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	HAL036013	A. BUILDING: _____ B. WING _____	03/31/2017

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 29, 30 and 31, 2017.	D 000	The following is the Plan of Correction for **Brookdale New Hope.** This Plan of Correction is in regards to the Statement of Deficiencies dated April 17, 2017, This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding.	
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure walls and floors were clean and in good repair in 9 Resident Bedrooms/Bathrooms and the Hallways and Dining room. The findings are: Observation of resident room #22 on 3/29/17 at 9:45am revealed: -There was small amount of paper debris scattered on the floor. -There were 2 carpet stains dark gray, ranging in approximate size from 6 to 20 inches. -There was one area which appeared to be worn approximately 4 inches in diameter. Observation of the bathroom in resident room #47 on 3/29/17 at 9:50am revealed: -A small amount of paper debris on the floor of the bathroom. -A crescent shaped tear approximately 2 inches in length in the vinyl flooring of the bathroom. Observation of resident room #12 on 3/29/17 at	D 074		

Reviewed and Acknowledged 5/23/17.
Joseph Cline

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D 074	Continued From page 1 9:53am revealed: -There was a small amount of paper debris, threads, and food crumbs scattered on the floor. Observation of resident room #19A on 3/29/17 at 10:00am revealed: -There were 2 carpet stains dark brown, ranging in approximate size from 6 to 12 inches. -The shared bathroom in suite #19 had toilet paper and loose red brown debris scattered on the floor. Observation of resident room #24 on 3/29/17 at 10:10am revealed: -There was a small amount of paper and thread debris scattered on the floor. Observation of resident room #20 on 3/29/17 at 10:15am revealed: -A carpet stain gray brown and approximately 12 inches in size. -There was small pieces of paper scattered on the floor. Observation of resident room #44 on 3/29/17 at 10:35am revealed: -A large amount of paper debris on the carpet all around the resident's bed and chair. -A large amount of paper on the floor of the bathroom. -Debris on the bathroom floor included a piece of plastic packaging and an empty cardboard toilet paper roll. Interview with the resident who resided in room #44 on 3/29/17 at 10:40am revealed: -Housekeeping staff usually cleaned his room once a week on Wednesday. -Staff had not cleaned his room today, (3/29/17 was a Wednesday.)	D 074	**10A NCAC 13f .0306(a)(1)** • Rooms 19A, 20, 15, and 29 will all be shampooed by 5/15/17. Rooms will be monitored by the housekeeping staff or designee on a weekly basis for stains and spot cleaned to remove stains. If stains cannot be removed by spot cleaning the housekeeping staff or designee will report it to the Maintenance Technician or designee and the Maintenance Technician or designee will schedule the room to be professionally steam cleaned.	

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D 074	Continued From page 3 been there "quite a while." -His roommate had spilled something on the carpet. -Staff had tried to clean it up. -Staff cleaned his room weekly. -The weekly cleaning consisted of changing sheets, vacuuming, and taking out the trash. -Staff cleaned his bathroom more often, but could not specify how often. Confidential interviews with 10 residents revealed: -The housekeeping could be better. -"The floors get vacuumed once a week." -The trashcan does not get emptied daily, and sometimes was full. -"The stains on my room floor has been there since I moved in." -"I think there needs to be more housekeepers." -"Some residents spill things in the hallway." -"My floors are not dirty, just stained and worn." -They had noticed the Maintenance Man cleaning the carpets. -They had seen an outside company cleaning carpets. -Resident stated they had spilled drinks on their floor and told staff, and the housekeeping would then try to clean it. -Some of the stains on the floor will not come up by cleaning. Observation of the dining room on 3/30/31 at 11:15pm revealed: -There were 3 damaged areas above the chair railing on the walls where the chairs had been pushed back and hit the walls all in length of approximately 3 feet. -There were stains on the floor gray and ranging in sized from 3 inches to 6 inches.	D 074	• The stains in the dining room carpet were removed on 4/1/17 and will be spot cleaned monthly by the Maintenance Technician or designee and professionally cleaned quarterly. • The three damaged areas on the walls in the dinning were repaired on 4/26/17. This damage was caused by the high back chairs in the dining room hitting the walls. The tables have been turned so that the chairs will not be up against the walls and create any more damage. The walls in the dining room will be monitored daily by the Maintenance Technician or designee to prevent damage to the walls.	

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D 074	Continued From page 5 -The residents eat and drink food in the rooms and hallways and occasionally spill food and drinks on the floor. -She did let the Administrator know when a room had a bad stain on the floor. -When a resident moved out the room carpet is cleaned and the walls are painted. -The Personal Care Aides let her know if there was a room that needed cleaned. -"We vacuum the resident rooms weekly and when needed." -The PCA's had access to the vacuums, so if the rooms need vacuumed in the evenings, they can do it. Review of documention provided by the Administrator on 3/31/17 of carpet cleaning completed in the facility by an outside carpet cleaning company revealed: -On 6/15/16 the dining room carpet had been cleaned. -On 7/7/16 rooms #46, #47, #49 and the Hallway had been cleaned. -On 8/16/16 rooms #45 and #46 had been cleaned, the common areas had been spot cleaned, hallways and the living room in front of facility had been cleaned. -On 9/26/16 rooms #12, #14, #19B, #24A, #27, #30, #35, #39, #40 and #49 had been cleaned. -On 11/1/16 rooms #18,#28,#51 and 52 had been cleaned. -On 2/8/17 all common areas had been cleaned. -On 2/10/17 the dining room had been cleaned. -On 2/14/17 furniture in the common areas had been spot cleaned. Interview with the Administrator on 3/30/17 at 3:40pm revealed: -"When a resident moves out of the facility the carpet is replaced in the room and the walls are	D 074		

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D 113	Continued From page 7 -At 10:10am, the hot water temperature of the sink for resident room #19 bathroom was 120 degrees F. -At 10:16am, the hot water temperature of the sink for resident room #24 bathroom was 120 degrees F. -At 10:18am, the hot water temperature of the sink for resident room #45 bathroom was 120 degrees F, and a shower hot water temperature of 114 degrees F. -At 10:34am, the hot water temperature of the sink for resident room #16 bathroom was 120 degrees F. -At 10:35am. the hot water temperature of the sink for resident room #44 bathroom was 118 degrees F. -At 10:40am, the hot water temperature of the sink for resident room #18 bathroom was 120 degrees F. -At 11:10am, the hot water temperature of the sink for resident room #47 bathroom was 120 degrees F. Random interviews with 8 residents revealed: -The hot water was not too hot for them. -They liked the water a little warmer. -They had never gotten burned. -They had not noticed the water was too hot. Interview on 3/29/17 at 11:15am with the Maintenance Man revealed: -He checked the water temperatures weekly. -He was notified on 3/29/17 at 10:45am by the Administrator about the elevated water temperatures which had been pointed out by the surveyor he immediately checked the thermostat and it was set at 120 degrees. -He turned the water temperature down to 114 degrees. -He did not know why the thermostat was set that	D 113	facility weekly and entering the temperatures into our TELS systems to ensure the temperatures stay under 116 degrees.	

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D 113	Continued From page 9 -To their knowledge no resident had ever been burned because the water was too hot. Interview on 3/29/17 at 11:20am with the Administrator revealed: -The maintenance man checked the water temperatures once per week. -On the weekends there was a manager on call who was responsible for checking water temperatures. -If the manager noticed the water temperature was too high, they have a key and are expected to adjust the thermostat. Observations in the facility on 3/29/17 of hot water temperatures revealed. -A recheck of the hot water temperature in resident room #44 bathroom sink was 114 degrees F at 4:13pm. -A recheck of the hot water temperature in resident room #45 bathroom sink was 114 degrees F at 4:15pm. -A recheck of the hot water temperature in resident room #47 bathroom sink was 114 degrees F at 4:20pm. -A recheck of the hot water temperature in resident room #23 bathroom sink was 114 degrees F at 4:30pm. -A recheck of the hot water temperature in resident room #19 bathroom sink was 114 degrees F at 4:25pm. -A recheck of the hot water temperature in resident room #24 bathroom sink was 114 degrees F at 4:33pm. Interview on 3/31/17 at 11:15am with the Dietary Manager revealed: -She had been the manager on call the previous weekend. -When she checked the dining room water	D 113		

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D 234	Continued From page 11 osteopenia. Review of Resident #5's Resident Register revealed the date of admission was 2/27/17. Review of Resident #5's record revealed no documentation of a TB test being completed. Interview with Resident #5 on 3/31/17 at 10:15am revealed: -She could not remember when she had a TB test. -She did not recall having one recently. -She had not had one at the facility. Interview on 3/31/17 at 2:15pm with the Resident Care Coordinator (RCC) revealed: -When a resident is admitted to the facility she was responsible for assuring the TB test was completed. -She was unsure of why Resident #5 did not have any documentation of a TB test. -She thought Resident #5 had a TB test at the physician's office before she was admitted to the facility. -She had attempted to make contact with the physician's office about Resident #5's TB test, but they would not return her call. Interview on 3/31/17 at 3:00pm with the Administrator revealed the Health and Wellness Director and the RCC were responsible to assure that TB testing was completed on every resident prior to admission.	D 234		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health	D 280		

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D 280	Continued From page 13 -Diagnoses included urinary retention, thrombocytopenia, benign prostate hyperplasia, and vitamin D deficiency. -The resident was semi-ambulatory and used a wheelchair for ambulation. -The resident had an order for Ted Hose (A compression sock used to prevent swelling and maintain blood flow) to be placed on in the morning and removed in the evening. -The resident had an indwelling catheter. Review of Resident #3's Resident Register revealed an admission date of 1/16/16. Review of Resident #3's current care plan, completed on 8/5/16 and signed by the physician indicated the resident required limited assistance for transfers and some assistance with toileting related to his catheter. Review of Resident #3's LHPS evaluations revealed: -An initial LHPS evaluation completed on 2/5/16 with transfers, Ted Hose and catheter care listed as LHPS tasks. -An LHPS evaluation completed on 3/12/16 with identified tasks of transfers, Ted Hose and catheter care. -An LHPS evaluation completed on 8/25/16 with identified tasks of transfers, Ted Hose and catheter care. Interview on 3/31/17 at 11:45am with Resident #3 revealed: -The staff put his Ted hose on in the morning and removed it at night. -"Some staff are better than others at getting it on and off." -He was able to transfer and get into his wheel chair with limited assistance.	D 280		

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D 280	Continued From page 15 blood sugar levels are less than 60 or greater than 500. Record review revealed a subsequent order dated 1/30/17 to increase the dose of Lantus at bedtime. Review of Resident #4's Medication Administration Records (MARs) for February and March 2017 revealed: -An additional diagnosis of diabetes due to underlying condition. -An entry for Lantus 30 units SQ at bedtime and an entry for Novolog insulin, 7 units SQ before meals. -An entry for finger stick blood sugars (FSBS) before meals and bedtime. Review of Resident #4's most recent Licensed Health Support (LHPS) assessment revealed: -An assessment date of 8/19/16. -The tasks identified were FSBS and medications by injection. Record review revealed no other LHPS assessments were documented as completed after 8/19/16 for Resident #4. Observation of a Medication Aide (MA) on 3/29/17 at 11:25am revealed she performed a FSBS using approved in accordance with approved infection control standards. Interview with Resident #4 on 3/29/17 at 11:35am revealed he believed he received his insulin injections and FSBS as ordered by his physician. Refer to interview on 3/30/17 at 11:10am with the Health and Wellness Director.	D 280		

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D 310	Continued From page 17 supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 3 sampled Residents (#1) with a physician ordered threaputic diet was served as ordered. The findings are: Review of Resident #1's current FL2 dated 11/28/16 revealed: -Diagnoses included coronary artery disease, stroke, congestive heart failure, transient ischemic attack, and diabetes. -A diet order for a regular diet. Review of an Addendum to the FL2 dated 12/5/16 revealed: -The FL2 Addendum contained a list of the available diets at the facility with the 2 gram sodium diet checked for Resident #1. -"The 2 gram sodium diet restricts sodium to no more than 2000 mg of sodium per day." -"Since food intake decreases as part of the normal aging process, the 2 gram sodium diet should be used with care with the older adult." Review of Resident #1's record revealed a subsequent order dated 12/19/16 affirmed the dietary order for Resident #1 as a 2 gram sodium diet. Review of the posted threaputic diet list for the facility revealed Resident #1 was to receive a regular diet.	D 310	**10A NCAC 13F .0904(e)(4)** • On 3/31/17 resident #1's primary care physician changed resident #1's diet to a no added salt diet. Diet was updated on the nutrition tracker, in point click care, and in the diet binder in the kitchen. • The Health and Wellness Director, Resident Care Coordinator, or designee will give all new diet orders to the Dining Services Coordinator or designee. The Dining Services Coordinator or designee will keep a binder in the kitchen of all diet orders.	

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D 310	Continued From page 19 Manager revealed: -She was not aware of any resident who was on a 2 gram sodium diet. -A 2 gram sodium diet was "very restrictive". -She serves frozen vegetables which are sodium free. -All stocks and broths used for cooking in the facility are low sodium. -She does not use any salt in cooking. -"With a 2 gram sodium diet canned vegetables are limited." -"Breakfast meats are substituted with a beef patty." -"A typical 2 gram sodium breakfast would be eggs, beef patty, grits, and one slice of toast." -Processed sandwich meats are limited to low sodium. Review on 3/31/17 of the facility "2 gram sodium diet guidelines" revealed: -The 2 gram sodium diet is appropriate for older adults for the management of congestive heart failure, high blood pressure and edema... -"The 2 gram sodium diet is planned as a modification of the Regular Diet. High sodium foods are restricted, medium sodium foods are limited." -"The 2 gram sodium diet allows a limited amount of salt in cooking and no salt is used at the table."	D 310		
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	D 358		

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D 358	Continued From page 21 itching. The National Institute of Health cautions against the use of diphenhydramine in the elderly due to a high risk of side effects including dizziness, dry mouth, blurred vision, constipation, and increased confusion.) Observation of Resident #7's bottle of diphenhydramine 25mg on 3/30/17 at 10:54am revealed: -The bottle originally contained 100 tablets of diphenhydramine 25mg with 44 tablets remaining in the bottle. -The expiration date on the bottle was 11/18. -The bottle of diphenhydramine 25mg was obtained from a local chain pharmacy. Record review revealed Resident #7 did not have a physician's order for diphenhydramine 25mg tablets. Confidential interview with a Medication Aide (MA) revealed: -The family brought Resident #7's medications into the facility. -The MAs let the families know when they are running how on medications. -If the families do not bring in the medications, we obtain them from our pharmacy provider. -She has given Resident #7 diphenhydramine in place of the fexofenadine. -She believed Resident #7 has gotten diphenhydramine in place of the fexofenadine "for quite a while." -She believed the two medications were the same or at least a similar product because they were both for allergies. -She believed Resident #7 had fexofenadine in the facility in the past, but could not say when. -When families brought medications into the facility, the MAs or the Health and Wellness	D 358	• Nightly the 3rd shift Med Tech will do med cart audits on all four med carts for medication accuracy or availability. • Training has been provided for all Med Techs on the importance of timely ordering of medications. • All medications that are brought in my family will be reviewed for accuracy by the HWD or designee prior to administration.	

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D 358	Continued From page 23 room. -Resident #7 was admitted to the hospital with possible congestive heart failure. Interview with Resident #7's relative on 3/31/17 at 11:07am revealed: -The family provided medications for Resident #7. -Another family member, "took the lead" in obtaining Resident #7's medications. -The other family member "probably thought the two medications (diphenhydramine and fexofenadine) were the same." -The bottle of diphenhydramine in the facility came from the resident's home. -The bottle wasn't full, but he wasn't sure how many tablets were in the bottle. -The family member was not sure if Resident #7 had ever had fexofenadine in the facility. -The family would provide Resident #7 the fexofenadine 180mg tablets as ordered by his physician. Interview with Resident #7's primary care provider on 3/31/17 at 11:58am revealed she did not believe Resident #7 receiving 1 tablet of 25mg diphenhydramine tablet a day instead of 1 tablet of 180mg fexofenadine was a significant medication error. Review of the facility's policy and procedures for pharmacy services for residents not using the preferred pharmacy provider revealed: -"I will be required to provide medications that are packaged in a unit of use packaging system, unless I have been granted an exemption to this requirement." -"I understand there is a service fee of $200.00 per month associated with using a pharmacy that does not package medications in the same manner as the preferred provider due to the	D 358		

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BROOKDALE NEW HOPE	1680 SOUTH NEW HOPE ROAD GASTONIA, NC 28054

(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 358	Continued From page 25 -An entry for furosemide 20mg, 1 tablet by mouth one time a day for swelling with a scheduled administration time of 8am. -An entry for furosemide 20mg, 1 tablet by mouth one time a day for swelling with a scheduled administration time of 5pm. -All doses of furosemide 20mg had been initialed as administered twice daily from 2/1/17 through 2/28/17. Review of Resident #1's MAR for March 2017 revealed: -An entry for furosemide 20mg, 1 tablet by mouth one time a day for swelling with an administration time of 8am. -An entry for furosemide 20mg, 1 tablet by mouth one time a day for swelling with a scheduled administration time of 5pm. -Furosemide 20mg had been initialed as administered daily at 8am except for the 18th and the 19th, where a chart code of 09 was noted on those days. -Furosemide 20mg had been initialed as administered daily at 5pm except for the 16th, 17th, 18th, and 19th, where a chart code of 09 was noted on those days. Review of the digital progress notes on the electronic MAR revealed the note text for the 09 chart code simply stated "awaiting pharmacy." Observation of Resident #1's medications on hand on 3/30/17 at 3:40am revealed: -Two bubble packs of furosemide 20mg tablets labeled, 1 tablet twice daily, with a dispense date of 3/18/17. -One of the bubble packs of furosemide 20mg contained 30 tablets, and the other contained 9 tablets.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 27 Interview with a pharmacist at the pharmacy provider on 3/31/17 at 10:40am revealed: -The furosemide 20mg refill for Resident #1 was ordered on 3/18/17 at 9:44pm. -The furosemide 20mg with a dispense date of 3/18/17 went out to the facility for delivery on the evening of 3/19/17 and would have been delivered to the facility on 3/19/17 between 8:30pm and 9:00pm. Interview with Resident #1's primary care provider on 3/31/17 at 11:58am revealed: -She had just examined Resident #1 and she had no complaints today. -The resident had no shortness of breath or edema today. -She saw Resident #1 last week casually in the hall and she had no edema or shortness of breath. -It was not good Resident #1 ran out of her furosemide 20mg, but missing those doses for a short period of time was not critical. C. Review of Resident #2's current FL2 dated 12/1/16 revealed: -Diagnoses included dementia, Alzheimer's type, tremors, depression and sinus tachycardia. -A medication order for Seroquel 25mg, 1 tablet daily and Seroquel 50mg at bedtime (Seroquel is an anti-psychotic medication that is used in the treatment of dementia.) Interview on 3/29/17 at 11:15am with Resident #2's roommate revealed: -She was a family member. -Resident #2 could not hold a conversation due to his dementia. -Resident #2 had been out of his Seroquel for several days.	D 358		

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D 358	Continued From page 29 Seroquel. Based on record review and observations it was determined that Resident #2 was not interviewable. Attempted telephone interview on 3/31/17 at 2:10pm with Resident #2's physician was unsuccessful. --- The facility failed to assure medications (furosemide, fexofenadine, and Seroquel) were administered as ordered by a licensed prescribing practitioner for 1 of 4 residents observed on a medication pass (Resident #7), and 2 of 5 residents (#1 and #2) sampled. Failure to administer furosemide and Seroquel as ordered exposed Residents #1 and #2 respectively to increased risks of the worsening of the symptoms of hypertension and congestive heart failure, and worsening of behaviors associated with dementia. The use of diphenhydramine in place of fexofenadine exposed Resident #7 to an increased risk of side effects associated with the use of older first generation antihistamines like diphenhydramine which include dizziness, dry mouth, blurred vision, constipation, confusion, and urinary retention. The failure to administer medications as ordered exposed these residents to serious side effects and adverse effects and constitutes a Type B Violation. --- Review of the Plan of Protection provided by the facility on 3/30/17 revealed: -The Health and Wellness Director and the Resident Care Coordinator will immediately audit all of the medication carts to assure all medications are available for administration.	D 358		

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D 367	Continued From page 31 signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure accurate documentation on 1 of 5 sampled resident's (#7) Medication Administration Records (MARs) by documenting the administration of a medication not available to administer. The findings are: Review of Resident #7's current FL2 dated 1/31/17 revealed: -Diagnoses included hypertension, gastroesophageal reflux disease, and transient ischemic attacks. -A medication order for fexofenadine 180mg, 1 tablet daily. (Fexofenadine is a non-sedating antihistamine use to treat allergic rhinitis.) Observation of the morning medication pass on 3/30/17 at 8:46am revealed Resident #7 received 6 oral medications, but no fexofenadine. Observation of Resident #7's medications on hand on 3/30/17 at 8:50am revealed: -No fexofenadine 180mg available to administer. -A partially filled 100 count bottle of diphenhydramine 25mg tablets. -The manufacturer's label for the diphenhydramine stated the tablets were for allergy symptoms. Observation of Resident #7's bottle of diphenhydramine 25mg on 3/30/17 at 10:54am revealed: -The bottle originally contained 100 tablets of	D 367	• Nightly the 3rd shift Med Tech will do med cart audits on all four med carts for medication accuracy or availability. • Training has been provided for all Med Techs on the importance of timely ordering of medications. • All medications that are brought in my family will be reviewed for accuracy by the HWD or designee prior to administration.	

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D 367	Continued From page 33 Confidential interview with a second MA revealed: -The Health and Wellness Director (HWD) was informed if a medication doesn't come in and was not available to administer. -All the MAs were told by the HWD not to leave gaps on the MARs if residents were out of their medications, but instead to document "resident refused, or resident spit out." Interview with the Resident Care Coordinator on 3/30/17 at 10:30am revealed: -Initially, she or the Health and Wellness Director checked in medications brought in by the families to make sure they are the correct medications. -After that initial check in, the Medication Aides can check the medications brought in by families. Interview with a pharmacist at the pharmacy provider on 3/30/17 at 10:58am revealed: -They did not have an order for fexofenadine 180mg in their system for Resident #7. -They had never sent any fexofenadine 180mg to the facility for Resident #7. An attempt to interview Resident #7 on 3/30/17 at 12:08pm was not successful due to resident sleeping. Interview with the Administrator on 3/31/17 at 10:11am revealed: -Resident #7 had gone out of the facility on the evening of 3/30/17 with a family member. -While they were out of the facility, the family member took Resident #7 to the local emergency room. -Resident #7 was admitted to the hospital with possible congestive heart failure. Interview with Resident #7's relative on 3/31/17 at	D 367		

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D912	Continued From page 35 appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Medication Administration (Residents #1 and#2). The findings are: Based on observations, record reviews, and interviews, the facility failed to assure medications (furosemide, fexofenadine, and Seroquel) were administered as ordered by a licensed prescribing practitioner for 1 of 4 residents observed on a medication pass (Resident #7), and 2 of 5 residents (#1 and #2) sampled. [Refer to Tag 358, 10A NCAC 13F .1004 (a) (Type B Violation)].	D912		