| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL056006 | A. BUILDING: _____ B. WING _____ | R 05/21/2025 |

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| {D 000} | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow up survey with the Macon County Department of Social Services from 05/20/25 to 05/21/25. | {D 000} | Responses to the cited deficiencies do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared solely as a matter of | |
| {D 358} | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 Residents (#2) including a medication used to treat mental health disorders and two medications used to prevent seizures.<br><br>The findings are:<br><br>Review of Resident #2's current FL2 dated 04/23/25 revealed:<br>-Diagnoses included vascular dementia and epilepsy.<br>-She was constantly disoriented.<br><br>Review of Resident #2's current physician orders dated 04/23/25 revealed:<br>-There was an order for quetiapine (an antipsychotic medication used to treat mental | {D 358} | 10A NCAC 13F .1004(a)<br><br>Executive Director, Care Coordinators and/or his/her designee to complete weekly medication cart audits to ensure all prescribed medications are available for use as prescribed by the resident's physician.<br><br>Clinical Nurse Consultant, RN to in-service Executive Director, Care Coordinators and/or his/her designee on the importance of and how to complete proper cart audits. | 6/27/2025 |


LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Utaman — TITLE: Executive Director — (X6) DATE: 6/17/25



Reviewed and Acknowledged LMJ 06/19/25

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| {D 358} | Continued From page 1<br>health disorders) 200mg tablet twice daily.<br>-There was an order for carbamazepine (used to treat epilepsy) 20mg tablet twice daily.<br>-There was an order for phenytoin sodium (used to treat epilepsy) 100mg capsule twice daily.<br><br>Review of Resident #2's April 2025 electronic medication administration record (eMAR) revealed:<br>-There was an entry for quetiapine 200mg tablet twice daily.<br>-The quetiapine was scheduled for administration at 9:00am and 9:00pm.<br>-There was documentation the quetiapine was placed "on hold" on 04/29/25 at 9:00am.<br>-There was an entry for carbamazepine 200mg tablet twice daily.<br>-The carbamazepine was scheduled for administration at 9:00am and 9:00pm.<br>-There was documentation the carbamazepine was placed "on hold" on 04/28/25 at 9:00am, 04/29/25 at 9:00am, and 04/30/25 at 9:00pm.<br>-There was an entry for phenytoin sodium 100mg capsule twice daily.<br>-The phenytoin sodium was scheduled for administration at 9:00pm.<br>-There was documentation the phenytoin sodium was placed "on hold" on 04/28/25 at 9:00am, 04/29/25 at 9:00am, and 04/30/25 at 9:00pm.<br><br>Review of Resident #2's May 2025 electronic medication administration record (eMAR) revealed:<br>-There was an entry for quetiapine 200mg tablet twice daily.<br>-The quetiapine was scheduled for administration at 9:00am and 9:00pm.<br>-There was documentation the quetiapine was placed "on hold" on 05/01/25 at 9:00pm and 05/02/25 at 9:00am. | {D 358} | | |

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| {D 358} | Continued From page 2<br>-There was an entry for carbamazepine 200mg tablet twice daily.<br>-The carbamazepine was scheduled for administration at 9:00am and 9:00pm.<br>-There was documentation the carbamazepine was placed "on hold" on 05/01/25 at 9:00am and 05/01/25 at 9:00pm.<br>-There was an entry for phenytoin sodium 100mg capsule twice daily.<br>-The phenytoin sodium was scheduled for administration at 9:00pm.<br>-There was documentation the phenytoin sodium was placed "on hold" on 05/01/25 at 9:00am, 05/01/25 at 9:00pm and 05/02/25 at 9:00am.<br><br>Interview with a MA on 05/21/25 at 9:15am revealed:<br>-She did not remember why she documented on the electronic medication administration report (eMAR) report on 04/25/25 to "hold" three of Resident #2's medications.<br>-The medications were "usually" placed on hold if the medication ran out.<br>-An order from the Primary Care Provider (PCP) was needed to place medications on hold.<br>-She did not find an order in the computer system for the three medications for Resident #2, but the Administrator should have a "copy" in the record.<br>-She reordered medications through the online system that communicated with the pharmacy.<br>-She contacted the pharmacy to ensure the refill request was received.<br>-The medications were usually delivered the same day or the next day.<br>-The controlled medication orders should be called in to the pharmacy from the PCP.<br>-She usually contacted the pharmacy the same day the PCP ordered the controlled medications to ensure the order was received but was not | {D 358} | | |

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| {D 358} | Continued From page 3<br>sure if she contacted the pharmacy on 04/25/25.<br>-She usually tried to contact the pharmacy to reorder medication 3 or 4 days before the medication ran out.<br><br>Interview with a second MA on 05/21/25 at 9:15am revealed:<br>-She originally let management staff know on 04/27/25 that Resident #2's quetiapine, carbamazepine, and phenytoin sodium were not available for administration.<br>-When she came back to work on 04/29/25, she informed management staff again that Resident #2's quetiapine, carbamazepine, and phenytoin sodium were not available for administration.<br>-She did not know why those 3 medications did not come in the weekly multi-dose pack for Resident #2.<br>-The Hospice Registered Nurse (RN) was making a weekly visit to Resident #2 on 04/29/25 and she told her the 3 medications were not available for administration to Resident #2.<br><br>Interview with the Memory Care Coordinator (MCC) on 05/21/25 at 8:40am revealed:<br>-Medication aides (MA) were responsible to let her know when a resident's medication was getting low and if they were out of medication for a resident.<br>-The MAs did not follow procedure to notify her Resident #2 was low on the quetiapine, carbamazepine, and phenytoin sodium or when the last dose was given.<br>-She was not notified until 04/29/25 by a MA that Resident #2 had been out of her quetiapine, carbamazepine, and phenytoin sodium for several days.<br>-She told the MA to put the quetiapine, carbamazepine and phenytoin sodium "on hold" until the medications were received from the | {D 358} | | |

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| {D 358} | Continued From page 4<br>pharmacy.<br><br>Interview with the Resident Care Coordinator (RCC) on 05/21/25 at 9:05am revealed:<br>-When a MA discovered a medication was not available for administration, the MA was responsible for letting her know or the MCC.<br>-The MA was responsible for calling the pharmacy to verify the medication was scheduled to be sent to the facility.<br>-The medication Resident #2 was prescribed was packaged in a multi-dose pack from the pharmacy and was delivered weekly.<br>-She and the MCC were responsible for verifying all the medications were in the multi-dose packs for each resident when they were received from the pharmacy.<br><br>Attempted telephone interview with the facility's contracted pharmacy on 05/21/25 at 9:38am was unsuccessful.<br><br>Telephone interview with the hospice primary care provider (PCP) on 05/21/25 at 10:35am revealed:<br>-She had not been informed by the facility that Resident #2 went without her quetiapine, carbamazepine, and phenytoin sodium for several days.<br>-She was in the facility most recently on 04/30/25 and reviewed and signed orders presented to her.<br>-There was not an order to hold Resident #2's quetiapine, carbamazepine, and phenytoin sodium presented to her to sign.<br><br>Interview with the Administrator on 05/21/25 at 10:58am revealed:<br>-Most all scheduled non-narcotic medications went sent to the facility weekly in a multi-dose pack from the pharmacy.<br>-There was lack of timely communication | {D 358} | | |

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| {D 358} | Continued From page 5<br>between the MAs and the MCC when it was discovered Resident #2 was missing 3 of her scheduled medications. | {D 358} | | |