STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BROOKDALE BURLINGTON AL (NC)	3615 SOUTH MEBANE STREET BURLINGTON, NC 27215

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on November 21 and 22, 2023.	D 000		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure foods were free from contamination related to dirty floors and shelves in the walk-in cooler and ice buildup in the walk-in freezer. The findings are: Observation of the walk-in cooler on 11/21/23 at 9:29am revealed: -There was a dried brownish red liquid that covered a large area of the floor.	D 283		

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D 283	Continued From page 1 -There was debris and various items on the floor including two unopened single serve pudding cups and pieces of tape with cardboard attached to them. -There was a green build-up on the floor and around the legs of the shelving. -The shelving had a white and black build-up on the rungs where the food items were stored. Observation of the walk-in freezer on 11/21/23 at 9:31am revealed: -There was ice build-up on the shelving to the right of the door that extended down several shelves and proceeded to accumulate on the floor. -There were substantially large mounds of ice build-up by the right side of the door, to the back of the freezer and between two shelves. -Each mound of ice build-up was approximately a foot long or longer and was six to eight inches deep. -There was a large amount of ice build-up on the floor under the shelving on the right-hand side of the walk-in freezer. -The ice build-up under the shelf was approximately four to six inches thick and reached between the rungs on the bottom shelf; there were various items stuck in the ice including a single serve ice cream cup, the handle of a tool and cardboard. -There was debris scattered about the floor of the freezer; including strips of tape with cardboard attached to them and various loose pieces of frozen food. Review of the local Environmental Health Services (EHS) Inspection Report dated 08/29/23 revealed: -The kitchen received a score of 96.5. -The walk-in freezer had a lot of ice build-up.	D 283		

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-The inspector instructed the facility to remove the ice and to investigate why the ice was building up.
-The inspector observed peppers with mold on them in the walk-in cooler.
-There was debris noted on the floor in several areas in the kitchen.

Review of the weekly cleaning schedule posted in the kitchen on 11/21/23 at 5:06pm revealed:
-There was a clip board with a stack of cleaning schedules hanging in the kitchen.
-The cleaning schedule had eight columns.
-There was a column with the various kitchen equipment listed under items; including the floors and shelves in the cooler.
-The freezer was not listed on the cleaning schedule.
-There was a second column with the various days of the weeks listed under frequency.
-There was a third column with morning or evening listed under assignment.
-There were five columns with week 1 through week 5 at the top and had blanks for initials.
-There was a space at the top right-hand corner to write in the month and the year.
-There were no other instructions on the cleaning schedule.
-The first cleaning schedule on the clipboard had November 2023 hand written on the right-hand corner; there was nothing else documented on the schedule.
-The second cleaning schedule on the clipboard was for October 2023; there were no initials after the first week.

Interview with a cook on 11/21/23 at 9:39am revealed:
-She and another cook worked in the kitchen with the Kitchen Manager (KM).

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-there was a cleaning schedule for mornings and evening.
-Whenever there was free time to cleaned items on the cleaning schedule.
-The floor to the walk-in cooler was swept and mopped the day of the food delivery which was once a week.
-The shelves for the walk-in cooler had not been deep cleaned since she had been there; she tried to wipe them down as they needed and weekly before food deliveries.
-The last time the walking cooler floor and shelves were wiped clean was a week ago.
-She used a hammer to chip away the ice in the walk-in freezer about every other week.
-The ice in the freezer had been chipped away by the maintenance department a week ago.
-She had been told by maintenance that the seal on the freezer door needed to be replaced.
-She had not had the KM sign off on the cleaning schedule, but she had completed the cleaning assignments.

Interview with the KM on 11/22/23 at 9:57am revealed:
-She signed off on the weekly cleaning schedule after the staff had completed the cleaning assignment.
-She had not signed off on the cleaning schedule recently because she had been busy.
-She did daily walk throughs and had checked the kitchen to make sure these staff were following the cleaning schedule.
-The shelves in the walk-in cooler were supposed to be wiped down with a bucket of soapy water and a towel and sanitized once a week.
-The floors in the walk-in cooler were supposed to be swept and mopped every evening by the cook.
-The eyes in the freezer was chipped away from the shelves and the floor once a week and the

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floor were also swept clean.
-She had been working with the Director of Maintenance (DM) for over a month to get the repairs to the freezer completed.

Interview with the DM on 11/22/23 at 10:53am revealed:
-He was aware that their freezer needed repaired; an outside company had been working on the walk-in freezer since 11/01/23.
-The outside company had canceled multiple service calls and he had not reached out to another company for the needed repairs.
-In the meantime, the kitchen staff was removing the ice and cleaning the walk-in freezer once a week.
-He thought it might be another month or so before the service could be done on the walk-in freezer to determine what exactly needed to be repaired.
-He was not responsible for removing the ice or cleaning of the walk-in freezer.

Interview with the Administrator on 11/22/23 at 12:58pm revealed:
-She knew there were issues with the walk-in freezer in the kitchen and that there were parts that needed to be replaced and were ordered.
-The kitchen staff were chipping the ice and cleaning the walk-in freezer with the maintenance department weekly.
-She was in the dining room and kitchen every day she had last looked at the ice in the walk-in freezer the day before.
-The amount of ice buildup that was currently in the walk-in freezer was the average weekly buildup.
-She had been told about the buildup on the shelves in the walk-in cooler by the KM the day before.

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D 283	Continued From page 5 -The shelving in the walk-in cooler should be cleaned with a bucket and soapy water once a week and a deep cleaning would need to be done monthly. -The floors and the walk-in cooler should be swept and mopped every day.	D 283		
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 nutritional supplement as ordered by a provider for 1 of 1 sampled resident (#1). The findings are: Review of Resident #1's current FL-2 dated 11/06/23 revealed: -Diagnoses included muscle wasting and atrophy, type 2 diabetes mellitus, chronic kidney disease, and acute appendicitis. -There was an order for a glucose-controlled nutritional supplement three times daily. -The FL-2 was completed at a nursing/rehabilitation facility. Review of Resident #1's physician's order dated 11/17/23 revealed an order for a glucose-controlled nutritional supplement three times daily.	D 310		

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Review of Resident #1's November 2023 electronic medication administration record (eMAR) from 11/06/23-11/22/23 revealed:
-There was an entry for a glucose-controlled nutritional supplement three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.
-The supplement was documented as administered 44 times.

Observation of Resident #1's room on 11/21/23 at 12:02pm revealed:
-There was a case of a glucose-controlled nutritional supplement dispensed from the pharmacy on 11/06/23 with the directions to drink one bottle three times daily.
-There were 18 bottles of a glucose-controlled nutritional supplement in the box.

Interview with Resident #1 on 11/21/23 at 12:09pm revealed:
-She did not know where the box of nutritional supplements came from; "it just showed up."
-She had tried to drink one nutritional supplement per day; she did not know how many she was supposed to drink.
-She did not recall anyone telling her to drink the nutritional supplement.

Interview with a medication aide (MA) on 11/22/23 at 12:18pm revealed:
-She administered Resident #1's nutritional supplement twice a day.
-She would take a nutritional supplement out of the refrigerator and put it beside Resident #1.
-She would then check back to make sure Resident #1 had drunk the supplement and she always had.

Telephone interview with a Pharmacist at the

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facility's contracted pharmacy on 11/22/23 at 1:14pm revealed 24 bottles of a nutritional supplement had been dispensed for Resident #1 on 11/06/23; there was no other nutritional supplement dispensed.

Telephone interview with a Pharmacist at Resident #1's previous pharmacy provider on 11/22/23 at 3:16pm revealed:
-Their pharmacy did provide Resident #1's medications at her previous facility.
-Resident #1 did not have an order for a nutritional supplement and none had been dispensed to her.

Interview with the Social Worker at the nursing/rehabilitation facility on 11/22/23 at 3:24pm revealed:
-Resident #1 was discharged from the nursing/rehabilitation facility to the current facility with an order for a liquid nutritional supplement.
-The nutritional supplement had been ordered for Resident #1 secondary to the resident complaining of difficulty swallowing and lack of appetite.
-The nutritional supplement was ordered three times per day to ensure Resident #1 was getting enough calories.
-The nutritional supplement was not sent with Resident #1 when she was discharged from the facility, they only sent medications such as creams and eye drops that had been opened.

Interview with Resident #1's family member on 11/22/23 at 3:46pm revealed:
-Resident #1 was a very picky eater.
-Resident #1 had told her she did not know how often she was supposed to be drinking the nutritional supplement.
-She had not brought any nutritional supplements

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D 310	Continued From page 8 to Resident #1. Interview with the Administrator on 11/22/23 at 5:38pm revealed: -The MAs were responsible for administering nutritional supplements. -The MAs were to give the nutritional supplement to the resident and then ensure that the resident had consumed the supplement before documenting on the eMAR. Attempted telephone interview with Resident #1's primary care provider (PCP) on 11/22/23 at 3:36pm was unsuccessful.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#3, #5) observed during the morning medication pass including errors with a supplement (#3) and a medication for fluid retention (#5). The findings are: Review of the facility's Medication Administration	D 358		

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policy dated October 2023 revealed the medication aide (MA) should follow the 7 rights of medication administration, including the right dose.

The medication error rate was 7.69% evidenced by the observation of 2 errors out of 26 opportunities during the 9:00am medication pass on 11/21/23.

1. Review of Resident #5's FL-2 dated 08/24/23 revealed diagnoses included orthopedic aftercare, allergic rhinitis, and overactive bladder.

Review of Resident #5's signed physician orders dated 10/02/23 revealed there was an order for furosemide 40mg (used to treat fluid retention) twice daily for 2 days then daily until follow-up in one week.

Review of Resident #5's signed physician orders dated 10/09/23 revealed there was an order for furosemide 20mg daily.

Observation of the morning medication pass on 11/21/23 at 9:29am revealed:
-The medication aide (MA) opened the second drawer on the medication cart and retrieved 14 bubble packs of medication.
-The MA prepared 14 pills for administration to Resident #5.
-The MA administered 14 pills to resident #5, including furosemide 40mg.

Review of Resident #5's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for furosemide 20mg daily with an administration time of 9:00am.
-There was documentation furosemide 20mg was

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D 358	Continued From page 10 administered on 11/21/23 at 9:00am. Observation of Resident #5's medication on hand n 11/21/23 at 9:24am revealed: -There was a bubble pack of furosemide 40mg available for administration dispensed on 11/13/23. -There was no furosemide 20mg available for administration. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 11/21/23 at 11:29am revealed: -The pharmacy had an order for furosemide 40mg daily. -The pharmacy dispensed 28 furosemide 40mg on 10/19/23 and 11/06/23. -The pharmacy did not have an order for furosemide 20mg daily. -The pharmacy received new orders from the facility by faxing the orders to the pharmacy and the Primary Care Physician (PCP) who would send new orders electronically. -The facility staff was responsible for entering the new orders into the eMAR. Interview with Resident #5 on 11/22/23 at 10:43am revealed: -She visited a specialist who ordered a fluid pill for the swelling in her legs. -She was ordered furosemide 40mg for a week, then it was changed to furosemide 20mg daily. -The swelling in her legs was much better. -She did not have any complaints of dizziness or light-headedness. Interview with the MA on 11/21/22 at 3:18pm revealed: -She administered medications to the residents this morning during the 9:00am medication pass.	D 358		

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-She checked each medication to ensure it was the right dosage.
-Resident #5 had an order for furosemide 20mg daily.
-She thought she administered furosemide 20mg to Resident #5 this morning.
-She did not know she administered furosemide 40mg to Resident #5 this morning.
-She made a careless mistake when she administered furosemide 40mg instead of 20mg.

Interview with the Clinical Coordinator (CC) on 11/21/23 at 3:55pm revealed:
-She had administered furosemide to Resident #5.
-She knew Resident #5 was on 20mg of furosemide.
-She did not know she had administered the incorrect dosage of furosemide.
-Resident #5 had not complained of dizziness or lightheadedness.

Interview with the Health and Wellness Coordinator (HWC) on 11/21/23 at 4:10pm revealed:
-The MAs should have noticed the entry in the eMAR was for furosemide 20mg and furosemide 40mg was on the medication cart.
-The MAs should have called the pharmacy to see why the correct dosage was not dispensed.

Interview with the Health and Wellness Director (HWD) on 11/21/23 at 4:35pm revealed:
-The MA should have compared the medication name and dosage on the packaged medication with the entry in the eMAR.
-The MA should have noticed the difference and called the pharmacy or notified her and she would have called the pharmacy.

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Attempted telephone interview with Resident #5's Pulmonologist on 11/22/23 at 11:25am was unsuccessful.

Refer to the interview with the MA on 11/21/23 at 3:18pm.

Refer to the interview with a second MA on 11/22/23 at 12:28pm.

Refer to the interview with the CC on 11/21/23 at 3:55pm.

Refer to the interview with the HWC on 11/21/23 at 4:10pm.

Refer to the interview with the HWD on 11/22/23 at 10:20am.

Refer to the interview with the Executive Director (ED) on 11/21/23 at 4:55pm.

2. Review of Resident #3's FL-2 dated 05/27/23 revealed diagnoses included polyneuropathy, disorder of the thyroid gland, disorder of bone density, and muscle weakness.

Review of Resident #3's signed physician orders dated 08/03/23 revealed there was an order for vitamin D3 (used as a supplement) 1000 IU daily.

Review of Resident #3's signed physician orders dated 11/12/23 revealed:
-There was an order to discontinue vitamin D3 1000 IU.
-There was an order to administer vitamin D3 2000 IU daily.

Observation of the morning medication pass on 11/21/23 at 9:16am revealed:

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-The medication aide (MA) opened the second drawer on the medication cart and retrieved 7 bubble packs of medication.
-The MA prepared 7 pills for administration to Resident #3.
-The MA administered 7 pills to Resident #3, including vitamin D3 1000 IU.

Review of Resident #3's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for vitamin D3 2000 IU daily with an administration time of 9:00am.
-There was documentation vitamin D3 2000 IU was administered on 11/21/23 at 9:00am.

Observation of Resident #3's medication on hand on 11/21/23 at 9:15am revealed:
-There was a bubble pack of vitamin D3 1000 IU available for administration dispensed on 11/13/23.
-The directions on the prescription label read take one capsule daily.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 11/21/23 at 11:29am revealed:
-The pharmacy had an order for vitamin D3 2000 IU daily dated 11/12/23.
-The pharmacy had not dispensed vitamin D3 2000 IU because Resident #3 previously was on vitamin D3 1000 IU.
-The MAs should have administered vitamin D2 1000 IU two tablets daily until the 1000IU were used.
-After the 1000IU was completed, the pharmacy would have dispensed the 2000IU.

Interview with Resident #3 on 11/22/23 at 10:30am revealed:

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-The MAs bring me a cup of medications each morning.
-She did not know if she was administered a vitamin D3 capsule or not.

Interview with the medication aide on 11/21/23 at 3:18pm revealed:
-She prepared 2 capsules of vitamin D3 1000 IU for administration.
-She dropped 1 of the capsules on the floor and forgot to "pop" another capsule from the bubble pack.
-She knew Resident #3 should receive two 1000 IU of vitamin D3 capsules.

Interview with Resident #3's Primary Care Provider (PCP) on 11/22/23 at 1:33pm revealed:
-Resident # 3's vitamin D3 was increased because her vitamin D level was low.
-She would have Resident 3's vitamin D level re-checked.
-She expected the MAs to administer medications as ordered.

Interview with the Clinical Coordinator (CC) on 11/21/23 at 3:55pm revealed:
-She had administered Resident #3 vitamin D3 but could not recall if she administered 1 or 2 capsules.
-She should have administered 2 capsules of vitamin D3 each time she administered morning medications to Resident #3.

Interview with the Health and Wellness Coordinator (HWC) on 11/21/23 at 4:10pm revealed:
-The MAs should have noticed the dosage for vitamin D3 that was on the medication cart was different than what was entered on the eMAR.
-The MAs should have noticed the dosage was

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not the same and should have called the pharmacy to see why the correct dosage was not dispensed.
-The facility staff entered orders into the eMAR, and a different staff member would approve the entry.
-The facility staff would fax the order to the pharmacy, so the medication could be dispensed.

Interview with the Health and Wellness Director (HWD) on 11/21/23 at 4:35pm revealed:
-She did not know why the pharmacy did not dispense vitamin D3 2000IU as ordered.
-The MA could have given two vitamin D3 1000IU to replace the 2000 IU capsule.

Refer to the interview with the MA on 11/21/23 at 3:18pm.

Refer to the interview with a second MA on 11/22/23 at 12:28pm.

Refer to the interview with the CC on 11/21/23 at 3:55pm.

Refer to the interview with the HWC on 11/21/23 at 4:10pm.

Refer to the interview with the HWD on 11/22/23 at 10:20am.

Refer to the interview with the Executive Director (ED) on 11/21/23 at 4:55pm.

_____

Interview with the medication aide (MA) on 11/21/23 at 3:18pm revealed:
-When the Primary Care Provider (PCP) wrote a new order, the Clinical Coordinator (CC), the Health and Wellness Coordinator (HWC) or the Health and Wellness Director (HWD) would enter

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the new order into the electronic medication administration record (eMAR).
-The new order would be faxed to the pharmacy by the CC, HWC, or the HWD.
-Once the order was entered into the eMAR, a different facility staff would approve the order so the medication could be administered.
-Medication cart audits were completed by the pharmacy each quarter.
-The medication aide would check the creams, eye drops, liquids, and inhalers for expiration date and for the date the medication was opened for use.

Interview with a second MA on 11/22/23 at 12:28pm revealed:
-She verified she administered the correct medication by comparing the medication to the eMAR.
-She verified the name of the medication but did not verify the dosage of the medication.
-She needed to compare the name of the medication and the dosage of the medication prior to administration.

Interview with the CC on 11/21/23 at 3:55pm revealed:
-She audited the medication carts when instructed to by the HWD.
-She would look for expired medications on the medication cart.
-She did not compare the medications with the entries on the eMAR.

Interview with the HWD on 11/21/23 at 4:10pm revealed:
-She ran a medication administration report daily.
-She could tell if a medication was not administered due to the medication not being available.

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D 358	Continued From page 17 -She did not audit the medication carts. -The pharmacy would audit the medication carts quarterly. -She did not know what the pharmacy was looking for when they audited the medication carts. Interview with the HWD on 11/22/23 at 10:20am revealed: -It was the responsibility of the MA to compare the medication on the medication cart with the eMAR. -If the medication on the medication cart does not match the entry on the eMAR the MA should call the pharmacy or let her know so she can call the pharmacy. -The third shift MA would audit the medication cart for expired medications. -The pharmacy audits the medication carts quarterly for expired medications and to ensure the medications were stored correctly. -New orders received at the facility were entered into the eMAR by the HWC or the HWD. -The new orders would be faxed to the pharmacy for the medication to be dispensed. Interview with the Executive Director (ED) on 11/21/23 at 4:55pm revealed the MAs were expected to administer medications as ordered.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the	D 366		

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medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medication aides observed residents take their medications for 3 of 3 residents (#7, #8, and #9) as evidenced by medication observed in the residents' rooms.

The findings are:

Review of the facility's Medication Policy and Procedure Manual (undated) revealed staff will provide documentation on the medication administration record (MAR) after observing the residents taking the medications and before administration to another resident.

1. Review of Resident #7's current FL-2 dated 04/20/23 revealed:
-Diagnoses included acute kidney failure, congestive heart failure, and chronic atrial fibrillation.
-There was an order for Potassium Citrate (used to make the urine less acidic) 10mg twice daily.

Review of Resident #7's November 2023 electronic medication administration record (eMAR) for 11/21/23 revealed Potassium was documented as administered at 9:00am.

Observation of Resident #7's room on 11/21/23 at 8:51am revealed a clear medication cup with one beige tablet with the number 537 imprinted.

Interview with Resident #7 on 11/21/23 at 8:56am revealed:

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-The medication cup with the tablet was Potassium she took every morning after she ate breakfast.
-The medication aides (MA) always left her medication because they knew she could be trusted to take the medication.
-She took all her other medication when the MA gave her the medication cup, but she saved this one to take after she ate breakfast.

Second observation of Resident #7's room at 5:40pm revealed the medication cup was empty.

Second interview with Resident #7 on 11/21/23 at 5:40pm revealed she took the Potassium tablet after she ate breakfast today, 11/21/23.

Interview with a MA on 11/23/23 at 12:11pm revealed:
-She watched Resident #7 take her Potassium when she administered it; she had never left Resident #7's potassium in the room for the resident to take later.
-Resident #7 counted her medication and then took the medication.
-She had never observed Resident #7 set any medication aside.

Attempted telephone interview on 11/22/23 at 3:44pm with the MA who documented administering Resident #7's Potassium on 11/21/23 at 9:00am was unsuccessful.

Refer to the interview with the Clinical Coordinator (CC) on 11/22/23 at 4:26pm.

Refer to the interview with the Health Wellness Coordinator (HWC) on 11/22/23 at 5:08pm.

Refer to the interview with the Executive Director

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D 366	Continued From page 20 (ED) on 11/22/23 at 5:38pm. 2. Review of Resident #8's current FL-2 dated 08/17/23 revealed: -Diagnoses included chronic pain, spinal stenosis, scoliosis, and age-related osteoporosis. -There was an order for Tylenol (used to treat mild pain) 500mg, take two tablets twice daily as needed for pain. Observation of Resident #8's room on 11/21/23 at 10:26am revealed a clear medication cup with two white oblong tablets with the number L484 imprinted. Interview with Resident #8 on 11/21/23 at 10:26am revealed: -The two white tablets were Tylenol. -He had asked for the Tylenol yesterday, 11/20/23, so when he needed it, he had it easily retrievable; he did not recall which medication aide (MA) provided him with the Tylenol. -He often needed Tylenol early in the morning or late at night and he had a hard time finding a MA to administer the medication, so he asked for it ahead of time. -He did not know when he planned to take the medication but was holding on to it until he needed it. Review of Resident #8's November 2023 electronic medication administration record (eMAR) for 11/01/23-11/22/23 revealed: -Tylenol 500mg had been documented as administered on 11/05/23, 11/05/23, and 11/22/23. -There was no documentation that Tylenol 500mg had been administered on 11/20/23. Interview with a MA on 11/23/23 at 12:11pm	D 366		

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revealed:
-She had administered Tylenol to Resident #8.
-Resident #8 always took his medications when she administered them.
-She had not observed Resident #8 hold onto medication to take later.

Refer to the interview with the Clinical Coordinator (CC) on 11/22/23 at 4:26pm.

Refer to the interview with the Health Wellness Coordinator (HWC) on 11/22/23 at 5:08pm.

Refer to the interview with the Executive Director (ED) on 11/22/23 at 5:38pm.

3. Review of Resident #9's current FL-2 dated 12/15/22 revealed:
-Diagnoses included late-onset Alzheimer's disease, type 2 diabetes with chronic kidney disease, and chronic low back pain.
-Resident #9 was constantly disoriented.

Review of Resident #9's signed physician's orders dated 10/26/23 revealed:
-There was an order for medication to be stored and administered by staff only.
-There was an order for Tylenol (used to treat pain) ER 650mg one tablet three times per day for pain.

Review of Resident #9's November 2023 electronic medication administration record (eMAR) for 11/01/23-11/22/23 revealed Tylenol 650mg was documented as daily administered at 9:00am, 2:00pm, and 8:00pm.

Observation of Resident #9's room on 11/21/23 at 8:43am revealed three oblong white tablets with the number G650 imprinted.

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D 366	Continued From page 22 Interview with Resident #9 on 11/21/23 at 8:43am revealed: -The medication aide (MA) brought her Tylenol to take. -She did not know why they gave her the Tylenol, who gave it to her, or when. -She did not know why she did not take the Tylenol when the MA gave it to her. Interview with a MA on 11/23/23 at 12:11pm revealed: -She administered Resident #9's medications. -She had never observed Resident #9 not take her medications when they were administered. Interview with the Clinical Coordinator (CC) on 11/22/23 at 4:26pm revealed she was concerned Resident #9 had three Tylenol tablets in her room because she could take all three at one time. Refer to the interview with the CC on 11/22/23 at 4:26pm. Refer to the interview with the Health Wellness Coordinator (HWC) on 11/22/23 at 5:08pm. Refer to the interview with the Executive Director (ED) on 11/22/23 at 5:38pm. _____ -Interview with the Clinical Coordinator (CC) on 11/22/23 at 4:26pm revealed: -The MA should observe residents take their medication. -Medication should never be left with a resident to take at a later time. -Leaving medication in a resident's room was a safety concern because there could be a concern with the resident not taking the medication as ordered or a possible overdose of the medication	D 366		

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D 366	Continued From page 23 and medication left in a resident's room could be accessible to other residents. Interview with the Health Wellness Coordinator (HWC) on 11/22/23 at 5:08pm revealed: -She expected the MAs to watch the residents take their medications. -There would be no reason to ever leave medication in a resident's room. -If the resident did not want to take the medication at that time the medication should be taken back to the medication cart. Interview with the Executive Director (ED) on 11/22/23 at 5:38pm revealed: -The MAs should make sure the resident took their medication before she left the resident's room. -She was concerned the resident did not take their medication as ordered, or the resident could then take too many if they held the medication.	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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;	D 367		

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D 367	Continued From page 24 (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 1 of 5 sampled residents (#4) for a high blood pressure medication. The findings are: Review of Resident #4's current FL-2 dated 01/12/23 revealed diagnoses included hypertensive chronic kidney disease. Review of Resident #4's signed physician's orders dated 07/06/23 revealed an order for Losartan Potassium 25mg; administer one-half tablet daily. Review of Resident #4's physician's order dated 09/09/23 revealed an order to change Losartan 25mg to one tablet daily. Review of Resident #4's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Losartan 25mg, one-half tablet daily for hypertension with a scheduled administration time of 6:00am. -Losartan 25mg (0.5 tablet) was documented as administered 09/01/23-09/30/23.	D 367		

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D 367	Continued From page 25 Review of Resident #4's October 2023 eMAR revealed: -There was an entry for Losartan 25mg one half tablet daily for hypertension with a scheduled administration time of 6:00am. -Losartan 25mg (0.5 tablet) was documented as administered 10/01/23-10/31/23. Review of Resident #4's November 2023 eMAR from 11/01/23-1/22/23 revealed: -There was an entry for Losartan 25mg one half tablet daily for hypertension with a scheduled administration time of 6:00am. -Losartan 25mg (0.5 tablet) was documented as administered 11/01/23-1/22/23. Observation of Resident #4's medications on hand on 11/21/23 at 4:25pm revealed there was a punch card labeled for Losartan 25mg with the directions to administer one tablet once daily; it was dispensed on 11/13/23. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/21/23 at 9:24am revealed: -Resident #4's current Losartan order was to administer Losartan 25mg once daily. -Losartan 25mg was dispensed on 09/16/23, 10/09/23, and 11/06/23. -The facility staff entered orders into the eMAR system. -The facility staff was responsible for making any changes in the eMAR when an order changed. -The pharmacy usually sent a copy of the order to the facility when the medication was first dispensed. Interview with a medication aide (MA) on 11/22/23 at 4:16pm revealed: -When she administered Resident #4's 6:00am	D 367		

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medications, she pulled out all the medications to be administered at 6:00am, she compared the medication cards to the eMAR to make sure the dosage matched, and the directions were the same before administering the medication.
-If she had noticed the dosage/directions on the medication card did not match the dosage/directions on the eMAR she would have pulled the medication card and called the pharmacy for clarification.
-New orders were entered into the eMAR by an MA or clinical staff and verified by a second staff member.
-New orders were processed using the new order tracking form.
-The order was checked to make sure it was entered correctly.
-When the medication was delivered, it was placed in the nurse's box and the nurse was responsible for verifying it as well.

Interview with the Health and Wellness Coordinator (HWC) on 11/22/23 at 4:26pm revealed:
-The MAs should pull the medication card and compare the label to the eMAR to make sure everything matched.
-If the directions/dosage did not match, she expected the MA to not administer the medication and let the clinical staff know so they could get it clarified.
-If there was a change in an order, the change would be made in the eMAR by the MA or any clinical staff.
-Once an order was entered into the eMAR it was checked by a second staff member.
-When the medication was delivered from the pharmacy staff were responsible for making sure the dosage/directions on the medication card matched the dosage/directions in the eMAR.

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D 367	Continued From page 27 Interview with the Health and Wellness Director (HWD) on 11/22/23 at 5:08pm revealed: -The staff member who received a new order was responsible for entering the order and having a second staff member verify the order was entered correctly. -The MA who received the delivered medication should make sure the medication matched. -If there was a discrepancy the MA should notify a clinical staff and/or pull the record and verify the order. -The MA should then correct the eMAR once verified. Interview with the Executive Director (ED) on 11/22/23 at 5:38pm revealed: -Changes in orders were completed by the MAs and/or the nurses in the eMAR. -When a medication was delivered, the MA or nurse should make sure the medication label matched the order in the eMAR. -Whoever administered the medication should have made sure the medication label matched the eMAR. -She was concerned no one had caught the order discrepancy.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.	D 371		

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D 371	Continued From page 28 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA), who administered eye drops, checked a fingerstick blood sugar (FSBS), and administered insulin and failed to wash her hands with soap and water before and after donning and doffing gloves. The findings are: Review of the facility's Medication Administration policy dated October 2023 revealed: -The medication aide (MA) should use infection control and prevention practices based on the Centers for Disease Control and Prevention guidelines for hand hygiene. -The MAs should wash their hands or use hand sanitizer prior to medication administration for each resident. -Hand washing should be performed with soap and water and not with the use of hand sanitizer solution when hands are visibly dirty -Medication directions on the Primary Care Provider (PCP) order and pharmacy label should correlate with the medication directions on the electronic medication administration record (eMAR). Review of the hand-washing policy dated June 2022 revealed: -After handling items potentially contaminated with any resident's blood, excretions, or secretions. -The use of gloves did not replace handwashing. -If soap and water were not available, the MA should use an antimicrobial hand gel to cleanse hands before and after each resident. -The MA should follow the handwashing/hand	D 371		

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hygiene procedures to help prevent the spread of infections to other residents.
-The Center for Disease Control recommended using an alcohol-based hand sanitizer with 60 to 95% alcohol before and after removing gloves and contact with medical equipment.

Observation of the MA administering medications during the 9:00am morning medication pass on 11/21/23 revealed:
-The MA administered an eye drop in the right eye without a glove on, then donned the gloves and placed an eye drop in the left eye of the resident.
-The MA removed her gloves and proceeded to administer medications without washing or sanitizing her hands.

Observation of the MA during the 12:00pm medication pass on 11/21/23 at 10:53pm revealed:
-The MA gathered supplies to check a FSBS for a resident.
-The MA donned gloves without washing or sanitizing her hands.
-The MA performed the FSBS on the resident, returned to the cart, gathered supplies for an insulin administration.
-The MA administered the insulin to the resident and returned to the medication cart.
-The MA removed her gloves and did not sanitize her hand.
-The MA did not change gloves between the FSBS and the insulin injection.

Interview with the MA on 11/21/23 at 3:18pm revealed:
-When administering eye drops, checking blood sugar readings, and administering insulin the MAs should wear gloves and wash their hands

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after removing the gloves.
-She forgot to put gloves on before the eye drops was administered.
-She rememeber to put gloves on after she had administerd eye drops in the first eye.
-She did not wash her hands or use sanitizer when she changed gloves.
-She did not wash her hands between obtaining a blood sugar reading and the administration of insulin.
-She was not sure what the facility policy was regarding washing and sanitizing hands when administering medications.

Interview with the Health and Wellness Coordinator (HWC) on 11/21/22 at 4:10pm revealed:
-The MAs should wash their hands or sanitize their hands between administration of medications to residents, before and after eye drops, and before and after donning and doffing gloves.
-The MAs should wash their hands after blood sugar checks because a drop of blood could have dropped on the glove.
-Hands were washed to prevent cross contamination.

Interview with the Health and Wellness Director (HWD) on 11/21/22 at 4:35pm revealed:
-The MAs should wash their hands before and after administering eye drops, insulin, and checking blood sugars.
-There was sanitizer available for the MAs to sanitize their hands if they were unable to use soap and water.

Interview with the Executive Director (ED) on 11/21/23 at 4:55pm revealed the MAs were expected to use sanitizer or soap and water to

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D 371	Continued From page 31 cleanse their hands to decrease the risk of infection transmission.	D 371		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 5 sampled residents (#2 and #10) who self-administered medications had orders to self-administer medications for a nasal spray, an pain relieve, a calcium supplement (#2) and a medication used to treat mild pain (#10). The findings are: 1. Review of Resident #2's current FL-2 dated 10/08/23 revealed diagnoses included interstitial lung disease, obesity, hyperlipidemia, diabetes, hypothyroidism, depression, and obstructive sleep apnea.	D 375		

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D 375	Continued From page 32 Observation of Resident #2's room on 11/21/23 at 8:35am revealed: -She was laying across her bed. -There were several miscellaneous items on top of the bedspread including over the counter (OTC) medications. -There was a bottle of used fluticasone nasal spray, an open bottle of ibuprofen tablets, and an open bottle of calcium supplements. Review of Resident #2's record on 11/21/23 revealed there was no self-administration evaluation available for review. Interview with Resident #2 on 11/21/23 at 8:35am revealed: -She thought the facility staff knew about her OTC medications because she had told them she needed them, and she thought the staff saw them in her room. -She did not know if she had a physician's order for the OTC medications because she was on them prior to being admitted to the facility a few months ago. -She purchased the OTC medications herself or a family member purchased them for her. -She had self-administered the OTC mediations herself when she was at home and could still self-administer them now that she was at the facility. -She had not been told she could not keep the medications in her room and would give them to the staff if she was not allowed. Telephone interview with the pharmacist from the facility's contracted pharmacy on 11/21/23 at 4:28pm revealed: -Resident #2 did not have an order to self-administer any medications.	D 375		

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-The pharmacy had not dispensed fluticasone nasal spray, ibuprofen or calcium supplements for Resident #2 because she did not have orders for the OTC medications.

Telephone interview with Resident #2's primary care provider (PCP) on 11/22/23 at 11:24am revealed:
-Resident #2 had not been evaluated for self-administration of her own medications.
-She had not signed a self-administration order for any of Resident #2's medications.
- Resident #2 Could not manage her own medications at home.
-Resident #2 was not supposed to have any medications in her room.
-It was hard to explain to Resident #2 that she could not have any of her own medications anymore.
-The facility was responsible for administering Resident #2's medication.

Interview with a medication aide (MA) on 11/22/23 at 12:05pm revealed:
-Resident #2 Did not self-administer any of her own medications.
-She had not seen any OTC medications in Resident #2's room.
-Resident #2 should not have any medications in her room.
-She looked around Resident #2's room when she was in there for any OTC medications.

Interview with the Health and Wellness Coordinator (HWC) on 11/22/23 at 12:28pm revealed:
-Resident #2 did not have an order to self-administer medications because she had not been evaluated.
-Resident #2 would leave the facility and would

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purchase OTC medications.
-Resident #2 had been educated about purchasing OTC medications and needing an order to self-administer them.
-She thought Resident #2 could self-administer OTC medications at some point, but she was not at that point yet because the PCP and the facility were still sorting her medication orders from her recent admission to the facility.
-These staff were supposed to scan the residents' rooms when they were in them to look for any medications that the residents might have.

Interview with the Health and Wellness Director (HWD) on 11/22/23 at 12:43pm revealed:
-Resident #2 did not have an order for self-administration of any medications.
-Part of the reason Resident #2 was admitted to the facility was because she was not managing her own medications at home.
-The facility sent a weekly e-mail to families informing them residents were not allowed to self-administer medications or to have OTC medications in their rooms.
-It Concerned her Resident #2 Was self-administering medications without the facility's or the physician's knowledge because they did not know what she was taking on her own.
-Staff were trained to scan the rooms of the residents when they were in them for medications.

Interview with the Administrator on 11/22/23 at 12:58pm revealed:
-Residents could not self-administer medications including over the counter OTC and less they had been evaluated by the PCP and had a self-administration order.
-She sent out a weekly e-mail to residents'

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families and as part of the e-mail she included residents were not allowed to self-administer medications and they were not allowed to have OTC medications in their room.
-Resident #2 was admitted with a large amount of medications; including expired medications and medications without physicians orders.
-Resident #2 had not been taking her medications correctly when she lived at home.
-The HWC and HWD have been working with the Resident #2's PCP to eliminate medications she might not need anymore.
-She was concerned Resident #2 had OTC medications in her room because the facility and the PCP did not know what she was self-administering.

2. Review of Resident #10's current FL2 dated 02/09/23 revealed:
-Diagnosis included malignant neoplasm of the prostate.
-There was no information related to Resident #3's orientation status.
-There was an order for Acetaminophen (used to treat mild pain) 650mg every six hours as needed for pain.
-There was no order to self-administer medications.

Observation of Resident #10's room on 11/21/23 at 9:00am revealed:
-Resident #10 was observed with three oblong white tablets on his tongue.
-Resident #10 took the medication with a glass of water.
-Resident #10 had a bottle of Acetaminophen 500mg sitting on his bed, the lid had been removed.
-Resident #10 closed the bottle and placed it in his nightstand drawer.

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D 375	Continued From page 36 Interview with Resident #10 on 11/21/23 at 9:02am revealed: -He was taking the Acetaminophen tablets because his head was "stopped up." -He usually took three Acetaminophen from the bottle "about once a day." Review of Resident #10's October 2023 electronic medication administration records (eMARs) revealed: -There was an entry for Acetaminophen 650mg, give one tablet every six hours as needed for general discomfort. -There was documentation that Acetaminophen 650mg was administered on 10/19/23 and 10/20/23; it was discontinued on 10/20/23. -There was a second entry for Acetaminophen 325mg to administer two tablets every six hours for temperature for five days. -There was documentation that Acetaminophen 325mg (2) tablets was administered four times daily on 10/21/23-10/24/23 and twice on 10/20/23 and 10/25/23; the stop date was 10/20/23. Review of Resident #10's November 2023 eMAR from 11/01/23-11/22/23 revealed there was no entry for Acetaminophen. Interview with Resident #10's Primary Care Provider (PCP) on 11/22/23 at 1:33pm revealed she would prefer the MAs administer Resident #10's medications. Interview with a medication aide (MA) on 11/22/23 at 12:11pm revealed: -The MAs administered all of Resident #10's medications. -She had never seen any medications in Resident #10's room.	D 375		

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D 375	Continued From page 37 -She did not know Resident #10 had Acetaminophen in his room and was taking the medication on his own. Interview with the Health and Wellness Coordinator (HWC) on 11/22/23 at 4:26pm revealed she did not know Resident #10 had Acetaminophen in his room and no order to self-administer; it could be a safety issue for the resident. Interview with the Health and Wellness Director (HWD) on 11/22/23 at 5:08pm revealed: -Resident #10 did not have an order to self-administer any medications. -The resident was supposed to notify the clinical staff if the resident had a medication, they wanted to take on their own. -The clinical staff would complete a self-assessment to determine if the resident could self-administer the medication. -She was concerned Resident #10 was taking Acetaminophen because the resident could take too many or be taking the medication for the wrong reason. Interview with the Executive Director (ED) on 11/22/23 at 5:38pm revealed: -She did not know Resident #10 had Acetaminophen in his room until today, 11/22/23. -If a resident had medication in their room, the resident should have a self-administration order.	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.	D 377		

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 safely and securely for 3 of 3 sampled residents (#6, #11, and #12) who self-administered medications.

The findings are:

Review of the facility's Self-Administration of Medication Policy dated 08/2023 revealed residents who self-administer their own medications may store and secure their non-controlled medications in their apartment by locking the apartment door each time upon departure.

1. Review of Resident #11's current FL-2 dated 08/08/23 revealed:
-There was documentation to see attached for diagnosis; there were no diagnoses attached.
-There was documentation to see attached for medications.

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-Attached medication list included Valsartan (used to treat high blood pressure) 80mg once daily, Aldactone (used to treat fluid retention) 50mg once daily, Zocor (used to treat high cholesterol) 20mg once daily, Simethicone (used to treat excessive gas) take one tablet as needed, Florastar (used for digestive) 250mg twice daily, Protonix (used to treat stomach acid) 40mg twice daily, Robaxin (used to treat muscle spasms) 500mg three times daily as needed, Meclizine (used to treat and prevent vomiting) 12.5mg three times daily as needed, Gabapentin (used to treat nerve pain) 300mg once daily, Vitamin D12 (supplement) 1250mcg once weekly, and Duloxetine (used to treat depression) 30mg once daily.

Review of Resident #11's problem list dated 01/30/23 revealed diagnoses included neck pain, plantar fasciitis, diabetes, hypertension, osteoarthritis, vitamin D deficiency, cervical myelopathy, and obesity.

Review of Resident #11's self-administration assessment dated 09/18/23 revealed Resident #11 was approved to self-administer medications and had demonstrated secure storage for medication by locking the door upon departure.

Review of Resident #11's November 2023 electronic medication administration record (eMAR) from 11/01/23-11/22/23 revealed Resident #11 self-administered all medications.

Observation of Resident #11's room on 11/21/23 at 9:16am and 5:47pm revealed:
-The door was closed, but the room was unlocked, and the resident was not present in the room.
-There were multiple medication bottles and a

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D 377	Continued From page 40 pre-filled daily medication container on the table visible when the door was opened. Interview with Resident #11 on 11/22/23 at 11:19am revealed: -They were assessed when they first moved into the facility to self-administer their own medications. -They did not recall anyone telling them where they should keep their medications, but they may have forgotten. -They kept their medication out so they would remember to take the medication. -They would start locking their room when they left the room. Interview with the medication aide (MA) on 11/22/23 at 12:11pm revealed she had not seen medications unlocked in Resident #11's room because she never went into the resident's room; the resident self-administered all medications. Interview with a housekeeper on 11/22/23 at 3:52pm revealed: -She had seen medications in Resident #11's room; the staff knew Resident #11 had medications in her room. -She had not observed Resident #11's room unlocked; Resident #11 was always in the room when she cleaned. Refer to the interview with a MA on 11/23/23 at 12:11pm. Refer to the interview with the Clinical Coordinator (CC) on 11/22/23 at 4:26pm. Refer to the interview with the Health Wellness Coordinator (HWC) on 11/22/23 at 5:08pm.	D 377		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001024	A. BUILDING: _____ B. WING _____	R 11/22/2023

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D 377	Continued From page 41 Refer to the interview with the Executive Director (ED) on 11/22/23 at 5:38pm. 2. Review of Resident #12's current FL-2 dated 08/08/23 revealed: -There was documentation to see attached for diagnosis; there were no diagnoses attached. -There was documentation to see attached for medications. -Attached medication list included Tylenol (used to treat mild pain) 500mg one tablet three times daily, Aspirin (used to prevent heart attacks/strokes) 81mg once daily, Zyrtec (used to treat allergies) 10mg once daily, Vitamin D3 (supplement) 1000u once daily, Vitamin B12 (supplement) 1000mcg once daily, Finasteride (used to treat enlarged prostate) 5mg once daily, Lasix (used to treat fluid retention) 20mg once daily as needed, Flomax (used to treat enlarged prostate) 0.4mg once daily, Exelon (used to treat dementia) take one capsule twice daily, Pravastatin (used to treat high cholesterol), Magnesium (supplement) 250mg once daily, and Omeprazole (used to treat reflux) 40mg once daily. Review of Resident #12's self-administration assessment dated 09/18/23 revealed Resident #11 was approved to self-administer medications and had demonstrated secure storage for medication by locking the door upon departure. Review of Resident #12's November 2023 electronic medication administration record (eMAR) from 11/01/23-11/22/23 revealed Resident #12 self-administered all medications. Observation of Resident #12's room on 11/21/23 at 9:16am and 5:47pm revealed: -The door was closed, but the room was	D 377		

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unlocked, and the resident was not present in the room.
-There were multiple medication bottles and a pre-filled daily medication container on the table visible when the door was opened.

Interview with Resident #11 on 11/22/23 at 11:19am revealed:
-They were assessed when they first moved into the facility to self-administer their own medications.
-They did not recall anyone telling them where they should keep their medications, but they may have forgotten.
-They kept their medication out so they would remember to take the medication.
-They would start locking their room when they left the room.

Interview with the medication aide (MA) on 11/22/23 at 12:11pm revealed she had not seen medications unlocked in Resident #12's room because she never went into the resident's room; the resident self-administered all medications.

Interview with a housekeeper on 11/22/23 at 3:52pm revealed:
-She had seen medications in Resident #12's room; the staff knew Resident #12 had medications in his room.
-She had not observed Resident #12's room unlocked; Resident #12 was always in the room when she cleaned.

Refer to the interview with a MA on 11/23/23 at 12:11pm.

Refer to the interview with the Clinical Coordinator (CC) on 11/22/23 at 4:26pm.

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D 377	Continued From page 43 Refer to the interview with the Health Wellness Coordinator (HWC) on 11/22/23 at 5:08pm. Refer to the interview with the Executive Director (ED) on 11/22/23 at 5:38pm. 3. Review of Resident #6's current FL-2 dated 05/02/23 revealed: -Diagnoses included atrial fibrillation, hypertension, hypotension, rheumatoid arthritis, osteoporosis, sleep apnea, gout, neuropathy, and leg edema. -Medications included elderberry 500mg (used as a supplement), bioflex (used as a supplement), carvedilol 3.125mg (used to treat high blood pressure), multi-vitamin (used as a supplement), co-enzyme Q-10 (used as a supplement), cranberry capsule (used as a supplement), Eliquis 5mg (used to decrease risk of a blood clot), famotidine 20mg (used to treat stomach ulcers), fexofenadine 180mg (used for seasonal allergies), fish oil 1000mg (used in the prevention of heart disease and stroke), folic acid 1mg (used as a supplement), furosemide 40mg (used for fluid retention), gabapentin 600mg (used to treat nerve pain), ginger root 25mg (used as a supplement), hydrochlorothiazide 12.5 (used to treat high blood pressure), hydralazine 25mg (used to treat high blood pressure), levothyroxine 50mcg (used to treat an underactive thyroid gland), losartan 50mg (used to treat high blood pressure), Metamucil (used to treat constipation), methotrexate 2.5mg (used to treat arthritis), Premarin 0.625mg (a hormone replacement), preservision (used to lower the risk of macular degeneration), Trelegy Ellipta 100-62.5-25mg (used to treat chronic obstructive pulmonary disease), turmeric 500mg (used as a supplement), Tylenol arthritis 650mg (used to treat pain), and vitamin D3 1000 units (used as a supplement).	D 377		

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D 377	Continued From page 44 Review of Resident #6's self-administration assessment dated 09/21/23 revealed Resident #6 was approved to self-administer medications and had demonstrated secure storage for medication by locking the door upon departure. Review of Resident #6's November 2023 electronic medication administration record eMAR) from 11/01/23-11/22/23 revealed Resident #6 self-administered all medications. Observation of Resident #6's room on 11/21/23 at 8:33am, 12:16pm, and 5:12pm revealed: -Resident #6's apartment was unlocked, and Resident #6 was not in her room. -There was a prescription bottle sitting on the nightstand between the recliner and the window. -There were two bottle tops with two different colored and shaped pills in each bottle top sitting on the nightstand. -There was a bottle of eye drops and a bottle of nasal spray on the nightstand. Interview with Resident #6 on 11/22/23 at 3:53pm revealed: -She kept her medications in her rooms and self-administered her medications. -She kept most of her medications locked in her closet. -She kept the levothyroxine by her bedside so she could take it before she went to breakfast. -She kept her hydralazine by her bedside to take in case her blood pressure was too high; she checked her blood pressure each morning. -She also had eye drops for dry eyes and a nasal spray for allergies. -It was convenient for her to keep these medications at her bedside. -She did not lock her bedroom door when she left	D 377		

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her room because she had a difficult time unlocking the door with a key.
-She was told to keep her medications locked by the facility staff.

Interview with a housekeeper on 11/22/23 at 3:52pm revealed:
She had seen medications in Resident #6's room; the staff knew Resident #6 had medications in her room.
-Resident #6's room was always open even when the resident was not in the room.

Interview with the Health Wellness Director (HWD) on 11/22/23 at 5:17pm revealed:
-Resident #6 was informed to keep her medications in her room locked.
-She did not lock the door to her room when she went to meals.
-Anyone could go in her room when Resident #6 was not in her room and take her medications.

Refer to the interview with a medication aide (MA) on 11/23/23 at 12:11pm.

Refer to the interview with the Clinical Coordinator (CC) on 11/22/23 at 4:26pm.

Refer to the interview with the Health Wellness Coordinator (HWC) on 11/22/23 at 5:08pm.

Refer to the interview with the Executive Director (ED) on 11/22/23 at 5:38pm.

_____
Interview with a medication aide (MA) on 11/23/23 at 12:11pm revealed:
-If she saw medication in a residents room, she would ask the clinical staff if the resident could have the medication.
-If the resident could have medication in their

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room, she would tell the resident to put the medication away, "out of sight."
-She would not want another resident to go into the residents room and take the medication.

Interview with the Clinical Coordinator (CC) on 11/22/23 at 4:26pm revealed:
-Any clinical staff should have directed residents who self-administered medication, on how to store their medications.
-It could be a safety hazard if another resident went into the room and the medication was accessible.

Interview with the Health Wellness Coordinator (HWC) on 11/22/23 at 5:08pm revealed:
-Self-administered medications had to be locked in the residents' rooms and controlled medication was to be double locked.
-When they did medication reviews, they would check to see where the medication was being stored.
- Self-administered medications needed to be locked because anyone could walk into the room and take the medications.

Interview with the Executive Director (ED) on 11/22/23 at 5:38pm revealed:
-The HWC was responsible for telling the residents who self-administered medication, how to store their medication.
-The nurses and the MAs routinely checked to ensure self-administered medications were stored correctly.
-It could be a safety concern if medications were not stored correctly as another resident could wander into the room.