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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow survey on May 23-25th with an exit conference via telephone on May 26th.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 3 sampled residents with a diet order for a mechanical soft, chopped diet (#2). The findings are: Review of Resident #2's current FL-2 dated 04/27/23 revealed: -Diagnoses included altered mental status, multi-infarct dementia, acute cerebral vascular accident, tachycardia, major depression, and hypertension. -There was an order for a mechanical chopped diet. Review of the therapeutic diet list posted in the kitchen on 05/23/23 at 9:30am revealed Resident #2 was ordered mechanical soft diet with chopped meat. Review of the mechanical soft chopped therapeutic menu for 05/23/23 revealed the lunch meal consisted of soft and bite sized garlic herb	D 310		

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pork roast, soft broccoli with cheese sauce, soft and bite sized roasted asparagus, moistened baked roll, and soft, chopped fruit.

Observation of the lunch meal on 05/23/23 at 12:07pm revealed:
-Resident #2 was served a ½ inch thick pork chop with gravy, broccoli and cheese, creamed potatoes, a biscuit, and pudding with cool whip.
-Resident #2's pork chop was not chopped, and the biscuit was not moistened.
-Resident #2 cut the pork chop using his knife and fork.
-Resident #2 consumed 100% of all food except broccoli and cheese, which was not touched.

Review of the mechanical chopped therapeutic menu for 05/24/23 revealed the lunch meal consisted of soft and bite sized hamburger gravy, moistened mashed potatoes, soft and bite sized grilled asparagus, soft and bite sized mixed vegetable with no corn or peas, moistened buttermilk biscuit and strawberry ice cream without nuts.

Observation of the lunch meal n 05/25/23 at 12:02pm revealed:
-Resident #2 was served a whole piece of Salisbury steak without gravy, mashed potatoes without gravy, a carrot and green bean medley, a dry biscuit, ice cream, lemonade, and water.
-Resident #2 ate 75% of his Salisbury steak, biscuit, and carrot medley, and ate 100% of his potatoes, ice cream and lemonade.

Review of the Primary Care Provider's (PCP) progress note dated 05/16/23 revealed:
-Resident #2 was hospitalized with a cerebral vascular accident with dysphagia.
-Continue to monitor for choking and coughing

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when eating.

Interview with Resident #2 on 05/23/23 at 12:40pm revealed:
-His meat was not chopped when his meal was served.
-He had never been served a meal with chopped meats.
-The staff did not cut his meat at each meal.
-He was able to cut his food when needed.
-He did not have any problems chewing or swallowing his meat, vegetables, or biscuit.

Interview with the Dietary Aide (DA) on 05/25/23 at 2:57pm revealed:
-She knew how many mechanical soft, chopped diets to prepare for the Memory Care Unit (MCU).
-She prepared 6 mechanical soft, chopped diets for the MCU.
-She did not know which residents received the mechanical soft, chopped diets.
-She did not serve the mechanical soft, chopped diet, she only plated the food.
-She did not need a posted dietary list to refer to for mechanical soft, chopped diets because she knew how to prepare a mechanical soft, chopped diet and she knew how many plates to prepare for the MCU.
-She was not aware Resident #2 was on a mechanical soft, chopped diet.
-Two to three plates of the mechanical soft, chopped diet were placed on a tray, another dietary staff handed the tray to a Personal Care Aide (PCA) and the dietary staff would tell the PCA who to give the plates to.

Interview with a PCA on 05/25/23 at 3:04pm revealed:
-She thought Resident #2 was on a regular diet.
-She had served Resident #2 his meal as

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instructed by the dietary staff and the meal was not soft and chopped.
-The dietary staff told her who to give each plate to.
-She had never noticed Resident #2 coughing or choking on his food.

Interview with a second PCA on 05/25/23 at 3:06pm revealed:
-Resident #2 was on a regular diet.
-Resident #2 did not receive a plate with chopped foods.
-The dietary staff would give the PCAs a tray of food and tell the PCAs who to serve the meals to.
-Resident #2 was always served a regular plate.
-She had not noticed any coughing while Resident #2 was eating.

Interview with a Medication Aide (MA) on 05/25/23 at 2:03pm revealed:
-Resident #2 was on a regular diet.
-She did not see his discharge papers from the hospital.
-She thought Resident #2 was on a regular diet.
-She did not know Resident #2 was ordered a mechanical chopped diet.
-She had not noticed Resident #2 coughing or having difficulty swallowing while eating.

Telephone interview with Resident #2's PCP on 05/25/23 at 10:00am revealed:
-Resident #2 had a stroke in March 2023 and was hospitalized.
-Resident #2 was re-admitted to the facility on 05/04/23 with an order for mechanical chopped diet.
-She watched Resident #2 at breakfast on 05/23/23 and Resident #2 did not have any problems with swallowing or choking.
-She planned to have speech therapy assess

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Resident #2 to see if his diet could be up-graded.
-She expected the facility to serve diet as ordered until reassessed by speech therapy.

Interview with the Kitchen Manager (KM) on 05/24/23 at 12:07pm revealed:
-She had a book in the kitchen with each Resident's diet order, and she referenced the book during meal service.
-She or a cook plated the food and handed it to the PCAs and other staff to serve to the residents.
-She told the staff the resident's name when she handed the plate to the staff.
-Residents who were ordered a mechanical soft diet with chopped meats were served their meals based on the therapeutic diet menu for the mechanical soft diet.
-Mechanical soft chopped meats were meats that were cut into bite sized pieces by the kitchen staff and moistened with gravy.
-The kitchen staff also moistened biscuits and rolls with water, milk or broth when following the mechanical soft therapeutic diet menu.

Second interview with the KM on 05/25/23 at 2:52pm revealed:
-She sometimes served residents their plates of food herself and sometimes she plated the food in the kitchen and staff served the meals.
-The diet list was updated once a week, she printed it off and placed it in a binder.
-She had added gravy to the Salisbury steak and moistened all the biscuits for the mechanical soft meals.
-She knew Resident #2 had an order for a mechanical soft diet with chopped meat; his entire meal was mechanical soft.
-She had plated Resident #2's lunch meal on 05/24/25, she did not know why he was not

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D 310	Continued From page 5 served the correct meal. Interview with the Memory Care Coordinator (MCC) on 05/25/23 at 3:17pm revealed: -Resident #2 was ordered a mechanical chopped diet. -Resident #2 had a stroke in March 2023 and was readmitted on 05/04/23 with an order for mechanical chopped diet. -The dietary staff was responsible for serving the correct diets to each resident. Interview with the Administrator on 05/25/23 at 4:13pm revealed: -Resident #2 was ordered a mechanical chopped diet. -The MCC or Resident Care Coordinator (RCC) entered the diet order into the computer and dietary would print a new dietary list each Monday. -The dietary list is kept in a notebook in the kitchen. -She expected the dietary staff to serve therapeutic diets as ordered.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner 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:	D 358		

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D 358	Continued From page 6 TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 4 of 6 sampled residents (#2, #3, #4, and #6) who had a medication to thin blood and a medication to stimulate appetite (#4); an order for a medication to lower blood sugars (#2); a medication for seizures (#6); and an ammonia reducer and a supplement for muscle cramps (#3). The findings are: Review of the facility policy for Medication Administration of a New Order revealed: -All medications orders, except antibiotics, shall be considered routine. -Orders received prior to 5:00pm, the medication should be started with the next regularly scheduled dose following the next regular pharmacy delivery. -Orders received after 5:00pm, the medication should be started no later than the regularly scheduled dose following the regular pharmacy delivery of the next business day. 1. Review of Resident #4's current FL-2 dated 01/11/23 revealed diagnoses included atrial fibrillation and depression. a. Review of Resident #4's current FL-2 dated 01/11/23 revealed an order for dabigatran etexilate 150mg (used to thin the blood) twice daily. Review of Resident #4's April 2023 from 04/04/23 to 04/30/23 electronic medication administration record (eMAR) revealed: -There was an entry for dabigatran etexilate	D 358		

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150mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation dabigatran etexilate was administered twice daily from 4/04/23 to 04/30/23.

Review of Resident #4's May 2023 eMAR from 05/01/23 to 05/23/23 revealed:
-There was an entry for dabigatran etexilate 150mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation dabigatran etexilate was administered twice daily from 5/01/23 to 05/23/23.

Observation of medication on hand on 05/23/23 at 3:10pm revealed:
-There was a bottle with 7 of 60 capsules dispensed on 04/03/23 available for administration.
-The direction on the prescription label read administer 1 capsule twice daily.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/24/23 at 2:20pm revealed:
-The pharmacy had an order for dabigatran etexilate 150mg twice daily dated 12/01/22.
-The pharmacy dispensed 60 capsules, a 30-day supply of dabigatran etexilate 150mg on 04/03/23.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/25/23 at 11:04am revealed:
-Dabigatran etexilate was a blood thinner used to control atrial fibrillation.
-Resident #4 could have thickened blood which could lead to a blood clot, atrial fibrillation and a stroke, if dabigatran etexilate was not

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D 358	Continued From page 8 administered as ordered. Review of eMAR documentation, medications dispensed, and medications on hand between 04/03/23 to 05/23/23 revealed: -There were 60 dabigatran etexilate dispensed on 04/03/23 available for administration from 04/04/23 to 05/04/23. -There would have been no dabigatran etexilate 150mg available to administer from 05/04/23 to 05/24/23 but there 7 remaining. Interview with a Medication Aide (MA) on 05/25/23 at 2:03pm revealed: -Resident #4's dabigatran etexilate was dispensed in a bottle, not in the blister pack. -The bottle of dabigatran etexilate should last 30 days. -She had not noticed the dispensed date of 04/03/23 on the prescription label on the bottle of dabigatran etexilate that was on the medication cart. -She thought she had administered dabigatran etexilate each time she worked. -She did not know why dabigatran etexilate had only been filled twice since December 2022 or why there were still capsules available for administration from the bottle dispensed on 04/07/23. Interview with a second MA on 05/25/23 at 2:36pm revealed: -She thought dabigatran etexilate was dispensed in the multi-dose pack. -She did not realize it was dispensed in a bottle. -She did not realize the medication had not been administered since it was not in the multi-dose pack. -She should be more careful when comparing the list of medications on the eMAR to the	D 358		

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medications in the multi-dose pack.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 05/25/23 at 10:00am revealed:
-Resident #4 was ordered dabigatran etexilate for atrial fibrillation.
-Resident #4 would be put at risk for blood clots and a higher risk for stroke if she was not receiving dabigatran etexilate as ordered.
-Resident #4 had not had any problems with atrial fibrillation since January 2023.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable

Refer to the telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/24/23 at 2:20pm.

Refer to the interview with a Medication Aide (MA) on 05/25/23 at 8:25am.

Refer to the interview with a second MA on 05/25/23 at 1:10pm.

Refer to the interview with the MCC on 05/25/23 at 3:17pm.

Refer to the interview with the Administrator on 05/25/23 at 4:13pm.

b. Review of Resident #4's physician's order dated 05/15/23 revealed there was an order for mirtazapine 7.5mg (used to stimulate appetite) nightly for appetite stimulation.

Review of Resident #4's May 2023 electronic medication administration record (eMAR) from

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05/16/23 to 05/23/23 revealed:
-There was an entry for mirtazapine 7.5mg at bedtime with a scheduled administration time of 8:00pm.
-There was documentation mirtazapine was administered at bedtime from 05/16/23 to 05/23/23.

Review of medications on hand on 05/24/23 at 3:05pm revealed:
-There was a blister pack with 7 of 10 mirtazapine 7.5mg tablets remaining for administration.
-The prescription label read administer one tablet at night.
-There was a handwritten start date of 05/16/23 on the blister pack.

Review of the pharmacy packing slip dated 05/15/23 revealed:
-Resident #4's order for mirtazapine 7.5mg was packaged for delivery on 05/15/23.
-There were 10 mirtazapine 7.5mg tablets packaged.
-The packaged slip was signed by the Resident Care Coordinator (RCC) on 05/16/23 acknowledging the medication had been received at the facility.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 05/25/23 at 10:00am revealed:
-Resident #4 was ordered mirtazapine 4mg to stimulate her appetite.
-It appeared someone was not administering mirtazapine as ordered if only 3 had been administered in 10 days.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/24/23 at 2:20pm revealed:

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D 358	Continued From page 11 -The pharmacy had an order for mirtazapine 7.5mg at bedtime dated 05/15/23. -The pharmacy dispensed 10 mirtazapine 7.5mg tablets on 05/15/23. -Mirtazapine 7.5mg should have arrived at the facility on 05/16/23 for administration to Resident #4 on 05/16/23. -Ten mirtazapine 7.5mg would be enough pills to be administered each night until 05/26/23, when the medication would be in the multi-dose pack for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/25/23 at 11:04am revealed: -Mirtazapine could be used to stimulate the appetite. -Resident #4 could continue with a decrease appetite and have weight loss if not administered as ordered. Review of eMAR documentation, medications dispensed and medications on hand between 05/16/23 to 05/23/23 revealed: -There was documentation mirtazapine 7.5mg was administered each night from 05/16/23 to 05/23/23. -There were 7 of 10 mirtazapine 7.5mg dispensed on 05/15/23 available for administration when there should have been 2 capsules remaining. Interview with a Medication Aide (MA) on 05/25/23 at 2:03pm revealed: -Resident #4 was ordered mirtazapine and it was sent from the pharmacy in a blister pack. -The blister pack should be stapled to the multi-dose pack. -The medication in the blister pack should last until the medication was placed in the multi-dose	D 358		

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pack.
-The new cycle would start on 05/26/23.
-She signed the eMAR that the medication was administered but forgot to administer the medication.
-She needed to slow down, take her time, and pay attention when administering medications.

Interview with a second MA on 05/25/23 at 2:36pm revealed:
-She knew mirtazapine was a new medication and was dispensed in a blister pack.
-She remembered administering mirtazapine.
-She did not know why there were so many tablets remaining in the bubble pack.
-She placed the blister pack with the multi-dose pack, so she would not forget to administer mirtazapine.

Interview with the MCC on 05/25/23 at 3:17pm revealed:
-The MAs knew orders were not approved on the eMAR until the medications were delivered to the facility and on the medication cart.
-Once the order was approved, the MAs could see the entry on the eMAR and should administer the medication.
-The MAs should look for the medication if it was not in the multi-dose pack.
-The medication was received in the facility and available for administration on 05/16/23.
-The MAs were documenting the medication was administered when it was not.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable

Refer to the telephone interview with a pharmacy technician at the facility's contracted pharmacy on

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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
D 358	Continued From page 13 05/24/23 at 2:20pm. Refer to the interview with a Medication Aide (MA) on 05/25/23 at 8:25am. Refer to the interview with a second MA on 05/25/23 at 1:10pm. Refer to the interview with the MCC on 05/25/23 at 3:17pm. Refer to the interview with the Administrator on 05/25/23 at 4:13pm. 2. Review of Resident #2's current FL-2 dated 4/24/23 revealed diagnosis of uncontrolled diabetes mellitus type 2 with hyperglycemic. Review of Resident #2's signed physician's order dated 05/16/23 revealed an order for glipizide 5mg (used to treat elevated blood sugars) daily. Review of Resident #2's May 2023 electronic medication administration record (eMAR) from 05/16/23 to 05/25/23 revealed: -There was an entry for glipizide 5mg daily with a scheduled administration time of 6:00am. -There was documentation glipizide 5mg was administered daily from 05/23/23 to 05/25/23. -There was no documentation glipizide 5mg was administered from 05/16/23 to 05/22/23. Review of Resident #2's Primary Care Provider's (PCP) progress note dated 05/16/23 revealed: -Fingerstick blood sugar (FSBS) readings reviewed and mostly in the upper 200's and 300's. -Glipizide would be added to see if improvement would be noted in Resident #2's FSBS readings.	D 358		

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D 358	Continued From page 14 -There was an electronic prescription for glipizide 5mg daily with start date 05/16/23. Review of Resident #2's FSBS readings on 05/23/23 revealed: -There were 15 FSBS readings obtained from 05/18/23 to 05/23/23. -The FSBS readings ranged from 189 to 539, with 8 readings from 189 to 254 and 7 readings from 319 to 539. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/24/23 at 2:20pm revealed: -The pharmacy had an order dated 05/18/23 for glipizide 5mg daily. -The order was received on 05/18/23; there was no order received on 05/16/23. -The pharmacy dispensed 6 glipizide 5mg tablets on 05/18/23. -Glipizide 5mg should have arrived at the facility on 05/19/23 for administration on 05/20/23. -Six glipizide would be enough medication to be administered each morning until 5/26/23, when the medication would be in the multi-dose pack (MDP) for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/25/23 at 11:04am revealed: -Glipizide was used to lower blood sugar readings. -Resident #2's blood sugar reading could increase if glipizide was not administered as ordered. Observation of medication on hand on 05/24/23 at 2:30pm revealed there was a blister pack with 5 of 6 glipizide 5mg remaining with a dispensed date of 05/18/23.	D 358		

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Review of the pharmacy packing slip dated 05/18/23 revealed:
-Resident #2's order for glipizide 5mg was packaged for delivery on 05/18/23.
-The packaged slip was signed by a Medication Aide (MA) on 05/19/23 acknowledging the medication had been received at the facility.

Interview with a MA on 05/25/23 at 8:25am revealed:
-She received 6 glipizide tablets from the pharmacy for Resident #2 on 05/19/23.
-She took a screenshot of the medication and sent it to the Memory Care Coordinator (MCC) to let the MCC know the medication had arrived.
-She placed the medication on the medication cart as instructed by the MCC.
-The MCC had to approve the glipizide order on the eMAR before the medication could be administered.

Interview with a second MA on 05/25/23 at 1:10pm revealed:
-She knew Resident #2 had a new order for glipizide 5mg daily.
-Glipizide was scheduled to be administered at 6:00am.
-She worked third shift and was responsible for administering glipizide.
-If the medication was not in the multi-dose pack, she would look for a blister pack.
-She thought she administered glipizide each time she worked.
-She made a mistake and clicked glipizide was administered when it was not.

Telephone interview with Resident #2's PCP on 05/25/23 at 10:00am revealed:
-Resident #2 was ordered glipizide 5mg because

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D 358	Continued From page 16 his blood sugars were consistently greater than 400. -She had been notified of several blood sugar readings greater than 400 since glipizide was ordered but did not know Resident #2 was not being administered glipizide 5mg. -She expected glipizide 5mg to be administered as ordered to help control Resident #2's blood sugar readings. -She was concerned Resident #2's would experience signs and symptoms of hyperglycemia (increase thirst, dry mouth, frequent urination). Interview with the MCC on 05/25/23 at 3:17pm revealed: -She and the RCC were not working on 05/19/23 when glipizide 5mg was received from the pharmacy. -There was no one else in the facilty who could approve a medication for administration. -The MAs would send a picture of the medication, once she verified the medication was in the facility, she could approve the medication for administration from her telephone. -The MA telephoned and sent a picture of glipizide that was received from the pharmacy, but she could not see the picture. -She did not approve any medications for administration that she did not see. -She approved the glipizide for administration on Monday morning, 05/22/23, when she returned to work. -It appeared someone did not administer glipizide as ordered if there was only 1 of 6 tablets missing from the blister pack and three tablets documented as administered from 05/23/23 to 05/25/23. -Resident #2 was ordered glipizide because his blood sugar readings were elevated.	D 358		

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D 358	Continued From page 17 Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable Refer to the telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/24/23 at 2:20pm. Refer to the interview with a Medication Aide (MA) on 05/25/23 at 8:25am. Refer to the interview with a second MA on 05/25/23 at 1:10pm. Refer to the interview with the MCC on 05/25/23 at 3:17pm. Refer to the interview with the Administrator on 05/25/23 at 4:13pm. 3. Review of Resident #6's current FL-2 dated 03/13/23 revealed diagnoses included dementia with behavioral disturbances, epilepsy, wedge compression fracture of T-11 and T-12 vertebra. a. Review of Resident #6's signed physician's order dated 05/18/23 revealed there was an order for levetiracetam 500mg every morning. Review of Resident #6's May 2023 eMAR from 05/21/23 to 05/25/23 revealed: -There was an entry for levetiracetam 500mg every morning for 7 days. -There was documentation levetiracetam 500mg was administered from 05/21/23 to 05/25/23. Observation of medication on hand on 05/25/23 at 9:00am revealed: -There was a blister pack of 7 of 7 levetiracetam	D 358		

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500mg with a dispensed date of 05/19/23, available for administration.
-The directions on the prescription label read administer 1 capsule every morning.

Review of eMAR documentation, medications dispensed and medications on hand between 05/21/23 to 05/25/23 revealed:
-There was documentation levetiracetam 500mg was administered each morning from 05/21/23 to 05/25/23.
-There were 7 levetiracetam 500mg dispensed on 05/19/23 remaining when there should have been 2 capsules remaining.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/24/23 at 2:20pm revealed:
-The pharmacy had an order for levetiracetam 500mg every morning for 7 days dated 05/18/23.
-The pharmacy dispensed 7 levetiracetam 500mg on 05/19/23.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/25/23 at 11:04am revealed:
-Levetiracetam was used to control and prevent seizures.
-Resident #6 could have additional seizures if the medication was not administered as ordered.

Review of the pharmacy packing slip dated 05/19/23 revealed:
-Resident #6's order for levetiracetam 500mg was packaged for delivery on 05/19/23.
-The packaged slip was signed by a medication aide (MA) on 05/20/23 acknowledging the medication had been received at the facility.

Telephone interview with the medical assistant at

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Resident #6's Neurologist office on 05/25/23 at 8:09am revealed:
-Resident #6 was seen by the Neurologist on 05/11/23.
-This was Resident #6's first appointment with the Neurologist.
-Resident #6 was referred to the Neurologist because of her diagnosis of epilepsy, difficulty walking and tremors.
-Resident #6 had blood drawn on 05/11/23 for levetiracetam level, which was 48. (The normal range for levetiracetam level was 10-40).

Interview with a Medication Aide (MA) on 05/25/23 at 1:10pm revealed:
-She did not recall receiving electronic communication from the Memory Care Coordinator (MCC) or the Resident Care Coordinator (RCC) that Resident #6 had a new medication, or that the medication had been delivered and was on the medication cart.
-She did not recall seeing levetiracetam 500mg entry on the eMAR.
-She did not recall administering levetiracetam 500mg to Resident #6.
-She signed the eMAR that levetiracetam 500mg was administered by mistake.

Interview with a second MA on 05/25/23 at 2:36pm revealed:
-She knew levetiracetam 500mg was a new medication and was dispensed in a blister pack.
-She forgot to staple the blister pack to the multi-dose pack, and she forgot to administer it.
-She needed to be careful when administering medications to ensure she had all the medications available to administer before clicking "given" on the eMAR.

Telephone interview with Resident #6's Primary

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D 358	Continued From page 20 Care Provider (PCP) on 05/25/23 at 9:55am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Refer to the telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/24/23 at 2:20pm. Refer to the interview with a Medication Aide (MA) on 05/25/23 at 8:25am. Refer to the interview with a second MA on 05/25/23 at 1:10pm. Refer to the interview with the MCC on 05/25/23 at 3:17pm. Refer to the interview with the Administrator on 05/25/23 at 4:13pm. 4. Review of Resident #3 current FL-2 dated 01/23/23 revealed diagnoses included bipolar II disorder, constipation, dysphagia, asthma and respiratory problems. a. Review of Resident #3's current FL-2 dated 01/23/23 revealed there was an order for lactulose (a laxative also used to reduce ammonia) 20gm/30mL twice daily. Review of Resident #3's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for lactulose 20gm/30mL twice daily scheduled at 8:00am and 8:00pm. -There was documentation lactulose was	D 358		

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D 358	Continued From page 21 administered twice daily from 03/01/23 to 03/31/23. Review of Resident #3's April 2023 eMAR revealed: -There was an entry for lactulose 20gm/30mL twice daily scheduled at 8:00am and 8:00pm. -There was documentation lactulose was administered twice daily from 04/0/1/23 to 04/30/23. Review of Resident #3's May 2023 eMAR from 05/01/23 to 05/23/23 revealed: -There was an entry for lactulose 20gm/30mL twice daily scheduled at 8:00am and 8:00pm. -There was documentation lactulose was administered twice daily from 05/0/1/23 to 05/23/23. -There were refusals documented on 05/10/23 to 05/11/23 at 8:00am and 8:00pm. Observation of Resident #3's medication on hand on 05/23/23 at 4:17pm revealed: -There was a 946mL bottle of lactulose dispensed on 04/25/2. -There was half a bottle of lactulose remaining and available for administration. Interview with Resident #3 on 05/25/23 at 3:02pm revealed: -She knew she was ordered lactulose, but she did not know why it was ordered. -She knew the lactulose gave her loose bowels. -She had been told by one of the medication aides (MA) that her order for lactulose was no longer on the eMAR so it must have been discontinued. -She had blood drawn about every three months; she had blood drawn today, 05/25/23.	D 358		

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D 358	Continued From page 22 Telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/24/23 at 8:34am revealed: -Resident #3 had a current order for lactulose 20gm/30mL twice daily. -The pharmacy dispensed 946mL of lactulose on 03/10/23, 04/08/23 and 04/25/23. -Each 946mL bottle of lactulose contained 31 doses and should have only lasted almost 16 days if administered as ordered. -Resident #3's lactulose was not on a cycle fill order and needed to be reordered by the facility. -Lactulose was used for constipation and to reduce ammonia levels in the blood. -Possible outcomes of not administering lactulose as ordered included increased levels of ammonia in the blood which could result in encephalopathy of the brain, increased mental impairment and confusion. Telephone interview with Resident #3's primary care provider (PCP) on 05/24/23 at 9:42am revealed: -She had ordered Resident #3 the lactulose because she was ordered another medication that increased her ammonia levels. -Resident #3 also benefited from lactulose being a laxative because she had constipation in the past. -Increased ammonia levels were associated with increased drowsiness, so she did not want Resident #3 to be drowsy during the day. -Resident #3 had not complained of drowsiness recently. -Resident #3's ammonia levels were monitored regularly due to her medication orders. -Resident #3's recent labs showed her ammonia was within normal levels. -She expected the medication orders for Resident #3 to be followed by the facility.	D 358		

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D 358	Continued From page 23 Interview with a MA on 05/25/23 at 9:58am revealed: -She administered Resident #3's morning medications. -Resident #3 was good about taking her lactulose and did not refuse it. -She did not know how long a bottle of lactulose would last Resident #3. -Resident #3 had smaller bottles and larger bottles of lactulose dispensed and some were used quicker than others. -She did not know why Resident #3 had lactulose available for administering from a bottle that was dispensed in April 2023. Interview with a second MA on 05/25/23 at 1:20pm revealed: -Resident #3 did not have an order for lactulose anymore, it was no longer on her eMAR. -She could not remember how long Resident #3's lactulose was not on the eMAR. -She told the other MAs about the lactulose not being on the eMAR. -She thought it had been discontinued. Interview with the Resident Care Coordinator (RCC) on 05/25/23 at 10:40am revealed: -Resident #3's lactulose dispensed on 04/25/23 should have been completely used and not on the medication cart and available for administering. -The lactulose should have been discovered during cart audits by the MAs and herself. -It appeared Resident #3 was not administered her lactulose as ordered because it was available for administration. Interview with the Administrator on 05/25/23 at 2:23pm revealed if Resident #3 had a half a bottle of lactulose dated 04/25/23 available for	D 358		

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D 358	Continued From page 24 administration it would allude to the medication not being administered as ordered. Refer to the telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/24/23 at 2:20pm. Refer to the interview with a Medication Aide (MA) on 05/25/23 at 8:25am. Refer to the interview with a second MA on 05/25/23 at 1:10pm. Refer to the interview with the MCC on 05/25/23 at 3:17pm. Refer to the interview with the Administrator on 05/25/23 at 4:13pm. b. Review of Resident #3's current FL-2 dated 01/23/23 revealed there was an order for coenzyme Q10 (a supplement used to promote heart health and muscle tone) 30mg once daily. Review of Resident #3's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for coenzyme Q10 30mg once daily scheduled at 8:00am. -There was documentation coenzyme Q10 was administered daily from 03/01/23 to 03/31/23. Review of Resident #3's April 2023 eMAR revealed: -There was an entry for coenzyme Q10 30mg once daily scheduled at 8:00am. -There was documentation coenzyme Q10 30mg was administered daily from 04/01/23 to 04/30/23.	D 358		

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Review of Resident #3's May 2023 eMAR from 05/01/23 to 05/23/23 revealed:
-There was an entry for coenzyme Q10 30mg once daily scheduled at 8:00am.
-There was documentation coenzyme Q10 was administered on 05/01/23 at 8:00am.
-There was a second entry for coenzyme Q10 30mg once daily scheduled at 8:00am.
-There was documentation coenzyme Q10 was administered once daily from 05/02/23 to 05/23/23 at 8:00am.

Observation of Resident #3's medication on hand on 05/23/23 at 4:17pm revealed:
-Seven tablets of coenzyme Q10 30mg were dispensed on 05/16/23 in a multidose package.
-Two tablets of coenzyme Q10 30mg remained in the multidose package.
-Seven tablets of coenzyme Q10 30mg were dispensed on 05/09/23 in a single dose bubble package.
-There were seven tablets of coenzyme Q10 30mg available for administration in the single dose bubble package.

Interview with Resident #3 on 05/25/23 at 3:02pm revealed she did not know what coenzyme Q10 was and she did not know if she had an order for it.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/24/23 at 8:34am revealed:
-Resident #3 had an order for coenzyme Q10 30mg once daily.
-Seven tablets of coenzyme Q10 30mg were dispensed on 05/09/23 in a single dose package.
-Seven tablets of coenzyme Q10 30mg were dispensed in a multidose package on 05/02/23,

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D 358	Continued From page 26 05/16/23 and 05/23/23. -Single dose packages were used to dispense medications for multiple reasons including new orders, dosage or frequency changes or the medication was not available at the pharmacy when the multidose packages were packed. -Resident #3 did not have a medication change order for the coenzyme Q10, so the coenzyme Q10 was most likely dispensed on 05/09/23 in a single dose package because it was not available at the pharmacy when the multidose packages were prepared. -Coenzyme Q10 was usually ordered for heart health or with a statin (used to lower cholesterol) to counter act possible muscle cramps caused by the statin. -Possible outcomes of not administering coenzyme Q10 as ordered could include muscle pain and cramps and overall weakness. Telephone interview with Resident #3's primary care provider (PCP) on 05/24/23 at 9:42am revealed: -Resident #3 had on order for coenzyme Q10 30mg once daily because she had a history of intolerance of statins. -Resident #3 was currently ordered a statin and complained of muscle pain in her legs while on the statin. -Since Resident #3 was ordered the coenzyme Q10 she had not had complaints of muscle pain. -She expected the facility staff to follow the medication orders as written. Interview with a MA on 05/25/23 at 9:58am revealed: -She administered Resident #3's morning medications. -Resident #3 was good about taking her medication and did not refuse her medications.	D 358		

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-Resident #3's coenzyme Q10 was dispensed in the multidose package.
-There were times the coenzyme Q10 was dispensed in a single dose package; maybe because of an order change.
-She did daily cart audits and did not notice Resident #3's single dose package of coenzyme Q10 had not been administered.
-When a medication was not in the multidose package she would look for a single dose package to administer from.

Interview with the Resident Care Coordinator (RCC) on 05/25/23 at 10:40am revealed:
- Resident #3's coenzyme Q10 was always dispensed in a multidose package; she did not recall ever seeing a single dose package.
-The seven tablets Resident #3's coenzyme Q10 should have been administered even if on the single card; they were probably not in the multidose package.
-The seven tablets of coenzyme Q10 should have been administered beginning 05/09/23 when they were dispensed.
-The single dose package of coenzyme Q10 should have been discovered during cart audits by the MAs and herself.
-It appeared Resident #3 was not administered coenzyme Q10 for the week of 05/09/23 because there were still seven tablets.
-The single dose package should have been stapled to the multidose package when it was received at the facility, that way the MAs would know where the medication was and so it would not be skipped.

Interview with the Administrator on 05/25/23 at 2:23pm revealed:
-Resident #3's was not administered the coenzyme Q10 if there were seven tablets still in

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a single dose package dated 05/09/23.
-The medication should not have still been available for administration.

Refer to the telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/24/23 at 2:20pm.

Refer to the interview with a Medication Aide (MA) on 05/25/23 at 8:25am.

Refer to the interview with a second MA on 05/25/23 at 1:10pm.

Refer to the interview with the MCC on 05/25/23 at 3:17pm.

Refer to the interview with the Administrator on 05/25/23 at 4:13pm.

d. Review of a physician's order for Resident #3 dated 04/28/23 revealed there was an order for meloxicam (used to treat inflammation) 7.5mg once daily for three weeks.

Review of Resident #3's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for meloxicam 7.5mg once daily for three weeks scheduled at 8:00am.
-There was documentation meloxicam was administered once at 8:00am on 04/30/23.

Review of Resident #3's May 2023 eMAR from 05/01/23 to 05/23/23 revealed:
-There was an entry for meloxicam 7.5mg once daily for three weeks scheduled at 8:00am.
-There was documentation meloxicam 7.5mg was administered from 05/01/23 to 05/08/23 at 8:00am.

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-There was a second entry for meloxicam 7.5mg once daily for three weeks scheduled at 8:00am.
-There was documentation meloxicam 7.5mg was administered from 05/10/23 to 05/22/23 at 8:00am.
-There was no documentation meloxicam was administered on 05/09/23.

Observation of Resident #3's medication on hand on 05/23/23 at 4:17pm revealed:
-There were 16 tablets dispensed of meloxicam 7.5mg once daily dispensed on 05/08/23 in a single dose package; ten tablets remained in the package and were available for administration.
-Handwritten in the top left-hand side of the package was, start date 05/10/23.
-On 05/23/23 there should have been only two tablets remaining in the package and available for administration.

Interview with Resident #3 on 05/25/23 at 3:02pm revealed:
-She had medication for the pain in her right foot.
-She was told she had plantar fasciitis about a month ago.
-When she had pain in her right foot, but she used ice packs she kept in her freezer in her room to control the pain.
-She thought the medication [meloxicam] and the ice packs were helping pain.
-He right foot was hurting her today, 05/25/23 but she had been wearing shoes without arch supports and that was where her foot pain was.
-She was going to apply her ice packs to relieve the pain.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/24/23 at 8:34am revealed:
-Resident #3 had an order for meloxicam 7.5mg

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once daily for three weeks dated 04/28/23.
-There were five tables of meloxicam 7.5mg dispensed on 04/28/23 and 16 tablets dispensed on 05/08/23.
-Meloxicam was used to relieve pain and inflammation.
-A possible outcome of not administering meloxicam as ordered could be an increase in inflammation, no relief from pain or increased pain.

Telephone interview with Resident #3's primary care provider (PCP) on 05/24/23 at 10:13am revealed:
-He had ordered Resident #3 the meloxicam for limited use after she had complaint of right foot pain; she had plantar fasciitis.
-He had ordered 21 doses of the meloxicam, enough for three weeks of administration.
-Meloxicam would help with the pain and tenderness in the bottom of Resident #3's foot.
-If the meloxicam was not administered as ordered she would have continued pain and tenderness in her foot.
-He had seen Resident #3 on 05/23/23 and she did not have complaint of foot pain.
-Resident #3 told him she had been applying ice packs to her foot and that helped her pain.
-He expected the facility to follow his orders as written.

Interview with a MA on 05/25/23 at 9:58am revealed:
-She administered Resident #3's morning medications.
-Resident #3 was good about taking her medication and did not refuse it.
-Resident #3's meloxicam 7.5mg was dispensed in the multidose package but she recalled a single dose package too.

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-She did daily cart audits and did not notice Resident #3's single dose package of meloxicam had not been administered.
-When a medication was not in the multidose package she would look for a single dose package to administer from.
-Resident #3 had not complained of foot pain to her.

Interview with the Resident Care Coordinator (RCC) on 05/25/23 at 10:40am revealed:
-There should not have been ten tablets of Resident #3's meloxicam available.
-There should have only been two or three tablets remaining.
-Staff were not administering Resident #3 her meloxicam because there were tablets available.
-The single dose package should have been stapled to the multidose package by the MAs when it was received at the facility, that way the MAs would know where the medication was and so it would not be skipped.
-The meloxicam should have been discovered on a medication cart audit.

Interview with the Administrator on 05/25/23 at 2:23pm revealed she did not know why Resident #3 had meloxicam available for administering.

Refer to the telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/24/23 at 2:20pm.

Refer to the interview with a Medication Aide (MA) on 05/25/23 at 8:25am.

Refer to the interview with a second MA on 05/25/23 at 1:10pm.

Refer to the interview with the MCC on 05/25/23

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D 358	Continued From page 32 at 3:17pm. Refer to the interview with the Administrator on 05/25/23 at 4:13pm. _____ Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/24/23 at 2:20pm revealed: -The pharmacy staff entered new medication orders onto the electronic medication administration record (eMAR). -New medication orders received before the "cut off" time would be filled and shipped the same day. -The new medication would be received in the facility the next day. -If new orders were received in the pharmacy after the "cut off" time, the medication would arrive in two days. -She thought the "cut off" time for the facility was 5:00pm. Interview with a Medication Aide (MA) on 05/25/23 at 8:25am revealed: -The facility was on a weekly cycle fill, which started every Friday. -The pharmacy would send a blister pack with the new medication until the medication was placed into the weekly multi-dose pack (MDP). -The blister pack would have enough pills to administer until the new medication was placed in the MDP. -The MAs should read the eMAR and compare the medications in the MDP. -If the medication was not in the MDP, the MA should look for a blister pack. -The MAs were responsible for the medication cart audits. -The Memory Care Coordinator (MCC) and the Resident Care Coordinator (RCC) scheduled the	D 358		

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medication cart audits.
-The medication cart audit form listed all the residents, and each MA was assigned to 3 or 4 residents each shift, Monday through Friday, of each week.
-The MA should print a copy of the physician orders and compare the orders to the medications on the medication cart.
-The MA should look for date opened for eye drops and inhalers, and re-order any medications that needed re-ordering.
-All findings from the medication cart audit should be documented on the copy of the physician orders and given to the MCC or RCC.

Interview with a second MA on 05/25/23 at 1:10pm revealed:
-The MAs could not see the entry on the eMAR until the MCC or RCC approved the medication order.
-The MCC and RCC were responsible for sending an electronic communication to the MAs when new medication orders were approved, the medication had arrived in the facility, and was placed on the medication cart.
-The pharmacy would send enough pills in a blister pack to administer until the medication was placed in the MDP.
-If the medication was not in the MDP, then the MA should look for a blister pack.

Interview with the MCC on 05/25/23 at 3:17pm revealed:
-The MAs completed medication cart audits each shift Monday through Thursday.
-Each MA audits medications for three to four residents.
-The MAs print the physician orders and make sure each medication was on the medication cart.
-The MA looked for expired medications and if a

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medication needs to be re-ordered.
-The MAs receive the medications for the pharmacy, make sure all medications listed on the package list were shipped, the count for each medication was correct and placed the medications on the correct medication cart.
-If everything was correct, the MA signed and dated the packing form.
-If a medication was ordered before 5:00pm, the medication should be delivered the following day.
-If the medication was ordered after 5:00pm, the medication would be delivered in two days.
-The MCC and RCC approve new medications.
-Each morning, Monday through Friday, the MCC and RCC check to see if new medications have been delivered.
-If the new medications have been delivered, the MCC or the RCC would approve the medication on the eMAR so the MAs could administer the medications.
-She should do weekly medication cart audits.
-The daily medication cart audits are not catching medications not being administered as ordered.

Interview with the Administrator on 05/25/23 at 4:13pm revealed:
-If a medication was not available, the MA should contact the MCC, the RCC, or the pharmacy.
-The MCC, RCC and the MAs were to conduct daily audits of the medication carts.
-Audits were conducted to ensure medications were administered as ordered.
-The MCC, RCC and the MAs compared the medication labels to the eMAR during the audit.
-The MAs were supposed to look at the medication labels and packages and compare them to the eMAR when administering medication.
-She did not know why the MAs were not comparing the eMAR to the medication on the

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D 358	Continued From page 35 medication cart when administering medication. -She expected the MAs to following medication orders and to document correctly on the eMAR. -The MAs were supposed to look at the medication labels and packages and compare them to the eMAR when administering medication. -She did not know why the MAs were not comparing the eMAR to the medication on the medication cart when administering medication. -She expected the MAs to following medication orders and to document correctly on the eMAR. The facility failed to ensure medications were administered as ordered for 4 sample residents, including a resident who was not receiving glipizide as ordered and his fingerstick blood sugars continued to be elevated as high as in the 500's for an additional week (#2); a resident who was not administered her blood thinner for atrial fibrillation which could lead to blood clots and a stroke and a medication to stimulate the appetite (#4); a resident who did not receive a lower dose of levetiracetam for one week as ordered due to an elevated levetiracetam blood level of 48. (normal range was 10 to 40) (#6); and a resident who did not receive an ammonia reducer ordered to reduce excess ammonia caused by another medication, a supplement ordered to prevent muscle cramps in the legs caused by another medication and an anti-inflammatory medication ordered to decrease pain caused by inflammation from plantar fasciitis (#3) 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 05/25/23, CORRECTION DATE FOR THE TYPE B	D 358		

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D 358	Continued From page 36 VIOLATION SHALL NOT EXCEED JULY 1, 2023.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure staff documented on the electronic administration medication record immediately after administering medication for 2 of 5 sampled residents (#2 and #4). The findings are: 1. Review of Resident #2's current FL-2 dated 04/27/23 revealed: -Diagnoses included altered mental status, multi-infarct dementia, acute cerebral vascular accident, tachycardia, major depression, and hypertension. -There was an order for acetaminophen 325mg (used to treat pain) 2 every 4 hours as needed for pain. Review of Resident #2's May 2023 electronic medication administration record (eMAR) from 05/04/23 to 05/24/23 revealed:	D 366		

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D 366	Continued From page 37 -There was an entry for acetaminophen 325mg 2 every 4 hours as needed for pain. -The was no documentation that acetaminophen 325mg had been administered to Resident #2. Observation of medication on hand on 05/24/23 at 2:30pm revealed: -There were 24 of 30 acetaminophen 325mg tablets remaining and available for administration. -The dispensed date on the prescription label was 05/04/23. Interview with a Medication Aide (MA) on 05/25/23 at 2:03pm revealed: -She had not administered acetaminophen 325mg to Resident #2. -Resident #2 did not complain of pain. -She did not know who administered the acetaminophen that was missing from Resident #2's blister pack. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Refer to the interview with a third MA on 05/25/23 at 1:10pm. Refer to the interview with the Memory Care Coordinator (MCC) on 05/25/23 at 3:17pm. Refer to the interview with the Administrator on 05/25/23 at 4:13pm. 2. Review of Resident #4's current FL-2 dated 01/11/23 revealed: -Diagnoses included atrial fibrillation, meningioma, dementia, hypertension, congested heart failure, hyperlipidemia, hyperglycemia, depression, and chronic kidney disease.	D 366		

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D 366	Continued From page 38 Review of Resident #4's FL-2 dated 11/22/22 revealed there was an order for acetaminophen 325mg (used to treat pain) every 4 hours as needed for pain. Review of Resident #4's current FL-2 dated 01/11/23 revealed there was an order for acetaminophen 325mg every 4 hours as needed for pain. Review of Resident #4's December 2022 electronic medication administration record (eMAR) revealed: -There was an entry for acetaminophen 325mg 2 every 4 hours as needed for pain. -There was no documentation acetaminophen 325mg was administered from 12/01/22 to 12/31/22. Review of Resident #4's January 2023 eMAR revealed: -There was an entry for acetaminophen 325mg 2 every 4 hours as needed for pain. -There was documentation 2 acetaminophen 325mg were administered on 01/02/23 at 6:53pm, on 01/03/23 at 8:24am and 8:26pm, on 01/08/23 at 4:13pm, and on 01/11/23 at 8:52am. -There was no other documentation acetaminophen was administered in January 2023. Review of Resident #4's February 2023 eMAR revealed: -There was an entry for acetaminophen 325mg 2 every 4 hours as needed for pain. -There was no documentation acetaminophen 325mg was administered from 02/01/23 to 02/28/23.	D 366		

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Review of Resident #4's March 2023 eMAR revealed:
-There was an entry for acetaminophen 325mg 2 every 4 hours as needed for pain.
-There was no documentation acetaminophen 325mg was administered from 03/01/23 to 03/31/23.

Review of Resident #4's April 2023 eMAR revealed:
-There was an entry for acetaminophen 325mg 2 every 4 hours as needed for pain.
-There was no documentation acetaminophen 325mg was administered from 04/01/23 to 04/30/23.

Review of Resident #4's May 2023 eMAR from 05/01/23 to 05/24/23 revealed:
-There was an entry for acetaminophen 325mg 2 every 4 hours as needed for pain.
-There was no documentation acetaminophen 325mg was administered from 05/01/23 to 05/24/23.

Observation of medication on hand on 05/24/23 at 3:30pm revealed:
-There were 32 of 60 acetaminophen 325mg tablets remaining and available for administration.
-The dispensed date on the prescription label was 12/01/22.

Interview with a Medication Aide (MA) on 05/25/23 at 2:03pm revealed:
-She had not administered acetaminophen to Resident #4.
-She did not know why there were acetaminophen tablets missing from Resident #4's blister pack.
-The medication could be given to close together if the MA did not sign the eMAR when the

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medication was administered.
-Resident #4 could receive too much acetaminophen and overdose if the medication was not documented on the eMAR when administered.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

Refer to the interview with a third MA on 05/25/23 at 1:10pm.

Refer to the interview with the Memory Care Coordinator (MCC) on 05/25/23 at 3:17pm.

Refer to the interview with the Administrator on 05/25/23 at 4:13pm.

b. Review of Resident #4's current FL-2 dated 01/11/23 revealed there was an order for ondansetron 4mg (used to treat nausea and vomiting) every 6 hours as needed for nausea and vomiting.
Review of Resident #4's January 2023 electronic medication administration record (eMAR) from 01/11/23 to 01/31/23 revealed:
-There was an entry for ondansetron 4mg every 6 hours as needed for nausea and vomiting.
-There was no documentation ondansetron was administered from 01/11/23 to 01/31/23.

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for ondansetron 4mg every 6 hours as needed for nausea and vomiting.
-There was no documentation ondansetron was administered from 02/01/23 to 02/28/23.

Review of Resident #4's March 2023 eMAR

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revealed:
-There was an entry for ondansetron 4mg every 6 hours as needed for nausea and vomiting.
-There was documentation ondansetron 4mg was administered on 03/06/23 at 10:50am and 03/27/23 at 11:54am.
-There was no other documentation ondansetron was administered in March 2023.

Review of Resident #4's April 2023 eMAR revealed:
-There was an entry for ondansetron 4mg every 6 hours as needed for nausea and vomiting.
-There was documentation ondansetron 4mg was administered on 04/12/23 at 11:24am.
-There was no other documentation ondansetron was administered in April 2023.

Review of Resident #4's May 2023 eMAR from 05/01/23 to 05/24/23 revealed:
-There was an entry for ondansetron 4mg every 6 hours as needed for nausea and vomiting.
-There was no documentation ondansetron was administered from 05/01/23 to 05/24/23.

Observation of medication on hand on 05/24/23 at 3:32pm revealed:
-There were 19 of 30 ondansetron 4mg tablets remaining and available for administration.
-The dispensed date on the prescription label was 01/10/23.

Interview with a Medication Aide (MA) on 05/25/23 at 2:03pm revealed:
-She had administered ondansetron to Resident #4.
-She had administered ondansetron 5 times to Resident #4.
-The last time she administered ondansetron to Resident #4 was 2 weeks ago.

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D 366	Continued From page 42 -She thought she had documented each time she administered ondansetron 4mg as needed. -The medication could be given to close together if the MA did not sign the eMAR when the medication was administered. Interview with a second MA on 05/25/23 at 2:36pm revealed: -She recalled administering ondansetron to Resident #4 when she complained of nausea. -She did not remember documenting ondansetron on Resident #4's eMAR. -She knew she should document all as needed medications on the eMAR but sometimes she would get busy and forget. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Refer to the interview with a third MA on 05/25/23 at 1:10pm. Refer to the interview with the Memory Care Coordinator (MCC) on 05/25/23 at 3:17pm. Refer to the interview with the Administrator on 05/25/23 at 4:13pm. _____ Interview with a third Medication Aide (MA) on 05/25/23 at 1:10pm revealed: -All "as needed" medications should be documented on the eMAR. -She could not recall if she had administered "as needed" medications or not, but she knew to document on the eMAR when she did administer them. Interview with the Memory Care Coordinator (MCC) on 05/25/23 at 3:17pm revealed:	D 366		

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D 366	Continued From page 43 -The MAs should document the administration of all "as needed" medications. -The MAs would not be able to follow up on the effectiveness of the medication if the administration of the medication was not documented on the eMAR. Interview with the Administrator on 05/25/23 at 4:13pm revealed: -All "as needed" medications should be documented on the eMAR when administered. -The "as needed" medications could be administered to close together if there was no documentation on the eMAR of the administration of the "as needed" medication. -If the resident was administered the same medication in a short time frame, the resident could have side effects from receiving too much medication. -The MAs should document all "as needed" medications on the eMAR.	D 366		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.	D 375		

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This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure 1 of 2 sampled residents (#7) had a physician's order to self-administer a dry mouth oral rinse and a dry mouth moisturizing spray.

The findings are:

Review of the facility's Resident Self-Management medications policy revealed:
-Any resident who desires to self-manage and administer his/her medications must successfully complete the Self-Administration assessment completed by the Resident Care Coordinator (RCC) or designee.
-Once the resident has satisfactorily passed the evaluation, the RCC or designee will ensure there was a physician's order in place that indicated the resident is able to self-administer his/her medications and the specific instructions for the use of the medications were printed on the medication label.

Review of Resident #7's current FL-2 dated 03/06/23 revealed:
-Diagnoses included acute kidney failure, hypertension, Crohn's disease and having intellectual disabilities.
-There was no order for biotine moisturizing dry mouth oral rinse.
-There was no order for biotine moisturizing dry mouth oral spray.
-There was no order for self-administration.

Observation of Resident #7's bathroom during the morning tour on 05/23/23 at 10:08am revealed:

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-There was a 2 fl. oz bottle of biotine moisturizing dry mouth oral rinse placed in the front of the storage cubicle.
-There was a 1.5 fl. oz. of biotine moisturizing dry mouth oral spray placed in the front of the storage cubicle.
-The biotine containers had no pharmacy labels for instruction for use or for self-administration.

Observation of Resident # 7's bathroom on 05/24/23 at 8:30am revealed:
-There was a 2 fl. oz bottle of biotine moisturizing dry mouth oral rinse placed in the front of the storage cubicle.
-There was a 1.5 fl. oz. of biotine moisturizing dry mouth oral spray placed in the front of the storage cubicle.
-The bottles of dry mouth oral rinse or the dry mouth oral spray had not been removed from Resident #7's bathroom by staff.

Interview with Resident #7 on 05/23/23 at 10:09am revealed:
-His family member gave him the rinse and the mouth spray for him to use almost a year ago.
-He used the biotine rinse and the biotine spray after he brushed his teeth twice a day.
-He always kept the biotine rinse and spray bottles on the same open shelf in the bathroom.
-Staff often come into his room giving him medications and said nothing about him needing having a self- administration order from his physician or having instruction labels on the containers.
-He kept his bathroom door open when not in use.

Review of Resident #7's record revealed:
There was no physician's order for Resident #7 for the use of biotine moisturizing dry mouth oral

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rinse.
-There was no physician's order for Resident #7 for the use of biotine moisturizing dry mouth oral spray.
-There was no successfully completed self-administration assessment completed by RCC or designee for Resident #7.

Interview with a Personal Care Aide (PCA) on 05/25/23 at 2:15pm revealed:
-She sometimes assisted Resident #7 with a shower, but he was mostly independent with bathing and grooming.
-She knew Resident #7 complained of having a dry mouth and asked her to bring him the moistening spray he kept in the bathroom to soothe his mouth.
-His family brought more biotine spray and mouth rinse when it ran out.

Attempted telephone interview with Resident #7's responsible party on 05/25/23 at 1:35pm was not successful.

Interview with a medication aide (MA) on 05/25 23 at 1:45pm revealed:
-If a MA saw medications in a resident's room, they should remove the medications unless the resident had an order from their physician to self-administer those medications.
-Resident #7 did not have a self-administration order for biotine oral rinse or spray.
-She had not noticed the biotine oral rinse and spray in Resident #7's bathroom.
-She should remove the biotine oral rinse and spray from Resident #7's bathroom, place them in the medication cart and notify the RCC.

Review of the electronic medication administration record (e-MARs) for Resident #7

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revealed:
-There was no order for biotine mouth rinse or for biotine mouth spray for March 2023.
-There was no self-administer order for biotine mouth rinse or for biotine spray for March 2023.
-There was no order for biotine mouth rinse or for biotine mouth spray for April 2023.
-There was no self-administer order for biotine mouth rinse or for biotine spray for April 2023.
-There was no order for biotine mouth rinse or for biotine mouth spray for May 2023.
-There was no self-administer order for biotine mouth rinse or for biotine spray for May 2023.

Attempted telephone interview with the primary care provider (PCP) at 2:45pm was unsuccessful.

Interview with the RCC on 05/25/23 at 1:50pm revealed:
-All medications should be kept in the medication cart unless a resident has a self- administration order.
-When a MA or other staff saw medications in resident's rooms, they were to remove the medications and bring them to her to check and determine why they were in the resident's room.
-If a resident wanted to self-administer their medications, they would need to complete an assessment and obtain an order from their physician.
-She was not aware Resident #7 had biotine mouth rinse and spray in his room and was self-administering.
-Resident #7 did not have a self-administer order
-Staff was to report any medications found in residents' rooms to her.

Interview with the Administrator at 3:00pm on 05/25/23 revealed:
-All medications were to be checked and given an

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D 375	Continued From page 48 order and label if brought in from the outside. -All medications were to be stored in the locked medication cart unless the resident had been given an order to self-administer medications in their room. -She was not aware Resident #7 had medications in his room and was self- medicating biotine rinse and spray. -She was not aware Resident #7's family were bringing the resident biotine rinse and spray. -Resident #7 did not have an order to self-administer biotine rinse and spray.	D 375		
D 377	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure residents	D 377		

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medication were stored in a safe and secure mummer for 1 of 2 (#7) sampled residents who self-administered medications.

The findings are:

Review of Resident #7's current FL-2 dated 03/06/23 revealed diagnoses included acute kidney failure, hypertension, Crohn's disease and intellectual disabilities.

Review of the facility's Medication Storage policy for residents revealed:
Medications will be stored in a manner that ensures the maintence of both the integrity of the medication and the safety of all residents residing in the community
-All medications, including over the counter (OTC) were always kept in locked storage.

Observation of Resident #7's bathroom during the morning tour on 05/23/23 at 10:08am revealed:
-There was a 2 fl. oz bottle of biotene moisturizing dry mouth oral rinse placed in the front of the storage cubicle.
-There was a 1.5 fl. oz. of biotine moisturizing dry mouth oral spray placed in the front of the storage cubicle.

Observation of Resident # 7's bathroom on 05/24/23 at 8:30am revealed:
-There was a 2 fl. oz bottle of biotine moisturizing dry mouth oral rinse placed in the front of the storage cubicle.
-There was a 1.5 fl. oz. of biotine moisturizing dry mouth oral spray placed in the front of the storage cubicle.
-The bottles of dry mouth oral rinse or the dry mouth oral spray had not been removed from Resident #7's bathroom by staff.

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D 377	Continued From page 50 Interview with Resident #7 on 05/23/23 at 10:09am revealed: -His family member gave him the rinse and the mouth spray for him to use almost a year ago. -He used the biotine rinse and the biotine spray after he brushed his teeth twice a day to keep his mouth from getting dry. -He always kept the biotine rinse and spray bottles on the same open shelf next to the bathroom door -Staff often came into his room giving him medications and said nothing about him needing to have the biotine rinse and oral spray stored on the medication cart. -The biotine rinse and spray were OTC medications and could be left in his room for easier use. -He always kept his bathroom door open and could reach for the biotine rinse and spray easily. -He did not have a self-administration order from his physician; no one said he needed one for an OTC medication. Interview with a Personal Care Aide (PCA) on 05/25/23 at 2:15pm revealed: -She sometimes assisted Resident #7 with a shower, but he was mostly independent with bathing and grooming. -Resident #7 often complained of having a dry mouth and used the moistening rinse and spray he kept in the bathroom. -His family brought more biotine spray and mouth rinse whenever they ran out. -She was not aware Resident #7's biotine medication was supposed to be stored in the medication cart. -No one told her the biotine medication was to be stored in the medication cart. -Resident #7 often leaves his room and bathroom	D 377		

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D 377	Continued From page 51 doors open. -Someone could walk down the hall, go into his room and take the biotine rinse and spray. Interview with a medication aide (MA) on 05/25 23 at 1:45pm revealed: -All medications should be stored on the medication cart unless determined otherwise. -If a MA saw medications in a resident's room, they should remove the medications, store them in the medication cart and notify the Resident Care Coordinator (RCC). -Resident #7 did not have a self-administration order to keep the biotine oral rinse in his room -She had not noticed the biotine oral rinse and spray in Resident #7's bathroom. Attempted telephone interview with the primary care provider (PCP) on 05/25/23 at 2:45pm was unsuccessful. Attempted telephone interview with the contracted pharmacist on 05/25/23 at 2:30pm was unsuccessful. Interview with the RCC on 05/25/23 at 1:50pm revealed: -All medications should be kept locked in the medication cart unless it is being administered by the MA or the resident has a self-administration order. -If a MA or other staff saw medications in resident's rooms, they were to remove the medications, lock them in the medication cart and notify her they were in the resident's room. -If a resident wanted to keep medications in their room, they would need to complete an assessment and obtain an order from their physician and keep self-administering and keep their medications locked in the room.	D 377		

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D 377	Continued From page 52 -She was not aware Resident #7 had biotine mouth rinse and spray stored in his room and was self-administering. -Resident #7 did not have a self-administer order to keep medications in his room. Interview with the Administrator at 3:00pm on 05/25/23 revealed: -All medications from other than the pharmacy, were to be checked, given an order and pharmacy label, stored and locked in the medication cart for safety. -All medications were to be stored in the locked medication cart unless the resident had been given an order to self-administer medications in their room. -She was not aware Resident #7 was keeping medications in his room and was self- medicating biotine rinse and spray. -She was not aware Resident #7's family were bringing the resident OTC biotine rinse and spray and were not directed to give the medications to the MAs to store in the medication cart. -Resident #7 did not have an order to self-administer biotine rinse and spray. -Staff was to report any medications found in residents' rooms directly to her. -She expected staff to be more aware of residents storing medications in unsafe conditions. -Resident #7's medications had not been stored in a safe and secure manner.	D 377		