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C 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey on 06/18/24.	C 000		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 interviews, observations and record reviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#1 and #2) including a resident with orders for a blood thinner, a cholesterol medication, a beta blocker, and an antidiabetic medication (#1), and a resident with an order for an anti-fungal cream (#2). The findings are: 1. Review of Resident #1's FL-2 dated 04/10/24 revealed diagnoses included schizoaffective disorder and bipolar disorder. a. Review of Resident #1's FL-2 dated 04/10/24 revealed there was an order for aspirin (a blood thinner used to prevent blood clots) 81mg take one tablet daily. Review of Resident #1's April 2024 medication	C 330		

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administration record (MAR) revealed:
-There was an entry for aspirin 81mg take one tablet daily scheduled for administration at 8:00am.
-There was documentation aspirin 81mg was administered as ordered from 04/01/24 to 04/30/24.

Review of Resident #1's May 2024 MAR revealed:
-There was an entry for aspirin 81mg take one tablet daily scheduled for administration at 8:00am.
-There was documentation aspirin 81mg was administered as ordered from 05/01/24 to 05/31/24.

Review of Resident #1's June 2024 MAR from 06/01/24 to 06/18/24 revealed:
-There was an entry for aspirin 81mg take one tablet daily scheduled for administration at 8:00am.
-There was no documentation aspirin 81mg was administered from 06/12/24 to 06/17/24.

Observation of Resident #1's medications on hand on 06/18/24 at 4:24pm revealed:
-There was an opened bottle of aspirin 81mg with a fill date of 01/03/24 with 56 of 120 tablets available for administration.
-There was an unopened bottle of aspirin 81mg dated 04/05/24 available for administration.

Attempted telephone interview with the facility's contracted pharmacy on 06/18/24 at 4:41pm unsuccessful.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/18/24 at 4:40pm was unsuccessful.

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C 330	Continued From page 2 Interview with Resident #1 on 06/18/24 at 5:01pm revealed: -He was always administered his medications and he had never gone without being administered medication, including aspirin. -He was able to identify his medications by name and he was administered aspirin for the last ten days. Interview with the Supervisor-in-Charge (SIC) on 06/18/24 at 5:00pm revealed: -She administered Resident #1's aspirin from 06/12/24 to 06/17/24, but forgot to document administration on the MAR. -The pharmacy sent extra medication for Resident #1 and she administered the older medication before administering newer medication. -She always administered Resident #1's medication and he never refused any of his medications. Refer to interview with the Supervisor-in-Charge (SIC) on 06/18/24 at 5:06pm. Refer to telephone interview with the Owner on 06/18/24 at 5:21pm. Refer to telephone interview with the Administrator on 06/18/24 at 5:35pm. b. Review of Resident #1's FL-2 dated 04/10/24 revealed there was an order for atorvastatin (a cholesterol medication used to treat high levels of lipids) 20mg take 1 tablet daily. Review of Resident #1's April 2024 medication administration record (MAR) revealed: -There was an entry for atorvastatin 20mg take	C 330		

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one tablet daily scheduled for administration at 8:00pm.
-There was documentation atorvastatin 20mg was administered as ordered from 04/01/24 to 04/30/24.

Review of Resident #1's May 2024 MAR revealed:
-There was an entry for atorvastatin 20mg take one tablet daily scheduled for administration at 8:00pm.
-There was documentation atorvastatin 20mg was administered as ordered from 05/01/24 to 05/31/24.

Review of Resident #1's June 2024 MAR from 06/01/24 to 06/18/24 revealed:
-There was an entry for atorvastatin 20mg take one tablet daily scheduled for administration at 8:00pm.
-There was no documentation atorvastatin 20mg was administered from 06/08/24 to 06/17/24.

Observation of Resident #1's medications on hand on 06/18/24 at 4:24pm revealed:
-There was an opened bottle of atorvastatin 20mg with a fill date of 03/06/24 with 29 of 90 tablets available for administration.
-There was an unopened bottle of atorvastatin 20mg dated 06/06/24 with 90 of 90 tablets available for administration.

Attempted telephone interview with the facility's contracted pharmacy on 06/18/24 at 4:41pm unsuccessful.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/18/24 at 4:40pm was unsuccessful.

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Interview with Resident #1 on 06/18/24 at 5:01pm revealed:
-He was always administered his medications and he had never gone without being administered medication, including atorvastatin.
-He was able to identify his medications by name and he was administered atorvastatin for the last ten days.

Interview with the Supervisor-in-Charge (SIC) on 06/18/24 at 5:00pm revealed:
-She administered Resident #1's atorvastatin from 06/08/24 to 06/17/24 but forgot to document administration on the MAR.
-The pharmacy sent extra medication for Resident #1 and she administered the older medication before administering newer medication.
-She always administered Resident #1's medication and he never refused any of his medications.

Refer to interview with the Supervisor-in-Charge (SIC) on 06/18/24 at 5:06pm.

Refer to telephone interview with the Owner on 06/18/24 at 5:21pm.

Refer to telephone interview with the Administrator on 06/18/24 at 5:35pm.

c. Review of Resident #1's FL-2 dated 04/10/24 revealed there was an order for carvedilol (a beta blocker used to treat high blood pressure) 12.5mg take 1 tablet twice daily.

Review of Resident #1's April 2024 medication administration record (MAR) revealed:
-There was an entry for carvedilol 12.5mg take 1 tablet twice daily scheduled for administration at

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8:00am and 8:00pm.
-There was documentation carvedilol 12.5mg was administered as ordered from 04/01/24 to 04/30/24.

Review of Resident #1's May 2024 MAR revealed:
-There was an entry for carvedilol 12.5mg take 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation carvedilol 12.5mg was administered as ordered from 05/01/24 to 05/31/24.

Review of Resident #1's June 2024 MAR from 06/01/24 to 06/18/24 revealed:
-There was an entry for carvedilol 12.5mg take 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was no documentation carvedilol 12.5mg was administered from 06/08/24 at 8:00pm to 06/18/24 at 8:00am.

Observation of Resident #1's medications on hand on 06/18/24 at 4:24pm revealed:
-There was an opened bottle of carvedilol 12.5mg with a fill date of 10/20/23 with 30 of 90 tablets available for administration.
-There was an unopened bottle of carvedilol 12.5mg dated 04/05/24 with 90 of 90 tablets available for administration.

Attempted telephone interview with the facility's contracted pharmacy on 06/18/24 at 4:41pm unsuccessful.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/18/24 at 4:40pm was unsuccessful.

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Interview with Resident #1 on 06/18/24 at 5:01pm revealed:
-He was always administered his medications and he had never gone without being administered medication, including carvedilol.
-He was able to identify his medications by name and he was administered carvedilol for the last ten days.

Interview with the Supervisor-in-Charge (SIC) on 06/18/24 at 5:00pm revealed
-She administered Resident #1's carvedilol from 06/08/24 to 06/18/24 but forgot to document administration on the MAR.
-The pharmacy sent extra medication for Resident #1 and she administered the older medication before administering newer medication.
-She always administered Resident #1's medication and he never refused any of his medications.

Refer to interview with the Supervisor-in-Charge (SIC) on 06/18/24 at 5:06pm.

Refer to telephone interview with the Owner on 06/18/24 at 5:21pm.

Refer to telephone interview with the Administrator on 06/18/24 at 5:35pm.

d. Review of Resident #1's FL-2 dated 04/10/24 revealed there was an order for glipizide (an antidiabetic medication used to control high blood sugar levels) 5mg take 1 tablet twice daily.

Review of Resident #1's April 2024 medication administration record (MAR) revealed:
-There was an entry for glipizide 5mg take one tablet twice daily scheduled for administration at

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8:00am and 8:00pm.
-There was documentation glipizide 5mg was administered as ordered from 04/01/24 to 04/30/24.

Review of Resident #1's May 2024 MAR revealed:
-There was an entry for glipizide 5mg take one tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation glipizide 5mg was administered as ordered from 05/01/24 to 05/31/24.

Review of Resident #1's June 2024 MAR from 06/01/24 to 06/18/24 revealed:
-There was an entry for glipizide 5mg take one tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was no documentation glipizide 5mg was administered from 06/08/24 to 06/18/24.

Observation of Resident #1's medications on hand on 06/18/24 at 4:24pm revealed:
-There was an opened bottle of glipizide 5mg with a fill date of 03/06/24 with 60 of 180 tablets available for administration.
-There was an unopened bottle of glipizide 5mg dated 06/03/24 with 180 of 180 tablets available for administration.

Attempted telephone interview with the facility's contracted pharmacy on 06/18/24 at 4:41pm unsuccessful.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/18/24 at 4:40pm was unsuccessful.

Interview with Resident #1 on 06/18/24 at 5:01pm

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revealed:
-He was always administered his medications and he had never gone without being administered medication, including glipizide.
-He was able to identify his medications by name and he was administered glipizide for the last ten days.

Interview with the Supervisor-in-Charge (SIC) on 06/18/24 at 5:00pm revealed:
-She administered Resident #1's glipizide from 06/08/24 to 06/18/24 but forgot to documentation administration on the MAR.
-The pharmacy sent extra medication for Resident #1 and she administered the older medication before administering newer medication.
-She always administered Resident #1's medication and he never refused any of his medications.

Refer to interview with the Supervisor-in-Charge (SIC) on 06/18/24 at 5:06pm.

Refer to telephone interview with the Owner on 06/18/24 at 5:21pm.

Refer to telephone interview with the Administrator on 06/18/24 at 5:35pm.

2. Review of Resident #2's FL-2 dated 09/18/23 revealed diagnoses included type 2 diabetes and hypertension.

Review of Resident #2's signed physician's order dated 05/21/24 revealed there was an order for nystatin cream 100,000units/gram apply moderate amount to affected area twice daily (used to treat infections of the skin).

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Review of Resident #2's May 2024 medication administration record (MAR) revealed there was no entry for nystatin cream 100,000units/gram and there was no documentation nystatin was administered as ordered from 05/01/24 to 05/31/24.

Review of Resident #2's June 2024 MAR from 06/01/24 to 06/18/24 revealed there was no entry for nystatin cream 100,000units/gram and there was no documentation nystatin was administered as ordered from 06/01/24 to 06/18/24.

Observation of Resident #2's medications on hand on 06/18/24 at 4:24pm revealed there was an opened 15gram tube of nystatin cream 100,000units/gram dated 06/16/24 available for administration with approximately three-quarters of the tube remaining.

Attempted telephone interview with the facility's contracted pharmacy on 06/18/24 at 4:41pm unsuccessful.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 06/18/24 at 4:40pm was unsuccessful.

Interview with Resident #2 on 06/18/24 at 3:15pm revealed:
-He was administered nystatin on 06/18/24.
-He was not certain if he was administered nystatin twice daily as ordered on 06/17/24.

Interview with the Supervisor-in-Charge (SIC) on 06/18/24 at 5:00pm revealed
-She administered Resident #2's nystatin cream twice a day due to a rash flare up.
-Nystatin cream was not documented as administered on Resident #2's MARs and she

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C 330	Continued From page 10 had not documented the nystatin administration elsewhere. -Resident #2 was ordered nystatin cream in November 2023 and still had some unopened nystatin on the medication cart. -She was told by the pharmacy that she could use the nystatin cream from November 2023 because it was still in date. -The pharmacy originally dispensed three 15gram tubes of nystatin cream. -She forgot to write in a new medication order entry for nystatin and document administration when it was reordered in May 2024. Refer to interview with the Supervisor-in-Charge (SIC) on 06/18/24 at 5:06pm. Refer to telephone interview with the Owner on 06/18/24 at 5:21pm. Refer to telephone interview with the Administrator on 06/18/24 at 5:35pm. _____ Interview with the Supervisor-in-Charge (SIC) on 06/18/24 at 5:06pm revealed her normal process when a new medication was ordered for a resident was to fax the order to the pharmacy, write in a new order entry on the medication administration record (MAR), and check the next month's MAR to ensure the new order was printed on the MAR. Telephone interview with the Owner on 06/18/24 at 5:21pm revealed she did not know the residents' medications were not administered as ordered and the SIC was responsible to administer medications as ordered. Telephone interview with the Administrator on 06/18/24 at 5:35pm revealed he did not know the	C 330		

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C 330	Continued From page 11 residents' medications were not documented as administered and the SIC was responsible to administer medications as ordered.	C 330		