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BROOKDALE SMITHFIELD	830 BERKSHIRE ROAD SMITHFIELD, NC 27577

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on September 18, 2024 and September 19, 2024.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 6 staff (Staffs A, B, and D) who administered medications had a completed medication clinical skills checklist evaluation prior to administration of medications. The findings are: 1. Review of the Staff B's personnel record on 09/19/24 revealed: -There was no hire date documented. -There was documentation Staff B completed the 15-hour state approved medication administration training program on 07/12/23. -There was no documentation Staff B passed the medication aide test. -There was no documentation of an employment	D 125		

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verification form for Staff B.
-There was no documentation Staff B completed the medication clinical skills competency validation checklist.

Interview with Staff B, Medication Aide on 09/19/24 at 10:45am revealed:
-He had been employed at the facility for about two months (no exact date of employment provided).
-He was a MA.
-He documented notes in resident's electronic medication administration records (EMARs) including medication refusals, medications used as needed, and blood sugar readings.

Observation of the 8:00am medication pass on 09/19/24 revealed:
-Staff B made a medication error while administering medications to a resident during the medication pass.
-Staff B administered 1 puff of Combivent Respimat inhaler (used to treat chronic obstructive pulmonary disease) instead of 2 puffs as ordered to the resident.

Observations of Staff B, MA on 09/19/24 at 11:04am revealed:
-Staff B entered a resident's room with equipment for blood sugar monitoring.
-Staff B obtained a blood sugar reading on the resident.

Review of Medication Administration Records (MAR) for August 2024 and September 2024 revealed Staff B documented administering medication to residents on 08/23/24, 08/23/24, 08/26/24, 08/28-31/24, 09/01/24, 09/02/24, 09/05-07/24, 09/09/24, 09/12/24, and 09/14-15/24.

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D 125	Continued From page 2 Interview with the Business Office Manager (BOM) on 09/19/24 at 6:10pm revealed: -Staff B was hired on 08/01/2024. -She was responsible for ensuring staff hired as medication aides completed and passed the medication aide test. -She checked the medication aide registry upon hire. -She did not always print verification of the staff passing the medication aide test when she checked for it. Observation of the BOM on 09/19/24 at 6:10pm revealed: -The BOM accessed the medication aide registry from her computer. -The BOM presented documentation that Staff B passed the medication aide test on 07/22/03. Interview with the Health and Wellness Director/Nurse (RN) on 09/19/24 between 6:14pm and 6:35pm revealed: -She scheduled the MAs to administer medications at the facility. -She was responsible to ensure MAs were qualified to administer medications. -She was responsible for performing the medication aide clinical skills competency evaluation. -She performed a medication aide clinical skills competency evaluation for Staff B on 08/12/24 according to documentation on her calendar. -She could not find the completed medication aide clinical skills competency validation checklist for Staff B. Interview with the Administrator on 09/19/24 at 6:15pm revealed: -He relied on the BOM to ensure the personnel	D 125		

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files were completed.
-He relied on the HWD to make sure the MAs were qualified to administer medications.
-He did not currently have a system to check the personnel files.

2. Review of Staff A's personnel record revealed:
-Staff A was hired as a medication aide (MA) on 02/22/24.
-There was documentation of Staff A passing the MA written exam on 03/22/17.
-There was documentation of Staff A completing the state-approved 15-hour MA training course on 02/15/17 and 03/07/24.
-There was a medication administration skills validation form for Staff A dated 03/15/24.
-The medication administration skills validation form was incomplete and only included the first and last pages of the form, which was sections 1, 2, 3, and 14 of the skills/tasks checklist.
-There was no page 3 or page 4 of the medication administration skills validation form for Staff A which was sections 4 through 13 of the form.

Review of residents' August 2024 - September 2024 electronic medication administration records (eMARs) on 09/19/24 revealed:
-Staff A documented administering medications on 6 of 31 days from 08/01/24 - 08/31/24, including 08/15/24, 08/16/24, 08/22/24, 08/24/24, 08/25/24, and 08/29/24.
-Staff A documented administering medications on 7 of 19 days from 09/01/24 - 09/19/24 including 09/10/24, 09/11/24, 09/12/24, 09/13/24, 09/16/24, 09/18/24 and 09/19/24.

Observation of the 8:00am medication pass on 09/19/24 revealed:
-Staff A made 3 medication errors while

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administering medications to two residents during the medication pass.
-Staff A administered Calcium with Vitamin D 600/400 units (a supplement) to a resident but the resident was ordered to receive Calcium with Vitamin D 600/200 units.
-Staff A did not instruct a resident to use 1 spray of Flonase nasal spray (for seasonal allergies) in each nostril and the resident used 2 sprays in the left nostril instead of 1 spray as ordered.
-Staff A did not administer Aspirin 81mg (used to prevent heart attack and stroke) to a resident due to the medication being unavailable.

Interview with the Business Office Manager (BOM) on 09/19/24 at 6:10pm revealed:
-She usually checked the online registry when a MA was hired to see if they had passed the MA written exam.
-The Health and Wellness Director (HWD) was responsible for MA qualifications such as the medication administration skills validation and the 5/10/15 hour MA training courses.
-She could not locate a medication administration skills validation form for Staff A.

Interview with the HWD on 09/19/24 at 6:16pm revealed:
-She was a registered nurse.
-Newly hired MAs usually shadowed another MA for 3 days during medication passes.
-On the third day, she usually observed the new MA during the medication pass and checked them off for the medication administration skills validation form.
-She checked off Staff A but she was not sure why Staff A's medication administration skills validation form was missing pages.
-She could not locate the missing pages.

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Interview with the Administrator on 09/19/24 at 6:15pm revealed:
-He was not aware Staff A's medication administration skills validation form was incomplete.
-He relied on the BOM to ensure the personnel files were completed.
-He relied on the HWD to make sure the MAs were qualified to administer medications.
-He did not currently have a system to check the personnel files.

3. Review of Staff D's personnel record revealed:
-Staff D was hired as a medication aide (MA) on 05/23/24.
-There was documentation of Staff D passing the MA written exam on 02/19/16.
-There was documentation of Staff D completing the state-approved 15-hour MA training course on 05/31/19.
-There was no documentation of Staff D completing the medication administration skills validation form.

Review of residents' July 2024 - September 2024 electronic medication administration records (eMARs) on 09/19/24 revealed:
-Staff D documented administering medication on 07/30/24.
-Staff D documented administering medications on 4 of 31 days from 08/01/24 - 08/31/24, including 08/09/24, 08/14/24, 08/23/24, and 08/28/24.

Interview with the Business Office Manager (BOM) on 09/19/24 at 6:10pm revealed:
-She usually checked the online registry when a MA was hired to see if they had passed the MA written exam.
-The Health and Wellness Director (HWD) was

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D 125	Continued From page 6 responsible for MA qualifications such as the medication administration skills validation and the 5/10/15 hour MA training courses. -She could not locate a medication administration skills validation form for Staff D. Interview with the HWD on 09/19/24 at 6:16pm revealed: -She was a registered nurse. -Newly hired MAs usually shadowed another MA for 3 days during medication passes. -On the third day, she usually observed the new MA during the medication pass and checked them off for the medication administration skills validation form. -She thought she had checked off Staff D on the medication administration validation form when Staff D was hired but she could not locate the form. Interview with the Administrator on 09/19/24 at 6:15pm revealed: -He was not aware Staff D did not have a medication administration skills validation form. -He relied on the BOM to ensure the personnel files were completed. -He relied on the HWD to make sure the MAs were qualified to administer medications. -He did not currently have a system to check the personnel files.	D 125		
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	D 234		

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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 record reviews and interviews, the facility failed to ensure 4 of 5 sampled residents (#2, #3, #4, #5) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services.

The findings are:

1. Review of Resident #3's FL2 dated 09/09/24 revealed diagnoses included, diabetes type II, unspecified dementia without behaviors, syncope and collapse, atherosclerotic heart disease of native coronary artery without angina pectoris, essential hypertension, chronic kidney disease, psychotic disturbance, mood disturbance and anxiety disorder.

Review of Resident #3's Resident Register revealed, Resident #3 was admitted to the facility on 04/12/24.

Review of Resident #3's record revealed:
-There was no documentation of a tuberculosis (TB) test since Resident #3 was admitted to the facility on 04/12/24.

Interview with Resident #3 on 09/19/24 at 5:17pm revealed:

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-She thought she had taken a TB skin test since she moved to the facility but could not remember the date of the TB test.
-She had not shown any signs or symptoms of TB.

Interview with the Health and Wellness Director (HWD) on 09/19/24 at 5:42pm revealed:
-She remembered Resident #3 taking the QuantiFERON-TB Gold (QFT) TB test, but she could not locate the TB test results.
-Resident #3 had not shown any symptoms of TB.
-The previous Health and Wellness Coordinator (HWC) was responsible for ensuring TB tests were completed.
-She would administer a TB rest for Resident #3 today, 09/19/24.

2. Review of Resident #4's current FL2 dated 09/09/24 revealed diagnoses included dementia without behavioral psychotic disturbance, mood disturbance and anxiety, atherosclerotic heart disease, osteoporosis, epilepsy, essential primary hypertension, major depressive disorder, and embolism and thrombosis of unspecified vein.

Review of Resident #4's Resident Register revealed:
-There was no information provided for the date of admission.
-The resident was admitted from a private residence.
-The document was signed on 03/21/23.

Review of Resident #4's TB skin testing records revealed:
-There was documentation of a TB skin test read as negative on 02/09/23.
-There was documentation of a second TB skin

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test placed on 04/02/23.
-There were no results of a reading for the 04/02/23 TB skin test placed.
-There was a TB Surveillance Questionnaire with an effective date of 04/04/23 documented and signed electronically on 04/20/23 with documented results of "this resident appears to be free of the clinical symptoms of tuberculosis".

Interview with the Health and Wellness Director/Nurse (RN) on 09/18/24 between 3:30pm to 3:40pm revealed:
-She could not find any documentation of the results for the TB skin test placed to Resident #4 on 04/02/23.
-She was currently performing dual roles because the Health and Wellness Coordinator position was vacant.
-She was unaware TB tests were not up to date.

Based on observations, interviews, and record review, it was determined Resident #4 was not interviewable.

3. Review of Resident #5's current FL-2 dated 09/09/24 revealed diagnoses included diabetes mellitus without complication, gastro-esophageal reflux disease, bipolar, hypomagnesemia, candidiasis of skin and nail, essential hypertension, osteoarthritis, and overactive bladder.

Review of Resident #5's Resident Register revealed:
-There was no information provided for the date of admission.
-The resident was admitted from a private residence.
-The document was signed on 07/29/23.

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Review of Resident #5's TB skin testing records revealed:
-There was documentation of a TB skin test placed on 07/27/23.
-There was no date documented of when the TB skin test was read.
-There was documentation of a TB skin test read as negative on 03/20/24.

Interview with the Health and Wellness Director/Nurse (RN) on 09/19/24 between at 12:30pm revealed:
-She could not find any documentation of the results for the TB skin test placed to Resident #5 on 07/27/23.
-She was not employed at the facility until October 2023.
-The Health and Wellness Coordinator (HWC) was responsible for ensuring 2-step TB skin tests were performed and documented and tracked on facility tracking log.
-She was currently performing dual roles because the HWC position was vacant.
-She was unaware TB tests were not up to date.

Based on observations, interviews, and record review, it was determined Resident #4 was not interviewable.

4. Review of Resident #2's current FL-2 dated 09/16/24 revealed diagnoses included low back pain, essential hypertension, metabolic encephalopathy, chronic respiratory failure, gastroesophageal reflux disease, wedge compression fracture of first lumbar vertebra, acute cystitis, bradycardia, chronic obstructive pulmonary disease, osteoporosis, Vitamin D deficiency, atherosclerotic heart disease, and anemia.

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Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 04/01/24.

Review of Resident #2's tuberculosis (TB) skin tests revealed:
-There was documentation of a TB skin test placed on 03/18/24 and read as negative on 03/20/24.
-There was no documentation of any other TB skin tests.

Interview with the Health and Wellness Director (HWD) on 09/19/24 at 12:25pm revealed:
-She was a registered nurse.
-She placed a TB skin test for Resident #2 today, 09/19/24, because she could not find a second step TB skin test in the resident's record.
-The Health and Wellness Coordinator (HWC) was responsible for resident TB skin tests, but the HWC position had been vacant since July 2024.
-The facility used a care tracker system and the HWC was responsible for the section of the care tracker for immunizations and TB skin tests.
-With her HWD duties, there had not been enough time to review the care tracker for all residents.

Interview with Resident #2 on 09/19/24 at 5:03pm revealed:
-The facility's HWD place a TB skin test for her today, 09/19/24.
-She did not recall having any TB skin tests prior to today, 09/19/24.
-She denied any symptoms of TB disease.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 09/19/24 at 4:29pm was unsuccessful.

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D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure care plan assessments were completed and signed within 15 days of completion for 2 of 5 sampled residents (#1, #2). The findings are: 1. Review of Resident #1's FL2 dated 03/27/24 revealed: -Diagnoses included multiple sclerosis, hyperlipidemia, essential (primary) hypertension, other specified hypothyroidism, and atherosclerotic heart disease of native coronary. -Resident #1 was semi-ambulatory with the use of a walker. Review of Resident #1's Resident Register dated 08/24/21 revealed Resident #1 was admitted to the facility on 08/31/24. Review of Resident #1's care plan dated 09/14/24 revealed:	D 263		

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-The care plan was not signed by Resident #1's primary care provider (PCP) within 15 days of completing the assessment.
-Resident #1 was assessed as a fall risk.
-Resident #1 used a walker and a wheelchair as a mobility aid.
-She was independent with bathing, grooming, dressing toileting, eating and transfers.

Review of Resident #1's care plan dated 03/14/24 revealed:
-The care plan was not signed by Resident #1's PCP within15 days of completing the assessment.
-Resident #1 was assessed as a fall risk.
-Resident #1 used a walker and a wheelchair as a mobility aid.
-She was independent with bathing, grooming, dressing toileting, eating and transfers.

Observation of Resident #1's room on 09/18/24 at 9:28pm revealed:
-Resident #1 was seated in a recliner in her living room.
-Resident #1 had her walked placed in front of her recliner.
-Resident #1 had a wheelchair folded and placed in the corner of the living room.

Interview with Resident #1 on 09/18/24 at 9:28pm revealed:
-She was a fall risk due to her diagnosis of multiple sclerosis.
-She was capable of bathing and dressing herself.
-She preferred to use her walker instead of the wheelchair because it helped to exercise her legs.
-She used to receive physical therapy that help her with her walking.

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D 263	Continued From page 14 Telephone interview with Resident #1's PCP on 09/19/24 revealed: -Resident #1 was a new patient and she had only two visits with Resident #1. -Her last visit with Resident #1 was on 09/09/24. -Resident #1 was a fall risk. -Resident #1 could ambulate with the use of a wheeler which she preferred to use. -Resident #1 was independent with transfers. -She had not reviewed or completed a care plan for Resident #1. Interview with the Health and Wellness Director (HWD) on 09/19/24 at 4:54pm revealed: -She did not know why Resident #1's PCP had not signed the care plan. -She completed chart audits for weekly but had not completed a chart audit in the past week. -She was responsible for reviewing all resident care plans to ensure the care plans were signed by all required parties. Interview with the Administrator on 09/19/24 at 5:20pm revealed the HWD was the person responsible for ensuring the care plans are completed and signed by the residents' PCP. 2. Review of Resident #2's current FL-2 dated 09/16/24 revealed: -Diagnoses included low back pain, essential hypertension, metabolic encephalopathy, chronic respiratory failure, gastroesophageal reflux disease, wedge compression fracture of first lumbar vertebra, acute cystitis, bradycardia, chronic obstructive pulmonary disease, osteoporosis, Vitamin D deficiency, atherosclerotic heart disease, and anemia. -The resident was documented as semi-ambulatory.	D 263		

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-The resident was documented as continent of bowel and bladder.
-The resident was documented as requiring personal care assistance with bathing and dressing.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 04/01/24.

Review of Resident #2's current assessment and care plan dated 07/29/24 revealed:
-The resident was independent with using oxygen and respiratory equipment.
-The resident did not require assistance with eating, but her food should be cut up in small pieces in the kitchen.
-The resident required physical assistance by staff with dressing tasks such as fastening/unfastening clothing, putting on/taking off socks/hose, and putting on/taking off shoes.
-The resident required staff supervision and/or verbal prompts as needed for bathing.
-The resident required physical assistance by staff with toileting.
-The resident used a walker and a manual wheelchair and required physical assistance with ambulation and mobility as needed.
-The resident was oriented to person, place, and time.
-The resident could communicate needs and preferences.
-The resident's care plan was not signed by a physician.

Interviews with the Health and Wellness Director (HWD) on 09/18/24 at 4:00pm and 09/19/24 revealed:
-She faxed Resident #2's assessment and care plan to the primary care provider (PCP) when she

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completed the assessment on 07/29/24.
-The PCP never returned a signed assessment and care plan to the facility.
-She faxed the assessment and care plan to the PCP again on 09/14/24 but had not received it back.
-She did not fax or contact the PCP regarding the 07/29/24 care plan after it was faxed on 07/29/24 until she faxed it again on 09/14/24.
-She was supposed to call the PCP in 48 hours of faxing the care plan if she had not received it back.
-The Health and Wellness Coordinator (HWC) position had been vacant since July 2024 and she had been busy trying to do her tasks as well as the HWC tasks.

Observation of Resident #2 on 09/19/24 at 5:03pm revealed:
-The resident was in the dining room eating supper independently.
-She was sitting in a wheelchair at the dining room table.
-The resident had an oxygen concentrator and was receiving oxygen via nasal cannula.

Interview with Resident #2 on 09/19/24 at 5:03pm revealed:
-She used continuous oxygen and she had an oxygen concentrator and portable oxygen tanks if needed.
-The facility staff assisted her with bathing and dressing.
-She just received a bath today, 09/19/24, with staff assistance.

Attempted telephone interview with Resident #2's PCP on 09/19/24 at 4:29pm was unsuccessful.

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D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a resident was provided non-disposable place settings including forks, knives, spoons, and cups at breakfast meal service for 1 of 5 sampled residents (#3). The findings are: Observation of Resident #3 on 09/18/24 at 9:01am revealed: -Resident #3 was eating breakfast in her room. -The resident's breakfast meal was on a styrofoam plate. -The resident's breakfast drinks were in styrofoam cups. -The resident was eating with a plastic fork. Interview with Resident #3 on 09/18/24 at 9:01am revealed: -Her breakfast meal was always served with a styrofoam plate, styrofoam cups, and plastic utensils. -She would rather use non-disposable plates,	D 286		

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cups, and utensils.

Second observation of Resident #3 on 09/19/24 at 8:21am revealed:
-Resident #3 was eating her breakfast meal in her room.
-Resident #3's breakfast meal was placed on a styrofoam plate.
-Resident #3 used plastic eating utensils to eat her breakfast meal.
-There were two styrofoam cups placed on her nightstand.
-One styrofoam cups was orange juice and the other cup was coffee.

Second interview with Resident #3 on 09/19/24 at 8:21am revealed:
-She ate her breakfast meal in her room.
-Her breakfast meal was served on styrofoam plates, and she received a plastic fork, knife and spoon for her breakfast meal.
-She did not know why she was served her breakfast meal on disposable plates and with disposable eating utensils.

Interview with a personal care aide (PCA) on 09/19/24 at 8:48am revealed:
-Resident #3 ate her breakfast meal in her room most of the time.
-She did not know why Resident #3's meal was served on disposable place settings but thought it was because Resident #3 had a better grip on the disposable plate.

Interview with a second PCA on 09/19/24 at 9:08am revealed:
-She had assisted with serving residents their breakfast meal on 09/19/24 and had served Resident #3 her breakfast meal in her room.
-Resident #3's breakfast meal was served on

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disposable place setting on 09/19/24.
-Resident #3's breakfast meal was not always served on disposable place setting.
-Resident #3's breakfast meal was served on disposable plates because she liked to place her plate in her lap while she ate, and she held the disposable plate better with her hands than the non-disposable plates.
-Resident #3 had not stated she preferred to use disposable plates and plastic eating utensils.

Interview with a medication aide (MA) on 09/19/24 at 8:55am revealed:
-Resident #3 liked to eat her breakfast meal in her room because she was a late sleeper.
-Resident #3's breakfast meal was served on disposable plates with plastic utensils; it was due to safety issues in case Resident #3 dropped her plate and cups and they shattered.
-Resident #3 had not requested her breakfast meal to be served on disposable place setting.

Interview with a Dietary Manager on 09/19/24 at 9:00am revealed:
-Disposable place settings were used for residents who ate their meals in their rooms.
-Using disposable place settings was due to safety and sanitation concerns when residents were sick, and some residents would not return the non-disposable place settings.

Interview with the Administrator on 09/19/24 at 5:20pm revealed:
-Disposable plates, cups, and plastic eating utensils were used when residents were quarantined due to COVID-19 restriction or other reasons for isolation when served meals in their rooms.
-He was not aware Resident #3's breakfast meals were served on styrofoam plates and cups with

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D 286	Continued From page 20 plastic eating utensils. -The facility had enough non-disposable place settings, cups and eating silverware to serve all residents who ate in their rooms and in the dining room.	D 286		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure nutritional supplements were served as ordered to 1 of 2 sampled residents (#2) who had orders to receive nutritional supplements. The findings are: Observation of the kitchen on 09/18/24 at 10:08am revealed: -There were 2 cases of nutritional supplements in the refrigerator. -One case was unopened, and the other case was over 3/4th full of 8-ounce cartons of chocolate nutritional supplement drinks. Review of Resident #2's current FL-2 dated 09/16/24 revealed: -Diagnoses included low back pain, essential hypertension, metabolic encephalopathy, chronic respiratory failure, gastroesophageal reflux disease, wedge compression fracture of first lumbar vertebra, acute cystitis, bradycardia,	D 310		

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chronic obstructive pulmonary disease, osteoporosis, Vitamin D deficiency, atherosclerotic heart disease, and anemia.
-There was an order for a nutritional supplement, drink 1 shake 3 times a day.

Review of Resident #2's monthly weight log for July 2024 - September 2024 revealed:
-On 07/29/24, the resident weighed 77.2 pounds.
-On 08/31/24, the resident weighed 77.6 pounds.
-On 09/10/24, the resident weighed 78.3 pounds.

Observation of the facility's therapeutic diet list posted in the kitchen on 09/18/24 revealed no nutritional supplements were included on the diet list, including for Resident #2.

Review of Resident #2's July 2024 - September 2024 electronic medication administration records (eMARs) revealed:
-There was no entry for a nutritional supplement 3 times a day on either of the eMARs from July 2024 - September 2024.
-No nutritional supplements were documented as given to the resident from July 2024 - September 2024.

Observation of the supper meal on 09/19/24 at 5:03pm revealed Resident #2 was not served or offered a nutritional supplement during the supper meal.

Interview with Resident #1 on 09/19/24 at 5:03pm revealed:
-She was supposed to be getting nutritional supplements, but she had not received any since she was at a rehabilitation facility a few months ago.
-She did not know why she had not received any nutritional supplements at the facility.

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D 310	Continued From page 22 Interview with a medication aide (MA) on 09/19/24 at 3:08pm revealed: -The MAs were responsible for giving nutritional supplements to residents. -The nutritional supplements should be included on the eMAR if there was an order. -She did not give nutritional supplements to Resident #2 because it was not included on the resident's eMAR. -She did not know if the resident had an order for nutritional supplements or if anyone was giving nutritional supplements to the resident. Interview with the Health and Wellness Director (HWD) on 09/19/24 at 5:35pm revealed: -Resident #2's order for nutritional supplements should be on the eMARs. -The MAs were responsible for giving nutritional supplements to the residents. -The Health and Wellness Coordinator (HWC) was responsible for making sure orders were sent to the pharmacy and put in the eMAR system. -The HWC position had been vacant since July 2024 so Resident #2's order for nutritional supplements must have been overlooked. Attempted telephone interview with Resident #2's primary care provider (PCP) on 09/19/24 at 4:29pm was unsuccessful.	D 310		
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	D 358		

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by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 4 residents (#6, #7, #8) observed during the medication pass including errors with an inhaler for chronic obstructive pulmonary disease (#6), a nasal spray for seasonal allergies (#8), a calcium and vitamin D supplement (#7), and a medication used prevent heart disease (#8); and for 2 of 5 residents (#3, #4) sampled for record review including an error with an iron supplement (#3) and a controlled substance for pain (#4).

The findings are:

1. The medication error rate was 14% as evidenced by 4 errors out of 27 opportunities during the 8:00am medication pass on 09/19/24.

a. Review of Resident #6's current FL-2 dated 09/09/24 revealed:
-Diagnoses included paroxysmal atrial fibrillation, chronic systolic congestive heart failure, cardiac pacemaker, sick sinus syndrome, essential primary hypertension, anxiety disorder, hypercholesterolemia, and ulcerative proctitis.
-There was an order for Combivent Respimat 20-100mcg/actuation (act) inhale 2 puffs (2 dosages) two times a day for shortness of breath. (Combivent Respimat inhaler is used to treat chronic obstructive pulmonary disease. According to the manufacturer, to prepare 1 dose (1 puff): hold the inhaler upright with the cap

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closed and turn the clear base until a click is heard; flip the cap open; breathe out slowly and fully; close lips around the mouthpiece, point the inhaler toward the back of throat; while taking a slow, deep breath in, press the dose release button; hold breath for 5 - 10 seconds; if more than one dose (1 puff) is needed, repeat these steps.)

Observation of the 8:00am medication pass on 09/19//24 revealed:
-The medication aide (MA) prepared Resident #6's Combivent Respimat inhaler by turning the base of the inhaler until one click was heard and administered the dosage to the resident at 7:55am.
-The MA did not instruct the resident on how to take the Combivent Respimat inhaler dosage.
-The resident took 2 quick inhalations from the inhaler for the 1 dosage prepared.
-The resident did not take a slow deep breath in or hold her breath for 5 to 10 seconds.
-The MA did not prepare the inhaler by turning the base until a click was heard for a second dosage (puff) to be administered to the resident.
-The resident received 1 puff (dosage) instead of 2 puffs (dosages) as ordered.

Review of Resident #6's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Combivent Respimat 20-100mcg/act inhale 2 puffs orally two times a day for shortness of breath.
-Combivent Respimat inhaler was scheduled at 8:00am and 7:00pm.
-Combivent Respimat inhaler was documented as administered from 09/01/24 - 09/19/24.

Observation of Resident #6's medications on

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hand on 09/19/24 at 11:34am revealed:
-There was a Combivent Respimat inhaler dispensed on 07/16/24 with an opened date of 07/24/24.
-The instructions were to inhale 2 puffs twice a day for shortness of breath as directed.

Interview with the MA on 09/19/24 at 11:39am revealed:
-He did not think about needing to turn the base of the inhaler for a second dosage (puff) to be prepared and released for administration.
-The resident sometimes held her breath in when she inhaled the Combivent dosage.
-The resident was not short of breath unless she moved around a lot.

Interview with the Health and Wellness Director (HWD) on 09/19/24 at 12:04pm revealed:
-For Resident #6's Combivent Respimat inhaler, the MA should have prepared 2 dosages.
-The MA should have counted to 10 after the first dosage, then he should have prepared a second dosage and administered it to the resident.
-The MA should have instructed the resident to hold her breath for a few seconds.
-The resident's shortness of breath varied but usually increased when the resident had swelling in her legs.

Based on observations, interviews, and record reviews, it was determined that Resident #6 was not interviewable.

Telephone interview with Resident #6's primary care provider (PCP) on 09/19/24 at 2:00pm revealed:
-Resident #6 should receive 2 puffs of Combivent Respimat inhaler.
-She did not have an immediate concern about

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the resident not receiving 2 puffs on 09/19/24, however, it was important to get the inhaler as prescribed to prevent respiratory issues such as shortness of breath and wheezing.

b. Review of Resident #7's current FL-2 dated 09/09/24 revealed:
-Diagnoses included osteoporosis with current pathological fracture, Alzheimer's disease with late onset, asthma, and major depressive disorder.
-There was an order for Calcium with Vitamin D3 600mg/20mcg (20mcg is equal to 800 units of Vitamin D3) give 1 tablet one time a day for osteoporosis.

Observation of the 8:00am medication pass on 09/19/24 revealed:
-The medication aide (MA) prepared and administered one Calcium 600mg with Vitamin D3 400 units tablet to Resident #7 at 8:25am.
-The resident was administered Calcium 600mg with Vitamin D3 400 units instead of Calcium 600mg with Vitamin D3 800 units as ordered.

Review of Resident #7's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Calcium with Vitamin D3 600mg/20mcg (800 units) give 1 tablet one time a day for osteoporosis.
-Calcium with Vitamin D3 was scheduled at 8:00am.
-Calcium with Vitamin D3 600mg/20mcg was documented as administered from 09/01/24 - 09/18/24.

Observation of Resident #7's medications on hand on 09/19/24 at 11:25am revealed:
-There was a supply of Calcium with Vitamin D3

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600mg/400 units with a cycle start date of 09/11/24.
-The instructions were to take 1 tablet every day.
-There were 19 of 28 tablets remaining.
-There was no supply of Calcium with Vitamin D3 600mg/20mcg (800 units) available for administration.

Interview with the MA on 09/19/24 at 11:25am revealed:
-Either the MAs or the Health and Wellness Director (HWD) entered orders into the eMAR system.
-She had not noticed the strength of Calcium with Vitamin D3 tablet in the eMAR system did not match the strength listed on the medication label.

Telephone interview with the Quality Assurance Specialist at the facility's contracted pharmacy on 09/19/24 at 2:44pm revealed:
-The pharmacy had an order dated 03/21/23 for Calcium 600mg with Vitamin D3 400 units 1 tablet daily.
-The pharmacy dispensed Calcium 600mg with Vitamin D3 400 units for the cycle start date of 09/11/24 based on the order dated 03/21/23.
-The pharmacy did not receive Resident #7's FL-2 or physician's order sheets dated 09/09/24 with an order for Calcium 600mg with Vitamin D3 20mcg (800 units).
-The facility was responsible for faxing FL-2s and physician's orders to the pharmacy.

Interview with the HWD on 09/19/24 at 12:07pm revealed:
-If the eMAR and the medication label did not match, the MAs were not supposed to administer a medication.
-The MAs should notify her of any discrepancies, including the discrepancy with Resident #7's

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Calcium with Vitamin D3 tablet.
-The MAs usually entered the orders into the eMAR system, and the night shift MAs were responsible for checking the eMARs and the medication labels.
-The Health and Wellness Coordinator (HWC) was responsible for doing medication audits weekly, but that position had been vacant since July 2024.

Interview with the Administrator on 09/19/24 at 12:55pm revealed:
-If the eMAR and the medication labels did not match, the MAs were supposed to go to the HWD or HWC.
-The HWC position was currently vacant, but the MAs should have notified the HWD that Resident #7's Calcium with Vitamin D3 did not match.

Interview with Resident #7 on 09/19/24 at 11:12am revealed she was not sure which medications she received or if she received a Calcium with Vitamin D3 tablet.

Telephone interview with Resident #7's primary care provider (PCP) on 09/19/24 at 2:00pm revealed:
-There had been no changes to the resident's Calcium with Vitamin D3 order; the resident should be receiving 800 units of Vitamin D3 with the Calcium.
-The resident was prescribed Calcium with Vitamin D3 for low Vitamin D3 levels.
-The resident's last Vitamin D3 level was stable but not receiving the correct dosage of Vitamin D3 could decrease her levels.

c. Review of Resident #8's current FL-2 dated 09/17/24 revealed:
-Diagnoses included essential primary

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hypertension, hyperlipidemia, macular degeneration, and anxiety disorder.
-There was an order for Aspirin 81mg 1 tablet one time a day. (Aspirin is used to prevent heart disease.)

Observation of the 8:00am medication pass on 09/19/24 revealed:
-The medication aide (MA) prepared and administered oral medications scheduled at 8:00am to Resident #8 at 8:40am, except for Aspirin 81mg.
-The resident did not receive Aspirin 81mg as ordered.

Interview with the MA on 09/19/24 at 8:40am revealed:
-The resident did not have any Aspirin 81mg tablets available for administration.
-She did not know how long the resident had been out of Aspirin.
-The resident usually ordered her own medications.
-The MAs usually let the resident know when she was down to 5 or 6 tablets of a medication and it needed to be ordered.
-The resident might be waiting for the Aspirin to come in.

Second interview with the MA on 09/19/24 at 11:21am revealed:
-The resident usually ordered all her prescription medications through a mail order pharmacy.
-The resident usually picked up her over-the-counter (OTC) medications when the resident went shopping to retail stores.
-The facility did not usually use the back-up pharmacy for Resident #8's medications because the MAs usually let the resident know in a timely manner when she was running low.

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D 358	Continued From page 30 Review of Resident #8's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 81mg 1 tablet one time a day scheduled at 8:00am. -Aspirin was documented as administered daily from 09/12/24 - 09/18/24, 09/17/24 and 09/18/24. -Aspirin was documented as not administered on 09/16/24 and 09/19/24 due to the medication being unavailable. Observation of Resident #8's medications on hand on 09/19/24 at 11:23am revealed there were no Aspirin 81mg tablets available for administration for the resident. Interview with the Health and Wellness Director (HWD) on 09/19/24 at 12:10pm revealed: -Resident #8 ordered her own medications through a mail order pharmacy. -The resident's family usually bought the resident's OTC medications. -The MAs were supposed to let the resident know when there was a 10-day supply of medications remaining. Interview with the Administrator on 09/19/24 at 12:56pm revealed: -The MAs should let Resident #8 know medications were needed before the resident ran out of medications. -He thought they only used the back-up pharmacy if it was too late to get a medication in the same night. Interview with Resident #8 on 09/19/24 at 5:05pm revealed: -She usually bought her OTC medications herself.	D 358		

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-The MAs usually let her know before she ran out of medication.
-She thought the MA had told her yesterday, 09/18/24, that she needed some Aspirin.
-She had not gone to the store to buy any Aspirin yet.

Telephone interview with a certified medical assistant (CMA) at Resident #8's primary care provider's (PCP) office on 09/19/24 at 4:25pm revealed:
-Resident #8 was taking Aspirin to prevent heart disease and because the resident had a coronary bypass graft.
-The resident should receive Aspirin every day.
-There were no immediate concerns for any problems related to one missed dose on 09/19/24.

d. Review of Resident #8's current FL-2 dated 09/17/24 revealed an order for Flonase Nasal Spray 50mcg use 1 spray in each nostril two times a day for nasal congestion. (Flonase is used to treat and prevent seasonal allergy symptoms.)

Observation of the 8:00am medication pass on 09/19/24 revealed:
-The medication aide (MA) handed the Flonase Nasal Spray bottle to Resident #8.
-The MA did not instruct the resident on how to use the Flonase or how many sprays to use.
-The resident used 1 spray in the right nostril and 2 sprays in the left nostril at 8:38am.
-The resident received 2 sprays in the left nostril instead of 1 spray as ordered.

Review of Resident #8's September 2024 electronic medication administration record (eMAR) revealed:

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D 358	Continued From page 32 -There was an entry for Flonase Nasal Spray use 1 spray in each nostril two times a day for nasal congestion. -Flonase was scheduled for administration at 8:00am and 8:00pm. -Flonase was documented as administered from 09/01/24 - 09/19/24. Observation of Resident #8's medications on hand on 09/19/24 at 11:23am revealed: -There was one bottle of over-the-counter (OTC) Flonase Nasal Spray 50mcg with the resident's name handwritten on the bottle. -There was no other labeling on the bottle. Interview with the MA on 09/19/24 at 11:21am revealed: -Resident #8 liked to hold the Flonase Nasal Spray bottle herself. -She usually watched the resident use the nasal spray to make sure the resident did it correctly. -The resident usually put 1 spray of Flonase in each nostril. Interview with the Health and Wellness Director (HWD) on 09/19/24 at 12:10pm revealed: -Resident #8 usually liked to hold the Flonase bottle herself to administer the medication. -The MAs should instruct the resident to make sure she used the correct dosage. Interview with the Administrator on 09/19/24 at 12:56pm revealed the MA should have instructed Resident #8 on how many sprays of the Flonase to use. Interview with Resident #8 on 09/19/24 at 5:05pm revealed: -She preferred to hold the Flonase bottle herself and spray it in her nostrils.	D 358		

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-She usually used 1 spray in each nostril.

Telephone interview with a certified medical assistant (CMA) at Resident #8's primary care provider's (PCP) office on 09/19/24 at 4:25pm revealed:
-Resident #8 was receiving Flonase Nasal Spray for seasonal allergies.
-The resident should receive Flonase as ordered to help prevent allergy symptoms.

2. Review of Resident #3's FL2 dated 09/09/24 revealed:
-Diagnoses included, diabetes type II, unspecified dementia without behaviors, syncope and collapse, atherosclerotic heart disease of native coronary artery without angina pectoris, essential hypertension, chronic kidney disease, psychotic disturbance, mood disturbance and anxiety disorder.
-There was an order for Ferrous Sulfate 325 mg 1 tablet every other day in the morning. (Ferrous Sulfate is used to treat or prevent low levels of iron).

Review of Resident #3's electronic medication administration record (eMAR) for July 2024 revealed:
-There was an entry for Ferrous Sulfate 325mg 1 tablet every other day in the morning at 8:00am, related to atherosclerotic heart disease of native coronary without angina pectoris.
-Ferrous Sulfate was documented as administered at 8:00am on 07/02/24 and 07/04/24.
-Ferrous Sulfate was documented as administered at 12:00pm on 07/06/24, 07/08/24, 07/10/24, 07/12/24, 07/14/24, 07/16/24, 07/18/24 07/20/24, 07/22/24, 07/24/24, 07/26/24, 07/28/24, and 07/30/24.

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D 358	Continued From page 34 Review of Resident #3's eMAR for August 2024 revealed: -There was an entry for Ferrous Sulfate 325mg 1 tablet every other day in the morning at 8:00am, related to atherosclerotic heart disease of native coronary without angina pectoris. -Ferrous Sulfate was documented as administered at 12:00pm on 08/01/24, 08/03/24, 08/05/24, 08/07/24, 08/09/24, 08/11/24, 08/13/24, 08/15/24, 08/17/24, 08/19/24, 08/21/24, 08/23/24, 08/25/24, 08/27/24, 08/29/24 and 08/31/24. Review of Resident #3's eMAR for September 2024 revealed: -There was an entry for Ferrous Sulfate 325mg 1 tablet every other day in the morning at 8:00am, related to atherosclerotic heart disease of native coronary without angina pectoris. -Ferrous Sulfate was documented as administered at 12:00pm on 09/02/24, 09/04/24, 09/06/24, 09/08/24, 09/10/24, 09/12/24, 09/14/24, 09/16/24 and 09/18/24. Interview with a medication aide (MA) on 09/19/24 at 5:14pm revealed: -She had not administered the Ferrous Sulfate 325mg to Resident #3 and was not aware the medication had been administered at the incorrect time. -Medications would populate at the time the medications were to be administered and not at a later time. Telephone interview with facility's local pharmacy on 09/19/24 11:54am revealed: -Resident #1 had an order for Ferrous Sulfate 325mg. -The Ferrous Sulfate was to be administered 1 tablet every day in the morning at 8:00am.	D 358		

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D 358	Continued From page 35 -The 8:00am time to administer the Ferrous Sulfate was created on the MAR, not 12:00pm. Interview with Resident #3's primary care physician (PCP) on 09/19/24 at 12:08pm revealed: -Resident #1 had an order for Ferrous Sulfate 325 1 tablet every other day in the morning. -The order was not written for any other designated time to be administered and should had been administered as ordered. Interview with the Health and Wellness Director (HWD) on 09/19/24 at 5:42pm revealed: -She confirmed the Ferrous Sulfate 325mg was to be administered 1 tablet in the morning every other day. -She was not aware Resident #3's Ferrous Sulfate was being administered at 12:00pm and not at 8:00am. -The MAs were to administer all medications as ordered. -The MAs could enter a different time when medications were not administered at its scheduled time. -Residents who were administered their medication late, were to be documented on the eMAR. Interview with the Administrator on 09/19/24 at 5:42pm revealed: -There was a grace period to administer medication, 1 hour before and 1 hour after the scheduled time unless there was an order to hold the medication. -The MAs were to administer all medications as ordered. -The HWD reviewed the eMARs for to ensure the medications were administered as ordered.	D 358		

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3. Review of Resident #4's current FL2 dated 09/09/24 revealed diagnoses included dementia without behavioral psychotic disturbance, mood disturbance and anxiety, atherosclerotic heart disease, osteoporosis, epilepsy, essential primary hypertension, major depressive disorder, and embolism and thrombosis of unspecified vein.

Review of a Primary Care Provider (PCP) triage note for Resident #4 dated 05/03/24 revealed:
-Resident #4 was seen due to staff reporting increased lethargy during the day after taking Tramadol 50mg tablet at 8:00am. (Tramadol is a controlled substance used to treat moderate to severe pain.)
-There was a physician's order to discontinue current Tramadol order.
-There was a physician's order to begin Tramadol 50mg one tablet at bedtime.
-There was a physician's order to begin Tramadol 50mg one tablet every day as needed for pain.

Continued review of physician orders for Resident #4 revealed:
-On 06/24/24, there was a "cancel Rx" physician prescription order for Tramadol 50mg one tablet every night at bedtime with a note documenting "completion of therapy".
-On 09/03/24, there was a new prescription for Tramadol 50mg one tablet at bedtime.
-There were no physician orders found for Tramadol 50mg tablets between 06/24/24 and 09/03/24.

Review of Resident #4's June 2024 electronic medication administration record (eMARs) revealed:
-There was an entry for Tramadol 50mg tablet take one tablet at bedtime and scheduled for

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administration at 8:00pm daily.
-There was continued documentation of administration for the Tramadol 50mg tablet at 8:00pm on 06/25/24 through 06/30/24 with a documented number of 5 on 06/25/24, 06/28-30/24 above the medication aides (MA) electronic signatures.
-There was no information on the eMAR to explain the meaning of the number 5 documented above the MAs electronic signatures.
-There was a second entry for Tramadol 50mg tablet every 24 hours as needed for pain, give as needed daily.
-There was one entry dated 06/07/24 on the eMAR for documentation of administration for the Tramadol 50mg tablet on an "as needed" basis and contained the number "5" documented above the MAs electronic signature in a section designated for "pain level".

Review of the June 2024 control substance logs (CSL) for Resident #4's Tramadol 50mg tablet revealed there was no documentation of administration for the Tramadol 50mg tablet at 8:00pm for 06/25/24 through 06/30/24.

Review of Resident #4's July 2024 eMARs revealed:
-There was an entry for Tramadol 50mg tablet take one tablet at bedtime and scheduled for administration at 8:00pm daily.
-There was documentation of administration for the Tramadol 50mg tablet at 8:00pm on 07/06-07/24, 07/09/24, 07/15-16/24, 07/20-25/24, and 07/27-29/24.
-There was documentation of administration for the Tramadol 50mg tablet at 8:00pm on 07/01/24, 07/03-04/24, 07/11-12/24, 07/14/24, and 07/19/24 with a documented number of 5 above the medication aides (MA) electronic signatures.

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-There was documentation of administration for the Tramadol 50mg tablet at 8:00pm on 07/02/24, 07/05/24, 07/10/24, 07/17-18/24, 07/26/24, and 07/30-31/24 with a documented number of 9 above the medication aides (MA) electronic signatures.
-There was no information on the eMARs to explain the meaning of the number 5 or 9 documented above the MAs electronic signatures.
-There was a second entry for Tramadol 50mg tablet every 24 hours as needed for pain, give as needed daily that included a section for documentation of the "pain level" above the MA electronic signature.
-There were no entries on the July 2024 eMAR for documentation of administration for the Tramadol 50mg tablet on an "as needed" basis.

Review of the July 2024 CSLs for Resident #4's Tramadol 50mg tablet revealed:
-The MAs documented administration of the Tramadol 50mg tablet at 7:00pm on 07/09/24, 07/15/24, 07/16/24, 07/22/24, 07/23/24, 07/24/24, and 07/25/24, and at 8:00pm on 07/20/24.
-There were no other entries on the CSL for documentation of administration for the Tramadol 50mg tablet for July 2024.

Review of Resident #4's August 2024 eMARs revealed:
-There was an entry for Tramadol 50mg tablet take one tablet at bedtime and scheduled for administration at 8:00pm daily.
-There was documentation of administration for the Tramadol 50mg tablet at 8:00pm on 08/01-03/24, 08/05-07/24, 08/09/24, 08/11-12/24, 08/14-17/24, and 08/19-31/24.
-There was documentation of administration for the Tramadol 50mg tablet at 8:00pm on 08/10/24

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with a documented number of 5 above the MA electronic signatures.
-There was documentation of administration for the Tramadol 50mg tablet at 8:00pm on 08/04/24 and 08/08/24 with a documented number of 9 above the medication aides (MA) electronic signatures.
-There was no information on the eMARs to explain the meaning of the number 5 or 9 documented above the MAs electronic signatures.
-There was a second entry for Tramadol 50mg tablet every 24 hours as needed for pain, give as needed daily that included a section for documentation of the "pain level" above the MA electronic signature.
-There were no entries on the August 2024 eMAR for documentation of administration for the Tramadol 50mg tablet on an "as needed" basis.

Review of the August 2024 CSLs for Resident #4's Tramadol 50mg tablet revealed:
-The MAs documented administration of the Tramadol 50mg tablet at 7:00pm on 08/01-02/24, 08/05-07/24, 08/09/24, 08/11-12/24, 08/14-17/24, and 08/19-31/24.
-There were no other entries on the CSL for documentation of administration for the Tramadol 50mg tablet for August 2024.

Review of Resident #4's September 2024 eMARs revealed:
-There was an entry for Tramadol 50mg tablet take one tablet at bedtime and scheduled for administration at 8:00pm daily.
-There was documentation of administration for the Tramadol 50mg tablet at 8:00pm on 09/01/24 with a documented number of16 above the MA electronic signatures.
-There was documentation of administration for

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	HAL051024	A. BUILDING: _____ B. WING _____	R 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SMITHFIELD	830 BERKSHIRE ROAD SMITHFIELD, NC 27577

(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
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the Tramadol 50mg tablet at 8:00pm on 09/02/24 and 08/03/24 with a documented number of 9 above the medication aides (MA) electronic signatures.
-There was no information on the eMARs to explain the meaning of the number 9 or 16 documented above the MAs electronic signatures.
-There was a second entry for Tramadol 50mg tablet every 24 hours as needed for pain, give as needed daily that included a section for documentation of the "pain level" above the MA electronic signature.
-There were no entries on the September 2024 eMAR for documentation of administration for the Tramadol 50mg tablet on an "as needed" basis.

Review of the September 2024 CSLs for Resident #4's Tramadol 50mg tablet revealed there were no entries on the CSL for documentation of administration for the Tramadol 50mg tablet on 09/01-03/24.

Interview with a MA on 09/19/24 at 2:10pm revealed:
-When a new order was received at the facility, the MA on duty was responsible to enter the new medication order to the eMARs.
-Once the physician's order was entered to the eMAR, the instructions for administration populated to the eMAR for the MA to administer the medication.
-The Health and Wellness Director (HWD) was able to view physician orders that were entered to the eMARs by the MAs.
-The MAs faxed new orders to the contracted pharmacy provider.

Interview with the HWD on 09/19/24 at 12:05pm revealed:

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-If medication instructions printed on the eMARs did not match the instructions printed on the medication labels, the MAs were not supposed to administer the medications and should check with her.
-The MAs entered new medication orders to the eMARs.
-She performed a second check of orders entered to the eMARs.
-She performed daily checks of orders entered to the eMARs by the MAs.
-The 11:00pm - 7:00am MA was responsible to check all new physician orders daily.
-The Health and Wellness Coordinator (HWC) was responsible to perform medication cart audits weekly prior to her leaving employment on 07/06/24.
-She (HWD) started performing medication cart audits but had not had time to keep up with the medication audits.

Interview with the contracted pharmacy provider on 09/19/24 at 2:20pm revealed:
-There was a current order dated 09/03/24 received for Tramadol 50mg tablet at bedtime for Resident #4.
-On 04/24/24 a prescription for Tramadol 50mg twice a day was received with a quantity of 60 tablets dispensed.
-On 05/03/24, a prescription for Tramadol 50mg one tablet at bedtime was received with a quantity of 30 tablets dispensed for Resident #4.
-Tramadol 50mg tablets, quantity of 30 were dispensed to the facility and delivered on 09/04/24 for Resident #4.
-There had not been any Tramadol 50mg tablets returned to the pharmacy for Resident #4 prior to 09/12/24 when a quantity of 24 tablets were returned from the 09/03/24 fill date.
-There had only been 60 tablets of Tramadol

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50mg dispensed for Resident #4 between 05/03/24 and 09/03/24.

Telephone interview with Resident #4's primary care provider (PCP) on 09/19/24 at 1:30pm revealed:
-Resident #4's scheduled dose for the Tramadol 50mg tablet was discontinued at the request of the HWD.
-The as needed order for the Tramadol 50mg tablet was continued.
-If the scheduled dose for the Tramadol 50mg tablet was still populating on the eMAR, the MAs would continue to administer it.
-A canceled prescription mant to discontinue the medication.
-She did not know why the scheduled dose for the Tramadol 50mg tablet would still populate on the eMAR.
-There was no impact to Resident #4 unless the resident became too drowsy.
-If Resident #4 needed the Tramadol 5omg tablet every night, it could be administered every night.

Second telephone interview with the PCP on 09/19/24 at 4:00pm revealed:
-The facility was instructed twice to cancel the scheduled dose of Tramadol 50mg at bedtime.
-She did not know why the scheduled dose of Tramadol 50mg at bedtime had not been cancelled.
-When she saw Resident #4 in June 2024, the HWD requested the Tramadol to be ordered on an as needed basis.

Interview with the Administrator on 09/19/24 at 5:00pm revealed:
-He expected medications to be administered as directed by the PCP.
-If a medication was discontinued, it was

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D 358	Continued From page 43 supposed to be removed from the medication cart and placed in the medication room to be sent back to the pharmacy. -All MAs were trained to enter physician orders into the facility eMAR system. Based on observations, interviews, and record review, it was determined Resident #4 was not interviewable.	D 358		