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WALTONWOOD LAKE BOONE	3560 HORTON STREET RALEIGH, NC 27607

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D 000	Initial Comments Th Adult Care Licensure Section conducted a follow-up survey and complaint investigation from 02/06/24 to 02/07/24. The complaint investigation was initiated by the Wake County Department of Social Services on 01/30/24.	D 000		
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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#1, #4) including errors with a controlled substance used to treat moderate to severe pain and a controlled substance used to treat nerve pain (#1) and a potassium supplement used to treat and prevent low potassium levels (#4). The findings are: 1. Review of Resident #1's current FL-2 dated 09/20/23 revealed diagnoses included diabetes	D 358		

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mellitus type 2, hypertension, dilated cardiomyopathy, atrial fibrillation, hyperlipidemia, sleep apnea, chronic anticoagulation, and cataract of both eyes.

a. Review of the facility's Pharmacy Services Policy revised 02/13/20 revealed all refills of medications must occur within 7 to 10 days before the last dose of the previous month to maintain resident supply.

Review of Resident #1's spine center provider's order dated 11/20/23 revealed an order for Xtampza ER 9mg twice a day. (Xtampza ER is a controlled substance used to treat moderate to severe pain.)

Review of Resident #1's spine center provider's order dated 01/18/24 revealed:
-There was an order for Xtampza ER 13.5mg 1 capsule twice a day.
-There was a fax confirmation date of 02/05/24 at the top of the page with the order.

Review of Resident #1's facility electronic progress notes revealed:
-01/30/24 at 10:13am: the physician was faxed for a refill of Xtampza ER 9mg capsule; resident had 11 capsules (5.5 days supply) remaining at that time.
-02/01/24 at 5:08pm: the physician was faxed again for a refill for Xtampza; resident had 7 capsules (3.5 days supply) remaining; the Assisted Living Wellness Coordinator (ALWC) was also notified.
-02/04/24 at 2:56pm: late entry for 02/03/24; the resident had 3 Xtampza ER 9mg capsules remaining; the physician had not responded to the faxes that were previously sent to refill the medication; the resident, ALWC, and the

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Resident Care Manager (RCM) were made aware.
-02/04/24 at 8:52pm: the resident received his last Xtampza ER.
-02/05/24 at 11:30am: the RCM called the physician's office and left a voice mail about a refill for Xtampza; the resident was out of medication.

Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Xtampza ER 9mg take 1 capsule twice daily scheduled for 8:00am and 8:00pm.
-Xtampza ER 9mg was documented as administered twice a day from 01/01/24 - 01/31/24.
-There was no entry for Xtampza ER 13.5mg as ordered on 01/18/24.

Review of Resident #1's February 2024 eMAR revealed:
-There was an entry for Xtampza ER 9mg take 1 capsule twice daily scheduled for 8:00am and 8:00pm.
-Xtampza ER 9mg was documented as not administered at 8:00am and 8:00pm on 02/05/24 due to "awaiting from pharmacy".
-The entry for Xtampza ER 9mg had a stop date of 02/05/24 at 10:00pm.
-There was an entry for Xtampza ER 13.5mg 1 capsule twice daily scheduled at 8:00am and 8:00pm.
-The date written noted on the eMAR for Xtampza ER 13.5mg was 01/18/24 but it was started on 02/06/24 at 8:00am.

Review of Resident #1's controlled substance (CS) logs for Xtampza ER 9mg revealed:

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-There was a CS log for Xtampza ER 9mg with a dispensed date of 12/29/23 for 60 capsules.
-The first dose was documented as administered on 01/06/24 at 8:48am and the last dose was documented as administered on 02/04/24 at 7:51pm, leaving a balance of 0.
-There were no subsequent CS logs for Xtampza ER 9mg and no doses were documented as administered on 02/05/24.

Review of Resident #1's CS logs for Xtampza ER 13.5mg revealed:
-There was a CS log for Xtampza ER 13.5mg with a dispensed date of 02/05/24 for 60 capsules and only 2 doses had been documented as administered.
-The first dose was documented as administered on 02/06/24 at 8:20am and a second dose was documented as administered on 02/07/24 at 8:02am, leaving a total balance of 58 capsules.
-There was no Xtampza ER 13.5mg capsule documented as administered on 02/06/24 at 8:00pm as ordered.

Observation of Resident #1's medications on hand on 02/07/24 at 4:40pm revealed:
-There was a supply of Xtampza ER 13.5mg capsules dispensed on 02/05/24.
-There were 58 of 60 capsules of Xtampza ER 13.5mg remaining.
-There were no Xtampza ER 9mg capsules on hand.

Interview with a medication aide (MA) on 02/07/24 at 4:55pm revealed:
-The MAs were responsible for ordering medications when there was an 8-day supply of medication remaining.
-She faxed Resident #1's spine center provider several times but the provider's office never

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responded to her knowledge.
-The resident did not complain of pain when he was out of Xtampza ER.

Interview with the ALWC on 02/07/24 at 11:41am revealed:
-The MAs had been faxing Resident #1's spine center provider to get a new order for Xtampza ER but the provider did not respond.
-When the MAs told her they were out of Resident #1's Xtampza ER (on 02/05/24), she called the spine center provider's office.
-The spine center provider indicated they had already faxed a prescription for the Xtampza ER.
-The spine center provider's office faxed a prescription dated 01/18/24 for Xtampza ER 13.5mg to the facility on 02/05/24.
-The facility never received the faxed order for Xtampza ER dated 01/18/24 until 02/05/24.

Interview with the RCM on 02/07/24 at 11:10am revealed:
-The MAs should fax the provider when there was a 7-day supply of a controlled substance remaining.
-If no response, the MAs should resend the fax at least every other day.
-The MAs should notify the ALWC if they did not receive a response back from the provider.
-The ALWC was responsible for contacting the provider.
-The facility had difficulties getting refills for Xtampza ER for Resident #1.
-The MAs notified the ALWC on 02/05/24 that Resident #1 was out of Xtampza ER.
-The MAs had sent several faxes to Resident #1's spine center provider regarding the Xtampza ER.
-The ALWC called the spine center provider and left a message on 02/05/24.
-The ALWC had called the spine center provider

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prior to 02/05/24 and should have documented it in the electronic progress notes.
-The spine center provider sent a fax on 02/05/24 with a new prescription for Xtampza ER dated 01/18/24 and the dosage had changed.
-The MA should have administered Xtampza ER 13.5mg to Resident #1 last night on 02/06/24.
-The MA made an error last night on 02/06/24 and administered two Lyrica capsules instead of one Lyrica and one Xtampza ER. (Lyrica is a controlled substance used to treat nerve pain.)

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/07/24 at 3:18pm revealed:
-The pharmacy received a faxed prescription dated 01/18/24 for Xtampza ER 13.5mg twice a day for Resident #1 on 02/05/24 from a spine center provider.
-They did not receive the prescription dated 01/18/24 prior to 02/05/24.
-They dispensed 60 Xtampza ER 13.5mg capsules on 02/05/24 and it was delivered to the facility on 02/05/24 at 11:00pm.
-Prior to that, they had dispensed 60 Xtampza ER 9mg capsules each on 12/29/23 and 12/03/23.
-For controlled substances, the facility usually let the provider know when they needed a new prescription and the provider usually sent electronic prescriptions.
-There was no documentation in the pharmacy records that the facility contacted them regarding the need for a refill on Resident #1's Xtampza ER.

Telephone interview with a pharmacy technician at Resident #1's spine center provider's office on 02/07/24 at 4:17pm revealed:
-Resident #1 was seen by the spine center provider for a visit on 01/18/24.

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D 358	Continued From page 6 -She usually faxed any prescriptions from patient visits to the pharmacy and the facility. -She was not working on 01/18/24 so Resident #1's prescriptions for that visit were faxed to the facility's contracted pharmacy. -A prescription for an increase to Xtampza ER 13.5mg twice a day was faxed to the pharmacy on 01/18/24. -She did not see a fax confirmation to indicate the prescription was faxed to the facility on 01/18/24. -The facility faxed a refill request to their office a few times and each time she sent a fax to the facility that the resident should not be low on the Xtampza ER because a prescription was sent to the pharmacy on 01/18/24. -She received a fax confirmation each time she responded via fax to the facility (could not recall specific dates). -No one from the facility called them regarding her faxed response to their request for a new prescription for Xtampza ER. -The provider increased Resident #1's Xtampza ER from 9mg to 13.5mg on 01/18/24 because the resident was having increased pain and the resident was scheduled for right shoulder surgery in March 2024. -She was contacted by the facility's ALWC on 02/05/24 regarding the Xtampza ER so she refaxed the prescription to the facility and the pharmacy on 02/05/24 at 11:24am. -Missing the doses of Xtampza ER could potentially cause the resident to have increased or uncontrolled pain. -Not starting the increased Xtampza ER 13.5mg dosage when ordered on 01/18/24 was not a big concern as they typically told patients to finish out their current dosage of medication and then start the new dosage. b. Review of Resident #1's spine center	D 358		

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provider's order dated 12/15/23 revealed an order for Lyrica 75mg 1 capsule twice a day. (Lyrica is a controlled substance used to treat nerve pain.)

Review of Resident #1's spine center provider's order dated 01/18/24 revealed:
-There was an order for Lyrica 100mg 1 capsule twice a day.
-The faxed stamp date at the top of the page was 02/05/24.

Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Lyrica 75mg 1 capsule twice daily scheduled at 8:00am and 8:00pm.
-Lyrica 75mg was documented as administered twice daily from 01/01/24 - 01/31/24.
-There was no entry for Lyrica 100mg, and none documented as administered in January 2024.

Review of Resident #1's February 2024 eMAR revealed:
-There was an entry for Lyrica 75mg 1 capsule twice daily scheduled at 8:00am and 8:00pm.
-Lyrica 75mg was documented as administered twice daily from 02/01/24 - 02/05/24.
-Lyrica 75mg was noted to be discontinued with a stop date of 02/05/24.
-There was an entry for Lyrica 100mg 1 capsule twice daily scheduled at 8:00am and 8:00pm.
-Lyrica 100mg was documented as administered from 8:00am on 02/06/24 through 8:00am on 02/07/24.

Review of Resident #1's controlled substance (CS) logs for Lyrica 75mg and Lyrica 100mg revealed:
-There was a CS log for Lyrica 75mg with a dispensed date of 01/15/24 for 60 capsules.

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D 358	Continued From page 8 -The first dose was documented as administered on 01/20/24 at 8:52am and the last dose was documented as administered on 02/06/24 at 7:26pm, leaving a balance of 25 capsules. -There was a CS log for Lyrica 100mg with a dispensed date of 02/05/24 for 60 capsules with 3 doses documented as administered. -The first dose was documented as administered on 02/06/24 at 8:20am and a second dose was documented as administered on 02/06/24 at 7:26pm. -There was documentation on the CS logs that Resident #1 was administered Lyrica 75mg and Lyrica 100mg for the 8:00pm dose on 02/06/24 for a total of 175mg of Lyrica. -The resident should have received Lyrica 100mg instead of 175mg at 8:00pm on 02/06/24. Observation of Resident #1's medications on hand on 02/07/24 at 4:40pm revealed: -There was a supply of Lyrica 100mg capsules dispensed on 02/05/24. -There were 57 of 60 capsules of Lyrica 100mg remaining. -There was a supply of Lyrica 75mg capsules dispensed on 01/15/24. -There were 25 of 60 capsules of Lyrica 75mg remaining. Telephone interview with a medication aide (MA) on 02/07/24 at 5:20pm revealed: -She did not realize she had made an error last night with Resident #1's medications until the Resident Care Manager (RCM) called her today, 02/07/24. -She administered 2 medications to Resident #1 last night, but she did not scan the labels on the medication cards. -She thought she pulled the cards for Xtampza and Lyrica.	D 358		

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-She did not realize the dosage for Lyrica had changed.
-The Lyrica 75mg card should have been pulled from the medication cart by the MA on duty when the order changed to Lyrica 100mg.
-She documented she administered Xtampza and Lyrica on the eMAR last night (02/06/24) because that was what she thought she had administered.
-She should have scanned the labels and read the labels more closely before administering the medications.
-Resident #1 did not complain of pain last night and he was not sleepy or oversedated.

Interview with Resident #1 on 02/07/24 at 5:40pm revealed:
-He usually received two pills at night.
-He received two pills from the MA last night (02/06/24).
-He did not have any problems with pain or drowsiness last night.

Interview with the Assisted Living Wellness Coordinator (ALWC) on 02/07/24 at 11:41am revealed:
-The facility did not receive Resident #1's prescription for Lyrica dated 01/18/24 until 02/05/24.
-She had not noticed there was an order change for Lyrica on the prescription dated 01/18/24.
-She did not realize Resident #1 should have been receiving Lyrica 100mg instead of 75mg since 01/18/24.

Interview with the RCM on 02/07/24 at 11:10am revealed:
-The spine center provider sent a fax on 02/05/24 with a new prescription for Lyrica dated 01/18/24 and the dosage had changed to 100mg.
-The MA made a medication error last night on

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02/06/24 when she administered Lyrica 75mg and Lyrica 100mg to Resident #1.
-The Lyrica order was increased to 100mg and the resident should have only received Lyrica 100mg.
-Lyrica 75mg should have been removed from the medication cart by the MA on duty when the order was changed to Lyrica 100mg.
-The MA should have administered Lyrica 100mg to Resident #1 last night on 02/06/24.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/07/24 at 3:18pm revealed:
-The pharmacy received a faxed prescription dated 01/18/24 for Lyrica 100mg twice a day for Resident #1 on 02/05/24 from a spine center provider.
-They did not receive the prescription dated 01/18/24 prior to 02/05/24.
-They dispensed 60 Lyrica 100mg capsules on 02/05/24 and it was delivered to the facility on 02/05/24 at 11:00pm.
-Prior to that, they had dispensed 60 Lyrica 75mg capsules on 01/15/24.
-For controlled substances, the facility usually let the provider know when they needed a new prescription and the provider usually sent electronic prescriptions.
-There was no documentation in the pharmacy records that the facility contacted them regarding Resident #1's Lyrica prior to 02/05/24.

Telephone interview with a pharmacy technician at Resident #1's spine center provider's office on 02/07/24 at 4:17pm revealed:
-Resident #1 was seen by the spine center provider for a visit on 01/18/24.
-She usually faxed any prescriptions from patient visits to the pharmacy and the facility.

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-She was not working on 01/18/24 so Resident #1's prescriptions for that visit were faxed to the facility's contracted pharmacy.
-A prescription for an increase to Lyrica 100mg twice a day was faxed to the pharmacy on 01/18/24.
-She did not see a fax confirmation to indicate the prescription was faxed to the facility on 01/18/24.
-The facility faxed a refill request to their office a few times and each time she sent a fax to the facility that a prescription was sent to the pharmacy on 01/18/24.
-She received a fax confirmation each time she responded via fax to the facility (could not recall specific dates).
-No one from the facility called them regarding her faxed response to their request for a new prescription for Lyrica.
-The provider increased Resident #1's Lyrica dosage on 01/18/24 because the resident was having increased pain and the resident was scheduled for right shoulder surgery in March 2024.
-She was contacted by the facility's ALWC on 02/05/24 so she refaxed the prescription to the facility and the pharmacy on 02/05/24 at 11:24am.
-Not starting the increased Lyrica 100mg dosage when ordered on 01/18/24 was not a big concern as they typically told patients to finish out their current dosage of medication and then start the new dosage.
-Receiving Lyrica 75mg and 100mg at the same time could cause the resident to have increased drowsiness.

2. Review of Resident #4's current FL-2 dated 11/14/23 revealed:
-Diagnoses included urinary retention, symptomatic benign prostatic hypertrophy, and atherosclerotic disease.

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D 358	Continued From page 12 -There was an order for Potassium Chloride ER 10mEq, 1 tablet by mouth 3 times weekly on Monday, Wednesday and Friday. (Potassium Chloride is used to treat and prevent low potassium levels.) Review of a hospital emergency room (ER) After Visit Summary (AVS) dated 02/01/24 revealed: -Resident #4 was seen for syncope (fainting or sudden loss of consciousness). -Diagnoses included fall, low blood potassium, and head injury. -There was a change to the Potassium Chloride to 20mEq, 1 tablet by mouth 2 times daily for 7 days. -The Potassium Chloride 20mEq prescription was sent to a local pharmacy. Review of Resident #4's electronic progress note dated 02/01/24 revealed: -Resident #4 had a new order for Potassium Chloride 20mEq by mouth two times a day for 7 days. -A new order was faxed to the facility's contracted pharmacy. Review of Resident #4's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Potassium Chloride 10mEq 1 tablet three times weekly on Monday, Wednesday and Friday scheduled at 8am. - Potassium Chloride 10mEq was documented as administered from 02/02/24 - 02/05/24. -There was no entry for Potassium Chloride 20mEq on the eMAR and none was documented as administered. Review of Resident #4's record revealed there was no current signed order for Potassium	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 _____	R 02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 13 Chloride 20mEq in the record. Observations of Resident #4's medications on hand on 02/07/24 at 4:45pm revealed: -There was a supply of Potassium Chloride 10mEq on hand that was dispensed on 01/14/24 and was to be administered 3 times weekly on Monday, Wednesday, and Friday. -There were 5 Potassium Chloride 10mEq tablets on hand. -There were no Potassium Chloride 20mEq tablets available to be administered. Interview of the Assisted Living Wellness Coordinator (ALWC) on 02/07/24 at 4:10pm revealed: -She was not aware Resident #4's Potassium Chloride dosage changed. -She was responsible for reviewing the hospital discharge papers. -She was responsible for sending hospital discharge papers to the facility's contracted pharmacy. -The process was to check the eMAR the next day to see if the order was in the system. -The eMAR was not checked the next day to see if there was an order in the system for Resident #4's Potassium Chloride. -She was out of the office on the day of Resident #4's return to the facility on 02/01/24. -In her absence, a medication aide (MA) faxed the hospital discharge paper to the pharmacy. -Hospital staff usually called the facility to notify them of a resident's discharge and discharge papers were usually sent to the facility prior to the resident returning so she could review any changes. -Facility staff were not informed by hospital staff that Resident #4 would be returning to the facility prior to his return on 02/01/24.	D 358		

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D 358	Continued From page 14	D 358		

-Resident #4's hospital discharge papers were not sent to the facility prior to his return, but were sent with the resident when he returned on 02/01/24.
-She did not see the change to Resident #4's Potassium Chloride the next day because the MA had put the AVS in the contracted facility provider's box.
-The facility's contracted pharmacy would not fill a prescription using an AVS because it was not signed by a physician.
-The MA did not know the AVS was not signed by a physician.
-The facility never received a copy of the signed order for Potassium Chloride 20mEq.

Interview with the MA on 02/07/24 at 4:30pm revealed:
-She remembered Resident #4's hospital papers with the change to the Potassium Chloride.
-Hospital discharge papers were supposed to be placed in either the facility's contracted primary care provider's (PCP) box or the Resident Care Manager's (RCM) box.
-She faxed Resident #4's hospital discharge papers to the facility's contracted pharmacy and then placed the papers in the box of either the ALWC, RCM, or the facility's contracted PCP.
-She could not recall which box she placed the discharge paper in.
-The facility's contracted pharmacy usually automatically added the medication to the eMAR.
-Third shift MAs were supposed to verify that the orders were in the system because the medications would be on eMAR on third shift.
-She did not know the AVS was not signed by a physician.
-She told Resident #4's family member not to pick the medication up from the local pharmacy because the order had to be sent to the facility's

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contracted pharmacy.
-The RCM usually followed up behind the MAs to ensure that the orders were done.

Telephone interview with a pharmacist at the local pharmacy on 02/07/24 at 5:50pm revealed:
-Potassium Chloride 20mEq tablets for Resident #4 were delivered to the facility on 02/01/24.
-He did not think there would have been an adverse effect to the resident not receiving the increased dosage of the Potassium Chloride 20mEq 1 tablet by mouth 2 times daily for 7 days since it was only ordered to be increased for 1 week.

Interview with the RCM on 02/07/24 at 5:54pm revealed:
-She was off last week when Resident #4 returned to the facility on 02/01/24.
-The ALWC was responsible for following up on orders.
-She was not aware of the Potassium Chloride change from 10mEq 3 times weekly to Potassium Chloride 20mEq 1 tablet 2 times daily for 7 days for Resident #4.
-She was not aware of a delivery of the Potassium Chloride 20mEq tablets for Resident #4 on 02/01/24 from a local pharmacy.
-She had not seen any Potassium Chloride 20mEq tablets on hand for Resident #4.

Interview with Resident #4 on 02/07/24 at 3:40pm revealed:
-He was tired but unsure how long he had been tired.
-Resident #4 did not answer anymore questions.

Attempted telephone interview with Resident #4's PCP on 02/07/24 at 4:05pm was unsuccessful.

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D 358	Continued From page 16 Attempted telephone interview with the facility's contracted pharmacy on 02/07/24 at 5:48pm was unsuccessful.	D 358		