STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080032	A. BUILDING: _____ B. WING _____	R-C 09/25/2024

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BETHAMY RETIREMENT CENTER	909 N SALISBULRY AVENUE SPENCER, NC 28159

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up and complaint investigation survey from 09/24/24 to 09/25/24.	D 000		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure contact with the resident's physician or prescribing practitioner for clarification of medication orders for 1 of 5 sampled residents (#1) who had an order for an anti-anxiety medication and an acid reflux medication. The findings are: Review of Resident #1's current FL2 dated 02/21/24 revealed diagnoses included quadriplegia, chronic pain, anxiety disorder, hypertension, and major depressive disorder. a. Review of Resident #1's current FL2 dated	D 344		

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D 344	Continued From page 1	D 344		

02/21/24 revealed an order for clonazepam (a controlled medication used to treat anxiety) 1mg twice daily.

Review of Resident #1's physician's order dated 08/19/24 revealed an order to refill clonazepam 1mg twice daily for anxiety.

Review of Resident #1's physician's orders for August 2024 revealed there was no order for clonazepam 0.5mg twice daily available for review.

Review of Resident #1's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 1mg twice daily scheduled at 8:00am and 8:00pm.
-There was documentation clonazepam 1mg was administered twice daily from 08/01/24 through 08/19/24.
-There was a second entry for clonazepam 0.5mg twice daily scheduled at 8:00am and 8:00pm.
-There was documentation clonazepam 0.5mg was administered twice daily from 08/20/24 through 08/31/24.

Review of Resident #1's September 2024 eMAR from 09/01/24 through 09/24/24 revealed:
-There was an entry for clonazepam 0.5mg twice daily scheduled at 8:00am and 8:00pm.
-There was documentation clonazepam 0.5mg was administered twice daily from 09/01/24 through 09/24/24.

Observation of medications on hand for Resident #1 on 09/24/24 at 2:18pm revealed there was one medication card for clonazepam 0.5mg tablets to take one tablet twice daily with 23 out of 28 dispensed tablets remaining and a dispensed

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D 344	Continued From page 2 date of 09/20/24. Interview with Resident #1 on 09/24/24 at 2:39pm revealed: -She had discussed her dose of clonazepam with her mental health provider (MHP). -She knew that her MHP planned to decrease the dose of clonazepam from 1mg twice daily to 0.5mg twice daily on 08/19/24. Interview with a medication aide (MA) on 09/25/24 at 9:15am revealed: -Since there was no Resident Care Coordinator (RCC) at the facility at that time, the MAs were responsible for processing all new medication orders. -She administered clonazepam 0.5mg twice daily as entered on Resident #1's eMAR and medication card. -She had not seen Resident #1's medication refill order dated 08/19/24 that was written for clonazepam 1mg twice daily, so when she saw that the order had changed to clonazepam 0.5mg twice daily on the eMAR, she assumed the order had been changed. -Whichever MA had been working while Resident #1's clonazepam refill order had been written would have been responsible for ensuring the pharmacy entered a matching order on the eMAR, or for reaching out to the prescribing provider to clarify the order. -The MAs were responsible for checking the order entered onto the eMAR by the pharmacy against the signed physician's order prior to approving the entry on the eMAR. -One of the MAs who no longer worked at the facility started an order tracking form for Resident #1's clonazepam 1mg twice daily, but a different MA approved the order on the eMAR and did not complete the order tracking form.	D 344		

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D 344	Continued From page 3	D 344		

-The MAs completed audits of the medication cart at least monthly, but they compared the medications in the cart against the orders in the eMAR, not against the orders written and placed in the resident's record.

Telephone interview with a representative from the facility's contracted pharmacy on 09/25/24 at 9:48am revealed:
-Resident #1 had a current order dated 08/19/24 for clonazepam 0.5mg twice daily.
-The prescription had been sent to the pharmacy electronically directly from the ordering prescriber.
-The pharmacy entered medication orders and order changes into the eMAR system for the facility, but someone at the facility had to approve the order before it became active in the eMAR system.

Telephone interview with a second MA on 09/25/24 at 1:30pm revealed:
-She approved Resident #1's clonazepam 0.5mg order in the eMAR after the pharmacy had entered the order.
-She did not clarify Resident #1's clonazepam order prior to approving the eMAR entry because the medication card that came from the pharmacy matched what had been entered on the eMAR.
-She did not notice that the written order was for clonazepam 1mg twice daily and the order she approved for clonazepam 0.5mg twice daily were not the same.
-She completed medication cart audits every week and she compared the eMAR to the medications on hand.
-She did not compare signed physician orders in the resident record to the order on the eMAR.

Interview with the Administrator on 09/25/24 at

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D 344	Continued From page 4	D 344		

1:40pm revealed:
-She was not aware Resident #1's clonazepam order had not been clarified.
-The discrepancy between Resident #1's clonazepam written refill order and how it was entered on the eMAR should have been caught during one of the MA's medication cart audits.

Attempted telephone interview with Resident #1's MHP on 09/25/24 at 10:30am was unsuccessful.

Refer to the interview with the Administrator on 09/25/24 at 1:40pm.

b. Review of Resident #1's hospital discharge orders dated 08/29/24 revealed an order to start taking famotidine (a medication used to treat acid reflux) 20mg twice daily.

Review of Resident #1's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for famotidine 20mg once daily scheduled at 8:00am.
-There was documentation famotidine 20mg was administered once daily on 08/30/24 and 08/31/24.

Review of Resident #1's September 2024 eMAR from 09/01/24 through 09/24/24 revealed:
-There was an entry for famotidine 20mg once daily scheduled at 8:00am.
-There was documentation famotidine 20mg was administered once daily from 09/01/24 through 09/24/24.

Observation of medications on hand for Resident #1 on 09/25/24 at 10:45am revealed there was one medication card dispensed on 09/24/24 for famotidine 20mg once daily and there were 29

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D 344	Continued From page 5 out of 30 tablets remaining. Interview with Resident #1 on 09/24/24 at 2:39pm revealed: -She remembered the hospital staff mentioning they were going to prescribe famotidine for her. -She did not have any symptoms of heart burn or reflux. Interview with a medication aide (MA) on 09/25/24 at 9:15am revealed: -Since there was no Resident Care Coordinator (RCC) at the facility at that time, the MAs were responsible for processing all new medication orders. -She administered famotidine 20mg once daily as it was entered on Resident #1's eMAR and medication card. -She had not been working when Resident #1 returned from the hospital on 08/29/24, so she had not processed her order for famotidine. -There was no order tracking form for Resident #1's famotidine in the order tracking book. -Whichever MA had been working when Resident #1 returned from the hospital would have been responsible for faxing the order to the pharmacy and then ensuring the pharmacy entered a matching order on the eMAR, or for reaching out to the hospital provider or Resident #1's primary care provider (PCP) to clarify the order if not. -The MAs were responsible for checking the order entered onto the eMAR by the pharmacy against the physician's order prior to approving the entry on the eMAR. -The MAs completed audits of the medication cart at least monthly, and they compared the medications in the cart against the orders in the eMAR, not against the orders written and placed in the resident's record.	D 344		

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D 344	Continued From page 6	D 344		

Telephone interview with a representative from the facility's contracted pharmacy on 09/25/24 at 9:48am revealed:
-Resident #1 had a current order dated 08/29/24 for famotidine 20mg once daily that had been called in to the pharmacy directly from staff at the hospital.
-The pharmacy had not received an order for famotidine 20mg twice daily for Resident #1.
-The pharmacy dispensed 30 tablets of famotidine 20mg on 08/29/24, and again on 09/24/24.
-The pharmacy entered medication orders and order changes into the eMAR system for the facility, but someone at the facility had to approve the order before it became active in the eMAR system.

Telephone interview with a second MA on 09/25/24 at 1:30pm revealed:
-She had not seen Resident #1's order for famotidine 20mg twice daily or noticed that it was entered on the eMAR for famotidine 20mg once daily.
-Resident #1 never complained of acid reflux or heartburn symptoms.
-She completed medication cart audits every week and she compared the eMAR to the medications on hand.
-She did not compare signed physician orders in the resident record to the order on the eMAR.

Interview with the Administrator on 09/25/24 at 1:40pm revealed:
-She was not aware Resident #1's famotidine order had not been clarified.
-The discrepancy between Resident #1's famotidine order on the hospital discharge paperwork and how it was entered on the eMAR should have been caught during one of the MA's

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D 344	Continued From page 7 medication cart audits. Attempted telephone interview with Resident #1's PCP on 09/25/24 at 10:30am was unsuccessful. Refer to the interview with the Administrator on 09/25/24 at 1:40pm. _____ Interview with the Administrator on 09/25/24 at 1:40pm revealed: -She expected the MAs to ensure that the signed physician's order matched the order that the pharmacy entered in the eMAR along with the instructions for administration written on the medication card prior to approving new order entries on the eMAR. -Whichever MA was on duty when an order changed was responsible for faxing that order to the pharmacy and starting an order tracking form. -Whichever MA was on duty when an order entry needed to be approved in the eMAR was responsible for checking the entry against the order tracking form and the signed physician's order first. -The MA should clarify any order discrepancies with the prescribing practitioner prior to approving the eMAR entry.	D 344		