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D 000	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services conducted an annual survey and complaint investigation on 12/06/23 to 12/07/23.	D 000	D306 10A NCAC 13F .0904(d)(4) Nutrition and Food Service Corrective Action: 1. On 12/7/23 at dinner meal service and ongoing on all future meals, all residents in the Special Care Unit were served water in addition to other beverages of their choice.	
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to serve water to each resident in the Special Care Unit. The findings are: Observation of the breakfast meal in the Special Care Unit (SCU) on 12/07/23 between 8:15am and 9:06am revealed: -There were 12 residents in the dining room. -Four residents were served orange juice only. -Three residents were served cranberry juice only. -One resident was served apple juice only. -Two residents were served cranberry juice and coffee. -One resident was served orange juice and coffee. -One resident was served orange juice and milk. -There was no water served to the residents.	D 306	2. On 01/12/24, the Culinary Services Manager and/or designee will begin observing meal services for compliance. The Culinary Services Manager and/or designee will address any discrepancies. Systemic Changes: 3. On 12/13/23, the Executive Director conducted a meeting with staff to reeducate on Nutrition and Food Services including the requirement to provide water at each meal in addition to other chosen beverages. On 01/10/24, the Resident Care Manager conducted a meeting with staff to reeducate on Nutrition and Food Services including the requirement to provide water at each meal in addition to other chosen beverages. On 01/12/24, the Culinary Services Manager conducted a meeting with culinary staff to reeducate on Nutrition and Food Services including the requirement to provide water at each meal in addition to other chosen beverages. Effective 1/12/24, the Culinary Services Manager and/or designee will conduct random weekly audits to ensure residents in the Special Care Unit are being served water at each meal in addition to their beverage of choice. The Culinary Services Manager will address any discrepancies identified. Monitoring: 4. Results on the random weekly audits, for compliance, will be reviewed monthly for 3 months, by the Executive Director and/or designee at the Quality Assurance and Assessment Committee. After 3 months, the facility will re-evaluate. Corrective Date 5. 1/21/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shanelle Armas | TITLE: Executive Director | (X6) DATE: 01/18/24

Reviewed and Acknowledged 01/22/24 Jamaal Willis

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D 306	Continued From page 1 -Staff did not offer the residents water. Observation of the lunch meal in the SCU on 12/07/23 from 11:46pm to 12:15pm revealed: -There were 13 residents in the dining room. -Six residents were served lemonade. -Seven residents were served tea. -There were 2 residents with a bottle of water they brought into the dining room. -Staff did not offer the other residents water. Interview with the dietary aide on 12/07/23 at 12:05pm revealed: -She did not serve water to the residents for breakfast because no one in the kitchen prepped it and she did not have time to prepare it herself. -She had water prepared for lunch, but she did not offer it to the residents nor serve it. Interview with the Dining Room Supervisor on 12/07/23 at 12:13pm revealed: -He was not aware there was a requirement to serve water to the residents at each meal, but he was trained to serve water. -The dietary staff was aware water was to be served to the residents.	D 306		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 2 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (# 6, #7) observed during the medication pass including errors with a medication used to treat heartburn and acid reflux (#6, #7) and a medication used to treat and prevent low blood potassium (#7); and 3 of 5 sampled residents for record review (#1, #2, #4) related to medications used to treat depression, obsessive-compulsive disorder, severe pain, Parkinson's disease, anxiety, and dry eyes (#1), medications used to treat and prevent blood clots, Parkinson's disease, and allergy symptoms, (#2) and a medication used to treat constipation (#4). The findings are: Review of the facility's Pharmacy Services Policy dated 02/13/20 revealed: -All refills of medications must occur within 7-10 days before the last dose of the previous month to maintain resident supply. -If the resident was using the services of another pharmacy, and the resident runs out of medication before the refill, the medication will be purchased through the preferred pharmacy and billed to the resident/authorized representative. Review of the facility's Medication Administration Policy dated August 2020 revealed: -The facility shall ensure the administration of medications, prescription and non-prescription, by team members were in accordance to orders by a licensed prescribing practitioner. -Transcription of orders into the electronic	D 358	D358 10A NCAC 13F .1004(a) Medication Administration Corrective Action: 1. On 12/7/23, the Resident Care Manager and/or designee began reviewing all residents Physician Orders vs. Medications available for administration in the Medication carts. The Resident Care Manager and/or designee will address any discrepancies identified. 2. On 12/13/23, the Resident Care Manager and/or designee began reeducating Medication Technicians regarding, Pharmacy Services Policy, Reordering medication process, Verification of pharmacy Emar order changes, Medication Technician responsibilities. Systemic Changes: 3. On 12/13/23, the Executive Director conducted a meeting with the staff discussing Medication Technicians regarding, Pharmacy Services Policy, Reordering medication process, Verification of pharmacy Emar order changes, Medication Technician responsibilities. On 12/13/23, the Resident Care Manager conducted a meeting with the Medication Technician staff reeducating on Medication Technicians regarding, Pharmacy Services Policy, Reordering medication process, Verification of pharmacy Emar order changes and Medication Technician responsibilities. Effective 1/12/23, the Resident Care Manager and/or designee will conduct random monthly audits to ensure Medications are being administered according to Physician order, The Resident Care Manager and/or designee will address any discrepancies identified. Monitoring: 4. Results on the random monthly audits, for Medication being administered according to Physician Order, will be reviewed monthly for 3 months, by the Executive Director and/or designee at the Quality Assurance and Assessment Committee. After 3 months, the facility will re-evaluate. Corrective Date 5. 1/21/24	

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medication administration record (eMAR) will be completed by the pharmacy via eMAR.
-Orders are to be faxed to the pharmacy. Pharmacy will enter the order online via eMAR.
-Orders are to be verified against physician orders for accuracy. If any discrepancies arise the physician is to be contacted for corrections and the medications are not to be administered until clarified.
-Review medication administration records monthly at the beginning of the cycle to assure accuracy and update the eMAR as needed.

1. The medication error rate was 10% as evidenced by 3 out of 28 opportunities observed during the 8:00am and 10:00am medication pass on 12/06/23.

1. Review of Resident #6's current FL-2 dated 09/20/23 revealed diagnoses included diabetes mellitus type 2, hypertension, atrial fibrillation, sleep apnea, hyperlipidemia, and chronic anticoagulation.

a. Review of a physician medication order dated 10/23/23 revealed an order for Nexium 40 mg, 1 capsule daily before breakfast. (Nexium is a medication used for heart burn and acid reflux).

Observation of the medication pass on 12/06/23 at 9:40am revealed Resident #6 was administered Nexium 40mg.

Review of Resident #6's December 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Nexium 40mg, 1 capsule daily before breakfast to be administered at 7:00am.
-There was documentation the Nexium 40mg, 1

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D 358	Continued From page 4 capsule was administered on 12/06/23. Interview with Resident #6 on 12/06/23 at 9:45am revealed he had eaten breakfast that morning and he took his medications after he ate. Interview with the medication aide (MA) on 12/06/23 at 2:00pm revealed: -She was a new MA on the medication cart. -She started her medication pass a little later than usual and the medication was given after Resident #6 had eaten. Telephone interview with the facility's contracted pharmacist on 12/07/23 at 9:42am revealed: -The current order for Resident #6 was for Nexium 40mg, 1 capsule daily before breakfast. -Nexium was used to prevent heartburn. -Nexium was ordered before breakfast to prevent the release of stomach acid from food consumption that caused heartburn. -If Nexium was given after food consumption, it would not be effective since the stomach acid had been released due to food consumption. Interview with the Resident Care Manager (RCM) on 12/07/23 at 3:30pm revealed she expected Resident #6's medication to be given before breakfast as ordered. Interview with the Administrator on 12/07/23 at 3:45pm revealed she expected Resident #6's medication to given as ordered for the medication to be effective. b. Review of Resident #7 current FL-2 dated 08/23/23 revealed: -Diagnoses included depression, hypertension, GERD, Alzheimer's, and chronic obstructive asthma.	D 358		

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-There was an order for Prilosec 20mg, 1 capsule daily (Prilosec was a medication used for acid reflux).

Observation of Resident #7's medication pass on 12/06/23 at 10:13am revealed:
-Prilosec 20mg, 1 capsule was not administered because it was not on the medication cart.
-The medication aide (MA) ordered the medication by clicking on the reorder button in the electronic system at that time (12/06/23).

Review of Resident #7's December 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Prilosec 20mg, 1 capsule daily to be administered at 10:00am.
-There was documentation Prilosec 20mg, 1 capsule daily was not administered because it was not on the medication cart and awaiting the medication from pharmacy

Interview with the MA on 12/06/23 at 10:15pm revealed she did not administer Resident #7's Prilosec because it was not on the medication cart and she would order the medication now.

Telephone interview with the facility's contracted pharmacist on 12/07/23 at 9:42am revealed:
-The current order for Resident #7 was for Prilosec 20mg, 1 capsule daily.
-Prilosec was used to decrease acid reflux.
-Prilosec was not dispensed in October 2023 or November 2023.
-Prilosec was dispensed on 12/06/23 for a quantify of 30 tablets for a 30-day supply.
-Medications for the facility were not on cycle-fill and the facility had to notify the pharmacy when a medication needed to be refilled.

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c. Review of Resident #7's physician order dated 08/23/23 revealed an order for Potassium Chloride 10meq ER, 1 tablet on Monday, Wednesday, and Friday. (Potassium Chloride is a medication used to treat low blood potassium).

Observation of Resident #7's medication pass on 12/06/23 (Wednesday) at 10:13am revealed:
-Potassium Chloride 10meq ER, 1 tablet was not administered because it was not on the medication cart.
-The MA ordered the medication by clicking on the reorder button in the electronic system at that time (12/06/23).

Review of Resident #7's December 2023 eMAR revealed:
-There was an entry for Potassium Chloride 10meq ER, 1 tablet daily on Monday, Wednesday, and Friday to be administered at 10:00am.
-There was documentation Potassium Chloride 10meq ER 1 tablet was not administered because it was not on the medication cart and awaiting the medication from pharmacy.

Interview with the medication aide (MA) on 12/06/23 at 10:15am revealed she did not administer Resident #7's Potassium Chloride because it was not on the medication cart and she would order the medication now.

Telephone interview with the facility's contracted pharmacist on 12/07/23 at 9:42am revealed:
-The current order for Resident #7 was Potassium Chloride 10meq ER, 1 tablet on Monday, Wednesday, and Friday.
-Potassium Chloride was used to treat low Potassium levels in the blood.
-Potassium Chloride was dispensed on 11/03/23

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for a quantity of 13 tablets, and on 12/06/23 for a quantify of 13 tablets for a 30-day supply.

Refer to interview with the MA on 12/07/23 at 3:00pm.

Refer to interview with the Resident Care Manager (RCM) on 12/07/23 at 3:30pm revealed:

Refer to interview with the Administrator on 12/07/23 at 3:45pm revealed:

2. Review of Resident #2's current FL-2 dated 11/22/23 revealed diagnoses included right hip fracture, anemia, hypertension, diabetes mellitus type 2, Parkinson's disease, glaucoma, insomnia, coronary artery disease, and benign prostate hypertrophy.

Review of a Resident #2's physician progress note dated 11/08/23 revealed:
-Resident #2 went to the local hospital emergency room (ER) on 09/29/23 due to a fall that resulted in a right hip fracture and repair.
-The resident was in the hospital from 09/29/23 through 10/04/23 and was sent to a rehabilitation facility.
-The resident was discharged from the rehabilitation facility and admitted back to the facility on 11/03/23.

a. Review of a signed physician progress note dated 11/22/23 revealed an order for Carbidopa 25mg-Levodopa 100mg, 2 tablets three times a day 30 minutes before meals.
(Carbidopa/Levodopa is a medication used to control tremors related to Parkinson's disease).

Review of Resident #2's October 2023 electronic medication administration record (eMAR)

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revealed no medications were administered in October due to the resident being out of the facility from 09/29/23 through 11/03/23.

Review of Resident #2's November 2023 eMAR revealed:
-There was an entry for Carbidopa 25mg-Levodopa 100mg, 2 tablets three times daily before meals to be administered at 7:30am, 11:30am, and 4:30pm.
-There was documentation Carbidopa 25mg-Levodopa 100mg, 2 tablets was not administered on 11/26/23 at 4:30pm, and 11/27/23 at 7:30am, 11:30am, and 4:30pm due to awaiting the medication from pharmacy.
-The resident missed four scheduled doses of the Carbidopa 25mg-Levodopa 100mg.

Observation of Resident #2's medications on hand on 12/07/23 at 2:30pm revealed 60 doses of Carbidopa 25mg-Levodopa 100mg with a dispense date of 11/25/23 for a quantity of 180 tablets.

Telephone interview with the facility's contracted pharmacist on 12/07/23 at 9:42am revealed:
-Carbidopa 25mg-Levodopa 100mg was used to control tremors due to reduced motor function related to Parkinson's disease.
-Resident #2's Carbidopa 25mg-Levodopa 100mg was dispensed on 09/20/23 for a quantity of 180 tablets for a 30-day supply.
-Resident #2's Carbidopa 25mg-Levodopa 100mg was dispensed on 11/25/23 for a quantity of 180 tablets for a 30-day supply.
-Missed doses of the medication could cause an increase in tremors.

Interview with Resident #2 on 12/07/23 at 3:00pm revealed:

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-He remembered missing some doses of the medication for his tremors.
-He could not recall the exact date, but remembered he experienced increased tremors.

Telephone interview with the Resident #2's family member on 12/07/23 at 8:15am revealed:
-Resident #2's Parkinson's medication (Carbidopa 25mg-Levodopa 100mg) was not available in the facility the weekend of 11/25/23.
-The resident missed some doses of the medication.
-The resident told her he experienced more tremors that usual during that time to the point where he could not drink his coffee without it spilling over.
-The family member had multiple conversations with the Resident Care Manager (RCM) and the Administrator regarding their concerns.

Telephone interview with Resident #2's Primary Care Provider (PCP) on 12/06/23 at 2:15pm revealed:
-Resident #2 was prescribed Carbidopa/Levodopa to control tremors related to Parkinson's disease.
-She was not aware the resident had missed 4 doses of the medication.
-Missed doses of the medication could increase the resident's tremors.

b. Review of Resident #2's local hospital emergency room (ER) summary visit report dated 11/08/23 revealed:
-The resident was seen in the local hospital (ER) for symptoms of chest pain and respiratory distress.
-The resident was diagnosed with a pulmonary embolism (blood clot in the lungs which can be life threatening without treatment)

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-There was an order to start the resident on Eliquis 5mg, 2 tablets (10mg) two times a day for 7 days, then 1 tablet two times a day for 23 days. (Eliquis is a medication used to treat and prevent blood clots).

Review of Resident #2's physician progress note dated 11/08/23 revealed:
-Resident was seen in the local hospital (ER) today and was diagnosed with a pulmonary embolism.
-The resident was prescribed Eliquis 5mg, 2 tablets (10mg) for 7 days to start on 11/08/23 and end on 11/15/23.
-The resident was prescribed Eliquis 5mg, 1 tablet for 23 days to start on 11/15/23.

Review of a signed physician progress note dated 11/22/23 revealed an order for Eliquis 5mg, 1 tablet two times day.

Review of Resident #2's November 2023 eMAR revealed:
-There was an entry for Eliquis 5mg, 2 tablets (10mg) two times daily for 7 days starting on 11/08/23.
-There was documentation Eliquis 5mg, 2 tablets (10mg) was administered from 11/08/23 though 11/14/23 at 8:00pm and from 11/09/23 through 11/15/23 at 8:00am.
-There was an entry for Eliquis 5mg, 1 tablet two times daily to be administered at 8:00am and 8:00pm.
-There was documentation Eliquis 5mg, 1 tablet was not administered on 11/15/23 at 8:00pm, 11/16/23 at 8:00am and 8:00pm.
-The resident missed 3 scheduled doses of Eliquis.

Telephone interview with the facility's contracted

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pharmacist on 12/07/23 at 9:42am revealed:
-Eliquis was a "blood thinner" and used to prevent blood clots.
-Resident #2's Eliquis 5mg, 2 tablets two times daily was dispensed on 11/08/23 for a 7-day supply.
-Resident #2's Eliquis 5mg, 1 tablet two times daily was dispensed on 11/15/23 for a quantity of 46 tablets for a 23-day supply.
-The Eliquis 5mg was delivered to the facility on 11/15/23.
-Resident #2's Eliquis 5mg, 1 tablet two times a daily was dispensed on 12/04/23 for a quantity of 60 for a 30-day supply
-Missed doses of Eliquis was "serious" and could place the resident at risk of developing another blood clot.

Review of a packing slip signed by a staff person at the facility that came with Resident #1's medications revealed Eliquis 5mg with a quantity of 46 tablets was delivered to the facilty on 11/17/23.

Telephone interview with Resident 2's Primary Cary Provider ({PCP) on 12/07/23 at 2:15pm revealed:
-Eliquis was prescribed for Resident #2 to treat and prevent blood clots.
-The resident was sent to the emergency room (ER) in November 2023 and diagnosed with a blood clot in the lungs.
-She was not aware Resident #2 missed 3 doses of Eliquis.
-She usually reviewed the resident's eMAR when she came to the facility.
-Missed doses of Eliquis could cause deep vein thrombosis (blood clot in the legs) or place the resident at increased risk of developing another blood clot in the lungs.

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D 358	Continued From page 12 Observation of Resident #2's medications on hand on 12/07/23 at 2:30pm revealed 4 doses of of Eliquis 5mg dispensed on 11/15/23 for a quantity of 46 and 60 doses of Eliquis 5mg dispensed on 12/05/23 for a quantity of 60. c. Review of Resident #2's signed physician progress note dated 09/27/23 revealed an order for Astepro Allergy 205.5mcg (0.15%), 2 spray twice daily. (Astepro is a medication used for allergy symptoms such as nasal congestion, sneezing, itching, and watery eyes, and running nose, also called Azelastine). Review of Resident #2's signed physician progress note dated 11/03/23 revealed an order for Azelastine 205.5mcg (0.15%), 2 sprays in each nostril twice daily. Review of Resident #2's signed physician medication order dated 11/28/23 revealed an order for Azelastine 205.5mcg (0.15%), 2 sprays into each nostril twice daily. Review of Resident #2's November electronic administration record (eMAR) 2023 revealed: -There was an entry for Azelastine SPR 0.1% (equivalent to Astelin/Astepro 0.1%), 1 spray in each nostril twice daily to be administered at 8:00am and 8:00pm. -There was documentation Azelastine SPR 0.1%, 1 spray in each nostril was administered from 11/04/23 to 11/30/23 at 8:00am and 8:00pm, except 11/10/23 8:00am due to awaiting medication from pharmacy. -There was an entry for Astepro 205.5MCG/ACT SPR, 2 sprays into each nostril twice daily, scheduled for administration at 8:00am and 8:00pm.	D 358		

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-There was documentation Astepro 205.5MCG/ACT SPR, 2 sprays was administered on 11/23/23 and 11/30/23 at 8:00am and 11/30/23 at 8:00pm.
-The Resident #2 received the incorrect dose of the nasal spray along with the ordered dose.

Review of Resident #2's December 2023 eMAR revealed:
-There was an entry for Azelastine SPR 0.1% (equivalent to Astelin/Astepro 0.1%), 1 spray in each nostril twice daily to be administered at 8:00am and 8:00pm.
-There was documentation Azelastine SPR 0.1%, 1 spray in each nostril was administered from 12/01/23 through 12/06/23 at 8:00am and from 12/01/23 through 12/05/23 at 8:00pm.
-There was an entry for Astepro 205.5MCG/ACT SPR, 2 sprays into each nostril twice daily to be administered at 8:00am and 8:00pm.
-There was documentation Astepro 205.5MCG/ACT SPR, 2 sprays into each nostril was administered from 12/01/23 thorough 12/06/23 at 8:00am and from 12/01/23 through 12/05/23 at 8:00pm.
-Resident #2 was received the incorrect dose of the nasal spray along with the ordered dose.

Telephone interview with the pharmacist on 12/07/23 at 9:42am revealed:
-Astepro 205.5MCG/ACT SPR was a new over-the-counter medication that was similar to Azestaline SPR 0.1%.
-The pharmacy was responsible for placing medication orders on the eMAR.
-One of the medications should have been taken off the eMAR by pharmacy.
-There had been multiple changes in the medication name originally starting with the order for Astepro, then Azestaline, then back to

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D 358	Continued From page 14 Astepro. -The current order was Astepro 205.5MCG, 2 sprays each nostril twice daily dated 11/28/23. Observation of Resident #2's medications on hand on 12/07/23 at 2:30pm revealed there was a bottle of Azestaline SPR 0.1% dispensed on 11/28/23 and a bottle of Astepro 205.5MCG/ACT SPR dispensed on 11/30/23. Interview with the MA on 12/07/23 at 3:00 revealed: -She did not realize Astepro and Azelastine were similar medications. -She administered Resident #2's medication according to the eMAR. _____ Interview with the MA on 12/07/23 at 3:00pm revealed: -The MAs were responsible for ensuring medications were on the medication cart. -MAs could reorder the medication from the pharmacy and also contact the prescriber if a new prescription was needed -The process was to reorder the medication when there were 7 tablets left in the bubble card. -She did not know why the process was not followed and the medications were not reordered. -If there was a problem with receiving the medication from pharmacy, she would notify the RCM or the Health and Wellness Coordinator (HWC) who would follow-up with pharmacy or the prescriber. Interview with the RCM on 12/07/23 at 3:30pm revealed: -The MAs were responsible for reordering medication from the pharmacy and contacting the prescriber if a new prescription was needed to ensure medications were on the medication cart.	D 358		

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D 358	Continued From page 15 -She expected medications to be reordered when there were between 7 to 10 tablets in the bubble card unless it was a controlled substance which would be ordered according to the prescriber's orders. -Medications were not reordered in a timely manner. Interview with the Administrator on 12/07/23 at 3:45 pm revealed: -The MAs were responsible for notifying the pharmacy when a medication needed to be reordered or notifying the prescriber when a medication needed a new prescription. -She expected medications to be on the medication cart and available to be administered to residents. -Medications should be ordered when there were between 5 and 7 tablets left in the bubble card. -If medications were not received when ordered, the MAs were expected to follow-up with pharmacy. -Medication cart audits were conducted every night by the the lead MA, but not an "eMAR" audit. -An "eMAR" audit included reviewing and comparing the orders against the medications in the cart and the eMAR for accuracy and for any clarification or communication that was needed by pharmacy or the prescriber. -More training and education were needed for the MAs and a process needed to be put in place for an "eMAR" audit to ensure residents' medications were available on the medication cart. 3. Review of Resident #1's current FL-2 dated 04/19/23 revealed diagnoses included	D 358		

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hypertension, diabetes mellitus type 2, and chronic pain.

a. Review of Resident #1's signed physician order dated 10/10/23 revealed an order for Bupropion HCL 150mg XL, take 3 tablets (450mg) daily. (Bupropion is a medication used to treat anxiety).

Review of Resident #1's electronic medication administration record (eMAR) for November 2023 revealed:
-There was an entry for Bupropion HCL 150mg XL, 3 tablets (450mg) daily.
-There was documentation Bupropion HCL 150mg XL was not administered on 11/17/23 and 11/18/23. (The medication was documented as not administered by medication aides' initials circled on the eMAR with "awaiting from pharmacy" as the reason).

Telephone interview on 12/07/23 at 9:43am with facilty's contracted pharmacist revealed:
-Resident #1's medications were on refill by request, there was an option for auto-refills.
-Bupropion HCL XL 150mg was dispensed on 9/16/23 for a 30-day supply (90 tablets).
-Bupropion HCL XL 150mg was dispensed on 11/18/2023 for a 30-day supply (90 tablets).
-There was no refills completed for Bupropion HCL XL 150mg in October 2023.
-The medication was used to treat depression.
-It was not advised to skip doses.
-Stopping the medication "cold turkey" or abruptly may cause side effects.
-There was no concern for missed doses of 1-2 days.

b. Review of Resident #1's signed physician order dated 10/10/23 revealed and order for Sertraline 25mg, take 1 tablet by mouth every

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morning.

Review of Resident #1's eMAR for November 2023 revealed:
-There was an entry for Sertraline 25mg, 1 tablet every morning.
-There was documentation Sertraline 25mg was not administered on 11/17/23 and 11/18/23. (The medication was documented as not administered by medication aides' initials circled on the MAR with "awaiting from pharmacy" as the reason).

Telephone interview with the facility's contracted pharmacist on 12/07/23 at 9:43am revealed:
-Sertraline 25 mg was dispensed on 9/16/23 for a 30-day supply (30 tablets).
-Sertraline 25mg was dispensed on 11/18/23 for a 30-day supply (30 tablets).
-There was no Sertraline 25mg dispensed in October 2023.
-The medication was used to treat depression.
-It was not advised to skip doses.
-The were no concerns for a few missed doses.
-If the medication was missed long term, there was a risk of increased symptoms of depression.

c. Review of Resident #1's signed physician order dated 10/10/23 revealed an order for Hydroco/APAP 10-325mg, take 1 tablet by mouth 4 times daily.

Review of Resident #1's eMAR for October 2023 revealed:
-There was an entry for Hydroco/APAP 10-325mg, 1 tablet 4 times a day.
-There was documentation Hydroco/APAP 10-325mg, 1 tablet was not administered on 10/03/23 and two doses were not administered on 10/04/23.
(The medication was documented as not

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administered by medication aides' initials circled on the MAR with "awaiting from pharmacy" as the reason)

Interview with Resident #1 on 12/07/23 revealed:
-During the summer 2023, she went without Hydroco/APAP for 3-4 days.
-She experienced side effects such as pain, achiness, feeling sluggish and having more pain in her back due to her spinal stenosis.
-She denied side effects of missing medications for 1-2 days.

Telephone interview with the facility's contracted pharmacist on 12/07/23 at 9:43am revealed:
-Hydroco/APAP 5-325mg (5 days supply) was written on 10/2/23 and filled by the pharmacy on the same day and delivered to the facility on 10/02/23.
-The medication was used to treat pain.
-Missed doses of the medication may cause withdrawal symptoms such as nausea, tremors, sweating, increased discomfort and pain.
-Side effects of missing dosages were non-life threatening.

d. Review of Resident #1's signed physician order dated 10/10/23 revealed and order for Ropinirole 1mg, take 1 tablet by mouth 4 times daily. (Ropinirole was used to treat Parkinson's disease and restless leg syndrome).

Review of Resident #1's eMAR for October 2023 revealed:
-There was an entry for Ropinirole 1mg, 1 tablet 4 times a day.
-There was documentation Ropinirole 1mg, 1 tablet was not administered on 10/18/23 at 8:00pm. (The medication was documented as not received by medication aides' initials circled

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D 358	Continued From page 19 on thee MAR with "awaiting from pharmacy" as the reason). Telephone interview with the facility's contracted pharmacist on 12/07/23 at 9:43am revealed: -Ropinirole 1mg was dispensed on 10/18/23 (1:30pm) for a 30-day supply (120 tablets). -Ropinirole 1 mg was dispensed on 11/12/23 for a 30-day supply (120 tablets). -The medication was used to treat Parkinson-like symptoms. -Missed doses could increase Parkinson symptoms such as tremors. -Missed doses could decrease motor functions. e. Review of Resident #1's signed physician order dated 10/10/23 revealed an order for Buspirone 7.5mg, take 1 tablet by mouth daily for anxiety. . Review of Resident #1's eMAR for October 2023 revealed : -There was an entry for Buspirone 7.5mg, 1 tablet daily. -There was documentation Buspirone 7.5 mg, 1 tablet was not administered on 10/16/23. (The medication was documented as not administered by medication aides' initials circled on the eMAR with "awaiting from pharmacy" as the reason) Telephone interview with the facility's contracted pharmacist on 12/07/23 at 9:43am revealed: -Buspirone (Buspar) 7.5mg was dispensed on 10/15/23 for a 30-day supply (60 tablets). -Buspirone 7.5mg was dispensed on 11/11/23 for a 30-day supply (60 tablets). -Buspirone 7.5mg was dispensed on 12/07/23 for a 30-day supply (60 tablets). -The medication was used to treat anxiety or unipolar depression. -There were no concerns over a couple of missed	D 358		

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D 358	Continued From page 20 dosages. f. Review of Resident's #1's subsequent physician orders dated 11/04/23 revealed Systane Comp Sol 0.6%, 1 drop in both eyes 3 times daily. Review of Resident's #1's electronic medication administration record (eMAR) December 2023 revealed: -There was an entry for Systane Comp Sol 0.6%, 1 drop in both eyes 3 times daily. -There was documentation Systane Comp Sol 0.6% was not administered from 12/01/23 through 12/04/23 (The medication was documented as not administered by medication aides' initials circled on the eMAR with "awaiting from pharmacy" as the reason). Telephone interview with facility's contracted pharmacist on 12/07/23 at 9:43am revealed: -Systane Comp Sol 0.6% was written and dispensed on 12/01/23. -The medication was used to treat eye irritation and dry eyes. -Not taking the medication as directed could increase eye irritation and dryness. Interview with a medication aide (MA) on 12/07/23 at 8:23am revealed: -MAs were responsible for reordering medications as needed. -If there were no remaining refills, the MA should contact the Primary Care Provider (PCP) to obtain an order. -Medications in pill packets were marked to indicate when it was time to refill the medication. -If medications were not in a pill packet, the MA ordered when the medication was visually low. -Medications were usually reordered 5-7 days before they run out.	D 358		

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-MA reported medications may run out if the refill request was not issued in time.
-There were 1-2 times per month a resident's medication may run out due to not placing refills in a timely manner
-The lead MAs did a random count and checked for narcotics only.

Interview with the Resident Care Manager (RCM) on 12/7/23 at 11:20am revealed:
-MAs (any shift) were responsible for medication refills in accordance with company policy.
-Cart audits were completed every Wednesday on 3rd shift.
-The RCM and Health and Wellness Coordinators (HWC) were responsible for checking the e-MAR system.
-The RCM and HWC did not complete cart audits.
-Medications should not run out and refills should be completed 5-7 days before the last dose was given.
-The eMARs were not crossed checked with medications on hand.

5. Review of the Resident #4's FL-2 dated 03/24/23 revealed diagnoses of Alzheimer's disease, dementia, hyperlipidemia, hypothyroidism, and history of chronic urinary tract infections.

Review of Resident #4's physician order dated 11/09/23 revealed:
-Stop senna 8.6mg tabs. (Senna was used to treat constipation).
-Start sennosides-docusate sodium 8.6mg- 50mg tablet. (Sennosides-docusate was used to treat constipation. Senna plus is the generic name).

Review of Resident #4's new prescription

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summary dated 11/13/23 revealed an order for Sennosides-Docusate 8.6mg- 50mg tablet, take 2 tablets by mouth at bedtime for constipation.

Review of Resident #4's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Senna tab 8.6mg 2 tablets 2 times a day for constipation scheduled for 8:00am and 8:00pm.
-The Senna tab 8.6mg was documented as administered from 11/01/23 to 11/30/23.
-There was an entry for Senna Plus 8.6mg- 50mg tablets 2 tablets daily at bedtime for constipation scheduled at 8:00pm.
-The Senna Plus 8.6mg- 50mg tablets were documented as administered from 11/14/23-11/30/23.

Review of Resident #4's December 2023 eMAR revealed:
-There was an entry for Senna tab 8.6mg 2 tablets 2 times a day for constipation scheduled for 8:00am and 8:00pm.
-The Senna tab 8.6mg was documented as administered from 12/01/23 to 12/06/23.
-There was an entry for Senna Plus 8.6mg- 50mg tablets 2 tablets daily at bedtime for constipation scheduled at 8:00pm.
-The Senna Plus 8.6mg- 50mg tablets were documented as administered from 12/01/23-12/06/23.

Interview with a medication aide (MA) on 12/06/23 at 1:46pm revealed:
-The facility followed a process when new orders came in for residents.
-When a new order came in, the MA faxed the order to the pharmacy, obtained a confirmation of the fax, placed the new order in a box, the order

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was then to be verified by comparing the order to the eMAR to ensure accuracy, once the order was verified the new medication was then scanned into the eMAR system, the pharmacy sheet was placed inside of a notebook kept in the work room for received and returned medications.
-The MA was responsible for notifying the wellness coordinator if a medication was discontinued and still on the eMAR.

Interview with the Memory Care Wellness Coordinator on 12/06/23 at 2:08pm revealed:
-When a new order comes in, the MA will retrieve it from the fax and fax it to the pharmacy.
-The MA who received the order from the fax was responsible for ensuring the MAR and order matched correctly.
-After the MA verified the order and MAR were correct, she was responsible to ensure orders waiting to be reviewed, approved, and rejected were compared to MAR and the order for accuracy.
-The medication should have been removed from the cart and the entry should have been removed from the MAR.
-She did not know why the process was not done.

Interview with the Resident Care Manager on 12/06/23 at 2:48pm revealed:
-The facility was responsible to ensure the medication order and the MAR matched.
-She started the verification process for the medication order, but it was not followed through.

Second interview with the Resident Care Manager on 12/07/23 at 11:35am revealed:
-The order for Resident #4 was placed in the new order bin, awaiting the MA or nurse to ensure the medication was in house, on the MAR and verified.

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D 358	Continued From page 24 -The verification process was to compare the order to the MAR. -The verification process did not happen. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/07/23 at 10:41am revealed: -The Senna and Senna Plus were used to treat constipation. -Both Senna and Senna Plus were the same medication except the plus added docusate. -Taking both medications at the same time could cause diarrhea for Resident #4. Interview with the Administrator on 12/06/23 at 2:43pm revealed the nurses had a process and the person processing the order should ensure the MAR and the order matched correctly. _____ The facility failed to administer medications as ordered for a resident (#2) who had a recent local hospital emergency room visit for chest pain and shortness of breath and was diagnosed with a pulmonary embolism (blood clot in the lungs). The resident missed 4 doses of a medication ordered to treat and prevent blood clots which increased the resident's risk of developing deep vein thrombosis or another blood clot in his lungs. He also had a diagnosis of Parkinson's Disease and missed 3 doses of the medication used to treat tremors associated with Parkinson's which resulted in the resident experiencing tremors to the degree it became difficult to drink a cup of coffee. This failure was detrimental to health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/07/23	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092210	A. BUILDING: _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 25 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 01/21/24.	D 358		