STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001134	A. BUILDING: _____ B. WING _____	R 04/24/2024

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THE OAKS OF ALAMANCE	1670 WESTBROOK AVENUE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Team conducted a follow-up survey on April 23 and April 24, 2024.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure staff who administered medications had successfully passed the state medication administration examination (Staff A) or completed the state-approved 5-hour,10-hour or 15-hour medication aide (MA) training courses as required prior to administering medications to residents for 1 of 3 sampled staff. The findings are: 1. Review of Staff A's, Medication Aide (MA), personnel record revealed: -Staff A was hired on 02/27/23 as a MA. -There was documentation that Staff A completed the 15-hour medication aide training on 04/28/23. -There was documentation of a medication clinical skills validation checklist completed for	D 125		

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Staff A on 05/31/23.
-There was documentation that Staff A had taken and passed the MA examination on 01/15/24.

Review of resident's March 15, 2024 through April 24, 2024 electronic medication administration (eMAR) records revealed:
-There was documentation that Staff A administered medications to residents on the first shift on 03/16/24, 03/17/24, and 03/31/24.
-There was documentation that Staff A administered medications to residents on the first shift on 04/19/24.
-There was documentation that Staff A administered medications to residents on the second shift on 04/05/24.

Interview with Staff A on 04/24/24 at 12:18pm revealed:
-She completed training last year with the Registered Nurse (RN).
-She had demonstrated administering medications and the RN checked her off on her skills.
-She had not taken the state-approved MA examination until 01/15/24, something happened with the laptop, and she could not complete the test.
-She attempted to take the test several times but had to reschedule.
-She administered medications to the residents on occasion.

Interview with the Administrator on 04/24/24 at 11:56am revealed:
-Multiple attempts were made to set up the MA training on the computer for Staff A.
-There were different problems each time an attempt was made to schedule Staff A's MA test.
-She was able to take the test on 01/15/24.

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D 125	Continued From page 2 -He did not realize Staff A should have taken the MA test within 60 days of the medication skills check list being completed.	D 125		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure notification to the primary care provider (PCP) for 2 of 5 sampled residents (#1, #4) for elevated blood pressures. The findings are: 1. Review of Resident #1's current FL-2 dated 08/29/23 revealed diagnoses dementia, hypertension, heart disease, and stage IV chronic kidney disease. Review of Resident #1's primary care provider (PCP) order dated 02/27/24 revealed there was an order to check blood pressures twice daily and to call the PCP for systolic blood pressures greater than 140 over 90 and blood pressures less than 100 over 50. Review of Resident #1's physician's notes dated 02/27/24 revealed an order for one-time dosage of metoprolol (used to treat hypertension) 12.5mg take now. Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed:	D 273		

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-There was an entry to check blood pressure twice daily scheduled at 8:00am and 8:00pm.
-Notify the physician if greater than 140/90 or less than 100/50.
-All blood pressures were within normal readings.

Review of Resident #1's March 2024 eMAR revealed:
-There was an entry to check blood pressure twice daily scheduled at 8:00am and 8:00pm.
-Notify the physician if greater than 140/90 or less than 100/50.
-On 03/15/24 at 8:00am there was blood pressure result of 154/77.
-On 03/16/24 at 8:00am there was a blood pressure result of 150/70 and at 8:00pm 160/70.
-On 03/17/24 at 8:00am there was a blood pressure result of 153/86 and at 8:00pm 167/70.
-On 03/19/24 at 8:00pm there was a blood pressure result of 156/70.
-On 03/20/24 at 8:00am there was a blood pressure result of 150/81 and at 8:00pm 149/77.
-On 03/17/24 at 8:00am there was a blood pressure result of 153/86 and at 8:00pm 167/70.
-On 03/21/24 at 8:00am there was a blood pressure result of 163/79.
-There was nothing documented on the eMAR for blood pressures outside of parameters.

Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/23/24 revealed:
-There was an entry to check blood pressure twice daily scheduled at 8:00am and 8:00pm.
-Notify the physician if greater than 140/90 or less than 100/50.
-On 04/01/24 at 8:00am there was a blood pressure result of 152/68.
-On 04/03/24 at 8:00am there was a blood pressure result of 187/67.
-On 04/04/24 at 8:00am there was a blood

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pressure result of 154/79 and at 8:00pm 153/79.
-On 04/05/24 at 8:00am there was a blood pressure result of 144/87.
-On 04/06/24 at 8:00am there was a blood pressure result of 157/81.
-On 04/09/24 at 8:00am there was a blood pressure result of 151/71 and at 8:00pm 158/72.
-On 04/19/24 at 8:00pm there was a blood pressure result of 165/65.
-On 04/23/24 at 8:00am there was a blood pressure result of 163/99.
-There was nothing documented on the eMAR for blood pressures outside of parameters.

Resident #1's progress notes were requested on 04/23/24 and 04/24/24 but were not provided.

Telephone interview with Resident #1's PCP on 04/24/24 at 11:50am revealed:
-The MA's usually called or text and sometimes they notified her by facts when blood pressures for residents were outside of parameters.
-All staff should have had her numbers including the MA.
-She expected to be called when the systolic or the diastolic blood pressure result was outside of the parameters.
-She did not always document when the facility called.
-She adjusted medication based on the blood pressure results.
-Resident #1's blood pressures had better from what they had been in the past.
-She still expected the facility to notify her when his blood pressures were outside of her recommended parameters.

Refer to interview with a medication aide (MA) on 04/24/24 at 10:05am.

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D 273	Continued From page 5 Refer to interview with the Memory Care Manager (MGM) on 04/24/24 at 10:30am. Refer to interview with the Resident Care Coordinator (RCC) on 04/24/24 at 3:15pm. Refer to interview with the Administrator on 04/24/24 at 3:30pm. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. 2. Review of Resident #4's current FL-2 dated 02/20/24 revealed: -Diagnoses included dementia and acute kidney injury. -There was an order to check blood pressure once daily and to notify the primary care provider (PCP) if were greater than 150/90. Review of Resident #4's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry to check blood pressure once daily scheduled at 8:00am. -Notify the physician if greater than 150/90. -All blood pressures were within normal readings. Review of Resident #4's March 2024 eMAR revealed: -There was an entry to check blood pressure once daily scheduled at 8:00am. -Notify the physician if greater than 150/90. -On 03/02/24 there was blood pressure result of 185/60. -On 03/11/24 there was blood pressure result of 181/72. -On 03/13/24 there was blood pressure result of 172/65.	D 273		

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-On 03/16/24 there was blood pressure result of 179/92.
-On 03/19/24 there was blood pressure result of 191/71.
-On 03/27/24 there was blood pressure result of 182/71.
-On 03/29/24 there was blood pressure result of 179/72.
-There was nothing documented on the eMAR for blood pressures outside of parameters.

Review of Resident #4's April 2024 eMAR from 04/01/24 to 04/23/24 revealed:
-There was an entry to check blood pressure once daily scheduled at 8:00am.
-Notify the physician if greater than 150/90.
-On 04/04/24 there was a blood pressure result of 152/68.
-On 04/10/24 there was a blood pressure result of 203/82.
-On 04/15/24 there was a blood pressure result of 176/65.
-On 04/16/24 there was a blood pressure result of 186/76.
-On 04/19/24 there was a blood pressure result of 187/80.
-There was nothing documented on the eMAR for blood pressures outside of parameters.

Resident #4's progress notes were requested on 04/23/24 and 04/24/24 but were not provided.

Telephone interview with Resident #4's PCP on 04/24/24 at 11:50am revealed:
-The MA's usually called or text and sometimes they notified her by facts when blood pressures for residents were outside of parameters.
-All staff should have had her numbers including the MA.
-She expected to be called when the systolic or

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the diastolic blood pressure result was outside of the parameters.
-She did not always document when the facility called.
-She adjusted medication based on the blood pressure results.
-She had been notified of Resident #4's blood pressures on Monday, 04/22/24, and she had adjusted her medications.
-She still expected the facility to notify her when his blood pressures were outside of her recommended parameters.

Refer to interview with a medication aide (MA) on 04/24/24 at 10:05am.

Refer to interview with the Memory Care Manager (MGM) on 04/24/24 at 10:30am.

Refer to interview with the Resident Care Coordinator (RCC) on 04/24/24 at 3:15pm.

Refer to interview with the Administrator on 04/24/24 at 3:30pm.

Based on observations, interviews and record reviews it was determined Resident #4 was not interviewable.

_____

Interview with a medication aide (MA) on 04/24/24 at 10:05am revealed:
-When the top [systolic] or the bottom [diastolic] bon a blood pressure reading was outside of parameter she notified the PCP.
-She notified the PCP via fax and would take the blood pressure again.
-Sometimes the blood pressures were taken before the resident ate breakfast or had their medication.
-A notation would be made in the resident eMAR

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D 273	Continued From page 8 when a blood pressure was rechecked. Interview with the Memory Care Manager (MGM) on 04/24/24 at 10:30am revealed: -She was not sure what parameters meant in relation to blood pressure checks. -She knew the top number [systolic] was the most important number and to notify the PCP if the top number was higher than what the doctor wanted it to be. -The MA was supposed to notify the PCP by fax when a resident's blood pressure was too high or too low. -The PCP called the facility to tell the staff what to do for the resident. -The PCP usually told the MA to recheck and call again if the blood pressure was still high. -The recheck and they call from the PCP were usually not documented anywhere. Interview with the Resident Care Coordinator (RCC) on 04/24/24 at 3:15pm revealed: -The MA's were supposed to fax or could text the PCP when a blood pressure was out of parameters. -Most of the time the PCP would contact her and give her instructions or tell her what to do for the resident. -She and the MCM were responsible for monitoring the eMARs for Discrepancies such as blood pressure check out of parameters. -The MAs should always notify her as well as the PCP when the blood pressure was out of parameter so that she could follow up. -Her concern with blood pressures outside of PCP's ordered parameters was always a possible stroke. Interview with the Administrator on 04/24/24 at 3:30pm revealed:	D 273		

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D 273	Continued From page 9 -The RCC and the MCM were responsible for monitoring the MAs. -The MAs were supposed to notify the PCP by fax of telephone call; fax was the preferred way of contact. -He expected the PCP to be notified by the MAs as soon as they took the resident's blood pressure.	D 273		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent dietary products were served three times daily to residents in the Memory Care Unit (MCU). Review of the facility's daily menu dated 04/23/24 revealed milk was listed as a for breakfast, lunch and dinner.	D 299		

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D 299	Continued From page 10 Observation of the dining room in the Memory Care Unit (MCU) on 04/23/24 from 11:21am to 12:00pm revealed: -There were 12 residents in the dining room. -Residents were served coffee, water and juices, but no milk was offered. Observation of the dining room in the Memory Care Unit (MCU) on 04/23/24 from 4:20pm to 4:45pm revealed: -There were 12 residents in the dining room. -Residents were served coffee, water and juices, but no milk was offered. -No other dairy items were served with the meal. Review of the facility's daily menu dated 04/24/24 revealed milk was listed as a for breakfast, lunch and dinner. Observation of the dining room in the Memory Care Unit (MCU) on 04/24/24 from 11:30am to 12:00pm revealed: -There were 11 residents in the dining room. -Residents were served coffee, water and juices, but no milk was offered. -No other dairy items were served with the meal. Interview with a resident on 04/23/24 at 8:45am revealed she was not served milk to drink at breakfast meals. Interview with a personal care aide (PCA) on 04/23/24 at 2:24pm revealed: -Milk was served to the MCU residents at breakfast. -The kitchen sent one gallon on milk a day for all the MCU residents. -The residents got water and another beverage at the other meals. -The residents did not ask for milk that would	D 299		

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D 299	Continued From page 11 probably drink it if it was given to them. Interview with a second PCA on 04/23/24 at 4:20 pm revealed: -They did not serve milk in the memory care unit with the dinner meal. -The residents were given nutritional supplements, lemonade and water with their dinner meal and that was a lot of fluids. Interview with the Dietary Manager (DM) on 04/24/24 at 1:45pm revealed: -Four gallons of milk were sent to the MCU every day. -The PCAs in the MCU were responsible for pouring the milk for the residents. -She did not monitor the meals in the MCU. Interview with the Memory Care Manager (MCM) on 04/24/24 at 2:15pm revealed: -The MCU staff got their milk from the kitchen every day; they usually used two gallons of milk every day. -Every resident in the MCU was supposed to get milk at every meal. -She usually monitored breakfast and lunch meals; she had not noticed milk not served to the residents. Interview with the Administrator o 04/24/24 at 3:30pm revealed: -The residents in the MCU were served milk three times a day with their meals. -The kitchen took the gallons of milk to the MCU when they took their meals. -The MCM was supposed to monitor the meals to ensure the residents were served milk.	D 299		

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D 310	Continued From page 12	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure therapeutic diets were served as ordered for 3 of 5 sampled residents with a diet order for no concentrated sweets (#1, #2, #5). The findings are: Observation of the dry storage in the main kitchen on 04/23/24 at 11:05am revealed: -There were no packages of sugar free powdered lemonade drink mix available for service. -There were packages of a non-sugar free powdered lemonade drink mix with 32gm of carbohydrates and 30gm of sugar. -There were single serve packages of sugar substitute. Review of the regular menu and therapeutic diet menu for 04/23/24 revealed: -the lunch and the dinner meals had been switched. -The regular lunch meal to be served was chopped steak, macaroni and cheese, green peas, fruit cup, bread, milk, water, and beverage of choice. -The NCS lunch meal was the same as the regular lunch meal with a diet beverage of choice. -The regular dinner menu was chicken pot pie, greens, bread, cookies, milk, water and beverage	D 310		

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of choice.
-The NCS dinner meal was the same as the regular dinner meal with a sugar free cookie and a diet beverage of choice.

1. Review of Resident #2's current FL-2 dated 03/27/24 revealed:
-Diagnoses included nontraumatic acute subdural hemorrhage, Parkinson's disease, hyperlipidemia, abnormality of gait and mobility.
-There was an order for a regular diet.

Review of Resident #2's signed physician orders dated 04/02/24 revealed an order for a no concentrated diet (NCS), chopped meats diet.

Observation of Resident #2's dinner meal service on 04/23/24 at 11:25am revealed:
-Resident #2 dined in his room for each meal.
-Resident #2 was served sweet tea.

Interview with Resident #2 on 04/24/24 at 1:45pm revealed:
-He did not know he was on a NCS diet.
-Sometimes he would get sweet tea and sometimes unsweet tea.

Interview with a dietary aide (DA) on 04/24/24 at 2:10pm revealed:
-She served the residents in the AL dining room.
-She served them based on cards that were at each place setting with the residents' beverage selections on them.
-She did not know what a NCS diet was.

Refer to interview with the Dietary Manager (DM) on 04/24/24 at 1:45pm.

Refer to interview with the Administrator on 04/24/24 at 12:25pm.

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D 310	Continued From page 14 2. Review of Resident #5's current FL-2 dated 04/01/24 revealed: -Diagnoses included diabetes mellitus type 2, depression, graves disease, obesity, and hyperlipidemia. -There was no diet order listed. Review of Resident #5's signed physician orders dated 04/01/24 revealed: -Resident #5 an order for a no concentrated sweet (NCS) diet. Observation of Resident #5's lunch meal service on 04/23/24 at 11:28 revealed Resident #5 was served sweet tea. Observation of Resident #5's dinner meal service on 04/23/24 at 4:25pm revealed Resident #5 was served sweet tea. Interview with Resident #5 on 04/24/24 at 1:42pm revealed: -She was not a diabetic. -She did not know she was ordered a NCS diet. -The medication aides (MA) checked her blood sugar because it had been high. -She did not know she had a diagnosis of diabetes and ordered a NCS diet. -She was served sweet tea with all meals. Interview with a dietary aide (DA) on 04/24/24 at 2:10pm revealed: -She served the residents in the AL dining room. -She served them based on cards that were at each place setting with the residents' beverage selections on them. -She did not know what a NCS diet was. Refer to interview with the Dietary Manager (DM)	D 310		

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D 310	Continued From page 15 on 04/24/24 at 1:45pm. Refer to interview with the Administrator on 04/24/24 at 12:25pm. 3. Review of Resident #1's current FL-2 dated 08/29/23 revealed: -Diagnoses dementia, hypertension, type two diabetes mellitus, and stage IV chronic kidney disease. -There was an order for a no concentrated sweets (NCS) diet. Observation of the dry storage in the Memory Care Unit (MCU) on 04/23/24 at 11:21am revealed there was an open package of a non-sugar free powdered lemonade drink mix with 32gm of carbohydrates and 30gm of sugar. Observation of Resident #1's lunch meal in the Memory Care Unit (MCU) on 04/23/24 at 11:21am revealed he was served lemonade from a powdered drink mix. Observation of Resident #1's dinner meal in the MCU on 04/23/24 at 4:23pm revealed he was served lemonade from a powdered drink mix. Interview with a personal care aide (PCA) in the MCU on 04/23/24 at 4:25pm revealed: -The powdered lemonade mix was sent to the MCU from the kitchen each day. -The PCAs in the MCU mixed the lemonade in a container in the unit. -All the residents were served the same lemonade once it was mixed because it was all sugar free. Attempted telephone interview with Resident #1's primary care provider (PCP) on 0424/24 at 2:30pm was unsuccessful.	D 310		

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D 310	Continued From page 16 Refer to interview with the Dietary Manager (DM) on 04/24/24 at 1:45pm. Refer to interview with the Administrator on 04/24/24 at 12:25pm. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. _____ Interview with the Dietary Manager (DM) on 04/24/24 at 1:45pm revealed: -She followed the regular menu and knew the residents who were ordered a NCS diet were supposed to be served sugar free items. -Only two residents were ordered a NCS diet; one resident resided in the AL side of the facility and the other resided in the MCU. -The kitchen only offered sugar free beverages made from a powdered drink mix for the residents; including lemonade. -The staff in the MCU mixed their own beverages for the residents from the drink mix she supplied them. -The DAs prepared sweet tea and unsweetened tea for the residents. -The DAs knew which residents were supposed to get sweet tea and unsweet tea. -She was surprised to see the powdered drink mix and some of the cookies she had been providing to the residents who were on a NCS diet were not sugar free. -She was not following the NCS therapeutic diet because she thought it was just about sugar free drinks and desserts. -She told the Administrator what he needed to order for the kitchen. Interview with the Administrator on 04/24/24 at	D 310		

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D 310	Continued From page 17 12:25pm revealed: -The kitchen staff were supposed to follow the NCS therapeutic menu that was provided. -He thought there were more than two residents who were ordered the NCS diet. -He purchased regular and sugar free items for the kitchen; including sugar free drink mixes. -The kitchen manager told him what she needed, and he ordered it. -He expected the kitchen staff to follow the NCS therapeutic menu.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#3) including a two medications for glaucoma. The findings are: 1. Review of Resident #3's current FL-2 dated 01/16/24 revealed diagnoses included glaucoma both eyes. a. Review of Resident #3's current physician's	D 358		

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order dated 01/16/24 revealed there was an order for brinzolamide 1% eye drops for glaucoma 1 drop into each eye daily at bedtime (may keep at bedside and self-administer).

Review of Resident #3's electronic medication administration record (eMAR) for March 2024 from 03/15/24-03/31/24 revealed there was no entry for brinzolamide 1% eye drops instilled in each eye at bedtime.

Review of Resident #3's eMAR for April 2024 from 04/01/24-04/23/24 revealed there was no entry for brinzolamide 1% eye drops instilled in each eye at bedtime.

Observation of Resident #3's medications on hand on 04/23/24 at 10:30am revealed there was an unopened bottle of brinzolamide 1% eyedropper on medication cart with a dispensed date of 01/28/24.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 04/24/24 at 10:25am revealed:
-Resident #3 had an order for brinzolamide 1% eye drops instill 1 drop in each eye at bedtime (may keep at bedside and self-administer).
-Brinzolamide had not been dispensed at pharmacy.
-One bottle of brinzolamide lasted approximately 30 days.
-Brinzolamide is used for intraocular pressure associated with glaucoma.
-The pharmacy did not receive an FL2 from the facility.
-Physician's orders are electronically sent directly to the pharmacy by the physician.

Interview with Resident #3 on 04/23/24 at 2:30pm

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revealed:
-He had not received the brinzolamide and it had never been in his bedroom.
-He knew there was an order for him to self-administer eye drops but could not recall which eye drops.

Attempted interview with Resident #3's Ophthalmologist on 04/23/24 at 3:25pm was unsuccessful.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 04/24/24 at 12:03pm revealed:
- The resident went to an ophthalmologist to get eye drops.
-She asked the resident to give her new medications received from the ophthalmologist to review.
-She was not concerned with the resident not administering his brinzolamide 1% eye drops because he was using a similar medication (Lumigan) also.

Interview with a medication aide (MA) on 04/24/24 at 11:07am revealed:
-She had not administered Resident #3's brinzolamide.
-She was not aware the resident did not have the eye drops in resident's bedroom because the eMAR stated it was self-administered.
-She was not aware Resident #3's medication was on the medication cart.
-She administered medication according to the eMAR.

Interview with a second MA on 04/24/24 at 12:18pm revealed:
-She administered medications on occasion.
-She thought Resident #3 had the medication in

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his bedroom because the eMAR listed the medication as self-administer.
-She was not aware the medication was on the medication cart.

Interview with Resident Care Coordinator (RCC) on 04/24/24 at 3:05pm revealed:
-The PCP notifies the RCC and MAs of changes with medications.
-RCC and MAs check resident's bedrooms for medications weekly.
-Medications without self-administration orders are removed and placed on the medication cart.
-She was not aware Brinzolamide was not in the resident's bedroom and was still on the medication cart.
-She knew there was a self-administer order for Resident #3.

Refer to interview with the Administrator on 04/24/24 at 3:53pm.

b. Review of Resident #3's physician's order dated 10/04/23 revealed Timolol Maleate 0.5% 1 drop twice daily in both eyes to be discontinued. Physician order dated 01/19/24 revealed Timolol Maleate 0.5% 1 drop twice daily in both eyes to be discontinued.

Review of Resident #3's electronic medication administration record (eMAR) for March 2024 from 03/15/24-03/31/24 revealed Timolol Maleate 0.5% for glaucoma 1 drop twice daily in both eyes was not listed on eMAR.

Review of Resident #3's eMAR for April 2024 from 04/01/24-04/23/24 revealed Timolol Maleate 0.5% 1 drop twice daily in both eyes was not listed on eMAR.

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D 358	Continued From page 21 Observation of Resident #3's medications on hand on 04/23/24 at 8:30am revealed there was an opened bottle of Timolol Maleate in the resident's bedroom. Telephone interview with the pharmacist from the facility's contracted pharmacy on 04/24/24 at 10:25am revealed: -Resident #3 there was no order for Timolol Maleate 0.5% 1 drop twice daily. -The pharmacy did not receive an FL2 from the facility. -Physician's orders are electronically sent directly to the pharmacy by the physician. Interview with Resident #3 on 04/23/24 at 2:30pm revealed: -He had the Timolol Maleate 0.5% 1 drop twice daily in his bedroom because he had an order to self-administer the eye drops. -He has had the eye drops for about 6 months and administers them at 9:am and 12pm daily. Attempted interview with Resident #3's Ophthalmologist on 04/23/24 at 3:25pm was unsuccessful. Telephone interview with Resident #3's Primary Care Provider (PCP) on 04/24/24 at 12:03pm revealed: - The resident went to an ophthalmologist to get eye drops. -She asked the resident to give her new medications received from the ophthalmologist to review. -She wrote an order to discontinue the Timolol on 01/19/24 after she saw the order written by the ophthalmologist on 10/04/23 to discontinue the medication. -She was not aware the resident continued to use	D 358		

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D 358	Continued From page 22 the eye drops. Interview with a medication aide (MA) on 04/24/24 at 11:07am revealed: -She had not administered Resident #3's Timolol. -She was not aware the resident had the medication in his bedroom. -The medication was not listed on the eMAR. -The Resident Care Coordinator (RCC) and MAs were responsible for checking bedrooms for medications. Interview with a second MA on 04/24/24 at 12:18pm revealed: -She administered medications on occasion. -She could not recall if she had administered the Timolol. -She was not aware the resident had the medication in his bedroom. -She was not aware of who should check the resident rooms for medication. Interview with RCC on 04/24/24 at 3:05pm revealed: -The PCP notifies the RCC and MAs of changes with medications. -RCC and MAs check resident's bedrooms for medications weekly. -Medications without self-administration orders are removed and placed on the medication cart. -She was not aware Resident #3 had Timolol in his bedroom. -MAs are to remove all discontinued medications from the resident's bedrooms. Refer to interview with the Administrator on 04/24/24 at 3:53pm. _____ Interview with the Administrator on 04/24/24 at 3:53pm revealed:	D 358		

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D 358	Continued From page 23 -He was not aware the resident had the medication in his bedroom without a self-administer order. -The RCC and MAs were responsible for removing expired medications from the resident's bedrooms. -He was not aware Resident #3 had a medication that was not being administered as ordered. -His expectation was that medications were to be administered as ordered by the physician. -Make sure medications in the resident's bedrooms have self-administered orders. -Expectations are that discontinued medications are removed from the resident's bedrooms.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 1 resident sampled (#3) related to having	D 375		

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D 375	Continued From page 24 physician's orders to self-administer medications. The findings are: Review of Resident #3's current FL-2 dated 01/16/24 revealed diagnoses included major depressive disorder, CKD stage 3A, CVD, Type II diabetes with peripheral angiopathy, GERD, hypertension, glaucoma both eyes, lower urinary tract symptoms benign prostatic hypertrophy. a. Review of Resident #3's current physician's order dated 01/16/24 revealed: -There was an order for brimonidine 0.2% eyedrops 1 drop into each eye twice a day. -There was not an order for Resident #3 to self-administer medication. Review of the facility's policy for self-administration of medications revealed "it is the policy of this facility to allow medications to be stored at bedside if the physician has written "may self-administer" order and the Administrator has agreed that the resident meets the facility's qualifications for self-medication." Observation of Resident #3's bedroom on 04/23/24 at 8:30am and 04/24/24 at 8:11am revealed there was a bottle of Brimonidine on his bed. Interview with Resident #3 on 04/23/24 at 8:35am revealed: -He had Brimonidine in his bedroom but could not remember how long. -He administers brimonidine twice a day at 9:00am and 12:00pm. -He said he had an order to self-administer eyedrops. -The Primary Care Provider (PCP) knew he had a	D 375		

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D 375	Continued From page 25 self-administer order. Telephone interview with the pharmacist from the facility's contracted pharmacy on 04/24/24 at 10:25am revealed: -Resident #3 had an order for brimonidine 0.2% eyedrops 1 drop into each eye twice a day. -Brimonidine was dispensed at pharmacy on 03/30/24. -The pharmacy had been contracting with the facility for two months. -There was no order to self-administer medication. Attempted interview with Resident #3's Ophthalmologist on 04/23/24 at 3:25pm was unsuccessful. Refer to interview with PCP on 04/24/24 at 12:03pm. Refer to interview with a medication aide (MA) on 04/24/24 at 11:07am. Refer to interview with a second MA on 04/24/24 at 12:18pm. Refer to interview with Resident Care Coordinator (RCC) on 04/24/24 at 3:05pm. Refer to interview with the Administrator on 04/24/24 at 3:53pm. b. Review of Resident #3's current physician's order dated 01/16/24 revealed: -There was an order for Lumigan 0.01% eyedrops 1 drop into each eye at bedtime. -There was not an order for Resident #3 to self-administer medication.	D 375		

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D 375	Continued From page 26 Observation of Resident #3's bedroom on 04/23/24 at 8:30am and 04/24/24 at 8:11am revealed there was a bottle of Lumigan on his bed. Interview with Resident #3 on 04/23/24 at 8:35am revealed: -He had Lumigan in his bedroom for about 2 months. -He administers Lumigan once a day at 9:00pm. -He said he had an order to self-administer eyedrops. -The Primary Care Provider (PCP) knew he had a self-administer order. Telephone interview with the pharmacist from the facility's contracted pharmacy on 04/24/24 at 10:25am revealed: -Resident #3 had an order for Lumigan 0.01% eyedrops 1 drop into each eye at bedtime. -Lumigan was dispensed at pharmacy on 04/23/24. -There was no order to self-administer medication. Telephone interview with Resident #3's Ophthalmologist on 04/23/24 at 3:25pm was unsuccessful. Refer to interview with PCP on 04/24/24 at 12:03pm. Refer to interview with a medication aide (MA) on 04/24/24 at 11:07am. Refer to interview with a second MA on 04/24/24 at 12:18pm. Refer to interview with RCC on 04/24/24 at 3:05pm.	D 375		

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D 375	Continued From page 27 Refer to interview with the Administrator on 04/24/24 at 3:53pm. _____ Interview with Resident #3's PCP on 04/24/24 at 12:03pm revealed: - Resident #3 went to an ophthalmologist to get eyedrops regularly. -She asked Resident #3 to give her new medications received from the ophthalmologist to review. -Resident #3 was a candidate for self-administration of medications because he is aware of all the medications he took. Interview with a medication aide (MA) on 04/24/24 at 11:07am revealed: -She had not administered Resident #3's Brimonidine or Lumigan. -She was not aware Resident #3 had the medications in his bedroom. -She removed any medications from a resident's bedroom if there is no self-administer order. -Resident #3 usually kept his eyedrops locked in his closet and staff do not always see what he has. Interview with a second MA on 04/24/24 at 12:18pm revealed: -She administered medications on occasion. -She was not aware Resident #3 had medication in his bedroom. Interview with RCC on 04/24/24 at 3:05pm revealed: -She was not aware Resident #3 had Brimonidine and Lumigan were in his bedroom. -She was aware Resident #3 had no order to self-administer the medications.	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001134	A. BUILDING: _____ B. WING _____	R 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 375	Continued From page 28 -RCC and MAs check resident's bedrooms for medications weekly. -She removed any medications from resident's bedroom and keep them on the medication cart if there is no self-administer order. -MAs are to remove all medications from the resident's bedrooms if there is no self-administer order. Interview with the Administrator on 04/24/24 at 3:53pm revealed: -He was not aware Resident #33 had medications at the bedside. -The resident should not have medications at the bedside if he did not have an order to self-administer medications. -He knew the resident had an order to self-administer an eyedrop but could not recall which medication. -All staff members are responsible for making sure medications are not left out at the bedside and, if found, should be taken to the MA.	D 375		