

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/24/2024
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES OF STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1372 EUFOLA ROAD STATESVILLE, NC 28677		
(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 a complaint investigation from 07/22/24 through 07/24/24. The complaint investigation was initiated by Iredell County Department of Social Services on 07/12/24.	D 000	Responses to the cited deficiencies do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The Plan of Correction is prepared solely as a matter of compliance with state laws.	
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to implement physician's orders for 1 of 3 sampled residents (#2) related to compression stockings. The findings are: Review of Resident #2's current FL2 dated 09/21/23 revealed diagnoses included peripheral vascular disease, muscle weakness and dementia. Review of Resident #2's record revealed: -There was an order dated 07/03/24 for compression stockings to be applied in the morning and removed at night. -There was a copy of a fax that was received at the facility from the pharmacy on 07/03/24 at 2:30pm requesting leg measurements before compression stockings could be dispensed.	D 276	10A NCAC 13F .0902(c)(3-4) Health Care Facility will ensure that all orders are that are written for procedures, treatments, by a physician or other licensed health professional are implemented within 24 hours of being written. If a issue arises that causes the order to not be able to be implemented the facility will notify the Primary Care Provider and document the conversation and any new order that the Primary Care provider may give. Compression Stocking training on measurements will be given to the Special Care Coordinator and to The Med Techs so that a order is not held up waiting on a nurse to send the measurements to pharmacy. Measurement Form will be filled out and sent to the pharmacy for ordering of the Compression Stockings. Special Care Coordinator will follow up with the pharmacy to ensure the pharmacy has all the information needed to process order and will ensure that the order is on the MAR for putting the Stockings on in the AM taking off in the PM. Management has hired a new Special Care Coordinator for the community that comes to the facility with many years of experience. Facility has also hired a outside consulting group to ensure medication management is overseen with the continued support of the Executive Director and facility staff. This facility will be in compliance by September 7, 2024	9-7-2024

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Spring Neal

Executive Director

8/30/2024

STATE FORM

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reviewed and acknowledged 09/06/24

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NAME OF PROVIDER OR SUPPLIER MEADOW LAKES OF STATESVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1372 EUFOLA ROAD STATESVILLE, NC 28677
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D 276	Continued From page 1 Review of Resident #2's Primary Care Provider (PCP) progress note dated 07/03/24 revealed: -Resident #2 was experiencing pain due to bilateral lower leg edema (fluid buildup). -Two weeks prior, Resident #2 started receiving a medication to reduce edema. -Due to continued edema the medication would be increased and compression stockings ordered. Review of Resident #2's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for compression stockings to be applied in the morning and removed at night with a note documenting pending confirmation of measurements for stockings. -There was no documentation compression stockings were applied. Interview with the Resident Care Coordinator (RCC) on 07/22/24 at 11:09am revealed: -She had been employed at the facility for one week. -She had not started conducting chart audits yet or she would have found the order for compression stockings and had the facility's contracted Registered Nurse (RN) obtain the measurements so the compression stockings could be ordered. Interview with the facility's contracted RN on 07/22/24 at 11:18am revealed: -She had been hired in May 2024 to conduct chart reviews. -She was at the facility once a week. -She did not know how she missed the order for compression stockings when she was conducting chart audits.	D 276	Special Care Coordinator walks building each morning along with the Executive Director to ensure that compression stockings have been applied. If any discrepancies are found the MAR is checked to observe for documentation of the why and how. PCP is notified after 3 consecutive refusals.	

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D 276	Continued From page 2 -She expected the RCC to inform her when orders were received that needed attention like leg measurements. -She did not know why the RCC who no longer worked at the facility, did not inform her of the order. Interview with the Administrator on 07/22/24 at 11:21am and 07/24/24 at 10:18am revealed: -The current RCC started work a week ago after the previous RCC resigned a few weeks ago. -She expected the RCC to inform the RN when leg measurements were needed. -There had been 2 RCCs and an RN in the facility conducting chart audits since the 07/03/24 order was received and did not know how the order was missed. -When orders were received from the PCP the medication aide (MA) was responsible for faxing the order to the pharmacy and then informing the RCC about the order. -The RCC or RN was responsible for verifying the order on the eMAR. Attempted telephone interview with Resident #2's PCP on 07/22/24 at 4:47pm was unsuccessful. Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable.	D 276		
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	D 344	10A NCAC 13F .1002(a) Medication Orders Facility will ensure that all orders are clarified with the Primary Care Provider when a resident has had a stay in the hospital, or is coming back from a rehab stay. If any of the orders are not 100% clear and accurate. Or are older than 24 hours from the time that the orders were written.	

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D 344	Continued From page 3 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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to clarify medications orders for 1 of 3 sampled residents (#3) regarding an order for a medication to treat seizures. The findings are: 1. Resident #3's current FL2 dated 04/05/24 revealed: -Diagnoses included dementia, other seizures, chronic kidney disease and bipolar disorder (mental illness associated with episodes of mood swings from depressive lows to manic highs). -He was intermittently disoriented. Review of Resident #3's signed physician orders dated 05/13/24 revealed an order for levetiracetam (a medication to treat seizures) 1000mg 1.5 tablet (1500mg) two times a day. Review of Resident #3's June 2024 electronic Medication Administration Record (eMAR) from 06/01/24 to 06/28/24 revealed: -There was an entry for levetiracetam 1000mg 1.5 tablets (1500mg) twice daily. -Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as administered from	D 344	Special Care Coordinator will ensure that all orders are accurate on the MAR. Special Care Coordinator will work with the pharmacy to ensure that the correct orders are the orders that are showing on the MAR. Med Techs will have training on the importance of the accuracy of the MAR and the role they play. Facility Management has hired a consulting firm to audit the carts monthly and Facility has hired a new Special Care Coordinator that comes to the facility with many years of experience. She has implemented many new process to ensure accuracy of MARs. Cart audits are done weekly by the Special Care Coordinator with the Med Techs to ensure that all Medications are current and accurate. Any discrepancies are immediately addressed with the pharmacy and Primary Care Provider to ensure that correct dosage is always given. All discontinued medications are pulled at time of discontinued order to ensure that they cannot be given in error. Facility will be in compliance by September 7, 2024	9-7-2024

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D 344	Continued From page 4 06/01/24 to 06/24/24 at 9:00am and 9:00pm. -Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as not administered from 06/25/24 to 06/27/24 at 9:00am and 9:00pm with a reason code of hospitalized. -Levetiracetam 1000mg 1.5 tablets (1500mg) was documented as not administered on 06/28/24 at 9:00am with a reason code of hospitalized. Review of Resident #3's hospital discharge summary dated 06/28/24 revealed: -Resident #3 was diagnosed with partial complex seizures. -An order for levetiracetam 750mg one tablet twice daily. Review of Resident #3's June 2024 electronic Medication Administration Record (eMAR) from 06/28/24 to 06/30/24 revealed: -Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as administered from 06/28/24 at 9:00pm to 06/30/24 at 9:00pm. -There was an entry for levetiracetam 750mg one tablet twice daily beginning 06/28/24. -Levetiracetam 750mg was documented as administered from 06/29/24 to 06/30/24 at 9:00am and 9:00pm. Review of Resident #3's July 2024 eMAR from 07/01/24 to 07/03/24 revealed: -There was an entry for levetiracetam 1000mg 1.5 tablets (1500mg) twice daily. -Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as administered from 07/01/24 to 07/21/24 at 9:00am and 9:00pm. -Levetiracetam 1000mg 1.5 tablets twice (1500mg) daily was documented as administered on 07/22/24 at 9:00am. -There was entry for levetiracetam 750mg one tablet twice daily.	D 344		

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D 344	Continued From page 5 -Levetiracetam 750mg 1 tablet twice daily was documented as administered on 07/01/24 and 07/02/24 at 9:00am and 9:00pm. -Levetiracetam 750mg 1 tablet twice daily was documented as administered on 07/03/24 at 9:00am. Review of Resident #3 signed physician orders dated 07/03/24 revealed an order to discontinue levetiracetam 1000mg 1.5 tablets (1500mg) twice daily. Review of Resident #3's July 2024 eMAR from 07/03/24 to 07/22/24 revealed: -There was an entry to D/C (discontinue) levetiracetam 750mg one tablet twice daily beginning 07/03/24 at 9:00am. -There was no documentation levetiracetam 750mg one tablet twice daily was administered from 07/03/24 at 9:00pm to 07/22/24 at 9:00am. -Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as administered from 07/03/24 through 07/22/24 and not discontinued per the physician orders dated 07/03/24. Interview with a medication aide (MA) on 07/23/24 revealed: -When a resident came back from the hospital with new medication orders the MA was responsible for faxing the new order to the pharmacy and follows up with a phone call to ensure the pharmacy received the order. -MAs were responsible for ensuring medications are off the cart and discontinued. -The Residential Care Coordinator (RCC) was responsible for sending the discontinued medication back to the pharmacy. -She did not recall seeing the discontinued order in Resident #3's record. -She had not been notified of any changes	D 344		

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D 344	Continued From page 6 regarding Resident #3 levetiracetam order or that it had been discontinued. -She acknowledged that Resident #3 should not have been given the Levetiracetam 1500mg after 07/03/24. -If she knew Resident #3 there were two orders for levetiracetam she would need to call the primary care provider (PCP) to clarify which order was correct. -She would have given Resident #3 the levetiracetam 750mg and clarified with the Administrator. Observation of Resident #3's medications on hand on 07/23/24 at 11:13am revealed: -There was one bubble pack of levetiracetam 1000mg halved tablets (500mg) with 1 tablet of 90 tablets remaining labeled with the resident's name and a dispense date of 04/23/24 take 1.5 tablets (1500mg) by mouth twice daily. -There was one bubble pack of levetiracetam 1000mg halved tablets (500mg) with 25 tablets of 90 tablets remaining labeled with the resident's name and a dispense date of 04/23/24 take 1.5 tablets (1500mg) by mouth twice daily and instructions to refill after 05/17/24. -There was one bubble pack of levetiracetam 1000mg with 25 tablets of 90 tablets remaining labeled with the resident's name and a dispense date of 04/23/24 take 1.5 tablets (1500mg) by mouth twice daily and instructions to refill after 05/17/24. -There was a drawer on the bottom right-hand side of the medication cart with a cardboard divider titled overstock. -There was one bubble pack of levetiracetam 750mg with 21 tablets of 60 tablets remaining labeled with the resident's name and a dispense date of 06/28/24 take one tablet by mouth twice daily and instructions to refill after 07/22/24.	D 344		

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D 344	Continued From page 7 -There was one bubble pack of levetiracetam 750mg with 30 tablets of 60 tablets remaining labeled with the resident's name and a dispense date of 06/28/24 take 1.5 tabs by mouth twice daily and instructions to refill after 07/22/24. Interview with the RCC on 07/23/24 at 1:28pm revealed: -She began working at the facility on 07/15/24 after this error was made. -The expectation was when a resident was discharged from the hospital, the discharge paperwork should have been put in the PCP folder by the RCC. -The RCC should make the PCP aware of the new medication orders and clarify if he was agreeable to the new orders. -The RCC was expected to document the change in medication in the communication book. -The RCC or MA should fax the new orders to the pharmacy, then call the pharmacy and confirm the order. -The RCC and the MA should verify the new orders were entered correctly in the eMAR system. Interview with the facility's contracted Registered Nurse (RN) consultant on 07/23/24 at 11:22am revealed: -When a medication order was changed, added or discontinued the order should be faxed to the pharmacy. -Staff who sent the fax were supposed to document the date and time faxed on the order and put in in the 24-hour report book. -The RCC was responsible for faxing the changes to the pharmacy and follow up to make sure the medications were entered correctly on the eMAR. -The RCC was responsible for returning	D 344		

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D 344	Continued From page 8 medications to the pharmacy. -The RCC would communicate the change in the 24-hour report book. -She and the RCC were responsible for ensuring medication changes were correct. -She acknowledged the provider should have been notified Resident #3 received both doses. -The pharmacy was responsible for entering the orders on the eMAR. -She acknowledged all medications need to be confirmed from the pharmacy to ensure the medication and orders were all correct. Telephone interview with the facility's contracted Pharmacist on 07/23/24 at 12:49pm revealed: -The pharmacy had a signed physician order dated 05/13/24 for levetiracetam 1000mg 1.5 tablets two times a day. -The pharmacy received an order dated 06/28/24 for Resident #3 that was written upon discharge from the hospital for levetiracetam 750mg one tablet twice daily. -On 07/03/24 the pharmacy received an order to discontinue levetiracetam 1000mg 1.5 tablets twice daily. -The pharmacy technician entered the medication orders into the eMAR, and the pharmacist verified the orders. -She did not know why the resident received both levetiracetam 750mg and levetiracetam 1500mg continued twice daily. Telephone interview with the facility's contracted primary care provider (PCP) on 07/24/24 at 10:37am revealed: -He wrote an order to discontinue the levetiracetam 1500mg twice daily on 07/03/24 because when Resident #3 was discharged from the hospital on 06/28/24 his levetiracetam was changed to levetiracetam 750mg twice daily and	D 344		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

MEADOW LAKES OF STATESVILLE

**1372 EUFOLA ROAD
STATESVILLE, NC 28677**

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D 344	Continued From page 9 Depakote (a medication to treat bipolar) was started due to his kidney function. -Resident #3 should not have been administered the levetiracetam 1500mg twice daily after 07/03/24. -The orders on the resident's hospital discharge did not include an order to discontinue the levetiracetam 1500mg twice daily. -Both orders for levetiracetam 1500mg twice daily and levetiracetam 750mg twice daily continued. -He was notified yesterday (07/23/24) that Resident #3 received both doses of levetiracetam 1500mg twice daily and the levetiracetam 750mg twice daily on 07/01/24, 07/02/24 and the 8:00am dose on 07/03/24. -The maximum dose of levetiracetam was 3000mg, could be given in higher doses, but he would not initiate a dose of 4500mg. -A higher dose could cause Resident #3 to experience fatigue, dizziness, memory loss and could impact his kidney function. -He was confused as to why the pharmacy would have entered the wrong medication (levetiracetam 750mg) on the eMAR as discontinued on 07/03/24 when levetiracetam 1500mg twice daily was to be discontinued. Interview with the Administrator on 07/24/24 at 1:22pm revealed: -The RCC was responsible to fax the new medication order to the pharmacy, save the fax confirmation and call the pharmacy to ensure the order was received and accurate. -The RCC was responsible for confirmation of the new medication order and ensure the order is correct on the eMAR. -The RCC should communicate any changes to medication orders to the MA and document the change in the internal communication book. -She was not aware that Resident #3 had	D 344		

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D 344	Continued From page 10 received both doses of the Levetiracetam 1500mg twice daily and the 750mg 1 tablet twice daily on 07/01/24, 07/02/24 and the morning of 07/03/24. -She was not aware that Resident #3 had received the 1500mg twice daily after it had been discontinued on 07/03/24. -It was her expectation that all orders were clarified and confirmed with the physician. The facility failed to clarify a new physician order for a seizure medication when Resident #3 was discharged from the hospital resulting in the resident being administered 4500mg daily of the seizure medication from 06/30/24 to 07/03/24, and on 07/03/24 when an order to discontinue 3000mg continued when the resident was to receive 1500mg daily increasing the resident's risks for kidney problems, dizziness, fatigue and memory loss. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/23/24 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 7, 2024.	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:	D 358	10A NCAC 13F .1004(a) Medication Administration Facility will ensure that medications are administered as ordered by prescribing physician. If a resident misses a dose of any medication that is life threatening the Primary Care Provider will be notified after the first dose. An other medication the facility will watch for three consecutive doses of missed medications to be missed before the Primary Provider is notified.	8/14/2024

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D 358	Continued From page 11 (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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (#1, #3) related to medications used to treat seizures (#3) and a medication to treat anxiety (#1). The findings are: 1. Resident #3's current FL2 dated 04/05/24 revealed: -Diagnoses included dementia, other seizures, chronic kidney disease and bipolar disorder (mental illness associated with episodes of mood swings from depressive lows to manic highs). -He was intermittently disoriented. Review of Resident #3's signed physician orders dated 05/13/24 revealed an order for levetiracetam (a medication to treat seizures) 1000mg 1.5 tablet (1500mg) two times a day. Review of Resident #3's hospital discharge medication orders dated 06/28/24 revealed an order for levetiracetam 750mg one tablet twice daily. Review of Resident #3's July 2024 eMAR from 07/01/24 to 07/03/24 revealed:	D 358	The Med Techs will have a training on the types of medications that are considered life threatening and must be reported after 1 dose missed. This training will be conducted by RCC and ED with guidance from the Nurse Consultant that has been hired for the community. Cart and Chart audits are being done weekly by the Special Care Coordinator to ensure accuracy of orders and to ensure that orders are followed from beginning to end. Special Care Coordinator is doing the filing in the resident charts to ensure the accuracy of the chart. Facility will be in compliance as of 8/14/2024.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/24/2024
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES OF STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1372 EUFOLA ROAD STATESVILLE, NC 28677		
(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 358	Continued From page 12 -There was an entry for levetiracetam 1000mg 1.5 tablets (1500mg) twice daily. -Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as administered from 07/01/24 to 07/21/24 at 9:00am and 9:00pm. -Levetiracetam 1000mg 1.5 tablets twice (1500mg) daily was documented as administered on 07/22/24 at 9:00am. -There was entry for levetiracetam 750mg one tablet twice daily. -Levetiracetam 750mg 1 tablet twice daily was documented as administered on 07/01/24 and 07/02/24 at 9:00am and 9:00pm. -Levetiracetam 750mg 1 tablet twice daily was documented as administered on 07/03/24 at 9:00am. Review of Resident #3 signed physician orders dated 07/03/24 revealed an order to discontinue levetiracetam 1000mg 1.5 tablets (1500mg) twice daily. Review of Resident #3's July 2024 eMAR from 07/03/24 to 07/22/24 revealed: -There was an entry to D/C (discontinue) levetiracetam 750mg one tablet twice daily beginning 07/03/24 at 9:00am. -There was no documentation levetiracetam 750mg one tablet twice daily was administered from 07/03/24 at 9:00pm to 07/22/24 at 9:00am. -Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as administered from 07/03/24 through 07/22/24 and not discontinued per the physician orders dated 07/03/24. Observation of Resident #3's medications on hand on 07/23/24 at 11:13am revealed: -There was one bubble pack of levetiracetam 1000mg halved tablets (500mg) with 1 tablet of 90 tablets remaining labeled with the resident's	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/24/2024
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D 358	Continued From page 13 name and a dispense date of 04/23/24 take 1.5 tablets (1500mg) by mouth twice daily. -There was one bubble pack of levetiracetam 1000mg halved tablets (500mg) with 25 tablets of 90 tablets remaining labeled with the resident's name and a dispense date of 04/23/24 take 1.5 tablets (1500mg) by mouth twice daily and instructions to refill after 05/17/24. -There was one bubble pack of levetiracetam 1000mg with 25 tablets of 90 tablets remaining labeled with the resident's name and a dispense date of 04/23/24 take 1.5 tablets (1500mg) by mouth twice daily and instructions to refill after 05/17/24. -There was a drawer on the bottom right-hand side of the medication cart with a cardboard divider titled overstock. -There was one bubble pack of levetiracetam 750mg with 21 tablets of 60 tablets remaining labeled with the resident's name and a dispense date of 06/28/24 take one tablet by mouth twice daily and instructions to refill after 07/22/24. -There was one bubble pack of levetiracetam 750mg with 30 tablets of 60 tablets remaining labeled with the resident's name and a dispense date of 06/28/24 take 1.5 tabs by mouth twice daily and instructions to refill after 07/22/24. Interview with a medication aide (MA) on 07/23/24 revealed: -When a resident came back from the hospital with new medication orders the MA was responsible for faxing the new order to the pharmacy and following up with a phone call to ensure the pharmacy received the order. -MAs are responsible for ensuring medications are off the cart and discontinued. -The Residential Care Coordinator (RCC) was responsible for sending the discontinued medication back to the pharmacy.	D 358		

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D 358	Continued From page 14 -She did not recall seeing the discontinued order in Resident #3's record. -She had not been notified of any changes regarding Resident #3 levetiracetam order or that it had been discontinued. -She administered Resident #3's levetiracetam on eight occasions from 07/04/24 through 07/22/24 as documented on the July eMAR. -She had followed the order on the eMAR which showed levetiracetam 750mg twice daily was discontinued and she administered levetiracetam 1500mg twice daily during her shift. Interview with the RCC on 07/23/24 at 1:28pm revealed: -She began working at the facility on 07/15/24 after this error was made. -The expectation was when a resident was discharged from the hospital, the discharge paperwork should have been put in the PCP folder by the RCC. -The RCC was expected to make the PCP aware of the new medication orders and clarify if he was agreeable to the new orders. -The RCC was expected to document the change in medication in the communication book. -The RCC or MA should fax the new orders to the pharmacy, then call the pharmacy and confirm the order. -The RCC and the MA should verify the new orders were entered correctly in the eMAR system. Interview with the facility's contracted Registered Nurse (RN) Consultant on 07/23/24 at 11:22am revealed: -When a medication order is changed, added or discontinued the order should be faxed to the pharmacy and document the date and the time it was faxed and put the information in the internal	D 358		

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D 358	Continued From page 15 24-hour report book. -The RCC was responsible for faxing the changes to the pharmacy. -The orders for the levetiracetam 1500mg twice daily and 750mg twice daily were not clarified. -Because the orders were not clarified Resident #3 continued to receive 4500mg of levetiracetam twice daily. -The MAs administered what was ordered according to the eMAR. Telephone interview with the facility's contracted Pharmacist on 07/23/24 at 12:49pm revealed: -The pharmacy had a signed physician order dated 05/13/24 for levetiracetam 1000mg 1.5 tablets two times a day. -The pharmacy received an order dated 06/28/24 for Resident #3 that was written upon discharge from the hospital for levetiracetam 750mg one tablet twice daily. -On 07/03/24 the pharmacy received an order to discontinue levetiracetam 1000mg 1.5 tablets twice daily. -The pharmacy technician entered the medication orders into the eMAR, and the pharmacist verified the orders. -She did not know why the resident received both levetiracetam 750mg and levetiracetam 1500mg twice daily. Telephone interview with the facility's contracted primary care provider (PCP) on 07/24/24 at 10:37am revealed: -He wrote an order to discontinue the levetiracetam 1500mg twice daily on 07/03/24 because when Resident #3 was discharged from the hospital on 06/28/24 his levetiracetam was changed to levetiracetam 750mg twice daily and Depakote (a medication to treat bipolar) was started due to his kidney function.	D 358		

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D 358	Continued From page 16 -Resident #3 should not have been administered the levetiracetam 1500mg twice daily after 07/03/24. -The orders on the resident's hospital discharge did not include an order to discontinue the levetiracetam 1500mg twice daily. -Both orders for levetiracetam 1500mg twice daily and levetiracetam 750mg twice daily continued. -He was notified yesterday (07/23/24) that Resident #3 received both doses of levetiracetam 1500mg twice daily and the levetiracetam 750mg twice daily on 07/01/24, 07/02/24 and the 8:00am dose on 07/03/24. -The maximum dose of levetiracetam was 3000mg, it could be given in higher doses, but he would not initiate a dose of 4500mg. -The higher doses could cause Resident #3 to experience fatigue, dizziness, memory loss and could impact his renal function. -He was confused as to why the pharmacy would have entered the wrong medication (levetiracetam 750mg) on the eMAR as discontinued on 07/03/24 when it should have been the levetiracetam 1500mg twice daily as discontinued. Interview with the Administrator on 07/24/24 at 1:22pm revealed: -The RCC was responsible to fax the new medication order to the pharmacy, save the fax confirmation and call the pharmacy to ensure the order was received and accurate. -The RCC was responsible for confirmation of the new medication order and ensure the order is correct on the eMAR. -The RCC should communicate any changes in medication orders to the MA and document the change in the internal communication book. -She was not aware that Resident #3 had received both doses of the Levetiracetam	D 358		

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D 358	Continued From page 17 1500mg twice daily and the 750mg one tablet twice daily on 07/01/24, 07/02/24 and the morning of 07/03/24. -She was not aware that Resident #3 had received the 1500mg twice daily after it had been discontinued on 07/03/24. -It was her expectation that all medication orders were clarified and confirmed to ensure they were administered correctly. Based on record reviews and observations it was determined Resident #3 was not interviewable. 2. Review of Resident #1's current FL2 dated 04/10/24 revealed: -Diagnoses included mood disturbance, psychotic disturbance (mental illness that affects the mind), and anxiety disorder. -There was an order for divalproex (a medication to treat anxiety) 125mg, two capsules daily. Review of Resident 1's hospice provider's note dated 04/17/24 revealed: -There was an order for divalproex 125mg, two capsules daily in the morning. -There was an order for divalproex 125mg, four capsules daily at bedtime. Review of Resident #1's July 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for divalproex 125mg, two capsules daily at 8:00am. -There was documentation divalproex 125mg, two capsules were administered daily at 8:00am from 07/01/24 through 07/22/24 except on 07/04/24 due to Resident #1 being hospitalized. -There was an entry for divalproex 125mg, four capsules daily at 8:00pm. -There was documentation divalproex 125mg,	D 358			

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STATE FORM

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If continuation sheet 18 of 26

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D 358	Continued From page 18 four capsules were administered daily at 8:00pm from 07/01/24 through 07/21/24. Observation on 07/22/24 at 2:05pm of medications on hand for Resident #1 revealed there was no divalproex 125mg available for administration. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 07/24/24 at 12:24pm revealed: -Resident #1 had a current order for divalproex 125mg, two capsules in the morning and four capsules in the evening. -The facility faxed a refill request to the pharmacy on 07/22/24 for Resident #1's divalproex 125mg. -On 05/22/24, divalproex 125mg, 150 tablets (25 day supply) were last dispensed to the facility. -Divalproex 125mg was not dispensed for Resident #1 in June 2024 because there were no refills remaining. -Resident #1 could experience mood deterioration if divalproex 125mg was not administered as ordered. -The facility requested a refill for Resident #1's divalproex 125mg on 07/22/24. Telephone interview with a medication aide (MA) on 07/23/24 at 10:45am revealed: -She worked the night shift on 07/20/24 and 07/21/24. -There was no divalproex 125mg to administer to Resident #1, so she borrowed medication from another resident and wrote it in the notebook kept on the medication cart. -She could not recall which resident she borrowed the medication from. -She told the first shift MA coming on duty on 07/21/24 and 07/22/24 that Resident #1 was out of divalproex 125mg, and it needed to be	D 358		

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D 358	Continued From page 19 reordered. -MAs were responsible to contact pharmacy if a medication was not available but it was hard to reach the pharmacy on night shift. Interview with the Resident Care Coordinator (RCC) on 07/23/24 at 1:05pm revealed: -She started working at the facility as the RCC last Monday (07/15/24). -She was not aware of any notebook kept on the medication cart. -A note was left on her desk yesterday morning (07/22/24) from the night shift MA informing her Resident #1 was out of his divalproex 125mg. -She contacted the pharmacy and was told Resident #1 needed a new order to be faxed to the pharmacy. -Resident #1's divalproex was delivered to the facility yesterday evening (07/22/24). Interview with the Administrator on 07/24/22 at 1:25pm revealed: -The RCC and the MAs were responsible for ordering the residents' medications when there were seven doses remaining. -If a medication was not available to administer, she expected the MA to reach out to the pharmacy and order it "stat" (immediately). -The previous RCC who left approximately two weeks ago and the current RCC were responsible for performing cart audits weekly to ensure all medications were available for administration. -She was not aware Resident #1 did not receive his divalproex 125mg as ordered. Attempted telephone interview on 07/24/24 at 1:55pm with Resident #1's hospice provider was unsuccessful. -Based on observations, interviews and record	D 358		

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D 358	Continued From page 20 reviews it was determined Resident #1 was not interviewable. The facility failed to administer a medication to treat seizures properly when Resident #3 was discharged from the hospital with an order to decrease his seizure medication dosage to 3000mg daily, but the resident received 4500mg. The 4500mg daily dose was not discontinued, increasing the residents' risks for renal issues, dizziness, fatigue and memory loss. Resident #1's anxiety medications was not refilled by the pharmacy in June 2024 which could cause the resident to experience mood deterioration. These failures were detrimental to the health, safety and welfare of the residents and constitutes a Type Unabated B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/23/24 for this violation.	D 358		
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;	D 367	10A NCAC 13F 1004(j) Medication Administration The facility will ensure that the medication is administered per the orders as written. SCC and Med Techs will ensure that each medication has a residents name, name of medication or treatment, strength and dosage or quantity of medication to be administered; clear instructions for administering the medication or treatment. If the medication is to be given as a PRN or as needed the Med Tech that is administering will document the resulting effect on the resident. Date and time of administration date and time of any omissions of any medications not given and documentation of any refusals. MAR will also indicate the initials of the MED TECH that is giving the medication and a signature that matches the initials will also be	09/07/2024

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D 367	Continued From page 21 (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 interviews, and record reviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 3 residents relating to inaccurate documentation of a medication to treat anxiety (Resident #1). The findings are: Review of Resident #1's current FL2 dated 04/10/24 revealed: -Diagnoses included mood disturbance, psychotic disturbance (mental illness that affects the mind), and anxiety disorder. -There was an order for divalproex (a medication to treat anxiety) 125mg, two capsules daily. Review of Resident 1's hospice provider's note dated 04/17/24 revealed: -There was an order for divalproex 125mg, two capsules daily in the morning. -There was an order for divalproex 125mg, four capsules daily at bedtime. Review of Resident #1's July 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for divalproex 125mg, two capsules daily at 8:00am. -There was documentation divalproex 125mg,	D 367	maintained on the MAR. Special Care Coordinator will ensure that orders are accurate by reviewing all orders that are placed on the Point Click Care electronic MAR system daily from the pharmacy before they are set to go live for Med Techs to administer. Med Techs will also review MARS daily for accuracy of MAR for any errors and report any discrepancies to the Special Care Coordinator to be addressed immediately so that medication and treatments can be given accurately. Med Techs will be trained on the importance of accurate documentation of the MAR by the Executive Director. Facility has also hired an outside consulting nurse to ensure that medication is given correctly and and that accurately and is visiting the facility monthly to ensure facility stays in compliance with medication related issues. Facility will be in compliance of this rule area no later September 7, 2024	

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D 367	Continued From page 22 two capsules were administered daily at 8:00am from 07/01/24 through 07/22/24 except on 07/04/24 due to Resident #1 being hospitalized. -There was an entry for divalproex 125mg, four capsules daily at 8:00pm. -There was documentation divalproex 125mg, four capsules were administered daily at 8:00pm from 07/01/24 through 07/21/24. Observation on 07/22/24 at 2:05pm of medications on hand for Resident #1 revealed there was no divalproex 125mg available for administration. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 07/24/24 at 12:24pm revealed: -Resident #1 had a current order for divalproex 125mg, two capsules in the morning and four capsules in the evening. -The facility faxed a refill request to the pharmacy on 07/22/24 for Resident #1's divalproex 125mg. -On 05/22/24, divalproex 125mg, 150 tablets (25 day supply) were last dispensed to the facility. -Divalproex 125mg was not dispensed for Resident #1 in June 2024 because there were no refills remaining. -Resident #1 could experience mood deterioration if divalproex 125mg was not administered as ordered. -The facility requested a refill for Resident #1's divalproex 125mg on 07/22/24. Telephone interview with a medication aide (MA) on 07/23/24 at 10:45am revealed: -She worked the night shift on 07/20/24 and 07/21/24. -There was no divalproex 125mg to administer to Resident #1, so she borrowed medication from another resident.	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/24/2024
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES OF STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1372 EUFOLA ROAD STATESVILLE, NC 28677		
(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 367	Continued From page 23 Interview with the Resident Care Coordinator (RCC) on 07/23/24 at 1:05pm revealed: -She started working at the facility as the RCC last Monday (07/15/24). -A note was left on her desk yesterday morning (07/22/24) from the night shift MA informing her Resident #1 was out of his divalproex 125mg. -She contacted the pharmacy and was told Resident #1 needed a new order to be faxed to the pharmacy. -When a medication was not available on the medication cart, it was the responsibility of the MA to document on the eMAR that the medication was not given and the reason. -She did not know why a medication was documented as administered when it was not available for administration. Interview with the Administrator on 07/24/22 at 1:25pm revealed: -It was the responsibility of the MA to accurately document in the eMAR system when a medication was not administered. -The corporate Registered Nurse (RN) completed cart audits monthly comparing medications on hand to the eMAR. -The RCC was responsible for completing cart audits weekly comparing medications on hand to the eMAR. -She was not aware Resident #1's divalproex 125mg was not available for administration.	D 367		
D 467	10A NCAC 13F .1308 (c) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (c) In units of 16 or more residents and any units	D 467	10A NCAC 13F .1308 (c) Special Care Unit Staffing Facility will ensure that a Special Care Coordinator is present on in the Special Care Unit for 40 hours per week. Special Care Coordinator will be present on the	9/7/2024

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D 467	Continued From page 24 that are freestanding facilities, there shall be a care coordinator as required in Paragraph (b) of this Rule in addition to the staff required in Paragraph (a) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure there was a Special Care Coordinator (SCC) on duty at least eight hours a day, five days a week. The findings are: Review of the facility's census on 07/22/24 revealed there were 30 residents who lived at the facility. Interview with the Administrator on 07/22/24 at 9:46am revealed the SCC was also the Activity Director (AD). Interview with the AD on 07/22/24 at 11:38am and 2:45pm revealed: -She started last Monday (07/15/24) as the AD. -Her job duties consisted of making the activity calendar, facilitating resident activities, and encouraging residents to participate in activities. - "Activities are my sole roll". -She worked Monday through Friday from 9:00am-5:00pm. -She did not do anything clinical. Review of the AD's personnel file revealed: -She applied for the AD position in July 2024. -There was documentation she signed the AD job duties descriptions upon hire.	D 467	unit for 8 hours per day at least 5 days per week. During this time she will not be counted into any other staffing budgets. This will be his/or her primary duty. The facility has hired a Special Care Coordinator at this time and she has been employed now with us approx. 2 months. Her presence in the unit has made large improvements and she is focusing on resident care. Facility will ensure that Special Care Coordinator is in the unit 40 hours per week or in a emergency community will designate a SIC to fulfill this role in compliance as of 1e until Special Care Coordinator returns. Facility will ensure that someone is always in the role. Facility is in compliance as of September 7, 2024	

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NAME OF PROVIDER OR SUPPLIER MEADOW LAKES OF STATESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1372 EUFOLA ROAD STATESVILLE, NC 28677		
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D 467	Continued From page 25 Interview with the Administrator on 07/22/24 at 2:24pm revealed: -The AD was the back-up to the Resident Care Coordinator (RCC). -The SCC was responsible for monitoring the residents and generally worked Monday through Friday from 9:00am-5:00pm. -The SCC did not do anything clinical. Interview with the RCC on 07/23/24 at 1:05pm revealed: -The AD only did activities and nothing clinical. -The AD was not her assistant or back-up. Interview with the Administrator on 07/23/24 at 4:10pm revealed: -The AD was not hired to be the SCC but they talked about her fulfilling that role in the future. -She, as the Administrator, did all the duties a SCC would do and was technically the SCC. -The RCCs were counted in staffing hours and therefore could not be considered the SCC. Interview with the facility's Vice President of Operations on 07/24/24 at 8:55am revealed: -The facility only employed RCCs, not a SCC. -The Administrator acted as a SCC.	D 467			