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D 000	Initial Comments The Adult Care Licensure Section and the Carteret County Department of Social Services conducted an annual survey on April 20, 2022 - April 21, 2022.	D 000		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on interviews, observations, and record reviews, the facility failed to have matching therapeutic menus to use as guidance in food service for 3 of 6 sampled residents (#2, #3, and #6) who had physician orders for therapeutic diets. The findings are: Observation of a bulletin board in the kitchen on 04/20/22 at 4:40pm revealed: -There was a daily regular menu posted for breakfast, light meal, main meal, and snacks for dates ranging from 04/17/22 through 04/23/22. -The posted daily menu was signed by a licensed dietician. -There were no matching gluten free therapeutic diet menus posted for each of the daily regular menus from 04/17/22 through 04/23/22. -There were no matching low sodium therapeutic diet menus posted for each of the daily regular	D 296		

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menus from 04/17/22 through 04/23/22.
-There were no matching carbohydrate-controlled therapeutic diet menus posted for each of the daily regular menus from 04/17/22 through 04/23/22.
-There were no matching low fat/low cholesterol therapeutic diet menus posted for each of the daily regular menus from 04/17/22 through 04/23/22.

Review of the facility's diet manual on 04/21/22 at 3:55pm revealed:
-The was a list of the facility's approved diets with a diet order translation last revised on 01/14/2018.
-There were guidelines for a gluten free diet, low sodium diet, carbohydrate-controlled diet, and a low fat/low cholesterol diet last revised on 04/01/21.
-There were tables for each therapeutic diet with columns labeled food group, foods allowed daily, daily allowances, and foods to avoid.

Review of an undated daily diet modification summary report submitted by the Administrator revealed:
-There were 2 different regular breakfast diets which consisted of a carbohydrate-controlled modified menu, and a low fat/low cholesterol modified menu.
-There were 2 different regular light meal diets which consisted of a carbohydrate-controlled modified menu, and a low fat/low cholesterol modified menu.
-There were 2 different regular main meal diets which consisted of a carbohydrate-controlled modified menu, and a low fat/low cholesterol modified menu.
-There were no menu modifications listed for a low sodium diet or gluten free diet.

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D 296	Continued From page 2 Interview with the dietary staff on 04/21/22 at 3:40pm revealed: -Diet orders were made available to the dietary staff by the Health and Wellness Coordinator (HWC) or medication aides (MAs). -The facility's therapeutic diet order list was updated on a regular basis. -The facility had a therapeutic diet menu for each daily regular menu, but she had not seen it in about 3 weeks. -She used the therapeutic diet menus to help her prepare the meals served to the residents with special diet orders. -She did not have access to the kitchen computer to print off the therapeutic diet menu, but the Administrator should have access to print it. 1. Review of Resident #2's current FL-2 dated 07/09/21 revealed: -Diagnoses included essential hypertension, transient cerebral ischemic attacks, unspecified atrial fibrillation, bradycardia, and generalized anxiety. -There was an order for a gluten free diet. (A gluten free diet is appropriate for older adults with a gluten intolerance.) Review of Resident #2's medication orders revealed the resident was allergic to gluten. Review of Resident #2's subsequent diet order from a cardiologist visit dated 02/10/22 revealed a low sodium diet. (A low sodium diet restricts the sodium intake to no more than 2,000 mg per day. Residents with congestive heart failure, high blood pressure, edema, and fluid retention benefit from a low sodium diet.) Review of the facility's therapeutic diet order list	D 296		

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dated 04/20/22 revealed Resident #2 was to be served gluten free foods.

Observation of Resident #2's lunch meal on 04/21/22 at 12:30pm revealed:
-He was served 2 slices of pepperoni pizza and a salad with a white creamy dressing.
-The resident ate approximately 85% of his lunch meal.

Review of the facility's diet manual on 04/21/22 at 3:55pm revealed there was no gluten free alternative food recommended to be served in place of pepperoni pizza.

Interview with Resident #2 on 04/21/22 at 4:06pm revealed:
-He was on a gluten free diet because of his Celiac's disease and sensitivity to gluten.
-Eating a large amount of gluten gave him stomach problems in the past, causing him to drop his weight down to 118 pounds at one time.
-He ate some gluten, but only in moderation.
-Most of the gluten free snacks offered by the facility were pre-packaged and labeled as gluten free.
-His family also brought gluten free snacks to keep in his room.
-He "policed" his own dietary needs because the facility kitchen staff could not be trusted to do so.
-He did not know if the facility had a dietician available to review his dietary needs.

Refer to interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 4:31pm.

Refer to the interview with the Administrator on 04/21/22 at 4:50pm.

2. Review of Resident #3's current FL-2 dated

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03/10/21 revealed:
-Diagnoses included hyperlipidemia, Type II diabetes mellitus, and long-term insulin use.
-There was an order for a carbohydrate-controlled diet. (A carbohydrate-controlled diet offers a consistent amount of carbohydrates at meals and snack on a day-to-day basis to help manage blood glucose.)

Review of Resident #3's subsequent diet order dated 08/01/21 revealed an order for a carbohydrate-controlled diet.

Review of the facility's therapeutic diet order list dated 04/20/22 revealed Resident #3 was ordered a carbohydrate-controlled diet.

Observation of Resident #3's breakfast meal on 04/21/22 at 8:04am revealed:
-He was served corn flakes with 2% milk and banana slices, canned peach slices, a biscuit and 1 patty of sausage.
-The resident ate approximately 100% of his breakfast meal.

Observation of Resident #3's lunch meal on 04/21/22 at 12:30pm revealed:
-He was served 2 slices of pepperoni pizza and a salad with a white creamy dressing.
-The resident ate approximately 95% of his lunch meal.

Interview with Resident #3 on 04/21/22 at 4:02pm revealed he was not on any special diet or restrictive diet.

Refer to interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 4:31pm.

Refer to the interview with the Administrator on

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04/21/22 at 4:50pm.

3. Review of Resident #6's FL-2 dated 10/22/20 revealed:
-Diagnoses included hyperlipidemia, chronic atrial fibrillation and hypertension.
-There was an order for a low fat/low cholesterol diet. (A low fat/low cholesterol diet is appropriate for the management of coronary artery disease.)

Review of Resident #6's subsequent diet order dated 02/10/22 revealed a low fat/low cholesterol diet.

Review of the facility's therapeutic diet order list dated 04/20/22 revealed Resident #6 was listed to be served a low fat/low cholesterol diet.

Observation of Resident #6's breakfast meal on 04/21/22 at 7:59am revealed:
-She was served raisin bran cereal with 2% milk, grits, 1 sausage patty, 1 biscuit, and canned sliced peaches.
-The resident ate approximately 95% of her breakfast meal.

Observation of Resident #6's lunch meal on 04/21/22 at 12:30pm revealed:
-She was served 1 slice of pepperoni pizza and a salad with a white creamy dressing.
-The resident ate approximately 75% of her lunch meal.

Interview with Resident #6 on 04/21/22 at 3:30pm revealed she ate whatever everyone else was eating because she was not on a special diet.

Interview with Resident #6's family member on 04/21/22 at 3:30pm revealed:
-She was not aware the resident had a special

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D 296	Continued From page 6 diet order. -The resident usually ate and drank whatever she wanted. Refer to interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 4:31pm. Refer to the interview with the Administrator on 04/21/22 at 4:50pm. _____ Interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 4:31pm revealed: -She was unable to locate the facility's therapeutic diet menus. -She was not aware there was a specific spreadsheet with a daily menu for each of the therapeutic diets listing substitutions for the regular menu. -Medications aides (MAs) were delegated the responsibility of ensuring residents were served the correct therapeutic diet. -She was responsible for ensuring the appropriate therapeutic diet menu was served to the residents with therapeutic diet orders. Interview with the Administrator on 04/21/22 at 4:50pm revealed: -She was unable to locate the facility's therapeutic diet menus. -Dietary and clinical personnel worked together in ensuring resident's with special diet orders received the appropriate menu.	D 296		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358		

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

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents sampled (#1) related to medications for pain and anxiety.

The findings are:

Review of Resident #1's current FL-2 dated 05/18/21 revealed diagnoses included malignant neoplasm of the left breast, calcium deficiency, hypertension, gastroesophageal reflux disease (GERD), dizziness, lumbar radicular pain and anxiety.

a. Review of signed physician's orders for Resident #1 dated 04/13/22 revealed there was an order for Xanax 0.5mg 1 tablet twice a day. (Xanax is a medication used to treat anxiety).

Observation of Resident #1's medications on hand on 04/21/22 at 9:45am revealed:
-There were 11 of 12 Alprazolam 0.5mg tablets that remained from a supply dispensed on 04/19/22.
-There was 1 of 2 Alprazolam 0.5mg tablets that remained from a second supply dispensed on 04/19/22.

Review of Resident #1's April 2022 electronic medication administration record (eMAR)

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revealed:
-There was an entry for Xanax 0.5mg 1 tablet twice a day scheduled at 8:00am and 8:00pm.
-On 04/15/22 at 8:00pm, Xanax was documented as not administered due to "Pharmacy Action Required."
-On 04/16/22 at 8:00pm, Xanax was documented as not administered due to "Other."
-On 04/17/22 at 8:00pm, Xanax was documented as not administered due to "Other."
-On 04/18/22 at 8:00am, Xanax was documented as not administered due to "Other" and documented as not administered at 8:00pm due to "Pharmacy Action Required."
-On 04/19/22 at 8:00am, Xanax was documented as not administered due to "Other."
-There were 6 of 39 doses of Xanax documented as not administered from 04/01/22 - 04/20/22.

Interview with Resident #1 on 04/20/22 at 10:00am revealed:
-She had not received her medications in the last 4 days due to medications not being available.
-Since she had not received her medications, she vomited x1 episode, had a decreased appetite and some generalized discomfort.
-Her PCP provided new prescriptions at the visit and medications were delivered to the facility on the evening of 04/19/22.

Telephone interview with a pharmacist for Resident #1 on 04/21/22 at 4:35pm revealed:
-Resident #1's Xanax was on a 28-day cycle fill and was automatically dispensed monthly.
-The pharmacy sent a communication via fax to Resident #1's primary care provider (PCP) on 03/18/22 and 04/13/22 requesting a new prescription for Xanax.
-The pharmacy received a new prescription for Resident #1's Xanax on 04/19/22 and dispensed

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medication on the same date.

Refer to interview with the Health and Wellness Coordinator on 04/21/22 at 12:20pm.

Refer to telephone interview with a nurse for Resident #1's primary care provider (PCP) on 04/21/22 at 3:28pm

Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/21/22 at 2:45 was unsuccessful.

b. Review of signed physician's orders for Resident #1 dated 04/13/22 revealed there was an order for Oxycodone 5mg 1 tablet every four hours as needed for moderate pain or 2 tablets every four hours as needed for severe pain. (Oxycodone is a medication used to relieve pain).

Observation of Resident #1's medications on hand on 04/21/22 at 9:45am revealed there were 57 of 60 Oxycodone 5mg tablets that remained from a supply dispensed on 04/19/22.

Interview with Resident #1 on 04/20/22 at 10:00am revealed:
-She had not received her medications in the last 4 days due to medications not being available.
-Since she had not received her medications, she vomited x1 episode, had a decreased appetite and some generalized discomfort.
-She went to her primary care provider (PCP) on 04/19/22 and had difficulty transferring to and from the wheelchair due to hip discomfort.
-Her PCP provided new prescriptions at the visit and medications were delivered to the facility on the evening of 04/19/22.

Telephone interview with a pharmacist for

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D 358	Continued From page 10 Resident #1 on 04/21/22 at 4:35pm revealed: -Resident #1's Oxycodone was not on a cycle fill and it was the facility's responsibility to notify the pharmacy when medication needed to be refilled. -The pharmacy sent a communication to Resident #1's PCP via fax on 03/18/22 and 04/13/22 requesting a new prescription for Oxycodone. -The facility notified the pharmacy via fax on 04/17/22 requesting a refill on Resident #1's Oxycodone. -The pharmacy notified the facility on 04/17/22 via fax that a new prescription was needed for Resident #1's Oxycodone. -The pharmacy received a new prescription for Resident #1's Oxycodone on 04/19/22 and dispensed the medication on the same date. -It was the responsibility of the PCP to write a new prescription each month for the dispensing of Resident #1's Oxycodone. -It was the responsibility of the facility to notify Resident #1's PCP when a new prescription was needed for her Oxycodone. Refer to interview with the Health and Wellness Coordinator on 04/21/22 at 12:20pm. Refer to telephone interview with a nurse for Resident #1's primary care provider (PCP) on 04/21/22 at 3:28pm Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/21/22 at 2:45 was unsuccessful. _____ Interview with the Health and Wellness Coordinator on 04/21/22 at 12:20pm revealed: -Resident #1 had been out of her medication for pain and anxiety for about 4 days.	D 358		

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D 358	Continued From page 11 -She had been reaching out to Resident #1's primary care provider (PCP) via fax and telephone for a new script however was not successful. -She scheduled an emergency appointment for Resident #1 to be seen by her PCP on 04/19/22 and new prescriptions were received. -Resident #1 received her Oxycodone and Xanax from the pharmacy on the night of 04/19/22. -It was the responsibility of the medication aides (MA) to notify the pharmacy when medications needed to be refilled. -It was the responsibility of the MA to notify the PCP if a new script needed to be completed for medication refills. Telephone interview with a nurse for Resident #1's primary care provider (PCP) on 04/21/22 at 3:28pm revealed: -Resident #1 was seen at the PCP office on 04/19/22 and new prescriptions were sent to the pharmacy for Xanax and Oxycodone. -She was not sure if the facility requested any new prescriptions prior to 04/19/22. -It was the responsibility of the facility to notify the PCP via fax if new prescriptions were needed for refills. -It was the responsibility of the PCP to complete new prescription requests within 48hrs after receipt.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	D 367		

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D 367	Continued From page 12 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of 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). This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the electronic medication administration records were accurate for 1 of 5 sampled residents including documentation of the administration of pain medication and antianxiety medication (#1). The findings are: Review of the facility's Medication and Treatment-Medication Administration Policy dated 12/2017 revealed: -After medications were consumed by the resident, the staff would document the 'Administered' chart code that reflected that the medication was taken, -If the medications were refused or not given/taken, the staff would document the appropriate chart code in the administration details that reflected the refusal or reason the medication was not given/taken.	D 367		

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D 367	Continued From page 13 -Upon saving the electronic medication administration record (eMAR) documentation, the associates' electronic signature would be electronically recorded. Review of Resident #1's current FL-2 dated 05/18/21 revealed diagnoses included malignant neoplasm of the left breast, calcium deficiency, hypertension, gastroesophageal reflux disease (GERD), dizziness, lumbar radicular pain and anxiety. Review of signed physician's orders for Resident #1 dated 04/13/22 revealed: -There was an order for Oxycodone 5mg 1 tablet every four hours as needed for moderate pain or 2 tablets every four hours as needed for severe pain. (Oxycodone is a medication used to relieve pain). Observation of Resident #1's medications on hand on 04/21/22 at 9:45am revealed: -There were 57 of 60 Oxycodone 5mg tablets that remained from a supply dispensed on 04/19/22. Review of Resident #1's controlled substance log revealed an entry for Oxycodone 5mg 1 or 2 tablets every four hours as needed for pain control. Review of Resident #1's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone 5mg 1 tablet every four hours as needed for moderate pain. -There was an entry for Oxycodone 5mg 2 tablets every four hours as needed for severe pain. -There were 13 doses of Oxycodone not documented on the eMAR as administered from 02/01/22 - 02/28/22.	D 367		

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D 367	Continued From page 14 -On 2/04/22, there was no documentation of administration of Oxycodone on the eMAR, but Oxycodone one tablet was documented as administered at 3:30pm on the resident's controlled substance log. -On 02/05/22 ,two Oxycodone 5mg tablets were documented as administered at 4:07pm on the resident's eMAR, but Oxycodone, one tablet was documented as administered at 4:00pm on the resident's control substance log. -On 02/06/22 ,there was no documentation of administration of Oxycodone the resident's eMAR, but Oxycodone, one tablet was documented as administered at 2:30pm on the resident's control substance log. -On 02/07/22 ,there was no documentation of administration of Oxycodone the resident's eMAR, but Oxycodone, one tablet was documented as administered at 5:00am on the resident's control substance log. -On 02/08/22 ,one Oxycodone 5mg tablet was documented as administered at 6:02am on the resident's eMAR, but Oxycodone, one tablet was documented as administered at 2:50pm on the resident's control substance log. -On 02/13/22 ,there was no documentation of administration of Oxycodone the resident's eMAR, but Oxycodone, one tablet was documented as administered at 2:45pm on the resident's control substance log. -On 02/19/22 ,there was no documentation of administration of Oxycodone the resident's eMAR, but Oxycodone, one tablet was documented as administered at 3:30pm on the resident's control substance log. -On 02/20/22 ,there was no documentation of administration of Oxycodone the resident's eMAR, but Oxycodone, one tablet was documented as administered at 10:30am on the resident's control substance log.	D 367		

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D 367	Continued From page 15 -On 02/24/22 ,there was no documentation of administration of Oxycodone the resident's eMAR, but Oxycodone, one tablet was documented as administered at 9:46am on the resident's control substance log. -On 02/25/22 ,there was no documentation of administration of Oxycodone the resident's eMAR, but Oxycodone, one tablet was documented as administered at 7:30pm on the resident's control substance log. -On 02/26/22 ,one Oxycodone 5mg tablet was documented as administered at 6:17am on the resident's eMAR, but Oxycodone, one tablet was documented as administered at 11:00am, 4:00pm, and 8:00pm on the resident's control substance log. Review of Resident #1's March 2022 eMAR revealed: -There was an entry for Oxycodone 5mg 1 tablet every four hours as needed for moderate pain. -There was an entry for Oxycodone 5mg 2 tablets every four hours as needed for severe pain. -There were 13 doses of Oxycodone not documented as administered on the eMAR from 03/01/22 - 03/31/22. -On 03/03/22, there was no documentation of administration of Oxycodone on the resident's eMAR, but Oxycodone, one tablet was documented as administered at 3:41pm on the resident's control substance log. -On 03/05/22, there was no documentation of administration of Oxycodone on the resident's eMAR, but Oxycodone, one tablet was documented as administered at 9:00am on the resident's control substance log. -On 03/06/22, one Oxycodone 5mg tablet was documented as administered at 11:00am on the resident's eMAR, but Oxycodone, two tablets were documented as administered at 3:39pm on	D 367		

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the resident's control substance log.
-On 03/10/22, there was no documentation of administration of Oxycodone on the resident's eMAR, but Oxycodone, one tablet was documented as administered at 3:40pm on the resident's control substance log
-On 03/12/22, two Oxycodone 5mg tablet was documented as administered at 6:13am on the resident's eMAR, but Oxycodone, one tablet was documented as administered at 6:13am on the resident's control substance log.
-On 03/17/22, there was no documentation of administration of Oxycodone on the resident's eMAR, but Oxycodone, one tablet was documented as administered at 2:00pm on the resident's control substance log.
-On 03/19/22, one Oxycodone 5mg tablet was documented as administered at 2:23pm on the resident's eMAR, but Oxycodone, one tablet were documented as administered at11:00am, 3:00pm, and 9:00pm on the resident's control substance log.
-On 03/20/22, there was no documentation of administration of Oxycodone on the resident's eMAR, but Oxycodone, one tablet was documented as administered at 3:30pm on the resident's control substance log.
-On 03/25/22, there was no documentation of administration of Oxycodone on the resident's eMAR, but Oxycodone, one tablet was documented as administered at 8:00pm on the resident's control substance log.
-On 03/26/22, two Oxycodone 5mg tablets were documented as administered at 3:43pm on the resident's eMAR, but Oxycodone, one tablet was documented as administered at 3:43pm on the resident's control substance log.
-On 03/27/22, one Oxycodone 5mg tablet was documented as administered at 5:56am, 2:45pm, and 9:59pm on the resident's eMAR, but

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Oxycodone, one tablet were documented as administered at 5:56am, 12:00pm, and 5:00pm on the resident's control substance log.

Review of Resident #1's April 2022 eMAR revealed:
-There was an entry for Oxycodone 5mg 1 tablet every four hours as needed for moderate pain.
-There was an entry for Oxycodone 5mg 2 tablets every four hours as needed for severe pain.
-There were 2 doses of Oxycodone not documented as administered from 04/01/22 - 04/20/22.
-On 04/10/22, there was no documentation of administration of Oxycodone on the resident's eMAR, but Oxycodone, one tablet was documented as administered at 3:15pm on the resident's control substance log.
-On 04/11/22, there was no documentation of administration of Oxycodone on the resident's eMAR, but Oxycodone, one tablet was documented as administered at 6:00pm on the resident's control substance log.

Interview with the Health and Wellness Coordinator on 04/21/22 at 5:00pm revealed:
-It was the responsibility of the medication aides (MA) to document on the eMAR and the control subtance logs after medications were administered.
-The documentation on the eMAR should match the documentation on the controlled substance log.

Interview with the Administrator on 04/21/22 at 5:05pm revealed:
-It was the responsibility of the MA to document on the eMAR after administration of medications.
-The controlled substance log documentation should match the documentation on the eMAR.

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D 367	Continued From page 18 Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/21/22 at 2:45pm was unsuccessful.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the morning medication pass observed on 04/21/22 related to medication administered to a resident after dropped on the floor. The findings are: Observation of the morning medication pass on 04/21/22 from 7:30am - 8:05am revealed: -The medication aide (MA) prepared Resident #7's medication at the medication cart and took them to her room. -Resident #7 poured the medications from the medication cup onto the bedside table and took medications one pill at a time. -Resident #7 dropped 2 pills onto the floor while consuming medications. -The MA picked up the 2 pills from the floor, gave the pills to Resident #7 and Resident #7 consumed the medication.	D 371		

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D 371	Continued From page 19 -The MA did not offer to replace the 2 pills that fell onto the floor. Interview with the MA on 04/21/22 at 8:00am revealed: -She did not offer to replace the 2 pills that Resident #7 dropped onto the floor. -Resident #7 poured medication on the bedside and often the medications dropped onto the floor. -She had offered in the past to replace medication that fell on the floor however Resident #7 declined due to the cost of medications. -She should offer each time to replace any medication that was dropped or spilled. Interview with the Health and Wellness Director on 04/21/22 at 12:20pm revealed it was the responsibility of the MA to replace any medications that are dropped or spilled. Interview with the Administrator on 04/21/22 at 3:00pm revealed it was the responsibility of the MA to replace any medications that are dropped or spilled.	D 371		
D 377	10A NCAC 13F .1006(a) Medication Storage 10a NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and	D 377		

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interviews, the facility failed to ensure that a residents' medications were stored in a safe and secure manner for 1 of 1 resident sampled (#2) who self-administered medications which included medications to treat heart rate, constipation, a supplemental vitamin, a controlled medication used to treat anxiety, an herbal supplement used for sleep, and a discontinued medication used to decrease stomach acid.

The findings are:

Review of the facility's policies and procedures for self-administration for medications with an effective date of March 2006 and a revised date of March 2022 revealed:
-Residents who desire to self-administer medication should be permitted to do so if the admitting medical provider verifies that it is appropriate, the nurse had confirmed the residents' abilities in this regard and any applicable state requirements were met.
-Residents who self-administer their own medications may store and secure their non-controlled medications in their apartment by locking the apartment door each time upon departure; should store controlled medications in a locked drawer or cabinet so that they are not accessible to others.
-Controlled medications were considered double locked when locked in a drawer/cabinet and when the apartment door was locked.

Review of Resident #2's current FL-2 dated 07/29/21 revealed:
-Diagnoses included essential hypertension, transient cerebral ischemic attacks, unspecified atrial fibrillation, bradycardia, and generalized anxiety.
-There was an order for MiraLAX 17grams once

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daily for constipation; unsupervised and self-administration mixed in liquid of choice. (MiraLAX is a medication used to treat constipation).
-There was an order for Melatonin 5mg daily at bedtime. (Melatonin is an herbal supplement used to promote sleep).

Review of Resident #2's subsequent medication orders revealed:
-There was an order dated 01/06/22 for Xanax 0.5mg ½ tablet for acute anxiety daily, may self-administer. (Xanax is a medication used to treat anxiety).
-There was an order dated 02/22/22 to discontinue the unsupervised self-administration of Xanax 0.5mg daily and start as needed Xanax 0.5mg daily as needed.

Review of an emegency room visit information form for Resident #2 dated 01/22/22 revealed a medication dose with instructions for Metoprolol Succinate XL 25 mg ½ tablet daily for 30 days. (Metoprolol is a blood pressure medication and used to help the heart from beating too fast).

Observation of Resident #2's room on 04/20/22 at 10:16am revealed there was a small medication cup containing a white colored tablet and a orange colored 1/2 tablet stored on the resident's nightstand beside the resident's bed.

Interview with Resident #2 on 04/20/22 at 10:16am revealed:
-The medications in the medication cup were a heart pill and an anxiety pill that he took only if he needed them.
-He took a Vitamin D2 supplement one time a week every Thursday.
-He took a 1/2 tablet of Metoprolol as needed

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when his heart was beating fast.
-He was taking Diazepam as needed but the medication was replaced with Xanax. (Diazepam and Xanax are medications used to treat anxiety).
-He kept his Metoprolol, Vitamin D2 and Xanax in his room.
-He had a bottle of Protonix in his room as well, but he was no longer taking this medication.

Interview with Resident #2 on 04/20/22 at 4:55pm revealed:
-He self-administered some of his medications.
-When he left his room, he did not lock his room door.
-He had a lock box under the sink but did not use the lock box to store his medications in.

Interview with the Administrator on 04/20/22 at 5:00pm revealed:
-All medications self-administered by residents must be kept locked/secured in the room.
-She was not aware Resident #2 had medications that were not locked/secured in his room.

Observation of a lock box in Resident #2's room on 04/21/22 at 9:10am revealed:
-The lock box had a key and was stored underneath a sink in the resident's room with paper bags stored on top of the lock box.
-There was a key inside the lock.
-There were no medications stored in the lock box.
-The resident turned the key to the locked position , then turned the key back to the unlocked position.

Interview with Resident #2 on 04/21/22 at 9:10am and 4:06pm revealed:
-He was getting ready to leave the facility for a medical appointment scheduled around 10:00am.

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D 377	Continued From page 23 -He was provided a lockable box when he first moved into the facility, but he had never used the lock box to store his medications in. -He had not been instructed he had to lock his medications up in his room in the lock box and had never had to lock his room door when he left his room for the 3 years he had lived at the facility. -There were no residents who wandered into his room. -He had never had any issues or concerns with any residents entering his room when he was not present in the room. -There had not been any questions how he stored his medications before. -He had been instructed (By the Health and Wellness Coordinator (HWC) and Administrator) today, 04/21/22, he was required to lock his medications in the lock box and lock his door when he was not in his room. Interview with a medication aide (MA) on 04/21/22 at 9:57am revealed: -She was aware there were some medications that Resident #2 had an order to self-administer. -The facility's policy required all medications self-administered by the resident to be stored locked/secured in the room . -She had never seen medications in Resident #2's room that was not locked and secured. -She thought Resident #2 locked his room door when he was not in the room. -There was one resident diagnosed with dementia who lived on the assisted living (AL) section of the facility however, the resident was moved to the special care unit (SCU) a few weeks ago. -Currently, there were no residents with wandering behaviors or diagnosed with dementia residing on the AL section of the facility.	D 377		

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D 377	Continued From page 24 Interview with the Administrator on 04/21/22 at 10:00am revealed: -She was not aware Resident #2 was not storing his medications in a locked box and did not lock his door when he was not in his room. -She, the HWC, and the Corporate Clinical Director would ensure Resident #2's self-administered medications were stored in his room secured/locked. Interview with the HWC on 04/21/22 at 4:32pm revealed: -She was not aware of the facility's specific policy regarding the storage of the resident's self-administered medications. -Today, 04/21/22, she and the Administrator had educated Resident #2 the medications in his room must always be kept secured by locking his room door and to store the medications in the locked box . -Controlled medications were considered double locked when locked in a drawer/cabinet and when the apartment door was locked. Interview with the Administrator on 04/21/22 at 10:00am revealed: -It was a problem that Resident #2's self-administration medications stored in his room were not locked especially medications that were a narcotic and a heart medication. -The resident had a narcotic that should have been stored and secured under a double lock. -Resident #2's self-administered medication must be stored secured/lock at all times for safety.	D 377		