STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092192	A. BUILDING: _____ B. WING _____	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING AT ROLESVILLE	129 NORTWICK ROAD ROLESVILLE, NC 27571

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 31, 2021.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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 interviews and record reviews, the facility failed to notify the primary care provider (PCP) 1 of 3 sampled resident (#3) of missed doses of medications which included a seizure medication and an anti-anxiety medication. The findings are: Review of the facility's medication error policy (not dated) revealed: -A medication error was defined as missed dose (any dose of medication that is not administered). -When the medication error occurred, staff was to notify the Administrator or designee immediately. -Staff were to follow all instructions provided by the Administrator or designee. -There was no documentation of a specific number of doses missed before the primary care provider (PCP) was to be notified. Review of Resident #3's current FL2 dated 01/04/21 revealed diagnoses included hyperlipidemia, anxiety disorder, seizures, insomnia and hypertension Review of Resident #3's Resident Register revealed there was an admission date of 01/07/21.	C 246		

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C 246	Continued From page 1 a. Review of Resident #3's current FL2 dated 01/04/21 revealed an order for levetiracetam (a medication used to treat seizures) 750 mg take one tablet daily. Review of Resident #3's March 2021 electronic medication administration record (eMAR) revealed: -There was an entry for levetiracetam 750 mg take one tablet daily at 8:00am. -There was documentation levetiracetam 750 mg take one tablet daily was not administered on 03/04/21, 03/06/21, 03/08/21, 03/09/21, 03/10/21 and 03/11/21 by circled initials on the front of the eMAR. -There was documentation on the back of the eMAR, "medication not available" for 03/04/21, 03/06/21 and 03/08/21 for the 8:00am dose. -There was documentation on the back of the eMAR, "don't have" for 03/09/21 at 7:15am. -There was documentation on the back of the eMAR, "pharmacy has not sent refill" for 03/10/21 at 8:12am. -There was documentation on the back of the eMAR, "waiting on refill" for 03/11/21 at 8:00am. -There was documentation levetiracetam 750 mg was not administered daily for 6 occurrences out of 31 opportunities from 03/01/21 to 03/31/21. Telephone interview with a nurse at Resident #3's primary care provider (PCP) office on 03/31/21 at 4:15pm revealed: -Resident #3 was last seen on 02/19/21. -Levetiracetam 750 mg was used to treat seizures. -The PCP did not know Resident #3 had missed six doses of the levetiracetam 750 mg take one tablet daily. -The request for refill was sent to the office on	C 246		

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03/11/21.
-The PCP expected to be notified after 2 missed doses of levetiracetam 750 mg.
-Resident #3 could have a seizure if the medication was taken as ordered.
-The PCP expected his orders to be followed as written.

Refer to interview with a medication aide (MA) on 03/31/21 at 1:56pm and 5:10pm.

Refer to interview with the Community Relations Director (CRD) on 03/31/21 at 4:43pm.

b.Review of Resident #3's current FL2 dated 01/04/21 revealed there was an order for levetiracetam (a medication used to treat seizures) 500 mg take one tablet daily.

Review of Resident #3's March 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for levetiracetam 500 mg take one tablet at bedtime at 8:00pm.
-There was documentation levetiracetam 500 mg take one tablet at bedtime was not administered on 03/01/21, 03/02/21, 03/03/21, 03/04/21, 03/05/21, 03/07/21, 03/08/21, 03/09/21 and 03/10/21 by circled initials on the front of the eMAR.
-There was documentation on the back of the eMAR, "medication not available" for 03/01/21, 03/02/21, 03/03/21, 03/04/21, 03/05/21, 03/07/21, 03/08/21, 03/09/21 and 03/10/21 for the 8:00pm dose.
-There was documentation levetiracetam 500 mg was not administered daily for 9 occurrences out of 31 opportunities from 03/01/21 to 03/31/21.

Telephone interview with a nurse at Resident #3's

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primary care provider (PCP) office on 03/31/21 at 4:15pm revealed:
-Resident #3 was last seen on 02/19/21.
-Levetiracetam 500 mg was used to treat seizures.
-The PCP did not know Resident #3 had missed six doses of the levetiracetam 500 mg take one tablet daily.
-The request for refill was sent to the office on 03/11/21.
-The PCP expected to be notified after 2 missed doses of levetiracetam 500 mg.
-Resident #3 could have a seizure if the medication was taken as ordered.
-The PCP expected his orders to be followed as written.

Refer to interview with a medication aide (MA) on 03/31/21 at 1:56pm and 5:10pm.

Refer to interview with the Community Relations Director (CRD) on 03/31/21 at 4:43pm.

c. Review of Resident #3's current FL2 dated 01/04/21 revealed there was an order for Prozac (used to treat anxiety) 20 mg take two capsules daily.

Review of Resident #3's March 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Prozac 20 mg take two capsules daily at 8:00am.
-There was documentation Prozac 20 mg take two capsules daily was not administered on 03/04/21, 03/06/21, 03/08/21, 03/09/21, 03/10/21 and 03/11/21 by circled initials on the front of the eMAR.
-There was documentation on the back of the eMAR, "medication not available" for 03/04/21,

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03/06/21 and 03/08/21 for the 8:00am dose.
-There was documentation on the back of the eMAR, "don't have it in the facility" for 03/09/21 at 7:15am.
-There was documentation on the back of the eMAR, "pharmacy has not sent refill" for 03/10/21 at 8:12am.
-There was documentation on the back of the eMAR, "waiting on refill" for 03/11/21 at 8:00am.
-There was documentation Prozac 20 mg was not administered daily for 6 occurrences out of 31 opportunities from 03/01/21 to 03/31/21.

Review of Resident #3's reorder request records from 02/15/21 - 03/31/21 revealed:
-Prozac 20 mg was last filled on 02/23/21.
-Prozac 20 mg was reordered on 03/05/21 and was "rejected no refills".
-Prozac 20 mg was reordered on 03/10/21 and was "rejected no refills" with a comment noted "the resident was completely out of the medication".

Telephone interview with a nurse at Resident #3's primary care provider (PCP) office on 03/31/21 at 4:15pm revealed:
-Resident #3 was last seen on 02/19/21.
-Prozac 20 mg was used to treat anxiety.
-The PCP did not know Resident #3 had missed six doses of the Prozac 20 mg take two capsules daily.
-The request for refill was sent to the office on 03/11/21.
-The PCP expected to be notified after 2 missed doses of Prozac 20 mg.
-Resident #3 could have a behavioral or mood changes if the medication was taken as ordered.
-The PCP expected his orders to be followed as given.

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C 246	Continued From page 5 Refer to interview with a medication aide (MA) on 03/31/21 at 1:56pm and 5:10pm. Refer to interview with the Community Relations Director (CRD) on 03/31/21 at 4:43pm. _____ Interview with a medication aide (MA) on 03/31/21 at 1:56pm and 5:10pm revealed: -Resident #3 was completely out of the medications at the beginning of March 2021 until 03/11/21 when the medication arrived from the pharmacy. -She was responsible for notifying the PCP of the missed doses of medication. -She was supposed to notify the PCP after one missed dose of medication. -She notified the PCP of the missed doses of medications on 03/09/21 (name of staff at PCP office unknown). -She did cart audits once a month. Interview with the Community Relations Director (CRD) on 03/31/21 at 4:43pm revealed: -On 03/04/21 she noticed that Resident #3 had missed doses of medications due to medications not being available. -There was a "drop in communication". -She did not contact the PCP to inform them of the missed doses of medication. -She and the MAs were responsible for notifying the PCP of missed doses	C 246		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications,	C 330		

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prescription and non-prescription and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#3) which included a seizure medication and an anti-anxiety medication.

The findings are:

Review of Resident #3's current FL2 dated 01/04/21 revealed diagnoses included hyperlipidemia, anxiety disorder, seizures, insomnia and hypertension.

Review of Resident #3's Resident Register revealed there was an admission date of 01/07/21.

Review of Resident #3's 24 hour chart notes dated 03/03/21 revealed at 5:15pm the Community Relations Director (CRD) conducted an electronic medication administration record (eMAR) audit and identified medications are not in the facility and called the medication aide (MA) on duty and provided directive to request the medication refills.

Review of Resident #3's 24 hour chart notes dated 03/09/21 revealed at 9:30am the MA called the facility's contract pharmacy to find out why the Resident #3's medication had not been refilled; the pharmacy informed the staff they were

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sending the refill request to the provider with no response; she asked the provider's name; the incorrect provider was given; she called the CRD and briefed her on the medication situation; The CRD identified that was the wrong provider and gave directive to call the current primary care provider (PCP) and request a medication refill and to brief the current PCP of the missing medications; current PCP called and medication refills requested, stat and PCP briefed on missing doses of medications.

a.Review of Resident #3's current FL2 dated 01/04/21 revealed an order for levetiracetam (a medication used to treat seizures) 750 mg take one tablet daily.

Review of Resident #3's March 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for levetiracetam 750 mg take one tablet daily.
-There was an entry for levetiracetam 750 mg take one tablet daily at 8:00am.
-There was documentation levetiracetam 750 mg take one tablet daily was not administered on 03/04/21, 03/06/21, 03/08/21, 03/09/21, 03/10/21 and 03/11/21 by circled initials on the front of the eMAR.
-There was documentation on the back of the eMAR, "medication not available" for 03/04/21, 03/06/21 and 03/08/21 for the 8:00am dose.
-There was documentation on the back of the eMAR, "don't have" for 03/09/21 at 7:15am.
-There was documentation on the back of the eMAR, "pharmacy has not sent refill" for 03/10/21 at 8:12am.
-There was documentation on the back of the eMAR, "waiting on refill" for 03/11/21 at 8:00am.
-There was documentation levetiracetam 750 mg

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C 330	Continued From page 8 was not administered daily for 6 occurrences out of 31 opportunities from 03/01/21 to 03/31/21. Review of Resident #3's reorder request records from 02/15/21 - 03/31/21 revealed: -Levetiracetam 750 mg was last filled on 02/17/21. -Levetiracetam 750 mg was reordered on 02/25/21 and was "rejected no refills". -Levetiracetam 750 mg was reordered on 03/05/21 and was "rejected no refills". -Levetiracetam 750 mg was reordered on 03/10/21 and was "rejected no refills" with a comment noted "the resident was completely out of the medication". Telephone interview with a nurse at Resident #3's primary care provider (PCP) office on 03/31/21 at 4:15pm revealed: -Resident #3 was last seen on 02/19/21. -Levetiracetam 750 mg was used to treat seizures. -The PCP did not know Resident #3 had missed six doses of the levetiracetam 750 mg take one tablet daily. -The request for refill was sent to the office on 03/11/21. -Resident #3 could have a seizure if the medication was taken as ordered. -The PCP expected his orders to be followed as written. Based on observation, interviews and record reviews it was determined Resident #2 was not interviewable. Refer to interview with a medication aide (MA) on 03/31/21 at 1:56pm and 5:10pm. Refer to interview with the Community Relations	C 330		

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C 330	Continued From page 9 Director (CRD) on 03/31/21 at 4:43pm. b.Review of Resident #3's current FL2 dated 01/04/21 revealed there was an order for levetiracetam (a medication used to treat seizures) 500 mg take one tablet daily. Review of Resident #3's March 2021 electronic medication administration record (eMAR) revealed: -There was an entry for levetiracetam 500 mg take one tablet at bedtime. -There was an entry for levetiracetam 500 mg take one tablet at bedtime at 8:00pm. -There was documentation levetiracetam 500 mg take one tablet at bedtime was not administered on 03/01/21, 03/02/21, 03/03/21, 03/04/21, 03/05/21, 03/07/21, 03/08/21, 03/09/21 and 03/10/21 by circled initials on the front of the eMAR. -There was documentation on the back of the eMAR, "medication not available" for 03/01/21, 03/02/21, 03/03/21, 03/04/21, 03/05/21, 03/07/21, 03/08/21, 03/09/21 and 03/10/21 for the 8:00pm dose. -There was documentation levetiracetam 500 mg was not administered daily for 9 occurrences out of 31 opportunities from 03/01/21 to 03/31/21. Review of Resident #3's reorder request records from 02/15/21 - 03/31/21 revealed Levetiracetam 500 mg was last filled on 02/20/21. Based on observation, interviews and record reviews it was determined Resident #2 was not interviewable. Telephone interview with a nurse at Resident #3's primary care provider (PCP) office on 03/31/21 at 4:15pm revealed:	C 330		

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-Resident #3 was last seen on 02/19/21.
-Levetiracetam 500 mg was used to treat seizures.
-The PCP did not know Resident #3 had missed six doses of the levetiracetam 500 mg take one tablet daily.
-The request for refill was sent to the office on 03/11/21.
-Resident #3 could have a seizure if the medication was taken as ordered.
-The PCP expected his orders to be followed as written.

Interview with a medication aide (MA) on 03/31/21 at 1:56pm and 5:10pm.

Refer to interview with the Community Relations Director (CRD) on 03/31/21 at 4:43pm.

c. Review of Resident #3's current FL2 dated 01/04/21 revealed there was an order for Prozac (used to treat anxiety) 20 mg take two capsules daily.

Review of Resident #3's March 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Prozac 20 mg take two capsules daily.
-There was an entry for Prozac 20 mg take two capsules daily at 8:00am.
-There was documentation Prozac 20 mg take two capsules daily was not administered on 03/04/21, 03/06/21, 03/08/21, 03/09/21, 03/10/21 and 03/11/21 by circled initials on the front of the eMAR.
-There was documentation on the back of the eMAR, "medication not available" for 03/04/21, 03/06/21 and 03/08/21 for the 8:00am dose.
-There was documentation on the back of the

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C 330	Continued From page 11 eMAR, "don't have it in the facility" for 03/09/21 at 7:15am. -There was documentation on the back of the eMAR, "pharmacy has not sent refill" for 03/10/21 at 8:12am. -There was documentation on the back of the eMAR, "waiting on refill" for 03/11/21 at 8:00am. -There was documentation Prozac 20 mg was not administered daily for 6 occurrences out of 31 opportunities from 03/01/21 to 03/31/21. Review of Resident #3's reorder request records from 02/15/21 - 03/31/21 revealed: -Prozac 20 mg was last filled on 02/23/21. -Prozac 20 mg was reordered on 03/05/21 and was "rejected no refills". -Prozac 20 mg was reordered on 03/10/21 and was "rejected no refills" with a comment noted "the resident was completely out of the medication". Based on observation, interviews and record reviews it was determined Resident #2 was not interviewable. Telephone interview with a nurse at Resident #3's primary care provider (PCP) office on 03/31/21 at 4:15pm revealed: -Resident #3 was last seen on 02/19/21. -Prozac 20 mg was used to treat anxiety. -The PCP did not know Resident #3 had missed six doses of the Prozac 20 mg take two capsules daily. -The request for refill was sent to the office on 03/11/21. -Resident #3 could have a behavioral or mood changes if the medication was taken as ordered. -The PCP expected his orders to be followed as written.	C 330		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING AT ROLESVILLE	129 NORTWICK ROAD ROLESVILLE, NC 27571

(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
C 330	Continued From page 12 Refer to interview with a medication aide (MA) on 03/31/21 at 1:56am and 5:10pm. Refer to interview with the Community Relations Director (CRD) on 03/31/21 at 4:43pm. _____ Interview with a medication aide (MA) on 03/31/21 at 1:56pm and 5:10pm revealed: -Resident #3 was completely out of the medications at the beginning of March 2021 until 03/11/21 when the medication arrived from the pharmacy. -She had sent multiple refill request to the pharmacy for Resident #3 medication. -She reached out to the previous provider on 03/02/21 and found the refill request were being sent to the previous primary care provider (PCP) who would not sign the refill request order. -Resident #3 had changed providers (date unknown). -She was unsure of the date she figured out who Resident #3's new PCP was but took a few days. -She did not tell the Community Relations Director (CRD) that she did not know who Resident #3's new provider was. -The medication aides (MAs) were responsible for ordering refills. -Refill requests were sent to the pharmacy when the residents had 7 pills left. -She was responsible for following up on refill request that did not come in from the pharmacy. -She was supposed to notify the PCP after one missed dose of medication. -She did cart audits once a month. Interview with the Community Relations Director (CRD) on 03/31/21 at 4:43pm revealed: -She completed a chart audit on Resident #3 on 03/04/21. -On 03/04/21 she noticed that Resident #3 had	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092192	A. BUILDING: _____ B. WING _____	03/31/2021

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C 330	Continued From page 13 missed doses of medications due to medications not being available. -She called the facility and asked the MA on duty to send the refill request to the pharmacy. -The pharmacy was sending the refill request to the wrong provider. -There was a "drop in communication". -She did not follow up with the MA to see if the medications had arrived from the pharmacy. -She did not contact the PCP to inform them of the missed doses of medication. -The MAs were responsible for requesting refills on medications.	C 330		