Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001047	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY TENDER LOVE AND CARE	532 GREENWOOD DRIVE BURLINGTON, NC 27215

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 10/10/24.	C 000		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration record (MAR) was accurate for 1 of 3 sampled residents (#1) related to an antidepressant medication. The findings are: Review of Resident #1's current FL-2 dated	C 342	Administrator or staff will make sure to check resident with Med's also MAR also A daily reminder with electronic device	11/6/24

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Rogers — TITLE: Administrator — (X6) DATE: 11/6/24

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C 342	Continued From page 1 06/19/24 revealed; -Diagnosis included unspecified schizoaffective disorder. -There was an order for trazadone (used to treat major depressive disorder) 50mg 1 tablet daily at bedtime. Review of Resident #1's August 2024 MAR revealed; -There was an entry for trazadone 50mg daily scheduled to be administered at 8:00pm. -There was documentation that trazadone 50mg was administered from 08/01/24 to 08/31/24 at 8:00pm. Review of Resident #1's September 2024 MAR revealed; -There was an entry for trazadone 50mg daily scheduled to be administered at 8:00pm. -There was documentation that trazadone 50mg was administered from 09/01/24 to 09/30/24 at 8:00pm. Review of Resident #1's October 2024 MAR from 10/01/24 to 10/09/24 revealed there was no entry for trazadone 50mg. Observation of Resident #1's medication available for administration on 10/10/24 at 11:00am revealed; -There was a supply of trazadone 50mg tablets dispensed on 09/24/24 with instructions to take 1 tablet at bedtime every day. -There were 17 of 20 tablets remaining in the bubble package that were dispensed on 09/24/24. Interview with Resident #1 on 10/10/24 at 12:20pm revealed; -He took his evening medications as the	C 342	Adminstrator or staff will make to check MAR, Resident, MCd's If there's a issue with MAR call pharmacy so it CAN be fixed Also a reminder with electronic device	~~11/6/24~~ 11/6/24

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C 342	Continued From page 2 Administrator provided them to him. -He did not know what his medications were. Telephone interview with a representative from the facility's contracted pharmacy on 10/10/24 at 11:55am revealed: -Trazadone 50mg for Resident #1 was last dispensed on 09/24/24 for a 30-day supply. -There was not an order to discontinue the trazadone 50mg from the facility. -The pharmacy was responsible for updating the residents' MARs monthly for the facility. -He was not aware an entry for trazadone 50mg was missing from the October 2024 MAR for Resident #1 and the pharmacy must have left the entry for trazadone off the MAR. -He expected the facility staff to follow up with the pharmacy when a medication was missing from the residents' MARs. Telephone interview with Resident #1's primary care provider (PCP) on 10/10/24 at 12:20pm revealed: -The PCP had ordered trazadone 50mg at bedtime to treat Resident #1's depression and insomnia. -The PCP had not discontinued trazadone 50mg for Resident #1. Interview with the Administrator on 10/10/24 at 11:40am revealed: -She was responsible for reviewing the MARs monthly and checking for new and discontinued orders. -She administered medications to the residents sometimes and had administered Resident #1's trazadone at 8:00pm from 10/01/24 to 10/09/24. -She did not know the entry for trazadone 50mg was not on the October 2024 MAR for Resident #1 and must have overlooked the missing entry.	C 342	Administrator will MAKE SURE MAR ARE checked to make sure the residents med's match MAR, resident and meds	11/6/24

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C 342	Continued From page 3 -She did not always check the MAR with the medications when she administered medications to the residents.	C 342	Adminstrator will check MAR EVERY time ~~MAR~~ MED's ~~ARE~~ CARE given to ASURE RESIDENTS MED's ARE documented	11/6/24