STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 08/13/24 through 08/15/24.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (#2) completed tuberculosis (TB) testing upon admission in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #2's current FL2 dated 02/07/24 revealed diagnoses included dementia, post traumatic stress disorder, hypertension, neuropathy, emphysema, hyperlipidemia, chronic obstructive pulmonary disease, and diabetes mellitus type II. Review of Resident #2's Resident Register	D 234		

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D 234	Continued From page 1	D 234		

revealed an admission dated of 05/11/22.

Review of Resident #2's TB skin tests revealed:
-There was documentation Resident #2 had a TB skin test that was read on 07/30/08 as negative, but there was no documentation when the test was placed.
-There was documentation Resident #2 had a TB skin test on 07/13/19 that was read on 07/16/19 as negative.

Interview with the Resident Care Coordinator (RCC) on 08/15/24 at 9:47am revealed:
-She was responsible for ensuring residents had their first step TB skin test completed prior to admission and a second step TB skin test scheduled upon admission.
-She started working at the facility after Resident #2 was admitted and she did not know Resident #2 did not have two TB skin tests completed upon his admission in 2022.
-There were no other TB skin tests available for review for Resident #2 after 07/16/19.

Interview with the Administrator on 08/15/24 at 10:45am revealed:
-The RCC was responsible for ensuring TB skin tests were completed for residents.
-The first step TB skin test was completed upon admission and the RCC scheduled for the resident to have a second step a few weeks later.
-Resident #2 resided in the facility's independent living prior to being admitted to the assisted living.
-She did not know Resident #2 should have had a second step TB sin test completed upon admission to the assisted living since he already resided at the facility in independent living.

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D 273	Continued From page 2	D 273		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .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: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 5 sampled residents (#2) related to laboratory testing. The findings are: Review of Resident #2's current FL2 dated 02/07/24 revealed diagnoses included dementia, hypertension, neuropathy, emphysema, hyperlipidemia, chronic obstructive pulmonary disease, and diabetes mellitus type II. Review of Resident #2's medication administration records (MARs) revealed Resident #2's diagnoses included acute kidney injury, hyperkalemia, and coronary artery disease. Review of Resident #2's hospital discharge summary reports dated 07/03/24 revealed: -His admission and discharge diagnoses included anemia and hypoxic respiratory failure. -Resident #2's family member stated he recently had 6 teeth pulled and had significant bleeding. -There was no acute bleeding noted. -Resident #2's hemoglobin (Hgb) was 5.8 from 9.1 one month prior (A normal Hgb range is 14.0 - 17.5.). -Resident #2's Hgb was 7.5 upon discharge. -There was a list of follow-up action items which included: please follow-up with a complete blood	D 273		

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count (CBC) laboratory test in 3-5 days to assess for improvement in hemoglobin.

Review of Resident #2's record revealed there was no documentation a CBC had been completed.

Interview with the Transportation Coordinator on 08/15/24 at 9:04am revealed:
-She scheduled and provided transportation for residents to appointments outside of the facility.
-She did not review residents' hospital reports.
-The Resident Care Coordinator (RCC) was responsible for reviewing residents' hospital reports and the RCC gave her a copy of any orders that needed follow-up with providers outside of the facility.
-Resident #2 was a Veteran's Administration Medical Center (VAMC) patient and saw providers at the VAMC for all his medical needs including his primary care provider (PCP).
-She did not receive any hospital discharge referrals from the RCC for Resident #2 to have a CBC completed within 3 to 5 days.
-If she had received the order for the CBC for Resident #2, she would have contacted the VAMC to schedule an appointment for him to have the CBC completed.
-She had not scheduled any appointments for Resident #2 to have a CBC completed.

Interview with the RCC on 08/15/24 at 9:47am revealed:
-She was responsible for reviewing hospital discharge summaries for follow-up actions.
-She thought she reviewed Resident #2's hospital discharge summary dated 07/03/24, but she did not know what happened with him having a CBC completed.
-Resident #2 would have had to have the CBC

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D 273	Continued From page 4 completed at the VAMC rather than at the facility, because the VAMC was his PCP. -After reviewing hospital discharge summaries, if there were orders or follow-up actions for follow-up outside of the facility, she usually made a copy of the discharge summary and gave a copy to the Transportation Coordinator to schedule the follow-up. -She did not know if there was an appointment made for Resident #2 to have a CBC completed with the VAMC. Interview with the facility's PCP on 08/14/24 at 10:24am revealed she did not provide PCP services to Resident #2 and would not have written an order for the facility to have the CBC laboratory test completed. Telephone interview with a nurse from the VAMC on 08/15/24 at 10:11am revealed there was no documentation the facility requested an appointment for a CBC laboratory test after 07/03/24. Interview with the Administrator on 08/15/24 at 10:45am revealed: -The RCC was responsible for reviewing hospital discharge summaries for needed follow-ups. -The RCC made a copy of the hospital discharge documents and gave them to the Transportation Coordinator to schedule follow-up visits. -She did not know there was an order for Resident #2 to have a CBC completed within 3 to 5 days after his hospital visit or that the CBC had not been completed.	D 273		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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D 367	Continued From page 5 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the accuracy of the medication administration records (MARs) for 2 of 5 residents, related to an as needed anti-anxiety medication (#3), and an as needed pain relief medications (#3 and #4). The findings are: 1. Review of Resident #3's current FL2 dated 04/01/24 revealed diagnoses included hyperkalemia, essential hypertension, chronic obstructive pulmonary disease, and coronary artery disease. a. Review of Resident #3's physician's orders	D 367		

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dated 04/17/24 revealed an order for oxycodone (used to treat moderate to severe pain) 10mg 1 tablet every 6 hours (4 times daily) as needed.

Review of Resident #3's physician's orders dated 06/27/24 revealed an order for oxycodone 10mg 1 tablet 3 times daily as needed.

Review of Resident #3's physician's orders dated 08/07/24 revealed an order for oxycodone 10mg 1 tablet 4 times daily as needed.

Review of Resident #3's medication administration record (MAR) for June 2024 revealed:
-There was an entry for oxycodone 1 tablet every 6 hours as needed for pain.
-Lorazepam was documented as administered for 59 opportunities between 06/01/24 and 06/30/24.

Review of Resident #3's controlled substance count sheet (CSCS) for June 2024 compared to Resident #3's June 2024 MAR revealed there was a total of 90 tablets signed out on the CSCS, but 31 tablets were not documented as administered on the MAR with examples as follows:
-On 06/02/24, there were 3 tablets signed out on the CSCS, but 1 tablet was documented as administered on the MAR.
-On 06/14/24, there were 3 tablets signed out on the CSCS, but 1 tablet was documented as administered on the MAR.
-On 06/21/24, there were 3 tablets signed out on the CSCS, but 1 tablet was documented as administered on the MAR.

Review of Resident #3's MAR for July 2024 revealed:
-There was a written entry for oxycodone 1 tablet

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every 6 hours as needed for pain.
-Oxycodone was documented as administered for 79 opportunities between 07/01/24 and 07/31/24.

Review of Resident #3's controlled substance count sheet (CSCS) for July 2024 compared to Resident #3's July 2024 revealed there was a total of 93 tablets signed out on the CSCS, but 14 tablets were not documented as administered on the MAR with examples as follows:
-On 07/01/24, there were 3 tablets signed out on the CSCS, but 1 tablet was documented as administered on the MAR.
-On 07/15/24, there were 3 tablets signed out on the CSCS, but 2 tablets were documented as administered on the MAR.
-On 07/23/24, there were 3 tablets signed out on the CSCS, but 2 tablets were documented as administered on the MAR.

Review of Resident #3's MAR from 08/01/24 through 08/14/24 revealed:
-There was a written entry for oxycodone 1 tablet 3 times daily as needed for pain.
-There was a written entry for oxycodone 10mg 1 tablet 4 times daily as needed for pain.
-Oxycodone was documented as administered for 36 opportunities between 08/01/24 and 08/14/24.

Review of Resident #3's controlled substance count sheet (CSCS) from 08/01/24 through 08/14/24 compared to Resident #3's MAR from 08/01/24 through 08/14/24 revealed there was a total of 46 tablets signed out on the CSCS, but 10 tablets were not documented as administered on the MAR with examples as follows:
-On 08/07/24, there were 3 tablets signed out on the CSCS, but 1 tablet was documented as administered on the MAR.
-On 08/11/24, there were 4 tablets signed out on

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the CSCS, but 3 tablets were documented as administered on the MAR.
-On 08/12/24, there were 4 tablets signed out on the CSCS, but 2 tablets were documented as administered on the MAR.

Observation of Resident #3's medications on hand on 08/14/24 at 3:28pm revealed:
-There was a bubble card of oxycodone 10mg 1 tablet 4 times daily as needed.
-Oxycodone 10mg was dispensed on 08/07/24 with a quantity of 20 tablets and 1 tablet was remaining.

Interview with a medication aide (MA) on 08/14/24 at 11:52pm revealed:
-When she administered controlled substances, she first checked to see if the dosing would be within the time frame for administration to the resident.
-She looked at the MAR and pulled the bubble card to compare the name of the resident, the name of the medication, and that it was the right dose.
-She signed the MAR and the CSCS and recorded the effectiveness of the controlled substance on the back of the MAR.
-She noticed there had been missing documentation of administration of controlled substances on the MAR compared to the CSCS and she reported it to the Special Care Unit Coordinator (SCUC)/Resident Care Coordinator (RCC).
-Resident #3 requested oxycodone at the same time daily and she thought she may have just forgotten to document administration of oxycodone to Resident #3 on the MAR.
-The SCUC/RCC checked the CSCS, but she did not know how often.
-The SCUC/RCC often spoke to the MAs about

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documenting CSCS accurately on the MAR and the CSCS with the last time being in August 2024.

Interview with a second MA on 08/14/24 at 2:38pm revealed:
-Resident #3 regularly asked for her as needed controlled substances at the same time every day.
-She looked at the MAR and the CSCS to see if the medication has been administered.
-Sometimes she forgot to document administration of as needed controlled substances, including oxycodone, on the MAR
-There had been no trainings regarding administration and documentation of controlled substances other than her initial medication administration training; however, the SCUC/RCC did mention documenting controlled substances correctly in their monthly meetings.

Refer to the interview with the SCUC/RCC 08/15/24 at 9:47am.

Refer to the interview with the Administrator on 08/15/24 at 10:45am.

b. Review of resident #3's physician's orders dated 05/31/24 revealed an order for Ativan (a controlled substance used to treat anxiety) 1mg every day as needed for anxiety.

Review of Resident #3's medication administration record (MAR) for June 2024 revealed:
-There was a written entry for lorazepam 1mg 1 tablet daily as needed for severe anxiety.
-Lorazepam was documented as administered for 3 opportunities on 06/07/24, 06/09/24, and on 06/21/24.

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Review of Resident #3's controlled substance count sheet (CSCS) for June 2024 compared to Resident #3's June 2024 MAR revealed there were 2 tablets signed out on the CSCS but not documented as administered on the MAR on 06/03/24 and 06/20/24 with documentation 1 tablet was signed out on the CSCS each day, but not documented as administered on the MAR.

Review of Resident #3's MAR for July 2024 revealed:
-There was an entry for lorazepam 1mg 1 tablet daily as needed for anxiety.
-Lorazepam was documented as administered for 6 opportunities on 07/01/24, 07/05/24, 07/12/24, 07/13/24, 07/14/24, and 07/22/24.

Review of Resident #3's CSCS for July 2024 compared to Resident #3's July 2024 MAR revealed there were 25 tablets signed out on the CSCS but not documented as administered on the MAR as follows: on 07/02/224, 07/03/24, 07/04/24, 07/06/24, 07/07/24, 07/08/24, 07/09/24, 07/10/24, 07/11/24, 07/15/24 through 07/21/24, and 07/23/24 through 07/31/24 there was documentation 1 tablet was signed out on the CSCS each day, but not documented as administered on the MAR.

Review of Resident #3's MAR from 08/01/214 through 08/13/24 revealed:
-There was an entry for lorazepam 1mg 1 tablet daily as needed for anxiety.
-Lorazepam was documented as administered for 3 opportunities on 08/09/24, 08/11/24, and on 08/13/24.

Review of Resident #3's CSCS from 08/01/24 through 08/14/24 compared to Resident #3's MAR from 08/01/24 through 08/14/24 revealed

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D 367	Continued From page 11 there were 10 tablets signed out on the CSCS but not documented as administered on the MAR as follows: on 08/01/224 through 08/07/24, 08/10/24, 08/11/24 at 12:00pm, and on 08/12/24 with documentation 1 tablet was signed out on the CSCS each day, but not documented as administered on the MAR. Observation of Resident #3's medications on hand on 08/14/24 at 3:28pm revealed: -There was a bubble card of lorazepam 1mg 1 tablet every day as needed. -Lorazepam 1mg was dispensed from the pharmacy on 05/31/24 with a quantity of 30 tablets and 27 tablets were remaining. Interview with a medication aide (MA) on 08/14/24 at 11:52pm revealed: -When she administered controlled substances, she first checked to see if the dosing would be within the time frame for administration to the resident. -She looked at the MAR and pulled the bubble card to compare the name of the resident, the name of the medication, and that it was the right dose. -She signed the MAR and the CSCS and recorded the effectiveness of the controlled substance on the back of the MAR. -She noticed there had been missing documentation of administration of controlled substances on the MAR compared to the CSCS and she reported it to the Special Care Unit Coordinator (SCUC)/Resident Care Coordinator (RCC). -Resident #3 requested lorazepam at the same time daily and she thought she may have just forgotten to document administration of lorazepam to Resident #3 on the MAR. -The RCC checked the CSCS, but she did not	D 367		

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know how often.
-The RCC often spoke to the MAs about documenting CSCS accurately on the MAR and the CSCS with the last time being in August 2024.

Interview with a second MA on 08/14/24 at 2:38pm revealed:
-Resident #3 regularly asked for her as needed controlled substances at the same time every day.
-She looked at the MAR and the CSCS to see if the medication has been administered.
-Sometimes she forgot to document administration of as needed controlled substances, including lorazepam, on the MAR
-There had been no trainings regarding administration and documentation of controlled substances other than her initial medication administration training; however, the SCUC/RCC did mention documenting controlled substances correctly in their monthly meetings.

Refer to the interview with the SCUC/RCC 08/15/24 at 9:47am.

Refer to the interview with the Administrator on 08/15/24 at 10:45am.

2. Review of Resident #4's current FL2 dated 03/20/24 revealed diagnoses included dementia, neuropathy, and hypertension.

Review of Resident #4's physician's orders dated 06/19/24 revealed there was an order for hydrocodone 5mg-acetaminophen 325mg (a controlled substance used to treat pain) 1 tablet every 6 hours as needed (PRN) for pain.

Review of Resident #4's June 2024 medication administration record (MAR) revealed:

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NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

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-There was an entry for hydrocodone 5mg-acetaminophen 325mg take 1 tablet every 6 hours as needed for pain.
-Hydrocodone 5mg-acetaminophen 325mg was documented as administered on 20 opportunities from 06/20/24 to 06/30/24.

Review of Resident #4's controlled substance count sheets (CSCS) from 06/19/24-06/30/24 compared to Resident #4's MAR revealed there were 2 hydrocodone 5mg-acetaminophen 325mg 1 tablets signed out on the CSCS but not documented as administered on the June 2024 MAR as follows:
-On 06/21/24 for 8:00am, one tablet was signed out on the CSCS but not documented on the MAR.
-On 06/26/24 for 11:00am, one tablet was signed out on the CSCS but not documented on the MAR.

Review of Resident #4's July 2024 MAR revealed:
-There was an entry for hydrocodone 5mg-acetaminophen 325mg take 1 tablet every 6 hours as needed for pain.
-Hydrocodone 5mg-acetaminophen 325mg was documented as administered on 9 opportunities from 08/01/24 to 08/14/24.

Review of Resident #4's CSCS from 07/01/24-07/31/24 compared to Resident #4's MAR revealed there were 4 hydrocodone 5mg-acetaminophen 325mg 1 tablet signed out on the CSCS but not documented as administered on the July 2024 MAR as follows:
-On 07/07/24 for 7:00am, one tablet was signed out on the CSCS but not documented on the MAR.
-On 07/08/24 for 7:00am, one tablet was signed out on the CSCS but not documented on the

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MAR.
-On 07/09/24 for 7:00am, one tablet was signed out on the CSCS but not documented on the MAR.
-On 07/26/24 for 12:00pm, one tablet was signed out on the CSCS but not documented on the MAR.

Review of Resident #4's August MAR 08/01/24-08/14/24 revealed:
-There was an entry for hydrocodone 5mg-acetaminophen 325mg take 1 tablet every 6 hours as needed for pain.
-Hydrocodone 5mg-acetaminophen 325mg was documented as administered on 10 opportunities from 08/01/24 to 08/14/24.

Review of Resident #4's CSCS from 08/01/24-08/14/24 compared to Resident #4's MAR revealed there were 7 hydrocodone 5mg-acetaminophen 325mg 1 tablet signed out on the CSCS but not documented as administered on the August 2024 MAR as follows:
-On 08/02/24 for 7:00am, one tablet was signed out on the CSCS but not documented on the MAR.
-On 08/04/24 for 8:00am, one tablet was signed out on the CSCS but not documented on the MAR.
-On 08/05/24 for 10:00am, one tablet was signed out on the CSCS but not documented on the MAR.
-On 08/06/24 for 1:00am, one tablet was signed out on the CSCS but not documented on the MAR.
-On 08/06/24 for 8:00am, one tablet was signed out on the CSCS but not documented on the MAR.
-On 08/09/24 for 12:00pm, one tablet was signed out on the CSCS but not documented on the

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D 367	Continued From page 15 MAR. -On 08/10/24 for 9:00am, one tablet was signed out on the CSCS but not documented on the MAR. Observation of medications on hand for Resident #4 on 08/14/24 at 12:00pm revealed there was one bubble card of hydrocodone 5mg-acetaminophen 325mg take 1 tablet every 6 hours as needed for pain that contained 8 of 30 tablets and a second with 30/30 tablets available for administration, both dispensed on 07/05/24. Interview with a medication aide (MA) on 08/14/24 at 12:05pm revealed: -The facility staff were supposed to document administration of PRN medications on the residents' MARs at the time the medications were administered. -The procedure for controlled medications administered PRN was for the MA to check the MAR for the PRN controlled medication order, prepare the PRN medication by retrieving the medication from the locked drawer on the medication cart, sign the medication out on the CSCS for the resident's medication, administer the medication, and document administration on the MAR. -She would get distracted or busy helping residents and would forget to go back and document administration of Resident #3's PRN controlled pain medication on the MAR. -The Special Care Unit Coordinator (SCUC)/Resident Care Coordinator (RCC) checked MARs for missing documentation and she would reinforce to the MAs the importance of documenting medication administration on each resident's MAR at monthly staff meetings. -She had MAR documentation training upon hire as well as training on administering narcotics.	D 367		

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D 367	Continued From page 16 Interview with a second MA on 08/14/24 at 12:10pm revealed: -The MAs were supposed to document administration of as PRN medications on the residents' MARs when the medications were administered. -The MAs were to check the resident's MAR for the PRN controlled medication order, retrieve the PRN controlled medication from the locked drawer on the medication cart, sign the medication out on the CSCS for the resident's medication, administer the medication, and document administration on the MAR. -If she omitted any medication administration on Resident #3's MAR it would be because she got distracted or went to help residents and forgot to go back and document administration of Resident #3's PRN controlled pain medication on the MAR. -She thought the SCUC/RCC checked MARs for missing documentation and she also told the MAs the importance of documenting medication administration on each resident's MAR at monthly staff meetings. -She had MAR and controlled substance administration and documentation training upon hire. Interview with Resident #4's primary care provider (PCP) on 08/14/24 at 10:30am revealed: -Resident #4 had chronic pain due to thoracic fractures (T6, T7 and T12). -Resident #4 was ordered hydrocodone-acetaminophen 5mg-325mg 1 tablet every 6 hours PRN for that pain and she was able to express her pain and request PRN pain medication. -She expected the facility staff to accurately document medication administration on each residents' MAR.	D 367		

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D 367	Continued From page 17 -She reviewed the residents' MARs occasionally and if the MAR documentation were not documented accurately, she would not be able to determine if changes to medication dosages or frequency were needed. Refer to interview with the SCUC/RCC 08/15/24 at 9:47am. Refer to interview with the Administrator on 08/15/24 at 10:45am. _____ Interview with the SCUC/RCC 08/15/24 at 9:47am revealed: -The MAs should remove the requested PRN medication from the medication cart or the locked controlled medication box, sign the CSCS for the medication removed, administer the medication and the immediately document the administration on the resident's MAR. -The MAs were to return within an hour and document effectiveness of the PRN that was given to the resident. -She reviewed MARs once at the beginning of each month for the previous month. -She routinely checked residents' MARs for missing documentation, but she did not have a system in place to audit MAR documentation of PRN medications compared to the CSCS for accuracy of administration and effectiveness. -MAs received training on accurate medication administration documentation and narcotic sign out documentation during orientation. -She had also repeatedly instructed MAs at the monthly staff meetings on the importance of proper documentation of scheduled and PRN medications. -She expected the MAs to document PRN controlled medications on the CSCS and on each residents' MAR.	D 367		

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D 367	Continued From page 18 Interview with the Administrator on 08/15/24 at 10:45am revealed: -When a resident requested a PRN medication or controlled medication, the MAs were to pull the medication, sign the CSCS when the medication was removed, administer the medication and document the PRN medication administration immediately on the resident's MAR. -The SCUC/RCC was responsible to review resident MAR documentation and to have MAs complete documentation. -The SCUC/RCC reviewed resident's MARs once a month for missing documentation on scheduled medications, but she was not sure if they compared CSCS sign outs or PRN medication administration to MAR documentation and effectiveness of PRNs. -She expected MAs to accurately document medication administration on all residents MARs.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.	D 375		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 1 sampled resident (#2) who self-admininsitered medications had physicians' orders to self-administer 2 inhaler medications.

The findings are:

Review of Resident #2's current FL2 dated 02/07/24 revealed:
-Diagnoses included dementia, hypertension, neuropathy, emphysema, hyperlipidemia, chronic obstructive pulmonary disease (COPD), and diabetes mellitus type II.
-There was an order tiotropium 18mcg (used to treat COPD) one capsule via device once daily; may keep at bedside.
-There was an order for albuterol 0.085% 2.5ml/3ml (used to treat lung diseases) one vial every 6 hours as needed for shortness of breath and wheezing; may keep at bedside.

Review of Resident #2's signed physician's orders dated 07/10/24 revealed:
-There was an order for tiotropium 18mcg inhale 1 capsule via device once daily; there was documentation Resident #2 could keep tiotropium at bedside.
-There was an order for albuterol 0.085% inhale 1 vial via nebulizer every 6 hours as needed for wheezing.; there was no documentation Resident #2 could keep tiotropium at bedside.

Review of Resident #2's monthly compliance checklists for self-administering residents revealed:
-Staff were to document which medications were

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in the resident's room, ask the resident what time and why they were taking the medications and ask the resident if there were any other medications in the room.
-Staff were to document whether there was a current order and communicate an order or self-administration concerns to the Resident Care Coordinator (RCC) or the Administrator.
-There was a checklist dated 06/19/24 and 07/19/24.
-Tiotropium and Albuterol were documented on both dates as being in Resident #2's room and there were physician's orders for both.
-There was no documentation of any order or self-administration concerns.

Review of Resident #2's care plan dated 02/27/24 revealed there was no documentation Resident #2 self-administered any of his medications or kept any medications at bedside.

Review of Resident #2's medication administration record (MAR) for July and August 2024 revealed:
-There was an entry for tiotropium 18mcg inhale 1 capsule via device once daily at 8:00am.
-There was written documentation on the MAR that tiotropium may be kept at bedside; there was no documentation tiotropium was administered by staff.
-There was an entry for albuterol 0.083% 2.5ml/3ml one vial every 6 hours as needed for wheezing scheduled for administration as needed.
-There was written documentation on the MAR that tiotropium may be kept at bedside; there was no documentation tiotropium was administered by staff.

Observation of Resident #4's room on 08/14/24 at

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D 375	Continued From page 21 11:05am revealed: -Resident #4 was in a room by himself. -There was a box of albuterol vials on resident #2's couch. -Resident #4's tiotropium was on top of a side table. -Resident #4 was unable to locate his tiotropium independently. Interview with Resident #4 on 08/14/24 at 11:06am revealed: -He took an albuterol treatment only when he needed to use it for difficulty breathing. -He did not know if he had tiotropium in his room. Observation of Resident #4's room on 08/14/24 at 11:09am revealed: -The RCC asked Resident #4 to show her where his tiotropium was. -Resident #4 was in his electric wheelchair and maneuvered the wheelchair to his living area, but he did not locate his tiotropium. -The RCC found Resident #4's tiotropium on the side table. Interview with the RCC on 08/14/24 at 11:11am revealed: -Resident #2 his albuterol vials and tiotropium in his room because he wanted to have the medications within reach. -She did not realize there were no current orders to keep Resident #2's albuterol vials and tiotropium at bedside. -Resident #2 had a monthly assessment for self-administration. -She did not know Resident #2 had difficulty with locating his medication until 08/14/24. A second interview with the RCC on 08/15/24 revealed:	D 375		

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-After visiting with Resident #2 on 08/14/24, she did not think he was able to safely administer his albuterol vials and tiotropium.
-She took the albuterol vials and tiotropium out of Resident #2's room on 08/14/24 and staff was currently administering the 2 medications.
-She was responsible for updating self-administration orders.
-She thought the self-administration orders were omitted from the physician's orders and MARs after Resident #2 was discharged from the hospital in July 2024.
-She did not know "may keep at bedside" was omitted from Resident #2's current albuterol vial and tiotropium orders.
-If the pharmacy did not see "may keep at bedside" on hospital discharge orders, then they would not enter "may keep at bedside" on the 6-month physician's orders or on the MAR.

Interview with a medication aide (MA) on 08/15/24 at 10:32am revealed:
-She thought Resident #2 had current self-administration orders for albuterol via nebulizer and tiotropium.
-She conducted the last monthly compliance checklists for self-administering residents dated 07/19/24.
-Resident #2 had nebulizer vials and tiotropium in his room, but he was hospitalized during her assessment on 07/19/24.
-She assessed Resident #2 when he returned from the hospital on 07/22/23 and he was able to use his albuterol via nebulizer and his tiotropium correctly and without difficulty.
-The RCC was responsible for maintaining self-administration orders.

Interview with the Administrator on 08/15/24 at 10:45am revealed:

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D 375	Continued From page 23 -She thought the orders to self-administer for Resident #2's albuterol via nebulizer and tiotropium were left off hospital discharge orders and therefore not entered on Resident #2's current orders. -The RCC was responsible for ensuring self-administration orders were current for residents who self-administered medications. -She did not know Resident #2 did not have current self-administration orders for albuterol via nebulizer or for tiotropium.	D 375		