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-C 06/26/2024

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

(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 Section conducted a follow-up survey and complaint investigation on June 25-26, 2024.	D 000	Topic: Medication Administration Regulatory 10ANCAC 13F .1004 (j) Corrective Action:	8/9/24
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration record was accurate for 1 of 5 sampled residents (#2) related to the failure to remove a discontinued medication used to treat pain or shortness of breath from the resident's medication administration record and inaccurate documentation of a medication used	D 367	Memory Care Coordinator and Assisted Living Director to confirm d/c orders within Yardi and the Pharmacy Medication Aides to be retrained by August 9,2024 on Yardi to ensure proper procedure in signing off on resident medication administration Medication Aides to be retrained by August 9, 2024 on Medication Administration using the Tarantino Training Manual Identification: All residents have the potential to be affected by the alleged deficient practice	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Riejinger — TITLE: Executive Director — (X6) DATE: 7/29/2024

Reviewed and acknowledged on 07/29/24 by JL

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D 367	Continued From page 1 to treat or prevent skin irritation. The findings are: Review of Resident #2's current FL2 dated 02/13/24 revealed diagnoses included dementia without behavioral disturbance, osteopenia, depression, and hyperlipidemia. a. Review of Resident #2's current FL2 dated 02/13/24 revealed there was an order for Morphine Sulfate 20mg/1ml give 1 prefilled syringe (0.25ml=5mg) every 4 hours for pain or shortness of breath (Morphine Sulfate is a medication used to treat moderate to severe pain and for relieving shortness of breath). Review of Resident #2's hospice physician order sheet dated 04/30/24 revealed an order to discontinue Morphine Sulfate. Review of Resident #2's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Morphine Sulfate 20mg/1ml give 1 prefilled syringe (0.25ml=5mg) every 4 hours for pain or shortness of breath with a start date of 02/23/24. -There was an entry for Morphine Sulfate 20mg/1ml give 1 prefilled syringe (0.25ml=5mg) by mouth every 4 hours as needed for pain/shortness of breath with a start date of 03/29/24. -There was no documentation of Morphine Sulfate being administered on 05/31/24. Review of Resident #2's June 2024 eMAR revealed: -There was an entry for Morphine Sulfate 20mg/1ml give 1 prefilled syringe (0.25ml=5mg)	D 367	Monitoring: Memory Care Coordinator will review the Cart Audits that the Med Aides complete. Memory Care Coordinator will complete an EMAR to Cart Audit weekly to ensure all medications are on cart. Assisted Living Director will receive and review all cart audits. Pharmacy Consultant will conduct quarterly audits during their visits. Report of findings will be provided to the Assisted Living Director, Memory Care Coordinator, and Executive Director. Nurse Consultant to conduct monthly EMAR to Cart audit. Audit will consist of 3 charts a month.	

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D 367	Continued From page 2 every 4 hours for pain/shortness of breath with a start date of 02/23/24. -There was an entry for Morphine Sulfate 20mg/1ml give 1 prefilled syringe (0.25ml=5mg) by mouth every 4 hours as needed for pain/shortness of breath with a start date of 03/29/24. -There was no documentation of Morphine Sulfate being administered 06/01/24 to 06/25/24. Observation of Resident #2's medication on hand on 06/26/24 at 10:25am revealed Resident #2 did not have any Morphine Sulfate available on the medication cart. Review of the facility's contracted pharmacy's medication return sheet revealed: -On 10/06/23, the facility's contracted pharmacy dispensed a quantity of 10 Morphine Sulfate 20mg/ml prefilled syringes containing 0.25ml=5mg. -On 02/14/24, the quantity of 10 Morphine Sulfate 20mg/ml prefilled syringes containing 0.25ml=5mg were returned to the facility's contacted pharmacy. Interview with a medication aide (MA) on 06/26/24 at 11:10am revealed: -Resident #2's Morphine Sulfate was discontinued. -Resident #2's Morphine Sulfate was returned to the facility's contracted pharmacy because the medication was expired. -The pharmacy Resident #2's family member was currently using did not fill medications in prefilled syringes. -The Memory Care Coordinator (MCC) was responsible for conducting medication cart audits. -The facility did not currently have a MCC. -She thought the third shift MAs did cart audits,	D 367		

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D 367	Continued From page 3 but she was unsure when or how often. Second interview with a MA on 06/26/24 at 12:06pm revealed: -When the facility received a medication order, the MCC processed the medication order. -MAs processed medication orders in the absence of the MCC. -When a medication order was processed, this included adding medication or discontinuing medication from the eMAR. -She was unsure why Morphine Sulfate was still on Resident #2's eMAR if the medication was discontinued. Interview with Resident #2's hospice nurse case manager on 06/26/24 at 11:49am revealed: -If a patient had an order for Morphine Sulfate and the medication expired, the hospice agency did not reorder the medication due to recent limited availability of the medication. -The hospice agency used to routinely order Morphine Sulfate for most patients but no longer ordered this medication unless the patient was transitioning to the end stages of life. -Resident #2's Morphine Sulfate order was discontinued on 04/30/24. -Resident #2's eMAR should reflect the current medication orders so facility staff knew the correct medications to administer. Interview with a representative from the facility's contracted pharmacy on 06/26/24 at 11:01am revealed: -The pharmacy had not filled any medications for Resident #2 since October 2023. -The pharmacy had not received any orders to discontinue Morphine Sulfate for Resident #2. -Resident #2 was listed for profile only which meant the pharmacy updated Resident #2's	D 367		

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D 367	Continued From page 4 eMARs when medication orders were sent, but the pharmacy did not fill those medications. Refer to interview with the Administrator on 06/26/24 at 2:59pm. b. Review of Resident #2's physician's order dated 05/08/24 revealed an order for Desitin Cream 13% apply to affected area twice a day on buttocks. Review of Resident #2's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Desitin Cream 13% apply to affected area twice a day on buttocks scheduled for 9:30am and 9:30pm. -Desitin Cream was documented as administered on 05/31/24 at 9:30am and 9:30pm. Review of Resident #2's June 2024 eMAR printed by the facility on 06/25/24 at 11:01am revealed: -There was an entry for Desitin Cream 13% apply to affected area twice a day on buttocks scheduled for 9:30am and 9:30pm. -Desitin Cream was documented as administered at 9:30am on all days except for 06/03/24 and 06/06/24. -On 06/03/24, the documentation was "OOF" which meant out of the facility according to the abbreviations listed on the eMAR abbreviations section. -On 06/06/24, the documentation was "DNG" which meant drug not given according to the abbreviations listed on the eMAR abbreviations section. -Desitin Cream was documented as administered at 9:30pm on all days except for 06/24/24. -On 06/24/24, the documentation was "DNA" which meant drug not available according to the	D 367		

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D 367	Continued From page 5 abbreviations listed on the eMAR abbreviations section. Observation of Resident #2's medications on hand on 06/26/24 at 10:25am revealed Resident #2 did not have any Desitin Cream available on the medication cart. Review of Resident #2's June 2024 eMAR printed by the facility on 06/26/24 at 12:23pm revealed: -There was an entry for Desitin Cream 13% apply to affected area twice a day on buttocks scheduled for 9:30am and 9:30pm. -Desitin Cream was documented as administered at 9:30am on all days except for 06/03/24, 06/06/24, and 06/25/24. -On 06/03/24 at 9:30am, the documentation was "OOF" which meant out of the facility according to the abbreviations listed on the eMAR abbreviations section. -On 06/06/24 at 9:30am, the documentation was "DNG" which meant drug not given according to the abbreviations listed on the eMAR abbreviations section. -On 06/25/24 at 9:30am, the documentation was "DNG" which meant drug not given according to the abbreviations listed on the eMAR abbreviations section. -Desitin Cream was documented as administered at 9:30pm on all days except for 06/24/24. -On 06/24/24, the documentation was "DNA" which meant drug not available according to the abbreviations listed on the eMAR abbreviations section. -Desitin Cream was documented as administered on 06/25/24 at 9:30pm and on 06/26/24 at 9:30am. Interview with a medication aide (MA) on 06/26/24 at 12:25pm revealed:	D 367		

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D 367	Continued From page 6 -When DNG was documented on the eMAR, that meant the drug was not given. -When DNA was documented on the eMAR, that meant the drug was not available. -If medication was needed for Resident #2, MAs had to contact Resident #2's family member. -Resident #2 did not use the facility's contracted pharmacy. -She had contacted Resident #2's family member this week to let him know Resident #2 needed Desitin Cream. -She followed up with Resident #2's family member this morning, 06/26/24, and asked him to bring Desitin Cream to the facility. -MAs usually reported any medications not available to the Memory Care Coordinator (MCC). -The facility did not have a MCC at this time. Interview with Resident #2's family member on 06/26/24 at 2:32pm revealed: -He did not have Resident #2's medications filled at the facility's contracted pharmacy due to the cost. -He purchased over-the-counter medications for Resident #2 and brought them to the facility. -He brought Desitin Cream to the facility today, 06/26/24. -The telephone call he received this morning, 06/26/24, was the first time he was notified that Resident #2 needed Desitin Cream. -He was unsure of the last time he brought Desitin Cream to the facility before today, 06/26/24. Attempted interview with the Assisted Living (AL) Director on 06/26/24 was unsuccessful. Attempted telephone interview with Resident #2's primary care provider (PCP) on 06/26/24 at 2:57pm was unsuccessful.	D 367		

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D 367	Continued From page 7 Refer to interview with the Administrator on 06/26/24 at 2:59pm. Interview with the Administrator on 06/26/24 at 2:59pm revealed: -Medication aides (MA) or the Memory Care Coordinator (MCC) should send new medication orders to the pharmacy. -The facility did not currently have a MCC, but the assisted living (AL) director from the AL facility on premises had been filling in for that position until the new MCC started in July 2024. -The AL director was currently responsible for ensuring the eMARs and medication orders were accurate. -She was unsure why Morphine Sulfate was still on Resident #2's eMAR if the medication had been discontinued. -MAs should document all medications administered or not administered on the eMAR appropriately. -If medication was not available on the medication cart, MAs should notify the resident's pharmacy to order the medication. -Resident #2's family member did not use the facility's contracted pharmacy. -MAs should contact Resident #2's family member for medications and document the notification to the family. -The resident's primary care provider (PCP) should be notified when residents did not receive their medications. -MAs should report any medications that were not available to the AL director until the new MCC started.	D 367		

Medication Management and Med Room Procedure

The objective of this procedure is to outline the responsibilities of Med Aides/Supervisors in maintaining the cleanliness and orderliness of the medication room, monitoring the refrigerator log, and managing the medication refill process in an assisted living community.

Med Room Cleanliness and Orderliness

Daily Inspection

- Conduct a daily inspection of the medication room to ensure it is clean, organized, and free from clutter.
- Dispose of expired or discontinued medications promptly.

Proper Storage

- Organize medications neatly on shelves and in designated areas.
- Ensure medications are stored according to safety guidelines, and refrigerated items are placed in the appropriate storage.

Refrigerator Log Monitoring

Daily Check

- Regularly check the refrigerator log to ensure it is filled out accurately.
- Verify that the log indicates the appropriate temperature readings for medication storage.

Temperature Monitoring

- Set a schedule for routine temperature checks of the refrigerator.
- If any deviations from the recommended temperature range are noted, take immediate corrective action, such as notifying maintenance or replacing the refrigerator if necessary.

Medication Refill Procedure

A. General Medication Refills

1. **Initiation Timeline**
   - All refills must be initiated when a resident has 7 days' worth of medications remaining.
   - If, for any reason, a refill is not available when the resident has 3 days of medication left, notify the supervisor immediately.
2. **Refill Authorization**
   - Obtain authorization from the healthcare provider for medication refills.
   - Collaborate with the pharmacy to ensure timely delivery of refilled medications.

B. VA Medication Refills

1. **Initiation Timeline for VA Medications**
   - For residents receiving medications from the VA, initiate refills when the resident has 21 days of available medication.
   - Coordinate with the VA pharmacy to ensure a seamless refill process.
2. **Communication with Resident**
   - Notify residents in advance about the initiation of VA medication refills.
   - Ensure residents are aware of the process and any changes to their medication routine.

Supervisor Notification

Timely Reporting

- If a resident is down to 3 days of medication and the refill is still not available, notify the supervisor immediately.
- Provide clear and detailed information about the situation, including any potential impact on the resident.

Medication Pass Procedure and Refusal Protocol

The objective of this procedure is to guide associates in the proper administration of medications during the Medication Pass and to outline the protocol for handling refusals of medication by residents in an assisted living community.

All outlined procedures below are subject to revision based on the information provided during the medication delegation and training classes. The content presented during these instructional sessions takes precedence over the procedures detailed below, ensuring that the most up-to-date and accurate guidelines are followed in medication management within the assisted living community.

Preparation

Gather Medications

- Collect the necessary medications from the designated storage area, ensuring accuracy and proper labeling.

Review Medication Orders

- Review the medication orders for each resident to confirm dosage, frequency, and any special instructions.

Wash Hands

- Wash hands thoroughly before handling medications to maintain hygiene.

Identification of Residents

Verify Identity

- Verify the identity of the resident using two identifiers (e.g., name and date of birth) before administering any medication.

Ask Open-Ended Questions

- Engage in open-ended conversation with the resident to assess their mental state and ability to comprehend the medication administration process.

Administration

Explain Medication

- Clearly explain each medication to the resident, including the purpose, dosage, and any potential side effects.

Allow Questions

- Encourage residents to ask questions or express concerns about their medications.

Administer Medication

- Administer medications according to the prescribed dosage and administration route (oral, subcutaneous, etc.).

Supervision for Self-Administration

- If a resident is capable of self-administration, provide necessary supervision and support.

Document Administration

- Immediately document the administration of each medication in the resident's medication administration record (MAR).

Protocol for Refusal of Medication

Assessment of Refusal

- In case of a refusal, ask the resident the reason for their decision.

Assess Mental State

- Assess the resident's mental state and capacity to make an informed decision.

Review Past Refusal Patterns

- Consider any past refusal patterns or concerns raised by the resident or their healthcare provider.

Communication and Reassurance

Open Dialogue

- Engage in an open and non-confrontational dialogue with the resident.

Reassure and Educate

- Reassure the resident about the importance of the medication and provide education about its benefits.

Offer Alternatives

- If appropriate, offer alternatives such as crushing the medication, changing the administration time, or providing liquid forms.

Documenting Refusal

Document in the MAR

- Document the resident's refusal in the MAR, including the reason, resident's response, and any actions taken.

Notify Supervisor

- Notify the supervisor promptly and provide details about the refusal.

Follow-Up Measures

Monitor Resident

- Monitor the resident for any adverse effects or changes in condition following a refusal.

Follow-Up Conversations

- Schedule follow-up conversations with the resident to address concerns and encourage compliance.