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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on July 18 and 19, 2023.	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, interviews, and record reviews the facility failed to serve a therapeutic diet and a nutritional supplement as ordered by the primary care provider (PCP) for 2 of 3 sampled residents who had orders for a finger food diet (#7) and a nutritional supplement (#4). The findings are: 1. Review of Resident #7's current FL-2 dated 04/14/23 revealed: -Diagnoses included dementia, hypertension, osteoporosis, and glaucoma. -Resident #7 resided in the memory care unit (MCU). Review of Resident #7's signed physician's order dated 06/16/23 revealed there was a diet order for regular, finger foods (FF). Review of Resident #7's signed diet order form dated 02/13/23 revealed there was a diet order for regular, FFs. (Finger foods were foods that could be eaten easily with hands instead of cutlery and could help to improve food intake.	D 310		

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D 310	Continued From page 1 Diet spreadsheets [therapeutic diet menus] identified appropriate menu options.) Review of the facility's menu and therapeutic diet menu for breakfast dated 07/18/23 revealed: -The menu for the breakfast meal was oatmeal, scrambled eggs, bacon and a cinnamon biscuit. -The therapeutic diet menu listed the FF diet meal as a pop tart to replace the oatmeal, a baked egg omelet to replace the scrambled eggs, bacon and a cinnamon biscuit. Observation of the breakfast meal on 07/18/23 at 8:40am revealed: -Resident #7 was served a bowl of oatmeal; she was not served a pop tart. -Resident scooped the oatmeal with her fingers and placed them in her mouth. Review of the facility's menu and therapeutic diet menu for breakfast dated 07/19/23 revealed: -The menu for the breakfast meal was grits, a biscuit topped with sausage gravy, and choice of eggs. -The therapeutic diet menu listed the FF diet meal as a pop tart to replace the grits, a biscuit with sausage gravy on the side and a hardboiled egg to replace the eggs of choice. Observation of the breakfast meal on 07/19/23 8:22am to 9:15am revealed: -Resident #7 was served a biscuit that was cut into quarters and two hardboiled eggs cut into quarters. -She was not served a pop tart or the sausage gravy. -Resident #7 ate 100 percent of her meal with her fingers. Observation of the kitchenette in the MCU on	D 310		

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07/19/23 at 8:49am revealed:
-There were four bowls of sausage gravy sitting on the counter.
-The Regional Director began to cover them with cellophane wrap.
-There were individual menus for each resident that included the resident's name, their therapeutic diet order and a list of food items for breakfast, lunch and dinner.
-The menus were dated for 07/19/23.
-There were food items circled on the menu and handwritten food items under each meal.

Review of Resident #7's individual menu dated 07/19/23 revealed:
-Breakfast items included grits, biscuit with sausage gravy and eggs of choice.
-The biscuit was circled and hardboiled had been hand written under eggs.

Telephone interview with Resident #7's primary care provider (PCP) on 07/19/23 at 5:03pm revealed:
-Resident #7 had been on a puree diet and was not eating well so she changed the diet order to FFs.
-She wanted Resident #7 to maintain some of her independence, so she had placed her on the FFs diet.
-She thought Resident #7 ate better since her diet was changed to FFs.
-She had reviewed the facility's therapeutic diet menu for FFs to determine if the diet was appropriate for Resident #7.
-She expected the facility to provide the food items as they were listed on the therapeutic FF menu for Resident #7.

Interview with a personal care aide (PCA) on 07/19/23 at 8:49am revealed:

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-She had selected Resident #7's food items for the day from the list on the individual select menu.
-Resident #7 was ordered a FFs diet because she could not use any utensils.
-Resident #7 could tell staff what she wanted to eat but staff selected for her.
-She did not select sausage gravy for Resident #7 because she was ordered an FF diets and it would be 'too messy" for her to eat the gravy.
-The kitchen staff plated the food for the residents; the plates had the gravy in a bowl on them.
-She knew the residents who were ordered an FF diet could not eat the gravy, so she set the bowls aside and did not serve them.
-She did not serve the residents who were ordered FFs any foods that were "messy" when they ate.

Interview with the Regional Director on 07/19/23 at 8:49am revealed:
-A dietitian prepared the therapeutic diet menu for the FF diet to include alternate items for the residents.
-They did not serve the residents who were ordered the FF diet something "messy" because they would get "messy" [eating] and it was a dignity standpoint.

Interview with the morning cook on 07/19/23 at 9:39am revealed:
-She followed the therapeutic diet menu when she prepared the residents' food.
-She used the individual resident selected menus when she plated food, but she also referenced the therapeutic menus to make sure she served the correct foods according to their diets.
-The individual resident selected menus did not have the foods from the therapeutic diets on

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them, only the regular menu items.
-She paid special attention to the FF diet because it had different food items from the regular diet menu.
-She did not serve hot breakfast cereals to residents who were ordered the FF diet; there were pop tarts in the MCU and the MCU staff served them to the residents.
-She had served the sausage gravy in a small bowl on the side of the plate for the FF diet on 07/19/23.
-She cut the biscuit into quarters so the residents ordered an FF diet could dip them into the gravy.
-Sometimes the MCU staff did not select all the items on the menu for the FF diets.
-The staff in the MCU told her they did not select the sausage gravy for the residents who were ordered the FF diet because they did not want them getting messy when they ate.
-The MCU staff said they were going to take the bowls sausage gravy off the plates because the residents "played" in it.
-The Kitchen Manager (KM) told her to follow the therapeutic menu for FF diets and serve the sausage gravy.
-She plated the food for the MCU according to the therapeutic menu; the MCU staff chose not to serve what she plated.

Interview with the KM on 07/19/23 at 10:19am revealed:
-The individual resident selected menus were provided to the residents to fill out; sometimes staff helped the residents select.
-The individual resident selected menus had the regular menu on them, they did not have the therapeutic diets menu information listed.
-She the MCU staff filled out the resident selected menus for the residents who resided in the MCU.
-She told the cooks to always follow the

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therapeutic diet menus when they plated the residents' food.
-The items on the FF diet were different from the regular menu.
-Because the FF diet was so different the cooks had to look at it when they plated the residents' meals to make sure they did not miss anything.
-She purchased pop tarts and placed them in the cabinets in the kitchenette in the MCU; she told the Memory Care Manager (MCM) and the MCU staff they were there.
-She also told the MCM and the MCU staff the pop tarts were supposed to be given to the residents who were ordered a FF diet instead of the hot breakfast cereal.
-She did not know if the residents were served the pop tarts at breakfast.
-The MCU staff had told her and the cooks not to serve the residents certain foods because the MCU residents played in their food and got messy.
-She told the cooks to plate the residents' food per the therapeutic diet and she did not know what happened after the MCU staff took the plate.
-The MCU staff told the cook not to serve the residents who had an order for a FF diet the gravy because they did not want to clean it up.
-She had told the cook to serve the sausage gravy in a bowl on the side of the plate because that was the way it was listed on the therapeutic diet menu for the finger food diet.
-She did not observe the meals in the dining room in the MCU because she was busy in the kitchen during meals.

Interview with the MCM on 07/19/23 at 11:16am revealed:
-She had wanted the residents who resided in the MCU to have the opportunity to select their meals from a menu.

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-The individual menus were selected by the staff when the residents could not select items.
-She helped to fill out the individual menus for the residents for the 07/19/23 meals.
-She was told on 07/18/23 by the MCU staff the residents who were ordered the FF diet were not supposed to get the sausage gravy, so she did not select it for the residents.
-She did not select the grits or oatmeal because the residents could not pick it up with their hands.
-She did not consult with the KM when she selected the residents' meals.
-She did not have access to the therapeutic diet menus.
-The kitchen plated the food and she thought they followed the therapeutic menu.
-She did not know the pop tarts that the kitchen provided were to be served instead of the hot breakfast cereal; she thought they were for a snack.
-The MCU staff did not know what the therapeutic diet menu had on it so they served what they though the residents could eat.
-She did not know the MCU removed the gravy from the residents' plated; the kitchen knew what to serve the MCU staff should have left the food the kitchen served alone and not removed anything.
-She did not care if the residents got messy when they ate because she expected the MCU staff could clean them up after they ate.
-She tried to be present for at least one meal a day; she was usually not at the facility for the breakfast meal service.

Interview with the Administrator on 07/19/23 at 2:24pm revealed:
-He had observed a few meals; but he was still new.
-He expected the kitchen staff to follow the

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therapeutic diet menu and prepare and serve the meals according to the therapeutic diet menu.
-The MCU staff were expected to serve the meals as the kitchen staff had prepared them and served them on the plates for the residents.
-The MCU staff should have been present when Resident #7 was eating and provided hand over hand guidance and queuing while she was eating.
-A FF diet was going to be messy; the MCU staff would be expected to clean the resident and the mess after the meal.
-The MCU staff should never make the decision to eliminate menu items from a therapeutic diet menu.
-There needed to be better communication between the kitchen and the MCU staff.

Attempted telephone interview with the dietitian who wrote the therapeutic menu on 07/19/23 at 11:04am was unsuccessful.

2. Review of Resident #4's current FL-2 dated 09/23/23 revealed diagnoses included constipation, delirium, neurocognitive disorder, anxiety, sleep, urinary tract infection, creatin elevation, and atrial fibrillation.

Review of Resident #4's physician's order dated 06/23/23 revealed an order to start nutritional shakes with breakfast.

Review of Resident #4's physician's order dated 06/30/23 revealed an order for Ensure shakes with breakfast (order clarification).

Review of Resident #4's July 2023 electronic medication administration record (eMAR) from 07/01/23-07/18/23 revealed:
-There was an entry for Ensure once daily with a scheduled administration time of 8:00am.

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-Ensure was documented as administered daily at 8:00am.
-Ensure was documented as administered 18 times.

Interview with Resident #4 on 07/18/23 at 3:41pm revealed:
-She was not served Ensure every day.
-She had been served some type of protein drink, "maybe twice", but not every day.
-She did not recall the last time she was served a protein drink.
-She did not know why the protein drink had been ordered.
-Her weight had been stable.

Interview with Resident #4 on 07/19/23 at 8:00am revealed:
-She had not been to breakfast.
-She had not been administered any medications or supplements today, 07/19/23.

Observation of Resident #4 on 07/19/23 between 8:24am-9:00am revealed:
-Resident #4 was served coffee, juice, and cereal with milk.
-Resident #4 was not served Ensure in the dining room.
-Resident #4 went to the hallway near the medication cart and waited until her medication was administered.
-Resident #4 was not served Ensure when her morning medications were administered.
-Resident #4 returned to her room.

Observation of Resident #4's medications on hand on 07/19/23 at 11:07am revealed there were 17 bottles of Ensure available to be administered.

Telephone interview with the Pharmacist at the

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facility's contracted pharmacy on 07/19/23 at 10:17am revealed:
-Resident #4's Ensure order was received on 06/30/23 for once a day.
-A case of twenty-four bottles of Ensure was sent to the facility for Resident #4 on 06/30/23.
-There had been no requests to order any additional Ensure for Resident #4.

Telephone interview with Resident #4's primary care provider (PCP) on 07/19/23 at 1:34pm revealed:
-Resident #4 was ordered Ensure because she knew the resident did not "love the food" she was served.
-She ordered Ensure to make sure Resident #4 received adequate nutrition.
-The order was for Ensure daily and she expected the order to be followed.

Interview with the medication aide (MA) on 07/19/23 at 10:34am revealed:
-Resident #4 received Ensure with her breakfast daily.
-She served Resident #4's Ensure at breakfast today, 07/19/23.
-She thought she had served Resident #4's Ensure today, she must have gotten busy and forgot.
-She documented she served Resident #4's Ensure today, 07/19/23, in error.
-She did not know why there was more Ensure on hand than should be based on the documentation of Ensure served.

Interview with the Resident Care Coordinator on 07/19/23 at 2:00pm revealed:
-She was not aware Resident #4 had more Ensure on hand than there should be based on the amount dispensed, compared to the amount

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D 310	Continued From page 10 documented on the eMAR. -Ensure was an order, and it sounded as if the MAs were clicking off, they had done something that they did not do. Interview with the facility's Registered Nurse (RN) on 07/19/23 at 2:43pm revealed: -She was concerned the MAs were checking off they had administered Resident #4's Ensure when they had not. -She was concerned the reason the Ensure had been ordered it would not be beneficial if Resident #4 was not receiving it as ordered. -She expected Resident #4's Ensure to be administered as ordered. Interview with the Administrator on 07/19/23 at 3:12pm revealed: -He was concerned the MAs were not following Resident #4's order for daily Ensure. -He was concerned Resident #4 was not receiving the Ensure for the purpose it was ordered. -He expected all orders to be followed 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.	D 358		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 4 residents (#7) observed during the morning medication pass including errors with a medication for constipation (#7); and for 1 of 6 sampled residents (#4) for record review including errors with a supplement used for vision, a medication used to treat acid reflux, and two medications used to treat constipation.

The findings are:

1. The medication error rate was 7% as evidenced by the observation of 2 errors out of 28 opportunities during the 8:00am medication pass on 07/19/23.

Review of Resident #7's current FL-2 dated 04/14/23 revealed diagnoses included dementia, hypertension, osteoporosis, and glaucoma.

Review of Resident #7's signed physician's orders dated 06/16/23 revealed there was an order for benefiber powder (used for constipation and abdominal discomfort) mix one tablespoon in liquid and drink daily.

Observation of the morning medication pass on 07/19/23 at 7:49am revealed:
-The medication aide (MA) removed the bottle of benefiber powder for the drawer of the medication cart.
-The MA removed a plastic teaspoon from the medication cart and placed one teaspoonful of benefiber powder in 8 ounces of water.
-The MA mixed the benefiber powder in the water by stirring with the plastic spoon.
-The MA handed the cup of water to Resident #7

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who drank ¾ of the liquid and handed the cup to the MA.
-The MA took the cup with ¼ of the liquid and through it in the trash.

Review of Resident #7's July 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for benefiber powder with a scheduled administration time of 8:00am.
-There was documentation benefiber powder was administered on 07/19/23 at 8:00am.

Observation of Resident #7's medication on hand on 07/19/23 at 8:49am revealed:
-There was a bottle of benefiber powder available for administration on the medication cart.
-The bottle of benefiber was ½ full.
-There was a prescription label on the bottle of benefiber that read mix 1 tablespoon in liquid and drink daily.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 07/19/23 at 10:38am revealed:
-The pharmacy had an order for benefiber powder mix 1 tablespoon in liquid and drink daily.
-Benefiber powder was used for constipation.
-Resident #7 may become constipated if the medication was not administered as ordered.

Interview with the MA on 07/19/23 at 1:45pm revealed:
-She used the spoon to measure the benefiber powder because she did not have a measuring cup.
-She did not think to use the graduated medication cup to measure a tablespoon of benefiber powder.
-She thought one spoonful of benefiber powder in

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CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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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liquid was ordered.
-She did not realize she used a teaspoon to measure the benefiber powder and not a tablespoon.
-Resident #7 did not drink all the liquid with the benefiber powder because she did not want it.

Interview with the Memory Care Director (MCD) on 07/19/23 at 2:02pm revealed:
-She tried to observe a medication pass daily on first or second shift.
-She would observe the MA administer the right medication and dosage to the right resident and document on the eMAR.
-The MA should prepare the right dosage of medication and document accurately on the eMAR.
-The MA should have measured the benefiber powder with a graduated medication cup.
-The MA should have worked with Resident #7 to take all the medication.
-The MA's documentation should reflect that Resident #7 did not take all the medication.
-She expected the MA to administer the correct dosage and to administer the medication as ordered.

Interview with the Registered Nurse (RN) on 07/19/23 at 2:42pm revealed:
-The MAs should administer the right medication and dosage to the right resident.
-The MA should use a graduated measuring cup when measuring a powdered medication in a liquid.
-The MA should use 4 to 6 ounces of water instead of 8 to mix the powder with so Resident #7 would possibly drink it all.
-The MA should document in the progress notes if Resident #7 did not consume all of the liquid the powder was mixed with.

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-She was concerned that Resident #7 did not receive her medication as ordered and could have complaints of constipation.
-She expected the MA to administer the medication as ordered and document correctly on the eMAR.

Interview with the Administrator on 07/19/23 at 3:16pm revealed:
-He was concerned Resident #7 did not receive the correct dosage of medication.
-Resident #7 did not receive the full benefit of why the medication was used.
-If one MA was administered the medication incorrectly, there probably were more MAs administering the medication incorrectly.
-He expected the MAs to read the medication orders and administer the medication as ordered.

Attempted telephone interview with Resident #7 Primary Care Provider (PCP) on 07/19/23 at 11:20am was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.

Refer to the interview with the facility's Registered Nurse (RN) on 07/19/23 at 2:43pm.

Refer to the interview with the Administrator on 07/19/23 at 3:12pm.

2. Review of Resident #4's current FL-2 dated 09/23/23 revealed diagnoses included constipation, delirium, neurocognitive disorder, anxiety, sleep, urinary tract infection, creatin elevation, and atrial fibrillation.

a. Review of Resident #4's physician's order

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dated 11/02/22 revealed an order for Preservision Areds 2 to take one capsule twice daily.

Review of Resident #4's signed physician's orders dated 05/10/23 revealed an order for Preservision Areds 2 to take one capsule twice daily.

Review of an order change clarification form dated 06/28/23 revealed:
-The request was from the pharmacy to a provider.
-The request was completed for Resident #4.
-The request was to change the Preservision Areds 2 from capsule to chewable due to a faulty product from the manufacturer.
-The form was not signed by the provider.

Review of Resident #4's May 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Preservision Areds 2 chewable administer twice daily with a scheduled administration time of 8:00am and 8:00pm.
-Preservision Areds 2 chewable was documented as administered daily at 8:0am-8:00pm with no exceptions documented.
-Preservision Areds 2 chewable was documented as administered 62 times.

Review of Resident #4's June 2023 eMAR revealed:
-There was an entry for Preservision Areds 2 chewable administer twice daily with a scheduled administration time of 8:00am and 8:00pm.
-Preservision Areds 2 chewable was documented as administered daily from 06/01/23-06/20/23 at 8:0am-8:00pm and on 06/21/23 at 8:00am with 3 exceptions documented.
-There was a second entry Preservision Areds 2

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capsules administer twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation the medication was administered twice daily from 07/22/23-07/30/23 and on 07/21/23 at 8:00pm.
-Preservision Areds 2 was documented as administered 57 times.

Review of Resident #4's July 2023 eMAR from 07/01/23-07/18/23 revealed:
-There was an entry for Preservision Areds 2 capsules administer twice daily with a scheduled administration time of 8:00am and 8:00pm.
-Preservision Areds 2 capsules was documented as administered daily at 8:0am-8:00pm with one exception documented on 07/11/23 at 8:00pm as medication not available.
-Preservision Areds 2 capsules was documented as administered 34 times.

Observation of Resident #4's medications on hand on 07/18/23 at 12:01pm revealed there were no Preservision Areds capsules or chewable available to be administered.

Interview with Resident #4 on 07/18/23 at 9:01am revealed:
-She was very concerned she had not received the medication she took for her macular degeneration.
-The medication was supposed to be administered twice a day and she had not received the medication; she could not recall the last time the medication was administered.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/18/23 at 12:25pm and 4:07pm revealed:
-Resident #4's current order was for PreserVision Areds 2 one tablet twice daily.

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D 358	Continued From page 17 -Preservision Areds 2 was dispensed on 04/12/23 for 56 tablets, on 05/10/23 for 60 tablets, and 0n 06/07/23 for 56 tablets. -They had not refilled the PreserVision Areds 2 because they had recalled all the capsules because they were leaking and were only filling the PreserVision Areds 2 chewable. -A faxed request for an order change to chewable was sent to the facility on 06/28/23. -They did not receive a signed order to change the medication to chewable. -There was no documentation that any staff from the facility had contacted the pharmacy about a refill for PreserVision Areds 2. -If someone had reached out to the pharmacy about the medication, they would have sent the medication from the backup pharmacy and worked on getting the order for the chewable. -The medication was a multivitamin supplement designed to preserve eyesight and was used to slow the degeneration of macular degeneration. Second interview with the Pharmacist at the facility's contracted pharmacy on 07/19/23 at 10:17am revealed: -Resident #4's Preservision Areds had been dispensed as chewable for the May 2023 and June 2023 dispensing. -He did not know why the order was changed in the system to capsules and there was confusion with the order because it appeared Resident #4 was already on the right product and did not need to be switched. -He did not see an order for capsules, so he did not know why it was changed. Interview with the medication aide (MA) on 07/18/23 at 4:37pm revealed: -She did not see Resident #4's Preservision Areds on the medication cart today 07/18/23.	D 358		

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-She thought the medication had just run out and she had reordered the medication today, 07/18/23.
-She thought the pharmacy had only sent one blister package on the last dispensing and thought it "ran out fast."
-Resident #4 had Preservision on the medication cart when she worked one-day last week.
-Refills are done on the computer and come in the same day or by the next day.

Interview with another MA on 07/19/23 at 10:34am revealed:
-There were no Preservision Areds on the medication cart today, 07/19/23, for Resident #4 so she called the pharmacy.
-An order was received to change Resident #4's Preservision Areds from capsules to chewable over a month ago.
-She had Resident #4's primary care provider (PCP) sign the form sent from the pharmacy and it was faxed back to the pharmacy.
-The MAs were responsible for faxing new orders to the pharmacy and using the new order tracking form.
-Once the medication was delivered, the new order tracking form would be removed from the binder and the form was given to the facility's Registered Nurse (RN).
-She looked through Resident #4's record and did not see the signed order for the Preservision Areds chewable.
-Usually, there would be a confirmation form attached to the order to show the order was sent to the pharmacy.
-She found the signed form in the office but there was no confirmation attached.
-She had administered the PreserVision gel capsules to Resident #4 this month because that was what was on the eMAR.

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-Resident #4 had a bottle of Preservision Areds yesterday, she thought the bottle was on the wrong cart.

Second observation of Resident #4's medication on hand on 07/19/23 at 11:09am revealed:
-The bottle for the Preservision capsules was over the counter with no pharmacy label.
-Resident #4's name was written on top of the bottle.
-The bottle was labeled as containing 130 soft gel tablets.
-The bottle contained 127 soft gel tablets when counted by the MA.

Second interview with the MA on 07/19/23 at 11:09am revealed the bottle of Preservision Areds for Resident #4 had been supplied by the resident's family.

Telephone interview with Resident #4's family member on 07/19/23 at 1:42pm revealed:
-He had been told not to bring OTC Preservision tablets to Resident #4.
-He had not had any OTC PreserVision tablets delivered to the facility since "sometime toward the end of last year."
-Resident #4 had complained to him yesterday she had not received her Preservision Areds.
-It had happened before that she had complained of not getting the Preservision Areds, he thought sometime last year.

Telephone interview with Resident #4's primary care provider (PCP) on 07/19/23 at 1:34pm revealed:
-Resident #4 was ordered Preservision Areds as a multivitamin for eyesight preservation.
-It was to supplement vitamins needed but not obtained in the diet.

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-Resident #4 was supposed to be administered Preservision Areds daily.
-She expected the order to be followed as written.

Interview with the Resident Care Coordinator (RCC) on 07/19/23 at 2:00pm revealed:
-She expected MAs to administer medications as ordered.
-If a medication was not available, she expected the MA to call the pharmacy to see what was going on.
-She knew Resident #4 was being administered her Preservision Areds until recently when the pharmacy changed the type of Preservision Areds they could provide.
-The MA told her she had fazed the signed order back to the pharmacy.
-She would have expected the MAs to follow up with the pharmacy or the PCP if the medication had not been delivered.

Refer to the interview with the facility's Registered Nurse (RN) on 07/19/23 at 2:43pm.

Refer to the interview with the Administrator on 07/19/23 at 3:12pm.

b. Review of Resident #4's after visit summary dated 06/14/23 revealed an order for Pantoprazole 40mg twice daily.

Review of a signed physician's order dated 06/22/23 revealed an order for Pantoprazole 40mg twice daily.

Review of Resident #4's electronic medication administration record (eMAR) for June 2023 and July 2023 revealed there was no entry for Pantoprazole 40mg and there was no documentation that Pantoprazole 40mg had been

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D 358	Continued From page 21 administered. Observation of Resident #4's medication on hand on 07/18/23 at 12:01pm revealed there was no Pantoprazole 40mg available to be administered. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/18/23 at 4:07pm revealed an order for Protonix 40mg twice daily had not been received at the pharmacy. Interview with a medication aide (MA) on 07/19/23 at 10:34am revealed: -She had not seen the order for Resident #4's Pantoprazole 40mg in the hospital discharge summary. -The second order for Resident #4's Pantoprazole was a follow-up appointment with the resident's Primary care Provider (PCP). -She did not know why the order for the Pantoprazole had not been sent to the pharmacy to be filled. Interview with Resident #4 on 07/18/23 at 3:41pm revealed: -She was not aware of an order for Pantoprazole. -She had gone to the hospital with problems with food backed up, but she did not know what was prescribed for it. -She had not had any problems with swallowing or acid reflux. Interview with the Resident Care Coordinator (RCC) on 07/19/23 at 2:00pm revealed: -She did not know what happened to Resident #4's order for the Protonix. -It was ultimately their responsibility to ensure the medication was available to be administered. -She and the Registered Nurse were responsible	D 358		

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for reading through the discharge paperwork.
-She had not completed chart audits.

Interview with the facility's Registered Nurse (RN) on 07/19/23 at 2:43pm revealed:
-Hospital discharge papers were not considered orders unless each page was signed by the provider.
-When a resident returned from the hospital the MA was supposed to do a medication reconciliation and if the medications did not match what the resident was receiving before the hospitalization, the MA should obtain clarification.
-New order tracking forms were used to track new orders and she was concerned the process did not work if the initial step did not occur with the order.

Attempted telephone interview with Resident #4's provider on 07/19/23 at 11:36am who wrote the order for Pantoprazole was unsuccessful.

Refer to the interview with the facility's Registered Nurse (RN) on 07/19/23 at 2:43pm.

Refer to the interview with the Administrator on 07/19/23 at 3:12pm.

c. Review of Resident #4's current FL-2 dated 09/23/23 revealed an order for MiraLAX (a laxative used to treat constipation) to mix one packet in 4-8 ounces of liquid of choice and administer twice (the remainder of the order was not viewable).

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/18/23 at 12:25pm revealed Resident #4's MiraLAX order was clarified on 09/28/23 for twice daily.

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D 358	Continued From page 23 Review of Resident #4's signed physician's orders dated 05/10/23 revealed an order for MiraLAX to mix one packet in 4-8 ounces of liquid of choice and administer twice daily. Review of Resident #4's May 2023 electronic medication administration record (eMAR) revealed: -There was an entry for MiraLAX to mix one packet in 4-8 ounces of liquid of choice and administer twice daily with a scheduled administration time of 8:00am and 8:00pm. -MiraLAX was documented as administered daily at 8:0am-8:00pm with no exceptions documented. -MiraLAX was documented as administered 62 times. Review of Resident #4's June 2023 eMAR revealed: -There was an entry for MiraLAX to mix one packet in 4-8 ounces of liquid of choice and administer twice daily with a scheduled administration time of 8:00am and 8:00pm. -MiraLAX was documented as administered daily at 8:0am-8:00pm with 3 exceptions documented. -MiraLAX was documented as administered 57 times. Review of Resident #4's July 2023 eMAR from 07/01/23-07/18/23 revealed: -There was an entry for MiraLAX to mix one packet in 4-8 ounces of liquid of choice and administer twice daily with a scheduled administration time of 8:00am and 8:00pm. -MiraLAX was documented as administered daily at 8:0am-8:00pm with no exceptions documented. -MiraLAX was documented as administered 35 times.	D 358		

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D 358	Continued From page 24 Observation of Resident #4's medications on hand on 07/18/23 at 12:01pm revealed no MiraLAX was available to be administered. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/18/23 at 12:25pm revealed: -Resident #4 had a prn order for MiraLAX that was dispensed on 12/02/22 for a bottle of MiraLAX that would last for 30 doses. -MiraLAX was last dispensed for twice a day on 01/17/23 for a total of 60 packets, which was a one-month supply. -MiraLAX was not considered a cycle medication and would have to be requested for refill. -There was no documentation Resident #4's MiraLAX had been requested for refill until today, 07/18/23 through the facilities eMAR. -MiraLAX was used as a preventive for constipation, to keep the resident regular. Interview with a medication aide (MA) on 07/18/23 at 12:01pm revealed: -Resident #4's MiraLAX was prn, and she was not administered any today, 07/18/23. -She looked in the medication cart and Resident #4's did not have any MiraLAX on hand, but she would order it today, 07/18/23. Interview with another MA on 07/19/23 at 10:34am revealed: -Resident #4's MiraLAX had always been dispensed in individual packets until today and a bottle of MiraLAX had been dispensed for the resident. -She knew Resident #4 had a "really big bag of packets", but she did not know how many. Interview with Resident #4 on 07/18/23 at 3:41pm	D 358		

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revealed:
-She had problems with constipation.
-She had several medications ordered to treat constipation.
-She was supposed to receive MiraLAX every day, but she did not.
-She had not had a bowel movement in two days.
-It felt like she needed to go but it would not come out.
-If she was receiving her medication for constipation, she would be getting some relief and she was not.

Interview with the same MA on 07/18/23 at 4:37pm revealed:
-She did not administer the last of any medication during today's morning medication pass for Resident #4.
-Resident #4's MiraLAX was scheduled.
-Resident #4's MiraLAX came in individual packets and were kept in a plastic bag on the medication cart.
-Resident #4's MiraLAX was in the water she gave her during the medication pass; the resident just did not know it was in the water because the resident had not asked.
-She administered the last packet of Resident #4's MiraLAX today, 07/18/23.

Interview with the Resident Care Coordinator (RCC) on 07/19/23 at 2:00pm revealed:
-She was not aware Resident #4's MiraLAX had not been available to be administered but was documented.
-The MA should not document they had administered a medication if it was not administered.
-She expected the MAs to contact the pharmacy to reorder medication when it needed to be refilled.

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CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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Interview with the facility's Registered Nurse (RN) on 07/19/23 at 2:43pm revealed:
-She was concerned that Resident #4 did not receive her medication as ordered and could have complaints of constipation.
-She expected the MA to administer the medication as ordered and document correctly on the eMAR.

Attempted telephone interview with Resident #4's provider on 07/19/23 at 11:36am who wrote the order for MiraLAX was unsuccessful.

Refer to the interview with the facility's Registered Nurse (RN) on 07/19/23 at 2:43pm.

Refer to the interview with the Administrator on 07/19/23 at 3:12pm.

c. Review of Resident #4's physician's order dated 06/07/23 revealed an order for Senna Plus 8.6-50mg take one tablet daily.

Review of Resident #4's June 2023 electronic medication administration record (eMAR) from 06/09/23-06/30/23 revealed:
-There was an entry for Senna Plus 8.6-50mg daily with a scheduled administration time of 8:00am.
-There was no documentation that Senna Plus was administered from 06/09/23-06/11/23.
-Senna Plus was documented as administered daily at 8:00am from 06/12/23-06/30/23 with 1 exception documented.
-Senna Plus was documented as administered 17 times.

Review of Resident #4's July 2023 eMAR from 07/01/23-07/18/23 revealed:

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-There was an entry for Senna Plus 8.6-50mg daily with a scheduled administration time of 8:00am.
-Senna Plus was documented as administered daily at 8:00am from 07/01/23-07/18/23 with no exceptions documented.
-Senna Plus was documented as administered 18 times.

Observation of Resident #4's medications on hand on 07/18/23 at 12:01pm revealed:
-There was a blister pack of Senna Plus 8.6-50mg dispensed on 06/08/23 for a quantity of 6 tablets with the directions to administer one tablet daily; 3 tablets remained.
-There was a blister pack of Senna Plus 8.6-50mg dispensed on 06/12/23 for a quantity of 28 tablets with the directions to administer one tablet daily; 17 tablets remained.
-There was a second blister pack of Senna Plus 8.6-50mg dispensed on 06/12/23 for a quantity of 28 tablets with the directions to administer one tablet daily; 28 tablets remained.
-There was a blister pack of Senna Plus 8.6-50mg dispensed on 07/12/23 for a quantity of 28 tablets with the directions to administer one tablet daily; 24 tablets remained.
-There was a second blister pack of Senna Plus 8.6-50mg dispensed on 07/12/23 for a quantity of 28 tablets with the directions to administer one tablet daily; 27 tablets remained.
-There was a total of 118 Senna Plus dispensed from the pharmacy from 06/08/23-07/12/23 and 99 remained on hand and available for administration.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/18/23 at 12:25pm revealed:
-An order was received on 06/7/23 for Senna

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D 358	Continued From page 28 Plus 8.6mg-50 daily. -Senna Plus 8.6-50mg was a cycle-filled medication. -Senna Plus was dispensed on 06/08/23 for a total of 8 tablets so the medication would then be with the cycled medication dispensed on 06/12/23. -Senna Plus was dispensed on 06/12/23 and 07/12/23 for a total of 28 tablets. -He saw where two blister packs of 28 had been dispensed on each day because of the way it was entered into the system. -A total of 56 tablets had been dispensed on 06/12/23 and 07/12/23. -Senna Plus was a stool softener and stimulant used to treat constipation -If Resident #4's Senna Plus was not administered as ordered the resident could experience having hard stool. Interview with Resident #4 on 07/18/23 at 3:41pm revealed: -She was supposed to receive Senna Plus every day, but she did not. -She thought the last time she had received her Senna Plus was at least two weeks ago. Interview with a medication aide (MA) on 07/18/23 at 4:37pm revealed: -She administered Resident #4's Senna Plus during the morning medication pass on 07/18/23. -She did not know why there were more tablets available to be administered than should be if the medication was administered every day as documented. Interview with another MA on 07/19/23 at 10:34am revealed: -She administered Resident #4's Senna Plus during the morning medication pass on 07/19/23.	D 358		

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-She did not know why there were more tablets available to be administered than should be if the medication was administered every day as documented.
-She can only say what she did, and she administered the medication every day she worked on Resident #4's medication cart.

Interview with the Resident Care Coordinator (RCC) on 07/19/23 at 2:00pm revealed:
-If there were more Senna tablets on hand for Resident #4 than should be it told her the medication had not been administered as ordered.
-She expected Resident #4's medication to be administered as ordered and not document something that had not been administered.

Interview with the facility's Registered Nurse (RN) on 07/19/23 at 2:43pm revealed:
-She was concerned that Resident #4 did not receive her medication as ordered and could have complaints of constipation.
-She expected the MA to administer the medication as ordered and document correctly on the eMAR.

Attempted telephone interview with Resident #4's provider on 07/19/23 at 11:36am who wrote the order for Senna Plus 8.6-50mg once daily was unsuccessful.

Refer to the interview with the facility's Registered Nurse (RN) on 07/19/23 at 2:43pm.

Refer to the interview with the Administrator on 07/19/23 at 3:12pm.

_____

Interview with Resident #4 on 07/18/23 at 3:41pm revealed:

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D 358	Continued From page 30 -She had problems with constipation. -She had several medications ordered to treat constipation. -She had not had a bowel movement in two days. -It felt like she needed to have a bowel movement, but she could not because she felt like her stool was too hard. -If she was receiving her medication for constipation, she would be getting some relief and she was not. _____ Interview with the facility's Registered Nurse (RN) on 07/19/23 at 2:43pm revealed: -She expected all medications to be administered as ordered. -She ran a report every morning for exceptions to monitor why medications were not administered. -If a medication was not available, she expected the MA to ensure it was not in the facility and then contact the pharmacy. -Medication that was ordered usually came in that evening from the pharmacy or it could be picked up from the backup pharmacy. -She had not completed chart to cart to eMAR audits. Interview with the Administrator on 07/19/23 at 3:12pm revealed: -He expected medication to be administered as ordered. -If a medication was not available, he expected the medication to be reordered and if the medication was not delivered, check on it. -The staff needed to do medication cart audits.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of	D 375		

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D 375	Continued From page 31 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. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 2 sampled residents (#9 and #10) had a physician's order to self-administer eye drops. The findings are: Review of the facility's Resident Self-Administration of Medications policy dated 03/23/23 revealed: -A self-administration of medication assessment would need to be completed quarterly. -The facility would maintain a medication administration record (MAR) for the self-administered medication. -The resident's care plan would include the resident's ability to self-administer medications. -If there were medications in the resident room not on their current eMAR the physician would be contacted for clarification on the continued usage of the medication.	D 375		

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Review of the facility's policy for self-administration of medications revealed:
-The Resident Care Director (RCD) or designee would assess the president's ability to identify, prepare and administer medications and would document on the self-administration medication form.
-The RCD would assess the accuracy and compliance of self-administration by periodic observation.
-An updated list of the resident's medications would be maintained in the resident record.

1. Review of Resident #9's current FL-2 dated 03/17/23 revealed:
-Diagnoses included peripheral artery disease, type II diabetes, urine retention, and chronic kidney disease.
-She did not have an order for eye drops.

Review of Resident #9's physicians order dated 05/12/23 revealed she did not have an order for eye drops.

Review of Resident #9's care plan dated 05/03/23 revealed the facility staff administered her medications.

Review of Resident #9's record on 07/18/23 revealed she did not have a medication self-administration management evaluation.

Observation of Resident #9's room on 07/18/23 at 9:13am revealed:
-There was a table next to a chair.
-There was a bottle of eye drops on the table.
-The resident was seated in the chair.

Interview with Resident #9 on 07/19/23 at

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12:21pm revealed:
-Her optometrist had told her to purchase the OTC eye drops for her dry eyes.
-She was sure she did not have a physician's order for the OTC eye drops.
-Her family purchased them for her about two weeks ago and used them every couple of days for her dry eyes.
-She did not know if the staff knew she had them; she had not told them about the eye drops.

Refer to interview with a personal care aide (PCA) on 07/18/23 at 3:36pm.

Refer to interview with a medication aide (MA) on 07/18/23 at 3:36pm.

Refer to interview with the Resident Care Coordinator (RCC) on 07/19/23 at 11:57am.

Refer to the interview with the facility's Registered Nurse (RN) on 07/19/23 at 1:55pm.

Refer to interview with the Administrator on 07/19/23 at 2:24pm revealed:

Attempted telephone interview with Resident #9's primary care provider (PCP) on 07/19/23 at 3:01pm was unsuccessful.

2. Review of Resident #10's current FL-2 dated 03/21/23 revealed:
-Diagnoses included chronic kidney disease, anemia, asthma and myeloma.

Review of Resident #10's physicians order dated 03/31/23 revealed he did not have an order for eye drops.

Review of Resident #9's record on 07/18/23

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revealed she did not have a current medication self-administration management evaluation.

Observation of Resident #10's room on 07/18/23 at 9:35am revealed:
-There a table with miscellaneous items on it next to a recliner the resident was sitting in.
-There was an opened box of eye drops on a table; the bottle of eye drops was still sealed closed with cellophane.

Interview with Resident #10 on 07/18/23 at 9:35am revealed:
-He purchased the eye drops himself about a week ago.
-He put the eye drops in himself when he needed them.
-He did not know if he had an order from his primary care provider (PCP) for the eye drops.
-He did not have eye drops on the medication cart and the staff did not give him eye drops.
-He did not know if the facility staff knew he had eye drops in his room.

Refer to interview with a personal care aide (PCA) on 07/18/23 at 3:36pm.

Refer to interview with a medication aide (MA) on 07/18/23 at 3:36pm.

Refer to interview with the Resident Care Coordinator (RCC) on 07/19/23 at 11:57am.

Refer to the interview with the facility's Registered Nurse (RN) on 07/19/23 at 1:55pm.

Refer to interview with the Administrator on 07/19/23 at 2:24pm revealed:

Attempted telephone interview with Resident #9's

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D 375	Continued From page 35 primary care provider (PCP) on 07/19/23 at 2:59pm was unsuccessful. Interview with a personal care aide (PCA) on 07/18/23 at 3:36pm revealed: -The PCAs were supposed to look for over the counter (OTC) medications in the resident's rooms when they were in the room doing personal care. -Residents were not allowed to have medications in their rooms. -When she found OTC medications in a resident's room, she would take it to the medication aide (MT). -She had not seen medication in resident rooms in several months. Interview with a medication aide (MT) on 07/18/23 at 3:26pm revealed: -Residents were not allowed to have medications in their rooms unless they had an order to self-administer them. -They looked for OTC medications when they were in a resident's room. -They would scan around the typical area's residents would leave OTC medications like on their nightstands or side tables, around the sink in the bathroom, or in their drawers when getting something out for a resident. -She did not go through a resident's personal belongings looking for OTC medications. -If she found medications in a resident's room, she explained to the resident why they could not have them in their room and removed the mediation. -She then notified the family and then notified the Resident Care Coordinator (RCC) or the facility's Registered Nurse (RN). -She was in and out of resident rooms multiple times a day.	D 375		

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-She had not seen any OTC medications, including eye drops or vitamins, in any residents' rooms.
-There was not a problem with residents keeping OTC medications in their rooms at the facility.

Interview with the RCC on 07/19/23 at 11:57am revealed:
-Residents were not allowed to have OTC medications in their rooms without a self-administer order and self-administer evaluation.
-It was difficult to keep up with purchases of OTC medications because the residents and their families did not always think of an OTC medication in the same way they did a physician ordered medication.
-The PCAs and MAs were supposed to do a periodic sweep of the residents' rooms and look for OTC medications.
-If staff were to find OTC medications in a resident's room, they were to collect it and take it to the medication cart.
-The family and the PCP would be notified of the medication.
-She and the RN would speak to the residents and discuss the possibility of a self-administering order for the medication and a medication self-administration management evaluation.

Interview with the facility's RN on 07/19/23 at 1:55pm revealed:
-Families and residents were told upon admission to the facility that purchasing OTC medications and keeping them in the residents' rooms was not allowed.
-There was a lot of room for disconnect with information and other medications the residents were ordered by physicians, so residents were not allowed to have self-administration orders

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D 375	Continued From page 37 unless very unusual circumstances. -The facility preferred residents did not have self-administered medications. -Residents were not allowed to keep any medications in their rooms. -PCAs and MAs were supposed to look for medications in the resident rooms when they were in their rooms. -When medications were discovered in the residents' room the medication would be immediately removed and secured in the mediation room until a physician's order was received for the staff to administer the medication or for a self-administration order and an evaluation for self-administering of medication was completed. Interview with the Administrator on 07/19/23 at 2:24pm revealed: -Self-administered medications were discouraged by the facility. -All staff should be aware and look for mediations in residents' rooms daily. -The facility needed to be aware of medications residents might have because they were responsible for the residents. -If a resident insisted on a self-administered medication order then the discussion with the family, the resident and the PCP would be done, and the medication self-administration management evaluation would need to be completed.	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	D 377		

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D 377	Continued From page 38 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 that the residents' medications were stored in a safe and secure manner for 3 of 3 sampled residents (#9, #10 and #11) who had eye drops (#9 and #10), dietary supplements and vitamins (#11) in their rooms. The findings are: Review of the facility's medication storage Review of the facility's Resident Self-Administration of Medications and Storage policy dated 03/23/23 revealed medications that were self-administered by residents, and were kept in the resident's room, must be stored in a locked cabinet, or a lock box. 1. Review of Resident #9's current FL-2 dated 03/17/23 revealed: -Diagnoses included peripheral artery disease,	D 377		

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type II diabetes, urine retention, and chronic kidney disease.
-She did not have an order for eye drops.

Review of Resident #9's physicians order dated 05/12/23 revealed she did not have an order for eye drops.

Review of Resident #9's care plan dated 05/03/23 revealed the facility staff administered her medications.

Observation of Resident #9's room on 07/18/23 at 9:13am revealed:
-There was a table next to a chair.
-There was a bottle of eye drops on the table.
-The resident was seated in the chair.

Interview with Resident #9 on 07/19/23 at 12:21pm revealed:
-Her optometrist had told her to purchase the OTC eye drops for her dry eyes.
-Her family purchased them for her about two weeks ago.
-She did not know if the staff knew she had them; she had not told them about the eye drops.
-She kept them on the table beside her chair.
-She could put them in the bathroom and lock the bathroom door.

Refer to interview with a personal care aide (PCA) on 07/18/23 at 3:36pm.

Refer to interview with a medication aide (MA) on 07/18/23 at 3:36pm.

Refer to interview with the Resident Care Coordinator (RCC) on 07/19/23 at 11:57am.

Refer to the interview with the facility's Registered

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	HAL019023	A. BUILDING: _____ B. WING _____	R 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 377	Continued From page 40 Nurse (RN) on 07/19/23 at 1:55pm. Refer to interview with the Administrator on 07/19/23 at 2:24pm. 2. Review of Resident #10's current FL-2 dated 03/21/23 revealed: -Diagnoses included chronic kidney disease, anemia, asthma and myeloma. -There was not an order for eye drops. Review of Resident #10's physicians order dated 03/31/23 revealed he did not have an order for eye drops. Review of Resident #10's record on 07/18/23 revealed she did not have a current medication self-administration management evaluation. Observation of Resident #10's room on 07/18/23 at 9:35am revealed: -There a table with miscellaneous items on it next to a recliner the resident was sitting in. -There was an opened box of eye drops on a table; the bottle of eye drops was still sealed closed with cellophane. Interview with Resident #10 on 07/18/23 at 9:35am revealed: -He purchased the eye drops himself about a week ago. -He did not know if the facility staff knew he had eye drops in his room. -He did not have anyway of locking the medications in a secure place while they were in his room. -He always kept them on the table with his other belongings. Refer to interview with a personal care aide	D 377		

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D 377	Continued From page 41 (PCA) on 07/18/23 at 3:36pm. Refer to interview with a medication aide (MA) on 07/18/23 at 3:36pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/19/23 at 11:57am. Refer to the interview with the facility's Registered Nurse (RN) on 07/19/23 at 1:55pm. Refer to interview with the Administrator on 07/19/23 at 2:24pm. 3. Review of Resident #11's current FL-2 dated 09/27/22 revealed: -Diagnoses included bipolar disorder, thrombocytopenia and essential tremors. -There was an order for glucosamine with chondroitin (used to reduce symptoms of osteoarthritis) one tablet once daily. -There was an order for calcium with vitamin D3 600/400 (used to treat low calcium and vitamin D levels) one tablet once daily. Observation of Resident #11's room on 07/18/23 at 9:24am revealed: -There was a bookshelf in the room with miscellaneous items on it. -There was a large bottle of glucosamine with chondroitin and a bottle of calcium with vitamin D. -Both bottles were unopened. Interview with Resident #11 on 07/19/23 at 10:59am revealed: -He had an order for the glucosamine with chondroitin and the calcium with vitamin D. -The facility administered his medications to him; he did not self-administer the glucosamine or the calcium.	D 377		

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D 377	Continued From page 42 -He ordered a six-month supply of the glucosamine and calcium on line. -The facility staff had asked him to store the extra bottles of medication for them because they did not have room on the medication cart. -He thought he had stored the two bottles in his room for about six months. -They had been sitting on the book shelf since he purchased them. -He did have a place to lock the bottles of medication and to keep them secure, but staff had never told him they needed to be locked and secured. Refer to interview with a personal care aide (PCA) on 07/18/23 at 3:36pm. Refer to interview with a medication aide (MA) on 07/18/23 at 3:36pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/19/23 at 11:57am. Refer to the interview with the facility's Registered Nurse (RN) on 07/19/23 at 1:55pm. Refer to interview with the Administrator on 07/19/23 at 2:24pm. _____ Interview with a personal care aide (PCA) on 07/18/23 at 3:36pm revealed: -The PCAs were supposed to look for over the counter (OTC) medications in the resident's rooms when they were in the room doing personal care. -Residents were not allowed to have medications in their rooms. -When she found OTC medications in a resident's room, she would take it to the medication aide (MT).	D 377		

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D 377	Continued From page 43 -She had not seen medication in resident rooms in several months. Interview with a medication aide (MT) on 07/18/23 at 3:26pm revealed: -Residents were not allowed to have medications in their rooms unless they had an order to self-administer them. -They looked for OTC medications when they were in a resident's room. -They would scan around the typical area's residents would leave OTC medications like on their nightstands or side tables, around the sink in the bathroom, or in their drawers when getting something out for a resident. -She did not go through a resident's personal belongings looking for OTC medications. -If she found medications in a resident's room, she explained to the resident why they could not have them in their room and removed the mediation. -She then notified the family and then notified the Resident Care Coordinator (RCC) or the facility's Registered Nurse (RN). -No medications were stored in residents' rooms; extra medications were stored in the medication cart in a drawer. -She was in and out of resident rooms multiple times a day. -She had not seen any OTC medications, including eye drops or vitamins, in any residents' rooms. -There was not a problem with residents keeping OTC medications in their rooms at the facility. Interview with the RCC on 07/19/23 at 11:57am revealed: -Residents were not allowed to have OTC medications in their rooms. -It was difficult to keep up with purchases of OTC	D 377		

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D 377	Continued From page 44	D 377		

medications because the residents and their families did not always think of an OTC medication in the same way they did a physician ordered medication.
-The PCAs and MAs were supposed to do a periodic sweep of the residents' rooms and look for OTC medications.
-The staff should always be on the look out for OTC medications whenever they are in a resident's room.
-If staff were to find OTC medications in a resident's room, they were to collect it and take it to the medication cart.
-The family and the PCP would be notified of the medication.
-Residents were not allowed to store their own medications; all medications should be stored in the medication carts.

Interview with the facility's RN on 07/19/23 at 1:55pm revealed:
-Families and residents were told upon admission to the facility that purchasing OTC medications and keeping them in the residents' rooms was not allowed.
-There was a lot of room for disconnect with information and other medications the residents were ordered by physicians, so residents were not allowed to have self-administration orders unless very unusual circumstances.
-Residents were not allowed to keep any OTC medications in their rooms.
-Medications were never allowed to be stored in a resident's room; excess medication should be stored in the medication cart.
-PCAs and MAs were supposed to look for medications in the resident rooms when they were in their rooms.
-It should be a part of the day to day routine for the staff to keep an eye out for medications in

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D 377	Continued From page 45 residents' rooms. -They were told to look in the most common and obvious places the residents would keep medications like the nightstand or their bathrooms. -When medications were discovered in the residents' room the medication would be immediately removed and secured in the mediation room until a physician's order was received. -Her concern was there was no control of the medication and who could be taking it because it was not known and not secured. Interview with the Administrator on 07/19/23 at 2:24pm revealed: -OTC medications should never be in a resident's room sitting out and unsecured. -If the resident had an order for a self-administered medication it should have been in a locked box, a locked drawer or cabinet. -All staff should be aware and look for mediations in residents' rooms daily. -The facility needed to be aware of medications residents might have because they were responsible for the residents.	D 377		