility's contracted pharmacy on 09/26/23 at 3:03pm revealed: -Resident #2 had an order for Systane eye drops instill 1 drop into left eye three to four times daily post-operative for three months; the order was dated 07/28/23. -One 10mL bottle of Systane eye drops was dispensed on 07/29/23; each bottle contained approximately 190 drops or 47 days' worth. -Systane eye drops were an over the counter (OTC) eye lubricant used to prevent dry eyes. -Systane eye drops mimicked tears and were ordered post-surgery due to decreased eye function and decreased tear production that eye surgery commonly caused. -Systane eye drops were not on a cycle fill and needed to be reordered by the facility staff. -There were not request for a refill for Resident #2's Systane eye drops. -If Systane eye drops were not administered as ordered post-surgery the resident could experience eye irritations due to dry eyes. Interview with Resident #2 on 09/28/23 at 8:09am revealed: -The staff administered eye drops in her left eye one or two times a day. -She did not recall if she was administered her eye drops in the past fourteen days. -She rubbed her left eye a lot because it made it feel better.	D 273		

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D 273	Continued From page 3 -She did not know why she rubbed her left eye, "it just made it feel better". Interview with a medication aide (MA) on 09/26/23 at 2:04pm revealed Resident #2 did not have Systane eye drops available for administration because there was a problem with the insurance coverage or the order from the physician. Interview with a second MA on 09/28/23 at 9:57am revealed: -The MAs were responsible for ordering refills on medications. -If there was an issue with an order or and insurance issue the MAs would reach out to the primary care provider (PCP) and see if they could help with the order; sometimes the PCP could help get the medication. -The Resident Care Coordinator (RCC) would also be notified when a medication was not available or could not be refilled. -The MAs or the RCC notified the PCP when medication doses were missed by a resident. -When the PCP was notified the MA was supposed to document the notification on the electronic progress notes. -She had requested a refill for the Systane eye drops from the pharmacy a couple of times but never heard back from the pharmacy; she did not recall the dates. -She thought she had left a voicemail with Resident #2's PCP about the issue with refilling Resident #2's Systane eye drops and she had documented the call to the PCP. -Resident #2 had not complained eye irritation and she had not noticed her rubbing her eye. Interview with the RCC on 09/28/23 at 9:20am revealed:	D 273		

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D 273	Continued From page 4 -She did cart audits weekly and asked the MA's if residents' medications were available for administration. -She and the MAs were responsible for reordering medication before the resident ran out. -When a medication was not on a cycle fill, she or the MA were responsible for calling the pharmacy and reordering. -The residents should never run out of a medication. -Resident #2's Systane eye drops had been delivered by the pharmacy last night, 09/27/23. -She thought the delay in refilling Resident #2's Systane eye drops was because it was too early to be refilled. -She was not aware Resident #2 had not had her Systane eye drops since 09/14/23. -If there was an issue with a medication being refilled the MAs should have notified the PCP or the ophthalmologist. -When the MAs notified the physician, they were required to document the call in the electronic progress notes. -She did not see where the physician had been notified when she reviewed Resident #2's electronic progress notes. Interview with the Administrator on 09/28/23 at 10:29am revealed: -The RCC was the only staff trained to reorder medication from the pharmacy. -The RCC was responsible for contacting the PCP when there was a problem with a medication order or refill request. -Contact with the PCP should have been documented in Resident #2's chart. -If the PCP had been contacted the PCP could have written a new order for the Systane eye drops before they ran out.	D 273		

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D 273	Continued From page 5 Attempted telephone interview with Resident #2's ophthalmologist on 09/27/23 at 1:24pm was unsuccessful. b. Review of Resident #2's current FL2 dated 06/27/23 revealed there was an order for hydralazine (used to treat high blood pressure) 25mg three times daily. Review of Resident #2's August 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for hydralazine 25mg every eight hours scheduled at 6:00am, 2:00pm, and 10:00pm. -There was documentation hydralazine 25mg was administered 89 of 93 opportunities from 08/01/23 to 08/31/23. -There was nothing documented on 08/18/23 and 08/30/23, at 10:00pm and there was nothing noted under the exceptions. -There was documentation Resident #2 refused her hydralazine 25mg on 08/14/23 and 08/16/23 at 10:00pm. Review of Resident #2's September 2023 eMAR dated from 09/01/23 to 09/26/23 revealed: -There was an entry for hydralazine 25mg every eight hours scheduled at 6:00am, 2:00pm, and 10:00pm. -There was documentation hydralazine 25mg was administered 73 of 79 opportunities from 09/01/23 to 09/26/23. -There was nothing documented on 09/01/23, 09/02/23, 09/04/23, 09/11/23, and 09/21/23 at 10:00pm and there was nothing noted on the exceptions. -There was nothing documented on 09/24/23 at 6:00am and nothing documented under the exceptions.	D 273		

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D 273	Continued From page 6 Review of Resident #2's electronic progress notes from 07/01/23 to 09/26/23 revealed there was no documentation of notification to the provider about Resident #2's missed doses of hydralazine 25mg. Observation of Resident #2's medication on hand on 09/26/23 at 2:04pm revealed: -On 09/05/23, 84 tablets of hydralazine 25mg were dispensed in three cards. -The medication instruction on the cards was hydralazine 25mg one tablet every eight hours. -The hydralazine medication cards were labeled one of one, one of two and one of three; each card contained 28 tablets. -The hydralazine medication card labeled one of three had 8 of 28 tablets available for administration. -The hydralazine medication card labeled two of three had 9 of 28 tablets available for administration. -The hydralazine medication card labeled three of three had 15 of 28 tablets available for administration. Telephone interview with the pharmacist from the facility's contracted pharmacy on 09/26/23 at 3:03pm revealed: -Resident #2 had a current order for hydralazine 25mg every eight hours. -Resident #2's hydralazine was on cycle fill. -On 08/01/23, a 30-day supply of 90 tablets of hydralazine 25mg was dispensed. -On 09/05/23, a 28-day supply of 84 tablets of hydralazine 25mg were dispensed. -Resident #2's hydralazine was dispensed into three medication cards; each card contained 28 tablets. -Hydralazine was a short acting blood pressure	D 273		

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D 273	Continued From page 7	D 273		

medication; it lowered blood pressure until the next scheduled dose.
-When a resident missed a dose of hydralazine their blood pressure would go up until the next dose.

Interview with Resident #2 on 09/28/23 at 8:09am revealed she did not know what here medications were ordered for or if she had high blood pressure.

Interview with a medication aide (MA) on 09/28/23 at 9:57am revealed:
-The MAs were required to document exceptions on the eMAR, including refusals.
-When nothing was documented for a medication it was considered a missed dose and all missed doses were considered a medication error.
-The MAs were supposed to notify the Resident Care Coordinator (RCC) and the resident's primary care provider (PCP) when there was a missed dose or medication error.
-The PCP was notified because they would advise the staff on what to do about the missed dose.
-The eMAR alerted the MAs of missed doses when they were in the system documenting administration of medications.
-The MAs or the RCC notified the PCP when medication doses were missed by a resident.
-When the PCP was notified the MA was supposed to document the notification on the electronic progress notes.
-She was not aware Resident #2 had missed doses of her hydralazine.

Interview with the RCC on 09/28/23 at 9:20am revealed:
-She did cart audits weekly, but she did not audit the eMAR for missed doses of medication.

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D 273	Continued From page 8 -She was not aware Resident #2 had missed 10 doses of her hydralazine from 08/01/23 to 09/26/23. -She did not know why there was nothing documented on Resident #2's eMAR or why the doses of hydralazine were missed. -The MAs should have notified her of Resident #2's missed hydralazine doses when they happened. -When a resident missed a dose of any blood pressure medication the PCP was supposed to be notified. -When the MAs notified the PCP, they were required to document the call in the electronic progress notes. -She did not see where the PCP had been notified when she reviewed Resident #2's electronic progress notes. Interview with the Administrator on 09/28/23 at 10:29am revealed: -Missed doses of medication should have something documented on the eMAR explaining why they were missed. -She was not sure what the protocol was for notifying the PCP about a missed dose or multiple missed doses of a medication. -The RCC was responsible for contacting the PCP when there was a problem with a medication. -Contact with the PCP should have been documented in Resident #2's chart. -If the PCP had been contacted the PCP could have guided the staff on what to do when a medication dose was missed. Attempted telephone interview with Resident #2's Primary Care provider (PCP) on 09/28/23 at 8:42am was unsuccessful.	D 273		

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D 296	Continued From page 9	D 296		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a therapeutic diet menu for 1 of 5 sampled residents (#1) with a diet order for a low concentrated sugar (LCS) diet (#1). The findings are: Observation of the kitchen during the initial tour on 09/26/23 at 10:32am revealed: -The kitchen manager (KM) had to look for the therapeutic diet menu. -The KM located the therapeutic diet menu in a box in the kitchen, it had plastic shrink wrap around it. -The therapeutic diet menu did not have a low concentrated sugar (LCS) diet available for the staff to reference. Review of Resident #1's current FL-2 dated 01/26/23 revealed diagnosis included diabetes mellitus type 2.	D 296		

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D 296	Continued From page 10 Review of Resident #1's diet order dated 09/06/23 revealed there was an order for a LCS diet. Interview with Resident #1 on 09/26/23 at 9:08am revealed: -She was diabetic. -She ate what the other residents ate. -She was served sugar free items if the kitchen had them. Interview with the cook on 09/26/23 at 10:39am revealed: -She did not use the therapeutic diet menu as a guide when preparing meals. -The residents the residents were all served the same thing. -Residents who were ordered an LCS diet were served sugar free items. Interview with the Kitchen Manager (KM) on 09/28/23 at 9:03am revealed: -The kitchen staff had started a new cycle menu on Monday, 09/25/23. -He did not realize the new therapeutic menu did not have the LCS diet on it. -He did not reference the therapeutic menu for an LCS diet because it basically was no sugar added to the food when cooking, half desserts and sugar free snacks. -He used the regular week at a glance menu when preparing meals, including the LCS diet. Interview with the Resident Care Coordinator (RCC) for the special care unit (SCU) on 09/28/23 at 9:20am revealed: -She gave the kitchen staff the list of residents and their diet orders and there were residents who had a physician's order for an LCS diet. -The facility house diets included an LCS diet.	D 296		

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D 296	Continued From page 11 -She was not aware there was not a therapeutic diet menu for an LCS diet available for the kitchen staff to reference. Interview with the Administrator on 09/28/23 at 10:29am revealed: -The kitchen staff were not supposed to begin the new cycle menu including the therapeutic diet menu because she had not had a chance to review it. -She did not know the LCS was not on the new therapeutic diet menu. -She went into the kitchen everyday and observed lunch and dinner every day. -She monitored for temperatures of equipment, cleanliness of the kitchen, what food was served, how it was prepared and how it was presented. -She expected the kitchen staff to follow the therapeutic diet menu. -The kitchen staff or the KM should have informed her they needed a therapeutic diet menu for the LCS diet. Attempted telephone interview with Resident #1's Primary Care provider (PCP) on 09/28/23 at 8:42am was unsuccessful	D 296		
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.	D 358		

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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 2 of 5 sample residents (#1, #2) including a medication for high blood pressure (#1) and an eye drop for irritation and a medication for high blood pressure (#2).

The findings are:

1. Review of Resident #2's current FL2 dated 06/27/23 revealed diagnoses included blindness of both eyes, and a history of carotid stenosis.

a. Review of an after-visit report from Resident #2's ophthalmologist dated 07/28/23 revealed:
-Resident #2 had cataract surgery on her left eye on 07/28/23.
-There was an order for Systane eye drops (used to treat dry eyes) instill one drop into the left eye four times daily for three months post-operative in surgical eye.

Review of Resident #2's July 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Systane eye drops instill 1 drop into left eye three to four times daily post op in surgical eye for three months scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-The Systane eye drops were documented as administered starting on 07/29/23 at 8:00am.
-There was documentation Systane eye drops were administered nine of twelve opportunities from 07/29/23 to 07/31/23.

Review of Resident #2's August 2023 eMAR revealed:
-There was an entry for Systane eye drops instill

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1 drop into left eye three to four times daily post op in surgical eye for three months scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation Systane eye drops were administered four times daily from 08/01/23 to 08/31/23.

Review of Resident #2's September 2023 eMAR dated from 09/01/23 to 09/26/23 revealed:
-There was an entry for Systane eye drops instill 1 drop into left eye three to four times daily post op in surgical eye for three months scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation Systane eye drops were administered four times daily from 09/01/23 to 09/14/23.
-There was documentation Systane eye drops were administered 19 of 45 opportunities from 09/15/23 to 09/26/23.
-There was an administration exception documented as, "physically not able to take-medication not in" 25 times from 09/15/23 to 09/26/23.

Observation of Resident #2's medication on hand on 09/26/23 at 2:04pm revealed there were no Systane eye drops available for administration.

Observation of Resident #2 on 09/28/23 from 8:09am to 8:12am revealed she rubbed her left eye four times with the heal of her left hand.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 09/26/23 at 3:03pm revealed:
-Resident #2 had an order for Systane eye drops instill 1 drop into left eye three to four times daily post-operative for three months; the order was dated 07/28/23.
-One 10mL bottle of Systane eye drops was

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dispensed on 07/29/23; each bottle contained approximately 190 drops or 47 days' worth.
-Systane eye drops were an over the counter (OTC) eye lubricant used to prevent dry eyes.
-Systane eye drops mimicked tears and were ordered post-surgery due to decreased eye function and decreased tear production that eye surgery commonly caused.
-Systane eye drops were not on a cycle fill and needed to be reordered by the facility staff.
-There were not request for a refill for Resident #2's Systane eye drops.
-If Systane eye drops were not administered as ordered post-surgery the resident could experience eye irritations due to dry eyes.

Interview with Resident #2 on 09/28/23 at 8:09am revealed:
-The staff administered eye drops in her left eye one or two times a day.
-She did not recall if she was administered her eye drops in the past fourteen days.
-She rubbed her left eye a lot because it made it feel better.
-She did not know why she rubbed her left eye, "it just made it feel better".

Interview with a medication aide (MA) on 09/26/23 at 2:04pm revealed Resident #2 did not have Systane eye drops available for administration because there was a problem with the insurance coverage or the order from the physician.

Interview with a second MA on 09/28/23 at 9:57am revealed:
-The MAs were responsible for ordering refills on medications.
-If there was an issue with an order or and insurance issue the MAs would reach out to the

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primary care provider (PCP) and see if they could help with the order; sometimes the PCP could help get the medication.
-The Resident Care Coordinator (RCC) would also be notified when a medication was not available or could not be refilled.
-She had requested a refill for the Systane eye drops from the pharmacy a couple of times but never heard back from the pharmacy; she did not recall the dates.
-Resident #2 had not complained eye irritation and she had not noticed her rubbing her eye.

Interview with the RCC on 09/28/23 at 9:20am revealed:
-She did cart audits weekly and asked the MA's if residents' medications were available for administration.
-She and the MAs were responsible for reordering medication before the resident ran out.
-When a medication was not on a cycle fill, she or the MA were responsible for calling the pharmacy and reordering.
-The residents should never run out of a medication.
-Resident #2's Systane eye drops had been delivered by the pharmacy on 09/27/23.
-She thought the delay in refilling Resident #2's Systane eye drops was because it was too early to be refilled.
-She was not aware Resident #2 had not had her Systane eye drops since 09/14/23.
-If there was an issue with a medication being refilled the MAs should have notified the PCP or the ophthalmologist.

Interview with the Administrator on 09/28/23 at 10:29am revealed:
-The RCC was the only staff trained to reorder medication from the pharmacy.

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-The RCC was responsible for contacting the PCP when there was a problem with a medication order or refill request.
-If the PCP had been contacted the PCP could have written a new order for the Systane eye drops before they ran out.
-Resident #2's Systane eye drops should have been reordered before they ran out so there would have been a reserve.

Attempted telephone interview with Resident #2's ophthalmologist on 09/27/23 at 1:24pm was unsuccessful.

b. Review of Resident #2's current FL2 dated 06/27/23 revealed there was an order for hydralazine (used to treat high blood pressure) 25mg three times daily.

Review of Resident #2's August 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for hydralazine 25mg every eight hours scheduled at 6:00am, 2:00pm, and 10:00pm.
-There was documentation hydralazine 25mg was administered 89 of 93 opportunities from 08/01/23 to 08/31/23.
-There was nothing documented on 08/18/23 and 08/30/23, at 10:00pm and there was nothing noted under the exceptions.
-There was documentation Resident #2 refused her hydralazine 25mg on 08/14/23 and 08/16/23 at 10:00pm.

Review of Resident #2's September 2023 eMAR dated from 09/01/23 to 09/26/23 revealed:
-There was an entry for hydralazine 25mg every eight hours scheduled at 6:00am, 2:00pm, and 10:00pm.

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D 358	Continued From page 17 -There was documentation hydralazine 25mg was administered 73 of 79 opportunities from 09/01/23 to 09/26/23. -There was nothing documented on 09/01/23, 09/02/23, 09/04/23, 09/11/23, and 09/21/23 at 10:00pm and there was nothing noted on the exceptions. -There was nothing documented on 09/24/23 at 6:00am and nothing documented under the exceptions. Observation of Resident #2's medication on hand on 09/26/23 at 2:04pm revealed: -On 09/05/23, 84 tablets of hydralazine 25mg were dispensed in three cards. -The medication instruction on the cards was hydralazine 25mg one tablet every eight hours. -The hydralazine medication cards were labeled one of one, one of two and one of three; each card contained 28 tablets. -The hydralazine medication card labeled one of three had 8 of 28 tablets available for administration. -The hydralazine medication card labeled two of three had 9 of 28 tablets available for administration. -The hydralazine medication card labeled three of three had 15 of 28 tablets available for administration. Telephone interview with the pharmacist from the facility's contracted pharmacy on 09/26/23 at 3:03pm revealed: -Resident #2 had a current order for hydralazine 25mg every eight hours. -Resident #2's hydralazine was on cycle fill. -On 08/01/23, a 30-day supply of 90 tablets of hydralazine 25mg was dispensed. -On 09/05/23, a 28-day supply of 84 tablets of hydralazine 25mg were dispensed.	D 358		

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D 358	Continued From page 18 -Resident #2's hydralazine was dispensed into three medication cards; each card contained 28 tablets. -Hydralazine was a short acting blood pressure medication; it lowered blood pressure until the next scheduled dose. -When a resident missed a dose of hydralazine their blood pressure would go up until the next dose. Interview with Resident #2 on 09/28/23 at 8:09am revealed she did not know what here medications were ordered for or if she had high blood pressure. Interview with a medication aide (MA) on 09/28/23 at 9:57am revealed: -The MAs were required to document exceptions on the eMAR, including refusals. -When nothing was documented for a medication it was considered a missed dose and all missed doses were considered a medication error. -The MAs were supposed to notify the Resident Care Coordinator (RCC) and the resident's primary care provider (PCP) when there was a missed dose or medication error. -The eMAR alerted the MAs of missed doses when they were in the system documenting administration of medications. -She was not aware Resident #2 had missed doses of her hydralazine. Interview with the RCC on 09/28/23 at 9:20am revealed: -She did cart audits weekly, but she did not audit the eMAR for missed doses of medication. -She was not aware Resident #2 had missed 10 doses of her hydralazine from 08/01/23 to 09/26/23. -She did not know why there was nothing	D 358		

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documented on Resident #2's eMAR or why the doses of hydralazine were missed.
-The MAs should have notified her of Resident #2's missed hydralazine doses when they happened.
-When a resident missed a dose of any blood pressure medication the PCP was supposed to be notified.
-She expected the MAs to administer the residents' medications as ordered and to notify her when there was a missed dose.

Interview with the Administrator on 09/28/23 at 10:29am revealed:
-Missed doses of medication should have something documented on the eMAR explaining why they were missed.
-She was not sure what the protocol was for notifying the PCP about a missed dose or multiple missed doses of a medication.
-She expected the MAs to follow the eMAR and administer the residents their medication as scheduled.

Attempted telephone interview with Resident #2's Primary Care provider (PCP) on 09/28/23 at 8:42am was unsuccessful.
2. Review of Resident #1's current FL-2 dated 01/26/23 revealed:
-Diagnosis included hypertension.
-There was an order for hydrochlorothiazide 25mg (used to treat high blood pressure) daily.

Review of Resident #1 physician's orders dated 06/13/23 revealed there was an order for hydrochlorothiazide 25mg daily.

Review of Resident #1 discharge summary dated 09/17/23 revealed there was no order for hydrochlorothiazide 25mg daily.

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Review of Resident #1's September 2023 electronic medication administration record (eMAR) from 09/18/23 to 09/26/23 revealed:
-There was an entry for hydrochlorothiazide 25mg daily with a scheduled administration time of 8:00am.
-There was documentation Resident #5 was administered hydrochlorothiazide 25mg daily from 09/18/23 to 09/26/23.

Observation of Resident #1's medications on hand on 09/26/23 at 1:41pm revealed:
-There was a bubble pack that contained 12 hydrochlorothiazide 25mg in the medication cart.
-The medication label read "take one tablet daily" with a dispensed date of 09/05/23.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/27/23 at 10:46am revealed:
-The pharmacy received a discharge summary for Resident #1 on 09/17/23.
-There was no order to continue administration of hydrochlorothiazide 25mg to Resident #1.
-Resident #1 had an order for hydrochlorothiazide 25mg daily before she was admitted to the hospital.
-The pharmacy sent a request to the facility and the Primary Care Provider (PCP) to see if the medication should be continued.
-The pharmacy had not received a response regarding the request they faxed.
-The pharmacy dispensed 30 hydrochlorothiazide on 09/05/23, prior to her hospitalization.

Observation of medication clarification request from the facility's contracted pharmacy dated 09/18/23 revealed:
-The fax was sent on 09/18/23 to request an

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D 358	Continued From page 21 order to continue or to discontinue hydrochlorothiazide 25mg for Resident #1. -There was confirmation the fax was received at the facility. Interview with Resident #1 on 09/27/23 at 8:15am revealed: -She was in the hospital for three days for a kidney infection. -She did not know if she was taking the same medications she was prior to the hospitalization. Interview with the Resident Care Coordinator (RCC) on 09/27/23 at 1:17pm revealed: -Discharge summaries were faxed to the pharmacy when a resident returned from the hospital. -The medication aide or the RCC would fax the discharge summary to the pharmacy. -She did not know hydrochlorothiazide was not on Resident #1's discharge summary. -She thought since it was not discontinued on Resident #1's discharge summary, Resident #7 was to continue taking the medication, since she was taking the medication prior to the hospitalization. -She did not contact the PCP to see if the hydrochlorothiazide was to continue. -She did not receive a fax from the pharmacy to verify if the hydrochlorothiazide 25mg was to be continued. Interview with the Administrator on 09/27/23 at 10:06am revealed: -The RCC was responsible for reviewing the discharge summary and faxing to the pharmacy. -The pharmacy entered the discontinued orders onto the eMAR. -She did not know hydrochlorothiazide was not on the discharge summary.	D 358		

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D 358	Continued From page 22 -She did not know the pharmacy had sent a request to verify whether to continue the hydrochlorothiazide. -She expected the RCC to review the discharge summary and to follow up on orders that were not clear. Attempted telephone interview with Resident #7's Primary Care Provider (PCP) on 09/27/23 at 9:32am and 11:30am.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 2 resident sampled (#6, #7) had a physician's order to self-administer creams for dry skin (#6) and a cream for skin irritation (#7). The findings are:	D 375		

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D 375	Continued From page 23 1. Review of Resident #6 current FL-2 dated 06/27/23 revealed: -Diagnoses included unspecified dementia, UTI delirium with acute cystitis and dry skin. -The Resident #6 was ambulatory, intermittently disoriented and was a wanderer. -Resident #6 resided in the special care unit (SCU). -There was no order for a lotion or cream for dry skin for Resident #6. -There was no order for self-administration of medications. Observation of Resident #6's room during the morning survey tour on 09/26/23 at 8:59am revealed: -There were 2 tubes of body cream lying on his bedside table, 3 oz. of SENSI CARE, a skin protectant with dimethicone and 2 oz. Once a Day moisturizing body cream. -The tubes of the skin creams were one-half full. Observation of Resident #6's room during the morning survey rounds on 09/27/23 at 8:15am revealed: -There were 2 tubes of body cream lying on his bedside table, 3 oz. of SENSI CARE, a skin protectant with dimethicone and 2 oz. Once a Day moisturizing body cream. -The tubes of the skin creams were one-half full. Interview with Resident #6 on 09/26/23 at 9:20am revealed: -The Resident always kept the tubes of cream on his bedside table. - He liked to rub the creams on his arms and hands when his skin felt dry. - He did not call on a personal care assistant (PCA) or medication aide (MA)to assist.	D 375		

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-No staff asked about the creams on his bedside table.
-No staff tried to take the creams and place them on the medication cart.
-A welfare group visits the facility and hands out creams and lotions to the residents.
-He showed his primary care provider (PCP) the creams but was not given a self-administration order or told he could not keep the creams at his bedside.

Interview with a personal care aide (PCA) on 09/27/23 at 8:45am revealed:
-She helped Resident with his baths and getting dressed.
-The medication aides (MA) were responsible for applying any creams or lotion to Resident #6.
-She did not remember seeing any skin creams in Resident #6's room.

Interview with a MA on 09/07/23 at 1:45pm revealed:
-Resident #6 did not have an order for skin creams.
-There were no skin creams in the medication cart for Resident #6.
-She administered Resident #6's medications in his room but she was not aware there were creams kept on his bedside table.
-Resident #6 did not have a self-administration order to keep medications in his room.
-She had not noticed the skin creams in Resident #6's room.

Review of the manufacturing company's on-line product information revealed:
- SENSI CARE, a skin protectant with dimethicone may produce allergic skin reactions of rash, itching, swelling and dizziness and trouble breathing.

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D 375	Continued From page 25 - Once a Day moisturizing body cream may produce skin burning and stinging. Interview with a pharmacist at the facility's contracted pharmacy on 09/28/23 at 9:20am revealed: -There was no physician's order for Resident #6 for self-administration for SENSI CARE or Once a Day moisturizing body creams. -Resident #6 was using medications for his skin that needed a physician's order and stored in the medication cart. - If Resident #6 became sick, Poison Control should be called. Interview with the Resident Care Coordinator (RCC) for the SCU on 09/28/23 at 8:30am revealed: -Yesterday (09/27/23) was the first day she saw the tubes of skin protectant and moisturizer in Resident #6's room and removed them herself. -All residents have a toileting box to keep personal items. -The MAs were responsible for keeping the boxes on shelves in the bathroom. -Resident #6 liked to use lotions and creams and liked to apply them himself. -Resident #6 did not have an order for self-administering medications. -It was not acceptable that the creams were staying on Resident #6's bedside table and no MAs see them. -It was not acceptable staff did not know how long the creams had been in his room. Refer to the interview with Administrator on 09/28/23 at 10:06am. Attempted telephone interview with Resident #6's PCP on 09/27/23 at 9:32am and 11:30am.	D 375		

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D 375	Continued From page 26 2. Review of Resident #7's current FL-2 dated 06/27/23 revealed: -Diagnoses including hypertension, gastric-esophageal reflux disease, constipation, depressive disorder, and hyperlipidemia. -There was no order for the self-administration of medications. Review of Resident #7's signed physician orders dated 07/18/23 revealed: -There was an order for triamcinolone cream (used to treat rash and itching) 0.1% apply to lower legs twice daily as needed for rash and itching. -There was no order for self-administration of medications. Observation of the top of Resident #7's dresser revealed: -There were three plastic medicine cups, each containing a white cream, sitting on top of the dresser. -The medications cups were filled to ½ full of the white cream. Interview with Resident #7 on 09/26/23 at 9:01am revealed: -He used the cream on his lower legs every day. -He used the cream to help with the itching on his lower legs. -The medication aides (MA) would give him the cream when he asked for it. -The MA would place the cream in the medication cup for him to take back to his room. -The cream was kept in a big, round jar on the medication cart. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/27/23 at	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 375	Continued From page 27 10:38am revealed: -Resident #7 had an order for triamcinolone cream twice daily as needed for dry, itching skin. -Triamcinolone cream was a low potency steroid used for rash and itching. -The pharmacy did not have a self-administration order for Resident #7. Interview with a personal care aide (PCA) on 09/28/23 at 9:43am revealed: -She assisted with care for Resident #7. -She had not seen any medications in Resident #7's room. -She would have told the MA if she saw medications in Resident #7's room. Interview with a MA on 09/28/23 at 9:22am revealed: -She did not give Resident #7 any cream in a medication cup to place on his legs. -Resident #7 had an "as needed" order for triamcinolone for his lower legs. -She would apply the topical cream when Resident #7 requested the medication. -She had not seen the cream in the medication cups in his room. -She did not know the medication was in his room. -She would have removed the medication from Resident #7's room if she had seen it. Interview with the Resident Care Coordinator (RCC) on 09/28/23 at 9:56am revealed: -Residents who administered their own medications require an order from the Primary Care Physician (PCP) for the resident to self-administer. -Resident #7 did not have a self-administration order. -She did not know Resident #7 had a topical	D 375		

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D 375	Continued From page 28	D 375		

cream in his room.
-Resident #7 would need to be assessed by the PCP to ensure Resident #7 could safely self-administer a topical cream.
-The MAs were not to give residents' medications and allow the residents to take the medications back to their rooms.
-She expected the MAs to observe the residents taking their medications.

Refer to the interview with Administrator on 09/28/23 at 10:06am.

Attempted telephone interview with Resident #7's PCP on 09/27/23 at 9:32am and 11:30am was unsuccessful.

_____

Interview with the Administrator on 09/28/23 at 10:06am revealed:
-Residents may self-administer medications after being assessed by the PCP.
-Medications should not be left in resident rooms unless they had an order for self-administration and had been assessed by the PCP.
-She expected the MAs to administer all medications to the residents if there was no self-administration order.