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
	fcl043037	A. BUILDING: _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE CARE FAMILY CARE II	431 JUNNY ROAD ANGIER, NC 27501

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and a complaint investigation on 07/16/24 to 07/17/24.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure follow-up to meet the acute health care needs of 1 of 3 sampled residents (#2) related to failure to notify a resident's primary care provider (PCP) of oxygen saturation readings outside of the established parameters. The findings are: Review of Resident #2's current FL2 dated 03/13/24 revealed: -Diagnoses included schizoaffective disorder, hypothyroidism, obesity, and bipolar disorder. -On the patient information section labeled respiration, there was an X marked beside oxygen and an X marked beside PRN, indicating Resident #2 required oxygen as needed (PRN is a medical abbreviation meaning as needed). -There was no indication of the amount of oxygen ordered on Resident #2's FL2. -There was an order to check pulse oximeter level and document weekly, notify primary care provider (PCP) of readings 89% or lower (A pulse oximeter is a device placed on the finger and is	C 246	10A NCAC 13G 0902(b) C246- Med Tech's will ensure all residents receiving O2 PRN or scheduled will have an order to include parameters for use, the amount to be given and the frequency. This order will then be faxed to the pharmacy to be put onto the MAR to ensure that the MTs (Med Techs) are monitoring the order and following through. Administration will monitor the MAR daily for 30 days, then bi-weekly. Continued below	This will be implemented 7/25/2024 and will be monitored daily for 30 days and then bi-weekly by Administration or their designee

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Lisa Steffa TITLE Admin on Duty (X6) DATE 8/20/2024

RECEIVED AND ACKNOWLEDGED ON 08/22/24 BY NURSE CONSULTANT

Tina B Nielsen

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C 246	Continued From page 1 used to measure oxygen saturation in the blood). Observation of Resident #2's room on 07/16/24 at 11:44am revealed an oxygen concentrator with a nasal cannula attached to the device. Review of Resident #2's primary care provider's (PCP) order dated 04/24/23 revealed an order for oxygen PRN, 2 liters by nasal cannula as needed for shortness of breath (A nasal cannula is a thin, flexible plastic tube that is connected to the oxygen source and is inserted into the nose to deliver oxygen). Review of Resident #2's May 2024 electronic medication administration (eMAR) record revealed: -There was an entry to check pulse oximeter level and document weekly, notify PCP for readings of 89% or less. -On 05/07/24, Resident #2's pulse oximeter level was documented as 86%. -On 05/14/24, Resident #2's pulse oximeter level was documented as 84%. -On 05/21/24, Resident #2's pulse oximeter level was documented as 86%. -On 05/28/24, Resident #2's pulse oximeter level was documented as 89%. -There was no documentation of Resident #2's PCP being notified of pulse oximeter readings. -There was no entry for oxygen 2 liters by nasal cannula as needed for shortness of breath. Review of Resident #2's June 2024 eMAR revealed: -There was an entry to check pulse oximeter level and document weekly, notify PCP for readings of 89% or less. -On 06/04/24, Resident #2's pulse oximeter level was documented as 79%.	C 246	10A NCAC 13G 0902(b) C 246- All MT's will download the Telmediq app onto their phone or use the tablet provided by the facility to notify providers when communicating with the providers. To further ensure MTs comply with a provider's order of notification when something is outside of the parameter's providers have established, MTs will send through Telmediq and write a note in the resident chart when they make contact with a PCP or any provider. The note will include: the date, time, the issue, time of contact with the provider, if available the provider's response will be noted and the MT will sign the note. Staff will receive continuing education through staff meetings, pharmacy education and the Clinical Nurse on her visits.	This will be implemented 7/25/2024 and will be monitored daily for 30 days and then bi-weekly by Administration or their designee

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C 246	Continued From page 2 -On 06/11/24, Resident #2's pulse oximeter level was documented as 85%. -On 06/20/24, Resident #2's pulse oximeter level was documented as 86%. -On 06/27/24, Resident #2's pulse oximeter level was documented as 88%. -There was no documentation of Resident #2's PCP being notified of pulse oximeter readings. -There was no entry for oxygen 2 liters by nasal cannula as needed for shortness of breath. Review of Resident #2's July 2024 eMAR revealed: -There was an entry to check pulse oximeter level and document weekly, notify PCP for readings of 89% or less. -On 07/02/24, Resident #2's pulse oximeter level was documented as 85%. -On 07/09/24, Resident #2's pulse oximeter level was documented as 89%. -On 07/16/24, Resident #2's pulse oximeter level was documented as 91%. -There was no documentation of Resident #2's PCP being notified of pulse oximeter readings. -There was no entry for oxygen 2 liters by nasal cannula as needed for shortness of breath. Interview with Resident #2 on 07/16/24 at 11:44am revealed: -The facility staff checked her oxygen saturation with a pulse oximeter every week. -She was not aware of her oxygen level being low in the last few months. -She was unsure what her oxygen saturation levels usually were when the staff checked them each week. -She did not currently feel as if she was having shortness of breath. -She could not recall having shortness of breath recently.	C 246	Please see above 10A NCAC 13G .0902 (b) C246	

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C 246	Continued From page 3 -She had an oxygen concentrator, but she did not use it regularly. -She was unsure of the last time she used the oxygen concentrator. -She did not feel like she needed to use her oxygen concentrator on a regular basis. Review of Resident #2's record revealed there was no documentation that the PCP had been notified of Resident #2's oxygen saturation levels being 89% or less. Interview with a medication aide (MA) on 07/16/24 on 07/16/24 at 2:30pm revealed: -Resident #2 had an order to check her oxygen saturation with a pulse oximeter every week. -Resident #2's pulse oximeter readings were documented on the eMAR. -If Resident #2's oxygen saturation level was 89% or less, she notified the PCP by sending an electronic message on a tablet or informed the Administrator and the Administrator notified the PCP by an application on her cell phone. -She had not documented any contact with Resident #2's PCP in the facility progress notes. -When the facility contacted the PCP, the PCP documented the information and sent the facility a copy of the documentation. -She recalled that she had notified the PCP about Resident #2's oxygen previously but was unsure when she had last notified the PCP. -The PCP had always instructed her to apply Resident #2's oxygen if Resident #2's oxygen saturation was low. -The only time she applied Resident #2's oxygen was if Resident #2's PCP instructed her to apply oxygen. -She had not needed to notify the PCP of Resident #2 having low oxygen saturation levels recently.	C 246	Please see above 10A NCAC 13G .0902 (b) C246	

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C 246	Continued From page 4 -Resident #2 had not needed to use her oxygen concentrator recently because she had not had any oxygen saturation levels of 89% or less and had not complained of any shortness of breath. -She was unsure of the last time she assisted Resident #2 with her oxygen concentrator. Telephone interview with a representative from Resident #2's PCP office on 07/17/24 at 10:04am revealed: -There was no documentation in Resident #2's electronic chart of the facility notifying Resident #2's PCP about Resident #2's oxygen saturation levels from May 2024 to July 2024. -Resident #2 was seen by the medical doctor (MD) and the PCP in June 2024. Interview with Resident #2's MD on 07/17/24 at 11:25am revealed: -Resident #2 was usually seen by her PCP every month. -She saw Resident #2 every 3 to 6 months. -The facility should have notified Resident #2's PCP of Resident #2's oxygen level being 89% or less. -Oxygen levels below 89% were a concern for Resident #2 because she was a smoker with other medical conditions. -Low oxygen levels could cause confusion and worsening of existing medical conditions. -She was not aware of the facility providing any notification to the PCP regarding Resident #2's low oxygen levels. -She was not aware of Resident #2 having low oxygen levels from May 2024 to July 2024. -Since Resident #2 was not having any symptoms of low oxygen such as confusion or shortness of breath, Resident #2 would need additional testing to determine the cause of her lower oxygen levels.	C 246	Please see above 10A NCAC 13G .0902 (b) C246	

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C 246	Continued From page 5 Interview with the Administrator on 07/17/24 at 12:00pm revealed: -She had contacted the Information Technology (IT) department of the pharmacy on 07/17/24. -She was unaware that the oxygen (O2) order was on the treatment administration records (TARs) and not on the medication administration records (MARs). -She did not know that she needed to print TARs since the O2 was on it nor did she know how to print it until she called IT. -The pharmacy IT staff had guided her through the process of printing the TARs so the O2 order would be available to the MAs. -She expected the MAs to follow the orders from the PCP and contact the PCP as directed. Interview with the Owner on 07/17/24 at 11:30am revealed: -Resident #2 had not had any issues with her breathing of which she was aware. -She had seen her out on the front porch smoking but she had not had any complaints. -She expected the MAs to follow the PCP's orders and to call when O2 saturations were below the parameters the PCP had given. Attempted telephone interview with Resident #2's primary care provider (PCP) on 07/16/24 at 2:48pm was unsuccessful. _____ The facility failed to inform a resident's (#2) primary health care provider (PCP) of pulse oximeter readings of 89% or less as indicated by the PCP's order putting the resident at risk for confusion and worsening of medical conditions. The facility's failure to notify the PCP of Resident #2's low pulse oximeter readings was detrimental to the resident's health, safety, and welfare and	C 246	Please see above 10A NCAC 13G .0902 (b) C246	

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C 246	Continued From page 6 constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/17/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 31, 2024.	C 246	10 A NCAC 13G .1004(a) C330- All provider orders when they come in for a resident either by fax, email, handwritten or on a hospital discharge form will be crossed referenced with the MAR. If the order does not appear on the MAR it will be faxed to the pharmacy "Attention Yellow Team" to be placed on the MAR as a new order or as a DC'd order. It will then be initialed and dated to indicate "faxed" a copy of the order will be given to the MT. So that they can go in and DC the order, if applicable per the provider's written order. Staff will be reeducated on this procedure. Staff will receive continuing education through staff meetings, pharmacy education and the Clinical Nurse on her visits.	This will be implemented 7/25/2024 and will be monitored daily for 30 days and then bi-weekly by Administration or their designee
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 observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#2) including a medication used to treat high blood pressure. The findings are: Resident #2's current FL2 dated 03/13/24 revealed: -Diagnoses included schizoaffective disorder, hypothyroidism, obesity, and bipolar disorder. -There was an order for Lisinopril 5mg, take one tablet every day (Lisinopril is a medication used to	C 330		

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C 330	Continued From page 7 treat high blood pressure). -There was an order to check blood pressure every week. Observation of Resident #2's medications on hand on 07/16/24 at 3:15pm revealed a unit dose card of Lisinopril 5mg was on the medication cart. Review of Resident #2's primary care provider's (PCP) order dated 06/21/24 revealed an order to discontinue Lisinopril 5mg. Review of Resident #2's June 2024 eMAR revealed: -There was an entry for Lisinopril 5mg, one tablet every day for high blood pressure scheduled at 8:00am. -Lisinopril 5mg was documented as administered daily at 8:00am from 06/01/24 to 06/30/24. -There was an entry to check Resident #2's blood pressure every week scheduled for 7:00am every Thursday. -On 06/06/24, Resident #2's blood pressure was documented as 112/88. -On 06/13/24, Resident #2's blood pressure was documented as 129/93. -On 06/20/24, Resident #2's blood pressure was documented as 132/76. -On 06/27/24, Resident #2's blood pressure was documented as 138/82. Review of Resident #2's July 2024 eMAR revealed: -There was an entry for Lisinopril 5mg, one tablet every day for high blood pressure scheduled at 8:00am. -Lisinopril 5mg was documented as administered daily at 8:00am from 07/01/24 to 07/16/24. -There was an entry to check Resident #2's blood pressure every week scheduled for 7:00am every	C 330	Please see above 10 A NCAC 13G .1004(a) C 330	

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C 330	Continued From page 8 Thursday. -On 07/04/24, Resident #2's blood pressure was documented as 140/76. -On 07/13/24, Resident #2's blood pressure was documented as 138/74. Interview with Resident #2 on 07/16/24 at 11:44am revealed: -The facility staff checked her blood pressure every week. -She had not had any blood pressure readings that were low. -She was unsure of what her blood pressure readings normally were. -She took medications for high blood pressure but was unsure of the names. -She was not aware of any recent medication changes. -The PCP usually informed her if there were any changes to her medications. -She did not recall feeling any weakness or dizziness recently. Interview with a medication aide (MA) on 07/16/24 at 2:30pm revealed: -All new medication orders were sent to the facility's contracted pharmacy via fax. -New medication orders were added to the eMAR by the pharmacy. -The pharmacy removed discontinued medications from the eMAR. -MAs could also discontinue medications on the eMAR. -She was not aware of Resident #2 having an order to discontinue Lisinopril 5mg. -Sometimes if an order was discontinued on the eMAR, the order remained on the eMAR and was not removed immediately. Telephone interview with a pharmacist from the	C 330	Please see above 10 A NCAC 13G .1004(a) C 330	

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C 330	Continued From page 9 facility's contracted pharmacy on 07/16/24 at 2:08pm revealed: -The facility faxed new medication orders to the pharmacy and the orders were then changed in the facility's eMAR system. -Any orders for discontinued medications were changed on the eMAR at the pharmacy when the order was received. -The pharmacy had not received an order to discontinue Resident #2's Lisinopril 5mg dated 06/21/24. -When the PCP discontinued a medication, the medication should be stopped immediately. -If Resident #2 took Lisinopril 5mg after it was stopped by the PCP, she could experience low blood pressure or dizziness. Telephone interview with a representative from Resident #2's PCP's office on 07/17/24 at 10:04am revealed: -Resident #2's PCP visited Resident #2 at the facility on 06/20/24. -The PCP's progress note from the visit on 06/20/24 in Resident #2's electronic chart indicated Lisinopril was discontinued due to Resident #2's blood pressure being stable. -Resident #2 took another medication to help lower blood pressure, so her PCP discontinued Lisinopril 5mg. -The order to discontinue Resident #2's Lisinopril 5mg was dated 06/21/24. Telephone interview with Resident #2's medical doctor (MD) on 07/17/24 at 11:25am revealed: -Resident #2 was usually seen by her PCP every month. -She saw Resident #2 every 3 to 6 months. -If the PCP discontinued Resident #2's Lisinopril 5mg, the medication should have been stopped immediately.	C 330	Please see above 10 A NCAC 13G .1004(a) C 330	

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C 330	Continued From page 10 -The PCP should be notified if medication changes were not made immediately. -If Resident #2 continued to take Lisinopril 5mg after being discontinued, her blood pressure could drop and become too low. Interview with the Administrator on 07/17/24 at 12:00pm revealed: -She was unaware that the Lisinopril order was not sent in to the pharmacy to discontinue it. -The MAs were responsible to send in orders by fax to the pharmacy. -The MAs had access to the office in order to fax orders when she was not there. Attempted telephone interview with Resident #2's primary care provider (PCP) on 07/16/24 at 2:48pm was unsuccessful.	C 330	Please see above 10 A NCAC 13G .1004(a) C 330	
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .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	C 342	10A NCAC 13G .1004 (j) C342 please see below	

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C 342	Continued From page 11 (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 accuracy of medication administration records for 2 of 3 sampled residents (#2, #3) related to the administration of oxygen and a medication used to treat skin irritation (#2), and documentation of medications documented as administered while the resident was out of the facility (#3). The findings are: 1. Resident #2's current FL2 dated 03/13/24 revealed diagnoses included schizoaffective disorder, hypothyroidism, obesity, and bipolar disorder. a. Review of Resident #2's FL2 dated 3/13/24 revealed: -On the patient information section labeled respiration, there was an X marked beside oxygen and an X marked beside PRN, indicating Resident #2 required oxygen as needed (PRN is a medical abbreviation meaning as needed). -There was no indication of the amount of oxygen ordered on Resident #2's FL2. Observation of Resident #2's room on 07/16/24 at 11:44am revealed an oxygen concentrator with a nasal cannula attached to the device. Review of Resident #2's primary care provider's (PCP) order dated 04/24/23 revealed an order for oxygen PRN, 2 liters by nasal cannula as needed	C 342	10A NCAC 13G .1004 (j) C 342- Med Tech's will ensure all residents receiving O2 PRN or scheduled will have an order to include parameters for use, the amount to be given and the frequency. This order will then be faxed to the pharmacy to be put onto the MAR to ensure that the MTs (Med Techs) are monitoring the order and following through. As well as having documentation of the O2 being administered. Administration will monitor the MAR daily for 30 days, then bi-weekly. All MT's will download the Telmediq app onto their phone or use the tablet provided by the facility to notify providers when communicating with the providers. To further ensure MTs comply with a provider's order of notification when something is outside of the parameter's providers have established, MTs will send through Telmediq and write a note in resident a chart when they make contact with a PCP or any provider. The note will include: the date, time, the issue, time of contact with the provider, if available the provider's response will be noted and the MT will sign the note. Continued below	This will be implemented 7/25/2024 and will be monitored daily for 30 days and then bi-weekly by Administration or their designee

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	fcl043037	A. BUILDING: _____ B. WING _____	07/17/2024

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C 342	Continued From page 12 for shortness of breath (A nasal cannula is a thin, flexible plastic tube that is connected to the oxygen source and is inserted into the nose to deliver oxygen). Review of Resident #2's May 2024 electronic medication administration record (eMAR) revealed there was no entry for oxygen 2 liters by nasal cannula as needed for shortness of breath. Review of Resident #2's June 2024 eMAR revealed there was no entry for oxygen 2 liters by nasal cannula as needed for shortness of breath. Review of Resident #2's July 2024 eMAR revealed there was no entry for oxygen 2 liters by nasal cannula as needed for shortness of breath. Interview with Resident #2 on 07/16/24 at 11:44am revealed: -The facility staff checked her oxygen saturation with a pulse oximeter every week. -She did not currently feel as if she was having shortness of breath. -She could not recall having shortness of breath recently. -She had an oxygen concentrator, but she did not use it regularly. -She was unsure of the last time she used the oxygen concentrator. -She did not feel like she needed to use oxygen concentrator on a regular basis. Interview with a personal care aide (PCA) on 07/16/24 at 1:37pm revealed: -He could not recall Resident #2 having complaints of shortness of breath. -He was aware Resident #2 had an oxygen concentrator. -He had seen Resident #2 use the oxygen	C 342	C342 continued: All provider orders when they come in for a resident either by fax, email, handwritten or on a hospital discharge form will be crossed referenced with the MAR. If the order does not appear on the MAR it will be faxed to the pharmacy " Attention Yellow Team" to be placed on the MAR as a new order or as a DC'd order. It will then be initialed and dated to indicate "faxed" a copy of the order will be given to the MT. So that they can go in and DC the order, if applicable per the provider's written order. Staff will be reeducated on this procedure. Staff will receive continuing education through staff meetings, pharmacy education and the Clinical Nurse on her visits.	

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C 342	Continued From page 13 concentrator previously but was unsure when he had last seen her use it. -The medication aides (MA) assisted Resident #2 with her oxygen concentrator. Interview with a MA on 07/16/24 at 2:30pm revealed: -Resident #2 had a PRN order for oxygen. -If she assisted Resident #2 with oxygen, she did not document this information in Resident #2's eMAR or any other facility documents. -Resident #2's oxygen order was not on the eMAR. -If MAs needed to know how much oxygen was needed for Resident #2, there was an order in her chart, or the PCP told them how much oxygen was needed for Resident #2. -Resident #2 had an order to check her oxygen saturation every week. -If Resident #2's oxygen saturation level was low, she notified the PCP by using a tablet or informed the Administrator and the Administrator notified the PCP by an application on her cell phone. -She recalled she had notified the PCP about Resident #2's oxygen saturation level but was unsure when she had last notified the PCP. -The PCP instructed her to apply Resident #2's oxygen if Resident #2's oxygen saturation was low. -She had not needed to notify the PCP of Resident #2 having low oxygen recently. -The only time she applied Resident #2's oxygen was if Resident #2's PCP instructed her to apply oxygen. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/16/24 at 2:08pm revealed: -The pharmacy would enter oxygen orders on the eMAR if the order was sent to the pharmacy.	C 342	10A NCAC 13G .1004 (j) C342 please see above	

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C 342	Continued From page 14 -Some facilities had a treatment administration record (TAR), and oxygen orders were sometimes added to that document. -The pharmacy had no current orders for oxygen for Resident #2. Interview with the Administrator on 07/16/24 at 2:29pm revealed the facility did not use TARs, all orders for medications and treatments were on the residents' eMARs. Second interview with the Administrator on 07/17/24 at 12:00pm revealed: -She had contacted the technology department of the pharmacy. -She was unaware that the oxygen order was on the TARs nor how to print TARs. -The pharmacy's technology staff had guided her through the process of printing the TARs so the oxygen order would be available to the MAs. Interview with the owner on 07/17/24 at 11:30am revealed: -Resident #2 had not had any issues with her breathing that she was aware of. -She had seen her out on the front porch smoking but she had not have any complaints. -She expected the MAs to follow the PCP's orders and to administer the oxygen as ordered. Interview with Resident #2's medical doctor (MD) on 07/17/24 at 11:25am revealed: -Resident #2 was usually seen by her PCP every month. -She saw Resident #2 every 3 to 6 months -The providers usually reviewed the residents' eMAR when they visited residents in the facility. -Resident #2's oxygen should be listed on the eMAR, so the staff members had instructions on how much oxygen Resident #2 needed to use.	C 342	10A NCAC 13G .1004 (j) C342 please see above	

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C 342	Continued From page 15 -The staff should document when Resident #2 needed to use oxygen since the oxygen was ordered on an as needed basis. Attempted telephone interview with Resident #2's primary care provider (PCP) on 07/16/24 at 2:48pm was unsuccessful. b. Review of Resident #2's primary care provider (PCP) order dated 12/21/23 revealed and order for Triamcinolone Acetonide 0.025% Topical Ointment, apply a small amount to affected area (neck rash) once a day as needed. Start date 12/21/23, stop date 01/11/24 (Triamcinolone Acetonide 0.025% Topical Ointment is a medication used to treat skin irritation). Observation of Resident #2's medications on hand revealed a full tube of Triamcinolone Acetonide 0.025% Topical Ointment on the medication cart. Review of Resident #2's PCP order dated 02/01/24 revealed an order to stop Triamcinolone Acetonide 0.025% Topical Ointment. Review of Resident #2's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Triamcinolone 0.025% cream, apply cream topically to neck once daily as needed for rash or irritation. -There were no doses of Triamcinolone 0.025% cream documented as administered in May 2024. Review of Resident #2's June 2024 eMAR revealed: -There was an entry for Triamcinolone 0.025% cream, apply cream topically to neck once daily as needed for rash or irritation.	C 342	10A NCAC 13G .1004 (j) C342 please see above	

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C 342	Continued From page 16 -There were no doses of Triamcinolone 0.025% documented as administered in June 2024. Review of Resident #2's July 2024 eMAR revealed: -There was an entry for Triamcinolone 0.025% cream, apply cream topically to neck once daily as needed for rash or irritation. -There were no doses of Triamcinolone 0.025% documented as administered in July 2024. Interview with Resident #2 on 07/16/24 at 11:44am revealed: -She did not currently have any skin irritation on her neck. -The staff had not applied any creams to her neck recently. Interview with a medication aide (MA) on 07/16/24 at 2:30pm revealed: -All new medication orders were sent to the facility's contracted pharmacy via fax. -New medication orders were added to the eMAR by the pharmacy. -The pharmacy removed discontinued medications from the eMAR. -MAs could also discontinue medications on the eMAR. -She was not aware of Resident #2 having an order to discontinue Triamcinolone 0.025% cream. -Sometimes if an order was discontinued on the eMAR, the order remained on the eMAR and was not removed immediately. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/16/24 at 2:08pm revealed: -The facility faxed new medication orders to the pharmacy and the orders were then changed in	C 342	10A NCAC 13G .1004 (j) C342 please see above	

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C 342	Continued From page 17 the facility's eMAR system. -Any orders for discontinued medications were changed on the eMAR at the pharmacy when the order was received. -The pharmacy had not received the order to discontinue Resident #2's Triamcinolone cream dated 02/01/24. Telephone interview with a representative from Resident #2's PCP's office on 07/17/24 at 10:04am revealed there was an order from Resident #2's PCP to discontinue Triamcinolone cream dated 02/01/24 in Resident #2's electronic chart. Interview with the Administrator on 07/17/24 at 11:30am revealed: -She expected the MAs to follow the PCP's orders and to send the orders in to the pharmacy. -She was not sure how Resident #2's Triamcinolone cream discontinue orders were overlooked. Attempted telephone interview with Resident #2's primary care provider (PCP) on 07/16/24 at 2:48pm was unsuccessful. 2. Review of Resident #3's FL-2 dated 04/29/24 revealed: -Diagnoses included dementia with behavior disturbances, hypertension, atrial flutter, chronic obstructive pulmonary disease and hypothyroidism. -He was semi-ambulatory. -He was intermittently disoriented. Review of Resident #3's incident and accident report dated 06/04/24 revealed he was sent to the local emergency department at 7:45am via ambulance complaining of pain in his side due to	C 342	10A NCAC 13G .1004 (j) C342 please see above	

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C 342	Continued From page 18 an unwitnessed fall late on the night of 06/03/24. Review of Resdient #3's local hospital records, he was admitted on 06/04/24 and dischrged on 06/27/24. Review of Resident #3's June electronic Medication Administration Record (eMAR) revealed: -There was an entry for eliquis 5mg tablet take twice a day was documented as administered on 06/04/24 at 8:00pm. -There was an entry for gabapentin 100mg tablet take one tablet at bedtime was documented as administered on 06/04/24 at 8:00pm. -There was an entry for haldol 5mg tablet take twice a day was documented as administered on 06/04/24 at 8:00pm. -There was an entry for memantine 5mg tablet take twice a day was documented as administered on 06/04/24 at 8:00pm. -There was an entry for metoprolol 25mg tablet take twice a day was documented as administered on 06/04/24 at 8:00pm. There was an entry for vitamin B-12 1000mcg tablet take one every evening was documented as administered on 06/04/24 at 8:00pm. Interview with Resident #3's power of attorney on 07/17/24 at 1:27pm revealed that Resident #3 was transported to the local emergency room on 06/04/24 and was admitted that day and discharged on 06/27/24. Interview with the Administrator on 07/17/24 at 11:30am revealed: -Resident #3 was transported to the local emergency department at 7:45am via ambulance complaining of pain in his side due to an unwitnessed fall late on the night of 06/03/24.	C 342	10A NCAC 13G .1004 (j) C 342- All MTs will be reeducated through contract pharmacy on all Med Tech education, with concentration on the 6 rights. Staff will be reeducated on the proper way to maneuver through the eMAR, when to click off on medication as prescribed. This will be completed when a medication is pulled and placed in the cup to be given to the resident. 1 resident at a time Staff will meet 1 on 1 with each resident ensuring it is the right resident that the medication is being administered to. Staff will also receive re=education from the clinical Nurse on her quarterly visits to the facility.	This will be imple-mented 7/25/2024 and will be monitored daily for 30 days and then bi-weekly by Administrat-ion or their designee

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C 342	Continued From page 19 -He was admitted that same day 06/04/24 and discharged from the local hospital to a skilled nursing facility on 06/27/24. -She was not sure why the medication aide documented that she had administered Resident #3's evening medicaitons on the evening of 06/04/24. -The MA knew the resdient was not in the facility. -She thought it was just a mistake of "the habit clicking off on the medications". -The MAs were taught to follow the 6 rights and she was not sure why the MA did not follow those rights. Attempted telephone interview with the medication aide on 07/17/24 at 10:00am was unsuccessful.	C 342	10A NCAC 13G .1004 (j) C342 please see above	