Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092141	A. BUILDING: _____ B. WING _____	R 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER COURT MEMORY CARE COMMUNITY	1130 FALLS RIVER AVENUE RALEIGH, NC 27614

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow survey and complaint investigation on April 17, 2024 and April 18, 2024. The Wake County Department of Social Services initiated the complaint investigation on April 4, 2024.	D 000	Topic:HousekeepingandFurnishings Regulatory#:10ANCAC13F.0306(a)(5) Corrective Action Potential hazards and/or toxic materials were removed from resident rooms/common areas and secured on 4.17.24.	5/31/24
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an environment free of hazards including razors, body wash, personal hygiene products, wound cleaner, and hand sanitizer, on the special care unit (SCU). The findings are: Review of the facility's census report dated 04/17/24 revealed there were 33 residents in the facility. Review of facility policy on 04/17/24 revealed the following: -Any potential hazards and/or toxic materials should be removed from the memory care environment, including resident rooms and common areas to prevent any preventable resident injuries.	D 079	Identification: All residents have the potential to be affected by the alleged deficient practice. System Changes ED sent email and letter to all Resident families/POA regarding storage of personal care items on May 21, 2024 Notification regarding storage of Resident personal items will be put in the admission packets. All Memory Care Staff were in serviced by Assisted Living Director and Nurse Consultant regarding proper storage of resident personal products, usage of personal products and return of personal products to secure setting. Our Residents will have individual containers labeled with Name, Room # that will be stored in laundry rooms of each corridor. The individual containers will be locked in the laundry room, staff will assist resident or family member with accessing these items for personal care or by resident request. For those residents that request their personal products, staff will assist in unlocking and providing supplies to the resident, allow time for grooming and then re-secure those items in the locked area	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Rushing — TITLE: Executive Director — (X6) DATE: 5/23/2024

Received via email on 05/23/2024.
Reviewed and Acknowledged 05/24/2024. N. Fortis, RN

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D 079	Continued From page 1 -Ensure that all laundry chemicals, cleaning chemicals, toiletries, or any other potentially hazardous or toxic materials are stored in a locked area not accessible by residents. -Any objects that could cause injury to self or others, such as sharp or pointed items should not be stored in a resident room or accessible to residents. Observations of resident rooms during facility tour on 04/17/24 from 9:00am to 10:30am revealed: -In room A4 there was a tube of deodorant in the unlocked bathroom cabinet -In room A5 there was a bottle of body wash on the bathroom counter. -In room A7 there was a pack of four disposable razor blade shavers on the bathroom counter. -In room B1 there was a bottle of baby powder in the unlocked cabinet and a bottle of liquid soap on the bathroom counter. -In room B8 there were bottles of lotion, shampoo and conditioner, body wash, and deodorant on the bathroom cabinet. -In room B6 there were bottles of body wash and shampoo in the unlocked bathroom cabinet. -In room C7 there were containers with manufacturer labels for 0.9% normal saline, odor eliminator, and wound cleanser on the dresser, and two bottles of lotion, a jar of cream, and a container of arm deodorant on a table. Interview with a personal care aide (PCA) on 04/17/24 at 9:50am revealed: -The resident's personal care products were supposed to be locked in a closet when not in use. -The PCAs were responsible for locking personal care products in the closet when not in use. Interview with a housekeeping staff on 9:58am	D 079	Monitoring:- The SIC of each shift will conduct rounds to ensure that residents rooms are debris free of all obstructions and hazards are located in the secured designated area. Assisted Living Director or Memory Care Director will conduct walk throughs and utilize the Management Round Checklist form. The rounds will consist of auditing the resident's rooms and common areas to ensure that they are uncluttered, clean and free of all obstructions and hazards. The walk throughs will be at a minimum of 3 days a week. Management Round Checklist form will be reviewed for compliance weekly by the Assisted Living Director and Executive Director. Executive Director will do walkthroughs at a minimum of twice a week to visually assess current compliance. Management Round Checklist Forms will be kept in a binder in the MCD office.	

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revealed:
-All of the resident's personal care products were supposed to be locked in a closet on B hall when not in use.
-The PCAs were responsible for locking personal care products in the closet when not in use.

Interview with a second PCA on 04/17/24 at 10:05am revealed:
-All of the resident's personal care products were supposed to be locked in a closet in B hall when not in use.
-The PCAs were responsible for locking personal care products in the closet when not in use.

Interview with the Special Care Coordinator (SCC) on 04/17/24 at 10:05am revealed:
-The resident's personal care products were supposed to be locked in a closet when not in use.
-When the PCAs were preparing to provide personal care for residents they went to the closet on B hall to get all of the personal care items to be used.
-The PCAs gave showers and provided personal care to residents in the morning and afternoon when the residents were available.
-PCAs should have returned personal care items to the locked closet after each use.
-Personal care items should be locked in memory care facilities because they could be a hazard to the residents.
-It was her responsibility to make sure the facility was free from hazards.

Interview with the Administrator on 04/17/24 at 10:20am revealed:
-She expected the SCC to ensure there were no ingestible items in the special care unit (SCU).
-Personal care items could be hazardous to

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D 079	Continued From page 3 residents in memory care facilities who might drink ingestible items. -Residents in memory care facilities should not have access to razors or personal care items they could ingest due to safety concerns. -All personal care items should have been locked when not in use. -It was the responsibility of the SCC to ensure the SCU was free of hazards.	D 079	Topic:MedicationAdministration Regulatory#:10ANCAC13F.1004(a) Corrective Action: Medication Techs were in serviced by the Assisted Living Director and Nurse Consultant on the following A) Medication Management, B) 6 Rights of Medication, and C) Notification to Physician/NP/RP/POA, D) Medication Administration, E) Resident Right, and F) Notification to Memory Care Director or Assisted Living Director for medication errors. Resident Antibiotics were placed in the narcotics door to ensure accuracy of distribution. Antibiotics are counted at the beginning and ending of shift for the duration of the ABT therapy Medication order times were reviewed by the Memory Care Director and Assisted Living Director to ensure cohesiveness of resident care. Immediate Chart reviews were conducted by the Assisted Living Director and Memory Care Director. Medication Techs performed cart audits to verify correct medication count for Residents.	5/31/24
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 6 residents (#6, #7, #8, #9) observed during the medication pass including errors with an eye drop for glaucoma (#6), a controlled substance for anxiety and an antipsychotic (#7), an oral and a topical medication for pain and inflammation (#8), and a mild pain reliever and a controlled substance for moderate to severe pain (#9); and for 2 of 5 sampled residents (#1, #2) including errors with an antibiotic for infection (#1) and a topical steroid cream for inflammatory skin conditions (#2).	D 358		

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D 358	Continued From page 4 The findings are: 1. The medication error rate was 28% as evidenced by 7 errors out of 25 opportunities during the 8:00am medication pass on 04/17/24. a. Review of Resident #6's current FL-2 dated 09/28/23 revealed: -Diagnoses included dementia, hypothyroidism, hyperlipidemia, and dysphagia. -There was an order for Dorzolamide / Timolol Maleate 2-0.5% instill 1 drop in each eye twice a day. (Dorzolamide / Timolol Maleate is a combination eye drop that contains two medications used to treat increased pressure in the eye caused by glaucoma.) Review of Resident #6's primary care provider (PCP) order dated 11/30/23 revealed: -The resident's family requested the resident's Dorzolamide / Timolol Maleate eye drops be changed from twice a day to once a day. -The PCP approved and ordered Dorzolamide / Timolol Maleate 2-0.5% 1 drop in each eye once a day. Observation of the 8:00am medication pass on 04/17/24 revealed: -The medication aide (MA) administered Timolol Maleate 0.25% 1 drop in each eye to Resident #6 at 9:32am. (Timolol Maleate is used to treat increased pressure in the eye due to glaucoma.) -The MA did not administer Dorzolamide / Timolol Maleate 2-0.5% as ordered. Review of Resident #6's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Dorzolamide / Timolol	D 358	Identification All Residents have the potential to be affected by the alleged deficient practice. System Changes Email and/or letters to Resident families/RP's was sent regarding pharmacy selection and blister packaging preference to ensure accuracy of medication administration. Monitoring Assisted Living Director (ALD) Memory Care Director to review staffing needs and scheduling weekly. SIC (11 pm to 7 am) to perform MAR to Cart Audit weekly to ensure medications were administered according to physician orders. Assisted Living Director or Memory Care Director will review the weekly MAR to Cart Audits Results of the above findings will be reported monthly by the ALD or MCD to the Executive Director.	

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D 358	Continued From page 5 Maleate 2-0.5% instill 1 drop into each eye every day scheduled at 8:00am. -Dorzolamide / Timolol Maleate was documented as administered from 04/01/24 - 04/17/24. -There was no entry for Timolol Maleate 0.25% and none documented as administered. Observation of Resident #6's medications on hand on 04/17/24 at 1:35pm revealed: -There was a box of unit dose vials of Timolol Maleate 0.25% eye drops dispensed on 01/13/24 with instructions to put 1 drop in both eyes every morning. -The original written date for the Timolol Maleate 0.25% prescription was documented as 08/04/23. -There was no supply of Dorzolamide / Timolol 2-0.5% eye drops available for administration. Interview with the MA on 04/17/24 at 1:34pm revealed: -The resident's family usually brought the resident's eye drops to the facility. -She did not notice the name of the eye drops listed on the eMAR did not match the name of the eye drops on the medication label. -Resident #6 had received the combination eye drops with Dorzolamide / Timolol Maleate in the past but she could not recall when. Interview with the Memory Care Director (MCD) on 04/17/24 at 1:47pm revealed: -Resident #6's family member usually brought her eye drops to the facility. -The MAs were responsible for checking the medications brought by family members to make sure they matched the orders and the eMARs. -The MAs should compare the eMAR with the medication labels when administering medications and if something did not match, the MAs should notify her and call the pharmacy and	D 358	Monitoring Pharmacy Consultant will conduct quarterly audits during their visits. Report of findings will be provided to the Assisted Living Director, Memory Care Director and Executive Director. Nurse Consultant will conduct monthly chart audit. Audit will consist of 3 charts a month. Findings will be presented to Memory Care Director and Assisted Living Director Memory Care Director or Assisted Living Director will observe medication pass 1 per shift each week. Memory Care Director will complete Chart Reviews quarterly along with Care Plans to ensure that all documentation is in order Quarterly Quality Assurance Meetings will be held beginning June 2024. Medication Administration will be included in the meeting. The Executive Director will present the results to the QA Committee for the next two months for the interdepartmental teams oversight and direction with additional follow-up as needed. Any new orders will be given to Memory Care Director or Assisted Living Director for proper verification	

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the provider.
-No one had reported any discrepancies with Resident #6's eye drops.

Telephone interview with a team lead front desk operator at Resident #6's eye care provider's office on 04/18/24 at 3:26pm revealed:
-Resident #6's eye care provider was unable to physically come to the phone so she would ask him about Resident #6's eye drops.
-The eye care provider reported Resident #6 should be receiving the combination eye drop with Dorzolamide / Timolol.
-Resident #6's eye pressure was high when the eye care provider checked it on 06/23/23 so the resident needed the combination eye drop to help lower the pressure in the resident's eyes.
-Not receiving the combination eye drops could cause the resident's eye pressure to increase.

Based on observations, interviews, and record reviews, it was determined that Resident #6 was not interviewable.

b. Review of Resident #7's current FL-2 dated 02/13/24 revealed:
-Diagnoses included dementia with behavioral disturbance, anxiety disorder, mood disorder, and gait abnormality.
-There was an order for Clonazepam 1mg 1 tablet 3 times a day. (Clonazepam is a controlled substance used to treat anxiety.)

Review of Resident #7's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Clonazepam 1mg 1 tablet 3 times a day scheduled at 7:00am, 1:00pm, and 8:00pm.
-Clonazepam was documented as administered

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D 358	Continued From page 7 from 04/01/24 - 04/17/24 (8:00am). Observation of the 8:00am medication pass on 04/17/24 revealed the medication aide (MA) prepared and administered Resident #7's Clonazepam 1mg tablet at 9:45am, 1 hour and 45 minutes beyond the allowed time frame. Interview with the MA on 04/17/24 at 1:20pm revealed: -She was running late with the medication pass that morning, 04/17/24, because she was the only MA administering medications. -There were usually 2 MAs administering medications for the 8:00am medication pass. -There were 2 or 3 staff who called out that morning, including the other MA scheduled to administer medications. -It was unusual to have call outs; she tried to call in other staff this morning but was unable to reach anyone. -There was another MA on duty but she was needed to work on the floor as a personal care aide (PCA) since they were short staffed that morning. Second interview with the MA on 04/17/24 at 1:28pm revealed she administered Resident #7's 1:00pm dose of Clonazepam around 1:20pm (about 3 hours and 35 minutes after the late morning dose). Interview with the Memory Care Director (MCD) on 04/17/24 at 1:47pm revealed: -There were usually 2 MAs administering medications during the morning medication pass. -They had a call out that morning on 04/17/24 so there was only 1 MA administering morning medications. -She did not think the MA met the 1-hour time	D 358		

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frame that morning for administering medications.
-She tried to call several MAs that morning but could not reach anyone.
-No MAs were available to help from the sister facility next door.
-She was unable to administer medications that morning because she was helping with feeding assistance in the dining room.
-She had a "big concern" about Resident #7's Clonazepam being administered late that morning.
-The morning Clonazepam was administered too close to the dosage scheduled for 1:00pm.
-Administering the Clonazepam too close together could cause sedation and falls.

Interview with the Administrator on 04/17/24 at 2:10pm revealed:
-There were typically 2 MAs administering medications on first shift, but some staff called out today, 04/17/24.
-Medications should be administered on time, within the required timeframes.

Telephone interview with Resident #7's mental health provider (MHP) on 04/18/24 at 3:57pm revealed receiving Clonazepam doses too close together could potentially cause sedation.

Review of Resident #7's MHP provider note dated 04/17/24 at 3:42pm revealed:
-Resident #7 was administered Clonazepam at 9:45am and again at 1:20pm.
-Clonazepam was scheduled for 7:00am, 1:00pm, and 8:00pm.
-The resident appeared to be at her baseline and MHP asked staff to monitor the resident for sedation and notify the MHP of any changes.

Based on observations, interviews, and record

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reviews, it was determined that Resident #7 was not interviewable.

c. Review of Resident #7's current FL-2 dated 02/13/24 revealed an order for Olanzapine 2.5mg 1 tablet twice a day for agitation. (Olanzapine is an antipsychotic that may be used to treat mood disorders.)

Review of Resident #7's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Olanzapine 2.5mg 1 tablet twice a day for agitation scheduled for 8:00am and 8:00pm.
-Olanzapine was documented as administered from 04/01/24 - 04/17/24 (8:00am).

Observation of the 8:00am medication pass on 04/17/24 revealed the medication aide (MA) prepared and administered Resident #7's Olanzapine 2.5mg tablet at 9:45am, 45 minutes beyond the allowed time frame.

Interview with the MA on 04/17/24 at 1:20pm revealed:
-She was running late with the medication pass that morning, 04/17/24, because she was the only MA administering medications.
-There were usually 2 MAs administering medications for the 8:00am medication pass.
-There were 2 or 3 staff who called out that morning, including the other MA scheduled to administer medications.
-It was unusual to have call outs; she tried to call in other staff this morning but was unable to reach anyone.
-There was another MA on duty but she was needed to work on the floor as a personal care aide (PCA) since they were short staffed that

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morning.

Interview with the Memory Care Director (MCD) on 04/17/24 at 1:47pm revealed:
-There were usually 2 MAs administering medications during the morning medication pass.
-They had a call out that morning on 04/17/24 so there was only 1 MA administering morning medications.
-She did not think the MA met the 1-hour time frame that morning for administering medications.
-She tried to call several MAs that morning but could not reach anyone.
-No MAs were available to help from the sister facility next door.
-She was unable to administer medications that morning because she was helping with feeding assistance to residents in the dining room.
-She was concerned about Resident #7's Olanzapine being administered late that morning.
-Every once in a while, Resident #7 had verbal outbursts when she was agitated.

Interview with the Administrator on 04/17/24 at 2:10pm revealed:
-There were typically 2 MAs administering medications on first shift but some staff called out today, 04/17/24.
-Medications should be administered on time, within the required timeframes.

Telephone interview with Resident #7's mental health provider (MHP) on 04/18/24 at 3:57pm revealed:
-Resident #7 should receive Olanzapine on time.
-She was not concerned about Resident #7 receiving Olanzapine late since it was a one-time occurrence.

Based on observations, interviews, and record

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D 358	Continued From page 11 reviews, it was determined that Resident #7 was not interviewable. d. Review of Resident #8's current FL-2 dated 12/20/23 revealed: -Diagnoses included dementia, anxiety disorder, osteoarthritis, peripheral vascular disease, depression, mood disorder, hyperlipidemia, gastroesophageal reflux disease, hypothyroidism, hyperlipidemia, dysphagia, and Vitamin D deficiency. -There was an order for Diclofenac Gel 1% apply 2gm to knees twice a day for pain. (Diclofenac Gel is a topical medication used to treat pain.) Review of Resident #8's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Diclofenac Gel 1% apply 2gm to knees twice a day for pain scheduled at 8:00am and 8:00pm. -Diclofenac Gel was documented as administered from 04/01/24 - 04/17/24 (8:00am). Observation of the 8:00am medication pass on 04/17/24 revealed the medication aide (MA) prepared and administered Resident #8's Diclofenac Gel at 9:57am, 57 minutes beyond the allowed time frame. Interview with the MA on 04/17/24 at 1:20pm revealed: -She was running late with the medication pass that morning, 04/17/24, because she was the only MA administering medications. -There were usually 2 MAs administering medications for the 8:00am medication pass. -There were 2 or 3 staff who called out that morning, including the other MA scheduled to administer medications.	D 358		

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-It was unusual to have call outs; she tried to call in other staff this morning but was unable to reach anyone.
-There was another MA on duty but she was needed to work on the floor as a personal care aide (PCA) since they were short staffed that morning.

Second interview with the MA on 04/17/24 at 1:29pm revealed Resident #8 usually complained about knee pain when her knees were touched; the resident usually "flinches" when her knees were touched.

Interview with the Memory Care Director (MCD) on 04/17/24 at 1:47pm revealed:
-There were usually 2 MAs administering medications during the morning medication pass.
-They had a call out that morning on 04/17/24 so there was only 1 MA administering morning medications.
-She did not think the MA met the 1-hour time frame that morning for administering medications.
-She tried to call several MAs that morning but could not reach anyone.
-No MAs were available to help from the sister facility next door.
-She was unable to administer medications that morning because she was helping with feeding assistance to residents in the dining room.
-She had a concern about Resident #8's Diclofenac Gel being administered late that morning.
-Resident #8 had a lot of body aches and pains and needed to get her medication on time to help with the pain.

Interview with the Administrator on 04/17/24 at 2:10pm revealed:
-There were typically 2 MAs administering

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medications on first shift but some staff called out today, 04/17/24.
-Medications should be administered on time, within the required timeframes.

Attempted telephone interview with Resident #8's primary care provider (PCP) on 04/18/24 at 4:35pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable.

e. Review of Resident #8's current FL-2 dated 12/20/23 revealed an order for Ibuprofen 400mg 1 tablet 3 times a day. (Ibuprofen is used to treat pain and inflammation.)

Review of Resident #8's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Ibuprofen 400mg 1 tablet 3 times a day scheduled for 8:00am, 2:00pm, and 8:00pm.
-Ibuprofen was documented as administered from 04/01/24 - 04/17/24 (8:00am).

Observation of the 8:00am medication pass on 04/17/24 revealed the medication aide (MA) prepared and administered Resident #8's Ibuprofen 400mg at 9:55am, 55 minutes beyond the allowed time frame.

Interview with the MA on 04/17/24 at 1:20pm revealed:
-She was running late with the medication pass that morning, 04/17/24, because she was the only MA administering medications.
-There were usually 2 MAs administering medications for the 8:00am medication pass.

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D 358	Continued From page 14 -There were 2 or 3 staff who called out that morning, including the other MA scheduled to administer medications. -It was unusual to have call outs; she tried to call in other staff this morning but was unable to reach anyone. -There was another MA on duty but she was needed to work on the floor as a personal care aide (PCA) since they were short staffed that morning. Second interview with the MA on 04/17/24 at 1:29pm revealed: -She administered Resident #8's 2:00pm dose of Ibuprofen around 1:10pm (about 3 hours and 15 minutes after the late morning dose). -The 8:00pm medication pass usually started around 7:00pm and that was when Resident #8 would receive her Ibuprofen dose scheduled at 8:00pm. -Resident #8 usually complained about knee pain when her knees were touched; the resident usually "flinches" when her knees were touched. Interview with the Memory Care Director (MCD) on 04/17/24 at 1:47pm revealed: -There were usually 2 MAs administering medications during the morning medication pass. -They had a call out that morning on 04/17/24 so there was only 1 MA administering morning medications. -She did not think the MA met the 1-hour time frame that morning for administering medications. -She tried to call several MAs that morning but could not reach anyone. -No MAs were available to help from the sister facility next door. -She was unable to administer medications that morning because she was helping with feeding assistance to residents in the dining room.	D 358		

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-She had a concern about Resident #8's Ibuprofen being administered late that morning.
-Resident #8 had a lot of body aches and pains and needed to get her medication on time to help with the pain.

Interview with the Administrator on 04/17/24 at 2:10pm revealed:
-There were typically 2 MAs administering medications on first shift but some staff called out today, 04/17/24.
-Medications should be administered on time, within the required timeframes.

Attempted telephone interview with Resident #8's primary care provider (PCP) on 04/18/24 at 4:35pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable.

f. Review of Resident #9's current FL-2 dated 06/21/23 revealed:
-Diagnoses included dementia without behavioral disturbances, osteoporosis, anxiety disorder, hypertension, hypothyroidism, and cataracts.
-There was an order for Xtampza ER 9mg 1 capsule twice a day. (Xtampza ER is a controlled substance used to treat moderate to severe pain.)

Review of Resident #9's physician's order dated 11/06/23 revealed an order for Xtampza ER 9mg 1 tablet every 12 hours.

Review of Resident #9's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Xtampza ER 9mg 1 tablet

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D 358	Continued From page 16 every 12 hours scheduled for 8:00am and 8:00pm. -Xtampza ER was documented as administered from 04/01/24 - 04/17/24 (8:00am). Observation of the 8:00am medication pass on 04/17/24 revealed the medication aide (MA) prepared and administered Resident #9's Xtampza ER 9mg at 10:05am, 1 hour and 5 minutes beyond the allowed time frame. Interview with the MA on 04/17/24 at 1:20pm revealed: -She was running late with the medication pass that morning, 04/17/24, because she was the only MA administering medications. -There were usually 2 MAs administering medications for the 8:00am medication pass. -There were 2 or 3 staff who called out that morning, including the other MA scheduled to administer medications. -It was unusual to have call outs; she tried to call in other staff this morning but was unable to reach anyone. -There was another MA on duty but she was needed to work on the floor as a personal care aide (PCA) since they were short staffed that morning. Second interview with the MA on 04/17/24 at 1:33pm revealed: -She was not sure why Resident #9 took pain medication. -The resident had never voiced any complaints about pain to her. Interview with the Memory Care Director (MCD) on 04/17/24 at 1:47pm revealed: -There were usually 2 MAs administering medications during the morning medication pass.	D 358		

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D 358	Continued From page 17 -They had a call out that morning on 04/17/24 so there was only 1 MA administering morning medications. -She did not think the MA met the 1-hour time frame that morning for administering medications. -She tried to call several MAs that morning but could not reach anyone. -No MAs were available to help from the sister facility next door. -She was unable to administer medications that morning because she was helping with feeding assistance to residents in the dining room. -She had a concern about Resident #9's Xtampza being administered late that morning. -Administering the Xtampza doses too close together could cause the resident to be sedated or have falls. Interview with the Administrator on 04/17/24 at 2:10pm revealed: -There were typically 2 MAs administering medications on first shift but some staff called out today, 04/17/24. -Medications should be administered on time, within the required timeframes. Attempted telephone interview with Resident #9's primary care provider (PCP) on 04/18/24 at 4:35pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #9 was not interviewable. g. Review of Resident #9's current FL-2 dated 06/21/23 revealed an order for Acetaminophen 500mg 2 tablets (1000mg) twice a day. (Acetaminophen is a mild pain reliever.) Review of Resident #9's April 2024 electronic	D 358		

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D 358	Continued From page 18 medication administration record (eMAR) revealed: -There was an entry for Acetaminophen 500mg 2 tablets (1000mg) twice a day scheduled for 8:00am and 8:00pm. -Acetaminophen was documented as administered from 04/01/24 - 04/17/24 (8:00am). Observation of the 8:00am medication pass on 04/17/24 revealed the medication aide (MA) prepared and administered Resident #9's Acetaminophen at 10:05am, 1 hour and 5 minutes beyond the allowed time frame. Interview with the MA on 04/17/24 at 1:20pm revealed: -She was running late with the medication pass that morning, 04/17/24, because she was the only MA administering medications. -There were usually 2 MAs administering medications for the 8:00am medication pass. -There were 2 or 3 staff who called out that morning, including the other MA scheduled to administer medications. -It was unusual to have call outs; she tried to call in other staff this morning but was unable to reach anyone. -There was another MA on duty but she was needed to work on the floor as a personal care aide (PCA) since they were short staffed that morning. Second interview with the MA on 04/17/24 at 1:33pm revealed: -She was not sure why Resident #9 took pain medication. -The resident had never voiced any complaints about pain to her. Interview with the Memory Care Director (MCD)	D 358		

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D 358	Continued From page 19 on 04/17/24 at 1:47pm revealed: -There were usually 2 MAs administering medications during the morning medication pass. -They had a call out that morning on 04/17/24 so there was only 1 MA administering morning medications. -She did not think the MA met the 1-hour time frame that morning for administering medications. -She tried to call several MAs that morning but could not reach anyone. -No MAs were available to help from the sister facility next door. -She was unable to administer medications that morning because she was helping with feeding assistance to residents in the dining room. -She had a concern about Resident #9's Acetaminophen being administered late that morning. -Resident #9 had body aches and needed to get her medication on time to help with the pain. Interview with the Administrator on 04/17/24 at 2:10pm revealed: -There were typically 2 MAs administering medications on first shift but some staff called out today, 04/17/24. -Medications should be administered on time, within the required timeframes. Attempted telephone interview with Resident #9's primary care provider (PCP) on 04/18/24 at 4:35pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #9 was not interviewable. 2. Review of Resident #1's current FL-2 dated 07/26/23 revealed diagnoses included dementia with behavioral disturbances, hypertension,	D 358		

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gastroesophageal reflux disease, hyperlipidemia, and major depressive disorder.

Review of Resident #1's emergency room (ER) discharge instructions dated 04/13/24 revealed:
-The resident was seen for a fall.
-The resident was diagnosed with closed head injury, laceration of the forehead (requiring sutures), and bladder infection.
-The resident was to start taking an antibiotic for infection.

Review of Resident #1's prescription dated 04/13/24 revealed an order for Macrobid 100mg 1 capsule twice a day for 5 days. (Macrobid is an antibiotic used to treat urinary tract infections.)

Review of Resident #1's April 2024 electronic medication administration record (eMAR) on 04/18/24 revealed:
-There was an entry for Macrobid 100mg take 1 capsule twice a day for 5 days scheduled for 8:00am and 8:00pm.
-The start date was documented as 04/14/24.
-The first dose of Macrobid 100mg was documented as administered at 8:00pm on 04/14/24 and it was documented as administered through 8:00am on 04/18/24, for a total of 8 doses.

Observation of Resident #1's medications on hand on 04/18/24 at 9:54am revealed:
-There was a supply of Macrobid 100mg capsules dispensed on 04/14/24.
-There were 7 of 10 Macrobid 100mg capsules remaining in the bottle.
-Only 3 (1.5-day supply) Macrobid 100mg capsules had been used from the supply of 10 capsules (5-day supply).

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D 358	Continued From page 21 Interview with the medication aide (MA) on 04/18/24 at 9:54am revealed: -She did not recall if she administered Resident #1's Macrobid that morning since it was in a prescription bottle and not a bubble card. -She thought since she documented it as administered that she did administer it. -She did not know why 8 doses of Macrobid were documented as administered but 7 of 10 doses remained in the prescription bottle. Interview with the Memory Care Director (MCD) on 04/18/24 at 10:28am revealed: -She was not aware Resident #1's Macrobid had not been administered as ordered for a urinary tract infection (UTI). -The MAs were trained to check the eMARs at least 3 times when administering medications to make sure medications were administered as ordered. -The MAs should not document a medication was administered if it was not administered. Telephone interview with Resident #1's mental health provider (MHP) on 04/18/24 at 3:58pm revealed: -The resident's primary care provider (PCP) would manage the resident's antibiotic. -She saw the resident for a visit last week and the resident did not look well. -Not receiving the Macrobid as ordered could put the resident at risk of continuing to have UTI symptoms. Telephone interview with an on-call provider for Resident #1's PCP on 04/18/24 at 5:32pm revealed: -If a provider ordered a medication, the medication should be administered as ordered. -Not receiving an antibiotic for a UTI could put a	D 358		

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resident at risk of sepsis (sepsis is a serious life-threatening medical condition that happens when the body's immune system has an extreme response to infection).

Review of Resident #1's PCP verbal order dated 04/18/24 at 2:49pm revealed:
-The resident missed doses of her antibiotic; will extend course until finished.
-There was an order for Macrobid 100mg 1 capsule twice a day until medication runs out.

Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable.

3. Review of Resident #2's current FL-2 dated 12/20/23 revealed diagnoses included dementia, hypertension, anemia, gout, hyperlipidemia, chronic kidney disease, constipation, peripheral vascular disease, coronary artery disease, Vitamin D deficiency, Vitamin B12 deficiency, and major depressive disorder.

Review of Resident #2's dermatology provider's order dated 02/12/24 revealed an order for Desonide 0.05% topical ointment apply a thin layer to face twice a day. (Desonide is a topical steroid ointment used treat inflammatory skin conditions.)

Review of Resident #2's dermatology provider's order dated 03/26/24 revealed:
-There was an order for Desonide 0.05% topical ointment apply a pea-sized amount to face as needed (prn) for flares of seborrheic dermatitis (a skin condition that causes scaly patches and red skin).
-Not to exceed 2 weeks out of the month.
-Please discontinue daily use of Desonide

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FALLS RIVER COURT MEMORY CARE COMMUNITY	1130 FALLS RIVER AVENUE RALEIGH, NC 27614

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D 358	Continued From page 23 ointment. Review of Resident #2's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Desonide ointment 0.05% apply a thin layer to face twice a day scheduled at 8:00am and 8:00pm. -Desonide ointment was documented as administered twice a day from 03/01/24 - 03/31/24. -There was no entry for Desonide ointment to be administered prn as ordered on 03/26/24. -The resident continued to be administered scheduled Desonide ointment after the scheduled dose was discontinued on 03/26/24. Review of Resident #2's April 2024 eMAR revealed: -There was an entry for Desonide ointment 0.05% apply a thin layer to face twice a day scheduled at 8:00am and 8:00pm. -Desonide ointment was documented as administered twice a day from 04/01/24 - 04/17/24. -There was no entry for Desonide ointment to be administered prn as ordered on 03/26/24. -The resident continued to be administered scheduled Desonide ointment after the scheduled dose was discontinued on 03/26/24. Observation of Resident #2's medications on hand on 04/18/24 at 6:24pm revealed: -There was a 60gm tube of Desonide ointment 0.05% dispensed on 03/07/24. -Instructions were to apply a thin layer to face twice a day. Interview with a medication aide (MA) on 04/18/24 at 6:15pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092141	A. BUILDING: _____ B. WING _____	R 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 24 -She administered Resident #2's Desonide ointment according to the instructions on the eMAR. -She was not aware of an order to change it to prn. Interview with the Memory Care Director (MCD) on 04/18/24 at 6:12pm revealed: -She was responsible for implementing new orders. -She overlooked Resident #2's order for prn Desonide ointment. -The resident should be receiving the Desonide ointment on a prn basis, not scheduled. Telephone interview with a medical assistant at Resident #2's dermatology provider's office on 04/22/24 at 4:25pm revealed: -Resident #2's dermatology was unable to come to the phone currently but she would ask her about the Desonide ointment. -The dermatology provider indicated the facility should have stopped administering Desonide ointment as a scheduled medication -Long-term use of a topical steroid could cause eventual thinning of the skin. Observation of Resident #2 on 04/18/24 at 6:10pm revealed the resident had a few light red/pink small, discolored areas of skin on his face. Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable. The facility failed to administer medications as ordered to 2 of 3 residents observed during the medication passes on 04/17/24 including a resident with increased eye pressure due to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 25 glaucoma who did not receive a combination eye drop as ordered, putting the resident at risk of more increased eye pressure. Three residents observed had medications ordered more than once a day administered from 45 minutes up to 1 hour and 45 minutes late. Resident #7's controlled substance for anxiety was administered too close together at 9:45am and again at 1:20pm, putting the resident at risk for sedation and falls. Resident #8 and Resident #9, who had body aches and pain, had oral and topical pain medications administered late putting the residents at risk of experiencing breakthrough pain. Resident #1 had a fall and went to the emergency room and was diagnosed with a bladder infection and did not receive an antibiotic as ordered putting the resident at risk of continuing to experience symptoms of a urinary tract infection and developing sepsis. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/18/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 2, 2024.	D 358		