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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on June 25-26, 2024.	D 000		
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		

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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)

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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,

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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

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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

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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:

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-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.

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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		