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	HAL092220	A. BUILDING: _____ B. WING _____	07/25/2024

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THE ADDISON OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

(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 an annual survey on July 23 - July 25, 2024.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) in residents' rooms as evidenced by 5 of 10 fixtures with water temperatures ranging from 95.9 to 119.7 degrees F. The findings are: Observation of the water temperatures on the A assisted living (AL) hall on 07/23/24 from 9:40am to 10:06am revealed: -The water temperature in the bathroom sink in room A9 was 118.2 degrees Fahrenheit (F). -The water temperature in the bathroom sink in room A10 was 118.6 degrees F. -The water temperature in the bathroom sink in room A18 was 118.4 degrees F. Observation of the water temperatures on the B AL hall on 07/23/24 from 10:10am to 10:39am	D 113		

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revealed:
-The water temperature in the bathroom sink in room B3 was 98.8 degrees F.
-The water temperature in the bathroom sink in room B12 was 95.9 degrees F.

Review of the facility's May 2024 water temperature logs revealed:
-On 05/04/24, five fixtures were checked, and the temperatures ranged from 110 degrees F to 114 degrees F.
-On 05/11/24, five fixtures were checked, and the temperatures ranged from 105 degrees F to 114 degrees F.
-On 05/18/24, five fixtures were checked, and the temperatures ranged from 113 degrees F to 116 degrees F.
-On 05/25/24, five fixtures were checked, and the temperatures ranged from 110 degrees F to 115 degrees F.

Review of the facility's June 2024 water temperature logs revealed:
-On 06/01/24, five fixtures were checked, and the temperatures ranged from 105 degrees F to 115 degrees F.
-On 06/08/24, five fixtures were checked, and the temperatures ranged from 110 degrees F to 114 degrees F.
-On 06/15/24, five fixtures were checked, and the temperatures ranged from 110 degrees F to 115 degrees F.
-On 06/22/24, five fixtures were checked, and the temperatures ranged from 110 degrees F to 115 degrees F.
-On 06/29/24, five fixtures were checked, and the temperatures ranged from 110 degrees F to 115 degrees F.

Review of the facility's July 2024 water

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temperature logs revealed:
-On 07/06/24, five fixtures were checked, and the temperatures ranged from 110 degrees F to 115 degrees F.
-On 07/13/24, five fixtures were checked, and the temperatures ranged from 110 degrees F to 116 degrees F.
-On 07/20/24, five fixtures were checked, and the temperatures ranged from 110 degrees F to 116 degrees F.

Interview with the resident in room A18 on 07/23/24 at 9:42am revealed:
-She had noticed the water in the bathroom being too hot at times.
-She could turn on the cold faucet if she needed to adjust the water temperature.
-She had not been burned by the hot water.

Interview with the resident in room A9 on 07/23/24 at 10:06am revealed:
-She had noticed the water was too warm sometimes.
-She was able to adjust the water temperature if needed.
-She had not been burned by the hot water.

Interview with the resident in room B12 in 07/23/24 at 10:27am revealed:
-The water in the bathroom usually took a while to become warm.
-She had not noticed the water being too cold when she used the sink.
-The water was usually warm enough for her showers.

Interview with a personal care aide (PCA) on 07/24/24 at 9:05am revealed:
-She had not noticed the water temperatures in the residents' rooms being too hot or too cold.

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-She always checked the water temperature with her hand before she assisted a resident into the shower.
-She used the cold and hot water faucets to adjust the water temperatures in residents' rooms.
-If she noticed any issues with the water temperature, she would report it to her supervisor.

Interview with the Maintenance Director on 07/23/24 at 10:45am revealed:
-He usually checked the water temperatures in the facility every week and documented them in the facility's maintenance software program.
-He had not checked water temperatures this week, but he had checked the water temperatures last week.
-He thought the range for water temperatures in residents' rooms should be 110-120 degrees F.
-He had not noticed any elevated water temperatures in residents' rooms when he checked the water temperatures.
-He had not received any reports of elevated water temperatures from residents or staff.
-He could attempt to adjust the water heaters and call a plumber if needed.

Second observation of the water temperatures on the A assisted living (AL) hall on 07/24/24 from 9:10am to 9:22am revealed:
-The water temperature in the bathroom sink in room A9 was 118.9 degrees F.
-The water temperature in the bathroom sink in room A10 was 119.3 degrees F.
-The water temperature in the bathroom sink in room A18 was 119.7 degrees F.

Second observation of the water temperatures on the B AL hall on 07/24/24 from 8:59am to 9:05am

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revealed:
-The water temperature in the bathroom sink in room B3 was 98.8 degrees F.
-The water temperature in the bathroom sink in room B12 was 95.9 degrees F.

Second interview with the Maintenance Director on 07/24/24 at 9:29am revealed:
-He did not have a chance to adjust the water heater and check the water temperatures in the residents' rooms on 07/23/24.
-He would attempt to adjust the water heaters today, 07/24/24.
-The facility had 4 water heaters.
-The facility's water heaters were replaced within the last year.
-If he was unable to get the residents' water temperatures in range, he would contact a plumber.

Interview with the Administrator on 07/23/24 at 10:55am revealed:
-The Maintenance Director was responsible for checking the water temperatures in the facility.
-She thought the Maintenance Director checked the water temperatures at least once a month.
-The Maintenance Director used a software program to track water temperatures and other maintenance tasks.
-She was unsure of what the water temperatures should be in the residents' rooms.
-She was concerned that the elevated water temperatures in the residents' rooms could be harmful to the residents and potentially cause residents to be burned.
-The facility could attempt to adjust the water temperature and contact a plumber if needed.
-The facility had contacted a plumber regarding the water temperature in October 2023.
-She was not aware of any water temperatures

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D 113	Continued From page 5 out of range since the plumber was at the facility for that issue in October 2023. Second interview with the Administrator on 07/25/24 at 12:25pm revealed the water temperatures should have been adjusted when the issue was found on 07/23/24 because elevated water temperatures could be a safety issue for the residents.	D 113		
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 administered medications had successfully completed the state-approved 5-hour, 10-hour or 15-hour medication aide (MA) training courses as required prior to administering medications for 2 of 6 sampled staff (Staff A and Staff F). The findings are: Review of Staff A's personnel record revealed: -She was hired as a medication aide (MA) on	D 125		

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05/12/24.
-There was a certificate showing Staff A had completed the 5-hour MA training on 03/18/24, however the certificate was not signed by the trainer.
-There was a certificate for Staff A had completed the 10-hour MA training on 03/20/24, however the certificate was not signed by the trainer.

Review of May 2024 electronic medication administration records (eMARs) revealed there was documentation that Staff A administered medications to residents on 05/07/24.

Review of June 2024 eMARs revealed there was documentation that Staff A administered medications to residents on 06/12/24, 06/19/24, 06/22/24, and 06/23/24.

Review of July 2024 eMARs revealed there was documentation that Staff A administered medications to residents on 07/06/24 and 07/07/24.

Attempted telephone interview with Staff A on 07/25/24 at 12:50pm was unsuccessful.

Refer to interview with the Executive Director on 07/25/24 at 12:43pm.

Refer to interview with the BOM on 07/25/24 at 2:30pm.

2. Review of Staff F's personnel record revealed:
-He was hired as a medication aide (MA) on 01/09/24.
-There was a certificate showing Staff F had completed the 10-hour MA training on 04/07/24, however the certificate was not signed by the trainer.

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D 125	Continued From page 7 -There was a certificate for Staff F had completed the 5-hour MA training on 04/13/24, however the certificate was not signed by the trainer. -The 10-hour MA training certificate was dated prior to the 5-hour MA training certificate. Telephone interview with Staff F on 07/25/24 at 1:05pm revealed: -He had started to work at the facility around the second week of January 2024. -He had completed the 10-hour and 5-hour programs on the computer. -The hands-on training was provided by the facility's contracted Registered Nurse (RN). -He had done "one on one" training on the medication cart with the Health and Wellness Director (HWD) for 3-4 weeks before he was able to take the cart by himself. Review of July 2024 electronic medication administration records (eMARs) revealed there was documentation Staff F had administered medications on 07/10/24. Review of June 2024 eMARs revealed there was documentation that Staff F had administered medications on 5 of 30 days from 06/01/24 - 06/30/24 including 06/19/24, 06/25/24, 06/28/24, 06/29/24, and 06/30/24. Refer to interview with the Executive Director on 07/25/24 at 12:43pm. Refer to interview with the BOM on 07/25/24 at 2:30pm. _____ Interview with the Executive Director on 07/25/24 at 12:43pm revealed: -She was unaware Staff A and Staff F had not had their certificates signed by the HWD.	D 125		

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D 125	Continued From page 8 -The Health and Wellness Director (HWD) was currently out of the office. -Staff A and Staff F had administered medications to residents. -The Business Office Manager (BOM) was responsible for ensuring staff personnel records were updated with the required documentation. Interview with the BOM on 07/25/24 at 2:30pm revealed: -She was responsible for the staff personnel records. -She had not completed audits to ensure the personnel records were complete. -She was not aware the HWD had not signed the 5-hour and 10-hour training certificates for Staff A and Staff F.	D 125		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions.	D 283		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure foods were stored in a sanitary manner and free from contamination related to uncovered and undated food items stored in a cooler.

The findings are:

Observation of the facility's kitchen on 07/23/24 at 3:25pm revealed there was an undated sign on the outside of the walk-in cooler that read "everything must be wrapped, labeled, and dated before placing in the cooler".

Observation of the facility's walk-in cooler on 07/23/24 at 3:25pm revealed:
-There was a metal rack in the cooler, containing trays of dessert.
-There was a tray containing an uncovered and undated piece of cake on a plate and half of a pie in a metal pan, partially covered with plastic wrap, with most of the pie exposed, with no date.
-There were 2 trays of uncovered and undated strawberry pie that had been cut and plated.
-There were 2 additional trays of uncovered and undated strawberry pie stored on a rolling cart in the cooler.
-There was a total of 35 pieces of uncovered and undated strawberry pie in the cooler.

Second observation of the facility's walk-in cooler on 07/24/24 at 8:10am revealed there was metal rack in the cooler with a tray containing an uncovered and undated piece of cake and half of a pie in a metal pan, partially covered with plastic wrap, with most of the pie exposed, with no date.

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D 283	Continued From page 10 Interview with a server on 07/23/24 at 3:26pm revealed: -The strawberry pie was going to be served at the evening meal, which started at 4:30pm. -The pie should have been covered before being stored in the cooler. -She was unsure why the pie was not covered before being stored in the cooler. Interview with a cook on 07/23/24 at 3:30pm revealed: -The servers were responsible for preparing desserts for meals. -Any food items stored in the cooler were supposed to be covered and dated. -He was unsure when the strawberry pies in the cooler were cut and plated. -He thought the items were uncovered because the servers would be serving them soon at the evening meal, which started at 4:30pm. Interview with the Dining Services Director (DSD) on 07/24/24 at 8:05am revealed: -Servers were responsible for preparing any pre-made pies and desserts for meal service. -When the servers cut and plated the pie, the pie should be covered and dated before it was placed in the cooler. -The strawberry pie that was left uncovered on 07/23/24 may have been left uncovered so the servers could access the pie quickly during the evening meal service. -If food items were prepared and were going to be used within a short time, the staff did not always cover and date the items before the items were placed in the cooler. -He was not concerned about uncovered food items becoming contaminated, especially if the items were placed on the top shelf of the cooler.	D 283		

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D 283	Continued From page 11 Interview with the Administrator on 07/25/24 at 12:25pm revealed: -Any food that was prepared or opened should be covered and labeled with the date before storing. -The DSD was responsible for ensuring food items were covered and dated. -The pies that were in the cooler on 07/23/24, should have been covered with plastic wrapped and dated before being placed in the cooler. -She was concerned that food items that were uncovered could become contaminated if not covered and stored properly.	D 283		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure verification or clarification of medication orders for 1 of 5 sampled residents (#3) including orders for a medication used to treat acid reflux disease, a medication used to treat or prevent iron deficiency, a medication used to treat or prevent	D 344		

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constipation, and a medication used to treat diarrhea.

The findings are:

Review of Resident #3's current FL2 dated 06/25/24 revealed diagnoses included thrombocytopenia, hypothyroidism, hyperlipidemia, major depressive disorder, chronic pain disorder, morbid obesity, and anxiety disorder.

a. Review of Resident #3's current FL2 dated 06/25/24 revealed there was an order for Omeprazole 20mg, 1 capsule every morning (Omeprazole is a medication used to treat acid reflux disease).

Observation of Resident #3's medications on hand on 07/24/24 at 2:10pm revealed there was no Omeprazole 20mg for Resident #3 on the medication cart.

Review of Resident #3's hospital discharge medication orders dated 04/30/24 at 2:27pm revealed an order to stop taking Omeprazole 20mg.

Review of Resident #3's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Omeprazole 20mg, 1 capsule daily scheduled for 6:00am.
-Omeprazole 20mg was documented as administered at 6:00am on 05/01/24.
-Omeprazole 20mg was documented as discontinued from 05/02/24 to 05/31/24.

Review of Resident #3's June 2024 eMAR revealed there was no entry for Omeprazole

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20mg, 1 capsule every morning.

Review of Resident #3's July 2024 eMAR revealed there was no entry for Omeprazole 20mg, 1 capsule every morning.

Interview with Resident #3 on 07/24/24 at 9:23am revealed:
-She was not currently experiencing any heartburn or acid reflux symptoms.
-A few months ago, she experienced significant acid reflux symptoms, but those symptoms had improved.
-She was unsure if she was currently taking anything for acid reflux.

b. Review of Resident #3's primary care provider's (PCP) orders dated 06/19/24 revealed there was an order for Ferrous Gluconate 324mg, 1 tablet every other day (Ferrous Gluconate is a medication used to treat or prevent iron deficiency).

Review of Resident #3's current FL2 dated 06/25/24 revealed there was no order for Ferrous Gluconate 324mg, take 1 tablet every other day.

Observation of Resident #3's medications on hand on 07/24/24 at 2:10pm revealed:
-There was a plastic bag labeled by the facility's contracted pharmacy which contained 8 tablets of Ferrous Gluconate 324mg.
-The label indicated a quantity of 15 tablets of Ferrous Gluconate 324mg was dispensed on 06/18/24.

Review of Resident #3's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Ferrous Gluconate

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324mg, one tablet every other day.
-Ferrous Gluconate 324mg was documented as administered at 8:00am on 06/26/24 and 06/28/24.

Review of Resident #3's July 2024 eMAR revealed:
-There was an entry for Ferrous Gluconate 324mg, one tablet every other day.
-Ferrous Gluconate 324mg was documented as administered at 8:00am on 07/02/24, 07/04/24, 07/06/24, 07/08/24, 07/10/24, 07/12/24, 07/14/24, 07/16/24, 07/20/24, and 07/22/24.
-Ferrous Gluconate 324mg was documented as DNG on 07/18/24 at 8:00am, which meant drug not given according to the abbreviation section on Resident #3's eMAR.

Interview with Resident #3 on 07/24/24 at 1:28pm revealed:
-She had a history of blood disorders, including anemia.
-She thought she was taking an iron supplement.
-She was not as familiar with her medications as she once was because her medications usually changed when she was hospitalized.

c. Review of Resident #3's primary care provider's (PCP) orders dated 06/19/24 revealed there was an order for Docusate Sodium 100mg, 1 capsule at bedtime (Docusate Sodium is a medication used to treat or prevent constipation).

Review of Resident #3's current FL2 dated 06/25/24 revealed there was no order for Docusate Sodium 100mg, 1 capsule at bedtime.

Observation of Resident #3's medications on hand on 07/24/24 at 2:10pm revealed:
-There was a unit dose card containing 27

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capsules of Docusate Sodium 100mg.
-The label indicated a quantity of 30 capsules of Docusate Sodium 100mg was dispensed on 07/18/24.

Review of Resident #3's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Docusate Sodium 100mg, 1 capsule at bedtime scheduled nightly at 8:00pm.
-Docusate Sodium 100mg was documented as administered at 8:00pm nightly from 06/25/24 to 06/30/24.

Review of Resident #3's July 2024 eMAR revealed:
-There was an entry for Docusate Sodium 100mg, 1 capsule at bedtime scheduled nightly at 8:00pm.
-Docusate Sodium 100mg was documented as administered at 8:00pm nightly from 07/01/24 to 07/22/24.

Interview with Resident #3 on 07/24/24 at 9:23am revealed:
-She had irritable bowel syndrome, so she sometimes had issues with constipation.
-She took something to help with constipation.
-She was not currently having any issues with constipation.

d. Review of Resident #3's primary care provider's (PCP) orders dated 06/19/24 revealed there was an order for Lomotil 2.5-0.025mg, 2 tablets as needed every 4 hours for diarrhea (Lomotil is a medication used to treat diarrhea).

Review of Resident #3's current FL2 dated 06/25/24 revealed there was no order for Lomotil

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2.5-0.025mg, 2 tablets as needed every 4 hours for diarrhea.

Observation of Resident #3's medications on hand on 07/24/24 at 2:10pm revealed:
-There was a unit dose card containing 30 tablets of Lomotil 2.5-0.025mg.
-The label indicated a quantity of 30 tablets of Lomotil 2.5-0.025mg was dispensed on 06/24/24.

Review of Resident #3's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Lomotil 2.5-0.025mg, 2 tablets as needed every 4 hours for diarrhea.
-There were no documented doses of Lomotil 2.5-0.025mg administered from 06/25/24 to 06/30/24.

Review of Resident #3's July 2024 eMAR revealed:
-There was an entry for Lomotil 2.5-0.025mg, 2 tablets as needed every 4 hours for diarrhea.
-There were no documented doses of Lomotil 2.5-0.025mg administered from 07/01/24 to 07/22/24.

Interview with Resident #3 on 07/24/24 at 9:23am revealed:
-She had irritable bowel syndrome, so she sometimes had issues with diarrhea.
-She was not currently having any issues with irritable bowel syndrome or diarrhea.
-She had medicine to take for diarrhea and upset stomach if she needed it.

Interview with the Resident Care Coordinator (RCC) on 07/25/24 at 11:52am revealed:
-She or the Health and Wellness Director (HWD) were responsible for ensuring the residents' FL2s

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were updated by the residents' PCP.
-Sometimes the PCP would complete the medication order section on the FL2, or the facility would attach a copy of the current medication orders.
-When the PCP completed a resident's FL2, the FL2 was faxed to the pharmacy and then filed in the resident's record.
-Resident #3's PCP completed the medication orders on Resident #3's FL2.
-She and the HWD were responsible for ensuring the residents' medication orders were accurate.
-She was not aware Resident #3's Omeprazole 20mg order was on the FL2 dated 06/25/24.
-She was not aware Resident #3's Ferrous Gluconate 324mg order, Docusate Sodium 100mg order, and Lomotil 2.5-0.025mg were not included on the FL2 dated 06/25/24.
-No one at the facility verified the medication orders on Resident #3's FL2.
-No one at the facility faxed the updated FL2 to the facility's contracted pharmacy.

Interview with the Administrator on 07/25/24 at 12:25pm revealed:
-The resident's PCP updated the resident's FL2s.
-The RCC, HWD, and Administrator were responsible for ensuring the FL2s were sent to the residents' PCPs to be updated.
-FL2 audits were conducted periodically, but there was no consistent schedule.
-The HWD had a tracking system to determine when FL2s were due to be updated by the PCP.
-When the FL2 was updated, the FL2 should be verified for accuracy and faxed to the pharmacy.
-She was unsure why Resident #3's FL2 was not verified for accuracy and faxed to the pharmacy.

Interview with a pharmacist from the facility's contracted pharmacy on 07/25/24 at 9:15am

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D 344	Continued From page 18 revealed: -The pharmacy did not receive Resident #3's FL2 dated 06/25/24 from the facility. -FL2s should be sent to the pharmacy when updated by the PCP so the pharmacy could check the medication orders for any changes. Interview with Resident #3's PCP on 07/25/24 at 11:03am revealed: -She preferred that the facility attached a copy of the resident's current eMAR to the FL2, so she would be aware of the most current medications the resident was taking. -She was unsure why Resident #3's Ferrous Gluconate 324mg order, Docusate Sodium 100mg order, and Lomotil 2.5-0.025mg orders were left off the updated FL2. -Resident #3 should be taking the medications left off the FL2. -Resident #3 should not be taking Omeprazole 20mg because the medication was discontinued when Resident #3 was in the hospital due to low platelets.	D 344		
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, interviews, and record	D 358		

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D 358	Continued From page 19 reviews the facility failed to administer medications as ordered for 2 of 3 residents observed during the medication pass (#4 and #6) including medications used to treat shortness of breath and wheezing (#4), and medications used to treat diabetes, tremors, a supplement, a stool softener, and a medication used to treat low levels of iron in the blood (#6). The findings are: Review of the facility's census on 07/23/24 revealed there were 36 residents in the assisted living (AL) side and 21 residents in the special care unit (SCU). Review of the facility's medication administration policy (dated 02/23/24) revealed: -Medication shall be administered in a safe and timely manner as prescribed by a physician or other authorized practitioner. -Medication shall be administered in accordance with the physician/authorized practitioner orders including any required time frame. -Medications may not be prepared in advance and must be administered within one hour of their prescribed time, unless otherwise specified. -If a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall indicate in the electronic Medication Administration Record (eMAR) the appropriate / related corresponding code and also complete a progress note in the resident record. -The individual administering medications must check the label three times to verify the right medication, the right dosage, the right time, and the right method (route) of administration before giving the medication.	D 358		

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Review of the facility's staff schedule revealed there was one medication aide (MA) assigned to the AL side and another MA assigned to the SCU.

The medication error rate was 23% as evidenced by the observation of 6 errors out of 26 opportunities during the 8:00am medication passes on 07/23/24 and 07/24/24.

1. Review of Resident #4's current FL-2 dated 10/18/23 revealed diagnoses included acute cystitis without hematuria, generalized weakness, fall, urinary tract infection, schizophrenia, and intellectual disability.

a. Review of Resident #4's medication order report dated 04/19/24 revealed there was an order for Ferrous Sulfate 325mg (used to prevent or treat iron deficiency anemia) three times a day.

Observation of the 8:00am medication pass on 07/23/24 revealed Ferrous Sulfate 325mg 1 tablet was administered to Resident #4 at 10:15am.

Review of Resident #4's July 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Ferrous Sulfate 325mg 1 tablet to be administered at 8:00am, 2:00pm, and 8:00pm.
-Ferrous Sulfate 325mg 1 tablet was documented as administered to Resident #4 at 8:00am on 07/23/24.

b. Review of Resident #4's medication order report dated 04/19/24 revealed there was an order for Benztropine Mesylate 0.5mg (used to treat tremors) twice a day.

Observation of the 8:00am medication pass on

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D 358	Continued From page 21 07/23/24 revealed Benztropine Mesylate 0.5mg 1 tablet was administered to Resident #4 at 10:15am. Review of Resident #4's July 2024 eMAR revealed: -There was an entry for Benztropine Mesylate 0.5mg 1 tablet to be administered at 8:00am and 8:00pm. -Benztropine Mesylate 0.5mg 1 tablet was documented as administered to Resident #4 at 8:00am on 07/23/24. c. Review of Resident #4's medication order report dated 04/19/24 revealed there was an order for Docusate Sodium 100mg (used to treat constipation) 1 twice a day. Observation of the 8:00am medication pass on 07/23/24 revealed Docusate Sodium 100mg 1 capsule was administered to Resident #4 at 10:15am. Review of Resident #4's July 2024 eMAR revealed: -There was an entry for Docusate Sodium 100mg 1 capsule to be administered at 8:00am and 8:00pm. -Docusate Sodium 100mg 1 capsule was documented as administered to Resident #4 at 8:00am on 07/23/24. d. Review of Resident #4's medication order report dated 04/19/24 revealed there was an order for Magnesium Oxide 400mg (a supplement) 2 tablets twice a day. Observation of the 8:00am medication pass on 07/23/24 revealed Magnesium Oxide 400mg 2 tablets were administered to Resident #4 at	D 358		

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D 358	Continued From page 22 10:15am. Review of Resident #4's July 2024 eMAR revealed: -There was an entry for Magnesium Oxide 400mg 2 tablets to be administered at 8:00am and 8:00pm. -Magnesium Oxide 400mg 2 tablets were documented as administered to Resident #4 at 8:00am on 07/23/24. e. Review of Resident #4's physician order dated 05/16/24 revealed an order for Metformin HCl (used to control high blood sugar to treat type 2 diabetes) 500mg/5ml take 10ml every morning and 5ml every evening. Observation of the 8:00am medication pass on 07/23/24 revealed Metformin HCl 500mg/5ml 10ml was administered to Resident #4 at 10:15am. Review of Resident #4's July 2024 eMAR revealed: -There was an entry for Metformin HCl 500mg/5ml 10ml to be administered at 8:00am and 5ml to be administered at 8:00pm. -Metformin HCl 500mg/5ml 10ml was documented as administered to Resident #4 at 8:00am on 07/23/24. Interview with MA assigned to the AL side on 07/23/24 at 9:45am revealed she had a medication pass at 8:00am and had one more resident to administer medications due to the resident being a late riser. At 10:10am, the MA informed the surveyor that Resident #4 still had his medications to take for the observation of the medication pass.	D 358		

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D 358	Continued From page 23 Telephone interview with the facility's contracted pharmacist on 07/24/24 at 11:10am revealed: -Resident #4's medications that were ordered more than once a day should be given on time since the second or third doses when given could be too close to the dose that was given late and cause issues. -The ferrous sulfate could cause stomach discomfort when given too close together to the other dose and should be given with food. -The other medications that were ordered twice a day could be given up to three times a day and did not cause concern for her. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Attempted telephone interview with Resident #6's primary care provider (PCP) on 07/25/25 at 11:15am was unsuccessful. Refer to interview with the Resident Care Coordinator (RCC) on 07/24/24 at 1:45pm. Refer to interview with the Executive Director (ED) on 07/25/24 at 12:43pm. 2. Review of Resident #6's current FL-2 dated 10/04/23 revealed: -Diagnoses included chronic bronchitis, chronic obstructive pulmonary disease, dysphasia, fall history, gastroesophageal reflux disease, hypertension, hypoosmolality, hyponatremia, and osteoporosis. -There was an order for Albuterol Sulfate HFA inhalation aerosol solution to inhale one puff by mouth twice a day (used to prevent and treat wheezing and shortness of breath caused by	D 358		

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breathing problems).

Observation of the 8:00am medication pass on 07/24/24 revealed Albuterol Sulfate inhalation aerosol solution was not administered to Resident #6.

Observation of Resident #6's medications on hand on 07/24/24 revealed there was no Albuterol Sulfate inhalation aerosol solution available for administration.

Review of Resident #6's July 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Albuterol Sulfate HFA inhalation aerosol solution to inhale one puff by mouth twice a day at 9:00am and 8:00pm.
-There was no documentation that Albuterol Sulfate HFA inhalation aerosol solution was administered at 8:00am on 07/24/24.

Telephone interview with the facility's contracted pharmacist on 07/24/24 at 11:10am revealed:
-Resident #6's Albuterol Sulfate inhalation aerosol solution not being available for administration could cause issues such as shortness of breath or wheezing.
-The last dispense date was 04/08/24 and should last 200 puffs.
-It should have run out around 07/17/24 if used correctly as ordered twice a day.
-The pharmacy had not received a request for a refill.

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

Attempted telephone interview with Resident #6's

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D 358	Continued From page 25 primary care provider (PCP) on 07/25/25 at 11:15am was unsuccessful. Refer to interview with the Resident Care Coordinator (RCC) on 07/24/24 at 1:45pm. Refer to interview with the Executive Director (ED) on 07/25/24 at 12:43pm. _____ Interview with the Resident Care Coordinator (RCC) on 07/24/24 at 1:45pm revealed: -The Health and Wellness Director (HWD) trained the medication aides (MAs), and the medication administration class covered the 5 rights of giving medication which included the right time. -She expected the MAs to give the medications at the right time, 1 hour before to 1 hour after the prescribed time. -The 8:00am medications could be given as early as 7:00am but not later than 9:00am. -She did not realize that Resident #4's medications were ordered at 8:00am. -She was not aware that Resident #6's Albuterol inhaler was not available to administer that morning. -The MAs, RCC, and HWD were all able to order medications from the pharmacy. Interview with the Executive Director (ED) on 07/25/24 at 12:43pm revealed: -She expected the residents to receive their medications as ordered. -The MAs had 1 hour before to 1 hour after the prescribed time to administer the residents their medication. -The MAs should follow the policies, procedures, and protocols that the facility had in place. -If the resident needed their medications to be given at a different time, the MA should notify the primary care provider (PCP) and get an order to	D 358		

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