

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL007019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/28/2023
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NAME OF PROVIDER OR SUPPLIER WASHINGTON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 609 WEST 2ND STREET WASHINGTON, NC 27889
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D 000	Initial Comments The Adult Care Licensure Section and the Beaufort County Department of Social Services conducted an annual and follow-up survey on November 28, 2023.	D 000		
D 113	<p>10A NCAC 13F .0311(d) Other Requirements</p> <p>10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 4 of 4 fixtures sampled.</p> <p>The findings are:</p> <p>Review of the facility's current license effective 01/01/23 revealed the facility was licensed with a capacity of 9 beds.</p> <p>Review of the facility's census reports provided on 11/28/23 revealed the facility's in-house census was 9 residents.</p> <p>Review of the North Carolina Division of Health Service Regulation Construction Section Hot</p>	D 113		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 113	<p>Continued From page 1</p> <p>Water Safety Guide revealed: -A water temperature of 127.4 degrees F could result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. -A water temperature of 131 degrees F could result in a first degree burn in 17 seconds and a second degree burn in 30 seconds.</p> <p>Observation of the bathroom on the left hall of the facility on 11/28/23 at 8:25am revealed: -The hot water temperature at the bathroom sink was 132 degrees F with visible steam. -The hot water temperature in the shower was 130 degrees F. -There were no caution signs posted for the hot water temperatures.</p> <p>Observation of the bathroom on the right hall of the facility on 11/28/23 at 8:29am revealed: -The hot water temperature at the bathroom sink was 129 degrees F. -The hot water temperature in the tub was 130 degrees F with visible steam. -There were no caution signs posted for the hot water temperatures.</p> <p>Review of Resident #3's current FL-2 dated 07/20/23 revealed: -Diagnosis included neuropathy (nerve damage that causes weakness, numbness, and pain). -The resident was intermittently disoriented.</p> <p>Interview Resident #3 on 11/28/23 at 8:38am revealed the water in the bathrooms always started off hot and he had to mix it with cold water so he could make the water temperature comfortable for him.</p> <p>Second interview with Resident #3 on 11/28/23 at 3:30pm revealed:</p>	D 113		

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D 113	<p>Continued From page 2</p> <p>-He took medication to help with his nervous system and pain from that.</p> <p>-His left leg caused the most issues with pain and numbness.</p> <p>Interview with a second resident on 11/28/23 at 8:45am revealed the water in the bathrooms was hot and he had to mix it with cold water.</p> <p>Interview with a third resident on 11/28/23 at 8:48 am revealed the water at the facility got "very very hot" so he added cold water to it to cool it down.</p> <p>Interview with a fourth resident on 11/28/23 at 9:04am revealed: -The water temperature in the bathroom at the facility was hot but he added cold water to it to balance it out. -The water temperature in the bathroom was very hot.</p> <p>Interview with a fifth resident on 11/28/23 at 9:22am revealed: -He had lived at the facility for several months. -The water in the bathrooms at the facility had always been too hot but he added cold water to it.</p> <p>Interview with the supervisor on 11/28/23 at 8:32am revealed: -He checked water temperatures at the facility once a week and recorded them in a book. -The water temperatures at the facility usually ranged from 112 degrees F to 115 degrees F. -He had not checked water temperatures at the facility this week. -He would turn down the temperatures on the hot water heaters.</p> <p>Review of the facility's October 2023 water temperature check log revealed:</p>	D 113		

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D 113	<p>Continued From page 3</p> <p>-The water temperature in the sink in the bathroom to the left of the facility was 116 degrees F and the water temperature in the sink in the bathroom to the right of the facility was 115 degrees F on 10/06/23.</p> <p>-The water temperature in the sink in the bathroom to the left of the facility was 114 degrees F and the water temperature in the sink in the bathroom to the right of the facility was 115 degrees F on 10/15/23.</p> <p>-The water temperature in the sink in the bathroom to the left of the facility was 114 degrees F and the water temperature in the sink in the bathroom to the right of the facility was 115 degrees F on 10/24/23.</p> <p>-The water temperature in the sink in the bathroom to the left of the facility was 115 degrees F and the water temperature in the sink in the bathroom to the right of the facility was 116 degrees F on 10/30/23.</p> <p>Review of the facility's November 2023 water temperature check log revealed:</p> <p>-The water temperature in the sink in the bathroom to the left of the facility was 116 degrees F and the water temperature in the sink in the bathroom to the right of the facility was 115 degrees F on 11/04/23.</p> <p>-The water temperature in the sink in the bathroom to the left of the facility was 116 degrees F and the water temperature in the sink in the bathroom to the right of the facility was 112 degrees F on 11/12/23.</p> <p>-The water temperature in the sink in the bathroom to the left of the facility was 115 degrees F and the water temperature in the sink in the bathroom to the right of the facility was 116 degrees F on 11/20/23.</p> <p>Second observation of the bathroom on the right</p>	D 113		

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D 113	<p>Continued From page 4</p> <p>side of the facility on 11/28/23 at 9:17am revealed: -The water temperature in the sink was 130 degrees F with the facility's thermometer. -The thermometer used by the facility to measure water temperatures was a meat thermometer. -The water temperature in the sink was 132 degrees F with the surveyor's thermometer. -There was a sign posted on the door which read "water too hot, do not use".</p> <p>Second observation of the bathroom on the left side of the facility on 11/28/23 at 9:19am revealed: -The water temperature in the sink was 122 degrees F with the facility's thermometer. -The water temperature in the sink was 127 degrees F with the surveyor thermometer. -There was a sign posted on the door which read "water too hot, do not use".</p> <p>Third observation of the bathroom on the right side of the facility on 11/28/23 at 11:31am revealed: -The water temperature in the sink was 75 degrees F. -The water temperature in the tub was 77 degrees F.</p> <p>Third observation of the bathroom on the left side of the facility on 11/28/23 at 11:31am revealed: -The water temperature in the sink was 109 degrees F. -The water temperature in the shower was 108 degrees F.</p> <p>Second interview with the supervisor on 11/28/23 at 11:41am revealed: -There were 2 separate hot water heaters at the facility, one for each bathroom.</p>	D 113		

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D 113	<p>Continued From page 5</p> <p>-He would turn up the temperature on the hot water heater that provided water to the bathroom on the right side of the facility.</p> <p>Third interview with the supervisor on 11/28/23 at 3:48pm revealed:</p> <p>-He had never calibrated the thermometer used by the facility to record water temperature.</p> <p>-He thought the thermometer used by the facility to record water temperatures was a water thermometer.</p> <p>-He did not know how to calibrate the thermometer used by the facility to record water temperatures.</p> <p>Interview with the facility's Administrator on 11/28/23 at 3:39pm revealed:</p> <p>-The supervisor checked water temperatures at the facility once a month.</p> <p>-Resident #2's neuropathy was in his legs and she was not concerned he would get burned by the water temperatures because water did not get on legs first when someone bathed.</p> <p>Telephone interview with the facility's primary care provider (PCP) on 11/28/23 at 3:10 pm revealed:</p> <p>-She expected the facility to accurately check water temperatures and adjust the water temperature if it was too hot.</p> <p>-A water temperature of 132 degrees F put residents at risk of being burned.</p> <p>-Resident #3 had neuropathy which made it harder to feel how hot the water was, and he may not be able to protect himself from being burned by the water.</p> <p>-Because Resident #3 had neuropathy it may take him longer to realize the water was too hot which put him at an increased risk for being burned by the water.</p>	D 113		

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D 113	<p>Continued From page 6</p> <p>The facility failed to ensure hot water temperatures for 4 of 4 fixtures (sink and shower) sampled in the facility were maintained between 100 - 116 degrees Fahrenheit (F). The water temperatures for the 4 fixtures ranged from 129 degrees F to 132 degrees F. This placed all residents at risk of being burned and placed a resident with neuropathy (#3) at an increased risk of being burned by the water at the facility because his neuropathy may cause him to take longer to realize the water was too hot. A water temperature of 127.4 degrees could result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. A water temperature of 131 degrees F could result in a first degree burn in 17 seconds and a second degree burn in 30 seconds. This failure of the facility was detrimental to the safety, health, and welfare of the residents and constitutes a Type B Violation.</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/28/23 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 12, 2024.</p>	D 113		
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of</p>	D 273		

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D 273	<p>Continued From page 7</p> <p>1 of 3 sampled residents (#3) related to failing to ensure scheduling of a cardiology appointment.</p> <p>The findings are:</p> <p>Review of Resident #3's current FL-2 dated 07/20/23 revealed diagnoses included coronary artery disease (CAD) and diastolic heart failure.</p> <p>Review of Resident #3's Resident Register revealed he was admitted to the facility on 04/29/19.</p> <p>Review of Resident #3's after visit summary dated 01/31/23 revealed: -There was an order to call cardiology to schedule an appointment. -There was a name and phone number of the cardiologist.</p> <p>Review of Resident #3's after visit summary dated 07/20/23 revealed: -There was an order to call cardiology to schedule an appointment. -There was a name and phone number of the cardiologist.</p> <p>Review of Resident #3's after visit summary dated 11/20/23 revealed: -There was an order to call cardiology to schedule an appointment. -There was a name and phone number of the cardiologist.</p> <p>Review of Resident #3's record on 11/28/23 revealed there were no notes from a cardiology visit.</p> <p>Interview with Resident #3 on 11/28/23 at 10:31am revealed he had seen a cardiologist in</p>	D 273		

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D 273	<p>Continued From page 8</p> <p>the past, but it had been a "pretty long time" since he had seen him.</p> <p>Second interview with Resident #3 on 11/28/23 at 3:33pm revealed he had not been having any chest pain or difficulty breathing.</p> <p>Interview with a receptionist at Resident #3's cardiologist's office on 11/28/23 at 10:31am revealed: -Resident #3 had not been seen by the cardiologist since 02/18/20. -Resident #3's last appointment at the cardiologist was on 01/18/22 but the resident was a no show.</p> <p>Interview with the supervisor on 11/28/23 at 10:38am revealed: -Sometimes he made medical appointments for residents and sometimes the resident's primary care provider (PCP) made the appointment. -He must not have looked at Resident #3's physician paperwork well enough because he did not notice the orders to schedule a cardiology appointment for him.</p> <p>Interview with the Administrator on 11/28/23 at 3:39pm revealed: -Normally resident's PCPs made appointments for them and would call the facility with the appointment day and time. -Since Resident #3's orders stated to make an appointment with his cardiologist should have been done by the facility. -She did not know why Resident #3's cardiology appointment did not get scheduled by the facility.</p> <p>Telephone interview with Resident #3's PCP on 11/28/23 at 3:10pm revealed: -Resident #3 had CAD and had not been seen by</p>	D 273		

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D 273	Continued From page 9 a cardiologist "for a while". -Resident #3 was not having any acute symptoms or problems with his heart at this time. -She expected the facility to scheduled Resident #3's cardiology appointment as ordered so he could have an evaluation to see if he needed any heart studies performed. Attempted telephone interview with Resident #3's cardiologist on 11/28/23 at 3:00pm was unsuccessful.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#2, #3) for record review including errors with a medication used to treat high blood pressure (#2) and medications used to treat urinary retention, nerve pain, gout, and high cholesterol (#3). The findings are:	D 358		

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D 358	<p>Continued From page 10</p> <p>1. Review of Resident #2's current FL-2 dated 08/01/2023 revealed: -Diagnosis included hypertension. -There was an order for Lisinopril 20mg take 1 tablet one time a day (Lisinopril is used to lower blood pressure).</p> <p>Review of Resident #2's November 2023 electronic medication administration records (eMAR) revealed: -There was an entry for Lisinopril 20mg take 1 tablet by mouth once daily for blood pressure scheduled for 7:00am. -Lisinopril was documented as administered at 7:00am on 11/01/23 to 11/28/23 except on 11/24/23 to 11/26/23 where it was not documented as administered with no explanation given. -There was an entry to check blood pressure (BP) daily scheduled for 7:00am. -BP was documented on 11/20/23 as 132/80. -BP was not documented on 11/21/23. -BP was documented on 11/22/23 as 132/72. -BP was documented on 11/23/23 as 164/91. -BP was documented on 11/24/23 as 165/86. -BP was documented on 11/25/23 as 166/93. -BP was documented on 11/26/23 as 147/92. -BP was documented on 11/27/23 as 136/78. -BP was documented on 11/28/23 as 134/80.</p> <p>Observation of Resident #2's medications on hand on 11/28/23 at 1:30pm revealed there was an empty pill pack of Lisinopril dispensed by the facility's contracted pharmacy to begin on 11/01/23.</p> <p>Observation of the November 2023 medication delivery log revealed 31 tablets of Lisinopril 20mg was delivered to the facility for Resident #2.</p>	D 358		

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D 358	<p>Continued From page 11</p> <p>Interview with Resident #2 on 11/28/23 at 10:30am revealed: -He had been out of his blood pressure medication since 11/22/23. -He had taken his last dose the morning of 11/22/23 and was informed the next morning he was out. -He had high blood pressure and felt "different" since he had not been taking Lisinopril. -He knew his blood pressure was elevated because his blood pressure was checked every morning and he saw his blood pressure was higher than normal when checked today.</p> <p>Interview with the supervisor on 11/28/23 at 10:45am revealed: -He thought he had given Resident #2 all his medications this morning. -The pharmacy should have delivered Resident #2's Lisinopril on 11/27/23 but the pharmacy was delayed. -He had called the pharmacy and was told Resident #2's Lisinopril would be delivered 11/28/23.</p> <p>Second interview with the supervisor on 11/28/23 at 1:35pm revealed: -Resident #2 had been out of Lisinopril and due to the holiday, the medication was late being ordered. -Sometimes pills "pop out" of the medication card and he would discard them which caused the medications to run out. -He did not keep a record of the discarded pills. -Resident #2 had been out of Lisinopril since 11/23/23 and the next batch of medications were delayed.</p> <p>Telephone Interview with a pharmacist technician at the facility's contracted pharmacy on 11/28/23</p>	D 358		

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D 358	<p>Continued From page 12</p> <p>at 11:45am revealed: -The pharmacy dispensed medication packs at the end of each month to begin the 1st of each month. -The last batch of medications was dispensed and delivered to the facility on 10/23/23. -The next batch of medication was dispensed on 11/21/23 and would be delivered on 11/28/23.</p> <p>2. Review of Resident #3's current FL-2 dated 07/20/23 revealed: -Diagnoses included coronary artery disease, neuropathy (nerve damage which causes weakness, pain, and numbness), and gout. -He was intermittently disoriented.</p> <p>a. Review of Resident #3's current FL-2 dated 07/20/23 revealed there was an order for Flomax (used to treat urinary retention) 0.4mg twice a day.</p> <p>Review of Resident #3's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Flomax 0.4mg 2 times a day scheduled for administration at 7:00am and 7:00pm. -Flomax 0.4mg was documented as administered at 7:00am and 7:00pm on 09/01/23 to 09/30/23.</p> <p>Review of Resident #3's October 2023 eMAR revealed: -There was an entry for Flomax 0.4mg 2 times a day scheduled for administration at 7:00am and 7:00pm. -Flomax 0.4mg was documented as administered at 7:00am and 7:00pm on 10/01/23 to 10/31/23.</p> <p>Review of Resident #3's November 2023 eMAR revealed:</p>	D 358		

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D 358	<p>Continued From page 13</p> <p>-There was an entry for Flomax 0.4mg 2 times a day scheduled for administration at 7:00am and 7:00pm.</p> <p>-Flomax 0.4mg was documented as administered at 7:00am on 11/01/23 to 11/28/23.</p> <p>-Flomax 0.4mg was documented as administered at 7:00pm on 11/01/23 to 11/27/23 except on 11/11/23 and 11/26/23 where it was documented as "needs appointment".</p> <p>Observation of Resident #3's medications on hand on 11/28/23 at 1:12pm revealed there was no Flomax.</p> <p>Interview with Resident #3 on 11/28/23 at 3:33pm revealed:</p> <p>-He did not know he was out of his Flomax.</p> <p>-He thought he had taken his Flomax this morning.</p> <p>Interview with the supervisor on 11/28/23 at 11:29am revealed:</p> <p>-He put an order in for Resident #3's Flomax with the facility's contracted pharmacy on either 11/24/23 or 11/25/23.</p> <p>-The batch medications for the facility were delivered last night but Resident #3's Flomax was not delivered.</p> <p>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/28/23 11:45am revealed:</p> <p>-Flomax was last dispensed for Resident #3 on 04/25/22.</p> <p>-The facility's contracted pharmacy had contacted his urologist for a refill on the medication on 04/25/22 and the refill was denied by the provider.</p> <p>Telephone interview with a second pharmacy technician at the facility's contracted pharmacy on</p>	D 358		

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D 358	<p>Continued From page 14</p> <p>11/28/23 at 1:21pm revealed: -There was a request sent to Resident #3's urologist in April 2022 to request refills for his Flomax. -The refill request was denied because the urologist said the resident needed to be seen at the office to get more refills. -Even though Flomax was listed on Resident #3's current FL-2 the facility's contracted pharmacy could not fill the medication without a current prescription. -Flomax was still listed on Resident #3's eMAR because the facility's contracted pharmacy never received a discontinue order for the medication.</p> <p>Second interview with the facility's supervisor on 11/28/23 at 1:17pm revealed: -He knew he was administering Flomax to Resident #3 twice a day. -He administered Flomax to Resident #3 last night, but he did not administer it to him this morning because it did not come in from the facility's contracted pharmacy last night. -He could not explain how he had been administering Flomax to Resident #3 if the pharmacy had not been filling the medication. -He thought Resident #3 had an overstock of Flomax and that was how he was able to administer the medication to the resident. -He did not know how he would have enough overstock of Flomax for Resident #3 to continue administering it to him since April of 2022.</p> <p>Third interview with the supervisor on 11/28/23 at 1:49pm revealed: -He was not sure why he documented on Resident #3's eMAR on 11/11/23 and 11/26/23 that Flomax was not administered because the resident needed an appointment. -He did not follow up like he should to make sure</p>	D 358		

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D 358	<p>Continued From page 15</p> <p>Resident #3's Flomax got refilled.</p> <p>Interview with the Administrator on 11/28/23 at 3:39pm revealed she was not sure how she could explain how Resident #3 had been receiving his Flomax twice a day if it had not been filled by the facility's contracted pharmacy since April 2022.</p> <p>Telephone interview with Resident #3's PCP on 11/28/23 at 3:10pm revealed:</p> <ul style="list-style-type: none"> -Resident #3 was prescribed Flomax because he had an enlarged prostate which caused him to have issues with urinary retention. -She looked at resident's eMARs at their appointments. -She was not aware Resident #3 had not been receiving Flomax because his eMAR indicated that he was receiving it. -Resident #3 not receiving Flomax as ordered could cause the resident to retain urine which could cause him to develop a urinary tract infection (UTI). <p>b. Review of Resident #3's current FL-2 dated 07/20/23 revealed there was an order for Neurontin (used to treat nerve pain) 400mg 3 times a day.</p> <p>Review of Resident #3's November 2023 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for Neurontin 400mg 3 times a day scheduled for administration at 7:00am, 12:00pm, and 4:45pm. -Neurontin 400mg was documented as administered at 7:00am, 12:00pm, and 4:45pm on 11/01/23 to 11/28/23 except on 11/24/23 and 11/25/23 where it was documented as "waiting on med" and at 7:00am on 11/26/23 where it was documented as "waiting on meds". 	D 358		

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D 358	<p>Continued From page 16</p> <p>Observation of Resident #3's medications on hand on 11/28/23 at 1:12pm revealed there was an empty medication pack for Neurontin 400mg which had a start date of 11/01/23.</p> <p>Interview with the supervisor on 11/28/23 at 1:17pm revealed: -Resident #3 was administered his last dose of Neurontin this morning. -The facility received batch medications from the facility's contracted pharmacy once a month. -The batch medications were supposed to be delivered to the facility on the night of 11/27/23 but they were not delivered.</p> <p>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/28/23 at 11:45am revealed 31 tablets of Neurontin 400mg were dispensed for Resident #3 on 10/17/23.</p> <p>Telephone interview with a second pharmacy technician at the facility's contracted pharmacy on 11/28/23 at 1:21pm revealed: -The facility's contracted pharmacy last dispensed 31 tablets of Neurontin 400mg for Resident #3 on 11/21/23. -The facility's contacted pharmacy would deliver Resident #3's Neurontin to the facility on the night of 11/28/23. -Resident #3's Neurontin was last delivered to the facility on 10/23/23. -The facility was supposed to start administering medications out of the new medication packs on the 1st of the month so Resident #3 should not be out of his Neurontin.</p> <p>Review of the facility's October 2023 medication delivery log revealed:</p>	D 358		

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D 358	<p>Continued From page 17</p> <ul style="list-style-type: none"> -The log was not dated. -Thirty-one tablets of Neurontin 400mg was delivered to the facility for Resident #3. <p>Second interview with the supervisor on 11/28/23 at 1:49pm revealed:</p> <ul style="list-style-type: none"> -He may have started a few of the resident's medication packs before 11/01/23. -Sometimes some of the pills accidentally popped out of resident's medication packs and he had to discard them. -He did not document anywhere when he discarded resident medication. -He did not know why he documented that he was waiting on Resident #3's Neurontin on 11/24/23, 11/25/23, and 11/26/23. <p>Interview with the Administrator on 11/28/23 at 3:39pm revealed:</p> <ul style="list-style-type: none"> -Resident medications were delivered to the facility once a month unless a resident had a new medication and if so that medication would come in the night after the new medication was ordered. -She could not explain how Resident #3 received his Neurontin this morning if he was waiting on the medication to be delivered on 11/24/23, 11/25/23, and 11/26/23. <p>Telephone interview with Resident #3's primary care provider (PCP) on 11/28/23 at 3:10pm revealed:</p> <ul style="list-style-type: none"> -Resident #3 was prescribed Neurontin to treat neuropathy in his foot and leg. -Resident #3 missing several days of Neurontin could cause him to have increased pain in his foot and leg. <p>c. Review of Resident #3's current FL-2 dated 07/20/23 revealed there was an order for</p>	D 358		

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D 358	<p>Continued From page 18</p> <p>allopurinol (used to treat gout which is caused by increase uric acid in the blood) 100mg every day.</p> <p>Review of Resident #3's November 2023 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for allopurinol 100mg every day scheduled for administration at 7:00am. -Allopurinol was documented as administered at 7:00am on 11/01/23 to 11/28/23 except on 11/26/23 where it was documented as "waiting on meds". <p>Observation of Resident #3's medications on hand on 11/28/23 at 1:12pm revealed there was an empty medication pack of allopurinol 100mg which had a start date of 11/01/23.</p> <p>Interview with the supervisor on 11/28/23 at 1:17pm revealed:</p> <ul style="list-style-type: none"> -Resident #3 was administered his last dose of Neurontin this morning. -The facility received batch medications from the facility's contracted pharmacy once a month. -The batch medications were supposed to be delivered to the facility on the night of 11/27/23 but they were not delivered. <p>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/28/23 at 11:45am revealed 31 tablets of allopurinol 100mg were dispensed for Resident #3 on 10/17/23.</p> <p>Telephone interview with a second pharmacy technician at the facility's contracted pharmacy on 11/28/23 at 1:21pm revealed:</p> <ul style="list-style-type: none"> -The facility's contracted pharmacy last dispensed 31 tablets of allopurinol 100mg for Resident #3 on 11/21/23. 	D 358		

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D 358	<p>Continued From page 19</p> <p>-The facility's contacted pharmacy would deliver Resident #3's allopurinol to the facility on the night of 11/28/23.</p> <p>-Resident #3's allopurinol was last delivered to the facility on 10/23/23.</p> <p>-The facility was supposed to start administering medications out of the new medication packs on the 1st of the month so Resident #3 should not be out of his allopurinol.</p> <p>Review of the facility's October 2023 medication delivery log revealed:</p> <p>-The log was not dated.</p> <p>-Thirty-one tablets of allopurinol were delivered to the facility for Resident #3.</p> <p>Second interview with the supervisor on 11/28/23 at 1:49pm revealed:</p> <p>-He may have started a few of the resident's medication packs before 11/01/23.</p> <p>-Sometimes some of the pills accidentally popped out of resident's medication packs and he had to discard them.</p> <p>-He did not document anywhere when he discarded resident medication.</p> <p>-He did not know why he documented that he was waiting on Resident #3's allopurinol on 11/26/23.</p> <p>Interview with the Administrator on 11/28/23 at 3:39pm revealed:</p> <p>-Resident medications were delivered to the facility once a month unless a resident had a new medication and if so that medication would come in the night after the new medication was ordered.</p> <p>-She could not explain how Resident #3 received his allopurinol this morning if he was waiting on the medication to be delivered on 11/26/23.</p> <p>Telephone interview with Resident #3's primary</p>	D 358		

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D 358	<p>Continued From page 20</p> <p>care provider (PCP) on 11/28/23 at 3:10pm revealed:</p> <ul style="list-style-type: none"> -Resident #3 was prescribed allopurinol to treat hyperuricemia (increased uric acid in the blood). -Resident #3 not having his allopurinol could cause him to have increased pain in his foot caused by gout. <p>d. Review of Resident #3's current FL-2 dated 07/20/23 revealed there was an order for Pravachol (used to treat high cholesterol) 40mg at bedtime.</p> <p>Review of Resident #3's November 2023 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for Pravachol 40mg at bedtime scheduled for administration at 7:00pm. -Pravachol 40mg was documented as administered at 7:00pm on 11/01/23 to 11/27/23 except on 11/23/23/ to 11/26/23 where it was documented as "waiting on meds". <p>Observation of Resident #3's medications on hand on 11/28/23 at 1:12pm revealed there was an empty medication pack of Pravachol 40mg which had a start date of 11/01/23.</p> <p>Interview with the supervisor on 11/28/23 at 1:17pm revealed:</p> <ul style="list-style-type: none"> -Resident #3 was administered his last dose of Pravachol last night. -The facility received batch medications from the facility's contracted pharmacy once a month. -The batch medications were supposed to be delivered to the facility on the night of 11/27/23 but they were not delivered. <p>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/28/23</p>	D 358		

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D 358	<p>Continued From page 21</p> <p>at 11:45am revealed 31 tablets of Pravachol 40mg were dispensed for Resident #3 on 10/17/23.</p> <p>Telephone interview with a second pharmacy technician at the facility's contracted pharmacy on 11/28/23 at 1:21pm revealed:</p> <ul style="list-style-type: none"> -The facility's contracted pharmacy last dispensed 31 tablets of Pravachol 40mg for Resident #3 on 11/21/23. -The facility's contacted pharmacy would deliver Resident #3's Pravachol to the facility on the night of 11/28/23. -Resident #3's Pravachol was last delivered to the facility on 10/23/23. -The facility was supposed to start administering medications out of the new medication packs on the 1st of the month so Resident #3 should not be out of his Pravachol. <p>Review of the facility's October 2023 medication delivery log revealed:</p> <ul style="list-style-type: none"> -The log was not dated. -Thirty-one tablets of Pravachol were delivered to the facility for Resident #3. <p>Second interview with the supervisor on 11/28/23 at 1:49pm revealed:</p> <ul style="list-style-type: none"> -He may have started a few of the resident's medication packs before 11/01/23. -Sometimes some of the pills accidentally popped out of resident's medication packs and he had to discard them. -He did not know why he documented that he was waiting on Resident #3's Pravachol on 11/23/23 to 11/26/23. <p>Interview with the Administrator on 11/28/23 at 3:39pm revealed:</p> <ul style="list-style-type: none"> -Resident medications were delivered to the 	D 358		

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D 358	<p>Continued From page 22</p> <p>facility once a month unless a resident had a new medication and if so that medication would come in the night after the new medication was ordered.</p> <p>-She could not explain how Resident #3 received his Pravachol last night if he was waiting on the medication to be delivered on 11/23/23 to 11/26/23.</p> <p>_____</p> <p>The facility failed to administer a blood pressure medication to a resident (#2) for 6 days who had an increase in blood pressure during that time and reported feeling different due to the increase in blood pressure. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/28/23 for this violation.</p> <p>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 12, 2024.</p>	D 358		
D 367	<p>10A NCAC 13F .1004(j) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:</p> <p>(1) resident's name;</p> <p>(2) name of the medication or treatment order;</p> <p>(3) strength and dosage or quantity of medication administered;</p> <p>(4) instructions for administering the medication or treatment;</p> <p>(5) reason or justification for the administration of</p>	D 367		

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D 367	<p>Continued From page 23</p> <p>medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were accurate for 2 of 3 sampled residents (#2, #3) including inaccurate documentation for medications used to treat urinary retention, nerve pain, gout, and high cholesterol (#3) and medications used to treat high blood pressure and dementia (#2).</p> <p>The findings are:</p> <p>1. Review of Resident #3's current FL-2 dated 07/20/23 revealed diagnoses included coronary artery disease, neuropathy (nerve damage which causes weakness, pain, and numbness), and gout.</p> <p>a. Review of Resident #3's current FL-2 dated 07/20/23 revealed there was an order for Flomax (used to treat urinary retention) 0.4mg twice a day.</p> <p>Review of Resident #3's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Flomax 0.4mg 2 times a day scheduled for administration at 7:00am and</p>	D 367		

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D 367	<p>Continued From page 24</p> <p>7:00pm. -There was a notation on the eMAR which read "MD denied refill- pt appointment". -Flomax 0.4mg was documented as administered at 7:00am and 7:00pm on 09/01/23 to 09/30/23.</p> <p>Review of Resident #3's October 2023 eMAR revealed: -There was an entry for Flomax 0.4mg 2 times a day scheduled for administration at 7:00am and 7:00pm. -There was a notation on the eMAR which read "MD denied refill- pt appointment". -Flomax 0.4mg was documented as administered at 7:00am and 7:00pm on 10/01/23 to 10/31/23.</p> <p>Review of Resident #3's November 2023 eMAR revealed: -There was an entry for Flomax 0.4mg 2 times a day scheduled for administration at 7:00am and 7:00pm. -There was a notation on the eMAR which read "MD denied refill- pt appointment". -Flomax 0.4mg was documented as administered at 7:00am on 11/01/23 to 11/28/23. -Flomax 0.4mg was documented as administered at 7:00pm on 11/01/23 to 11/27/23 except on 11/11/23 and 11/26/23 where it was documented as "needs appointment".</p> <p>Observation of Resident #3's medications on hand on 11/28/23 at 1:12pm revealed there was no Flomax on the medication cart for the resident.</p> <p>Interview with the supervisor on 11/28/23 at 11:29am revealed: -He put an order in for Resident #3's Flomax with the facility's contracted pharmacy on either 11/24/23 or 11/25/23. -The batch medications for the facility were</p>	D 367		

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D 367	<p>Continued From page 25</p> <p>delivered last night but Resident #3's Flomax was not delivered.</p> <p>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/28/23 11:45am revealed: -Flomax was last dispensed for Resident #3 on 04/25/22. -The facility's contracted pharmacy had contacted his urologist for a refill on the medication on 04/25/22 and the refill was denied by the provider.</p> <p>Telephone interview with a second pharmacy technician at the facility's contracted pharmacy on 11/28/23 at 1:21pm revealed: -There was a request sent to Resident #3's urologist in April 2022 to request refills for his Flomax. -The refill request was denied because the urologist said the resident needed to be seen at the office to get more refills. -There was no backup pharmacy listed for Resident #3. -Even though Flomax was listed on Resident #3's current FL-2 the facility's contracted pharmacy could not fill the medication without a current prescription. -Flomax was still listed on Resident #3's eMAR because the facility's contracted pharmacy never received a discontinue order for the medication.</p> <p>Second interview with the facility's supervisor on 11/28/23 at 1:17pm revealed: -The facility did not have a backup pharmacy and only received medications from their contracted pharmacy. -He administered Flomax to Resident #3 last night, but he did not administer it to him this morning because it did not come in from the facility's contracted pharmacy last night.</p>	D 367		

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D 367	<p>Continued From page 26</p> <p>-He could not explain how he had been administering Flomax to Resident #3 if the pharmacy had not been filling the medication. -He thought Resident #3 had an overstock of Flomax and that was how he was able to administer the medication to the resident. -He did not know how he would have enough overstock of Flomax for Resident #3 to continue administering it to him since April of 2022.</p> <p>Third interview with the supervisor on 11/28/23 at 1:49pm revealed: -He was not sure why he documented on Resident #3's eMAR on 11/11/23 and 11/26/23 that Flomax was not administered because the resident needed an appointment. -Sometimes he sent refill requests to Resident #3's primary care provider (PCP). -He did not follow up like he should to make sure Resident #3's Flomax got refilled.</p> <p>Interview with the Administrator on 11/28/23 at 3:39pm revealed: -The facility only received medications from their contracted pharmacy. -She was not sure how she could explain how Resident #3 had been receiving his Flomax twice a day if it had not been filled by the facility's contracted pharmacy since April 2022.</p> <p>Refer to telephone interview with the facility's primary care provider (PCP) on 11/28/23 at 3:10pm.</p> <p>b. Review of Resident #3's current FL-2 dated 07/20/23 revealed there was an order for Neurontin (used to treat nerve pain) 400mg 3 times a day.</p> <p>Review of Resident #3's November 2023</p>	D 367		

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D 367	<p>Continued From page 27</p> <p>electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for Neurontin 400mg 3 times a day scheduled for administration at 7:00am, 12:00pm, and 4:45pm. -Neurontin 400mg was documented as administered at 7:00am, 12:00pm, and 4:45pm on 11/01/23 to 11/28/23 except on 11/24/23 and 11/25/23 where it was documented as "waiting on med" and at 7:00am on 11/26/23 where it was documented as "waiting on meds". <p>Observation of Resident #3's medications on hand on 11/28/23 at 1:12pm revealed there was an empty medication pack for Neurontin 400mg which had a start date of 11/01/23.</p> <p>Interview with the supervisor on 11/28/23 at 1:17pm revealed:</p> <ul style="list-style-type: none"> -Resident #3 was administered his last dose of Neurontin this morning. -The facility received batch medications from the facility's contracted pharmacy once a month. -The batch medications were supposed to be delivered to the facility on the night of 11/27/23 but they were not delivered. <p>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/28/23 at 11:45am revealed 31 tablets of Neurontin 400mg were dispensed for Resident #3 on 10/17/23.</p> <p>Telephone interview with a second pharmacy technician at the facility's contracted pharmacy on 11/28/23 at 1:21pm revealed:</p> <ul style="list-style-type: none"> -The facility's contracted pharmacy last dispensed 31 tablets of Neurontin 400mg for Resident #3 on 11/21/23. -The facility's contacted pharmacy would deliver 	D 367		

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D 367	<p>Continued From page 28</p> <p>Resident #3's Neurontin to the facility on the night of 11/28/23.</p> <ul style="list-style-type: none"> -Resident #3's Neurontin was last delivered to the facility on 10/23/23. -The facility was supposed to start administering medications out of the new medication packs on the 1st of the month so Resident #3 should not be out of his Neurontin. <p>Review of the facility's October 2023 medication delivery log revealed:</p> <ul style="list-style-type: none"> -The log was not dated. -Thirty-one tablets of Neurontin 400mg were delivered to the facility for Resident #3. <p>Second interview with the supervisor on 11/28/23 at 1:49pm revealed:</p> <ul style="list-style-type: none"> -He may have started a few of the resident's medication packs before 11/01/23. -Sometimes some of the pills accidentally popped out of resident's medication packs and he had to discard them. -He did not document anywhere when he discarded resident medication. -He did not know why he documented that he was waiting on Resident #3's Neurontin on 11/24/23, 11/25/23, and 11/26/23. <p>Interview with the Administrator on 11/28/23 at 3:39pm revealed:</p> <ul style="list-style-type: none"> -Resident medications were delivered to the facility once a month unless a resident had a new medication and if so that medication would come in the night after the new medication was ordered. -She could not explain how Resident #3 received his Neurontin this morning if he was waiting on the medication to be delivered on 11/24/23, 11/25/23, and 11/26/23. 	D 367		

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D 367	<p>Continued From page 29</p> <p>Refer to telephone interview with the facility's primary care provider (PCP) on 11/28/23 at 3:10pm.</p> <p>c. Review of Resident #3's current FL-2 dated 07/20/23 revealed there was an order for allopurinol (used to treat gout) 100mg every day.</p> <p>Review of Resident #3's November 2023 electronic medication administration record (eMAR) revealed: -There was an entry for allopurinol 100mg every day scheduled for administration at 7:00am. -Allopurinol was documented as administered at 7:00am on 11/01/23 to 11/28/23 except on 11/26/23 where it was documented as "waiting on meds".</p> <p>Observation of Resident #3's medications on hand on 11/28/23 at 1:12pm revealed there was an empty medication pack of allopurinol 100mg which had a start date of 11/01/23.</p> <p>Interview with the supervisor on 11/28/23 at 1:17pm revealed: -Resident #3 was administered his last dose of allopurinol this morning. -The facility received batch medications from the facility's contracted pharmacy once a month. -The batch medications were supposed to be delivered to the facility on the night of 11/27/23 but they were not delivered.</p> <p>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/28/23 at 11:45am revealed 31 tablets of allopurinol 100mg were dispensed for Resident #3 on 10/17/23.</p> <p>Telephone interview with a second pharmacy</p>	D 367		

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D 367	<p>Continued From page 30</p> <p>technician at the facility's contracted pharmacy on 11/28/23 at 1:21pm revealed:</p> <ul style="list-style-type: none"> -The facility's contracted pharmacy last dispensed 31 tablets of allopurinol 100mg for Resident #3 on 11/21/23. -The facility's contacted pharmacy would deliver Resident #3's allopurinol to the facility on the night of 11/28/23. -Resident #3's allopurinol was last delivered to the facility on 10/23/23. -The facility was supposed to start administering medications out of the new medication packs on the 1st of the month so Resident #3 should not be out of his allopurinol. <p>Review of the facility's October 2023 medication delivery log revealed:</p> <ul style="list-style-type: none"> -The log was not dated. -Thirty-one tablets of allopurinol were delivered to the facility for Resident #3. <p>Second interview with the supervisor on 11/28/23 at 1:49pm revealed:</p> <ul style="list-style-type: none"> -He may have started a few of the resident's medication packs before 11/01/23. -Sometimes some of the pills accidentally popped out of resident's medication packs and he had to discard them. -He did not document anywhere when he discarded resident medication. -He did not know why he documented that he was waiting on Resident #3's allopurinol on 11/26/23. <p>Interview with the Administrator on 11/28/23 at 3:39pm revealed:</p> <ul style="list-style-type: none"> -Resident medications were delivered to the facility once a month unless a resident had a new medication and if so that medication would come in the night after the new medication was ordered. 	D 367		

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D 367	<p>Continued From page 31</p> <p>-She could not explain how Resident #3 received his allopurinol this morning if he was waiting on the medication to be delivered on 11/26/23</p> <p>Refer to telephone interview with the facility's primary care provider (PCP) on 11/28/23 at 3:10pm.</p> <p>d. Review of Resident #3's current FL-2 dated 07/20/23 revealed there was an order for Pravachol (used to treat high cholesterol) 40mg at bedtime.</p> <p>Review of Resident #3's November 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Pravachol 40mg at bedtime scheduled for administration at 7:00pm. -Pravachol 40mg was documented as administered at 7:00pm on 11/01/23 to 11/27/23 except on 11/23/23/ to 11/26/23 where it was documented as "waiting on meds".</p> <p>Observation of Resident #3's medications on hand on 11/28/23 at 1:12pm revealed there was an empty medication pack of Pravachol 40mg which had a start date of 11/01/23.</p> <p>Interview with the supervisor on 11/28/23 at 1:17pm revealed: -Resident #3 was administered his last dose of Pravachol last night. -The facility received batch medications from the facility's contracted pharmacy once a month. -The batch medications were supposed to be delivered to the facility on the night of 11/27/23 but they were not delivered.</p> <p>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/28/23</p>	D 367		

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D 367	<p>Continued From page 32</p> <p>at 11:45am revealed 31 tablets of Pravachol 40mg were dispensed for Resident #3 on 10/17/23.</p> <p>Telephone interview with a second pharmacy technician at the facility's contracted pharmacy on 11/28/23 at 1:21pm revealed:</p> <ul style="list-style-type: none"> -The facility's contracted pharmacy last dispensed 31 tablets of Pravachol 40mg for Resident #3 on 11/21/23. -The facility's contacted pharmacy would deliver Resident #3's Pravachol to the facility on the night of 11/28/23. -Resident #3's Pravachol was last delivered to the facility on 10/23/23. -The facility was supposed to start administering medications out of the new medication packs on the 1st of the month so Resident #3 should not be out of his Pravachol. <p>Review of the facility's October 2023 medication delivery log revealed:</p> <ul style="list-style-type: none"> -The log was not dated. -Thirty-one tablets of Pravachol were delivered to the facility for Resident #3. <p>Second interview with the supervisor on 11/28/23 at 1:49pm revealed:</p> <ul style="list-style-type: none"> -He may have started a few of the resident's medication packs before 11/01/23. -Sometimes some of the pills accidentally popped out of resident's medication packs and he had to discard them. -He did not know why he documented that he was waiting on Resident #3's Pravachol on 11/23/23 to 11/26/23. <p>Interview with the Administrator on 11/28/23 at 3:39pm revealed:</p> <ul style="list-style-type: none"> -Resident medications were delivered to the 	D 367		

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D 367	<p>Continued From page 33</p> <p>facility once a month unless a resident had a new medication and if so that medication would come in the night after the new medication was ordered.</p> <p>-She could not explain how Resident #3 received his Pravachol last night if he was waiting on the medication to be delivered on 11/23/23 to 11/26/23.</p> <p>Refer to telephone interview with the facility's primary care provider (PCP) on 11/28/23 at 3:10pm.</p> <p>2. Review of Resident #2's current FL-2 dated 08/01/23 revealed diagnoses included hypertension and schizoaffective disorder .</p> <p>a. Review of Resident #2's current FL-2 dated 08/01/23 revealed there was an order for Lisinopril 20mg take 1 tablet one time a day (Lisinopril is used to lower blood pressure).</p> <p>Review of Resident #2's November 2023 electronic medication administration record (eMAR) revealed:</p> <p>-There was an entry for Lisinopril 20mg take 1 tablet by mouth once daily for blood pressure scheduled for 7:00am.</p> <p>-Lisinopril was documented as administered at 7:00am on 11/01/23 to 11/28/23 except on 11/24/23 to 11/26/23 where it was not documented as administered with no explanation given.</p> <p>Observation of Resident #2's medications on hand on 11/28/23 at 1:30 pm revealed there was an empty pill pack for Lisinopril.</p> <p>Interview with the supervisor on 11/28/23 at 1:35pm revealed:</p>	D 367		

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D 367	<p>Continued From page 34</p> <ul style="list-style-type: none"> -The resident has been out of medication and due to the holiday, the medication was late being ordered. -The resident had been out of medication since 11/23/23 and the next batch of medications were delayed. -He must have hit the button that indicated the medication was administered by mistake. <p>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/28/23 at 11:45am revealed:</p> <ul style="list-style-type: none"> -The pharmacy dispensed medication packs at the end of each month to begin the 1st of each month. -The last batch of medications was dispensed and delivered to the facility on 10/23/23. -The next batch of medication was dispensed on 11/21/23 and will be delivered on 11/28/23. <p>Refer to telephone interview with the facility's primary care provider (PCP) on 11/28/23 at 3:10pm.</p> <p>b. Review of Resident #2's current FL-2 dated 08/01/23 revealed there was no order for Namenda (used to treat dementia) 10mg .</p> <p>Review of Resident #2's November 2023 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for Namenda 10mg take 1 tablet by mouth twice daily for memory scheduled for 7:00am and 7:00pm. -Namenda was documented as administered 11/01/23 to 11/03/23 at 7:00am -Namenda was documented as administered 11/01/23 and 11/02/23 at 7:00pm -Namenda was not documented as administered 11/03/23 at 7:00pm where it was documented as 	D 367		

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D 367	<p>Continued From page 35</p> <p>"patient refused medication".</p> <p>-Namenda was not documented as administered 11/04/23 and 11/05/23 at 7:00am and 7:00pm where it was documented as "patient refused medication".</p> <p>-Namenda was not documented as administered 11/06/23 at 7:00am where it was documented as "patient refused medication".</p> <p>-Namenda was documented as administered 11/06/23 to 11/08/23 at 7:00pm</p> <p>-Namenda was documented as administered 11/07/23 to 11/09/23 at 7:00am</p> <p>-Namenda was not documented as administered 11/09/23 at 7:00pm where it was documented as "patient refused medication".</p> <p>-Namenda was not documented as administered 11/10/23 to 11/12/23 at 7:00am or 7:00pm where it was documented as "patient refused medication".</p> <p>-Namenda was not documented as administered 11/13/23 at 7:00am.</p> <p>-Namenda was documented as administered 11/13/23 and 11/14/23 at 7:00pm.</p> <p>-Namenda was documented as administered 11/14/23 and 11/15/23 at 7:00am.</p> <p>-Namenda was not documented as administered 11/15/23 and 11/16/23 at 7:00pm where it was documented as "patient refused medication".</p> <p>-Namenda was not documented as administered 11/16/23 and 11/17/23 at 7:00am where it was documented as "patient refused medication".</p> <p>-Namenda was documented as administered 11/17/23 at 7:00pm.</p> <p>-Namenda was documented as administered 11/18/23 and 11/21/23 at 7:00am and 7:00pm.</p> <p>-Namenda was documented as administered 11/22/23 at 7:00am</p> <p>-Namenda was not documented as administered 11/23/23 to 11/26/23 at 7:00am and 7:00pm where it was documented as "patient refused medication".</p>	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL007019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/28/2023
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NAME OF PROVIDER OR SUPPLIER WASHINGTON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 609 WEST 2ND STREET WASHINGTON, NC 27889
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(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 367	<p>Continued From page 36</p> <p>medication".</p> <ul style="list-style-type: none"> -Namenda was documented as administered 11/27/23 at 7:00am and 7:00pm. -Namenda was documented as administered 11/28/23 at 7:00pm. <p>Observation of Resident #2's medications on hand on 11/28/23 at 1:30 pm revealed there was not a pill pack of Namenda.</p> <p>Interview with Resident #2 on 11/28/23 at 10:30am revealed he had not had Namenda since May 2023.</p> <p>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/28/23 at 11:45am revealed:</p> <ul style="list-style-type: none"> -Resident #2's Namenda was last dispensed on 05/18/23 and included 62 pills. -The pharmacy had not received an order for the medication to be discontinued therefore the medication remained on the eMAR but was not dispensed. <p>Telephone interview with a nurse at Resident #2's mental health provider's office on 11/28/23 at 2:22pm revealed:</p> <ul style="list-style-type: none"> -The doctor had discontinued Resident #2's Namenda "officially" on 08/01/2023. -The doctor was aware the original order to discontinue medication on 01/25/23 had not been received therefore the pharmacy had continued to send the medication to the facility. -The resident had complained of adverse side effects therefore the medication was discontinued. <p>Interview with the supervisor on 11/28/23 at 1:34pm revealed:</p> <ul style="list-style-type: none"> -He was aware that Resident #2's Namenda at 	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL007019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/28/2023
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NAME OF PROVIDER OR SUPPLIER WASHINGTON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 609 WEST 2ND STREET WASHINGTON, NC 27889
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(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 367	<p>Continued From page 37</p> <p>been discontinued on 08/01/23. -He had mistakenly documented that Resident #2's Namenda had been administered.</p> <p>Refer to telephone interview with the facility's primary care provider (PCP) on 11/28/23 at 3:10pm.</p> <p>_____</p> <p>Telephone interview with the facility's primary care provider (PCP) on 11/28/23 at 3:10pm revealed it was important that the facility record resident's medications accurately on the electronic medication administration record (eMAR) because she reviewed the eMARs at appointments and if it was marked that a resident was receiving a medication, she assumed the resident has been receiving it.</p>	D 367		