STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049036	A. BUILDING: _____ B. WING _____	R-C 10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LAKES OF STATESVILLE	1372 EUFOLA ROAD STATESVILLE, NC 28677

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigations on October 8-9, 2024.	D 000	Responses to the cited deficencies do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficencies or corrective action report. The Plan of Correction is prepared soley as a matter of compliance with state laws.	
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (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, record reviews and interviews, the facility failed to administer medication as ordered for 1 of 3 residents observed during the morning medication pass who had orders for a blood pressure medication and a potassium supplement (#5); and 2 of 4 sampled residents for record review (#1, and #4) including medications for lowering ammonia and constipation (#1) and medication for constipation (#4). The findings are: 1. The medication error rate was 7% as evidenced by observation of 2 errors out of 26 opportunities during the 8:00am medication pass on 10/09/24. Review of Resident #5's current FL2 dated 02/02/24 revealed diagnoses included vascular dementia, heart failure, and severe intellectual	D 358	10A NCAC 3F 1004(a) Medication Administration Facility will ensure that Medications are given as ordered. Med Techs will be retrained on medication administration particular focus on crushing of medications. Med techs will be retrained to notify SCC or ED of any medication that is not to be crushed or chewed per the package that it is also added to the emar system for a extra notification each time meds are passed. Med techs will be retrained on the importance of giving medications as directed and to ensure that meds are ordered as they are to be given. Medication will be ordered as they are required monthly for all resients as per the orders.	11/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Spring Neal — TITLE: Executive Director — (X6) DATE: 10/25/2024

Received and Acknowledged 10/28/24 Janet Thornburg

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D 358	Continued From page 1 disability. Review of Resident #5's physicians' order dated 11/16/23 revealed an order to crush all applicable medications. a. Review of Resident #5's current FL2 dated 02/02/24 and physician's orders dated 08/01/24 revealed there was an order for metoprolol succinate Extended-Release (ER) 24 hour [used to treat high blood pressure and prevent heart pain] once a day. (Extended-Release tablets provide slow release of medication over an extended period and should not be crushed or chewed to preserve the slow-release process.) Interview with the medication aide (MA) on 10/09/24 at 8:04am revealed Resident #5's medications were crushed and mixed with applesauce prior to administration. Observation of the morning medication pass on 10/09/24 from 8:05 to 8:25am revealed: -The MA removed 19 oral medications from Resident #5 medications packaged in bingo packages, using the medications displayed on the electronic medication administration record (eMAR), including one metoprolol succinate ER 24 hour, in a plastic souffle cup. -The MA removed several capsules from the souffle cup. -The MA placed metoprolol succinate ER 24 hour, along with other medications, in a plastic sleeve used to crush medication in the tablet crusher. -The MA indicated she was ready to crush the tablets in the plastic sleeve. -The MA was stopped from crushing metoprolol succinate ER 24 hour. Observation of medication administration on	D 358	SCC will do a cart audit weekly to ensure compliance of this standard of pactice is followed. ED will do a cart audit with the SCC once monthly to ensure that compliance is adhered too for 3 months. ED will do cart audits with staff on a periodic selection of resident once weekly for the next month to ensure they understand the procedure and expectations going forward. Facility will be in compliance with rule area by 11/13/2024.	

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D 358	Continued From page 2 10/09/24 at 8:30am revealed the MA administered one whole metoprolol succinate ER 24 hour tablet mixed in applesauce to Resident #5 without incident. Review of Resident #5's October 2024 eMAR at 9:55am on 10/09/24 revealed: -There was an entry for metoprolol succinate ER 24 hour once a day scheduled for administration at 8:00am daily. -The was no documentation for do not crush metoprolol succinate ER 24 hour listed on the eMAR. Observation of medication on hand for Resident #5 on 10/09/24 at 8:05am revealed: -There was a partial bingo card of for metoprolol succinate ER 24 hour with instruction to administer once a day. -The bingo card was dispensed on 09/20/24 for 30 tablets with 15 tablets remaining. -DO NOT CRUSH or CHEW was documented on the upper right-hand part of the pharmacy label affixed to the bingo package. Interview with the MA on 10/09/24 at 10:55am revealed: -Resident #5 had several medications scheduled in the morning. -The MA prepared medications from the bubble packages sent by the contracted pharmacy on cycle fill monthly. -She was trained on the medication cart by a former MA no longer working at the facility. -She knew capsules should not be crushed. -Resident #5 had capsules included in her medications which she routinely removed prior to crushing the medications that were tablets. -She did not read DO NOT CRUSH or CHEW documented on the upper right-hand part of the	D 358		

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D 358	Continued From page 3 label affixed to the bingo package containing metoprolol succinate ER 24 hour. -She had been routinely crushing Resident #5's metoprolol succinate ER 24 hour tablets when she administered her medications. Interview with the Corporate Director of Clinical Services on 10/09/24 at 10:30am revealed: -She had been working with in the facility for 10 days prior to 10/09/24. -The facility had a new Administrator. -The facility's Special Care Coordinator (SCC) was hired at the end of July 2024. -The MAs were supposed to compare all the medications listed on the eMAR computer screen, read the labels on the medications for directions on the label compared to the eMAR and any additional information on the label. -The MA should administer medications according to orders and the pharmacy labels on the medications. -MAs should have been trained related to not crushing extended-release tablets or capsules during MA training and orientation. Interview with the SCC on 10/09/24 at 11:00am revealed: -She was employed in late July 2024. -She had been auditing resident records for medications administered according to orders and filing medication orders in the residents' records. -The MAs should be reading medication labels prior to administering medications. -She did not know MAs were crushing Resident #5's metoprolol succinate ER 24 hour and administering in applesauce. Telephone interview with Resident #5's Primary Care Provider (PCP) on 10/09/24 at 12:15pm	D 358		

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D 358	Continued From page 4	D 358		

revealed:
-Resident #5's metoprolol succinate ER 24 hour should not be crushed.
-The MAs should be reading labels on medications and not crushing medications labeled to not crush.
-She had not been contacted related to any issues with crushing medications for Resident #5.
-She had not observed any signs of dizziness or changes to the resident's blood pressure readings which could be adverse effects of crushing metoprolol succinate ER tablets..

Telephone interview with a representative from Resident #5's pharmacy on 10/09/24 at 1:50pm revealed:
-The pharmacy dispensed routine medications monthly for Resident #5 in bubble packages that contained one month of medication.
-Medications that should not be crushed routinely had DO NOT CRUSH or CHEW typed on the pharmacy label affixed to the medication to assist with correctly administering the medications.
-Resident #5's metoprolol succinate ER 24 hour was dispensed in the cycle fill dated 09/20/24 for 30 tablets.
-The pharmacy label had DO NOT CRUSH or CHEW typed on the label.

Interview with the Administrator on 10/09/24 at 3:30pm revealed:
-The MAs should be trained regarding medication administration.
-MAs should not be crushing medication that were time release.
-She did not know Resident #5's metoprolol succinate ER 24 hour was routinely crushed and added to applesauce for administration.

Based on observations, interviews, and record

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D 358	Continued From page 5 reviews it was determined that Resident #5 was not interviewable. b. Review of Resident #5's current FL2 dated 02/02/24 and physician's orders dated 08/01/24 revealed there was an order for potassium chloride 20 MEQ Extended-Release (ER) [used to treat low potassium] every day. (Extended-Release tablets provide slow release of medication over an extended period and should not be crushed or chewed to preserve the slow-release process.) Interview with the medication aide (MA) on 10/09/24 at 8:04am revealed Resident #5's medications were crushed and mixed with applesauce prior to administration. Observation of the morning medication pass on 10/09/24 from 8:05 to 8:25am revealed: -The MA removed 19 oral medications from Resident #5 medications packaged in bingo packages, using the medications displayed on the electronic medication administration record (eMAR), including one potassium chloride 20 MEQ tablet, in a plastic souffle cup. -The MA removed several capsules from the souffle cup. -The MA placed the potassium chloride 20 MEQ ER tablet, along with other medications, in a plastic sleeve used to crush medication in the tablet crusher. -The MA indicated she was going to crush the tablets in the plastic sleeve. -The MA was stopped from crushing the potassium chloride 20 MEQ tablet. Observation of medication administration on 10/09/24 at 8:30am revealed the MA administered one whole potassium chloride 20	D 358		

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D 358	Continued From page 6 MEQ ER tablet mixed in applesauce to Resident #5 without incident. Review of Resident #5's October 2024 eMAR at 9:55am on 10/09/24 revealed: -There was an entry for potassium chloride 20 MEQ tablet once a day scheduled for administration at 8:00am. -The was no documentation for do not crush potassium chloride 20 MEQ tablet listed on the eMAR. Observation of medication on hand for Resident #5 on 10/09/24 at 8:05am revealed: -There was a partial bingo card of metoprolol succinate ER 24 hour with instruction to administer once a day. -The bingo card was dispensed on 09/20/24 for 30 tablets with 16 tablets remaining. -DO NOT CRUSH or CHEW before swallowing was documented on the upper right-hand part of the pharmacy label affixed to the bingo package. Interview with the MA on 10/09/24 at 10:55am revealed: -Resident #5 had several medications scheduled in the morning. -The MA prepared medications from the bubble packages sent by the contracted pharmacy on cycle fill monthly. -She was trained on the medication cart by a former MA no longer working at the facility. -She knew capsules should not be crushed. -Resident #5 had capsules included in her medications which she routinely removed prior to crushing the medications that were tablets. -She did not read DO NOT CRUSH or CHEW documented on the upper right-hand part of the label affixed to the bingo package containing potassium chloride 20 MEQ.	D 358		

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D 358	Continued From page 7 -She had been routinely crushing Resident #5's potassium chloride 20 MEQ tablets when she administered her medications. Interview with the Corporate Director of Clinical Services on 10/09/24 at 10:30am revealed: -She had been working with in the facility for 10 days prior to 10/09/24. -The facility had a new Administrator. -The facility's Special Care Coordinator (SCC) was hired at the end of July 2024. -The MAs were supposed to compare all the medications listed on the eMAR computer screen, read the labels on the medications for directions on the label compared to the eMAR and any additional information on the label. -The MA should administer medications according to orders and the pharmacy labels on the medications. -MAs should have been trained related to not crushing extended-release tablets or capsules during MA training and orientation. Interview with the SCC on 10/09/24 at 11:00am revealed: -She was employed in late July 2024. -She had been auditing resident records for medications administered according to orders and filing medication orders in the residents' records. -The facility had turnover in the MA staff with some former MAs being rehired. -The MAs should be reading medication labels prior to administering medications. -She did not know MAs were crushing Resident #5's potassium chloride 20 MEQ and administering in applesauce. Telephone interview with Resident #5's Primary Care Provider (PCP) on 10/09/24 at 12:15pm	D 358		

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D 358	Continued From page 8 revealed: -Resident #5's metoprolol succinate ER 24 hour should not be crushed. -The MAs should be reading labels on medications and not crushing medications label to not crush. -She had not been contacted related to any issues with crushing medications for Resident #5. -Potassium chloride could be irritating to the stomach lining causing indigestion or stomach pain. -Resident #5 had not complained of stomach distress or pain. Telephone interview with a representative from Resident #5's pharmacy on 10/09/24 at 1:50pm revealed: -The pharmacy dispensed routine medications monthly for Resident #5 in bubble packages that contained one month of medication. -Medications that should not be crushed routinely had DO NOT CRUSH or CHEW typed on the pharmacy label affixed to the medication to assist with correctly administering the medications. -Resident #5's potassium chloride 20 MEQ was dispensed in the cycle fill dated 09/20/24 for 30 tablets. -The pharmacy label had DO NOT CRUSH or CHEW typed on the label. Interview with the Administrator on 10/09/24 at 3:30pm revealed: -The MAs should be trained regarding medication administration. -MAs should not be crushing medication that were time release. -She did not know Resident #5's potassium chloride 20 MEQ was routinely crushed and added to applesauce for administration.	D 358		

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D 358	Continued From page 9 Based on observations, interviews, and record reviews it was determined that Resident #5 was not interviewable. 2. Review of Resident #1's current FL-2 dated 09/04/24 revealed diagnoses included dementia, and obesity. Review of an after visit summary report from Resident #1's primary care provider (PCP) dated 09/18/24 revealed a reason he was being seen for chronic constipation. a. Review of Resident #1's current FL-2 dated 09/04/24 revealed there was an order for lactulose 10gm/15ml (a laxative used to lower ammonia levels in the body) 30ml once daily. Review of Resident #1's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for lactulose 30ml once daily scheduled at 9:00am. -Lactulose was documented as administered once daily at 9:00am for 31 of 31 opportunities from 08/01/24 to 08/31/24. -There were no exceptions documented on the lactulose entry. Review of Resident #1's September 2024 eMAR revealed: -There was an entry for lactulose 30ml once daily scheduled at 9:00am. -Lactulose was documented as administered once daily at 9:00am for 30 of 30 opportunities from 09/01/24 to 09/30/24. -There were no exceptions documented for Resident #1's lactulose. Review of Resident #1's October 2024 eMAR from 10/01/24 to 10/08/24 revealed:	D 358		

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D 358	Continued From page 10 -There was an entry for lactulose 30ml once daily scheduled at 9:00am. -Lactulose was documented as administered once daily at 9:00am for 8 of 8 opportunities from 10/01/24 to 10/08/24. -There were no exceptions documented for Resident #1's lactulose. Observation of Resident #1's medication on hand on 10/08/24 at 4:04pm revealed: -There were two bottles of lactulose dispensed on 08/01/24; each bottle held 450ml or 15oz of lactulose. -The first bottle had less than 1oz of lactulose available for administration. -The second bottle had 8oz of lactulose available for administration. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/09/24 at 8:49am revealed: -Resident #1 had a current order for lactulose 30ml once daily. -Resident #1 was dispensed a thirty-day supply of 30 doses of lactulose in two bottles on 08/01/24; each bottle had 450ml or 15 doses in it. -A thirty-day supply of lactulose was dispensed in May 2024 for Resident #1; there were no other dispense dates. Telephone interview with Resident #1's primary care provider (PCP) on 10/09/24 at 10:29am revealed: -Resident #1 had elevated ammonia levels when his levels were last checked in April 2024. -The normal high limit for ammonia was 80 and Resident #1's level was 114 in April 2024. -Resident #1 was on another medication that would cause elevated ammonia levels in the body; the lactulose worked to lower the elevated	D 358		

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D 358	Continued From page 11 ammonia caused by the other medication Resident #1 was ordered. -There had not been any clinical symptoms indicating Resident #1's ammonia levels were too high. -Resident #1 had a history of chronic constipation. -Resident #1 had complaints of constipation in September 2024 but there were no issues beyond the constipation. -Resident #1 did not experience discomfort, nausea or bloating from constipation. -He expected his order to be followed. Interview with Resident #1 on 10/09/24 at 8:57am revealed: -He knew he took a laxative; he thought it was as needed. -He could not recall if he drank a liquid every morning. -He had not had any issues with constipation recently. -He drank a sweet green fluid the medication aide (MA) gave him; he thought he took it almost every day. Interview with a MA on 10/08/24 at 4:08pm revealed: -She had been working at the facility for two weeks. -Resident #1 always took his medication and never refused. -She administered him his lactulose that morning, 10/08/24. Interview with the Special Care Coordinator (SCC) on 10/09/24 at 2:17pm revealed: -She had not realized Resident #1's lactulose was not dispensed since 08/01/24. -She could not say if he was administered the	D 358		

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D 358	Continued From page 12 lactulose or if was not administered the lactulose. -She understood he was dispensed a thirty-day supply. -She saw there were two bottles of lactulose for Resident #1 and thought each bottle had 30 doses in it. -She thought the lactulose was only a laxative. -Lactulose was not on cycle fill and had to be ordered from the pharmacy by the SCC. -Any medications ordered for a resident were supposed to be administered. Interview with the Administrator on 10/09/24 at 2:05pm revealed: -If Resident #1 had an order for lactulose on the eMAR and the medication was on the cart then she expected the medication to be administered as ordered. -Resident #1 had a thirty-day supply of lactulose dispensed on 08/01/24 then there should have been another thirty-day supply ordered on 09/01/24 and 10/01/24. b. Review of Resident #1's current FL-2 dated 09/04/24 revealed there was an order for polyethylene glycol 3350 (used to treat constipation) 17gm mixed in an acceptable fluid once daily. Review of Resident #1's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for polyethylene glycol 17gm once daily scheduled at 9:00am. -Polyethylene glycol was documented as administered once daily at 9:00am for 31 of 31 opportunities from 08/01/24 to 08/31/24. -There were no exceptions documented for Resident #1's polyethylene glycol.	D 358		

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MEADOW LAKES OF STATESVILLE	1372 EUFOLA ROAD STATESVILLE, NC 28677

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 Review of Resident #1's September 2024 eMAR revealed: -There was an entry for polyethylene glycol 17gm once daily scheduled at 9:00am. -Polyethylene glycol was documented as administered once daily at 9:00am for 30 of 30 opportunities from 09/01/24 to 09/30/24. -There were no exceptions documented for Resident #1's polyethylene glycol. Review of Resident #1's October 2024 eMAR from 10/01/24 to 10/08/24 revealed: -There was an entry for polyethylene glycol 17gm once daily scheduled at 9:00am. -Polyethylene glycol was documented as administered once daily at 9:00am for 8 of 8 opportunities from 10/01/24 to 10/08/24. -There were no exceptions documented for Resident #1's polyethylene glycol. Observation of Resident #1's medication on hand on 10/08/24 at 4:04pm revealed: -There was a 17.9oz bottle of polyethylene glycol 3350 dispensed on 09/18/24; the bottle indicated it contained 30 doses. -The bottle was full. -The foil seal on the bottle was still intact and not been removed or lifted. Observation of Resident #1's medication on hand on 10/09/24 at 1:49pm revealed the bottle was unopened and the foil seal on the bottle was still intact and not been removed or lifted. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/09/24 at 8:49am revealed: -Resident #1 had a current order for polyethylene glycol 17gm once daily. -Resident #1 was dispensed a thirty-day supply of	D 358		

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D 358	Continued From page 14 30 doses of polyethylene glycol on 09/18/24. -There were no other dispense dates for Resident #1's polyethylene glycol. Telephone interview with Resident #1's primary care provider (PCP) on 10/09/24 at 10:29am revealed: -Resident #1 had a history of chronic constipation. -Resident #1 had complaints of constipation in September 2024 but there were no issues beyond the constipation. -Resident #1 did not experience discomfort, nausea or bloating from constipation but would experience the symptoms if he was not administered the polyethylene glycol. -He expected his order to be followed. Interview with Resident #1 on 10/09/24 at 8:57am revealed: -He knew he took a laxative; he thought it was as needed. -He could not recall if he drank a liquid every morning. -He had not had any issues with constipation recently. Interview with a MA on 10/08/24 at 4:08pm revealed: -She had been working at the facility for two weeks. -Resident #1 always took his medication and never refused. -She had used the last of his old bottle of polyethylene glycol that morning and had not opened the new bottle yet. -She had discarded the bottle because it was empty. Interview with the Special Care Coordinator	D 358		

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D 358	Continued From page 15 (SCC) on 10/09/24 at 2:17pm revealed: -She had administered Resident #1 his polyethylene glycol herself when she had worked on the medication cart. -She did not know why Resident #1's bottle of polyethylene glycol dispensed on 09/18/24 was not opened. -She thought the MAs might have administered polyethylene glycol to Resident #1 from another resident's bottle. -Polyethylene glycol was not on cycle fill and had to be ordered from the pharmacy by the SCC. -Any medications ordered for a resident were supposed to be administered. Interview with the Administrator on 10/09/24 at 2:05pm revealed: -Resident #1's family did not provide medications for him. -If Resident #1 had an order for polyethylene glycol on the eMAR and the medication was on the cart then she expected the medication to be administered as ordered. 3. Review of Resident #4's current FL-2 dated 09/20/24 revealed: -Diagnoses of chest pain and uncontrolled hypertension. -There was an order for polyethylene glycol 17gm (used to treat constipation) in 8 ounces of liquid daily. Review of Resident #4's signed physician orders dated 08/14/24 revealed: -Diagnoses of dementia, psychotic disorder, and major depressive disorder. -There was an order for polyethylene glycol 17gm in 8-ounces of water daily. Review of Resident #4's August 2024 electronic medication administration record (eMAR) from	D 358		

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D 358	Continued From page 16 08/14/24 to 8/31/24 revealed: -There was an entry for polyethylene glycol 17gms in 8-ounces of water liquid with a scheduled administration time of 9:00am. -There was documentation polyethylene glycol was administered daily from 08/14/24 to 08/31/24. Review of Resident #4's September 2024 eMAR revealed: -There was an entry for polyethylene glycol 17gms in 8-ounces of water daily with a scheduled administration time of 8:00am. -There was documentation polyethylene glycol was administered liquid from 09/01/24 to 09/17/24 and from 09/21/24 to 09/30/24. -There were exceptions documented from 09/18/24 to 09/20/24; the exceptions were hospitalization. Review of Resident #4's October 2024 eMAR from 10/01/24 to 10/08/24 revealed: -There was an entry for polyethylene glycol 17gms in 8-ounces of liquid daily with a scheduled administration time of 8:00am. -There was documentation polyethylene glycol was administered daily from 10/01/24 to 10/08/24. Observation of Resident #4's medication on hand on 08/08/24 at 3:05pm revealed: -There was a 510gm bottle of polyethylene glycol available for administration. -There was a dispensed date of 08/14/24 on the prescription label. -The bottle of polyethylene glycol was ¾ full of powdered medication. Telephone interview with a representative from the facility's contracted pharmacy on 10/09/24 at	D 358		

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D 358	Continued From page 17 9:10am revealed: -Resident #4 had an order for polyethylene glycol 17gm (one capful) in 8-ounces of liquid daily dated 05/14/24. -The pharmacy dispensed a 510gm bottle of polyethylene glycol powder on 05/14/24 and 08/14/24. -A 510gm bottle of polyethylene glycol would last 30 days if 17gms of medication was administered daily. -Polyethylene glycol was used for constipation. Interview with a personal care aide (PCA) on 10/09/24 at 3:00pm revealed Resident #4 had not complained of constipation. Interview with a medication aide (MA) on 10/09/24 at 1:44pm revealed: -She administered medications to Resident #4 when she worked as the MA. -She administered polyethylene glycol to Resident #4 as ordered. -Resident #4 had not refused polyethylene glycol when she worked as the MA. -She had not noticed the dispensed date of the bottle of the polyethylene glycol, which was 08/14/24. -She did not know why the bottle of polyethylene glycol was ¾ full, when it should be empty. -Resident #4 had not complained of constipation. Telephone interview with Resident #4's primary care provider (PCP) on 10/09/24 at 11:22am revealed: -Resident #4 was ordered polyethylene glycol daily for constipation. -Resident #4 had not complained about constipation to him. -Resident #4 had complaints of nausea related to peptic ulcer disease and gastroparesis.	D 358		

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D 358	Continued From page 18 Interview with the Special Care Coordinator (SCC) on 10/09/24 at 1:55pm revealed: -She audited medication carts twice a week. -She compared the medications on the medication cart to the medications listed on the eMAR to ensure all medications were available for administration. -She did not look at dispensed dates of medication to ensure the medication was being administered. -She did not do medication administration observations with the MAs. -She had not noticed the polyethylene glycol was dispensed on 08/24/24. -She did not know the 510gm bottle of polyethylene glycol was a 30-day supply. -If a 510gm bottle of polyethylene glycol would last 30 days, then the bottle should be empty. Interview with the Administrator on 10/09/24 at 2:30pm revealed: -The MA should read the eMAR and compare the medication to the eMAR 3 times. -The MAs were expected to administer medications as ordered by the PCP. -If the 510gm bottle of polyethylene glycol on the medication cart was dispensed on 08/14/24, the bottle should be empty and re-ordered in the middle of September. -Resident #4 could have problems with constipation if the medication was not administered correctly. -She expected the MAs to administer the medications as ordered if the medication was on the medication cart. -The SCC audited medication carts weekly to ensure all medications were on the medication cart for administration, to remove discontinued medications from the medication cart, and to	D 358		

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D 358	Continued From page 19 re-order medications if the medications were getting low. -She did not know if the SCC looked at dispensed dates of medication when the SCC was auditing the medication. Attempted interview with Resident #4 on 10/09/24 at 8:30am was unsuccessful.	D 358		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL049036 Y1	A. Building B. Wing Y2	10/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LAKES OF STATESVILLE	1372 EUFOLA ROAD STATESVILLE, NC 28677

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0276	Correction	ID Prefix D0344	Correction	ID Prefix D0367	Correction
Reg. # 10A NCAC 13F .0902(c) (3-4)	Completed	Reg. # 10A NCAC 13F .1002(a)	Completed	Reg. # 10A NCAC 13F .1004(j)	Completed
LSC	09/07/2024	LSC	09/07/2024	LSC	09/07/2024
ID Prefix D0467	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 10A NCAC 13F .1308 (c)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/07/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Janet Houlton	10/14/24
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 7/24/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: 7ISH12