STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL09234	A. BUILDING: _____ B. WING _____	R 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL # 2	2305 GLASCOCK STREET RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services conducted an annual and follow-up survey on 08/03/23.	C 000		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 3 sampled residents (#1, #2) who had medication dose changes ordered for medications used to control blood sugar (#1) and medications to control psychotic symptoms (#2).	C 342		

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C 342	Continued From page 1 The findings are: 1. Review of Resident #2's current FL2 dated 12/23/22 revealed: -Diagnoses included schizophrenia. -There was no documentation of orientation status. Interview with Resident #2 on 08/03/23 at 8:09am revealed: -She saw a mental health provider because she had a "nervous breakdown" a few years ago. -She was administered several medications twice daily for mental health. a.Review of Resident #2's current FL2 dated 12/23/22 revealed there was an order for aripiprazole 15mg to be administered once daily. (Aripiprazole is an antipsychotic medication used to treat schizophrenia.) Review of Resident #2's physicians order dated 07/26/23 revealed aripiprazole 5mg was to be administered each day for 14 days and discontinue. Observation of medications on hand for administration for Resident #2 on 08/03/23 at 11:13am revealed there were 7 tablets of aripiprazole 5mg was available for administration. Review of Resident #2's MAR for July 2023 revealed: -There was a computerized entry for aripiprazole 15mg to be administered each morning. -There was documentation aripiprazole 15mg was administered each morning at 8:00am. -There was no entry for aripiprazole 5mg tablets daily for 14 days.	C 342		

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Review of Resident #2's MAR for August 2023 revealed:
-There was a hand written entry for Aripiprazole 5mg to be administered each day for 14 days then discontinue.
-There was no documentation of administration.

b. Review of Resident #2's current FL2 dated 12/23/22 revealed there was an order for citalopram 20mg to be administered once daily. (Citalopram is a medication used to treat depression.)

Review of Resident #2's physicians order dated 07/26/23 revealed citalopram 20mg, one half tablet (10mgs) was to be administered for 14 days then discontinued.

Observation of medications on hand for administration for Resident #2 on 08/03/23 at 11:13am revealed there were 7 tablets of citalopram 20mg one half tablets available for administration through.

Review of Resident #2's MAR for July 2023 revealed:
-There was a computerized entry for citalopram 20mg to be administered each morning.
-There was documentation citalopram 20mg was administered each morning at 8:00am on 07/01/23 to 07/31/23.
-There was no entry for citalopram 20mg 1/2 tablets daily for 14 days.

Review of Resident #2s MAR for August 2023 revealed:
-There was a hand-written entry for citalopram 10mg, administer a half tablet by mouth for 14 days then discontinue.
-There was no documentation citalopram 20mg

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C 342	Continued From page 3	C 342		

was administered.

c. Review of Resident #2's current FL2 dated 12/23/22 revealed an order for mirtazapine 7.5mg to be administered each night at bedtime. (Mirtazapine is a medication used to treat depression.)

Review of Resident #2's physicians order dated 07/26/23 revealed mirtazapine 30mg was to be administered each night at bedtime.

Observation of medications on hand for administration for Resident #2 on 08/03/23 at 11:13am revealed 2 tablets of mirtazapine 15mg were available for administration, dispensed in multidose cycle fill pack.

Review of Resident #2's MAR for July 2023 revealed:
-There was a computerized entry for mirtazapine 7.5mg to be administered each night at bedtime.
-There was documentation mirtazapine 7.5mg was administered each night at 8:00pm.

Review of Resident #2s MAR for August 2023 revealed there was no entry for mirtazapine and no documentation of administration of mirtazapine at any dosage.

Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 08/03/23 at 2:23pm revealed:
-Resident #2 was ordered mirtazapine 7.5mg to be administered each night and it was last dispensed in cycle fill on 05/25/23.
-There was an order for mirtazapine 15mg written on 06/19/23 and discontinued on 07/26/23 when the dose increased to 30mg each night at bedtime.

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C 342	Continued From page 4 Interview with the medication aide on 08/03/23 at 1:00pm revealed: -She administered all medications from the multidose packs for each resident and then document administration of the medications. -She compared the medication label on the multidose pack to the computer for administration. -She realized pages of the MAR were missing on 08/01/23 and did not document the medications she administered for 08/01/23 to 08/03/23. -She called the pharmacy on 08/01/23 when she realized the error but she had not called them again because she did not want to worry them. -She should have called the facility manager regarding the missing MAR but she got distracted. -She compared the new MARs to the current MARs prior to putting them in place for medication administration on 08/01/23. Refer to telephone interview with the pharmacy technician at the facility's contracted pharmacy on 08/03/23 at 2:23pm . Refer to telephone interview with Resident #1's pharmacist on 08/03/23 at 4:57pm. Refer to interview with the with the facility manager on 08/03/23 at 10:31am. Refer to telephone interview with the Administrator on 08/03/23 at 5:51pm. 2. Review of Resident #1's current FL2 dated 12/23/22 revealed: -Diagnoses included diabetes type 2. -There was no documentation of orientation status.	C 342		

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C 342	Continued From page 5 Interview with Resident #1 on 08/03/23 at 7:37am revealed: -She received insulin injections three times each day. -Her blood sugar usually ran between 200 and 300. a.Review of Resident #1's current FL2 dated 12/23/22 revealed there was an order for Humalog 100 unit/ml, 15 units to be administered three times each day with meals. (Humalog is a short-acting insulin injection used to control blood glucose levels.) Review of Resident #1's physician's order dated 06/14/23 revealed Humalog 100 unit/ml, 21 units to be administered each morning with breakfast, 19 units to be administered day with lunch and 17 units to be administered each evening with dinner. Review of Resident #1's MAR for August 2023 revealed: -There was a computerized entry for Humalog 100 unit/ml, 15 units to be administered three times daily before meals -There was documentation Humalog 100 unit/ml, 15 units was administered three times daily before meals at 7:00am, 11:00am and 4:00pm. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 08/03/23 at 2:23pm revealed: -Resident #1 was currently prescribed Humalog 100 unit/ml 21 units to be administered each morning with breakfast, 19 units to be administered each day with lunch and 17 units to be administered each day with dinner per physician's order dated 06/14/23.	C 342		

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C 342	Continued From page 6 -1 box with a quantity of 5 injection pens was last dispensed on 07/24/23. Observation of Resident #1's medications on hand for administration on 08/03/23 at 10:23am revealed there was a box of Humalog Kwikpen labeled with dispense date of 07/24/23 with instructions to inject 15 units three times each day before meals. Refer to telephone interview with the pharmacy technician at the facility's contracted pharmacy on 08/03/23 at 2:23pm . Refer to telephone interview with Resident #1's pharmacist on 08/03/23 at 4:57pm. Refer to telephone interview with the Administrator on 08/03/23 at 5:51pm b. Review of Resident #1's current FL2s dated 12/23/22 revealed there was an order for Levemir 40 units to be administered each morning and 44 units to be administered each night at bedtime. (Levemir is a long acting insulin injection used to control blood glucose levels.) Review of Resident #1's physician's order dated 06/14/23 revealed Levemir 45 units was to be administered each morning and each night at bedtime. Review of Resident #1's MAR for July 2023 revealed: -There was a computerized entry for Levemir flexpen 100 unit/ml to be administered each morning and each night at bedtime with the number "45" hand written over the number of units. -There was documentation Levemir flexpen 100	C 342		

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C 342	Continued From page 7 unit/ml , 45 units was administered each day a 8:00am and 8:00pm from 07/01/23 to 07/31/23. Review of Resident #1's MAR for August 2023 revealed: -There was a computerized entry for Levemir Flexpen 100 unit/ml, 33 units to be administered each morning and 42 units to be administered each night at bedtime. -There was documentation Levemir Flexpen 100 unit/ml, 33 units was administered each morning at 8:00am and 42 units was administered each night at bedtime. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 08/03/23 at 2:23pm revealed: -There was an order for Resident #1 to receive Levemir 100 unit/ml 33 units to be administered each morning and 42 units each night at bedtime written on 02/10/23. -Resident #1's current order was for Levemir 100 unit/ml, 45 units each morning and each night at bedtime which was ordered on 06/14/23. Interview with the Medication Aide on 08/03/23 at 10:45am revealed she administered Levemir 45 units twice daily to Resident #1 because the Administrator told her that was what was ordered. Refer to telephone interview with the pharmacy technician at the facility's contracted pharmacy on 08/03/23 at 2:23pm . Refer to telephone interview with Resident #1's pharmacist on 08/03/23 at 4:57pm. Refer to interview with the with the facility manager on 08/03/23 at 10:31am.	C 342		

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C 342	Continued From page 8 Refer to telephone interview with the Administrator on 08/03/23 at 5:51pm. _____ Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 08/03/23 at 2:23pm revealed: -The pharmacy printed MARs monthly around the 15th of each month. -Medication changes after the printing of the MARs would not be printed on the new MAR. -The facility should review the MARs to ensure the orders were accurate, note any changes and transcribe the current order on the MAR. -Writing over the printed medication instructions could be unclear and not reflect what medication was given accurately. Telephone interview with Resident #1's pharmacist on 08/03/23 at 4:57pm revealed: -It was important MARs were accurate for orders and documentation of administration of medications. -Providers use the MAR to make decisions on dosing, evaluate the need to change treatment by monitoring to see if the medication was administered as intended. -Inaccurate MARs could prompt a provider to change treatment when it wasn't needed if the MAR did not reflect accurate administration. Interview with the facility manager on 08/03/23 at 10:31am revealed: -MARs were printed by the pharmacy and sent to the facility the last week of the month for the following month. -She expected the medication aides (MAs) to review the MAR and check against the current MAR to ensure it was correct. -She was not aware new orders for the residents were not on the MAR for accurate administration.	C 342		

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C 342	Continued From page 9 Telephone interview with the Administrator on 08/03/23 at 5:51pm revealed: -The pharmacy would put the orders on the MAR and the Medication Aides were responsible for transcribing the new order on the current MAR. -The facility's contracted pharmacy sent resident's MARs once a month, a week or so prior to the upcoming month. -MAs were responsible for comparing the MARs for the upcoming month with the current MAR to make sure they were accurate and reflected order changes after the MARs were printed by the pharmacy. -New orders and orders for dose changes were to be transcribed accurately onto the MAR in a new block. -MAR accuracy was a top priority because the MAR was sent with residents to physicians appointments for the doctor to review. -Physicians needed to be aware of medications that are administered and how they were administered in order to make decisions on dose or treatment changes. -She expected all medications that were administered to be documented at the time of administration and, if a medication was not administered as ordered, there should be documentation as to why it was not.	C 342		