STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032020	A. BUILDING: _____ B. WING _____	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM PARKWAY DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey and Follow Up Survey on 08/31/22-09/02/31.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (#2) related to not notifying the primary care provider (PCP) of blood pressures. The findings are: Review of Resident #2's current FL-2 dated 02/10/22 revealed diagnoses included compression, anemia, anxiety, arrythmia, arthritis, diabetes mellitus hyperlipidemia hypertension and osteoporosis. Review of Resident #2's physician order dated 06/08/22 revealed there was an order for blood pressure checks once daily; notify the primary care provider (PCP) when blood pressures were greater than 170. Review of Resident #2's physician order dated 08/31/22 revealed Resident #2 was ordered daily blood pressure check with parameters; call the PCP for blood pressures greater or equal to 170. Review of Resident #2's electronic medication administration record (eMAR) for June 2022, July	D 273	All medication technicians will receive training on the importance of following physician orders and notifying providers as instructed. Facility will utilize EMR alert that requires staff to contact provider when parameters are ordered. Community nurse or designee will complete monthly MAR audit.	11/30/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deon K Simpson | TITLE: Administrator | (X6) DATE: 10/17/2022

Reviewed and acknowledged 10/20/22.
Kathy Gray

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2022 and August 2022 revealed there was not an entry to check Resident #2's blood pressures daily or to notify the PCP if blood pressures were greater than or equal to 170.

Review of Resident #2's blood pressure logs for June 2022 revealed:
-Resident #2's blood pressure was documented as taken daily from 06/01/22 to 06/30/22.
-On 06/05/22 Resident #2's blood pressure was documented as 193 at 7:36am.
-On 06/18/22 Resident #2's blood pressure was documented as 176 at 9:42pm.
-On 06/19/22 Resident #2's blood pressure was documented as 179 at 9:04pm.
-On 06/23/22 Resident #2's blood pressure was documented as 179 at 9:37pm.
-On 06/26/22 Resident #2's blood pressure was documented as 176 at 8:46pm.
-There were no parameters documented on the log.

Review of Resident #2's blood pressure logs for July 2022 revealed:
-Resident #2's blood pressure was documented as taken daily from 07/01/22 to 07/28/22 and 07/30/22 to 07/31/22; there was nothing documented for 07/29/22.
-On 07/01/22 Resident #2's blood pressure was documented as 174 at 9:23pm.
-On 07/09/22 Resident #2's blood pressure was documented as 175 at 7:21pm and 175 at 8:57pm.
-On 07/14/22 Resident #2's blood pressure was documented as 178 at 9:33pm.
-On 07/16/22 Resident #2's blood pressure was documented as 177 at 9:48pm.
-On 07/22/22 Resident #2's blood pressure was documented as 173 at 2:02pm and 8:56pm.
-On 07/26/22 Resident #2's blood pressure was

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documented as 175 at 9:37am.
-On 07/30/22 Resident #2's blood pressure was documented as 176 at 9:50pm.

Review of Resident #2's blood pressure logs for August 2022 revealed:
-Resident #2's blood pressure was documented as taken daily from 08/01/22 to 08/20/22 and 08/22/22 to 08/31/22; there was nothing documented for 07/21/22.
-On 08/14/22 Resident #2's blood pressure was documented as 176 at 9:38pm.
-On 08/15/22 Resident #2's blood pressure was documented as 170 at 2:48pm.
-On 08/17/22 Resident #2's blood pressure was documented as 175 at 9:49pm.
-On 08/25/22 Resident #2's blood pressure was documented as 173 at 12:18pm.
-On 08/27/22 Resident #2's blood pressure was documented as 173 at 2:17pm and 9:35pm.
-On 08/28/22 Resident #2's blood pressure was documented as 184 at 8:46pm.

Review of Resident #2's facility progress notes and PCP notification forms revealed there was no documentation the PCP was notified for blood pressure readings greater than or equal to 170 from 06/01/22 to 08/31/22.

Review of Resident #2's electronic medication administration records (eMAR) for June 2022 , July 2022 and August 2022 revealed there was no documentation the PCP was notified for blood pressure readings greater than or equal to 170.

Interviews with Resident #2 on 08/31/22 at 8:27am and 4:00pm revealed:
-He knew he had high blood pressure, but he did not know what he took for it.
-Staff took his blood pressures but he did not

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know how often.
-He had been feeling fine; he thought he saw his PCP last week.

Telephone interview with Resident #2's primary care provider (PCP) on 09/01/22 at 2:21pm revealed:
-There had not been any communication from the facility about Resident #2's blood pressure.
-She expected the facility to contact her when there were blood pressures that were above parameters.
-If the facility staff had let her know there were blood pressures equal to or above 170, she could have ordered Resident #2 an additional medication.
-The facility should always let the PCP know so medications could be increased or withheld.
-Resident #2's blood pressure went up and down; she needed to be notified so she could make a plan.
-The concern was Resident #2's blood pressure could become too high and he would be at increased risk for stroke.

Interview with a personal care aide (PCA) on 09/01/22 at 4:45pm revealed:
-The PCAs did the blood pressure checks for Resident #2.
-She gave the sheet she documented the blood pressure checks on the MA after she was done.
-She did not notify the PCP because she did not know what everyone's parameters were.

Interview with a medication aide (MA) on 09/01/22 at 3:26pm revealed:
-If a resident's blood pressure was too high, she would recheck it and then notify the PCP.
-The PCAs took the daily blood pressures and gave them to her to enter into the eMAR system.

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D 273	Continued From page 4 -She had to contact the PCP once because Resident #2's blood pressures were outside of the parameters. -She had documented it in the 24-hour report; she did not recall when it was or what she was told to do about the blood pressure. -She also reported the increased blood pressures to the facility nurse. Interview with the Licensed Practical Nurse (LPN) on 09/01/22 at 4:59pm revealed: -She expected the MAs to note the blood pressures and when they were outside of the parameters to notify the PCP. -The PCAs took blood pressures and documented them on a sheet, they then gave the sheet to the MA who would notify the PCP when there were concerns about parameters. -When a blood pressure reading was considered critical then the PCP should be called immediately, and the facility nurse should also be called. Interview with the Administrator on 09/01/22 at 6:02pm revealed: -It appeared staff did not notify the PCP; there should have been documentation somewhere in the progress notes or on the eMAR system. -Staff should have notified the PCP when the blood pressures were outside of parameters. -She would be concerned Resident #2 would be in discomfort. -The ordered to notify the PCP should have been followed.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the	D 276		

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D 276	Continued From page 5 following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure compression stocking application were applied for 1 of 5 residents, (#2). The findings are: Review of Resident #2's current FL-2 dated 02/10/22 revealed diagnoses included compression, anemia, anxiety, arrythmia, arthritis, diabetes mellitus hyperlipidemia hypertension and osteoporosis. Review of Resident #2's physicians order dated 05/02/22 revealed: -There was an order for compression hose to the knee; 15-20mmgh for orthostatic hypotension; application would reduce orthostasis. -The compression hose were to be applied in the morning and removed in the evening to help maintain blood pressure when standing and sitting. Review of Resident #2's physicians order dated 08/31/22 revealed there was an order for compression hose to the knee to be applied to the lower legs in the morning and removed in the evening. Review of Resident #2's Licensed Health Profession Support (LHPS) report dated 08/30/22	D 276	All medication technicians will receive training on the importance of executing Physician's orders and notifying administration if product is unavailable. Nurse to assess availability and placement of hose during LHPS audits and Medication tech or designee to complete daily ted hose audit.	11-30-2022

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revealed Resident #2 had a task for TED hose to be applied and removed every day.

Observation of Resident #2 on 08/31/22 from 8:27am to 3:33pm revealed:
-At 8:27am Resident #2 was sitting in a recliner in his room; he did not have on compression hose.
-At 12:00pm he was in the dining room eating lunch and he did not have on compression hose.
-At 3:33pm he was sitting in his recliner in his room; he did not have on compression hose.
-There was a pair of black compression stockings on a small table in his room.

Observation of Resident #2 on 09/01/22 from 9:35am to 4:45pm revealed:
-At 9:35am he was sitting in his recliner in his room; he did not have on compression hose.
-At 11:15am he was in the main living area playing a group game; he did not have on his compression hose.
-At 4:45pm he was sitting in his room; he did not have on compression hose.
-There were three pair of black compression hose in his top dresser drawer.

Review of Resident #2's June 2022 eMAR revealed:
-There was an entry for compression stocking to be applied in the morning and removed in the evening.
-From 06/02/22 to 06/30/22 Resident #2's compression stocking were not applied and were documented as on hold 24 times.

Review of Resident #2's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for compression stocking to be applied in the morning and removed in the

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evening.
-From 07/01/22 to 07/31/22 Resident #2's compression stocking were not applied and were documented as not administered.
-There was notation three times that Resident #2' hose were pending measurements on 07/07/22, 07/16/22 and 07/20/22.

Review of Resident #2's August 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for compression stocking to be applied in the morning and removed in the evening.
-From 08/01/22 to 08/31/22 Resident #2's compression stocking were not applied and were documented as not administered.
-There was notation four times that Resident #2' hose were "pending" on 08/13/22, 08/14/22, 08/19/22 and 08/27/22.
-There was documentation on 08/02/22 Resident #2 had been refusing measurements stating that he was not going to wear the stockings.

Interview with Resident #2 on 08/31/22 at 3:33pm revealed:
-He could not recall if he ever had compression stockings applied.
-He could not remember talking to anyone about them or being measured for compression stocking.
-He could not remember why he needed to wear compression stockings.
-He would wear them if he was told to wear them.

Telephone interview with Resident #2's family member on 09/01/22 at 4:29pm revealed:
-He received a telephone call on 09/01/22 about Resident #2's compression hose; he did not know until that day that he needed to purchase the

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compression hose for Resident #2.
-Resident #2 had compression hose at one time but he did not know what happened to them.
-The facility gave him the measurements so he could purchase the correct hose.

Telephone interview with Resident #2's pharmacy on 08/31/22 at 4:38pm revealed:
-They did not supply Resident #2 with compression hose.
-They did not enter the order into the eMAR.

Telephone interview with Resident #2's primary care provider (PCP) on 09/01/22 at 2:21pm revealed:
-Resident #2 was ordered the compression hose for orthostatic hypostatic to help maintain blood pressure when sitting.
-When he was walking it helped to keep the pressure low when he was standing up.
-She had written the order on 05/02/22; she had hoped the facility would have ordered the compression hose and had them for use withing a couple of weeks.
-The PCP's concern was for low blood pressure with standing and he would become a fall risk.
-The PCP expected the order to be followed as written.

Interview with a personal care aide (PCA) on 09/01/22 at 4:45pm revealed:
-She knew Resident #2 had compression hose available to wear.
-She would remove his hose in the evening if he had them on.
-She would report to the medication aide (MA) on second shift that Resident #2 did not have his compression hose on to remove at night.

Interview with the MA on 08/31/22 at 3:50pm

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revealed:
-At first Resident #2 refused to be measured for his compression stockings.
-He told her he was not going to wear them.
-Resident #2 had a pair because she measured him not to long ago.
-He refused to wear them now that he had them.
-His compression stocking came from the pharmacy on 08/20/22.
-The MAs applied the compression stocking in the mornings between 6:00am and removed them around 8:00pm to 9:00pm every evening.
-He could not remove them or apply them himself.

Interview with a second MA on 09/01/22 at 12:02pm revealed:
-Resident #2 was measured for him for compression hose on third shift and they sent the order to the pharmacy.
-The pharmacy did not fill the order due to insurance reasons.
-The family was responsible for suppling the compression hose.
-She could not recall when she had measured Resident #2; it was recently.
-The pharmacy did not let them know they did not fill the order, they had to call the pharmacy to find out what had happened.

Interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 12:23pm revealed:
-She found out about Resident #2's compression hose about three weeks ago.
-It was brought to her attention by a MA; it had been a flag on the eMAR because it had been red.
-She had measured Resident #2 on third shift and had sent to order to the pharmacy herself.
-She contacted the pharmacy on 8/30/22 to find

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D 276	Continued From page 10 out when the compression hose was going to be sent; she was told they could not supply them for insurance reasons. -She reached out to the family so they could purchase them for Resident #2. -Resident #2 had some edema when she checked on him last week; he had some swelling 3 plus. Interview with the Administrator on 09/01/22 at 6:02pm revealed: -The PCP usually ordered compression hose and sent the order to the pharmacy for filling. -If the PCP did not measure for the compression hose then the pharmacy would send the form to measure the hose to the facility. -The MA or the LPNN would measure the resident for the compression hose and send the order to the pharmacy. -She thought Resident #2's compression hose had been ordered the week before or the beginning of the current week. -They should have been documentation on the eMAR when the compression hose were not applied; there should have been documentation on the 24-hour report so the other shifts would know and so would the LPN. -The concern was no one was notified the compression hose were not applied; there could have been an issue with gait while walking and a risk for fall. -There should have been more done than just documentation; the LPN should have been made aware Resident #2's compression hose were not being applied or not available to be applied.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders	D 344		

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D 344	Continued From page 11 (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 residents sampled (#5) who had an order for a daily blood thinner but had been receiving the blood thinner twice daily. The findings are: Review of Resident #5's FL-2 dated 03/22/22 revealed: -Diagnoses included dementia and hypertension. -There was an order for Eliquis (used as a blood thinner to prevent clots from forming) 2.5mg twice daily. Review of Resident #5's current FL-2 dated 06/22/22 revealed: -Diagnoses included dementia and hypertension. -There was an order for Eliquis 2.5mg daily. Review of Resident #5's physician's orders dated 08/31/22 revealed an order for Eliquis 2.5mg every 12 hours.	D 344	All medication technicians will receive training on the importance of following physician orders and contacting provider for clarification as needed. Nurse and or designee will complete daily new order verification.	11-30-2022

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D 344	Continued From page 12 Review of Resident #5's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Eliquis 2.5mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Eliquis 2.5mg was administered twice daily from 06/01/22 to 06/30/22. Review of Resident #5's July 2022 eMAR revealed: -There was an entry for Eliquis 2.5mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Eliquis 2.5mg was administered twice daily from 07/01/22 to 07/31/22. Review of Resident #5's August 2022 eMAR revealed: -There was an entry for Eliquis 2.5mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Eliquis 2.5mg was administered twice daily from 08/01/22 to 08/31/22. Observation of Resident #5's medication on hand on 09/01/22 at 9:32am revealed: -There was a bubble pack labeled Eliquis 2.5mg every 12 hours with 8 of 30 tablets remaining with a dispensed date of 08/05/22. -There was a second bubble pack labeled Eliquis 2.5mg every 12 hours with 30 of 30 tablets remaining with a dispensed date of 08/05/22. -There was a third and fourth bubble pack labeled Eliquis 2.5mg every 12 hours with 30 of 30 tablets remaining in each bubble pack with a dispensed	D 344		

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D 344	Continued From page 13 date of 08/27/222. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/01/22 at 10:16am revealed: -The pharmacy had an order for Eliquis 2.5mg every 12 hours dated 03/31/22. -The pharmacy dispensed 60 Eliquis 2.5mg (a 30-day supply) on 06/14/22, 08/05/22, and 08/27/22. -The pharmacy did not receive Resident #5's FL-2 dated 06/22/22 with the order for Eliquis 2.5mg daily. Interview with a medication aide (MA) on 09/01/22 at 4:34pm revealed: -She administered medications to Resident #5. -Resident #5 received Eliquis 2.5mg twice a day according to the entry on the eMAR. -She had not seen the FL-2 dated 06/22/22 and did not know there had been a change in the order for Eliquis. -The Licensed Practical Nurse (LPN) received and reviewed the FL-2 and entered the orders in the electronic medical record. -She administered medications to Resident #1 based on the entry on the eMAR and the medication dispensed by the pharmacy. -The entry on the eMAR and the medication dispensed by the pharmacy where the same; Eliquis 2.5mg twice daily. Telephone interview with the Primary Care Provider (PCP) on 09/01/22 at 1:48pm revealed: -Resident #5 was ordered Eliquis because of a history of strokes. -The normal dosing of Eliquis was twice a day. -She did not know why Eliquis was changed from twice a day to daily on the FL-2 dated 06/22/22. -She thought it was an oversight when the order	D 344		

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D 344	Continued From page 14 was written on the FL-2 and it should have been written as Eliquis 2.5mg twice daily. Interview with the facility's LPN on 09/01/22 at 4:41pm revealed: -The FL-2 was completed by the PCP. -The LPN was responsible for entering new or changed orders into the eMAR. -She did not recall reviewing Resident #5's FL-2 dated 06/22/22. -She was not sure who reviewed Resident #5's FL-2 dated 06/22/22. -She would have called the PCP to clarify the order since Resident #5 had been receiving Eliquis 2.5mg twice daily since admission in March 2022. Interview with the Administrator on 09/01/22 at 5:53pm revealed: -There appeared to be a discrepancy in the order on the FL-2 dated 06/22/22 with what was currently being administered. -Resident's FL-2's was reviewed by the LPN for accuracy. -The PCP should have been notified when the discrepancy was found to clarify the order for Eliquis. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.	D 344		
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	D 358		

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D 358	Continued From page 15 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 ensure medications were administered as ordered for 3 of 5 sampled residents (#1, #2, and #3) including two residents whose blood pressure was not taken prior to administering a blood pressure medication (#1,#2), a medication for tremors and mobility related to Parkinson's disease, a medication to help with depression and anxiety, a medication to treat mood, a supplement, and an ointment to help with skin irritation (#1); a pain medication (#2); and a blood pressure medication used to treat tremors and control high blood pressure, three antibiotics, a medication for an overactive bladder and a medication used for sleep and the dosage of a medication used to treat mild pain was not decreased for 30-days after the ordered changed (#3). The findings are: 1. Review of Resident #3's current FL-2 dated 07/12/22 revealed diagnoses included neurogenic bladder (neurogenic bladder is a urinary condition in people who lack bladder control due to a brain, spinal cord, or nerve problem), hypertension, and spinocerebellar ataxia (a progressive, degenerative disease that causes poor balance and lack of coordination). Review of Resident #3's resident register	D 358	All medication aides will complete the 10-hour State required training with a focus on medication administration. Nurse manager will complete MAR to cart audit on the residents identified during the survey process. In addition to the identified residents the Nurse manager and or designee will complete 100% MAR to cart audit x 3 months.	11-30-2022

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D 358	Continued From page 16 revealed the resident did not have a resident register. Review of Resident #3's chart notes revealed an admission date of 07/19/22. a. Review of Resident #3's physician's orders dated 07/19/22 revealed an order for Tylenol ER 650mg (2 tablets) three times a day. Review of Resident #3's physician's orders dated 07/30/22 revealed an order for Tylenol ER 650mg three times a day. Review of Resident #3's electronic medication administration record (eMAR) for 07/31/22 revealed: -There was an entry for Tylenol 650 mg ER, 650mg three times a day with a scheduled administration time of 7:00am, 11:30am, and 8:30pm. -There was documentation Tylenol 650mg ER was administered at 7:00am, 11:30am, and 8:30pm on 07/31/22. Review of Resident #2's August 2022 eMAR revealed: -There was an entry for Tylenol 650 mg ER, 650mg three times a day with a scheduled administration time of 7:00am, 11:30am, and 8:30pm. -There was documentation Tylenol 650mg was administered at 7:00am twenty-two times from 08/01/22-08/05/22, 08/07/22-08/08/22, and 08/10/22-08/31/22. -There was documentation Tylenol 650mg was administered at 11:30am twenty-four times from 08/01/22-08/07/22, 08/10/22-08/11/22, 08/13/22-08/14/22, 08/16/22-08/28/22. -There was documentation Tylenol 650mg was	D 358		

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administered at 8:30pm twenty-nine times. from 08/01/22-08/27/22, and 08/29/22-08/30/22.

Observation of Resident #3's medications on hand on 08/31/22 at 2:40pm revealed:
-There was a bubble pack labeled Tylenol ER 650mg take 2 tablets three times a day dispensed on 08/17/22; each bubble contained two tablets.
-Twelve bubbles had been punched and there were 18 bubbles (two tablets in each bubble) for a total of 36 tablets of Tylenol ER 650mg remaining in the bubble pack.
-There was a second bubble pack labeled Tylenol ER 650mg take 2 tablets three times a day dispensed on 08/17/22; each bubble contained two tablets for a total of 1300mg.
-There were 30 bubbles of two tablets of Tylenol 650mg ER (1300mg) remaining in the bubble pack, for a total of 60 tablets.

Observation of a medication aide (MA) on 08/31/22 at 2:40pm revealed she punched one bubble (two tablets) of Resident #3's Tylenol ER 650mg (1300mg) into a medication cup and administered the medication to Resident #3.

Interview with the MA on 09/01/22 at 11:20am revealed:
-She administered Resident #2 two tablets of Tylenol at 7:00am.
-Resident #3 was supposed to receive two tablets of Tylenol at 11:30am, but the resident did not want the Tylenol again until 1:00pm-2:00pm.
-Resident #3's Tylenol was scheduled to be administered three times per day; each dosage was two tablets.
-When she administered medication, she compared the eMAR to the prescription label before administering the medication.
-Resident #3 had not had any medications where

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the eMAR and the prescription label did not match.
-She had not had to waste (dispose of) any of Resident #3's Tylenol.
-She administered two of Resident #3's Tylenol because she thought each tablet was 325mg to equal 650mg.
-The Tylenol ER 650mg had been clarified with the pharmacy and each tablet was 325mg; she did not know who clarified the order or when.

Telephone interviews with a pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 9:21am and 11:58am revealed:
-Resident #3's current order on file was Tylenol ER 650mg take 2 tablets (1300mg) three times a day received on 07/19/22.
-They had not received an order for Tylenol ER 650mg one tablet three times a day dated 07/30/22.
-The pharmacy dispensed 3 punch cards of 60 tablets (180 tablets) of Tylenol ER 650mg on 07/19/22 and 08/17/22 for a 30-day supply at each dispensing.
-Each punch card dispensed had 30 bubbles and each bubble contained two tablets to equal 1300mg.

Review of the manufacturer's prescribing information for Tylenol revealed:
-Liver warning: This product contains acetaminophen. Severe liver damage may occur if you take more than 6 caplets in 24 hours, which is the maximum daily amount
-The recommended daily dosage should not exceed 3,000 mg.

Based on interviews, record reviews, and observations, Resident #2 was administered 78 doses of Tylenol 650mg ER two tablets to equal

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1300mg after the order had been changed to one tablet of Tylenol ER 650mg. Two tablets of Tylenol ER 650mg (1300mg) was administered three times a day for 29 days from 07/31/22-08/31/22 for a total of 3900mg per day exceeding the recommended 3000mg daily total.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/01/22 at 12:04pm revealed:
-Tylenol was a medication that was metabolized in the liver.
-The maximum amount of Tylenol to be safely used should not exceed 3000mg per day.
-If Resident #3 was administered more than 3000mg per day it increased her risk of liver damage.

Telephone interviews with a pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 11:58am revealed:
-Each of the two tablets in the individual bubbles were 650mg, so two tablets equaled 1300mg.
-No one had called to clarify the milligrams of each tablet.
-They had not dispensed Tylenol 325mg for Resident #3 to equal 650mg.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/01/22 at 1:49pm revealed:
-She had lowered Resident #3's daily dosage of Tylenol 650mg (2) tablets three times per day to 650mg (1) tablet three times per day because she did not want the resident to receive more than 3000mg daily on an ongoing basis.
-In addition to the Tylenol, Resident #3 took other medications that could affect the liver and she was being cautious with the Tylenol dosage to lower the risk of liver damage.

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D 358	Continued From page 20 -If Resident #3 had been administered two tablets of Tylenol ER 650mg three times a day, it was more than she had planned on and increased her risk of liver damage. Interview with Resident #3 on 09/01/22 at 4:25pm revealed: -She took 2 tablets of Tylenol when she was administered Tylenol. -She thought her dosage of Tylenol had been lowered, but she had not asked anyone about the two tablets. Interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:41pm revealed: -She had not looked at the medication cart at Resident #3's medication. -She was not aware of any issues with Resident #3's Tylenol. -If Resident #3's Tylenol label did not match the eMAR entry for Tylenol it should have been clarified as to what was the correct dosage to administer. Interview with the Administrator on 09/01/22 at 5:53pm revealed: -When Resident #3's Tylenol order changed from two tablets to one tablet, the medication should have been returned to the pharmacy and repackaged. -Resident #3 being administered two tablets of Tylenol instead of one was a medication error. -She was concerned about the implications of not getting medication as ordered. Refer to the Interview with a MA on 09/01/22 at 2:00pm. Refer to the interview with the facility's LPN on 09/01/22 at 4:41pm.	D 358		

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D 358	Continued From page 21 Refer to the interview with the Administrator on 09/01/22 at 5:53pm. b. Review of Resident #3's physician's orders dated 07/12/22 revealed an order for Methenamine Hippurate (used to prevent or control returning urinary tract infections) 1 gram daily. Review of Resident #3's electronic medication administration record (eMAR) for 07/20/22-07/31/22 revealed: -There was an entry for Methenamine Hippurate 1 gram with a scheduled administration time of 9:00am. -There was documentation Methenamine Hippurate was administered at 9:00am from 07/20/22-07/31/22; there were no exceptions documented. Review of Resident #2's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Methenamine Hippurate 1 gram with a scheduled administration time of 9:00am. -There was documentation Methenamine Hippurate was administered at 9:00am from 08/01/22-08/31/22; there were no exceptions documented. Observation of Resident #3's medications on hand on 08/31/22 at 2:40pm revealed: -There was a bubble pack labeled Methenamine Hippurate 1 gram take one tablet daily dispensed on 08/17/22. -Three tablets had been punched and; there were 27 tablets remaining in the bubble pack.	D 358		

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D 358	Continued From page 22 Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 9:21am revealed: -Resident #3's current order on file was Methenamine Hippurate 1 gram once daily. -The pharmacy dispensed 30 tablets of Methenamine Hippurate 1 gram on 08/17/22 for 30-day supply. Based on observations, interviews, and record reviews, the total doses of Methenamine Hippurate documented (14) exceeded the total number of doses administered because there were only 3 tablets punched from the bubble pack. Interview with a MA on 09/01/22 at 3:38pm revealed: -She could not think of a reason why Resident #3 would have most of her Methenamine Hippurate remaining in her bubble pack. -She knew she administered Resident #3's Methenamine Hippurate when she worked. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/01/22 at 12:04pm revealed: -Methenamine Hippurate was an antibiotic. -If Resident #3 was not administered Methenamine Hippurate as ordered, it increased her risk of getting a urinary tract infection (UTI). Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/01/22 at 1:49pm revealed Resident #3 had been ordered Methenamine Hippurate 1 gram because she had a history of recurrent UTIs. Refer to the Interview with a MA on 09/01/22 at 2:00pm.	D 358		

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D 358	Continued From page 23 Refer to the interview with the facility's LPN on 09/01/22 at 4:41pm. Refer to the interview with the Administrator on 09/01/22 at 5:53pm. c. Review of Resident #3's physician's orders dated 07/12/22 revealed an order for Keflex (an antibiotic used to treat infections) 250mg daily. Review of Resident #3's electronic medication administration record (eMAR) for 07/19/22-07/31/22 revealed: -There was an entry for Keflex 250mg with a scheduled administration time of 9:00pm. -There was documentation Keflex was administered at 9:00pm from 07/19/22-07/31/22; there were no exceptions documented. Review of Resident #2's August 2022 eMAR revealed: -There was an entry for Keflex 250mg with a scheduled administration time of 9:00pm. -There was documentation Keflex was administered at 9:00pm from 08/01/22-08/11/22, 08/13/22-08/27/22, and 08/29/22-08/30/22. -There was no documentation Keflex was administered on 08/12/22 and 08/28/22 and no exceptions as to why the medication was not administered. Observation of Resident #3's medications on hand on 08/31/22 at 2:40pm revealed: -There was a bubble pack labeled Keflex 250mg take one tablet daily dispensed on 07/27/22. -Twenty tablets of Keflex had been punched and there were 10 tablets of Keflex remaining in the bubble pack.	D 358		

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Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 9:21am revealed:
-The pharmacy dispensed 30 tablets of Keflex 250mg on 07/27/22 for a 30-day supply.
-Resident #3's medications had to be requested for a refill and there had been no requests for Keflex to be filled since 07/27/22.

Based on observations, interviews, and record reviews, there were 31 doses of Keflex documented as administered between 07/27/22-08/31/22 which exceeded the total number of doses that could have been administered because there were 10 of 30 tablets remaining in the punch card dispensed on 07/27/22.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/01/22 at 12:04pm revealed:
-Keflex was an antibiotic.
-If Resident #3 was not administered Keflex as ordered, it increased the resident's risk of getting a urinary tract infection (UTI).

Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/01/22 at 1:49pm revealed Resident #3 had been ordered Keflex 250mg because she had a history of recurrent UTIs.

Refer to the Interview with a MA on 09/01/22 at 2:00pm.

Refer to the interview with the facility's LPN on 09/01/22 at 4:41pm.

Refer to the interview with the Administrator on 09/01/22 at 5:53pm.

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CROASDAILE VILLAGE	2600 CROASDAILE FARM PARKWAY DURHAM, NC 27705

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d. Review of Resident #3's physician's orders dated 07/12/22 revealed an order for Doxycycline (an antibiotic used to treat and prevent infections) 100mg daily.

Review of Resident #2's August 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Doxycycline 100mg with a scheduled administration time of 9:00am.
-There was documentation Doxycycline was administered at 9:00am from 08/01/22-08/31/22; there were no exceptions documented.

Observation of Resident #3's medications on hand on 08/31/22 at 2:40pm revealed:
-There was a bubble pack labeled Doxycycline 100mg take one tablet daily dispensed on 08/08/22.
-Twelve tablets of Doxycycline had been punched and there were 18 tablets of Doxycycline remaining in the bubble pack.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 9:21am revealed the pharmacy dispensed 30 tablets of Doxycycline 100mg on 08/08/22 for a 30-day supply.

Based on observations, interviews, and record reviews, there were 23 doses of Doxycycline documented as administered between 08/08/22-08/31/22 which exceeded the total number of doses that could have been administered because there were 18 of 30 Doxycycline tablets remaining in the bubble pack dispensed on 08/08/22.

Telephone interview with a Pharmacist at the

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facility's contracted pharmacy on 09/01/22 at 12:04pm revealed:
-Doxycycline was an antibiotic.
-If Resident #3 was not administered Doxycycline as ordered, it increased the resident's risk of getting a urinary tract infection (UTI).

Interview with a MA on 09/01/22 at 3:38pm revealed:
-She could not think of a reason why Resident #3 would have too many tablets of Doxycycline remaining in her bubble pack.
-She knew she administered Resident #3's Doxycycline when she worked.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/01/22 at 1:49pm revealed Resident #3 had been ordered Doxycycline 100mg because she had a history of recurrent UTIs.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/01/22 at 1:49pm revealed:
-Because Resident #3 had a neurogenic bladder she would not have symptoms of a UTI so it was important to prevent the UTIs.
- If Resident #3 had a UTI she would be at risk for falls and a change in mental status.

Interview with Resident #3 on 09/01/22 at 4:25pm revealed:
-She could not feel if she had any symptoms of a UTI because of her condition, but she took medications to prevent UTIs.
-She was administered medications daily, but she did not always look at the medications administered because she took so many pills.

Refer to the Interview with a MA on 09/01/22 at

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D 358	Continued From page 27 2:00pm. Refer to the interview with the facility's LPN on 09/01/22 at 4:41pm. Refer to the interview with the Administrator on 09/01/22 at 5:53pm. e. Review of Resident #3's physician's orders dated 07/12/22 revealed an order for Trazadone (an antidepressant used to treat depression)100mg at bedtime. Review of Resident #3's electronic medication administration record (eMAR) for 07/19/22-07/31/22 revealed: -There was an entry for Trazadone 100mg with a scheduled administration time of 9:00pm. -There was documentation Trazadone was administered at 9:00pm from 07/19/22-07/31/22; there were no exceptions documented. Review of Resident #2's August eMAR revealed: -There was an entry for Trazadone 100mg with a scheduled administration time of 9:00pm. -There was documentation Trazadone was administered at 9:00pm from 08/01/22-08/11/22, 08/13/22-08/27/22, and 08/29/22-08/30/22. -There was no documentation Trazadone 100mg was administered on 08/12/22 and 08/28/22 and no exceptions as to why the medication was not administered. Observation of Resident #3's medications on hand on 08/31/22 at 2:40pm revealed: -There was a bubble pack labeled Trazadone 100mg take one tablet at bedtime dispensed on 07/27/22. -Nineteen tablets of Trazadone had been punched and there were 11 tablets of Trazadone	D 358		

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D 358	Continued From page 28 remaining in the bubble pack. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 9:21am revealed: -The pharmacy dispensed 30 tablets of Trazadone on 07/27/22 for a 30-day supply. -Resident #3's medication was no on auto refill and there had been no requests for the resident's Trazadone to be filled since 07/27/22. Based on observations, interviews, and record reviews, there were 31 doses of Trazadone documented as administered between 07/28/22-08/31/22 which exceeded the total number of doses that could have been administered because there were 11 of 30 tablets of Trazadone remaining in the bubble pack dispensed on 07/27/22. Interview with a medication aide (MA) on 09/01/22 at 4:13pm revealed: -She administered Resident #3's Trazadone every night she worked. -She did not know why Resident #3 had tablets remaining on a punch card dispensed in July 2022. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/01/22 at 12:04pm revealed: -Trazadone was an antidepressant that was often used as a sedative for sleep when it was ordered to be administered at bedtime. -If Resident #3 was not administered Trazadone as ordered, the medication would not be effective in improving the resident's sleep. Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/01/22 at 1:49pm	D 358		

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revealed:
-Resident #3 had been ordered Trazadone to help with sleep and depression.
-If Resident #3's Trazadone had not been administered as ordered, the resident would not have a good night's sleep, and not getting a good night's sleep would affect the resident's mood.

Interview with Resident #3 on 09/01/22 at 4:25pm revealed:
-She had not been doing well sleeping since she moved into the AL.
-Her sleeping was worse because she was not administering her own medications and there was often a delay in getting medications at night.

Refer to the Interview with a MA on 09/01/22 at 2:00pm.

Refer to the interview with the facility's LPN on 09/01/22 at 4:41pm.

Refer to the interview with the Administrator on 09/01/22 at 5:53pm.

f. Review of Resident #3's physician's orders dated 07/12/22 revealed an order for Myrbetriq (used to treat overactive bladder) ER 50mg daily.

Review of Resident #2's 08/17/22-08/30/22 electronic medication administration record (eMAR) revealed:
-There was an entry for Myrbetriq ER 50mg with a scheduled administration time of 9:00am.
-There was documentation Myrbetriq ER was administered at 9:00am from 08/17/22-08/31/22; there were no exceptions documented.

Observation of Resident #3's medications on hand on 08/31/22 at 2:40pm revealed:

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D 358	Continued From page 30 -There was a bubble pack labeled Myrbetriq ER 50mg take one tablet daily dispensed on 08/17/22. -Two tablets had been punched and there were 28 tablets remaining in the bubble pack. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 9:21am revealed the pharmacy dispensed 30 tablets of Myrbetriq ER 50mg on 08/17/22 for a 30-day supply. Based on observations, interviews, and record reviews, there were 14 doses of Myrbetriq documented as administered between 08/18/22-08/31/22 which exceeded the total number of doses that could have been administered because there were 28 of 30 Myrbetriq tablets remaining in the bubble pack dispensed on 08/17/22. Interview with a medication aide (MA) on 09/01/22 at 3:38pm revealed: -She could not think of a reason why Resident #3 would have most of her Myrbetriq 50mg remaining in her bubble pack. -She knew she administered Resident #3's Myrbetriq 50mg when she worked. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/01/22 at 12:04pm revealed: - Myrbetriq 50mg was used to treat an overactive bladder and incontinence. -If Resident #3's Myrbetriq was not administered as ordered, the resident would not have an improvement in her incontinence. Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/01/22 at 1:49pm and	D 358		

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2:45pm revealed:
-Resident #3 had been ordered Myrbetriq for an over-active bladder.
-Resident #3 had asked her this week (she did not provide the date) if her medications could be changed due to episodes of incontinence but the resident was already on two medications for an over-active bladder and no additional medication should be added.
-She and Resident #3 discussed leaving the medications as scheduled so she could continue to participate in activities during the day and she could wear incontinence pads to help at night.

Interview with Resident #3 on 09/01/22 at 4:25pm revealed she had been having some incontinence episodes during the day which was frustrating.

Refer to the Interview with a MA on 09/01/22 at 2:00pm.

Refer to the interview with the facility's LPN on 09/01/22 at 4:41pm.

Refer to the interview with the Administrator on 09/01/22 at 5:53pm.

g. Review of Resident #3's physician's orders dated 07/12/22 revealed an order for Propranolol (a beta blocker used to treat high blood pressure) 20mg twice daily.

Review of Resident #2's electronic medication administration record (eMAR) for 08/25/22-09/01/22 revealed:
-There was an entry for Propranolol 20mg with a scheduled administration time of 9:00am and 9:00pm.
-There was documentation Propranolol was administered at 9:00am on 08/26/22-08/31/22

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D 358	Continued From page 32 -There was documentation Propranolol was administered at 9:00pm from 08/25/22-08/27/22, and 08/29/22-09/01/22. -There was no documentation Propranolol was administered on 08/28/22 at 9:00pm and 09/01/22 at 9:00am and no exceptions as to why the medication was not administered. Observation of Resident #3's medications on hand on 08/31/22 at 2:40pm revealed: -There was no Propranolol 20mg punch card provided from medications removed from the medication cart. -There was one bubble pack labeled Propranolol 20mg take one tablet twice a day dispensed on 08/25/22; it was locked in the medication room in a cabinet used for overstock and 30 of 30 tablets remained on the punch card. Observation of Resident #3's medication on hand on 09/01/22 at 11:15am revealed: -There was one bubble pack labeled Propranolol 20mg take one tablet twice a day dispensed on 08/25/22. -The Propranolol punch card was at the back of the drawer of the medication cart and was turned in the opposite direction of the resident's other medications and 30 of 30 tablets remained on the punch card. -The second bubble pack labeled Propranolol 20mg take one tablet twice a day dispensed on 08/25/22 was in the medication room in the cabinet used for overstock and 30 of 30 tablets remained on the punch card. Interview with a medication aide (MA) on 09/01/22 at 11:15am revealed: -The punch cards turned backwards were extra medications and were not used during Resident #3's medication pass today, 09/01/22.	D 358		

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-She administered Resident #3's Propranolol 20mg today, 09/01/22, when she administered morning medications.
-Resident #3 did not have a punch card for Propranolol in the medication cart because she administered the last Propranolol from Resident #3's punch card this morning.
-When she administered the last tablet of a resident's medication, she pulled the top/label off the punch card.

Observation of the MA on 09/01/22 at 11:15am revealed:
-She had the tops/labels torn from punch cards stacked on top of the medication cart.
-She looked through the stack of tops/labels.

Second interview with the MA on 09/01/22 at 11:16am revealed:
There was no top/label from Resident #3's Propranolol in the stack of cards on the medication cart.
-She did not know where the empty Propranolol package was, but she knew she administered the last tablet this am (09/01/22).

Interview with another MA on 09/01/22 at 4:13pm revealed:
-She administered Resident #3's Propranolol every night she worked.
-She did not know why Resident #3 had 60 of 60 tables remaining on the punch cards dispensed on 08/25/22.
-She administered Resident #3's Propranolol last night, 08/31/22.
-She administered the last tablet on Resident #3's punch card of Propranolol and disposed of the empty punch card.

Telephone interview with a pharmacy technician

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D 358	Continued From page 34 at the facility's contracted pharmacy on 09/01/22 at 9:21am revealed the pharmacy dispensed 60 tablets of Propranolol 20mg on 08/25/22 for a 30-day supply. Based on observations, interviews, and record reviews, there were 12 doses of Propranolol documented as administered between 08/25/22-08/30/22 which exceeded the total number of doses that could have been administered because there were 30 of 30 tablets in the bubble pack dispensed on 08/25/22. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/01/22 at 12:04pm revealed: -Propranolol was a beta blocker used to treat high blood pressure and heart rates. -If Resident #3 was not administered Propranolol as ordered, the resident could experience an elevated heart rate and blood pressure. Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/01/22 at 1:49pm revealed: -Originally Resident #3 had been ordered Propranolol to help with tremors, but Resident #3 also took medication that could cause an elevated blood pressure. -On her last visit (this week) Resident #3's BP was 144/76. -If Resident #3's Propranolol had not been administered as ordered, the resident could have more tremors and would not be able to do her daily activities such as feed herself. Interview with Resident #3 on 09/01/22 at 4:25pm revealed she had not seen any difference in her tremors and was able to do her activities of daily living.	D 358		

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D 358	Continued From page 35 Refer to the Interview with a MA on 09/01/22 at 2:00pm. Refer to the interview with the facility's LPN on 09/01/22 at 4:41pm. Refer to the interview with the Administrator on 09/01/22 at 5:53pm. 2. Review of Resident #2's current FL-2 dated 02/10/22 revealed diagnoses included compression, anemia, anxiety, arrythmia, arthritis, diabetes mellitus, hyperlipidemia, hypertension, and osteoporosis. a. Review of Resident #2's current FL-2 dated 02/10/22 revealed there was an order for Tylenol extra strength (used to relieve pain) 500mg take 2 tablets (1000mg) take every eight hours. Review of Resident #2's physician's orders dated 08/31/22 revealed an order for Tylenol extra strength 500mg take 2 tablets (1000mg) three times daily. Review of Resident #2's electronic medication administration record (eMAR) for June 2022 revealed: -There was an entry for Tylenol ER 500mg take two tablets three times daily scheduled at 6:00am, 2:00pm, and 10:00pm. -There was documentation Tylenol ER 500mg was administered 30 of 30 opportunities at 6:00am, 26 of 30 opportunities at 2:00pm and 28 of 30 opportunities at 10:00pm. -There was documentation Resident #2 was out of the facility three times and refused medication once; there was no documentation of administration on two opportunities.	D 358		

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D 358	Continued From page 36 Review of Resident #2's July 2022 eMAR revealed: -There was an entry for Tylenol ER 500mg take two tablets three times daily scheduled at 6:00am, 2:00pm, and 10:00pm. -There was documentation Tylenol ER 500mg was administered 31 of 31 opportunities at 6:00am, 26 of 31 opportunities at 2:00pm and 30 of 31 opportunities at 10:00pm. -There was documentation Resident #2 was out of the facility five times and there was no documentation of administration on 07/15/22 at 10:00pm. Review of Resident #2's August 2022 eMAR revealed: -There was an entry for Tylenol ER 500mg take two tablets hree times daily scheduled at 6:00am, 2:00pm, and 10:00pm. -There was documentation Tylenol ER 500mg was administered 31 of 31 opportunities at 6:00am, 29 of 30 opportunities at 2:00pm and 29 of 30 opportunities at 10:00pm. -There was documentation Resident #2 was out of the facility once and refused medication once; there was no documentation of administration on 08/05/22, 08/12/22 and 08/31/22 at 10:00pm. Observation of Resident #2's medications on hand on 09/01/22 at 12:08pm revealed: -There were five bubble packs of Tylenol ER 500mg take two tablets scheduled three times daily. -There were three bubble packs each with a package date of 07/11/22 and 60 tablets were dispensed in each pack; each bubble had two tablets. -Two of the bubble packs had 60 tablets available for administration and one package had 16	D 358		

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tablets available for administration; each bubble had two tablets.
-There were two bubble packs with a package date of 08/03/22 and 60 tablets were dispensed in each pack; each bubble had two tablets.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 09/01/22 at 11:31am revealed:
-Resident #2 had a current order for Tylenol ER 500mg take two tablets three times daily.
-Resident #2's Tylenol was dispensed on 06/01/22, 06/30/22 and 08/03/22.
-A thirty-day supply was dispensed each date with two tablets per bubble and 60 tablets per card; three cards were dispensed with a total of 180 tablets.
-The Tylenol was not on a cycle fill and had to be reordered when needed from the facility via fax or telephone call and would be delivered the same day or the next depending on the time of the day the refill request was received.
-Tylenol was usually ordered for pain relief; if Resident #2 was not administered the Tylenol as ordered he could have increased daily pain.

Based on observations, interviews, and record reviews of medications dispensed, medications on hand, and eMAR documentation from 06/01/22 to 09/03/22 revealed:
-There were 540 tablets of Tylenol ER 500mg dispensed from 06/01/22 to 08/03/22.
-There were 257 doses of Tylenol ER 500mg were documented as administered with 19 dosages documented as not administered on the eMAR from 06/01/22 to 08/31/22.
-Two hundred and fifty-six tablets or 128 doses of Tylenol ER 500mg remained available for administration as of 09/01/22; there should have been appoximately 6 to 9 doses available for

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CROASDAILE VILLAGE	2600 CROASDAILE FARM PARKWAY DURHAM, NC 27705

(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
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administration.
-The number of Tylenol ER 500mg tablets remaining for administration as of 09/01/22 exceeded the number of tablets dispensed and documented as administered from 06/30/22 to 08/31/22.

Interviews with Resident #2 on 08/31/22 at 8:27am and 4:00pm revealed:
-He did not know what medications he took but he took them in the morning; he did not refuse to take his medications.
-He did not know if he took anything for pain.
-He did not have any more pain than normal.
-The staff would give him medication for pain if he complained.

Interview with Resident #2's primary care provider (PCP) on 09/01/22 at 2:21pm revealed:
-Resident #2 was ordered Tylenol 1000mg three times daily to help control pain in his joints.
-He had seen Resident #2 last week and he did not complain of pain.
-He expected the facility to administer medications as ordered.
-Resident #2 could experience increased joint pain if the Tylenol was not administered as ordered.

Interview with a medication aide (MA) on 09/01/22 at 12:09pm revealed:
-She had not administered Resident #2 the Tylenol today, 09/01/22 because he said he did not have any pain.
-She knew the Tylenol was not an as needed (PRN) order for Resident #2 but he refused his Tylenol that morning; he was scheduled a dose of Tylenol at 9:00am.
-Resident #2 still had Tylenol available from July 2022 because she used the medication packages

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that came in later before using the older packages.
-She administered Resident #2 his medication as ordered and she documented when her refused his medications.
-She could not explain why there were so many packages of Tylenol available for administration for Resident #2.
-She thought maybe the packages had been misplaced and that was why there were so many packages.
-She did not reorder his medications she only administered them.

Telephone interview with a second MA on 09/01/22 at 3:48pm revealed:
-She had administered Resident #2 his 10:00pm dose of Tylenol.
-He did not refuse his medications and usually took them as ordered.
-She had not noticed the extra packages of Tylenol for Resident #2, but there could have been extra stored in the medication room and not on the medication cart.
-She ordered refills on medications when there was only one package with only seven or fewer tablet left in the package.
-She used the oldest medication packages first when she administered medications or started a new package.
-She did not notice the extra packages of Resident #2's Tylenol.

Interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:59pm revealed:
-She knew Resident #2 had been back and forth to the hospital.
-She wanted to be sure the staff monitored Resident #2's pain.
-Resident #2 was frail but could complain of pain;

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he had not complained that she was aware.
-The staff were good about reporting any complaints of pain from residents to her.
-If his medication was scheduled at 6:00am then he may have been asleep and refused at that time.
-The refusals should have been documented and the medications should have already been punched out of the package so there should have not been so many tablets available.
-She thought there were extra Tylenol tablets available because Resident #2 had refused and had been out of the facility multiple times even though it was not documented.

Interview with the Administrator on 09/01/22 at 6:02pm revealed:
-She expected the MAs to administer medications as ordered by the PCP.
-She did not know why there would be extra Tylenol tablets but not extra tablets of any other medications other than a breakdown in the system.
-If there were extra medications it could have been because the resident refused to take them or was out to the hospital and it was not documented.
-She had not heard of Resident #2 complaining of any pain; she thought maybe the order needed to be changed to PRN.

Refer to the interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:41pm.

Refer to the interview with the Administrator on 09/01/22 at 5:53pm.

b. Review of Resident #2's current FL-2 dated 02/10/22 revealed there was an order for metoprolol 25mg take one tablet once daily.

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D 358	Continued From page 41 Review of Resident #2's physician order dated 08/31/22 revealed there was an order for metoprolol (used to treat high blood pressure) 25mg take one tablet twice daily; hold for systolic blood pressure (SBP) less than 110. Review of the facility's medication administration policy dated 03/13/20 revealed vital signs must be checked for each resident prior to administration of medications, when necessary. Review of Resident #2's electronic medication administration record (eMAR) for June 2022 revealed: -There was an order for metoprolol 25mg take one tablet twice daily scheduled at 9:00am and 9:00pm; hold for SBP less than 110. -There was documentation metoprolol 25mg was administered 60 of 60 opportunities at 9:00am and 9:00pm. -There was no documentation Resident #2's blood pressure was taken on 9 opportunities, but the metoprolol was documented as administered. Review of Resident #2's July 2022 eMAR revealed: -There was an order for metoprolol 25mg take one tablet twice daily scheduled at 9:00am and 9:00pm; hold for SBP less than 110. -There was documentation metoprolol 25mg was administered 62 of 62 opportunities at 9:00am and 9:00pm. -There was no documentation Resident #2's blood pressure was taken on 12 opportunities, but the metoprolol was documented as administered. Review of Resident #2's August 2022 eMAR revealed:	D 358		

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D 358	Continued From page 42 -There was an order for metoprolol 25mg take one tablet twice daily scheduled at 9:00am and 9:00pm; hold for SBP less than 110. -There was documentation metoprolol 25mg was administered 62 of 62 opportunities at 9:00am, and at 9:00pm. -There was no documentation Resident #2's blood pressure was taken on 13 opportunities, but the metoprolol was still documented as administered. Observation of Resident #2's medications on hand on 09/01/22 at 12:08pm revealed: -There were 30 tablets of metoprolol 25mg dispensed on 08/01/22 in a bubble pack. -There were twenty tablets remaining in the pack. Telephone interview with the pharmacist from the facility's contracted pharmacy on 08/31/22 at 4:38pm revealed: -Resident #2 had a current order for metoprolol 25mg take one tablet twice daily; hold for SBP less than 110. -Resident #2's metoprolol was dispensed on 06/01/22, 06/30/22 and 08/01/22; two packs were dispensed with thirty tablets each which was a thirty-day supply. -Metoprolol was a beta blocker used to lower blood pressures. -There were parameters listed with the metoprolol because if Resident #2 was administered metoprolol and his SBP was below 110 he could experience low energy and was at risk for falls. Interviews with Resident #2 on 08/31/22 at 8:27am and 4:00pm revealed: -He did not know what medications he took but he took them in the morning. -He knew he had high blood pressure, but he did not know what he took for it.	D 358		

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D 358	Continued From page 43 -His blood pressure was taken but he did not know how often. Interview with Resident #2's primary care provider (PCP) on 09/01/22 at 2:21pm revealed: -Resident #2 was ordered metoprolol 25mg take one tablet twice daily; it was used to lower blood pressure. -He expected the facility staff to follow his orders and take Resident #2's blood pressures before administering the medications. -He expected the facility to administer medications as ordered and to hold the metoprolol if Resident #2's SBP was below 110. -Resident #2 should not have been administered his medication if a blood pressure was not done before administration. -Resident #2's blood pressure could drop too low and he could experience orthostatic hypotension (a form of low blood pressure when standing up from sitting or lying down) and would be at risk for a fall when he stood up. -He had not been notified by the facility about missed blood pressure checks or asked him if it was okay to administer the metoprolol with out them. Interview with a medication aide (MA) on 09/01/22 at 3:26pm revealed: -She always took Resident #2's blood pressure before administering his metoprolol. -His SBP had never been low; it was always above 110. -She took his blood pressures herself and always documented the blood pressure results on the eMAR. Telephone interview with a second MA on 09/01/22 at 3:48pm revealed: -The personal care aides (PCA) took the	D 358		

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residents' blood pressure checks and reported the results to her.
-If the SBP was below 110, she would check it again herself and not administer the metoprolol if it was still 110 or less.
-The PCAs always took the residents' blood pressures between 3:00pm and 5:00pm.
-She may have not remembered to document blood pressure results every time she administered Resident #2 his metoprolol, but she was sure his SBP was above 110.

Interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:59pm revealed:
-When a medication had parameters for blood pressures,the blood pressures were to be taken by the MA just before administration of the medication.
-The MAs were expected to take the blood pressures because they needed to know what the blood pressures were prior to administering the medications; if they administered the medication they were responsible for the blood pressure check.
-Resident #2's SBP should have been documented in the eMAR prior to administering his metoprolol.
-If Resident #2 had parameters to hold the medication if SBP was 110 or below, the MAs should have followed the order.
-If the MA administered metoprolol without a blood pressure check, Resident #2's blood pressure could have dropped even lower if the SBP was already below 110.
-He would have been at risk for a fall if his blood pressure drooped too low and made him unsteady.

Interview with the Administrator on 09/01/22 at 6:02pm revealed:

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D 358	Continued From page 45 -She expected the MAs to administer medications as ordered by the PCP; including medications with parameters for SBP. -Blood pressure checks were to be done by the MA or the PCA before the medication was administered so the MA would know if they were within parameters. Refer to the interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:41pm. Refer to the interview with the Administrator on 09/01/22 at 5:53pm. 3. Review of Resident #1's current FL-2 dated 08/31/22 revealed diagnoses included Parkinson's disease and depression. a. Review of Resident #1's physician's orders dated 05/07/22 revealed an order for Sinemet 25mg-100mg (used to treat tremors, muscle stiffness and unsteady movement) ½ tablet at bedtime. Review of Resident #1's current FL-2 dated 08/31/22 revealed an order for Sinemet 25mg-100mg ½ tablet at bedtime. Review of Resident #1's July 2022 eMAR revealed: -There was an entry for Sinemet 25mg-100mg ½ tablet at bedtime with a scheduled administration time of hour of sleep. -There was documentation Sinemet 25mg-100mg was administered at bedtime on 07/01/22, from 07/03/22 to 07/28/22, and from 07/30/22 to 07/31/22. -There was no documentation Sinemet 25mg-100mg was administered on 07/02/22 and 07/29/22.	D 358		

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D 358	Continued From page 46 Review of Resident #1's August 2022 eMAR revealed: -There was an entry for Sinemet 25mg-100mg ½ tablet at bedtime with a scheduled administration time of hour of sleep. -There was documentation Sinemet 25mg-100mg was administered at bedtime from 08/01/22 to 08/05/22, from 08/07/22 to 08/11/22, from 08/13/22 to 08/15/22 and from 08/17/22 to 08/31/22. -There was no documentation Sinemet 25mg-100mg was administered on 08/06/22, 08/12/22 and 08/16/22 at bedtime. Observation of Resident #1's medication on hand on 08/31/22 at 2:23pm revealed: -There was a bubble pack labeled Sinemet 25mg-100mg with 6 one-half tablets of 30 one-half tablets remaining with a dispensed date of 07/25/22. -There was a second bubble pack labeled Sinemet 25mg-100mg with 30 of 30 one-half tablets remaining with a dispense date of 08/25/22. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 10:59am revealed: -The pharmacy had an order for Sinemet 25mg-100mg ½ tablet at bedtime dated 05/07/22. -The pharmacy dispensed 30 Sinemet 25mg-100mg ½ tablet (a 30-day supply) on 06/30/22, 07/25/22, and 08/25/22. -The facility was not on cycle fill; the staff would re-order medications when needed, by faxing a request or calling. Based on observations, interviews, and record reviews of medications dispensed, medications	D 358		

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on hand, and eMAR documentation from 06/30/22 to 08/31/22 revealed:
-There were ninety-1/2 tablets (90 day supply) of Sinemet 25-100mg dispensed from 06/30/22 to 08/25/22.
-There were fifty-seven-1/2 tablets of Sinemet 25-100mg documented as administered with 5 dosages not documented as administered on the eMAR from 07/01/22 to 08/31/22.
-There were thirty-six-1/2 tablets of Sinemet 25-100mg remaining for administration as of 08/31/22 when there should have been 24 tablets remaining for administration.
-The number of Sinemet 25-100 1/2 tablets remaining for administration as of 08/31/22 exceeded the number of tablets dispensed and documented as administered from 06/30/22 to 08/31/22.

Telephone interview with a MA on 09/01/22 at 2:22pm revealed:
-She had administered medication to Resident #1 during the evening hours.
-She did not know why Resident #1 was being administered medications from the 07/25/22 bubble pack.

Interview with another MA on 09/01/22 at 4:13pm revealed:
-She had always administered Resident #1's medications as ordered.
-She did not know why Resident #1 was being administered medications from the 07/25/22 bubble pack.

Refer to the Interview with a MA on 09/01/22 at 2:00pm.

Refer to the interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:41pm.

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D 358	Continued From page 48 Refer to the interview with the Administrator on 09/01/22 at 5:53pm. b. Review of Resident #1's physician's order dated 05/07/22 revealed an order for Sinemet 25mg-100mg 2 tablets at 7:00am and 11:00am. Review of Resident #1's current FL-2 dated 08/31/22 revealed an order for Sinemet 25mg-100mg 2 tablets at 7:00am and 11:00am. Review of Resident #1's June 2022 electronic medication administration record (eMAR) from 06/25/22 to 06/30/22 revealed: -There was an entry for Sinemet 25mg-100mg 2 tablets with a scheduled administration time of 7:00am and 11:00am. -There was documentation Sinemet 25mg-100mg 2 tablets were administered at 7:00am and 11:00am from 06/25/22 to 06/30/22. Review of Resident #1's July 2022 eMAR revealed: -There was an entry for Sinemet 25mg-100mg 2 tablets with a scheduled administration time of 7:00am and 11:00am. -There was documentation Sinemet 25mg-100mg 2 tablets were administered at 7:00am and 11:00am from 07/01/22 to 07/31/22. Review of Resident #1's August 2022 eMAR revealed: -There was an entry for Sinemet 25mg-100mg 2 tablets with a scheduled administration time of 7:00am and 11:00am. -There was documentation Sinemet 25mg-100mg 2 tablets were administered at 7:00am and 11:00am from 08/01/22 to 08/31/22.	D 358		

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D 358	Continued From page 49 Observation of Resident #1's medication on hand on 08/31/22 at 2:23pm revealed: -There was a bubble pack labeled Sinemet 25mg-100mg 2 tablets with 20 of 60 tablets remaining with a dispensed date of 08/22/22. -There was a second bubble pack labeled Sinemet 25mg-100mg 2 tablets with 60 of 60 tablets remaining with a dispensed date of 08/22/22. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 10:59am revealed: -The pharmacy had an order for Sinemet 25mg-100mg 2 tablets at 7:00am and 11:00am dated 05/07/22. -The pharmacy dispensed 120 Sinemet 25mg-100mg tablets (a 30-day supply) on 06/24/22, 07/22/22, and 08/22/22. -The facility was not on cycle fill; the staff would re-order medications when needed, by faxing a request or calling. Based on observations, interviews, and record reviews of medications dispensed, medications on hand, and eMAR documentation from 06/24/22 to 08/31/22 revealed: -There were 360 tablets (90 days supply) of Sinemet 25-100mg, 2 tablets twice daily, dispensed from 06/24/22 to 08/22/22. -There were 272 tablets (68 days) of Sinemet 25-100mg documented as administered from 06/25/22 to 08/31/22. -There were 80 tablets of Sinemet 25-100mg remaining for administration as of 08/31/22 when there should have been 88 tablets remaining for administration. -The number of Sinemet 25-100 tablets remaining for administration as of 08/31/22 was less than the number of tablets dispensed and	D 358		

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documented as administered from 06/24/22 to 08/31/22.

Interview with another MA on 09/01/22 at 4:13pm revealed:
-She had always administered Resident #1's medications as ordered.
-She did not know why Resident #1 was being administered medications from the 07/25/22 bubble pack.

Refer to the Interview with a MA on 09/01/22 at 2:00pm.

Refer to the interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:41pm.

Refer to the interview with the Administrator on 09/01/22 at 5:53pm.

c. Review of Resident #1's physician's order dated 04/08/22 revealed an order for Sinemet 25mg-100mg extended release (ER) 2 tablets 5 times daily.

Review of Resident #1's current FL-2 dated 08/31/22 revealed an order for Sinemet 25mg-100mg ER 2 tablets 5 times daily.

Review of Resident #1's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Sinemet 25mg-100mg ER 2 tablets 5 times daily with a scheduled administration time of 7:00am, 11:00am, 3:00pm, 7:00pm and 10:30pm.
-There was documentation Sinemet 25mg-100mg ER was administered at 7:00am, 11:00am, 3:00pm and 7:00pm from 06/01/22 to 06/30/22; and 10:30pm from 06/01/22 to 06/16/22, 06/18/22

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to 06/20/22, 06/22/22 to 06/24/22, 06/26/22 to 06/28/22 and on 06/30/22.
-There was no documentation that Sinemet 25mg-100mg ER was administered at 10:30pm on 06/17/22, 06/21/22, 06/25/22 and 06/29/22.

Review of Resident #1's July 2022 eMAR revealed:
-There was an entry for Sinemet 25mg-100mg ER 2 tablets 5 times daily with a scheduled administration time of 7:00am, 11:00am, 3:00pm, 7:00pm and 10:30pm.
-There was documentation Sinemet 25mg-100mg ER was administered at 7:00am, 11:00am and 3:00pm from 07/01/22 to 07/31/22; at 7:00pm from 07/01/22 to 07/14/22 and 07/16/22 to 07/31/22; at 10:30pm on 07/01/22; from 07/03/22 to 07/28/22; and from 07/30 to 07/31/22.
-There was no documentation Sinemet 25mg-100mg ER was administered at 7:00pm on 07/15/22 and at 10:30pm on 07/02/22 and 07/29/22.
-There was an exception documented on 07/09/22 at 10:30pm, 07/10/22 at 11:00am, 07/10/22 at 3:00pm, 07/10/22 at 9:28pm and 07/11/22 at 10:57am medication not administered pending delivery.

Review of Resident #1's August 2022 eMAR revealed:
-There was an entry for Sinemet 25mg-100mg ER 2 tablets 5 times daily with a scheduled administration time of 7:00am, 11:00am, 3:00pm, 7:00pm and 10:30pm.
-There was documentation Sinemet 25mg-100mg ER was administered at 7:00am, 11:00am and 3:00pm from 08/01/22 to 08/31/22; at 7:00pm from 08/01/22 to 08/18/22 and 08/20/22 to 08/31/22; and at 10:30pm from 08/01/22 to 08/05/22, from 08/07/22 to 08/11/22, from

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08/13/22 to 08/15/22 and from 08/17/22 to 08/31/22.
-There was no documentation Sinemet 25mg-100mg ER was administered at 7:00pm on 08/19/22 and at 10:30 on 08/06/22, 08/12/22 and 08/16/22.

Observation of Resident #1's medication on hand on 08/31/22 at 2:22pm revealed:
-There was a bubble pack labeled Sinemet 25mg-100mg ER with 40 of 60 tablets remaining with a dispense date of 08/08/22.
-There was a second bubble pack labeled Sinemet 25mg-100mg ER with 60 of 60 tablets remaining with a dispensed date of 08/08/22.

Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 10:59am revealed:
-The pharmacy had an order for Sinemet 25mg-100mg ER 2 tablets 5 times daily dated 04/08/22.
-The pharmacy dispensed 300 Sinemet 25mg-100mg ER tablets (a 30-day supply) on 05/31/22, 07/09/22, and 08/08/22.
-The pharmacy did not receive a refill request from the facility in June 2022 for Sinemet 25mg-100mg ER.
-The facility was not on cycle fill; the staff would re-order medications when needed, by faxing a request or calling.

Based on observations, interviews, and record reviews of medications dispensed, medications on hand, and eMAR documentation from 05/31/22 to 08/31/22 revealed:
-There were 900 tablets (90 days) of Sinemet 25-100mg ER, 2 tablets 5 times daily, dispensed from 05/31/22 to 08/08/22.
-There were 920 tablets (92 days) of Sinemet

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D 358	Continued From page 53 25-100mg ER documented as administered with 11 dosages not documented as administered on the eMAR from 06/01/22 to 08/31/22. -There were 100 tablets of Sinemet 25-100mg ER remaining for administration as of 08/31/22. -There should have been no Sinemet 25-100 ER tablets remaining for administration as of 08/31/22. Telephone interview with a MA on 09/01/22 at 2:22pm revealed: -She had administered medication to Resident #1 during the afternoon and evening hours. -She did not know why Resident #1's medications were not re-ordered in June 2022. Interview with a MA on 09/01/22 at 4:13pm revealed: -She had always administered Resident #1's medications as ordered. -She did not know why Resident #1's medications was not re-ordered in June 2022. _____ Review of Resident #1's office visit with the Geriatric Physician dated 08/03/22 revealed: -Resident #1 had very mild left-hand resting tremor. -Resident #1 complained of increased freezing and feeling that her feet were stuck to the floor. Interview with Resident #1 on 08/31/22 at 2:15pm revealed: -She had difficulty walking at times; her feet would "get stuck" and would not move. -She used the electric wheelchair daily. -She resided at the facility because she would forget to take her medications at home. Telephone interview with the Primary Care	D 358		

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D 358	Continued From page 54 Provider (PCP) on 09/01/22 at 1:48pm revealed: -Resident #1 was ordered Sinemet to help with movement such as walking, swallowing, tremors and activities of daily living. -She could experience an increase in difficulty with mobility if medications were not administered as ordered. -She expected Resident #1's medications to be administered as ordered. _____ Refer to the Interview with a MA on 09/01/22 at 2:00pm. Refer to the interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:41pm. Refer to the interview with the Administrator on 09/01/22 at 5:53pm. d. Review of Resident #1's physician's order dated 02/23/22 revealed an order for escitalopram (used to treat depression and anxiety) 20mg daily. Review of Resident #1's current FL-2 dated 08/31/22 revealed an order for escitalopram 20mg daily. Review of Resident #1's June 2022 electronic medication administration record (eMAR) from 06/21/22 to 06/30/22 revealed: -There was an entry for escitalopram 20mg daily with a scheduled administration time of 9:00am. -There was documentation escitalopram 20mg was administered daily from 06/21/22 to 06/30/22. Review of Resident #1's July 2022 eMAR revealed:	D 358		

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-There was an entry for escitalopram 20mg daily with a scheduled administration time of 9:00am.
-There was documentation escitalopram 20mg was administered daily from 07/01/22 to 07/31/22.

Review of Resident #1's August 2022 eMAR revealed:
-There was an entry for escitalopram 20mg daily with a scheduled administration time of 9:00am.
-There was documentation escitalopram 20mg was administered daily from 08/01/22 to 08/31/22.

Observation of Resident #1's medication on hand on 08/31/22 at 2:22pm revealed there was a bubble pack labeled escitalopram 20mg daily with 30 of 30 tablets remaining with a dispensed date of 08/22/22.

Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 10:59am revealed:
-The pharmacy had an order for escitalopram 20mg daily dated 02/23/22.
-The pharmacy dispensed 30 escitalopram 20mg daily (a 30-day supply) on 06/20/22, 07/18/22, and 08/17/22.
-The facility was not on cycle fill; the staff would re-order medications when needed, by faxing a request or calling.

Based on observations, interviews, and record reviews of medications dispensed, medications on hand, and eMAR documentation from 06/20/22 to 08/31/22 revealed:
-There were 90 tablets (90 day supply) of escitalopram 20mg dispensed from 06/20/22 to 08/17/22.
-There were 72 tablets of escitalopram 20mg

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documented as administered from 06/21/22 to 08/31/22.
-There were 30 tablets of escitalopram 20mg remaining for administration as of 08/31/22 when there should have been 18 tablets remaining for administration.
-The number of escitalopram 20mg tablets remaining for administration as of 08/31/22 exceeded the number of tablets dispensed and documented as administered from 06/21/22 to 08/31/22.

Telephone interview with the Primary Care Provider (PCP) on 09/01/22 at 1:48pm revealed:
-Resident #1 received escitalopram to treat depression.
-Resident #1 had not experienced any increase in symptoms of depression.
-He expected Resident #1's medications to be administered as ordered.

Refer to the Interview with a MA on 09/01/22 at 2:00pm.

Refer to the interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:41pm.

Refer to the interview with the Administrator on 09/01/22 at 5:53pm.

e. Review of Resident #1's physician's order dated 06/28/22 revealed an order for quetiapine (used to treat depression and manic episodes) 50mg twice daily.

Review of Resident #1's current FL-2 dated 08/31/22 revealed an order for quetiapine 50mg twice daily.

Review of Resident #1's office visit with the

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Geriatric Physician dated 08/03/22 revealed she expressed an increase in anxiety due to separation from family.

Review of Resident #1's July 2022 eMAR revealed:
-There was an entry for quetiapine 50mg twice daily with a scheduled administration time of 9:00am and 8:00pm.
-There was documentation quetiapine 50mg was administered twice daily from 07/01/22 to 07/14/22 and 07/16/22 to 07/31/22 and at 9:00am on 07/15/22.
-There was no documentation quetiapine 50mg was administered at 8:00pm on 07/15/22.

Review of Resident #1's August 2022 eMAR revealed:
-There was an entry for quetiapine 50mg twice daily with a scheduled administration time of 9:00am and 8:00pm.
-There was documentation quetiapine 50mg was administered twice daily from 08/01/22 to 08/19/22 and from 08/21/22 to 08/31/22 and at 9:00am on 08/20/22.
-There was no documentation quetiapine 50mg was administered at 8:00pm on 08/20/22.

Observation of Resident #1's medication on hand on 08/31/22 at 2:22pm revealed there were two bubble packs labeled quetiapine 50mg twice daily with 30 of 30 tablets in each bubble pack remaining with a dispensed date of 08/25/22.

Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 10:59am revealed:
-The pharmacy had an order for quetiapine 50mg twice daily dated 06/2/22.
-The pharmacy dispensed 60 quetiapine 50mg

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twice daily (a 30-day supply) on 06/29/22, 07/27/22, and 08/25/22.
-The facility was not on cycle fill; the staff would re-order medications when needed, by faxing a request or calling.

Based on observations, interviews, and record reviews of medications dispensed, medications on hand, and eMAR documentation from 06/29/22 to 08/31/22 revealed:
-There were 180 tablets (90 day supply) of quetiapine 50mg dispensed from 06/29/22 to 08/25/22.
-There were 122 tablets of quetiapine 50mg documented as administered and there were 2 days there was no documentation of administration from 06/30/22 to 08/31/22.
-There were 60 tablets of quetiapine 50mg remaining for administration as of 08/31/22 when there should have been 56 tablets remaining.
-The number of quetiapine 50mg tablets remaining for administration as of 08/31/22 exceeded the number of tablets dispensed and documented as administered or no documentation on the eMAR as administered from 06/30/22 to 08/31/22.

Telephone interview with the Primary Care Provider (PCP) on 09/01/22 at 1:48pm revealed:
-Resident #1 was ordered quetiapine for anxiety and agitation.
-The staff had not reported any increase in anxiety and agitation.
-She could experience an increase in anxiety and agitation if the medications was not administered as ordered.
-She expected Resident #1's medications to be administered as ordered.

Refer to the Interview with a MA on 09/01/22 at

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D 358	Continued From page 59 2:00pm. Refer to the interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:41pm. Refer to the interview with the Administrator on 09/01/22 at 5:53pm. f. Review of Resident #1's physician's order dated 06/28/22 revealed an order for potassium chloride (used to prevent or treat low potassium) extended release (ER) 10mEq daily. Review of Resident #1's current FL-2 dated 08/31/22 revealed an order for potassium chloride (ER) 10mEq daily. Review of Resident #1's July 2022 eMAR revealed: -There was an entry for potassium chloride (ER) 10mEq daily with a scheduled administration time of 9:00am. -There was documentation potassium chloride (ER) 10mEq was administered daily from 07/01/22 to 07/31/22. Review of Resident #1's August 2022 eMAR revealed: -There was an entry for potassium chloride (ER) 10mEq daily with a scheduled administration time of 9:00am. -There was documentation potassium chloride (ER) 10mEq was administered daily from 08/01/22 to 08/31/22. Observation of Resident #1's medication on hand on 08/31/22 at 2:20pm revealed: -There was a bubble pack labeled potassium chloride ER 10mEq with 5 of 30 tablets remaining with a dispense date of 07/25/22.	D 358		

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D 358	Continued From page 60 -There was a second bubble pack labeled potassium chloride ER 10mEq with 30/30 tablets remaining with a dispensed date of 08/25/22. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 10:59am revealed: -The pharmacy had an order for potassium chloride ER 10mEq daily dated 06/28/22. -The pharmacy dispensed 30 potassium chloride ER (a 30-day supply) on 06/29/22, 07/25/22, and 08/25/22. -The facility was not on cycle fill; the staff would re-order medications when needed, by faxing a request or calling. Based on observations, interviews, and record reviews of medications dispensed, medications on hand, and eMAR documentation from 06/29/22 to 08/31/22 revealed: -There were 90 tablets (90 day supply) of potassium chloride ER 10mEq dispensed from 06/29/22 to 08/25/22. -There were 62 tablets of potassium chloride ER 10mEq documented as administered from 07/01/22 to 08/31/22. -There were 35 tablets of potassium chloride ER 10mEq remaining for administration as of 08/31/22 when there should have been 28 tablets remaining. -The number of potassium chloride ER 10mEq tablets remaining for administration as of 08/31/22 exceeded the number of tablets dispensed and documented as administered from 06/29/22 to 08/31/22. Telephone interview with the Primary Care Provider (PCP) on 09/01/22 at 1:48pm revealed: -Resident #1 was ordered potassium chloride due to a low potassium level.	D 358		

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-The potassium chloride kept Resident #1's potassium level within normal range.
-Resident #1 could have dizziness, increased weakness and an irregular heartbeat if her potassium level was too low.
-She expected medications for Resident #1 to be administered as ordered.

Refer to the Interview with a MA on 09/01/22 at 2:00pm.

Refer to the interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:41pm.

Refer to the interview with the Administrator on 09/01/22 at 5:53pm.

g. Review of Resident #1's physician's order dated 04/25/22 revealed an order for metoprolol tartrate (used to treat elevated blood pressure) 25mg ½ tablet every 12 hours; hold if systolic blood pressure is less than 100 or heart rate is less than 50.

Review of Resident #1's current FL-2 dated 08/31/22 revealed an order for metoprolol tartrate 25mg ½ tablet every 12 hours; hold if systolic blood pressure is less than 100 or heart rate is less than 50.

Review of the facility's medication administration policy dated 03/13/2020 revealed vital signs must be checked for each resident prior to administration of medications, when necessary.

Review of Resident #1's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for metoprolol tartrate 25mg ½ tablet every 12 hours; hold if systolic blood

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pressure is less than 100 or heart rate is less than 50.
-There was documentation metoprolol tartrate 25mg ½ tablet was administered every 12 hours from 06/01/22 to 06/30/22 with no recorded blood pressure or heart rate on 06/04/22, 06/05/22, 06/18/22 and 06/19/22 at 9:00am; and on 06/02/22, 06/04/22, 06/08/22, 06/21/22, 06/24/22 and 06/25/22 at 9:00pm.
-Metoprolol tartrate 25mg ½ tablet was administered without obtaining a heart rate or blood pressure reading 10 times out of 60 opportunities.

Review of Resident #1's July 2022 eMAR revealed:
-There was an entry for metoprolol tartrate 25mg ½ tablet every 12 hours with a scheduled administration time of 9:00am and 9:00pm; hold if systolic blood pressure is less than 100 or heart rate is less than 50.
-There was documentation metoprolol tartrate 25mg ½ tablet was administered every 12 hours from 07/01/22 to 07/31/22 with no recorded blood pressure or heart rate on 07/17/22, 07/26/22, 07/28/22, 07/29/22 and 07/30/22 at 9:00am; on 07/04/22, 07/10/22, 07/15/22, 07/19/22, 07/23/22, 07/24/22 and 07/29/22 at 9:00pm.
-Metoprolol tartrate 25mg ½ tablet was administered without obtaining a heart rate or blood pressure reading 12 times out of 62 opportunities

Review of Resident #1's August 2022 eMAR revealed:
-There was an entry for metoprolol tartrate 25mg ½ tablet every 12 hours with a scheduled administration time of 9:00am and 9:00pm; hold if systolic blood pressure is less than 100 or heart rate is less than 50.

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CROASDAILE VILLAGE	2600 CROASDAILE FARM PARKWAY DURHAM, NC 27705

(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 63 -There was documentation metoprolol tartrate 25mg ½ tablet was administered every 12 hours from 08/01/22 to 08/31/22 with no recorded blood pressure or heart rate on 08/09/22 at 9:00am; on 08/02/22, 08/06/22, 08/10/22, 08/12/22, 08/15/22, 08/16/22, 08/20/22, 08/22/22, 08/26/22, 08/30/22 at 9:00pm. -Metoprolol tartrate 25mg ½ tablet was administered without obtaining a heart rate or blood pressure reading 11 times out of 60 opportunities. Observation of Resident #1's medication on hand on 08/31/22 at 2:22pm revealed there was a bubble pack labeled metoprolol tartrate 25mg with 24 one-half tablets of 30 one- half tablets in the bubble pack remaining with a dispensed date of 08/01/22. Review of Resident #1's office visit report with the Geriatric Physician dated 08/03/22 revealed: -Resident #1 complained of dizziness but denied any falls. -Resident #1's systolic blood pressure was volatile, ranging from 90 - 190. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 10:59am revealed: -The pharmacy had an order for metoprolol tartrate 25mg ½ tablet every 12 hours; hold if systolic blood pressure was less than 100 or heart rate was less than 50 dated 04/25/22. -The pharmacy dispensed 60 one-half tablets of metoprolol tartrate 25mg (a 30-day supply) on 04/25/22 and 08/01/22. Interview with Resident #1 on 08/31/22 at 2:15pm revealed: -She did experience dizziness and light	D 358		

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headedness a few times a week, but she did not recall falling in the past three months.
-She knew she had a medication that required her blood pressure to be taken before it was administered.
-She knew her blood pressure and heart rate were taken frequently but she was not sure it was twice a day.

Telephone interview with a MA on 09/01/22 at 2:22pm revealed:
-She had administered medication to Resident #1 during the afternoon and evening hours.
-The personal care aide (PCA) would check Resident #1's blood pressure and heart rate before dinner; somewhere between 3:00pm and 5:00pm.
-There was no certain time to check Resident #1's blood pressure and heart rate.
-She would administer Resident #1's 9:00pm dose of metoprolol based on the heart rate and blood pressure reading obtained by the PCA.
-She thought she documented the blood pressure reading and the heart rate on the eMAR.
-She did not recall administering metoprolol without obtaining Resident #1's blood pressure and heart rate.

Interview with a MA on 09/01/22 at 4:13pm revealed:
-She administered medication to Resident #1.
-She had administered metoprolol to Resident #1.
-She always checked Resident #1's blood pressure and heart rate before administering metoprolol.
-She forgot to document Resident #1's blood pressure reading and heart rate on the eMAR.

Telephone interview with the Primary Care Provider (PCP) on 09/01/22 at 1:48pm revealed:

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-Metoprolol would lower Resident #1's blood pressure and heart rate.
-The MAs should be checking Resident #1's blood pressure reading and heart rate prior to administering metoprolol.
-If Resident #1 was administered metoprolol without blood pressure and heart rated checked, and it was already below the ordered ranges, Resident #1's blood pressure and heart rate could drop even lower.
-Resident #1 could be at risk for light-headedness, dizziness and falls.
-She expected Resident #1's blood pressure and heart rate to be obtained prior to the administration of metoprolol.

Interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:41pm revealed:
-Resident #1's blood pressure reading and heart rate should be taken before metoprolol was prepared for administration.
-The MA was expected to take Resident #1's blood pressure and heart rate.
-Resident #1's blood pressure reading and heart rate should be documented on the eMAR twice daily as ordered.
-Resident #1's blood pressure and heart rate could drop if the metoprolol was administered without Resident #1's blood pressure and heart rate being taken.

Interview with the Administrator on 09/01/22 at 5:53pm revealed:
-Resident #1's blood pressure and heart rate should be obtained before administration of metoprolol.
-The PCA or the MA should obtain the blood pressure reading and heart rate.

Refer to the Interview with a MA on 09/01/22 at

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D 358	Continued From page 66 2:00pm. Refer to the interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:41pm. Refer to the interview with the Administrator on 09/01/22 at 5:53pm. h. Review of Resident #1's physician's order dated 07/15/22 revealed an order for calmoseptine (used to treat skin irritation) ointment twice daily to excoriated area of the intergluteal cleft. Review of Resident #1's current FL-2 dated 08/31/22 revealed an order for calmoseptine ointment twice daily to excoriated area of the intergluteal cleft. Review of Resident #1's July 2022 electronic treatment record revealed: -There was an entry for calmoseptine ointment to the intergluteal cleft twice daily with a scheduled administration time of 9:00am and 9:00pm. -There was documentation calmoseptine was applied at 9:00am on 07/31/22 and 9:00pm on 07/18/22 and 07/26/22. -There was no documentation calmoseptine ointment was applied at 9:00am on 07/22/22, 07/26/22, 07/28/22, and 07/29/22; at 9:00pm on 07/20/22, 07/21/22, 07/25/22, 07/30/22 and 07/31/22. -There were exceptions documented at 9:00am from 07/17/22 to 07/21/22, 07/23/22 to 07/25/22, on 07/27/22 and 07/30/22; at 9:00pm on 07/17/22, 07/19/22, from 07/22/22 to 07/24/22 and from 07/27/22 to 07/29/22. -The documented reason for the exceptions was treatment not administered pending delivery.	D 358		

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D 358	Continued From page 67 Review of Resident #1's August 2022 electronic treatment record revealed: -There was an entry for calmoseptine ointment to the intergluteal cleft twice daily with a scheduled administration time of 9:00am and 9:00pm. -There was documentation calmoseptine was applied at 9:00am from 08/01/22 to 08/13/22; from 08/14/22 to 08/22/22; and from 08/24/22 to 08/31/22; and at 9:00pm on 08/04/22, 08/10/22. 08/11/22, 08/15/22, 08/16/22, 08/21/22, 08/22/22, 08/26/22, 08/30/22 an 08/31/22. -There was no documentation calmoseptine ointment was applied at 9:00am on 08/14/22 and 08/23/22; and at 9:00pm on 08/02/22, 08/03/22, 08/05/22, 08/06/22, 08/08/22, 08/09/22, 08/12/22 - 08/14/22, 08/17/22 - 08/20/22, 08/23/22 - 08/25/22 and 08/27/22 - 08/29/22. -There were exceptions documented on 08/01/22 and 08/07/22 treatment not administered pending delivery. Observation of Resident #1's medication on hand on 08/31/22 at 2:20pm revealed: -There was no calmoseptine ointment available to be administered to Resident #1. -There was a tube of calmoseptine ointment on the treatment cart with no prescription label or resident's name that was opened. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 09/01/22 at 10:59am revealed: -The pharmacy did not have an order for calmoseptine ointment for Resident #1. -The facility staff should electronically send or fax new orders to the pharmacy. Interview with Resident #1 on 08/31/22 at 2:15pm revealed: -She complained of her backside being irritated; it	D 358		

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D 358	Continued From page 68 burned when she moved in the bed; it was a very sensitive area. -She knew the Primary Care Provider (PCP) had ordered a cream for her backside. -The staff told her that the cream had not arrived from the pharmacy and she the cream had not been applied to her backside. -The staff told her they had called the pharmacy, but she did not know what they were told by the pharmacy staff. -She did not know why the pharmacy had not sent the medication. Interview with a medication aide (MA) on 09/01/22 at 2:00pm revealed: -She did not recall applying calmoseptine ointment on Resident #1. -Normally ointments were applied after showers. -Resident #1 complained of irritation to her bottom about 3 weeks ago. -She had not heard Resident #1 complain of her bottom in the past 3 weeks. -The personal care aide (PCA) would apply the ointment and the MA would document on the eMAR. -She would click on the eMAR when Resident #1's medication was prepared and then click the eMAR Resident #1's medications were administered when the medication was not on the medication cart to be administered. Telephone interview with a MA on 09/01/22 at 2:22pm revealed: -She had administered medication to Resident #1 during the afternoon and evening hours. -She or the PCA had applied the ointment to Resident #1 several times during the evening hours. -She did not recall Resident #1 asking about the medication or the need to apply the ointment.	D 358		

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D 358	Continued From page 69 Telephone interview with the PCP on 09/01/22 at 1:48pm revealed: -Calmoseptine ointment was ordered for Resident #1 because of excoriation in the intergluteal folds. -Resident #1 could have further skin irritation or breakdown if calmoseptine ointment was not applied has ordered to the skin irritation. -She did not know that Resident #1 had not received calmoseptine ointment. -She had not been notified by the facility staff that Resident #1 did not have calmoseptine ointment. Interview with the Administrator on 09/01/22 at 5:53pm revealed: -She was unaware that Resident #1 did not have calmoseptine ointment. -She thought this was kept in house stock for all residents. Refer to the Interview with a MA on 09/01/22 at 2:00pm. Refer to the interview with the facility's Licensed Practical Nurse (LPN) on 09/01/22 at 4:41pm. Refer to the interview with the Administrator on 09/01/22 at 5:53pm. _____ Interview with a medication aide (MA) on 09/01/22 at 2:00pm revealed: -The MAs were responsible for re-ordering medications when there were about 5 days of medication left to administer. -The medications were re-ordered by calling or faxing the pharmacy. -She could recall a few times she documented on the eMAR when the medication was not available to administer. -She would click on the eMAR when Resident	D 358		

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D 358	Continued From page 70 #1's medication was prepared and then click the eMAR Resident #1's medications were administered when the medication was not on the medication cart to be administered. Interview with the LPN on 09/01/22 at 5:53pm revealed: -Most orders were entered into the computer by the facility's PCP. -If the MA entered an order the PCP would approve the order in the computer system. -When there was "about 7-days" left of the medication, she expected the MAs to reorder the medication. -She had not completed cart audits since she started working part time at the facility. -She had looked at the medication carts to ensure eyes drops, nasal sprays, and rectal items were stored separately. -She had checked the medication refrigerator. -Medication cart audits were completed by third shift MAs. -She did spot checks on some of the resident's medications. Interview with the Administrator on 09/01/22 at 5:53pm revealed: -She expected MAs to utilize the medication rights when administering medication, including right person, right dose, right route, and right frequency. -She expected the MAs to compare the eMAR and pharmacy label at every medication pass. -If a pharmacy label and eMAR entry did not match, she expected the MA to get clarification from the PCP. -New orders from the PCP were transcribed by the MA into the eMAR for time code, printed and sent to the pharmacy by fax. -Since the documentation of medication	D 358		

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D 358	Continued From page 71 administered did not align to the count on hand, there appeared to be some discrepancy. -She was concerned about the implication of residents not getting medication as ordered. _____ The facility failed to ensure medications were administered as ordered including two residents who were administered a blood pressure medication 24 times (#1) and 20 times (#2) without obtaining the required blood pressure readings and heart rate prior to administration of a medication that could lead to further decreasing the residents' blood pressure and heart rate leading to an increased risk of falls; and did not increase the dosage of scheduled Tylenol for 29 days when the provider lowered the dosage to protect the resident's liver. The facility's failure to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/01/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 16, 2022.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912	All medication technicians will receive training on the importance of following physician orders and notifying providers as instructed. Facility will utilize EMR alert that requires staff to contact provider when parameters are ordered. Community nurse or designee will complete monthly MAR audit.	11/30/2022

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D912	Continued From page 72 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents (#1, #2, and #3) including two residents whose blood pressure was not taken prior to administering a blood pressure medication (#1,#2), a medication for tremors and mobility related to Parkinson's disease, a medication to help with depression and anxiety, a medication to treat mood, a supplement, and an ointment to help with skin irritation (#1); a pain medication (#2); and a blood pressure medication used to treat tremors and control high blood pressure, three antibiotics, a medication for an overactive bladder and a medication used for sleep and the dosage of a medication used to treat mild pain was not decreased for 30-days after the ordered changed (#3). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform	D935	All current medication technician will complete the 10-hour State required training course. Ongoing human resources will ensure new employees have worked as a medication aide within the last 24 months.	9-28-2022

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D935	Continued From page 73 any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 5 of 6 sampled medication aides had successfully completed the 5, 10, or 15-hour medication class (Staff A, B, C, D and F)	D935		

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D935	Continued From page 74 The findings are: 1. Review of Staff A's personnel file on 08/05/22 revealed: -Staff A was hired on 01/26/22. -Staff A's position title was a medication aide (MA). -There was no documentation Staff A had taken and successfully passed the 5, 10, or 15 medication class. Review of resident's August 2022 electronic Medication Administration Records (eMAR) revealed: -On 08/02/22, Staff A signed the eMARs for medication administration. -On 08/06/22, Staff A signed the eMARs for medication administration. -On 08/16/22, Staff A signed the eMARs for medication administration. Interview with Staff A on 09/02/22 at 9:22am revealed: -She was hired in January 2022 as a MA. -She worked as a MA on second shift. -She took the 15-hour course in 2005 or 2006. -She had worked as a MA in another facility, but it had been greater than 2 years since she had passed medications prior to being hired in January 2022. -She had not received any medication training classes since being hired in January 2022. Refer to the interview with the Human Resources Director (HRD) on 09/02/22 at 10:58pm. Refer to the interview with the Administrator on 09/02/22 at 11:16am.	D935		

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D935	Continued From page 75 2. Review of Staff B's personnel file revealed: -Staff B was hired on 01/06/20. -Staff B's position title was a medication aide (MA). -There was no documentation Staff B had taken and successfully passed the 5, 10, or 15-hour medication class. Review of resident's August 2022 electronic Medication Administration Records (eMAR) revealed: -On 08/02/22, Staff B signed the eMARs for medication administration. -On 08/06/22, Staff B signed the eMARs for medication administration. -On 08/16/22, Staff B signed the eMARs for medication administration. Interview with Staff B on 09/02/22 at 9:34am revealed: -She was hired in January 2020 as a MA. -She worked as a MA on first shift. -She took the 15-hour medication administration course in 2007. -She had worked as a MA in another facility until December 2019. -She did not know if the previous facility provided an employment verification or not. -She had not received any medication training classes since being hired in January 2020. Refer to the interview with the Human Resources Director (HRD) on 09/02/22 at 10:58pm. Refer to the interview with the Administrator on 09/02/22 at 11:16am. 3. Review of Staff C's personnel file revealed: -Staff C was hired on 09/19/19. -Staff C's position title was a medication aide	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032020	A. BUILDING: _____ B. WING _____	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM PARKWAY DURHAM, NC 27705

(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
D935	Continued From page 76 (MA). -There was no documentation Staff C had taken and successfully passed the 5, 10, or 15-hour medication class. Review of resident's August 2022 electronic Medication Administration Records (eMAR) revealed: -On 08/01/22, Staff C signed the eMARs for medication administration. -On 08/03/22, Staff C signed the eMARs for medication administration. -On 08/17/22, Staff C signed the eMARs for medication administration. Interview with Staff B on 09/02/22 at 10:05am revealed: -She was hired on 09/19/19 as a MA. -She worked as a MA on second shift. -She took the 15-hour medication administration course in 2017 or 2018. -She had worked as a MA in another facility until March 2019. -The facility did request my employment verification; she also retained a copy of the employment verification. -She had received a refresher course for medication administration since she was hired. Refer to the interview with the Human Resources Director (HRD) on 09/02/22 at 10:58pm. Refer to the interview with the Administrator on 09/02/22 at 11:16am. 4. Review of Staff D's personnel file revealed: -Staff D was hired on 10/29/21. -Staff D's position title was a medication aide (MA). -There was no documentation Staff D had taken	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032020	A. BUILDING: _____ B. WING _____	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM PARKWAY DURHAM, NC 27705

(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
D935	Continued From page 77 and successfully passed the 5, 10, or 15-hours medication class. Review of resident's August 2022 electronic Medication Administration Records (eMAR) revealed: -On 08/01/22, Staff D signed the eMARs for medication administration. -On 08/02/22, Staff D signed the eMARs for medication administration. -On 08/16/22, Staff D signed the eMARs for medication administration. Interview with Staff D on 09/02/22 at 9:56am revealed: -She was hired in November 2021 as a MA. -She worked as a MA. -She did not recall when she took the 15-hour medication administration course, but she had worked as a MA for years. -She had worked as a MA in other facilities. -She did not know if the previous facility provided an employment verification or not. Refer to the interview with the Human Resources Director (HRD) on 09/02/22 at 10:58pm. Refer to the interview with the Administrator on 09/02/22 at 11:16am. 5. Review of Staff F's personnel file revealed: -Staff F was hired on 03/07/01. -Staff F's position title was a medication aide (MA). -There was no documentation Staff F had taken and successfully passed the 5, 10, or 15-hour medication class. Review of resident's August 2022 electronic Medication Administration Records (eMAR)	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032020	A. BUILDING: _____ B. WING _____	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM PARKWAY DURHAM, NC 27705

(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
D935	Continued From page 78 revealed: -On 08/02/22, Staff F signed the eMARs for medication administration. -On 08/06/22, Staff F signed the eMARs for medication administration. -On 08/16/22, Staff F signed the eMARs for medication administration. Interview with Staff F on 09/02/22 at 9:57am revealed: -She had been employed for 21 years but had only worked as a MA for a year. -She took the medication aide administration course years ago; she read the manual and took the test. -She worked as a MA on first shift. -She had worked as a MA in another facility until December 2019. -She had not received any medication training classes since she started administering medications. Refer to the interview with the Human Resources Director (HRD) on 09/02/22 at 10:58pm. Refer to the interview with the Administrator on 09/02/22 at 11:16am. _____ Interview with the Human Resources Director (HRD) on 09/02/22 at 10:58pm revealed: -Her department was responsible for maintaining the medication aides (MA) personal records to include the 5, 10, or 15-hour certificate or the employment verification. -Her department was responsible for contacting the previous employer to obtain employment verification. -It was very difficulty to receive employment verification from other facilities.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032020	A. BUILDING: _____ B. WING _____	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM PARKWAY DURHAM, NC 27705

(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
D935	Continued From page 79 -She did not know she needed to let the Administrator know that the employment verification was not obtained. -She had not been instructed to tell the Administrator that the employment verification was not obtained. Interview with the Administrator on 09/02/22 at 11:16am revealed: -The facility did not offer the 5, 10, 15-hour medication administration course. -It was the responsibility of the Human Resources Department to manage the employee's personal records and check employment verification. -She was not aware that the MAs did not have a certificate for the 5, 10 ,15-hour medication administration course or an employment verification from their previous employer.	D935		