STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051072	A. BUILDING: _____ B. WING _____	R 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARES ADULT HOMES # 2	103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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{D 000}	Initial Comments	{D 000}		

The Adult Care Licensure Section conducted a follow-up survey on 01/18/24.

D 237 10A NCAC 13F .0703 (c-3) Tuberculosis Test Medical Examination And Im

10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations

The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:

(3) In the case of an emergency admission, the medical examination and completion of the FL-2 or MR-2 as required by this rule shall be within 72 hours of admission as long as current medication and treatment orders are available upon admission or there has been an emergency medical evaluation, including any orders for medications and treatments, upon admission.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure that the examination date on a resident's FL2 was within 72 hours of a resident's emergency admission to the facility (Resident #2).

The findings are:

Review of Resident #2's current FL2 dated 02/23/23 revealed diagnoses included paranoid

D 237

All Chart Audit and updated and RCC will do on A Weekly check 3/3/24

Going forward on Placement or any Emergency Placement RCC And Administrator will make sure that FL-2 is updated and clarify within 72 hours by the Provider, Medication order be current on their Admissions 3-3-24

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angie Pearson | TITLE: Administrator | (X6) DATE: 02-23-24

Reviewed and acknowledged on 03/07/24 by JL

Revised 2-26-24 AD
Revised 03-04-24 AD
Revised 03-04-24 AD

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schizophrenia, anxiety disorder, essential hypertension, and peripheral vascular disease.

Review of Resident #2's Resident Register revealed an admission date of 12/21/23.
Interview with a medication aide (MA) on 01/18/24 at 11:18am revealed:
-The Administrator or Resident Care Coordinator (RCC) verified the residents' medication orders at admission.
-He was unsure if Resident #2 had seen his primary care provider (PCP) since his admission to the facility.

Interview with the RCC on 01/18/24 at 11:50am revealed:
-The RCC or Administrator was responsible for verifying the residents' medication orders and FL2 upon admission.
-She was not employed at the facility when Resident #2 was admitted on 12/21/23.
-She started working at the facility as the RCC on 01/01/24.

Interview with Resident #2's PCP on 01/18/24 at 5:24pm revealed:
-He visited the facility weekly.
-His initial visit with Resident #2 was on 01/10/24.
-The last FL2 he had on file for Resident #2 was dated 02/23/23 and was signed by his previous PCP.
-The facility did not request a new FL2 for Resident #2 at the visit on 01/10/24.

Interview with the Administrator on 01/18/24 at 5:40pm revealed:
-It was the responsibility of the MA, RCC, or Administrator to verify residents' admission medication orders and FL2.
-Resident #2 previously resided at a facility that

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closed abruptly, so his admission was an emergency admission.
-She became aware of Resident #2's pending admission on 12/20/23 and he was admitted 12/21/23.
-She was aware medication orders needed to be verified if the FL2 was dated more than 24 hours prior to admission.
-She contacted the facility's contracted primary care service on 12/29/23 to add Resident #2 to the list of residents being seen by the PCP on 01/03/24.
-She was unaware Resident #2 was not seen by the facility's PCP until 01/10/24.
-She was unsure if any of the staff members had asked the PCP to see Resident #2 prior to 01/10/24.
-The facility should have followed through with ensuring that Resident #2's admission medication orders were verified and an updated FL2 was completed.

{D 358} 10A NCAC 13F .1004(a) Medication Administration

{D 358}

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 A2 VIOLATION.

The Type A2 Violation was abated.

(D358)
RNE Med Tech done a Current Chart and Meds cart Audit to ensure that all orders are current And RCC will monitor MARS, Charts And med cart ON A weekly Check And Administrator will monitor ON A monthly Check to ensure that all Order being follow as the provider orders, 3-3-24

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{D 358}	Continued From page 3 Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents (#1) sampled including errors with medications used to treat lung disease and breathing problems, a long-acting insulin used to lower blood sugar levels, and a controlled substance for moderate to severe pain. The findings are: Review of Resident #1's current FL-2 dated 01/12/23 revealed diagnoses included chronic obstructive pulmonary disease, chronic back pain, type 2 diabetes, hypertension, coronary artery disease, hyperlipidemia, debility, chronic kidney disease, and depression. a. Review of Resident #1's physician's order dated 12/13/23 revealed an order for Tresiba FlexTouch insulin pen, inject 25 units twice a day; do not give insulin if blood sugar is less than (<) 100; call physician if blood sugar is greater than (>) 450. (Tresiba is long-acting insulin used to lower blood sugar levels in diabetics.) Review of Resident #1's December 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Tresiba FlexTouch inject 25 units under the skin 2 times a day for diabetes; do not give if blood sugar is < 100; if blood sugar > 450, call physician. -Tresiba FlexTouch was scheduled to be administered at 8:00am and 8:00pm. -Tresiba was documented as administered on 2	{D 358}	(D358) All Med Tech had a retrained by the LHPS Nurse on Diabetes Disease man insulin order of following the Provider written orders. Ace will do a daily monitor of MAR's And Administrator will do a weekly monitoring of MAR's.	

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of 2 occasions when the blood sugar was < 100 and should not have been administered from 12/22/23 - 12/31/23.
-On 12/22/23 at 8:00pm, the blood sugar was 97 but Tresiba FlexTouch was documented as administered.
-On 12/30/23 at 8:00pm, the blood sugar was 68 but Tresiba FlexTouch was documented as administered.
-The resident's blood sugar ranged from 68 - 258 from 12/22/23 - 12/31/23.

Review of Resident #1's January 2024 eMAR revealed:
-There was an entry for Tresiba FlexTouch inject 25 units under the skin 2 times a day for diabetes; do not give if blood sugar is < 100; if blood sugar > 450, call physician.
-Tresiba FlexTouch was scheduled to be administered at 8:00am and 8:00pm.
-Tresiba was documented as administered on 12 of 12 occasions when the blood sugar was < 100, ranging from 73 - 99, and should not have been administered.
-On 01/03/24 at 8:00am, the blood sugar was 93 but Tresiba FlexTouch was documented as administered.
-On 01/04/24 at 8:00pm, the blood sugar was 99 but Tresiba FlexTouch was documented as administered.
-On 01/05/24 at 8:00am, the blood sugar was 98 but Tresiba FlexTouch was documented as administered.
-On 01/07/24 at 8:00am, the blood sugar was 85 but Tresiba FlexTouch was documented as administered.
-On 01/08/24 at 8:00pm, the blood sugar was 93 but Tresiba FlexTouch was documented as administered.
-On 01/10/24 at 8:00am, the blood sugar was 98

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but Tresiba FlexTouch was documented as administered.
-On 01/11/24 at 8:00am, the blood sugar was 99 but Tresiba FlexTouch was documented as administered.
-On 01/11/24 at 8:00pm, the blood sugar was 73 but Tresiba FlexTouch was documented as administered.
-On 01/16/24 at 8:00pm, the blood sugar was 79 but Tresiba FlexTouch was documented as administered.
-On 01/17/24 at 8:00am, the blood sugar was 97 but Tresiba FlexTouch was documented as administered.
-On 01/17/24 at 8:00pm, the blood sugar was 78 but Tresiba FlexTouch was documented as administered.
-On 01/18/24 at 8:00am, the blood sugar was 84 but Tresiba FlexTouch was documented as administered.
-The resident's blood sugar ranged from 73 - 202 from 01/01/24 - 01/18/24.

Interview with a medication aide (MA) on 01/18/24 at 2:41pm revealed:
-Resident #1 received Tresiba FlexTouch insulin every morning and every night at bedtime.
-He had not held Resident #1's Tresiba because he had not noticed the instructions not to administer it if the blood sugar was < 100.
-When the resident's blood sugar got low, "like 79 or 80", he gave the resident orange juice.
-Resident #1 would sometimes "shake" when his blood sugar was low but the resident also would "shake" sometimes when his blood sugar was normal.

Telephone interview with a second MA on 01/18/24 at 4:55pm revealed:
-Resident #1 received Tresiba FlexTouch insulin

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every morning and every night at bedtime
-He had never held Resident #1's Tresiba FlexTouch insulin.
-He would hold the insulin if the resident's blood sugar was way too low, "like 50 or 70".
-He had not noticed the instructions not to administer Resident#1's Tresiba FlexTouch insulin if the blood sugar was < 100.

Interview with the Resident Care Coordinator (RCC) on 01/18/24 at 4:24pm revealed:
-The MAs were responsible for reading the eMARs and administering or holding medications according to the order.
-Resident #1's Tresiba FlexTouch insulin should not have been administered when the resident's blood sugar was < 100.
-Administering Tresiba when the resident's blood sugar was < 100 could have made the resident's blood sugar go to low or cause "diabetic shock".
-The Administrator was currently on leave so she was not aware of a system to check the eMARs.
-She started working at the facility on 01/01/24, but just got a code to access the eMARs yesterday, 01/17/24.

Telephone interview with the Administrator on 01/18/24 at 5:20pm revealed:
-The MAs were supposed to read the eMARs and follow the instructions when administering medications.
-The MAs should not have administered Resident #1's Tresiba FlexTouch insulin when the resident's blood sugar was < 100.
-Administering the Tresiba FlexTouch insulin when the resident's blood sugar was < 100 could potentially jeopardize the resident and cause his blood sugar to drop even lower.
-She had been out on leave since 01/02/24 but prior to that she was checking the eMARs once a

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week for accuracy.
-She had not noticed the MAs were documenting they administered Resident #1's insulin even when the blood sugar was < 100.

Telephone interview with Resident #1's primary care provider (PCP) on 01/18/24 at 5:26pm revealed:
-The order to hold Tresiba FlexTouch insulin for Resident #1 was in place to prevent the resident's blood sugar from dropping too low.
-Receiving insulin when the resident's blood sugar was low could have serious outcomes.
-Since Tresiba was long-acting insulin, serious outcomes were probably not likely but could still occur such as low blood sugar, passing out which could lead to a fall with head injury, and death.

Interview with Resident #1 on 01/18/24 at 4:49pm revealed:
-He usually received Tresiba FlexTouch insulin twice a day even if his blood sugar was low.
-He was not sure why the MAs administered the insulin when his blood sugar was low.
-He usually got nervous, sweaty, and ill when his blood sugar was low.
-He had to drink orange juice when his blood sugar was low.

b. Review of Resident #1's current FL-2 dated 01/12/23 revealed an order for Budesonide 0.5mg/2ml, inhale 1 vial via nebulizer two times a day. (Budesonide is used to treat inflammation of the airways in lung disease.)

Review of Resident #1's physician's order sheet dated 12/13/23 revealed an order for Budesonide 0.5mg/2ml, inhale 1 vial via nebulizer every 12 hours for shortness of breath/wheezing.

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Review of the facility's undated pharmacy policy and procedure manual revealed:
-Re-orders of non-batch filled medications should be done on a pharmacy communication sheet and faxed to the pharmacy no later than 3:00pm.
-If a medication was urgently needed between regularly scheduled delivery/pickup (night, weekends, or holidays), the facility staff should page the pharmacist on-call to arrange filling and delivering the medication in question.
-The facility staff was responsible for ensuring medications were checked every week to ensure a continuous supply over a weekend or holiday.
-Approximately a one-week supply should be maintained in the facility at all times.

Review of Resident #1's December 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Budesonide 0.5mg/2ml, inhale 1 vial via nebulizer every 12 hours for shortness of breath/wheezing scheduled for 8:00am and 8:00pm.
-Budesonide was documented as not administered at 8:00pm on 12/31/23 due to "waiting on pharmacy".

Review of Resident #1's January 2024 eMAR revealed:
-There was an entry for Budesonide 0.5mg/2ml, inhale 1 vial via nebulizer every 12 hours for shortness of breath/wheezing scheduled for 8:00am and 8:00pm.
-Budesonide was documented as not administered from 8:00am on 01/01/24 - 8:00pm on 01/02/24 due to waiting on prescription and waiting on delivery.

Observation of Resident #1's medications on hand on 01/18/24 at 11:11am revealed:

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-There was a supply of Budesonide 0.5mg/2ml inhalation suspension dispensed on 12/30/23.
-There were 9 of 30 vials remaining.

Interview with a medication aide (MA) on 01/18/24 at 2:41pm revealed:
-He did not recall why Resident #1 ran out of Budesonide, but the Budesonide should have been ordered before it ran out.
-He was still getting used to the new eMAR system and ordering system.
-The MAs were responsible for ordering medications and the Budesonide should have been ordered when there were 5 to 6 vials remaining.
-He was not aware of a system to use a back-up pharmacy to get medication for residents.
-He was not aware of Resident #1 having trouble breathing while he was out of the Budesonide.

Telephone interview with a second MA on 01/18/24 at 4:55pm revealed:
-He could not recall why Resident #1 ran out of Budesonide.
-When he documented "awaiting pharmacy" on the eMAR, it was because the medication had run out.
-He was not aware of a system to use a back-up pharmacy to get medication for residents.
-He observed Resident #1 breathing heavy at times, but the resident had never complained to him about being short of breath.

Interview with the Resident Care Coordinator (RCC) on 01/18/24 at 4:24pm revealed:
-The MAs were responsible for ordering medications when there was a 1-week supply remaining.
-She was not aware Resident #1 had run out of Budesonide.

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-The MAs should notify her if a resident's medication was unavailable.
-She started working at the facility on 01/01/24, but just got a code to access the eMARs yesterday, 01/17/24.
-The Administrator was currently on leave, so she was not aware of a system to check the eMARs.
-She was concerned that Resident #1 ran out of the Budesonide because the resident had a history of breathing problems.
-She had not observed Resident #1 being short of breath.

Telephone interview with a pharmacist at the facility's contracted pharmacy provider on 01/18/24 at 2:25pm revealed:
-They started servicing the facility on 11/01/23.
-They received an order for Resident #1's Budesonide on 11/08/23 and dispensed a 15-day supply on that same day.
-They dispensed a 15-day supply on 12/08/23 and another 15-day supply on 12/30/23.
-Budesonide was not a batch filled medication, so the facility had to request refills when needed for this medication.
-They did not receive a request from the facility to refill the medication after 12/08/23 until 12/30/23.
-The supply dispensed on 12/30/23 was delivered to the facility on 01/02/24.
-She was unsure of why there was a delay in delivering the supply dispensed on 12/30/23 because they usually delivered the same day it was dispensed.
-The facility had an option to call the pharmacy and they could call the medication order into a back-up pharmacy so the medication could have been received sooner.
-The facility did not request the Budesonide be called into a back-up pharmacy provider.

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Telephone interview with the Administrator on 01/18/24 at 5:20pm revealed:
-The MAs were responsible for ordering medications when there was about a 5-day to 7-day supply of medication remaining.
-The MAs should notify her or the RCC when a resident's medication was unavailable.
-She was not notified that Resident #1's Budesonide ran out on 12/31/23.
-The MAs could have also contacted the pharmacy or the primary care provider (PCP) if refills were needed.
-Not receiving the Budesonide could have caused Resident #1 to have more breathing problems.
-She did not know if Resident #1 had more breathing problems when he missed the doses of Budesonide because she had been out on leave since 01/02/24.

Telephone interview with Resident #1's PCP on 01/18/24 at 5:26pm revealed:
-Resident #1 was "somewhat" short of breath each time he saw the resident for a care visit.
-Resident #1 needed to receive Budesonide as ordered because he had severe chronic obstructive pulmonary disease.
-Not receiving Budesonide could exacerbate the resident's chronic obstructive pulmonary disease, causing shortness of breath and difficulty breathing which could lead to hospitalization and respiratory arrest.

Interview with Resident #1 on 01/18/24 at 4:49pm revealed:
-The facility ran out of his Budesonide at the end of December 2023 and first part of January 2024.
-He had shortness of breath when he did not receive the Budesonide.
-He had to use his Albuterol inhaler (used as rescue inhaler to treat acute episode of shortness

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARES ADULT HOMES # 2	103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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of breath) more often while he was out of the Budesonide from 12/31/23 - 01/02/24.

c. Review of Resident #1's physician's order dated 12/13/23 revealed an order for Xtampza ER 18mg every 12 hours as needed (prn) for pain. (Xtampza ER is a controlled substance used to treat moderate to severe pain.)

Review of Resident #1's December 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Xtampza ER 18mg take 1 capsule every 12 hours as needed for pain.
-Xtampza ER 18mg was documented as administered on 18 occasions from 12/22/23 - 12/31/23.
-Xtampza ER was documented as administered less than 12 hours apart on 9 occasions from 12/22/23 - 12/31/23, including 7 occasions when it was administered from 30 minutes to 56 minutes too soon.
-Xtampza was documented as administered at 7:47am on 12/22/23 and again at 7:14pm on 12/22/23, 33 minutes too soon.
-Xtampza was documented as administered at 7:53am on 12/23/23 and again at 7:23pm on 12/23/23, 30 minutes too soon.
-Xtampza was documented as administered at 7:52am on 12/26/23 and again at 7:20pm on 12/26/23, 32 minutes too soon.
-Xtampza was documented as administered at 7:48am on 12/27/23 and again at 6:58pm on 12/27/23, 50 minutes too soon.
-Xtampza was documented as administered at 7:52am on 12/28/23 and again at 7:05pm on 12/28/23, 47 minutes too soon.
-Xtampza was documented as administered at 7:51am on 12/30/23 and again at 7:11pm on 12/30/23, 40 minutes too soon.

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-Xtampza was documented as administered at 8:02am on 12/31/23 and again at 7:06pm on 12/31/23, 56 minutes too soon.

Review of Resident #1's January 2024 eMAR revealed:
-There was an entry for Xtampza ER 18mg take 1 capsule every 12 hours as needed for pain.
-Xtampza ER 18mg was documented as administered on 18 occasions from 01/01/24 - 01/18/24.
-Xtampza ER was documented as administered less than 12 hours apart on 14 occasions from 01/01/24 - 01/18/24, including 9 occasions when it was administered from 30 minutes to 1 hour and 58 minutes too soon.
-Xtampza was documented as administered at 7:54am on 01/01/24 and again at 7:18pm on 01/01/24, 36 minutes too soon.
-Xtampza was documented as administered at 8:44pm on 01/07/24 and again at 7:57am on 01/08/24, 47 minutes too soon.
-Xtampza was documented as administered at 7:57am on 01/08/24 and again at 5:59pm on 01/08/24, 1 hour and 58 minutes too soon.
-Xtampza was documented as administered at 9:06pm on 01/10/24 and again at 7:56am on 01/11/24, 1 hour and 10 minutes too soon.
-Xtampza was documented as administered at 9:10pm on 01/11/24 and again at 8:00am on 01/12/24, 1 hour and 10 minutes too soon.
-Xtampza was documented as administered at 8:38pm on 01/12/24 and again at 7:51am on 01/13/24, 47 minutes too soon.
-Xtampza was documented as administered at 8:57pm on 01/14/24 and again at 7:50am on 01/15/24, 1 hour and 7 minutes too soon.
-Xtampza was documented as administered at 7:50am on 01/15/24 and again at 7:06pm on 01/15/24, 44 minutes too soon.

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-Xtampza was documented as administered at 7:48am on 01/17/24 and again at 7:03pm on 01/17/24, 45 minutes too soon.

Interview with a medication aide (MA) on 01/18/24 at 2:41pm revealed:
-Resident #1 usually took Xtampza ER 18mg for back pain.
-He usually administered Xtampza ER to the resident in the morning and at night.
-Xtampza ER was a prn medication and the eMAR usually noted the last time it was administered.
-He had not noticed that he had administered Resident #1's Xtampza ER sooner than the ordered 12-hour time frame.
-The resident reported Xtampza ER usually helped with his pain about 20 minutes after he took the medication.
-The resident was not usually drowsy after he took the Xtampza ER.

Telephone interview with a second MA on 01/18/24 at 4:55pm revealed:
-Resident #1 wanted the Xtampza ER in the morning and at night.
-He usually tried to administer the Xtampza ER around 8:00am and 8:00pm but may have administered it early one or two times.
-The last administration time usually showed on the eMAR but he had not noticed it was too early to administer the medication during his medication passes.
-The resident had not been sleepy or oversedated after taking the Xtampza ER to his knowledge.

Interview with the Resident Care Coordinator (RCC) on 01/18/24 at 4:24pm revealed:
-Resident #1's Xtampza ER should be

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administered no less than 12 hours apart.
-She was not aware Resident #1 was receiving the prn Xtampza ER more often than every 12 hours.
-The MAs should check the last administration time on the eMAR before administering a dose of Xtampza ER to ensure the dosages were at least 12 hours apart.
-She was concerned administering Xtampza ER too close together could overmedicate the resident and cause drowsiness or cause the resident to constantly sleep.
-She had not observed the resident being drowsy or sleeping too much.
-The Administrator was currently on leave, so she was not aware of a system to check the eMARs.
-She started working at the facility on 01/01/24 but just got a code to access the eMARs yesterday, 01/17/24.

Telephone interview with the Administrator on 01/18/24 at 5:20pm revealed:
-Resident #1's prn Xtampza ER should not be administered until at least 12 hours had passed since the last administered dose.
-For example, if Xtampza ER was administered at 8:45am, it should not be administered again until at least 8:45pm that same day.
-If Xtampza ER was administered too close together, it could cause the resident to overdose.
-She had been out on leave since 01/02/24 but prior to that she was checking the eMARs once a week for accuracy.
-She had not noticed the MAs were documenting they administered Resident #1's prn Xtampza ER more often than every 12 hours as ordered.

Telephone interview with Resident #1's orthopedic provider on 01/19/24 at 1:21pm revealed:

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-It was dangerous for Resident #1 not to receive Xtampza as ordered.
-If doses of Xtampza were administered too close together, it could cause oversedation, decreased breathing which could increase the severity of the resident's chronic obstructive pulmonary disease, increase risk of falls and fractures due to falls, and worst-case scenario could even lead to death.

Interview with Resident #1 on 01/18/24 at 4:49pm revealed:
-He took Xtampza ER mostly for lower back pain.
-He had to ask for the Xtampza ER when he needed it, which was usually twice a day, around 8:00am and 8:00pm.
-The Xtampza ER usually helped his pain.
-He denied any symptoms of drowsiness, lightheadedness, or loss of balance.

The facility failed to administer 3 medications as ordered for 1 of 3 sampled residents (#1) including long-acting insulin that was administered 14 times when the resident's blood sugar was less than 100 and the resident had low blood sugar symptoms including nervousness and sweating; the resident missed 5 doses of a nebulizer medication causing increased shortness of breath and increased use of the resident's rescue inhaler; and the resident was administered a prn controlled substance pain medication sooner than ordered 18 times, increasing the resident's risk for oversedation, falls, and decreased respirations. The failure of the facility to administer medications as ordered was detrimental to the 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 01/18/24 for

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{D 358}	Continued From page 17 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2024.	{D 358}		