STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051025	A. BUILDING: _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW ASSISTED LIVING	250 HIGHWAY 210 WEST SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure section conducted an annual and complaint investigation survey from 10/25/23 to 10/26/23.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure hot water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) as evidenced by 3 of 6 fixtures with hot water temperatures from 80 to 98 degrees F. The findings are: Observations of hot water temperatures on the 300 hall on 10/25/23 at 9:10am revealed: -The hot water temperature in the bathroom shower of resident's room 301 and 303 was 80 degrees F. -The hot water temperature in the bathroom shower of resident's room 302 was 82 degrees F. -The hot water temperature in the bathroom shower of resident's room 305 and 307 was 98 degrees F. Record review of the facility water temperatures	D 113		

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D 113	Continued From page 1	D 113		

dated 10/25/23 revealed a handwritten sticky note for residents' rooms 305 and 307's shower was 97.2 degrees F.

Interview with resident in room 301 on 10/25/23 at 9:00am revealed:
-Our bathroom hot water had been cool for a couple of weeks.
-The resident washed off at the sink because the shower had been too cold.

Interview with second resident in room 302 on 10/25/23 at 9:17am revealed:
-She had a shower on Monday (10/23/23) but it was cold and had been cold since she moved in a couple of weeks ago.

Interview with third resident in room 303 on 10/25/23 at 9:22am revealed:
-She had showered herself last night, but the water was cold.
-The water had been cold for about a month.

Interview with fourth resident in room 305 on 10/25/23 at 9:40am revealed:
-She could not take a shower yesterday (10/24/23) because the water was cold.
-The water had been cold for weeks.

Interview with personal care aide (PCA) on 10/25/23 at 9:22am revealed:
-The hot water had been cold for about a month.
-She had notified the Resident Care Director (RCD).
-Residents had complained that the water in the shower was too cold.

Interview with medication aide (MA) on 10/25/23 at 9:30am revealed:
-The water temperature on the 300 hall had been

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D 113	Continued From page 2 cold for about a month. -The MA had notified the RCD and the Administrator. -Residents had complained about the shower water being too cold and that they could not take a shower. Interview with the Resident Care Director (RCD) on 10/25/23 at 10:40am revealed: -The RCD did not know the hot water was cold on the 300 hall. -The RCD did not know of any problems with the hot water heater. -The Maintenance Director (MD) was responsible for ensuring the hot water temperatures were monitored and maintained. Interview with the Regional Vice President of Operations (VPO) on 10/25/23 at 10:40am revealed: -The Maintenance Director (MD) was responsible for ensuring the hot water temperatures were monitored and maintained. -She had not known of any problems with the hot water heater and the MD's last day was Monday (10/23/23). -The VPO provided an email that was sent to the Administrator dated 10/24/23 at 12:00am that indicated water heater #4 that had been shutting down and overheating. -She contacted a company on 10/25/23 that would repair the hot water heater on 10/26/23. -The company that was hired would perform a temporary fix and would return on 10/27/23 to complete the hot water heater repair.	D 113		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

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D 273	Continued From page 3 (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the acute healthcare needs for 1 of 5 sampled residents (#5) was met related to failing to schedule a psychiatric appointment ordered for the resident. The findings are: Review of Resident #5's current FL-2 dated 11/15/22 revealed diagnoses included major depressive disorder and anxiety disorder. Review of Resident #5's electronic progress note dated 09/12/23 revealed she was seen by the primary care provider (PCP) on 09/12/23 and there was a new order for a referral to a psychiatric provider. Review of another PCP progress note dated 09/12/23 revealed: -A mental health consult was needed for Resident #5 due to her son being in the hospital on a ventilator with a trach and doctors were unsure if he was going to make it and she was unable to get transportation to see him. -An order for a referral to a psychiatric provider was entered. Interview of Resident #5 on 10/26/23 at 9:30am revealed: -Her son was in the hospital in Raleigh and she could not "get to him." -She did not see a psychiatric provider but would like to. -She did not tell anyone at the facility that she	D 273		

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D 273	Continued From page 4 wanted to see a psychiatric provider. -She was not aware of a psychiatric referral being made. Interview of the Resident Care Director (RCD) on 10/26/23 at 9:40am revealed: -She was responsible for following up on third party referrals for residents. -She did a weekly audit of records for referrals when she had the time. -She was aware of the psychiatric referral for Resident #5 but assumed that the referral had been made by the provider. -She did not follow up to ensure the referral and appointment was made. -She was not aware that the referral had not been made until today. Interview of the Regional Director of Clinical Operations on 10/26/23 at 10:30am revealed: -The RCD was responsible for following up on third party referrals for residents. -The expectation was that referrals would be followed up on and carried out by the RCD. Attempted interview with the PCP on 10/26/23 at 11:07am was unsuccessful. The Administrator was unavailable for interview.	D 273		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage	D 286		

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D 286	Continued From page 5 containers. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure mealtime service consisted of non-disposable place settings. The findings are: Observations during the breakfast meal on 10/26/23 between 8:35am and 8:43am revealed: -There were scrambled eggs, a hashbrown, a sausage patty and an English muffin served on a disposable plate, a disposable foam bowl of oatmeal, and a disposable foam cup containing juice, a combination pack of a plastic fork, spoon, and knife in a residents' room. -There were scrambled eggs and a sausage patty served on a disposable plate, an empty disposable foam bowl on the food tray, and a disposable foam cup containing juice in a second residents' room. -There was a utility cart being transported on the 200-hall consisting of 7 disposable plates covered with plastic containing scrambled eggs, a hashbrown, a sausage patty and an English muffin and a disposable foam bowl of oatmeal. -There were 18 disposable cups filled with a beverage on the utility cart. -There were at least 6 plastic forks, spoons, and knives in a combination packet on the utility cart. Interview with the Dietary Manager on 10/26/23 at 10:45am revealed: -The kitchen served disposable place settings for	D 286		

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D 286	Continued From page 6 all meals to residents who ate in their rooms. -The kitchen served disposable place settings to residents who ate in their rooms to prevent plates and bowls from being misplaced. -She was not aware disposables could not be served to residents. Interview with the Director of Resident Care on 10/26/23 at 8:35am and 10:51am revealed: -She was responsible for the dietary staff and the kitchen when the Administrator was absent. -The facility served disposable place settings daily to residents who ate in their rooms. -She did not know why the disposable place settings were served to the residents. -She was aware disposable place settings were not to be served to the residents unless there was an outbreak. -There was no communicable disease outbreak in the facility.	D 286		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	D 344		

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D 344	Continued From page 7 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#3) for an inhaler for breathing problems. The findings are: Review of Resident #3's current FL-2 dated 08/30/23 revealed diagnoses included chronic obstructive pulmonary disease (COPD), diabetes mellitus, and coronary artery disease. Review of Resident #3's emergency department (ED) after visit summary (AVS) dated 09/25/23 revealed: -The resident was seen and diagnosed with difficulty breathing and shortness of breath. -The resident had COPD. -The medication list included for the resident to start taking Albuterol HFA inhaler and the medication was to be picked up at a pharmacy. (Albuterol HFA is an inhaler used to treat breathing problems associated with COPD such as shortness of breath and wheezing.) -The discharge order section included Albuterol HFA 90mcg every 4 hours as needed (prn). -The instructions did not include the number of puffs or the indication for administration of the prn Albuterol. -The AVS did not include a provider's signature. Review of Resident #3's ED provider notes dated 10/10/23 revealed: -The resident was seen for a fall with posterior head strike. -The resident's list of current outpatient medications included Albuterol HFA 90mcg inhale 2 puffs every 4 hours prn for wheezing. -The resident's medication list expected at	D 344		

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discharge included Albuterol HFA 90mcg inhale 2 puffs every 4 hours prn for wheezing.
-The start date for Albuterol HFA inhaler was documented as 09/25/23.

Review of Resident #3's September 2023 and October 2023 electronic medication administration records (eMARs) revealed there was no entry for prn Albuterol on either eMAR and none was documented as administered.

Observation of Resident #3's medications on hand on 10/26/23 at 3:50pm revealed there was no Albuterol HFA inhaler available for administration.

Review of Resident #3's physician's orders and facility progress notes dated September 2023 - October 2023 revealed no documentation of clarification for the Albuterol HFA inhaler.

Interviews with Resident #3 on 10/25/23 at 9:23am and 10/26/23 at 5:44pm revealed:
-She had COPD and difficulty breathing.
-She used a walker and had to sit on the walker multiple times to catch her breath when she was walking from her room to the dining room.
-She thought she was supposed to have an inhaler to help with her breathing but she did not have one.
-She was not sure why she was not receiving an inhaler to help with her breathing problems.

Interview with the Resident Care Director (RCD) on 10/26/23 at 5:54pm revealed:
-She was responsible for clarifying any unclear or incomplete medication orders.
-She overlooked the instructions to start Albuterol HFA 90mcg inhaler for Resident #3 on the AVS dated 09/25/23.

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D 344	Continued From page 9 -Albuterol HFA 90mcg inhaler should have been clarified so the resident could receive the medication when needed.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications and treatments as ordered and in accordance with the facility's policies for 2 of 6 residents (#6, #7) observed during the medication passes including errors with a medication used to lower blood sugar (#6) and medications for depression, constipation, seasonal allergies, breathing problems, dry skin, nasal congestion and sinus symptoms, a vitamin supplement, and an eyelid scrub (#7). The findings are: The medication error rate was 41% as evidenced by the observation of 12 errors out of 29 opportunities during the 7:00am, 7:30am, and 8:00am medication passes on 10/26/23.	D 358		

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D 358	Continued From page 10 a. Review of Resident #6's current FL-2 dated 12/14/22 revealed: -Diagnoses included type 2 diabetes mellitus, severe dementia, and chronic kidney disease-stage 3B. -There was an order for Metformin 1,000mg twice a day with meals. (Metformin lowers blood sugar. According to the manufacturer, Metformin should be taken with meals to help reduce stomach irritation and other gastrointestinal side effects.) Review of Resident #6's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Metformin 1,000mg twice a day with meals scheduled at 7:30am and 5:30pm. -Metformin was documented as administered from 10/01/23-10/26/23. Observation of the 7:30am medication pass on 10/26/23 revealed: -Resident #6 told the medication aide (MA) he was not going to the dining room to eat breakfast. -The MA did not offer a snack to Resident #6. -The MA administered Metformin 1,000mg to Resident #6 at 7:48am. -Metformin was not administered with a meal as ordered. Interview with the MA on 10/26/23 at 9:02am revealed: -If medications were ordered to be given with meals, she had one hour before the scheduled time and up to one hour after the scheduled time to administer the medication. -Resident #6 was not going to the dining room to eat breakfast so she requested a tray for him. -She was unsure what time the resident would receive his breakfast tray.	D 358		

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D 358	Continued From page 11 Interview with Resident #6 on 10/26/23 at 9:06am revealed he had not eaten breakfast today because he did not want to go to the dining room because his stomach was bothering him. Observation of Resident #6 on 10/26/23 at 9:14am revealed the resident's breakfast tray was delivered to his room and he started eating at 9:14am. Interview with Resident Care Director (RCD) on 10/26/23 at 1:35pm revealed when a medication was ordered with meals it should be administered when food was in front of the resident, and they were eating. Review of Resident #6's emergency department visit dated 09/26/23 at 3:01pm revealed: -His chief complaint was abdominal pain. -His final diagnoses was gastritis (inflammation of the lining of the stomach), presence of bleeding unspecified, unspecified chronicity, unspecified gastric type. Attempted telephone interview with Resident #6's primary care provider (PCP) on 10/26/23 at 4:34pm was unsuccessful. b. Review of Resident #7's current FL-2 dated 06/08/23 revealed: -Diagnoses included hypothyroidism, Vitamin D deficiency, hyperlipidemia, bipolar disorder, allergic rhinitis, and gastro-esophageal reflux disease without esophagitis. -There was an order for Vitamin D3 1,000IU (25mcg) take 5 tablets by mouth once daily. (Vitamin D3 is a vitamin supplement to replace low levels of Vitamin D in the body.)	D 358		

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D 358	Continued From page 12 Review of Resident #7's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D3 1,000IU (25mcg) take 5 tablets by mouth daily scheduled at 8:00am. -Vitamin D3 1,000IU (25mcg) 5 tablets was documented as administered from 10/01/23-10/26/23 except 10/14/23 when the resident was documented as being out of the facility. Observation of the 8:00am medication pass on 10/26/23 revealed the medication aide (MA) prepared and administered 5 tablets of Vitamin D3 2,000IU (50mcg) to Resident #6 at 8:10am, instead of 5 tablets of Vitamin D3 1,000IU (25mcg) as ordered. Observation of Resident #7's medications on hand on 10/26/23 at 1:01pm revealed: -There was a bottle of Vitamin D3 2,000IU (50mcg) tablets dispensed from a Veteran's Administration (VA) pharmacy on 08/23/23. -The instructions were to administer 1 tablet every day but the "1" was marked through and a "5" was handwritten above the "1". -There was a second bottle of Vitamin D3 1,000IU (25mcg) tablets dispensed by a VA pharmacy on 07/13/23. -The instructions were to take 5 tablets once daily. Interview with the MA on 10/26/23 at 12:59pm revealed: -She did not know who had changed the number of tablets administered on the medication label from 1 to 5 tablets for the Vitamin D3 2,000IU (50mcg) tablets. -She asked the previous Administrator, about 4	D 358		

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months ago and the previous Administrator told her to continue administering 5 tablets.
-She had not noticed the eMAR had Vitamin D3 1,000IU (25mcg) tablets and the label on the medication bottle she administered from this morning was Vitamin D3 2,000IU (50mcg) tablets.

Interview with the Resident Care Director (RCD) on 10/26/23 at 1:45pm revealed
-The MAs should be using the six rights of medication administration.
-The MAs were trained to compare the eMARs with the medication labels.
-If the eMAR and medication labels did not match, the MA should not administer the medication.
-The MA should check the order in the resident's record and if there was still a question, the MA should come to her.
-She was not aware of the discrepancy with Resident #7's Vitamin D.

Interview with Regional Vice President of Operations (RVPO) on 10/26/23 at 1:45pm revealed the MAs had been trained to compare the eMAR to the medication labels and not to administer if they did not match; then check the physician's orders and let the RCD know if there was still a discrepancy.

Interview with Resident #7 on 10/26/23 at 12:40pm revealed:
-He was not familiar with all of the medications he received.
-His medications were filled by a VA pharmacy, and he was unsure if he was taking Vitamin D.
-He was not experiencing any side effects from taking his medications.

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D 358	Continued From page 14 Attempted telephone interview with Resident #7's primary care provider (PCP) on 10/26/23 at 4:44pm was unsuccessful. c. Review of Resident #7's current FL-2 dated 06/08/23 revealed an order for Buspirone 5mg 1 tablet twice daily. (Buspirone is an antidepressant and may be used to treat anxiety.) Observation of the 8:00am medication pass on 10/26/23 revealed: -The medication aide (MA) prepared Resident #7's morning medications for administration. -The MA placed one Buspirone 10mg tablet from one medication container labeled by the pharmacy with Resident #7's name into a plastic medication cup. -The MA placed one Buspirone 5mg tablet from a second medication container labeled by the pharmacy with Resident #7's name into the same plastic medication cup. -The MA administered 2 Buspirone tablets totaling 15mg to Resident #7 at 8:23am instead of one 5mg tablet as ordered. Review of Resident #7's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Buspirone 5mg take one tablet twice a day scheduled for 8:00am and 8:00pm. -Buspirone 5mg one tablet was documented as administered at 8:00am from 10/01/23-10/13/23 and 10/15/23-10/26/23. -The resident was documented as out of the facility on 10/13/23-10/14/23. -Buspirone 5mg one tablet was documented as administered at 8:00pm from 10/01/23-10/02/23, 10/04/23-10/12/23, and 10/14/23-10/25/23. -It was documented on 10/03/23 that the	D 358		

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medication was not on the medication cart.

Observation of Resident #7's medications on hand on 10/26/23 at 1:00pm revealed:
-There was a medication bottle dispensed by a Veteran's Administration (VA) pharmacy on 09/29/23 with Resident #7's name for Buspirone 10mg tablet take one-half tablet every morning and every night for anxiety.
-There was a second medication bottle dispensed by a VA pharmacy on 10/20/23 with Resident #7's name for Buspirone 5mg tablet take one tablet every morning and every night for anxiety.

Interview with the MA on 10/26/23 at 12:59 pm revealed:
-She did not mean to administer one tablet from each Buspirone medication bottle.
-She did not know why there were two different strengths for the same medication on the medication cart for Resident #7.

Interview with Resident Care Director (RCD) on 10/26/23 at 1:45pm revealed:
-The MAs should be using the six rights of medication administration.
-The MAs were trained to compare the eMARS with the medication labels.
-If the eMAR and medication labels did not match the MA should not administer the medication.
-The MA should check the order in the resident's record and if there was still a question, the MA should come to her.
-She was not aware of the discrepancy with Resident #7's Buspirone.

Interview with Regional Vice President of Operations (RVPO) on 10/26/23 at 1:45pm revealed the MAs had been trained to compare the eMAR to the medication labels and not

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administer if they did not match; then check the physician's orders and let the RCD know if there was still a discrepancy.

Interview with Resident #7 on 10/26/23 at 12:40pm revealed:
-The resident was not familiar with all of the medications he received.
-He had not been sleepier today than usual.
-He was not experiencing any side effects from taking his medications.
-His medications were filled by a VA pharmacy, and he was unsure if he was taking Buspirone.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 10/26/23 at 4:44pm was unsuccessful.

Attempted telephone interview with Resident #7's VA pharmacy on 10/26/23 at 4:46pm was unsuccessful.

d. Review of Resident #7's physician's order dated 10/14/23 revealed an order for Albuterol HFA 90mcg inhale 2 puffs every 6 hours as needed (prn) for wheezing. (Albuterol is a rescue inhaler used to treat wheezing.)

Observation of the 8:00am medication pass on 10/26/23 revealed:
-The resident was not wheezing and did not request the Albuterol inhaler.
-The medication aide (MA) put the inhaler mouthpiece in the resident's mouth and pressed the inhaler 2 quick times in a row at 8:24am.
-The MA instructed the resident to inhale a "deep breath" when she pushed down on the inhaler.
-The resident did not take a deep breath.
-The MA did not wait between puffs (According to Guidelines for the Medication Administration

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Clinical Skills Checklist, waiting at least 1 minute between puffs may permit additional puffs to penetrate the lungs better).
-The resident did not inhale so the medication vapors came back out of the resident's mouth and not into the resident's lungs.

Review of Resident #7's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Albuterol HFA 90 mcg inhale 2 puffs every 4 hours prn for breathing.
-There was no documentation that Resident #7 received any prn Albuterol from 10/01/23-10/26/23.

Observation of Resident #7's medications on hand on 10/26/23 at 1:16pm revealed:
-There was one Albuterol 90 mcg inhaler dispensed by a Veteran's Administration (VA) pharmacy on 08/23/23.
-The instructions were to inhale 2 puffs every 4 hours as needed for breathing.

Interview with the MA on 10/26/23 at 12:59pm revealed:
-Resident #7 did not ask for his Albuterol inhaler.
-The resident was breathing hard when he first got up that morning.
-She waited until after the resident ate breakfast to administer his prn Albuterol inhaler.
-She forgot to document she had administered the Albuterol inhaler to Resident #7 with his morning medications.

Interview with the Resident Care Director (RCD) on 10/26/23 at 1:45pm revealed:
-Resident #7's Albuterol inhaler was prn and should have been administered when the resident was having symptoms earlier that morning.

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D 358	Continued From page 18 -The MA should have waited 3-5 minutes between puffs. Interview with Resident #7 on 10/26/23 at 12:40pm revealed: -Resident#7 was not experiencing any shortness of breath or breathing hard this morning that he recalled. -He usually received 2 different inhalers each day whether he asked for them or not. Attempted telephone interview with Resident #7's primary care provider (PCP) on 10/26/23 at 4:44pm was unsuccessful. e. Review of Resident #7's physician's order sheet dated 10/20/23 revealed an order for Psyllium Powder mix one teaspoonful with 8 ounces of water and take in the morning. (Psyllium Powder is a fiber laxative used to treat and prevent constipation.) Observation of the 8:00am medication pass on 10/26/23 revealed: -The medication aide (MA) poured Psyllium Powder into a clear medication cup with marked measurements. -The MA poured the Psyllium Powder to the ½ teaspoon marking on the cup. -The MA stated the powder measured one teaspoon in the plastic medication cup. -The MA poured the Psyllium Powder into a cup and added about 8 ounces of water and mixed it with a straw. -The MA administered ½ teaspoonful of Psyllium Powder to Resident #7 at 8:23am instead of 1 teaspoonful as ordered. Review of Resident #7's October 2023 electronic medication administration record (eMAR)	D 358		

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revealed:
-There was an entry for Psyllium Powder mix 1 teaspoonful with 8 ounces of water and take in the morning, scheduled at 8:00am.
-Psyllium Powder was documented as administered from 10/01/23-10/13/23 and 10/15/23-10/26/23.
-The resident was documented as being out of the facility on 10/14/23.

Observation of Resident #7's medications on hand on 10/26/23 at 1:24pm revealed:
-There was a container of Psyllium Powder dispensed on 07/21/23.
-The instructions were to mix 1 teaspoonful with 8 ounces of water and take in the morning.

Interview with the MA on 10/26/23 at 12:59pm revealed:
-She usually administered 1 teaspoonful of Psyllium Powder to Resident #7 every morning.
-She did not realize she had measured incorrectly and administered ½ teaspoonful that morning.
-The resident had not complained of any issues with constipation.

Interview with the Resident Care Director (RCD) on 10/26/23 at 1:45pm revealed:
-The MAs had been trained on how to measure medications.
-The MA should have measured the dosage of Psyllium Powder as ordered.

Interview with Resident #7 on 10/26/23 at 12:40pm revealed:
-He received fiber every day.
-He denied any current symptoms of constipation or diarrhea.

Attempted telephone interview with Resident #7's

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primary care provider (PCP) 10/26/23 at 4:44pm was unsuccessful.

f. Review of Resident #7's physician order sheet dated 07/27/23 revealed an order for Minerin Cream apply topically to feet once a day, not between toes. (Minerin Cream is used to treat and prevent dry skin.)

Review of Resident #7's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Minerin Cream apply topically to feet once a day (not between toes).
-Minerin Cream was scheduled for administration at 11:00am.
-The medication was documented as applied from 10/01/23-10/13/23 and 10/15/23-10/26/23.
-The resident was documented as being out of the facility on 10/14/23.

Observation of the 8:00am medication pass on 10/26/23 revealed:
-Minerin Cream was applied to both of Resident #7's feet at 8:27am.
-Minerin Cream was administered during the 8:00am medication pass instead of 11:00am as scheduled.

Interview with the medication aide (MA) on 10/26/23 at 12:59pm revealed:
-Resident #7 used the Minerin Cream for real dry skin.
-She knew the Minerin Cream was scheduled at 11:00am.
-She applied the Minerin Cream with the residents 8:00am medications so she would not forget to administer the Minerin Cream when it was due at 11:00am.

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Interview with the Resident Care Director (RCD) on 10/26/23 at 1:45pm revealed the MA should have administered Resident #7's Minerin Cream at 11:00am when it was scheduled.

Interview with Resident #7 on 10/26/23 at 12:40pm revealed:
-Minerin Cream was applied to his feet at the same time he received his morning medications this morning.
-The Minerin Cream was for his dry skin, and it helped.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 10/26/23 at 4:44pm was unsuccessful.

g. Review of Resident #7's current FL-2 dated 06/08/23 revealed an order for Cetirizine 5mg daily. (Cetirizine is an antihistamine used to treat seasonal allergies.)

Review of Resident #7's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Cetirizine 5mg take 1 tablet once a day.
-Cetirizine was scheduled for administration at 8:00pm.
-Cetirizine was documented as administered from 10/1/23-10/12/23 and 10/14/23-10/25/23.
-The resident was documented as being out of the facility on 10/13/23.

Observation of the 8:00am medication pass on 10/26/23 revealed Cetirizine 5mg was administered to Resident #7 at 8:23am instead of 8:00pm as scheduled.

Interview with the medication aide (MA) on

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D 358	Continued From page 22 10/26/23 at 12:59pm revealed: -Resident #7's Cetirizine used to be administered in the morning. -She did not notice it was scheduled for 8:00pm on the eMAR. -It should have been administered at 8:00pm. Observation of Resident #7's medications on hand on 10/26/23 at 12:59pm revealed: -There was a supply of 90 Cetirizine 5mg tablets dispensed on 10/26/23. -The instructions were to take 1 tablet every night. Interview with the Resident Care Director (RCD) on 10/26/23 at 1:45pm revealed: -Resident #7's Cetirizine should have been administered at 8:00pm when it was scheduled to be administered. -The MAs had been trained to read the eMARs and administer the medication as ordered. Interview with Resident #7 on 10/26/23 at 12:40pm revealed: -He did not know the name of the allergy medication he received but he thought he received an allergy pill in the morning and at night. -It helped with his allergy symptoms. Attempted telephone interview with Resident #7's primary care provider (PCP) on 10/26/23 at 4:44pm was unsuccessful. h. Review of Resident #7's current FL-2 dated 06/08/23 revealed an order for Saline Nasal Spray 0.65% use 1 spray in each nostril 4 times daily. (Saline Nasal Spray is used to relieve nasal dryness and congestion associated with seasonal allergies.)	D 358		

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D 358	Continued From page 23 Review of a physician visit form dated 08/23/23 revealed Resident #7 was diagnosed with persistent nasal polyposis (non-cancerous growths that line the nasal passages) and moderate pansinusitis (a condition in which the cavities around the nasal passages become inflamed.) Review of Resident #7's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Saline Nasal Spray 0.65% use 1 spray each nostril 4 times daily scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm -Saline Nasal Spray was documented as administered from 10/01/23-10/26/23 except on 10/13/23 and 10/14/23 when the resident was documented as being out of the facility. Observation of the 8:00am medication pass on 10/26/23 revealed Saline Nasal Spray was not administered to Resident #7 at 8:23am when he received his other morning medications scheduled for 8:00am. Observation of Resident #7's medications on hand on 10/26/23 at 1:22pm revealed: -There was a bottle of Saline Nasal Spray 0.65% dispensed on 09/29/23. -The instructions were to spray 2 sprays into each nostril 4 times a day. Interview with the medication aide (MA) on 10/26/23 at 12:59pm revealed: -She forgot to administer Saline Nasal Spray to Resident #7 this morning during the 8:00am medication pass. -She documented the medication as administered	D 358		

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on the eMAR by mistake.
-The resident had bad sinus problems and got congested.

Interview with the Resident Care Director (RCD) on 10/26/23 at 1:45pm revealed the MAs should read the eMAR and administer the medications as ordered.

Interview with the Regional Vice President of Operations (RVPO) on 10/26/23 at 1:45pm revealed the MAs had been trained to compare the eMARs to the medication labels when administering medications.

Interview with Resident #7 on 10/26/23 at 12:40pm revealed:
-He usually received 2 nasal sprays in the morning and during the day for allergies.
-He was not sure why he only received one of his nasal sprays that morning.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 10/26/23 at 4:44pm was unsuccessful.

i. Review of Resident #7's current FL-2 dated 06/08/23 revealed an order for Sinus Rinse once daily in the morning. (Sinus Rinse is used to relieve sinus symptoms from allergies.)

Review of a physician visit form dated 08/23/23 revealed Resident #7 was diagnosed with persistent nasal polyposis (non-cancerous growths that line the nasal passages) and moderate pansinusitis (a condition in which the cavities around the nasal passages become inflamed.)

Review of Resident #7's October 2023 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Sinus Rinse once daily in the morning scheduled at 8:00am.
-Sinus Rinse was documented as administered from 10/01/23 -10/26/23 except on 10/14/23 when the resident was documented as being out of the facility.

Observation of the 8:00am medication pass on 10/26/23 revealed Sinus Rinse was not prepared and administered to Resident #7 at 8:23am when the resident received his other medications scheduled at 8:00am.

Interview with the medication aide (MA) on 10/26/23 at 12:59pm revealed:
-She had not noticed the order for Sinus Rinse on the eMAR.
-She thought Sinus Rinse was the same thing as the Saline Nasal Spray.
-She mistakenly documented the Sinus Rinse was administered that morning.
-She did not see any Sinus Rinse in the medication cart.

Observation of Resident#7's medications on hand on 10/26/23 at 1:37pm revealed:
-The MA found a supply of Sinus Rinse in the back up medication storage area.
-It was in the over-the-counter manufacturer container with the resident's name written on the box.

Interview with the Resident Care Director (RCD) on 10/26/23 at 1:45pm revealed the MAs should read the eMARS and administer the scheduled medications as ordered.

Interview with Regional Vice President of

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Operations (RVPO) on 10/26/23 at 1:45pm revealed the MAs had been trained to compare the eMARs to the medication and administer the scheduled medications as ordered.

Interview with Resident #7 on 10/26/23 at 12:40pm revealed:
-He did not receive Sinus Rinse to his knowledge.
-He denied any current sinus problems or symptoms.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 10/26/23 at 4:44pm was unsuccessful.

j. Review of Resident #7's current FL-2 dated 06/08/23 revealed an order for warm compress and eye lid scrubs twice a day. (Warm compresses and eyelid scrubs are used to cleanse, soothe, and treat eye conditions.)

Review of Resident #7's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for warm compress and eye lid scrubs twice a day scheduled at 8:00am and 8:00pm.
-Warm compress and eyelid scrubs were documented as administered from 10/01/23 -10/26/23 except on 10/13/23 and 10/14/23 when the resident was documented as being out of the facility.

Observation of the 8:00am medication pass on 10/26/23 revealed warm compress and eye lid scrubs were not administered to Resident #7 at 8:23am when he received his other medications scheduled at 8:00am.

Interview with the medication aide (MA) on

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	HAL051025	A. BUILDING: _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW ASSISTED LIVING	250 HIGHWAY 210 WEST SMITHFIELD, NC 27577

(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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10/26/23 at 12:59pm revealed:
-She had never administered warm compress and eyelid scrubs to Resident #7 because she had not noticed the order on the eMAR.
-She mistakenly documented it was administered that morning.
-The resident did not have any eye lid scrub medication in the medication cart.

Observation of Resident #7's medications on hand on 10/26/23 at 3:40pm revealed the MA was unable to locate any eyelid scrub medication for Resident #7.

Interview with the Resident Care Director (RCD) on 10/26/23 at 1:45pm revealed:
-The MAs should be using the six rights of medication administration.
-The MAs should read the eMARs and administer the scheduled medications as ordered.

Interview with the Regional Vice President of Operations (RVPO) on 10/26/23 at 1:45pm revealed the MAs had been trained to compare the eMARs to the medication labels when administering medications.

Interview with Resident #7 on 10/26/23 at 12:40pm revealed:
-He had not been receiving warm compresses or eyelid scrubs.
-He denied any current symptoms with his eyes.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 10/26/23 at 4:44pm was unsuccessful.

k. Review of Resident #7's current FL-2 dated 06/08/23 revealed an order for Fluticasone Propionate 93mcg use 2 sprays in both nostrils

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daily. (Fluticasone Propionate is a nasal spray used to treat nasal symptoms associated with seasonal allergies.)

Review of a physician visit form dated 08/23/23 revealed Resident #7 was diagnosed with persistent nasal polyposis (non-cancerous growths that line the nasal passages) and moderate pansinusitis (a condition in which the cavities around the nasal passages become inflamed.)

Review of Resident #7's physician's order dated 07/20/23 revealed Fluticasone Propionate 93mcg was discontinued due to the resident's Veteran's Administration (VA) pharmacy not having the medication in stock.

Review of Resident #7's physician's orders dated July 2023 - October 2023 revealed there was no order for any dosage of Fluticasone Propionate nasal spray to be administered to the resident.

Observation of the 8:00am medication pass on 10/26/23 revealed the medication aide (MA) prepared and administered Fluticasone Propionate 50mcg, 1 spray in each nostril to Resident #7 at 8:24am.

Review of Resident #7's October 2023 electronic medication administration record (eMAR) revealed:
-There was no entry for Fluticasone Propionate 93mcg and none was documented as administered.
-There was no entry for Fluticasone Propionate 50mcg and none was documented as administered.

Observation of Resident #7's medications on

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hand on 10/26/23 at 1:21pm revealed:
-There was one bottle of Fluticasone Propionate 50mcg nasal spray dispensed by the resident's VA pharmacy on 03/30/23.
-Instructions on the label were to instill 2 sprays into each nostril at bedtime, maximum of 2 sprays in each nostril daily for allergies.
-There was no supply of any other strengths of Fluticasone Propionate nasal spray.

Interview with the MA on 10/26/23 at 12:59pm revealed:
-She usually administered the Fluticasone Propionate 50mcg nasal spray to Resident #7 each morning because the resident had bad sinuses.
-She had not noticed the Fluticasone Propionate nasal spray was not included on the eMAR.
-She had not noticed the instructions on the label were for 2 sprays in each nostril at bedtime.

Interview with Resident #7 on 10/26/23 at 12:40pm revealed:
-He usually received 2 different nasal sprays in the morning and during the day.
-He did not know the name of the nasal sprays he received.
-He used nasal sprays for his allergies and they helped.

Interview with the Resident Care Director (RCD) on 10/26/23 at 1:45pm revealed:
-The MAs were trained to compare the eMARs with the medication labels and if something did not match, the medication should not be administered.
-The MAs should check the resident's orders when there were discrepancies and if they still had questions, the MAs should check with her.
-No discrepancies regarding Resident #7's

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medications had been reported to her.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 10/26/23 at 4:44pm was unsuccessful.

Attempted telephone interview with Resident #7's VA pharmacy on 10/26/23 at 4:46pm was unsuccessful.

I. Review of Resident #7's physician's order dated 10/16/23 revealed an order for Nasacort 55mcg instill 1 spray into each nostril daily. (Nasacort nasal spray is reduces inflammation to relieve nasal allergy symptoms.)

Review of a physician visit form dated 08/23/23 revealed Resident #7 was diagnosed with persistent nasal polyposis (non-cancerous growths that line the nasal passages) and moderate pansinusitis (a condition in which the cavities around the nasal passages become inflamed.)

Review of Resident #7's physician's orders dated October 2023 revealed there was no order to discontinue Nasacort nasal spray.

Observation of the 8:00am medication pass on 10/26/23 revealed the medication aide (MA) did not administer Nasacort nasal spray to Resident #7 when he received his other morning medications.

Review of Resident #7's October 2023 electronic medication administration record (eMAR) revealed there was no entry for Nasacort nasal spray and none was documented as administered in October 2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 31 Observation of Resident #7's medications on hand on 10/26/23 at 1:08pm revealed there was no Nasacort nasal spray available for administration to the resident. Interview with the MA on 10/26/23 at 12:59pm revealed there was no Nasacort nasal spray on hand for Resident #7 and he had not received any to her knowledge. Interview with Resident #7 on 10/26/23 at 12:40pm revealed: -He usually received 2 different nasal sprays in the morning and during the day. -He did not know the name of the nasal sprays he received. -He used nasal sprays for his allergies and they helped. Interview with the Resident Care Director (RCD) on 10/26/23 at 1:45pm revealed: -Resident #7's medications came from a VA pharmacy. -She was not aware of the order for Nasacort and did not know it was not being administered. Attempted telephone interview with Resident #7's primary care provider (PCP) on 10/26/23 at 4:44pm was unsuccessful. Attempted telephone interview with Resident #7's VA pharmacy on 10/26/23 at 4:46pm was unsuccessful. _____ The facility failed to administer medications as ordered to 2 of 6 residents observed during the medication pass on 10/26/23 resulting in a 41% medication error rate. Resident #6 who was diagnosed with abdominal pain and gastritis received a medication for diabetes on an empty	D 358		

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D 358	Continued From page 32 stomach putting the resident at risk of gastrointestinal side effects. There were 11 medications not administered as ordered to Resident #7. Resident #7 was administered triple the dose ordered of an antidepressant and 5 times the dose of a Vitamin D supplement putting the resident at risk of side effects. Resident #7 was administered half the dose of a fiber laxative due to the MA measuring the dosage incorrectly. Resident #7 was not administered an Albuterol inhaler as needed when the MA observed the resident was breathing hard prior to breakfast. Resident #7 who was diagnosed with sinus problems was not administered two nasal sprays and Sinus Rinse as ordered. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/23/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 10, 2023.	D 358		