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D 000	Initial Comments The Adult Care Licensure section conducted an annual and follow-up survey on October 29-30, 2024.	D 000		
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, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 residents (#2, #4, and #5) related to a nasal spray (#2); an insulin (#4); and a supplement (#5). The findings are: 1. Review of Resident #2's current FL-2 dated 05/09/24 revealed: -Diagnoses included acute respiratory infections, hypertension, and cellulitis. -There was an order for fluticasone propionate spray (used to treat seasonal allergies) 50mcg 2 sprays in both nostrils daily. Review of Resident #2's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for fluticasone propionate spray 50mcg 2 sprays in both nostrils daily	D 358		

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scheduled at 8:00am.
-There was documentation fluticasone nasal spray was administered 31 of 31 opportunities from 08/01/24 to 08/31/24.

Review of Resident #2's September 2024 eMAR revealed:
-There was an entry for fluticasone propionate spray 50mcg 2 sprays in both nostrils daily scheduled at 8:00am.
-There was documentation fluticasone nasal spray was administered 30 of 30 opportunities from 09/01/24 to 09/30/24.

Review of Resident #2's October 2024 eMAR from 10/01/24 to 10/29/24 revealed:
-There was an entry for fluticasone propionate spray 50mcg 2 sprays in both nostrils daily scheduled at 8:00am.
-There was documentation fluticasone nasal spray was administered 28 of 29 opportunities from 10/01/24 to 10/29/24.
-There was one documented exception on 10/07/24.

Observation of Resident #2's medications on hand on 10/29/24 at 11:30am revealed
-There was one bottle of fluticasone 50mcg nasal spray.
-The bottle of fluticasone 50mcg nasal spray still had solution in the bottle.
-The bottle of fluticasone 50mcg nasal spray was dispensed on 09/10/24.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/29/24 at 11:50am revealed:
-Resident #2 had a current order for fluticasone nasal spray 50mcg 2 sprays both nostrils daily.
-One bottle of fluticasone nasal spray was

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dispensed on 09/10/24 and 07/23/24; each bottle would last for 28-30 days.
-Fluticasone nasal spray was ordered by the facility that morning, 10/29/24.
-The facility had to reorder the fluticasone nasal spray; it was not included in the cycle fill.
-Fluticasone nasal spray was used to treat seasonal allergies.

Interview with Resident #2 on 10/29/24 at 9:38am revealed:
-She had seasonal allergies.
-She used a nasal spray for the allergies; the medication aide (MA) brought it to her.
-She had a runny nose all the time.
-She did not refuse her medications.

Telephone interview with Resident #2's primary care provider (PCP) on 10/29/24 at 8:40am revealed:
-Resident #2 was prescribed fluticasone nasal spray for seasonal allergies.
-She was to receive the nasal spray each day.
-She was concerned Resident #2 had not received nasal spray as ordered.
-She had not been informed Resident #2 refused medications.

Interview with the MA on 10/29/24 at 2:00pm revealed:
-Resident #2 did not refuse her medications.
-She gave Resident #2 her nasal spray daily.

Interview with the Administrator on 10/30/24 at 11:15am revealed:
-Audits of medication carts were conducted weekly by the MAs.
-The audits were just put into place about a week ago.
-Audits included checking medications on hand

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and checking physician's orders.
-She expected MAs to give the medications as ordered.

2. Review of Resident #4's current FL-2 dated 07/08/24 revealed diagnoses included diabetes mellitus type 2.

Review of Resident #4's record revealed a physician's order dated 10/14/24 for Novolin R flexpen 100 unit/ml insulin pen give subcutaneous injection three times daily before meals and at bedtime per sliding scale: if 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 untis, 351-400=10 units, 401-450=12 units. Call primary care provider (PCP) if finger stick blood sugar (FSBS) is greater than 450 or less than 60.

Review of Resident #4's October 2024 electronic medication administration record (eMAR) from 10/14/24 to 10/29/24 revealed:
-There was an entry for Novolin R flexpen 100 unit/ml insulin pen give subcutaneous injection three times daily before meals and at bedtime per sliding scale: if 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 untis, 351-400=10 units, 401-450=12 units. Call PCP if (FSBS) is greater than 450 or less than 60.
-On 10/17/24 at 8:00pm, Resident #4's FSBS was documented as 146 and 2 units of insulin were administered.
-On 10/19/24 at 7:30am, Resident #4's FSBS was documented as 107 and 2 units of insulin were administered.
-On 10/19/24 at 11:30am, Resident #4's FSBS was documented as 122 and 2 units of insulin were administered.

Interview with Resident #4 on 10/30/24 at 10:40am revealed:

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-She took insulin at least 4 times a day.
-She received insulin before meals based on her FSBS result.
-She did not know how much insulin she received.

Interview with Resident #4's (PCP) on 10/30/24 at 8:45am revealed:
-She ordered a sliding scale for Resident #4 earlier this month to try to get her FSBS results more controlled.
-Resident #4 was to receive insulin at meals and at bedtime based on what her FSBS results were.
-The sliding scale started at 150; if Resident #4's FSBS was below 150, she was not to receive insulin.
-She was not aware that on 10/17/24 at 8:00pm and on 10/19/24 at 7:30am and 11:30am Resident #4's received insulin when she should not have.
-She was concerned the medication aides (MAs) administered insulin outside of the range of the sliding scale provided.
-She hoped the MAs administered the insulin at a meal to keep the blood sugar from dropping too low.
-She was not too worried about Resident #4 because her FSBS ran high and she was non-compliant with her diet but, she did expect the sliding scale orders to be followed to prevent low blood sugars.

Telephone interview with a MA on 10/30/24 at 9:10am revealed:
-When she entered Resident #4's blood sugar into the eMAR, the entire sliding scale showed up on the screen and she determined how many units of insulin to give.
-It must have been an oversight that she administered insulin to Resident #4 when the

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D 358	Continued From page 5 FSBS result was below 150. Interview with the Resident Care Coordinatror (RCC) on 10/30/24 at 9:00am revealed: -The eMAR system showed how much insulin to give based on the FSBS result. -The MAs had to read the scale to determine how much insulin to give. -She did not know how insulin could have been given if the FSBS was under 150 if the MAs just read the sliding scale instructions. Interview with the Administrator on 10/30/24 at 11:15am revealed: -It was important for MAs to read the directions for sliding scale insulin carefully and follow them. -She was concerned Resident #4 received insulin when she should not have and could have a negative outcome. 3. Review of Resident #5's current FL-2 dated 10/15/24 revealed diagnoses included dementia, hyperlipidemia, diabetes mellitus, and major depression. Review of Resident #5's signed physician order dated 08/01/24 revealed there was an order for ferrous sulfate 325mg (used as a supplement) daily. Review of Resident #5's signed physician order dated 09/17/24 revealed there was an order to discontinue ferrous sulfate 325mg daily. Review of Resident #5's current FL-2 dated 10/15/24 revealed there was an order for ferrous sulfate 325mg daily. Review of Resident #5's complete blood count (CBC) dated 09/11/24 revealed: -There was a hemoglobin (a protein in red blood	D 358		

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cells that carries oxygen to your body) reading of 13.4 (normal range was 12.0 to 17.5).
-There was a hematocrit (measures the percentage of red blood cells in your body) reading of 40.2 (normal range was 35.8 - 52.9).

Review of Resident #5's visit summary note dated 09/17/24 revealed:
-Resident #5's recent labs showed hemoglobin level was 13.4 and hematocrit level was 40.2, indicating an improvement in his anemia.
-There was an order to discontinue ferrous sulfate 325mg daily and repeat CBC in 3 months.

Review of Resident #5's September 2024 electronic medication administration record (eMAR) from 09/17/24 to 09/30/24 revealed:
-There was an entry for ferrous sulfate 325mg daily with a scheduled administration time of 8:00am.
-There was documentation ferrous sulfate was administered each morning from 9/17/24 to 09/30/24.

Review of Resident #5's October 2024 eMAR from 10/01/24 to 10/14/24 revealed:
-There was an entry for ferrous sulfate 325mg daily with a scheduled administration time of 8:00am.
-There was documentation ferrous sulfate was administered each morning from 10/01/24 to 10/14/24.

Observation of Resident #5's medication on hand on 10/29/24 revealed ferrous sulfate was in the weekly multi-dose pack at 8:00am and available for administration.

Interview with Resident #5 on 10/30/24 at 9:35am revealed:

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D 358	Continued From page 7 -He knew he took medication for his diabetes. -He did not know if he took anything for feeling tired. Telephone interview with a representative from the facility's contracted pharmacy on 10/29/24 at 3:45pm revealed: -The pharmacy had an order for ferrous sulfate 325mg daily for Resident #5. -The pharmacy dispensed the ferrous sulfate in the 8:00am multi-dose pack. -The pharmacy did not have a discontinued order for ferrous sulfate. -The pharmacy received new orders by fax machine, notification through the computer, or the primary care provider with send the order directly to the pharmacy. Interview with the Special Care Coordinator (SCC) on 10/30/24 at 9:10am revealed: -Resident #5's Primary Care Provider (PCP) would send orders directly to the pharmacy. -The PCP may tell the SCC that she has written a new order, but mostly the SCC will read about the new order on the PCP's visit summary note received 5 days after the visit. -She reviewed the visit summary note dated 09/17/24 and saw the order to discontinue the ferrous sulfate. -She did not discontinue the medication on the current multi-dose pack that was in the medication cart. -She did not realize the pharmacy had not discontinued the ferrous sulfate. -She can see on the facility's computerized system for the pharmacy that the pharmacy did receive the order to discontinue the ferrous sulfate. Interview with the Administrator on 10/30/24 at	D 358		

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D 358	Continued From page 8 11:20am revealed: -The SCC could fax new orders to the pharmacy, or the PCP could send them through the computer system. -The SCC reviewed the PCP's visit summary note once it was available to see if any new orders were written. -The SCC should have documented on Resident #5's multi-dose pack in the medication cart and placed a "order changed" sticker on the multi-dose pack to alert the MA that there was a change in the medication. Attempted interview with Resident #5's PCP on 10/30/24 at 8:15am was unsuccessful.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be	D 367		

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documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 5 sampled residents (#3) including a medication for gastric-esophageal reflux disease (GERD).

The findings are:

Review of Resident #3's current FL-2 dated 02/20/24 revealed diagnoses included dementia, cognitive communication deficit, and abnormality of gait and mobility.

Review of Resident #1's signed physician orders dated 05/20/24 revealed there was an order for omeprazole 20mg daily (used to treat heartburn or indigestion) as needed for indigestion.

Review of Resident #3's visit summary note dated 10/11/24 revealed:
-Resident #3's GERD was currently managed with omeprazole.
-Resident #3 was to continue with omeprazole as ordered, with stability noted at this time.
-Adjustments to the regimen would be made as needed.

Review of Resident #3's September 2024 electronic medication administration record (eMAR) from 09/23/24 to 09/30/24 revealed:
-There was an entry for omeprazole 20mg daily as needed for indigestion.
-There was no documentation that omeprazole 20mg was administered from 09/23/24 to 09/30/24.

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D 367	Continued From page 10 Review of Resident #3's October 2024 eMAR from 10/01/24 to 10/29/24 revealed: -There was an entry for omeprazole 20mg daily as needed for indigestion. -There was no documentation that omeprazole 20mg was administered from 10/01/24 to 10/29/24. Observation of Resident #3's medication on hand on 10/29/24 at 2:10pm revealed: -There was a bubble pack of 30 omeprazole 20mg capsule dispensed on 09/23/24 with 8 of omeprazole remaining for administration. -There were 22 omeprazole 20mg unaccounted for. Telephone interview with a representative from the facility's contracted pharmacy on 10/29/24 at 11:50am revealed: -Resident #3 had an order for omeprazole 20mg daily as needed for indigestion. -The pharmacy dispensed 30 omeprazole capsules on 09/23/24. -Omeprazole was not on cycle-fill since it was an "as needed" medication. -All "as needed" medications had to be re-ordered by fax or clicking on the re-order tab on the computer. Interview with a medication aide (MA) on 10/30/24 at 9:25am revealed: -Resident #3's omeprazole was ordered as needed for indigestion. -She had not administered an as needed dose of omeprazole to Resident #3. -Resident #3 used to take omeprazole daily at 6:00am and the third shift MA would administer the 6:00am medications, but the scheduled dose of omeprazole had been discontinued months	D 367		

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ago.
-It appeared the omeprazole was given daily as a scheduled medication when looking at the bubble pack, but the eMAR looked as if the medication had not been given.

Telephone interview with Resident #5's Power of Attorney on 10/30/24 at 9:58am revealed:
-She could tell if Resident #3 was in pain by the way she acted, holding her stomach and grimacing of her face.
-Resident #3 had made no indications that she was uncomfortable or had indigestion in the past couple of weeks.

Telephone interview with a third shift MA on 10/30/24 at 9:43am revealed:
-She worked third shift in the Special Care Unit (SCU).
-She administered 6:00am medications to Resident #3.
-She administered only one medication to Resident #3 at 6:00am and it was levothyroxine.
-She had not administered omeprazole to Resident #3.
-She did not know what happened to the 22 capsules that were unaccounted for.

Interview with the Special Care Coordinator (SCC) on 10/30/24 at 9:00am revealed:
-Resident #3 had an order for omeprazole 20mg daily as needed for indigestion.
-The MAs should document on the eMAR when omeprazole was given.

Interview with the Administrator on 10/30/24 at 11:20am revealed:
-The MAs should document on the eMAR each time an as needed medication was administered.
-The MA should return to the eMAR in an hour

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D 367	Continued From page 12 and document the effectiveness of the medication. -She expected the MAs to administer medication as ordered. Attempted telephone interview with a second third shift MA on 10/30/24 at 9:48am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.	D 367		