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SOUNDVIEW FAMILY CARE HOMES UNIT F	24 EAST MONET FLAT ROCK, NC 28731

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/29/23 to 03/30/23.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to notify the prescribing practitioner for 2 of 3 sampled residents (#1 and #2) of missed doses of a medication used to prevent migraines (#1), treat neuropathy (#1), and treat involuntary movements due to the side-effects of certain psychiatric medications (#2). The findings are: 1. Review of Resident #1's current FL2 dated 12/13/22 revealed diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease, and tobacco abuse. a. Review of Resident #1's FL2 dated 12/13/22 revealed there was an order for Emgality (used to prevent migraines in adults) 120mg/ml 1 ml subcutaneously every 28 days. Review of Resident #1's Neurologist letter dated 11/03/22 revealed Resident #1 may self-administer the Emgality injections. Review of Resident #1's December 2022 to March 2023 electronic Medication Administration Records (eMARs) revealed:	C 246		

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C 246	Continued From page 1 -There were entries for Emgality 120mg/ml inject 1ml subcutaneously every 28 days after the initial dose. -There were notes on the entries "not given by facility." -There were no documented administrations of the Emgality from 12/01/23 to 03/29/23. Observation of Resident #1's medications on hand on 03/29/23 at 10:46am revealed: -There were 4 boxes of unopened Emgality 120mg/ml injections available in the facility medication refrigerator. -The dispense dates on the injections were 10/25/22, 12/14/22, 01/17/23, and 03/14/23. Interview with Resident #1 on 03/29/23 at 11:00am revealed: -Facility staff told him there were 4 Emgality injections available in storage for him. -He had not received Emgality injections since the initial dose in September 2022. -He was supposed to be getting the Emgality every 28 days to prevent migraines. -He received training at the Neurologist's office on how to administer the injections to himself. -The Neurologist had written an order to enable him to self-administer the Emgality injections. -Facility staff had asked him to call the Neurologist and clarify who was supposed to give the Emgality injections in October 2022. -He had tried to call the Neurologist but the phone number did not work. -He had been unable to speak with anyone at the Neurology office about the Emgality injections. Interview with the Supervisor-in-Charge (SIC) on 03/29/23 at 11:30am revealed: -She was responsible to administer Resident #1's medications.	C 246		

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C 246	Continued From page 2 -She knew there was an order to administer Emgality injections to Resident #1 every 28 days. -She knew there were four Emgality injections in the medication refrigerator for Resident #1. -She did not know how to administer the Emgality injections to Resident #1. -She did not know Resident #1 could self-administer the Emgality injections. -She did not reach out to the Neurologist to let them know Resident #1 had not had any Emgality injections since the initial dose in September 2022. Interview with the Relief SIC on 03/29/23 at 11:35am revealed: -Resident #1 used to get the Emgality injections at the Neurologist's office. -Then the Neurologist allowed the Emgality to be self-administered. -He called the facility's contracted pharmacy to find out why they were sending so many Emgality injections. -The contracted pharmacy told him the Emgality were self-administer every 28 days. -He could not remember when he spoke with the contracted pharmacy about the Emgality injections. -He did not notify Resident #1's Neurologist about the missed Emgality injections. Telephone interview with Resident #1's primary care Nurse Practitioner (NP) on 03/30/23 at 8:49am revealed staff did not notify her of Resident #1's missed Emgality injections. Interview with the Administrator on 03/29/23 at 10:30am revealed: -The SIC told him today (03/29/23) she did not administer the Emgality to Resident #1. -The SIC was unaware Resident #1 could	C 246		

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C 246	Continued From page 3	C 246		

self-administer the Emgality injections.
-The SIC did not communicate with him concerning Resident #1's missed Emgality injections.
-The SIC did not notify Resident #1's Neurologist about the missed Emgality injections.
-He could find no documentation of any staff member notifying a health care provider of Resident #1's missed Emgality injections.

Attempted interview with Resident #1's Neurologist on 03/29/23 at 11:15am was unsuccessful.

b. Review of Resident #1's FL2 dated 12/13/22 revealed there was an order for gabapentin (used to treat neuropathy) 400mg 1 capsule twice daily.

Review of Resident #1's Physician's Assistant (PA) order dated 01/10/23 revealed gabapentin 400mg 1 capsule twice daily.

Review of Resident #1's December 2022 to March 2023 electronic Medication Administration Records (eMARs) revealed:
-There were entries for gabapentin 400mg 1 capsule twice daily scheduled at 8:00am and 8:00pm.
-The gabapentin was documented as administered as ordered for 55 occurrences out of 62 opportunities from 12/01/22 to 12/31/22.
-The gabapentin was documented as administered as ordered for 54 occurrences out of 62 opportunities from 01/01/23 to 01/31/23.
-The gabapentin was documented as administered as ordered for 40 occurrences out of 56 opportunities from 02/01/23 to 02/28/23.
-The gabapentin was documented as administered as ordered for 57 occurrences out of 57 opportunities from 03/01/23 to 03/29/23.

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C 246	Continued From page 4 Observation of Resident #1's medications on hand on 03/29/23 at 10:46am revealed: -There were 24 capsules of gabapentin 400mg on hand. -The dispense date was 03/12/23. Telephone interview with a representative from the facility's contracted pharmacy on 03/29/23 at 10:22am revealed: -They had an active prescription for Resident #1 for gabapentin 400mg 1 capsule twice daily starting 12/08/22 with three refills. -On 12/13/22, Resident #1's Nurse Practitioner (NP) approved the gabapentin 400mg 1 capsule twice daily for another 12 month's of refills. -The pharmacy sent 60 capsules of gabapentin 400mg on 12/08/22, enough supply to last until 01/07/23. -The pharmacy sent 60 capsules of gabapentin 400mg on 12/31/22, enough supply to last until 02/06/23. -The pharmacy sent 60 capsules of gabapentin 400mg on 01/23/23, enough supply to last until 03/08/23. -The pharmacy sent 60 capsules of gabapentin 400mg on 02/16/23, enough supply to last until 04/07/23. -The pharmacy sent 60 capsules of gabapentin 400mg on 03/13/23. -The pharmacy sent a total of 300 capsules of gabapentin 400mg from 12/08/22 to 03/13/23. Interview with Resident #1 on 03/29/23 at 11:00am revealed: -The Supervisor-in-Charge (SIC) routinely administered his medications. -The SIC told him "earlier in the year" he was out of his gabapentin. -He called the facility's contracted pharmacy to	C 246		

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get a refill.
-The contracted pharmacy told him they had an active prescription, but it was not time to refill it.
-He thought it was "strange" that he didn't have the gabapentin, but the pharmacy said they had sent it.
-He experienced more pain in his right knee during the time when he was out of the gabapentin.
-The gabapentin was a "nerve blocker" that helped with the "aches and pains of old age."

Interview with the SIC on 03/29/23 at 11:44am revealed:
-She administered the gabapentin as ordered administering Resident #1 one capsule in the morning and one at night.
-She and the Relief SIC were the only ones that administered medications in the facility.
-She and the Relief SIC were the only ones that had a key to access Resident #1's medications in the facility.
-Resident #1's gabapentin supply was out at various times from December 2022 to February 2023 because the pharmacy would not refill the medication..
-She did not know what to do.
-She did not report gabapentin being out to the facility Administrator.
-She did not report the missed gabapentin doses to Resident #1's Neurologist or primary care provider.

Interview with the Administrator on 03/29/23 at 10:30am revealed:
-The SIC did not let him know about Resident #1's missed gabapentin.
-He could find no documentation of any staff member notifying a health care provider of Resident #1's missed gabapentin doses.

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C 246	Continued From page 6 Telephone interview with Resident #1's primary care Nurse Practitioner on 03/30/23 at 8:49am revealed: -She did not understand how the gabapentin had run out, as there was an adequate supply sent from the pharmacy. -Facility staff did not notify her about Resident #1's missed doses of gabapentin. Attempted interview with Resident #1's Neurologist on 03/29/23 at 11:15am was unsuccessful. 2. Review of Resident #2's current FL2 dated 02/08/23 revealed: -Diagnoses included schizoaffective disorder bipolar type, autism, and hypertension. -There was an order for benztropine (used to treat involuntary movements due to the side-effects of certain psychiatric medications) 1mg 1 tablet twice daily. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 01/27/23. Review of Resident #2's February 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for benztropine 1mg 1 tablet twice daily scheduled at 8:00am and 8:00pm. -The benztropine was documented as administered as ordered for 31 occurrences out of 56 opportunities. -The benztropine was documented as not administered for 25 occurrences due to "resident refused." Review of Resident #2's March 2023 eMAR	C 246		

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C 246	Continued From page 7 revealed: -There was an entry for benztropine 1mg 1 tablet twice daily scheduled at 8:00am and 8:00pm. -The benztropine was documented as administered as ordered for 30 occurrences out of 57 opportunities. -The benztropine was documented as not administered for 27 occurrences due to "resident refused." Interview with the Administrator on 03/29/23 at 2:00pm revealed: -He could find no documentation that staff notified Resident #1's mental health provider about the resident refusing the evening dose of benztropine in February and March 2023. -The Supervisor-in-Charge (SIC) told him she had not notified any of Resident #2's medical providers about the resident's refusals of the benztropine. -Resident #2 told him he routinely refused the evening dose of benztropine, because he did not like the way the second dose of the medication made him feel. Attempted telephone interview with Resident #2's mental health Physician's Assistant (PA) on 03/30/23 at 9:07am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.	C 246		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained	C 311		

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C 311	Continued From page 8 and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents were treated with dignity and respect in regards to residents being yelled at by the Supervisor-in-Charge (SIC). The findings are: Interview with the SIC on 03/29/23 at 8:09am revealed there were 6 residents who resided in the facility. Observations in the dining room on 03/29/23 at 8:15am revealed: -The SIC set the dining room table with bowls and utensils for the residents' breakfast. -The SIC placed two boxes of cereal on the dining room table. -The SIC yelled loudly "Breakfast." -The SIC yelled loudly "Use the open box of cereal first, before opening the other box." -Only 2 of 6 residents responded and came to the table to eat breakfast. Interview with one resident on 03/29/23 at 8:35am revealed: -Staff yelled at him "a lot." -Once, he used a paper napkin that was under a spoon. -He did not know until after the incident, the spoon was to be used by everyone to stir their coffee and then placed back on the napkin. -The SIC yelled at him for using the paper napkin. -The SIC told him she did not "like people." -The SIC told him she did not "like people in general." -He risked "the fear of God" now if he asked for a napkin.	C 311		

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C 311	Continued From page 9 -It made him feel "bad" when the SIC yelled at him. -He felt he should "move" to another facility. Interview with a second resident on 03/29/23 at 11:00am and 3:14pm revealed: -The SIC had a real "attitude problem." -He was "tired" of the SIC's attitude that the residents were there to be "punished." -One example of punishment occurred when the residents failed to turn off the coffee pot off, the SIC would threaten the residents would not be allowed to have coffee anymore. -The SIC would punish the residents by taking away privileges. -A second example of punishment occurred when one resident was taking snacks and drinking cups from the kitchen into their room. -As a result, all of the residents were punished when the staff started locking up the kitchen. Interview with the SIC on 03/29/23 at 3:16pm revealed: -She could get "a little cranky sometimes." -She was "a little stressed." Interview with the Administrator on 03/29/23 at 3:35pm revealed he could stress resident rights to his staff, but "people do what they want" when he was "not around."	C 311		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:	C 330		

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C 330	Continued From page 10 (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 1 of 3 sampled residents (#1) including a medication to prevent migraines and to treat neuropathic pain. The findings are: 1. Review of Resident #1's current FL2 dated 12/13/22 revealed diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease, and tobacco abuse. a. Review of Resident #1's FL2 dated 12/13/22 revealed: -There was an order for Emgality (used to prevent migraines in adults) 120mg/ml 1 ml subcutaneously every 28 days. -There was an order for rizatriptan (treats symptoms of migraine headaches) 10mg 1 tablet at onset of migraine. -There was an order for rizatriptan 10mg may repeat 1 dose in 2 hours if needed for migraine if no relief from initial dose. Review of Resident #1's Neurologist letter dated 11/03/22 revealed Resident #1 may self-administer the Emgality injections. Review of Resident #1's December 2022 electronic Medication Administration Record	C 330		

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C 330	Continued From page 11 (eMAR) revealed: -There was an entry for Emgality 120mg/ml inject 1ml subcutaneously every 28 days after the initial dose. -There was a note on the entry "not given by facility." -There were no documented administrations of the Emgality from 12/01/23 to 12/31/23. -There was an entry for rizatriptan 10mg 1 tablet at onset of migraine. -There were 10 occurrences of rizatriptan initial dose documented as administered from 12/01/22 to 12/31/22 with 1 repeat dose administered on 12/08/22. Review of Resident #1's January 2023 eMAR revealed: -There was an entry for Emgality 120mg/ml inject 1ml subcutaneously every 28 days after the initial dose. -There was a note on the entry "not given by facility." -There were no documented administrations of the Emgality from 01/01/23 to 01/31/23. -There was an entry for rizatriptan 10mg 1 tablet at onset of migraine. -There were 12 occurrences of rizatriptan initial dose documented as administered from 12/01/22 to 12/31/22 with no repeat doses. Review of Resident #1's February 2023 eMAR revealed: -There was an entry for Emgality 120mg/ml inject 1ml subcutaneously every 28 days after the initial dose. -There was a note on the entry "not given by facility." -There were no documented administrations of the Emgality from 02/01/23 to 02/28/23. -There was an entry for rizatriptan 10mg 1 tablet	C 330		

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at onset of migraine.
-There were 12 occurrences of rizatriptan initial dose documented as administered from 02/01/23 to 02/28/23 with 1 repeat dose on 02/09/23.

Review of Resident #1's March 2023 eMAR revealed:
-There was an entry for Emgality 120mg/ml inject 1ml subcutaneously every 28 days after the initial dose.
-There was a note on the entry "not given by facility."
-There were no documented administrations of the Emgality from 03/01/23 to 03/31/23.
-There was an entry for rizatriptan 10mg 1 tablet at onset of migraine.
-There were 5 occurrences of rizatriptan initial dose documented as administered from 03/01/23 to 03/29/23 with no repeat doses.

Observation of Resident #1's medications on hand on 03/29/23 at 10:46am revealed:
-There were 4 boxes of unopened Emgality 120mg/ml injections available in the facility medication refrigerator.
-The dispense dates on the injections were 10/25/22, 12/14/22, 01/17/23, and 03/14/23.

Interview with the Administrator on 03/29/23 at 10:30am revealed:
-The Supervisor-in-Charge (SIC) told him today (03/29/23) she had a difficult time getting the the contracted pharmacy to deliver the Emgality for Resident #1.
-The SIC did not communicate with him concerning Resident #1's missed Emgality injections.
-He told the SIC on 03/29/23, he needed to know about issues with medications like this and he could have gotten the situation "worked out" so

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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the resident would have had the medication as ordered.

Interview with Resident #1 on 03/29/23 at 11:00am revealed:
-Facility staff told him there were 4 Emgality injections available in storage for him.
-He had not received Emgality injections since the initial dose in September 2022.
-He was supposed to be getting the Emgality every 28 days to prevent migraines.
-He received training at the Neurologist's office on how to administer the injections to himself.
-The Neurologist had written an order to enable him to self-administer the Emgality injections.
-Facility staff had asked him to call the Neurologist and clarify who was supposed to give the Emgality injections in October 2022.
-He had tried to call the Neurologist but the phone number did not work.
-He had been unable to speak with anyone at the Neurology office about the Emgality injections.
-He was also prescribed rizatriptan as needed for migraines.

Interview with the SIC on 03/29/23 at 11:30am revealed:
-She routinely was responsible to administer Resident #1's medications.
-She knew there was an order to administer Emgality injections to Resident #1 every 28 days.
-She knew there were Emgality injections in the medication refrigerator for Resident #1.
-She did not know how to administer the Emgality injections to Resident #1.
-She had not seen the letter dated 11/03/22 from Resident #1's Neurologist which allowed the resident to self-administer the Emgality injections every 28 days.
-She reordered Resident #1's Emgality injection

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when it "pops" in the eMAR and then she would store them in the refrigerator.
-She did not reach out to the Neurologist to ask who was to administer the Emgality injections.

Interview with the Relief SIC on 03/29/23 at 11:35am revealed:
-Resident #1 used to get the Emgality injections at the Neurologist's office.
-Then the Neurologist allowed the Emgality to be self-administered.
-He called the facility's contracted pharmacy to find out why they were sending so many Emgality injections.
-The contracted pharmacy told him the Emgality were self-administer every 28 days.
-He could not remember when he spoke with the contracted pharmacy about the Emgality injections.

Telephone interview with the facility's contracted pharmacy on 03/29/23 at 12:05pm revealed:
-There was an order dated 09/16/22. for a one time dose of Emgality 240mg/ml 1 ml subcutaneously and Emgality 120mg/ml 1ml subcutaneously every 28 days after the initial dose.
-The pharmacy delivered the inital Emgality 240mg/1ml dose on 09/29/22.
-The pharmacy delivered Emgality 120mg/1ml injection doses to the facility on 10/26/22, 12/15/22, 01/19/23, and 03/15/23.

Telephone interview with Resident #1's primary care Nurse Practitioner on 03/30/23 at 8:49am revealed:
-It would have been helpful for Resident #1 to have received the Emgality injections as ordered to prevent migraine headaches.
-As a result, rizatriptan was administered on

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C 330	Continued From page 15 numerous occasions during December 2022 to March 2023 to control the migraine symptoms Resident #1 experienced. Attempted interview with Resident #1's Neurologist on 03/29/23 at 11:15am was unsuccessful. b. Review of Resident #1's FL2 dated 12/13/22 revealed there was an order for gabapentin (used to treat neuropathic pain) 400mg 1 capsule twice daily. Review of Resident #1's Physician's Assistant (PA) order dated 01/10/23 revealed gabapentin 400mg 1 capsule twice daily. Review of Resident #1's December 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for gabapentin 400mg 1 capsule twice daily scheduled at 8:00am and 8:00pm. -The gabapentin was documented as administered as ordered for 55 occurrences out of 62 opportunities. -The gabapentin was documented as not administered for 7 occurrences (12/06/22 at 8:00am, 12/06/22 at 8:00pm, 12/07/22 at 8:00am, 12/08/22 at 8:00am, 12/30/22 at 8:00am, 12/30/22 at 8:00pm, and 12/31/22 at 8:00am due to "new med order hasn't arrived from pharmacy." Review of Resident #1's January 2023 eMAR revealed: -There was an entry for gabapentin 400mg 1 capsule twice daily scheduled at 8:00am and 8:00pm. -The gabapentin was documented as administered as ordered for 54 occurrences out	C 330		

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of 62 opportunities.
-The gabapentin was documented as not administered for 8 occurrences from 01/19/23 at 8:00pm to 01/23/23 at 8:00am due to "new med order hasn't arrived from pharmacy."

Review of Resident #1's February 2023 eMAR revealed:
-There was an entry for gabapentin 400mg 1 capsule twice daily scheduled at 8:00am and 8:00pm.
-The gabapentin was documented as administered as ordered for 40 occurrences out of 56 opportunities.
-The gabapentin was documented as not administered for 16 occurrences including 02/08/23 at 8:00am, and 02/09/23 at 8:00am to 02/16/23 at 8:00am due to "new med order hasn't arrived from pharmacy."

Review of Resident #1's March 2023 eMAR revealed:
-There was an entry for gabapentin 400mg 1 capsule twice daily scheduled at 8:00am and 8:00pm.
-The gabapentin was documented as administered as ordered for 57 occurrences out of 57 opportunities.

Observation of Resident #1's medications on hand on 03/29/23 at 10:46am revealed:
-There were 24 capsules of gabapentin 400mg on hand.
-The dispense date was 03/12/23.

Interview with Resident #1 on 03/29/23 at 11:00am revealed:
-The Supervisor-in-Charge (SIC) routinely administered his medications.
-The SIC told him "earlier in the year" he was out

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C 330	Continued From page 17 of his gabapentin. -He had called the facility's contracted pharmacy to get a refill. -The contracted pharmacy told him they had an active prescription, but it was not time to refill it. -He thought it was "strange" that he didn't have the gabapentin, but the pharmacy said they had sent it. -He did experience more pain in his right knee during the time when he was out of the gabapentin. -The gabapentin was a "nerve blocker" that helped with the "aches and pains of old age." Telephone interview with a representative from the facility's contracted pharmacy on 03/29/23 at 10:22am revealed: -They had an active prescription for Resident #1 for gabapentin 400mg 1 capsule twice daily starting 12/08/22 with three refills. -On 12/13/22, Resident #1's Nurse Practitioner (NP) approved the gabapentin 400mg 1 capsule twice daily for another 12 month's of refills. -The pharmacy sent 60 capsules of gabapentin 400mg on 12/08/22, enough supply to last until 01/07/23. -The pharmacy sent 60 capsules of gabapentin 400mg on 12/31/22, enough supply to last until 02/06/23. -The pharmacy sent 60 capsules of gabapentin 400mg on 01/23/23, enough supply to last until 03/08/23. -The pharmacy sent 60 capsules of gabapentin 400mg on 02/16/23, enough supply to last until 04/07/23. -The pharmacy sent 60 capsules of gabapentin 400mg on 03/13/23. -The pharmacy sent a total of 300 capsules of gabapentin 400mg from 12/08/22 to 03/13/23.	C 330		

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C 330	Continued From page 18 Review of Resident #1's record revealed: -There were 174 documented adminstrations of gabapentin 400mg from 12/08/22 to 03/29/23. -There were 300 capsules of gabapentin 400mg sent to the facility. -There were 24 capsules of gabapentin 400mg remaining of the supply sent from the pharmacy. -There were 102 capsules of gabapetin 400mg missing from the resident's supply. Interview with the SIC on 03/29/23 at 11:44am revealed: -She did not know why the gabapentin 400mg capsules ran out sooner than it should. -She only administered 2 capsules of gabapentin 400mg a day to Resident #1. -She administered the gabapentin as ordered administering Resident #1 one capsule in the morning and one at night. -She and the Relief SIC were the only ones that administered medications in the facility. -She and the Relief SIC were the only ones that had a key to access Resident #1's medications in the facility. -The gabapentin supply was out from 02/08/23 to 02/16/23, because the pharmacy would not refill it. -She had only been working there as the SIC for a year. -She did not know what to do. -She did not report gabapentin being out to the facility Administrator or Resident #1's prescriber. Interview with the Adminstrator on 03/29/23 at 10:30am revealed: -The Supervisor-in-Charge (SIC) told him today (03/29/23) she had a difficult time getting the the contracted pharmacy to deliver the gabapentin for Resident #1. -He could tell in the eMAR system the SIC had	C 330		

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C 330	Continued From page 19 tried to reorder the gabapentin on 02/06/23, 02/07/23, 02/12/23, 02/14/23, 02/15/23, 02/16/23 and again in March 2023. -The SIC did not communicate with him concerning Resident #1's missed gabapentin. -He told the SIC on 03/29/23, he needed to know about issues with medications like this and he could have gotten the situation "worked out" so the resident would have had the medication as ordered. Telephone interview with Resident #1's primary care Nurse Practitioner on 03/30/23 at 8:49am revealed: -Resident #1 was prescribed gabapentin to treat neuropathy pain. -She did not understand how the gabapentin had run out, as there was an adequate supply sent from the pharmacy. Attempted interview with Resident #1's Neurologist on 03/29/23 at 11:15am was unsuccessful. _____ The facility failed to provide migraine prevention injections to Resident #1 from October 2022 to March 2023 resulting in the resident experiencing 39 migraine headaches from December 2022 to March 2023 which could have been prevented and increased pain in Resident #1's right knee due to missed doses of gabapentin. These failures were detrimental to the health, safety, and welfare of Resident #1 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/29/23 for this violation. CORRECTION DATE FOR THE TYPE B	C 330		

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C 330	Continued From page 20 VIOLATION SHALL NOT EXCEED MAY 14, 2023.	C 330		
C 377	10A NCAC 13G .1009(a)(3) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (3) review of the medication system utilized by the facility, including packaging, labeling and availability of medications; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure pharmaceutical reviews identified significant medication problems during monitoring visits for 2 of 3 sampled residents (#1 and #2). The findings are: 1. Review of Resident #1's current FL2 dated 12/13/22 revealed diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease, and tobacco abuse. a. Review of Resident #1's FL2 dated 12/13/22 revealed there was an order for Emgality (used to	C 377		

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prevent migraines in adults) 120mg/ml 1 ml subcutaneously every 28 days.

Review of Resident #1's Neurologist letter dated 11/03/22 revealed Resident #1 may self-administer the Emgality injections.

Observation of Resident #1's medications on hand on 03/29/23 at 10:46am revealed:
-There were 4 boxes of unopened Emgality 120mg/ml injections available in the facility medication refrigerator.
-The dispense dates on the injections were 10/25/22, 12/14/22, 01/17/23, and 03/14/23.

Interview with Resident #1 on 03/29/23 at 11:00am revealed:
-Facility staff told him there were 4 Emgality injections available in storage for him.
-He had not received Emgality injections since the initial dose in September 2022.

Review of Resident #1's Pharmaceutical Review dated 12/19/22 revealed there were no recommendations.

Review of Resident #1's Pharmaceutical Review dated 03/21/23 revealed there were no recommendations.

Telephone interview with the Registered Nurse (RN) who performed the pharmaceutical reviews on 03/29/23 at 3:55pm revealed:
-A pharmaceutical review included electronic Medication Administration Record review, new order review, and drug to drug interaction review.
-His reviews did not include reviewing medications available in the medication cart or medication refrigerator.
-He did not discover Resident #1 did not receive

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C 377	Continued From page 22 Emgality injections during his reviews on 12/19/22 and 03/21/23. b. Review of Resident #1's FL2 dated 12/13/22 revealed there was an order for gabapentin (used to treat neuropathy) 400mg 1 capsule twice daily. Review of Resident #1's Physician's Assistant (PA) order dated 01/10/23 revealed gabapentin 400mg 1 capsule twice daily. Review of Resident #1's December 2022 to March 2023 electronic Medication Administration Records (eMARs) revealed: -There were entries for gabapentin 400mg 1 capsule twice daily scheduled at 8:00am and 8:00pm. -The gabapentin was documented as administered as ordered for 55 occurrences out of 62 opportunities from 12/01/22 to 12/31/22 due to "new med order hasn't arrived from pharmacy." -The gabapentin was documented as administered as ordered for 54 occurrences out of 62 opportunities from 01/01/23 to 01/31/23 due to "new med order hasn't arrived from pharmacy." -The gabapentin was documented as administered as ordered for 40 occurrences out of 56 opportunities from 02/01/23 to 02/28/23 due to "new med order hasn't arrived from pharmacy." -The gabapentin was documented as administered as ordered for 57 occurrences out of 57 opportunities from 03/01/23 to 03/29/23 due to "new med order hasn't arrived from pharmacy." Observation of Resident #1's medications on hand on 03/29/23 at 10:46am revealed: -There were 24 capsules of gabapentin 400mg on hand. -The dispense date was 03/12/23.	C 377		

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C 377	Continued From page 23 Telephone interview with a representative from the facility's contracted pharmacy on 03/29/23 at 10:22am revealed: -They had an active prescription for Resident #1 for gabapentin 400mg 1 capsule twice daily starting 12/08/22 with three refills. -On 12/13/22, Resident #1's Nurse Practitioner (NP) approved the gabapentin 400mg 1 capsule twice daily for another 12 month's of refills. -The pharmacy sent 60 capsules of gabapentin 400mg on 12/08/22, enough supply to last until 01/07/23. -The pharmacy sent 60 capsules of gabapentin 400mg on 12/31/22, enough supply to last until 02/06/23. -The pharmacy sent 60 capsules of gabapentin 400mg on 01/23/23, enough supply to last until 03/08/23. -The pharmacy sent 60 capsules of gabapentin 400mg on 02/16/23, enough supply to last until 04/07/23. -The pharmacy sent 60 capsules of gabapentin 400mg on 03/13/23. -The pharmacy sent a total of 300 capsules of gabapentin 400mg from 12/08/22 to 03/13/23. Review of Resident #1's record revealed: -There were 174 documented administrations of gabapentin 400mg from 12/08/22 to 03/29/23. -There were 300 capsules of gabapentin 400mg sent to the facility. -There were 24 capsules of gabapentin 400mg remaining of the supply sent from the pharmacy. -There were 102 capsules of gabapentin 400mg missing from the resident's supply. Review of Resident #1's Pharmaceutical Review dated 12/19/22 revealed there were no recommendations.	C 377		

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C 377	Continued From page 24 Review of Resident #1's Pharmaceutical Review dated 03/21/23 revealed there were no recommendations. Telephone interview with the Registered Nurse (RN) who performed the pharmaceutical reviews on 03/29/23 at 3:55pm revealed: -A pharmaceutical review included electronic Medication Administration Record review, new order review, and drug to drug interaction review. -His reviews did not include reviewing medications available in the medication cart or medication refrigerator. -He did not discover Resident #1's missed administrations of gabapentin during his reviews on 12/19/22 and 03/21/23. -He would only ask questions of staff if he saw on the eMARs "a lot" of missed administrations of a medication. 2. Review of Resident #2's current FL2 dated 02/08/23 revealed: -Diagnoses included schizoaffective disorder bipolar type, autism, and hypertension. -There was an order for benztropine (used to treat involuntary movements due to the side-effects of certain psychiatric medications) 1mg 1 tablet twice daily. Review of Resident #2's February 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for benztropine 1mg 1 tablet twice daily scheduled at 8:00am and 8:00pm. -The benztropine was documented as administered as ordered for 31 occurrences out of 56 opportunities. -The benztropine was documented as not administered for 25 occurrences due to "resident refused."	C 377		

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C 377	Continued From page 25 Review of Resident #2's March 2023 eMAR revealed: -There was an entry for benztropine 1mg 1 tablet twice daily scheduled at 8:00am and 8:00pm. -The benztropine was documented as administered as ordered for 30 occurrences out of 57 opportunities. -The benztropine was documented as not administered for 27 occurrences due to "resident refused." Interview with the Administrator on 03/29/23 at 2:00pm revealed Resident #2 told him he routinely refused the evening dose of benztropine, because he did not like the way the second dose of the medication made him feel. Review of Resident #2's Pharmaceutical Review dated 03/21/23 revealed there were no recommendations. Telephone interview with the Registered Nurse (RN) who performed the pharmaceutical reviews on 03/29/23 at 3:55pm revealed: -A pharmaceutical review included electronic Medication Administration Record review, new order review, and drug to drug interaction review. -His reviews did not include reviewing medications available in the medication cart or medication refrigerator. -He did not discover Resident #2's refusals of benztropine during his review on 03/21/23. -Routinely when he saw "a lot" of refusals on an eMAR, it would prompt him to start asking questions.	C 377		