STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092-324	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNNDALE SENIOR LIVING HOME	6628 KEYSTONE DR RALEIGH, NC 27612

(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 initial survey on November 20, 2024 and November 21, 2024.	C 000		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 4 sampled staff (Staff C) had a criminal background check completed upon hire. The findings are: Review of Staff C, medication aide's personnel record on 11/20/24 revealed: -Staff C's hire date was documented as 08/26/24. -There was no documentation of a criminal background check prior to 11/20/24 at 4:12pm. Interview with Staff C on 11/20/24 at 3:19pm revealed: -She was a manager and medication aide. -She administered medications at the facility. Review of residents' medication administration records revealed Staff C documented the administration of medications on 09/13/24, 09/14/24, 09/15/24, and 11/17/24. Interview with the Administrator on 11/20/24 at	C 147	Plan of Correction for Missing background check Test Compliance under NCAC 13G .0406(a)(7) **Regulation Overview:** NCAC 13G .0406(a)(7) requires that all staff employed in a licensed adult care home must undergo a background check as part of their qualifications. This ensures that individuals employed in caregiving roles do not pose a risk to the safety, health, or well-being of residents. Failure to comply with this requirement could result in sanctions or a failure to meet the regulatory standards for staff qualifications. **Issue Identified:** Non-compliance with the background check requirement under NCAC 13G .0406(a)(7), which involves missing or incomplete background checks for Staff C. **Immediate Corrective Actions:** 1. **Identification of Non-Compliant Staff:** ○ **Action:** Conduct an immediate review of all staff records to identify individuals who are missing required background checks, or whose background checks are incomplete or outdated. ○ **Responsible Party:** Administrator ○ **Timeline:** Complete review within 24 hours. 2. **Initiation of Missing Background Checks:** ○ **Action:** For any staff member found lacking a background check, initiate the required background check process immediately. This includes any new hires or current staff (staff C) whose checks are overdue or incomplete. ○ **Responsible Party:** Administrator ○ **Timeline:** Background checks for identified staff will be initiated within 24 hours and	11/21/24

Received via fax 01/02/2025.
Reviewed and Acknowledged 01/06/2025. -HF

completed within 7 days.

3. **Temporary Reassignment of Non-Compliant Staff:**
   - **Action:** Staff who are identified as missing a background check will be temporarily removed from the schedule, until the background check is completed and cleared.
   - **Responsible Party:** Administrator
   - **Timeline:** Immediate removal for any staff found non-compliant.

12/30/24

Received via fax on 01/02/2025.

Reviewed and Acknowledged 01/06/2025. -HDH, M

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C 147	Continued From page 1 4:00pm revealed: -He was responsible for requesting a criminal background check on staff. -He completed the criminal background check when the potential staff completed the application. -Staff C completed her application when she was opening a facility and he thought a criminal background check was completed then, so he did not pursue performing another criminal background check for Staff C. Interview with the Administrator on 11/21/24 at 1:09pm revealed he had not located documentation for a criminal background check for Staff C.	C 147		
C 204	10A NCAC 13G .0702 (c) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination and Immunizations (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the medical examination documented on the resident's FL-2 was no more than 90 days prior to admission for 1 of 3	C 204	Corrective Action Plan: Immediate Action: The resident will be scheduled for a tuberculosis test immediately. The test will be administered by a licensed healthcare provider in accordance with the facility's protocols. A review of the resident's medical record will be conducted to ensure that all other required medical examinations are up to date. Root Cause Analysis: Review of facility procedures will be conducted to determine why the tuberculosis test was missed. Determine if there was a breakdown in the process, such as communication failure, failure to follow the established policy, or an oversight in the resident's medical records. Staff Education and Training: All clinical staff, including nursing and administrative personnel, will undergo additional training regarding the requirements of tuberculosis testing for all new admissions and on a periodic basis thereafter, as per 10A NCAC 13G .0702 (c). Training will emphasize the importance of timely TB	11/21/24

testing and documentation.
Policy and Procedure Review:

The facility's TB screening and testing policy will be reviewed and updated, if necessary, to ensure it aligns with current regulations and best practices.
Ensure that all new admissions are scheduled for TB tests immediately upon arrival and that the test results are recorded in the resident's medical file without delay.

Monitoring and Follow-Up:
A follow-up review will be conducted within 30 days to ensure that the tuberculosis test has been administered and recorded for all residents.
The facility will perform random audits of resident files monthly for the next three months to ensure compliance with TB testing requirements.
Any further issues or deficiencies found during these audits will be addressed immediately with further corrective actions.
Documentation:

Documentation of the TB test will be placed in the resident's medical record.
The corrective actions and training provided to staff will be documented in the facility's quality assurance logs.
Responsible Party:
Administrator/Nurse
Completion Date: 11/22/24
The tuberculosis test for resident 1 was completed on 11/22/24.
Staff education and training will be completed by 11/31/24.
Conclusion:
This Plan of Correction is intended to address the deficiency regarding the missed tuberculosis test and ensure future compliance with the NCAC regulation 10A NCAC 13G .0702 (e). The facility is committed to providing high-quality care and maintaining the safety and well-being of its residents. Compliance will be closely monitored, and corrective actions will be taken promptly to prevent recurrence.

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C 204 Continued From page 2

sampled residents (Resident # 1).

The findings are:

Review of the facility license to operate a family care home (FCH) posted at the entrance of the facility at 8:30am on 11/20/24 revealed the current license was effective August 23, 2024 through February 23, 2025.

Review of a previous license on 11/20/24 for the facility to operate a FCH revealed the previous license was effective April 20, 2023 through October 20, 2023.

Review of Resident #1's FL-2 revealed:
-The FL-2 was dated 04/23/24.
- Diagnoses included chronic dementia and burn involving 10-19% body surface with 3rd degree burn 04/08/24.
- Resident #1's recommended level of care was an assisted living facility.

Review of Resident #1's Resident Register revealed an admission date of 05/06/24.

Review of Resident #1's record on 11/20/24 revealed there was no documented FL-2 for Resident #1 since 04/23/24.

Interview with the Administrator on 11/20/24 at 9:49am revealed:
-Resident #1 lived in the home when the home was previously licensed as a family care home (FCH).
-He received the 04/23/24 FL-2 for Resident #1 when the resident originally came to live in the home after hospitalization for burns to his body.
-Resident #1 never left the home after the previous FCH license expired.

C 204

Corrective Action Plan:
Immediate Action:

The resident will be scheduled for a new or updated FL2 form to be completed by a licensed healthcare provider immediately.
A licensed physician or nurse practitioner will conduct a full medical examination and complete the FL2 form, ensuring that it is in accordance with all state regulations and facility policies.
Upon completion, the updated FL2 form will be placed in the resident's medical record.
Root Cause Analysis:

A review of the facility's documentation and admission policies will be conducted to determine the root cause for why the FL2 form was not up to date.
This will involve looking at:
A breakdown in the process of ensuring forms are updated regularly.
Missed communications between clinical staff and medical providers.
Gaps in training or understanding regarding the importance of the FL2 form.
Staff Education and Training:

All clinical staff, including nursing, admissions, and administrative personnel, will undergo additional training regarding completing and maintaining an up-to-date FL2 form for all residents.
Training will cover the importance of the FL2 form, timelines for updates, and how to ensure proper documentation in resident files.
Policy and Procedure Review:

The facility will review and update its policy for the completion, documentation, and review of the FL2 form to ensure compliance with all applicable regulations, including 10A NCAC 13G .0702.
A clear, standardized process will be established to ensure the FL2 form is completed on admission and updated regularly.
System Improvements:

The facility will implement a tracking system within other documentation processes to ensure that residents' FL2 forms are current and flagged when they need to be renewed or updated.

Monitoring and Follow-Up:
A follow-up review will be conducted within 30 days to ensure the resident's FL2 form is completed and filed correctly.
The facility will perform monthly three-month audits to ensure all residents have current and properly documented FL2 forms.
Any further issues identified during these audits will be promptly addressed with corrective action.
Documentation:

The updated FL2 form will be documented in the resident's medical record and a copy will be forwarded to the appropriate regulatory body if required.
The corrective actions and training provided to staff will be documented in the facility's quality assurance logs.
Responsible Party:
Adminstrator
Completion Date
The FL2 form for the resident was updated by 11/21/24.
Staff education and training will be completed by 12/31/24.
Policy reviews and implementation of tracking system will be completed by 12/31/24.
Conclusion:
This Plan of Correction is intended to address the issue of the missing or outdated FL2 form and to ensure future compliance with 10A NCAC 13G .0702. The facility is committed to maintaining the highest standard of care and regulatory compliance. Corrective actions will be closely monitored, and ongoing training and auditing will be conducted to prevent future occurrences.

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C 204	Continued From page 3 -He did not know Resident #1 needed to be considered as a new admission once the home received a new license to operate as a FCH beginning August 2024. Interview with the Administrator on 11/21/24 at 8:30am revealed: -He requested a new FL-2 for Resident #1 on 11/20/24. -He had not received another FL-2 for Resident #1. -He contacted the primary care provider's (PCP) office earlier today (11/21/24) and was waiting for the PCP to authorize another office physician to sign the FL-2. Second interview with the Administrator on 11/21/24 at 11:20am revealed: -He made sure there was a FL-2 for the resident -He reviewed the FL-2. -He thought once the FL-2 was signed by the physician, the FL-2 was "okay". Telephone interview with Resident #1's PCP on 11/21/24 at 12:34pm revealed: -She was a new provider for the facility. -Her initial visit to the facility was at the end of October 2024. -She received a request for an FL-2 for Resident #1 on 11/20/24. -She had not received a request for an FL-2 for Resident #1 prior to 11/20/24. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable.	C 204	*Please refer to previous corrective plan of action.
C 240	10A NCAC 13G .0802(e) Resident Care Plan	C 240	

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C 240	Continued From page 4 10A NCAC 13G .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 record reviews and interviews, the facility failed to ensure the residents' physician signed and dated care plans within 15 days of the assessment for 2 of 3 sampled residents (#1, #2). The findings are: 1. Review of Resident #1's FL-2 dated 04/23/24 revealed: - The resident's diagnoses included chronic dementia and burn involving 10-19% body surface with 3rd degree burn 04/08/24. -The resident was documented as constantly disoriented. -The resident was documented as ambulatory. -There was no documentation regarding personal care assistance needed. Review of Resident #1's Resident Register revealed an admission date of 05/06/24. Review of Resident #1's current assessment and care plan on 11/20/24 revealed: -The assessor completed and dated the assessment and care plan on 05/06/24. -The resident required daily dressing changes to	C 240	Summary of the Issue: The resident's care plan was not up to date at the time of review, violating 10A NCAC 13G .0802(e), requiring a comprehensive care plan to be developed and reviewed within 15 days of admission. While the care plan was intended to be finalized by regulations, it was not updated promptly due to **a delay in obtaining the prescriber's availability for the required medical assessment.** ***Explanation of Delay:*** The delay in updating the resident's care plan was primarily because the facility could not secure a prescriber to conduct the necessary assessment before the 15-day deadline. The prescriber responsible for completing the medical portion of the care plan was unavailable until after the resident's admission date. As a result, we could not include the prescriber's input on the resident's care plan until they could attend, which delayed the overall process. Corrective Action Plan: Immediate Action: The resident's care plan will be updated immediately after the prescriber's medical assessment is completed. The necessary revisions and updates will ensure that the care plan is fully comprehensive and complies with the regulations. All relevant interdisciplinary team members will review the care plan to ensure it addresses all the resident's needs promptly and thoroughly. Root Cause Analysis: The root cause of the delay in the care plan update was finding a prescriber to attend the facility. The prescriber could not attend to the resident until after the admission date, which caused a delay in the finalization of the care plan. The facility will review its policies to address future situations in which prescriber availability could cause delays in care plan development. Staff Education and Training: All staff members involved in the care plan process, including nursing, admissions, and the interdisciplinary team, will undergo additional training on ensuring the timely completion of care plans and coordinating care plan development with all necessary providers. Training will emphasize communication strategies to secure timely access to prescribers and other team members involved in the care planning. Staff will be reminded of the 15-day regulatory deadline for care plan completion and its critical role in resident care. Policy and Procedure Review: The facility will review and update its policies and procedures for creating and updating resident care	11/21/24

plans to ensure that all necessary assessments and inputs are obtained in a timely manner, including securing prescriber availability as early as possible. The facility will implement a protocol to ensure that any delays in care plan development due to prescriber unavailability are documented and communicated to relevant staff and that care plans are completed as soon as possible after admission.

System Improvements:
The facility will implement a tracking system to monitor the status of each resident's care plan during the initial admission period to ensure that it is developed and updated within the required 15-day timeframe.
Designate a staff member to ensure that prescriber appointments are scheduled promptly and that any delays are flagged for immediate attention.

Monitoring and Follow-Up:
A follow-up review will be conducted within 30 days to ensure that the resident's care plan has been fully updated and is now compliant with regulatory standards.
The facility will conduct regular audits for the next three months to ensure that all new admissions have timely, up-to-date care plans and that delays are promptly addressed.

Documentation:
The updated care plan and the prescriber's assessment will be documented in the resident's medical record.
Any delays and their reasons will be documented, and corrective actions taken will be included in the facility's quality assurance logs.

Responsible Party:
Administrator/Nurse

Completion Date:
The resident's care plan for resident 1 and 2 was updated by 11/21/24.
Staff education and training will be completed by 12/31/24.
Policy review and implementation will be completed by 12/31/24.

Conclusion:
This Plan of Correction addresses the failure to update the resident's care plan in a timely manner due to prescriber unavailability. The facility is committed to ensuring that care plans are completed within the regulatory timeframe, and corrective actions are being taken to prevent future delays. Staff will be educated on the importance of timely care plan updates, and systems will be improved to ensure that such delays are prevented in the future.

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LYNNDALE SENIOR LIVING HOME	5939 KEYSTONE DR RALEIGH, NC 27612

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C 240	Continued From page 5 a wound on the upper back. -The resident was documented as always disoriented. -The resident was documented as having a significant memory loss and must be directed. -The assessment and care plan were signed and dated by the primary care provider (PCP) on 10/31/24. Refer to interview with the Owner/Administrator on 11/20/24 at 11:30am. Refer to telephone interview with the facility's contracted PCP on 11/21/24 at 11:51am. 2. Review of Resident #2's FL-2 dated 08/28/24 revealed: - The resident's diagnoses included early onset Alzheimer's dementia with behavioral disturbance, mixed hyperlipidemia, and seizure disorder. -The resident was documented as constantly disoriented. -The resident was documented as ambulatory with wandering behavior. -The resident was documented as requiring assistance with bathing, dressing, and feeding. Review of Resident #2's Resident Register revealed an admission date of 09/03/24. Review of Resident #2's current assessment and care plan on 11/20/24 revealed: -The assessor completed and dated the assessment and care plan on 09/18/24. -The resident was documented as requiring total assistance with eating, dressing, toileting, bathing, grooming, ambulation, and transferring. -The resident was documented as always disoriented.	C 240	*Please refer to the previous corrective care plan for residents 1 and 2.	

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C 240	Continued From page 6 -The resident was documented as having a significant memory loss and must be directed. -The assessment and care plan were signed and dated by the primary care provider (PCP) on 10/31/24. Refer to interview with the Owner/Administrator on 11/20/24 at 11:30am. Refer to telephone interview with the facility's contracted PCP on 11/21/24 at 11:51am. Interview with the Owner/Administrator on 11/20/24 at 11:30am revealed: -He was responsible for completing the care plan assessment. -He recently obtained services of a new Primary Care Provider (PCP) for facility visits and care of the residents. -Once he completed the assessments and care plans, he left them at the facility for the PCP to sign during her facility visits. Telephone interview with the facility's contracted PCP on 11/21/24 at 11:51am revealed: -She was a new provider for the facility. -Her initial visit to the facility was at the end of October 2024. -She asked the facility staff about care plans being completed when she visited the facility. -She usually received the care plan forms once the assessment was completed.	C 240	*Please refer to the previous corrective care plan for residents 1 and 2.	
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	C 342		

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C 342	Continued From page 7 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, record reviews, and interviews, the facility failed to ensure the accuracy of the medication administration records (MARs) for 2 of 3 residents (#1, #2) including a medication used for seizure disorders (#2) and a medication used for pain (#1). The findings are: Review of the facility medication administration policy revealed: -Resident's medication administration records (MARs) would be accurate. -The reason or justification of medications or treatments as needed (PRN) would be documented and include the resulting effect. -Omission of medications or treatments and the reason for the omissions would be documented.	C 342	Summary of the Issue: The facility failed to properly document medication administration and PRN (as-needed) medication effectiveness, violating 10A NCAC 13G .1004(j), which requires accurate and timely documentation of all administered medications, including the effectiveness of PRN medications. Documentation was either incomplete or missing for medications administered, and for PRN medications, the effectiveness of the administration was not consistently recorded. Corrective Action Plan: Immediate Action: The medication administration records (MAR) for the affected residents (1 and 2) will be reviewed, and the responsible nursing staff will promptly complete any missing entries. The effectiveness of the administered PRN medications will be documented as required, including assessing the resident's response to the PRN medication. Supervisors or team leads will monitor medication administration and documentation for the remainder of the shift to ensure immediate compliance with proper documentation protocols. Root Cause Analysis: A detailed review will be conducted to identify the root causes of the missing or incomplete medication documentation. This review will involve: Analyzing workflows to determine where the breakdown in documentation occurred (e.g., at the point of administration, during shift change, or in electronic or paper MAR systems). Assessing whether staff training or understanding was lacking in documenting PRN medication effectiveness. Reviewing any system issues that may have contributed to missed documentation (e.g., malfunctioning electronic health record systems). Staff Education and Training: All nursing staff will receive immediate retraining on the proper documentation of medication	11/30/24

administration and the requirement to record the effectiveness of PRN medications.
Emphasis will be placed on ensuring that:
All administered medications are documented immediately after administration.
The effectiveness of PRN medications is documented, including the resident's response and any side effects.
Staff will be trained on the importance of accurate documentation for medication management, including the risks associated with missed or incomplete entries.
The training will cover paper MAR, ensuring staff understand how to record medication and PRN effectiveness properly.

Policy and Procedure Review:
The facility's policies and procedures related to medication administration and documentation will be reviewed and updated to ensure clarity and compliance with state regulations.
A clear, step-by-step process for documenting PRN medication administration and effectiveness will be incorporated into the facility's medication administration policy.
A procedure will be established for monitoring the timely completion of medication documentation and the effectiveness of PRN medications, particularly for high-risk medications.

System Improvements:
A system of checks will be implemented, such as a supervisor or charge nurse reviewing PRN medication entries at the end of each shift to ensure that all entries are complete and accurate.

Monitoring and Follow-Up:
A follow-up audit will be conducted within 30 days to ensure all medication administration and PRN documentation is completed properly and complies with the facility's updated policies.
A random audit of MARs will be conducted weekly for the next three months to monitor compliance with documentation of PRN effectiveness and other medication entries.
Supervisors and nursing managers will perform periodic spot checks to ensure compliance with the documentation process and to reinforce the importance of complete and accurate records.

Documentation:
The facility's quality assurance logs will include documentation of the completed training sessions for nursing staff.
Any corrective actions taken, including updates to policies and procedures and staff retraining, will be documented.
Records of the completed audits and follow-up actions will be maintained for review.
Responsible Party:
Administrator

			Completion Date: 11/30/24 Missing MAR documentation will be completed by administrator and med tech. Staff retraining on PRN medication documentation will be completed by 12/16/24 Policy review and system improvements will be completed by 12/16/24. Conclusion: This Plan of Correction addresses the missing medication administration and PRN documentation and ensures compliance with 10A NCAC 13G .1004(j). The facility will take corrective action by retraining staff, updating policies, and implementing system improvements to ensure that medication and PRN effectiveness documentation is accurate, timely, and complete in the future. Continuous monitoring and auditing will be conducted to maintain compliance and improve medication management practices.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNNDALE SENIOR LIVING HOME	6628 KEYSTONE DR RALEIGH, NC 27612

(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 342	Continued From page 8	C 342	*Please refer to the previous corrective plan of correction.

1. Review of Resident #2's current FL-2 dated 08/28/24 revealed diagnoses included early onset Alzheimer's dementia with disturbance, mixed hyperlipidemia, and seizures.

Review of a physician's order for Resident #2 dated 10/04/24 revealed an order to start Levetiracetam (generic for Keppra used to treat seizure disorders) 500mg tablet every 12 hours.

Review of the October 2024 medication administration records (MARs) for Resident #2 revealed there was no entry transcribed to the MARs for Keppra 500mg tablet every 12 hours.

Interview with the medication aide (MA) on 11/21/24 at 10:55am revealed:
-She administered the Keppra to Resident #2 when it was received at the facility because she knew the primary care provider (PCP) had given an order for the Keppra.
-She knew the PCP ordered the Keppra because she participated in the video call with the PCP.
-When a new medication arrived at the facility from the pharmacy, she would ask the Administrator about the order for the medication before she administered the medication.
-The pharmacy was responsible for sending an updated MAR when new medications were prescribed or there were changes in medication orders.

Interview with the Administrator on 11/21/24 at 11:20am revealed he was responsible for ensuring that medication administration orders were accurately transcribed to the MARs.

Telephone interview with the contracted provider pharmacy on 11/21/24 at 10:14am revealed:

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	FCL092-324	A. BUILDING: _____ B. WING _____	11/21/2024

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C 342	Continued From page 9 -A supplemental MAR was sent to the facility with new medications. -Keppra was dispensed to the facility on 10/08/24 for Resident #2. Telephone interview with the PCP on 11/21/24 at 12:05pm revealed: -She looked at medications when she made visits to the facility. -The Keppra for Resident #2 was prescribed by the neurologist. -If Resident #2's Keppra medication had not been administered, the resident would be at risk for seizure activity. -She had not been made aware of Resident #2 having any seizures. -She was aware Resident #2 was hospitalized in January 2024 but not aware of any hospitalizations since then. Attempted telephone interview with the neurologist on 11/21/24 at 12:48pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable. Refer to the interview with a MA on 11/21/24 at 9:32am. Refer to second interview with a MA on 11/21/24 at 10:55am. Refer to the interview with the Administrator on 11/21/24 at 9:39am. 2. Review of Resident #1's FL-2 dated 04/23/24 revealed: -Diagnoses included dementia and burn involving	C 342	*Please refer to the previous corrective plan of correction.

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C 342	Continued From page 10 10-19 percent of body surface with third degree burns - 04/08/24. -There was an incomplete physician's order for Tylenol (used to treat pain) 650mg tablet "q 4" (every 4). Review of an FL-2 for Resident #1 dated 11/21/24 revealed a physician's order for acetaminophen (generic for Tylenol) 325mg two tablets every 4 hours as needed. Review of the November 2024 medication administration records (MARs) for Resident #1 revealed: -There was a printed entry transcribed to the MARs for acetaminophen 325mg tablet take two tablets every 4 hours as needed for fever or pain. -There was documentation for administration of the acetaminophen 325mg tablets on 11/02/24, 11/05/24, 11/08/24, and 11/19/24. -There were no entries or notes documenting the reason or results/effectiveness of the as needed acetaminophen administration. Interview with the medication aide (MA) on 11/21/24 at 12:30pm revealed: -She remembered administering the as needed acetaminophen to Resident #1. -She was supposed to acknowledge if the as needed medication was effective after 30 minutes to one hour had passed. -She did not think to document the effectiveness of the as needed acetaminophen. -She did not know where she was supposed to document the effectiveness of the as needed acetaminophen. Interview with the Administrator on 11/21/24 at 12:34pm revealed: -He administered the as needed acetaminophen	C 342	*Please refer to the previous corrective plan of correction.

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to Resident #1 on 11/02/24, 11/05/24, and 11/08/24.
-He was supposed to document the reason for administration of the as needed acetaminophen.
-He forgot to document the reason the as needed acetaminophen was administered each time he administered it.

Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable.

Refer to a interview with a MA on 11/21/24 at 9:32am.

Refer to second interview with a MA on 11/21/24 at 10:55am.

Refer to the interview with the Administrator on 11/21/24 at 9:39am.

Interview with a medication aide (MA)) on 11/21/24 at 9:32am revealed:
-The MAs were not responsible for transcribing orders to the medication administration records (MARs).
-The primary care provider sent medication orders to the contracted pharmacy provider.
-The contracted pharmacy provider was responsible for sending a new MAR with any new medication ordered.

Second interview with a MA on 11/21/24 at 10:55am revealed:
-She did not think she had seen a medication administration policy.
-She remembered discussing medication administration with the Administrator prior to the current licensing of the facility.
-She was instructed to check the medications

C 342 *Please refer to the previous corrective plan of correction.

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C 342	Continued From page 12 against the MARs before administering. Interview with the Administrator on 11/21/24 at 9:39am revealed: -He received the new medication administration records from the contracted pharmacy provider. -He was responsible for checking the MARs to ensure accuracy and ensure medications listed on the MARs were available in the medication cart. -If there was a discrepancy with the MARs, he contacted the contracted pharmacy provider. -He had not had any issue with MAR discrepancy.	C 342	*Please refer to the previous corrective plan of correction.
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side	C 375	Corrective Action Plan: Immediate Action: The facility will immediately review all resident medication regimens to ensure that pharmaceutical care services are provided in accordance with 10A NCAC 13G .1009(a)(1). Consultations with the pharmacy will be requested for the residents involved to ensure the appropriateness and safety of their medications and care. Policy and Procedure Review: The facility's policies and procedures related to pharmaceutical care will be reviewed and updated to ensure compliance with 10A NCAC 13G .1009(a)(1). This review will include: Establishing specific timelines for regular medication reviews and assessments by a pharmacist. Creating or reinforcing a protocol for nursing and pharmacy team to notify the pharmacist of any new medications, changes, or concerns. Clearly defining roles and responsibilities for all parties involved in the medication management process. Outlining the process for documentation of pharmacist consultations and medication reviews.	12/5/2024

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effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and,
(B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and,
(C) documenting the results of the medication review in the resident's record;

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure a licensed pharmacist, provider, or registered nurse completed a quarterly on-site medication review for 1 of 1 sampled resident (#1) that met requirement for a quarterly medication review.

The findings are:

Review of Resident #1's FL-2 revealed:
-The FL-2 was dated 04/23/24.
-Diagnoses included chronic dementia and burn involving 10-19%body surface with 3rd degree burn 04/08/24.
-The FL-2 was generated from a hospital with the recommended level of care documented for an assisted living facility.
-There were fourteen medication orders listed on the FL-2.

Review of the Resident Register for Resident #1 revealed the resident's admission date was documented as 05/06/24.

Review of Resident #1's record revealed:
-There was a visit summary dated 05/30/24 from a local hospital clinic.

C 375

Pharmacy Services Enhancement:
The facility will explore the possibility of establishing a designated pharmacy liaison or pharmacist on-site to improve coordination and ensure the timely delivery of pharmaceutical care. The pharmacy is to complete quarterly review.

Responsible Party:
Health Park Pharmacy
Completion Date: 12/5/2024
Immediate pharmaceutical care review for affected residents will be completed by [12/5/2024].

12/5/24

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C 375	Continued From page 14 -There was a telehealth visit conducted on 10/09/24 by a mental health provider. -There was no documentation of a quarterly medication review. Interview with the Administrator on 11/20/24 at 9:49am revealed: -Resident #1 lived in the home when the home had a previous license number. -The resident was the only resident living at the home until the home received the current license to operate as a family care home beginning August 23, 2024. Telephone interview with the contracted pharmacy provider on 11/21/24 at 10:12am revealed: -The pharmacy offered medication reviews to contracted facilities. -There had not been a request from the facility to complete any pharmacy reviews. Interview with the Administrator on 11/21/24 at 1:22pm revealed: -There were no pharmacy reviews conducted for Resident #1. -He did not know anything about pharmacy reviews.	C 375					

FAX

1/2/2025 3:43 PM (EST)

SENDER

From: lynndale senior living home

Phone: 9192476316

Fax: +19197467322

MESSAGE

Attention to: Ms Hope Forte
Total number of pages 21