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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an Annual survey on April 5, 2022 through April 7, 2022. | D 000 | | |
| D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure orders were implemented and documented for 1 of 5 sampled residents (#1,) the application and removal of graduated compression socks.<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 06/24/21 revealed diagnoses included mixed hyperlipidemia, dementia without behaviors, hypertension, emphysema, chronic kidney disease and congestive heart failure.<br><br>Review of Resident #1's Licensed Health Professional Support (LHPS) report dated 01/26/22 revealed:<br>-There was a task to apply and remove TED (thrombo-embolus deterrent compression stockings) hose.<br>-The LHPS nurse noted Resident #1 had an order to apply TEDs in the morning and to remove them | D 276 | | |

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in the evenings.

Review of an after-visit summary from Resident #1's vascular physician dated 03/07/22 revealed she was seen by the vascular physician for chronic venous insufficiency.

Review of Resident #1's physician's order dated 03/07/22 revealed:
-There was an order to apply knee-high graduated compression stockings, 15-20mmHg (millimeters of mercury indicating the level of compression) every morning and remove in the evening.
-The order was signed by Resident #1's vascular physician.

Review of a physician's order dated 01/26/22 revealed:
-There was a request from the facility for the physician to renew the order for TED (thrombo-embolus deterrent compression stockings) hose for Resident #1.
-The request was signed by the facility's Resident Care Coordinator (RCC) on 01/26/22.
-The order for TED hose apply every morning and remove at bedtime was signed by the primary care provider (PCP) on 03/19/22.

Review of Resident #1's electronic medication administration records (eMARs) dated January 2022 revealed:
-There was an entry to apply TED hose every morning and remove at bedtime scheduled at 7:00am and 8:00pm.
-There was documentation Resident #1's TED hose were applied and removed from 01/01/22 to 01/17/22; there was no other documentation of application or removal after 01/18/22.
-There was notation on the eMAR indicating the

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| D 276 | Continued From page 2<br>order for TED hose was discontinued.<br><br>Review of Resident #1's eMARs for February 2022, March 2022 and April 2022 revealed there were no entries for applying and removal of TED hose or compression stockings.<br><br>Observation of Resident #1 on 04/05/22 at 8:23am revealed:<br>-She had fluffy, non-skid ankle socks on her feet.<br>-She did not have on knee-high socks, compression stockings or TED hose.<br>-She appeared to have slight swelling in her legs above the ankle.<br><br>Interviews with Resident #1 on 04/05/22 at 8:23am and 4:06pm revealed:<br>-She was seen by a vascular physician because she had swelling in her legs.<br>-The vascular physician had an ordered TED hose for her about two months ago.<br>-The order for the TED hose be applied in the mornings and removed in the evenings.<br>-No one had measured her for the TED hose; she thought the order was from about two months ago.<br>-She had not complained to the staff about not having TED hose because she did not want to bother anyone.<br>-She had three pairs of knee-high socks that she applied herself; her family purchased them at a drugstore years ago.<br>-One pair of the knee-high socks did not fit her and did not reach her knees, so she did not wear them.<br>-She tried to remember to apply the knee-high socks herself, but she could not always put them on by herself.<br>-She usually applied the knee-high socks after she got out of bed and dressed in the morning. | D 276 | | |

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-The medication aide (MA) had helped her apply her knee socks two times.
-None of the staff checked her legs to see if her knee-high socks were on in the mornings or at night.
-She did not know why no one had measured her for the TED hose.
-She had edema and sometimes her legs swelled and felt bad.
-Her knee-high socks helped with some of the swelling, but she thought the vascular physician wanted her to have more support [compression] that is why he ordered the TED hose.
-She had forgotten to apply her knee-high socks this morning, 04/05/22.

Telephone interview with Resident #1's family member on 04/06/22 at 9:52am revealed:
-She had purchased Resident #1 over the counter (OTC) compression socks at the local pharmacy a few years ago.
-Resident #1's vascular physician had ordered a certain gauge compression stocking for Resident #1 at her last appointment about three weeks ago.
-Resident #1 was ordered a specific type of compression stocking because her legs tended to swell.
-Sometimes Resident #1 would have her OTC compression stocking on and sometimes she did not.
-She would apply Resident #1's OTC compression stocking if she did not have them on when she visited the resident.
-Resident #1's memory was not very good, and she would forget to apply them in the morning.
-Resident #1 would attempt to apply her TED hose herself and would not get them all the way up or they would roll.
-She had seen the order the vascular physician

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had signed, and it had applied in the morning and remove at bedtime.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 04/05/22 at 3:21pm revealed:
-The pharmacy was responsible for entering orders for applying and removal of TED hose in the eMAR.
-The order for the TED hose could only be entered into the eMAR once the pharmacy received the measurements for the TED hose from the facility; the formulary for the eMAR would not allow the order to be entered without the measurements.
-The pharmacy would send new TED hose to the facility based on the measurements they received from the facility.
-Resident #1 did not have TED hose in her profile so there would be no entry in the eMAR.
-The facility faxed the order for Resident #1's TED hose to the pharmacy on 03/07/22.
-The pharmacy faxed the facility a form to document Resident #1's measurements for TED hose on 03/07/22.
-The facility faxed the measurement form to the pharmacy on 03/09/22; there were no measurements documented on the form.
-The was  hand-written documentation on the measurement form stating Resident #1 had plenty and did not need any more [TED hose].
-Without measurements the pharmacy was unable to enter the order for Resident #1's TED hose on the eMAR.

Telephone interview with a certified medical assistant (CMA) from Resident #1's vascular physician's office on 04/06/22 revealed:
-Resident #1 was ordered 15-20mmHg above the knee compression stocking by the vascular

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physician on 03/07/22 to control her mild edema.
-The vascular physician did not measure for TED hose; the facility should have measured her.
-The vascular physician ordered the TED hose for Resident #1 to control her edema in her legs.
-He expected the order for TED hose for Resident #1 to be applied by the facility staff every morning and removed every evening.
-Possible outcomes of Resident #1's TED hose not being applied and removed everyday could be her edema would get worse and possibly out of control.

Interview with a medication aide (MA) on 04/06/22 at 1:58pm revealed:
-The MAs applied and removed TED hose and TED hose.
-The MAs could measure residents for TED hose.
-She could not remember if Resident #1 had an order to apply and remove TED hose daily.
-She did not remember applying TED hose to Resident #1's legs.
-She could not enter an order for TED hose into the eMAR; the pharmacy had to enter the order.
-The pharmacy sent a form to the facility to measure a resident for TED hose.
-Once the measurements were faxed to the pharmacy the TED hose would be delivered by the pharmacy in a day or two.

Interview with the Resident Care Coordinator (RCC) on 04/06/22 at 2:23pm revealed:
-When a resident had an order for TED hose the order would be faxed to the pharmacy and the pharmacy would fax a sheet to document measurements on.
-The MAs, the RCC or the facility's Registered Nurse (RN) could measure residents for TED hose or TED hose.
-The facility faxed the measurements to the

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pharmacy so they order could be entered into the eMAR.
-The MAs were responsible for applying and removal of TED hose.
-Resident #1 had compression socks and she could apply them herself.
-She would remind staff if she needed help applying or removing them.
-She sometimes checked Resident #1 to see if she had her compression socks on.
-The MAs should check Resident #1 daily to see if she is wearing her compression socks and if they were on correctly.
-She had asked Resident #1's primary care provider (PCP) to write an order for the compression socks for the resident because she had noticed they were no longer on the eMAR.
-She had called the pharmacy and told them Resident #1 did not need anymore compression socks because she had plenty of pairs.
-She had forgotten to follow through with the pharmacy to ensure the compression socks were on the eMAR.
-She was responsible for ensuring the TED hose were on the eMAR.

Interview with the facility's RN on 04/06/22 at 2:51pm revealed:
-The MAs or the RCC were responsible for faxing orders to the pharmacy.
-TED hose were considered a medication so the pharmacy had to enter the order into the eMAR.
-The RCC and the RN were responsible for monitoring the eMARs for accuracy.
-When there was an order for TED hose the order needed to be faxed to the pharmacy and the measurements for the TED hose also needed to be faxed.
-The MAs, the RCC or she could measure for TED hose.

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| D 276 | Continued From page 7<br>-The MAs should have applied and removed Resident #1's TED hose.<br>-She was not aware Resident #1's order for TED hose was not on the eMAR.<br>-Resident #1 did have some edema in her legs.<br>-She was concerned Resident #1's TED hose were not applied because Resident #1 could experience increased edema and circulation problems that could led to health issues and possibly a visit to her physician.<br><br>Interview with the Administrator on 04/07/22 at 11:18am revealed:<br>-The pharmacy entered the order for a resident's TED hose after they received the measurements from the facility.<br>-The RCC and the RN were responsible for ensuring any new orders are entered onto the eMAR.<br>-Resident #1 should have been measured for her TED hose and staff should have not written anything but measurements on the form the pharmacy provided.<br>-She expected all physician orders to be followed, including TED hose.<br><br>Attempted telephone interview with the Licensed Health Professional Support (LHPS) Nurse on 04/07/22 at 10:47am was unsuccessful. | D 276 | | |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. | D 310 | | |

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This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to serve therapeutic diets as ordered by the physician for 1 of 4 sampled residents (#7) with a diet order for ground diet.

The findings are:

Review of Resident #7's current FL-2 dated 08/10/21 revealed:
-Diagnoses included vascular dementia without behavioral disturbances, mood disorder, spinal stenosis, and chronic kidney disease.
-There was an order for a chopped diet.

Review of a signed physician's order for Resident #7 dated 02/17/22 revealed there was an order for a ground diet.

Review of Resident #7's current care plan dated 02/15/22 revealed ground diet was listed under additional instructions for eating.

Review of a resident diet list posted in the kitchen dated 07/14/21 revealed Resident #7 had a pureed diet ordered.

Review of the diet menu for 04/04/22 revealed a hot turkey sandwich was on the menu; the turkey on the ground diet menu was chopped meat.

Observation of the lunch meal on 04/04/22 at 11:54am revealed:
-Resident #7 was served a turkey sandwich with

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slices of turkey on white bread, mashed potatoes and juice.
-Resident #7's ate 100 percent of his mashed potatoes and only ate 75 percent of his turkey sandwich,

Review of the diet menu for 04/06/22 revealed chicken jambalaya was on the menu; the ground diet was listed as ground chicken jambalaya.

Observation of the lunch meal on 04/06/22 at 11:56am revealed Resident #7 was served chicken jambalaya with chunks of chicken.

Telephone interview with Resident #7's primary care provider (PCP) on 04/06/22 at 9:40am revealed:
-Resident #7 was ordered a ground diet because there were concerns with him coughing while eating.
-The diet order was expected to be followed as written.
-Resident could choke and aspirate if the diet was not followed.

Interview with the cook on 04/06/22 at 12:13pm revealed:
-None of the residents were ordered a ground diet.
-Resident #7 was ordered a chopped diet.
-She followed the diet order for each diet; she knew to chop meets for the chopped diet and if there was a resident ordered a ground diet, she would grind the meats.

Interview with the Dining Services Director (DSD) on 04/07/22 at 9:05am revealed:
-There was a diet list posted in the kitchen for the kitchen staff to follow.
-The kitchen staff should have followed the diet

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| D 310 | Continued From page 10<br>menu as well as the diet list so residents would be served the correct diets.<br>-She trained the cooks and sometimes the cooks trained each other.<br>-The Memory Care Coordinator (MCC) gave her the updates for diets for the residents.<br>-She thought Resident #7 was ordered a chopped diet.<br><br>Interview with the MCC on 04/07/22 at 10:01am revealed:<br>-She was responsible for giving the updated diet orders to the DSD.<br>-Resident #7 had coughed on the chopped diet so his diet was changed to a ground diet.<br>-She thought Resident #7's diet had been upgraded from a ground diet to a chopped diet because he did not like the ground diet.<br>-She did not know when Resident #7's diet had been upgraded to the chopped diet.<br><br>Interview with the Administrator on 04/07/22 at 11:18am revealed:<br>-She expected the cooks to follow the diet orders for the residents by following the diet menus.<br>-The diet written and signed by the PCP for medical reasons.<br>-She expected the diet orders to be updated in the kitchen as soon as the PCP wrote them.<br>-She was not sure why Resident #7 was ordered a ground diet, but she expected it to be followed as ordered. | D 310 | | |
| D 344 | 10A NCAC 13F .1002(a) Medication Orders<br><br>10A NCAC 13F .1002 Medication Orders<br>(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for | D 344 | | |

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medications and treatments:
(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#4) with the prescribing physician for a medication used to lower blood sugar and was to be administered at mealtime and an supplement which was to be administered sublingually (#4).

The findings are:

1. Review of Resident #4's current FL-2 dated 01/04/22 revealed diagnoses included diabetes mellitus, hypoosmolality, hyponatremia, dementia with behavioral disturbances, Alzheimer's disease, mild cognitive impairment.

a. Review of Resident #4's physician's orders signed 01/04/22 revealed there was an order for metformin (used to lower blood sugar) 1000mg twice a day with meals.

Review of Resident #4's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for metformin 1000mg twice a day with meals.

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-Metformin 1000mg was scheduled for administration at 8:00am and 8:00pm.
-There was documentation metformin was administered at 8:00pm from 02/01/22 to 02/28/22, instead of with a meal.

Review of Resident #4's March 2022 eMAR record revealed:
-There was an entry for metformin 1000mg twice a day with meals.
-Metformin 1000mg was scheduled for administration at 8:00am and 8:00pm.
-There was documentation metformin was administered at 8:00pm from 03/01/22 to 03/31/22, instead of with a meal.

Review of Resident #4's April 2022 eMAR revealed:
-There was an entry for metformin 1000mg twice a day with meals.
-Metformin 1000mg was scheduled for administration at 8:00am and 8:00pm.
-There was documentation metformin was administered at 8:00pm from 04/01/22 to 04/06/22, instead of with a meal.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 04/06/22 at 9:56am revealed:
-Metformin was used to lower blood sugar.
-Metformin should be administered with meals to decrease side effects of the medication.
-Metformin could cause abdominal discomfort when given on an empty stomach.
-A resident's blood sugar could drop more than expected if the medication was not given with food.

Telephone interview with a data entry personnel from the facility's contracted pharmacy on

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| D 344 | Continued From page 13<br><br>04/06/22 at 10:06am revealed:<br>-The pharmacy enters all orders into the eMAR.<br>-The facility staff can make changes to medication administration times.<br>-She did not know who entered the administration time of 8:00am and 8:00pm.<br><br>Interview with a medication aide (MA) on 04/06/22 at 10:52am revealed:<br>-She knew the metformin was to be administered with meals.<br>-She was aware the order read to administer with meals.<br>-She administered the 8:00am dose with breakfast.<br>-She administered metformin at 8:00pm as it was scheduled.<br>-The staff could not change the administration time without an order.<br><br>Interview with a second MA on 04/06/22 at 3:58pm revealed:<br>-He would get clarification if the order was not clear.<br>-He had not noticed that metformin was ordered with a meal.<br>-He would have called the PCP had he noticed and received clarification of time of administration.<br>-He could change the time on the eMAR once the order was clarified.<br>-The evening dose of metformin used to be scheduled at mealtime but did not recall when it was changed.<br>-Metformin popped up on the eMAR to be administered at 8:00pm and he did not notice "with meals" in the order.<br>-He knew metformin should be administered with food. | D 344 | | |

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Interview with Resident #4's Primary Care Provider (PCP) on 04/06/22 at 9:32am revealed:
-Metformin was used to lower blood sugar.
-Metformin was tolerated better when administered with meals.
-Resident #4 may have gastritis if metformin was administered without food.

Interview with Resident #4 on 04/06/22 at 11:02am revealed:
-He knew he took medication for his diabetes.
-He did not know what other medications he took.
-He did not have and had not had any abdominal discomfort.

Interview with the Special Care Coordinator (SCC) on 04/06/22 at 11:09am revealed:
-She did not know why the metformin was scheduled at 8:00pm when the order stated with meals.
-The pharmacy must have scheduled it for 8:00am and 8:00pm.
-The MAs should have notified the PCP for clarification of the times of administration of the metformin.

Refer to the interview with the Administrator on 04/07/22 at 2:47pm.

b. Review of Resident #4's physician's orders signed 01/04/22 revealed there was an order for vitamin B-12 sublingually daily.

Review of Resident #4's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for vitamin B-12 place under tongue daily.
-There was documentation that vitamin B-12 was given sublingually from 02/1/22 to 02/28/22.

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| D 344 | Continued From page 15<br><br>Review of Resident #4's March 2022 eMAR record revealed:<br>-There was an entry for vitamin B-12 place under tongue daily.<br>-There was documentation that vitamin B-12 was given sublingually from 03/1/22 to 03/31/22.<br><br>Review of Resident #4's April 2022 eMAR revealed:<br>-There was an entry for vitamin B-12 place under tongue daily.<br>-There was documentation that vitamin B-12 was given sublingually from 02/1/22 to 02/28/22.<br><br>Telephone interview with the Pharmacist from the facility's contracted pharmacy on 04/05/22 at 10:46am revealed:<br>-Vitamin B-12 was administered for B-12 deficiency.<br>-The absorption rate of vitamin B-12 would be faster if administered sublingually.<br>-The vitamin B-12 dispensed for sublingual administration could be administered orally.<br><br>Interview with Resident #4 on 04/06/22 at 11:02am revealed he did not take any medication under his tongue.<br><br>Interview with a medication aide (MA) on 04/06/22 at 10:52am revealed:<br>-She knew Resident #4's vitamin B-12 was ordered to be administered sublingually.<br>-Resident #4 refused to take the vitamin B-12 sublingually so she administered it orally.<br>-She had not asked the PCP for an order to change the route of vitamin B-12.<br>-She should have asked the PCP for an order to change the route of vitamin B-12. | D 344 | | |

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| D 344 | Continued From page 16<br><br>Interview with Resident #4's Primary Care Provider (PCP) on 04/06/22 at 9:32am revealed:<br>-He did not realize the order was written to be administered sublingually.<br>-Resident #4 should not have a problem swallowing vitamin B-12.<br>-He had not been contacted by the staff to change the vitamin B-12 order from SL to oral.<br><br>Interview with the Special Care Coordinator (SCC) on 04/06/22 at 11:09am revealed:<br>-The original order for vitamin B-12 was for daily; there was no route of administration noted.<br>-She did not know why the route of administration for the vitamin B-12 was sublingual.<br>-The MAs should have notified the PCP for clarification of route of administration of the vitamin B-12.<br><br>Refer to the interview with the Administrator on 04/07/22 at 2:47pm.<br><br>_____<br>Interview with the Administrator on 04/07/22 at 2:47pm revealed:<br>-The medications aides (MAs) should compare the medication label to the entry in the electronic medication administration record (eMAR).<br>-They should notify the Special Care Coordinator (SCC) and the pharmacy when discrepancies were noted.<br>-She expected the MAs to read the eMARs prior to administering medication. | D 344 | | |
| 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, | D 358 | | |

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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:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#5) observed during the morning medication pass including errors with the administration of medication used to treat an enlarged prostate, an iron supplement, and a medication used to treat an overactive bladder (#5); and for 3 of 5 sampled residents (#1, #3, #5) for record review including errors with a vitamin D supplement and medication used to treat migraines (#5); and a medication used to treat and prevent ulcers in the small intestine (#1); and a stool softener (#3).

The findings are:

1. The medication error rate was 11% as evidenced by the observation of 3 errors out of 27 opportunities during the 8:00am medication pass on 04/05/22.

a. Review of Resident #5's current FL-2 dated 06/24/21 revealed there were no diagnoses.

Review of Resident #5's physician's orders signed 12/28/21 revealed:
-Diagnosis included anxiety, benign prostate hypertrophy (BPH), constipation, dementia, depression, insomnia, neuropathy, tremors, and

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unsteady gait.
-There was an order which read may crush medications or open capsules and administer in apple sauce unless contraindicated.

a. Review of Resident #5's physician's orders dated 12/28/21 revealed there was an order for tamsulosin (used to treat BPH) 0.4mg daily - "Do Not Open - Do Not Crush".

Observation of the medications administered during the medication pass on 04/05/22 at 8:00am revealed:
-The medication aide (MA) popped the tamsulosin capsule from the bubble pack.
-The MA opened the capsule and poured the medication into apple sauce.
-Resident #5 was administered medications placed in apple sauce including tamsulosin.

Interview with the MA on 04/06/22 at 8:50am:
-She compared the medications with the eMAR before preparing them for administration.
-Resident #5 had an order which read may crush medications.
-She did not notice the do not open, do not crush instructions for tamsulosin.

Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for tamsulosin 0.4mg daily - "Do Not Open - Do Not Crush".
-There was documentation that tamsulosin was administered on 04/05/22 at 8:00am.

Observation of medications on hand on 04/05/22 at 8:21am revealed a bubble pack for Resident #5 of tamsulosin 0.4mg with a prescription label that read "take 1 capsule by mouth every day (Do

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| D 358 | Continued From page 19<br>not open-Do not crush).<br><br>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/05/22 at 10:46am revealed:<br>-The manufacturer recommended tamsulosin capsules not be opened for administration.<br>-She did not know the side effects of the tamsulosin capsule being opened and administered.<br><br>Interview with a second MA on 04/06/22 at 11:29am revealed:<br>-Resident #5 would ask for his medications to be crushed sometimes.<br>-She would always ask him if he wanted the medications crushed or not before preparing his medications.<br>-Resident #5 had an order to crush his medications; but there were a few that could not be crushed.<br>-If the directions stated "Do not crush" then she did not crush the medications.<br><br>Interview with the Resident Care Coordinator (RCC) on 04/06/22 at 11:33am revealed:<br>-She did not crush Resident #5's medications for administration.<br>-The MA should have read the order and noticed the instructions for tamsulosin stated, "Do not open, Do not crush".<br>-Physician orders should be followed as written.<br><br>Telephone interview with Resident #5's Primary Care Provider (PCP) on 04/06/22 at 9:32am revealed:<br>-Resident #5 was prescribed tamsulosin for an enlarged prostate.<br>-He was not sure if the tamsulosin capsule could be opened and placed in applesauce for | D 358 | | |

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administration.
-He expected the pharmacy to label the medication if the capsule could not be opened and dispensed in apple sauce.

Interview with the Registered Nurse (RN) on 04/07/22 at 2:04pm revealed:
-The MAs should be reading the prescription labels and comparing it with the eMAR.
-If the prescription stated "Do not open and Do no crush" then the MA should not open the capsule.
-She expected the MAs to administer medications as ordered.

Interview with the Administrator on 04/07/22 at 2:47pm revealed:
-She expected the MAs to follow the directives of the orders.
-She was concerned that the MAs were not following the directives of the orders.

2. Review of Resident #5's physician's orders dated 12/28/21 revealed there was an order for ferrous sulfate (used to treat anemia) 325mg daily - "Do Not Crush".

Observation of medications administered during the medication pass on 04/05/22 at 8:00am revealed:
-The medication aide popped the ferrous sulfate from the bubble pack.
-She placed the ferrous sulfate in a clear bag with 3 other pills and crushed them.
-Resident #5 was administered crushed oral medications in applesauce including ferrous sulfate.

Interview with the MA on 04/06/22 at 8:50am:
-She compared the medications with the eMAR before preparing them for administration.

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| D 358 | Continued From page 21<br>-Resident #5 had an order may crush medications.<br>-She did not notice the instructions that the ferrous sulfate tablet could not be crushed and mixed with applesauce for administration.<br><br>Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for ferrous sulfate 325mg daily - "Do Not Crush".<br>-There was documentation that ferrous sulfate 325mg was administered on 04/05/22 at 8:00am.<br><br>Observation of medications on hand on 04/05/22 at 8:21am revealed a bubble pack of ferrous sulfate 325mg with a prescription label that read "take 1 tablet by mouth every day. "Do not crush".<br><br>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/05/22 at 10:46am revealed:<br>-Ferrous sulfate was an enteric coated tablet that was not to be crushed.<br>-Ferrous sulfate could cause nausea and vomiting if administered crushed.<br>-Ferrous sulfate had an unpleasant taste when crushed.<br><br>Interview with a second MA on 04/06/22 at 11:29am revealed:<br>-Resident #5 would ask for his medications to be crushed sometimes.<br>-She would always ask him if he wanted the medications crushed or not before preparing his medications.<br>-Resident #5 had an order to crush his medications, but there were a few that could not be crushed.<br>-If the directions stated "Do not crush" then she | D 358 | | |

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| D 358 | Continued From page 22<br>did not crush the medications.<br><br>Interview with the Resident Care Coordinator (RCC) on 04/06/22 at 11:33am revealed:<br>-She did not crush Resident #5's medications for administration.<br>-The MA should have read the order and noticed that it stated, 'DO NOT CRUSH'.<br>-Physician orders should be followed as written.<br><br>Telephone interview with Resident #5's Primary Care Provider (PCP) on 04/06/22 at 9:32am revealed:<br>-Resident #5 was prescribed ferrous sulfate for iron deficiency.<br>-Ferrous sulfate was an enteric coated medication and was not to be crushed.<br>-Ferrous sulfate could cause abdominal discomfort if administered crushed.<br><br>Interview with the Registered Nurse (RN) on 04/07/22 at 2:04pm revealed:<br>-The MAs should be reading the prescription labels and comparing the labels with the eMAR.<br>-If the prescription stated "Do no crush" then the MA should not open the capsule.<br>-She expected the MAs to administer medications as ordered.<br><br>Interview with the Administrator on 04/07/22 at 2:47pm revealed:<br>-She expected the MAs to follow the directives of the orders.<br>-She was concerned that the MAs were not following the directives of the orders.<br><br>3. Review of Resident #5's physician's order dated 01/04/22 revealed there was an order for myrbetriq ER (to treat overactive bladder) 25mg daily. | D 358 | | |

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| D 358 | Continued From page 23<br><br>Observation of medications administered during the medication pass on 04/05/22 at 8:00am revealed:<br>-The medication aide (MA) popped the myrbetriq ER from the bubble pack.<br>-She placed the myrbetriq ER in a clear bag with 3 other pills and crushed them.<br>-Resident #5 was administered crushed oral medications in applesauce including myrbetriq ER.<br><br>Interview with a MA on 04/06/22 at 8:50am:<br>-She compared the medications with the eMAR before preparing them for administration.<br>-Resident #5 had an order may crush medications.<br>-She did not notice the instructions that the myrbetriq ER could not be crushed and mixed with applesauce for administration.<br><br>Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for myrbetriq ER 25mg daily - DO NOT CRUSH.<br>-There was documentation that myrbetriq was administered on 04/05/22 at 8:00am.<br><br>Observation of medications on hand on 04/05/22 at 8:21am revealed a bubble pack of myrbetriq ER 25mg with a prescription label that read "take 1 tablet by mouth every day. "Do not crush".<br><br>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/05/22 at 10:46am revealed:<br>-Myrbetriq ER was an extended release medication; an extended release medication was administered daily and the medication would be | D 358 | | |

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timed released throughout the day.
-Extended release medications should not be crushed; if crushed, all the medication would be released at once.
-Myrbetriq ER could cause abdominal discomfort or constipation if administered crushed.

Interview with Resident #5 on 04/05/22 at 4:05pm revealed:
-He did not have any abdominal pain or constipation today, 04/05/22.
-He had constipation but he took medication to help his bowels move.
-He had been constipated for five days.
-He had a bowel movement yesterday, 04/04/22.
-He got constipated frequently.

Interview with a second MA on 04/06/22 at 11:29am revealed:
-Resident #5 would ask for his medications to be crushed sometimes.
-She would always ask him if he wanted the medications crushed or not before preparing his medications.
-Resident #5 had an order to crush his medications, but there were a few that could not be crushed.
-If the directions stated "Do not crush" then she did not crush the medications.

Telephone interview with Resident #5's Power of Attorney (POA) on 04/06/22 at 8:56am revealed:
-Resident #5 did not complain of abdominal discomfort unless he was constipated.
-Resident #5 had problems with constipation for years.
-Resident #5 did not need his medications crushed.

Interview with the Resident Care Coordinator

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| MEBANE RIDGE ASSISTED LIVING | 1999 SOUTH NC HWY 119 MEBANE, NC 27302 |

| (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 |
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| D 358 | Continued From page 25<br>(RCC) on 04/06/22 at 11:33am revealed:<br>-She did not know why he had an order to crush his medications.<br>-The MA should have read the order and noticed that it stated, 'DO NOT CRUSH'.<br>-Physician orders should be followed as written.<br><br>Telephone interview with Resident #5's Primary Care Provider (PCP) on 04/06/22 at 9:32am revealed:<br>-Resident #5 was prescribed myrbetriq ER for an overactive bladder.<br>-Myrbetriq ER should not be crushed; it was an extended release medication.<br>-If Myrbetriq ER was crushed and administered, it would not be affective; it was intended to release medication for 24 hours.<br><br>Interview with the Registered Nurse (RN) on 04/07/22 at 2:04pm revealed:<br>-The MAs should be reading the prescription labels and comparing the label with the eMAR.<br>-If the prescription stated "Do not open and Do no crush" then the MA should not open the capsule.<br>-She expected the MAs to administer medications as ordered.<br><br>Interview with the Administrator on 04/07/22 at 2:47pm revealed:<br>-She expected the MAs to follow the directives of the orders.<br>-She was concerned that the MAs were not following the directives of the orders.<br><br>2. Review of Resident #5's current FL-2 dated 06/24/21 revealed there were no diagnoses.<br><br>Review of Resident #5's physician's orders dated 12/28/21 revealed diagnosis included anxiety, benign prostate hypertrophy, constipation, | D 358 | | |

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| D 358 | Continued From page 26<br>dementia, depression, insomnia, neuropathy, tremors and unsteady gait.<br><br>a. Review of Resident #5's physician's orders dated 12/28/21 revealed there was an order for topiramate 25mg (used to treat migraine headaches) twice daily.<br><br>Review of Resident #5's February 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for topiramate 25mg twice daily with a scheduled administration time of 8:00am and 8:00pm.<br>-There was documentation that topiramate was administered twice daily at 8:00am and 8:00pm from 02/01/22 to 02/28/22.<br><br>Review of Resident #5's March 2022 eMAR revealed:<br>-There was an entry for topiramate 25mg twice daily with a scheduled administration time of 8:00am and 8:00pm.<br>-There was documentation that topiramate was administered twice daily at 8:00am and 8:00pm from 03/01/22 to 03/31/22.<br><br>Review of Resident #5's April 2022 eMAR revealed:<br>-There was an entry for topiramate 25mg twice daily with a scheduled administration time of 8:00am and 8:00pm.<br>-There was documentation that topiramate was administered twice daily at 8:00am and 8:00pm from 04/01/22 to 04/04/22 and at 8:00am on 04/05/22.<br><br>Review of the Neurologist visit note for Resident #5 dated 01/24/22 revealed:<br>-Resident #5 was seen for memory loss. | D 358 | | |

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-Documented goals were to follow the Neurologist's treatment plan and follow up as scheduled; take all medications as prescribed and report any changes as necessary.
-There was documentation the Neurologist wanted to stop topiramate due to cognition.
-"Stop topiramate due to cognition" was highlighted in yellow.
-There were new concerns of depression contributing to memory loss.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/06/22 at 2:13PM revealed:
-The pharmacy had an order on file for topiramate 25mg to be administered twice a day.
-The pharmacy dispensed 56 tablets of topiramate 25mg on 01/19/22, 02/16/22 and 03/16/22.
-The pharmacy did not have an order to discontinue topiramate 25mg.
-Topiramate could cause cloudy, unclear feelings; like being in a "fog".
-Topiramate could cause a resident to take longer to 'connect the dots"; a resident could still think, and say what he wanted but it would take longer.

Observation of Resident #5's medication on hand on 04/05/22 at 8:22am revealed:
-There were two bubble packs labeled topiramate 25 mg.
-One bubble pack contained 2 tablets and the second bubble pack contained 28 tablets; the dispense date was 03/16/22.

Telephone interview with a certified medical assistant (CMA) from Resident #5's Neurologist's office on 04/06/22 at 2:46pm revealed:
-Resident #5 was seen by the Neurologist for memory loss on 01/24/22.

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-Resident #5 was taking topiramate 25mg for migraine headaches.
-The treatment plan of care was to stop the topiramate 25mg due to cognitive issues.
-The Neurologist visit note was given to Resident #5's Power of Attorney (POA) and the visit note was be taken to the facility.
-She did not know what problems Resident #5 could have if the topiramate was not discontinued.

Telephone interview with Resident #5's POA on 04/07/22 at 8:25am revealed:
-She had made the neurology appointment for Resident #5 for 01/24/22.
-Resident #5 was being seen for his memory and inability to "get his words out".
-Resident #5 had an increase in confusion for the past two years.
-The Neurologist wanted to stop his topiramate because of Resident #5's memory loss and increase in confusion.
-She took Resident #5's 01/24/22 neurology visit note to the facility; she gave the note to the receptionist.
-She always gave Resident #5's visit notes to the receptionist or the staff.

Interview with a personal care aide (PCA) on 04/07/22 at 8:54am revealed:
-Resident #5 was very sensitive and had been crying a lot for the past couple of months.
-She thought Resident #5 was declining because the resident was more forgetful and needed more assistance.
-Resident #5 used to know when it was mealtimes, but now the resident did not know when it was time to go to a meal.
-Resident #5 was requiring more assistance at meals.

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| D 358 | Continued From page 29<br>-Resident #5 used to be completely independent with meals, but now required assistance with things like cutting up his food.<br>-Resident #5's was more repetitive with questions.<br>-Resident #5's gait was slower as well.<br><br>Telephone interview with a medication aide (MA) on 04/07/22 at 9:15am revealed:<br>-Resident #5 was very emotional and cried a lot.<br>-Resident #5 had been more forgetful.<br>-Resident #5 had been getting his days and nights mixed up.<br>-Resident #5 got frustrated with himself, such as he had an incontinent episode "the other morning" and the resident got upset with himself.<br><br>Interview with a second MA on 04/07/22 at 10:16am revealed:<br>-Physician visit notes were given to the MA when a resident returned from a specialist visit.<br>-The MA would look for any orders or changes to medications on the visit notes.<br>-The Primary Care Provider (PCP) would be notified of any new orders or changes by fax or phone; if the PCP was coming to the facility the next day, the visit note would be placed in the PCP's box for review.<br>-The orders would be faxed to the pharmacy; the orders would be dated an initialed when faxed.<br>-A copy of the new order would be placed in the new order book.<br>-She did not recall seeing visit notes from Resident #5's neurologist appointment on 01/24/22.<br>-The MAs documented changes in medications on the 24-hour shift report.<br>-She did not recall seeing any changes to Resident #5's topiramate on the 24-hour shift report. | D 358 | | |

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| D 358 | Continued From page 30<br>-Resident #5's had problems with his memory.<br>-She did not recall Resident #5 having an appointment with the neurologist.<br><br>Interview with the Resident Care Coordinator (RCC) on 04/06/22 at 9:13am revealed:<br>-The physician's visit notes were given to the MAs by the family; they should be given to the RCC.<br>-The MA should fax new orders to the pharmacy and file the visit note in the resident's record.<br>-Sometimes she would not get the visit report and she would locate it in the resident's record.<br>-She had noticed a decline in Resident #5's memory and forgetfulness.<br>-Resident #5 had left the water running in his bathroom sink, the sink overflowed and there was water on the bathroom floor and on the carpet.<br>-Resident #5 would ask the same questions over and over.<br>-Resident #5 would ask if it was time for lunch as soon as he finished eating breakfast.<br>-Resident #5 could not remember that he received his shower in the evenings.<br>-She did not recall receiving a physician's visit note from the neurologist on 01/24/22.<br>-She did not know the neurologist wanted the topiramate stopped due to cognition.<br>-She did not know who highlighted "Stop topiramate due to cognition" on the visit note.<br>-She would have notified the neurologist and asked for an order to be faxed to the pharmacy to discontinue the topiramate had she seen the visit note.<br><br>Interview with Resident #5's PCP on 04/07/22 at 11:34am revealed:<br>-He did not recall Resident #5 having a neurology appointment on 01/24/22.<br>-He did not recall reviewing the neurological visit note dated 01/24/22. | D 358 | | |

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-Resident #5's neurologist managed the topiramate.
-Resident #5 received topiramate for migraine headaches.
-Topiramate could cause drowsiness and dizziness.
-He expected the staff to review the neurology visit note and notify him when new orders were written for Resident #5.

Interview with the facility's Registered Nurse (RN) on 04/07/22 at 2:04pm revealed:
-Physician visit notes should be given to the MA when the resident returned from the MD office visit.
-The MA should fax new orders to the facility's contracted pharmacy and place a copy of the order in the new order book.
-New orders should be documented on the 24-hour shift report.
-The 24-hour shift report would alert the MAs about the new orders.
-The MA should look in the new order book and review the new order.
-A copy of the visit note should be placed in the PCP binder for review.
-The PCP reviewed new orders that the Specialist had written on the visit note.
-She had not seen Resident #5's visit notes from the Neurologist dated 01/24/22 until today, 04/07/22.
-She did not know the neurologist wanted the topiramate stopped from the 01/24/22 office visit.
-She did know who highlighted "stop topiramate due to cognition" on the visit note.
-The MA should have notified the neurologist regarding his notation of stopping the topiramate.
-If the MA notified the neurologist, the communication should be documented in the progress notes.

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| D 358 | Continued From page 32<br>-She did not know why the MA or the RCC did not follow up on the "stop topiramate" order.<br>-She expected the ordering physician to be notified for clarification to see if the discontinue order was faxed to the pharmacy; if not, the MA should have requested a prescription to discontinue the topiramate to be faxed to the pharmacy.<br>-She had not received any reports that Resident #5 had an increase if forgetfulness<br>-She was concerned that topiramate was continued after the neurologist wanted it stopped.<br>-Continuation of topiramate could contribute to increased confusion.<br>-She expected the MA to review the visit note and follow through with new orders; if the MA had questions, she should have notified the ordering physician.<br><br>Interview with the Administrator on 04/07/22 at 2:47pm revealed:<br>-Resident's physician visit notes should be given to the MA upon return to the facility.<br>-The MA should review the visit notes and fax new orders to the pharmacy<br>-After review, the MA should give the visit note to the RCC for review to ensure new orders were followed.<br>-She expected the MA or RCC to notify the ordering physician for any questions regarding new orders noted on the physician's visit note.<br>-The MAs were expected to follow the PCP orders.<br>-She was concerned about Resident #5's cognitive status since the Neurologist ordered the topiramate to be discontinued on the 01/24/22 office visit.<br><br>Attempted telephone interview with the Neurologist Physician's Assistant on 04/07/22 at | D 358 | | |

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| D 358 | Continued From page 33<br>8:30am and 1:30pm and 04/08/22 at 8:30am was unsuccessful.<br><br>b. Review of Resident #5's Neurologist visit note dated 01/24/22 revealed:<br>-Resident #5 was seen for a vitamin deficiency and memory loss.<br>-Resident #5 had a vitamin D level lab drawn in the neurologist's office on 01/24/22.<br><br>Review of Resident #5's physician's orders dated 01/27/22 revealed there was an order for vitamin D2, 50,000 units one capsule weekly for 8 weeks.<br><br>Review of Resident #5's January 2022 electronic medication administration record (eMAR) revealed there was no entry for vitamin D2, 50,000 units one capsule weekly for 8 weeks and no documentation of administration.<br><br>Review of Resident #5's February 2022 eMAR revealed there was no entry for vitamin D2, 50,000 units one capsule weekly for 8 weeks and no documentation of administration.<br><br>Review of Resident #5's March 2022 eMAR revealed there was no entry for vitamin D2, 50,000 units one capsule weekly for 8 weeks and no documentation of administration.<br><br>Review of Resident #5's physician's order dated 01/24/22 revealed:<br>-An order for vitamin D2, 50,00 units one capsule weekly for 8 weeks was faxed to the facility on 01/27/22 from the neurologist.<br>-There was a stamp placed on the vitamin D2 order; the stamp read "faxed".<br>-There was a handwritten date of 01/28/22 indicating the day the order was faxed to the facility's contracted pharmacy. | D 358 | | |

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| D 358 | Continued From page 34<br><br>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/06/22 at 3:32pm revealed:<br>-She could see the vitamin D2 entry on the eMAR.<br>-The vitamin D2 was entered to start and stop on the same day.<br>-The facility staff would not see the vitamin D entry since the stop date was the same day as the start date.<br>-The stop date for vitamin D should have been entered 8 weeks from the start date.<br>-The prescription was filled and vitamin D2 was sent to the facility<br>-There were 4 capsules of Vitamin D2 dispensed on 01/28/22.<br>-There were 4 capsules of Vitamin D2 dispensed on 02/16/22.<br>-The facility should have notified the pharmacy when they received a medication for administration and there was no entry on the eMAR.<br>-The pharmacy could not send medication to the facility without an order.<br><br>Observation of Resident #5's medication on hand on 04/06/22 at 4:08pm revealed there was no vitamin D2, 50,000 units available for administration.<br><br>Review of the facility's medication delivery policy dated 07/15/20 revealed:<br>-Medications delivered to the facility were to be checked in by a community representative.<br>-The individual checking in the medications must check the contents in the pharmacy tote against the medications documented on the delivery sheet.<br>-At the time of the delivery, the community | D 358 | | |

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representative would verify the label on the medication with the order in the resident's record.
-If there was a discrepancy in the delivery and the order, the pharmacy and/or physician would be contacted for clarification.
-The external medication delivery log would be maintained.

Review of the external medication delivery log dated 01/28/22 revealed:
-Resident #5 received 4 capsules of vitamin D2, 50,000 units from the facility's contracted pharmacy.
-The packing slip of the external medication delivery was signed and dated by a medication aide (MA) on 01/29/22.

Review of the external medication delivery log dated 02/18/22 revealed:
-Resident #5 received 4 capsules of vitamin D2, 50,000 units from the facility's contracted pharmacy.
-The packing slip of the external medication delivery was not signed and dated by the facility staff receiving the medication delivery.

Review of the facility's medication disposition log dated 02/23/22 revealed Resident #5 had 4 capsules of vitamin D2, 50,000 units, returned to the facility's contracted pharmacy.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 04/07/22 at 11:03am revealed four capsules of vitamin D2 for Resident #5 were returned to the pharmacy in February 2022.

Telephone interview with Resident #5's Power of Attorney (POA) on 04/07/22 at 8:25am revealed:
-She transported Resident #5 to the Neurologist

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appointment.
-Resident #5 was being seen for a vitamin deficiency.
-Resident #5 had blood drawn to check his vitamin D level.
-She received a call from the neurologist's office and was informed that Resident #5's vitamin D level was low and that vitamin D would be ordered.
-The vitamin D order should have been faxed to the facility.
-She did not know what the vitamin D level was.
-She thought Resident #5 was being administered vitamin D.
-Resident #5's vitamin D level had not been re-checked as far as she knew.

Telephone interview with a certified medical assistant (CMA) from the Neurologist office on 04/06/22 at 2:46pm revealed:
-Resident #5 had a vitamin D2 level drawn at the neurology appointment on 01/24/22.
-Resident #5's vitamin D2 level was 9; the normal range was 30-100.
-The PA ordered vitamin D2, 50,000 units, one capsule weekly for 8 weeks.
-The order for vitamin D2 was faxed to the facility on 01/27/22.
-Resident #5 would have his vitamin D level re-checked on 06/02/22, his follow up appointment.

Interview with a MA on 04/07/22 at 10:16am revealed:
-When new orders were received, they were faxed to the pharmacy.
-The MA was responsible for faxing new orders to the pharmacy; the new order would be dated and initialed when faxed to the pharmacy.
-The pharmacy would deliver the medication the

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same night on third shift.
-The third shift MAs received medications from the pharmacy and place them on the medication cart.
-The MA documented new medications on the 24-hour shift report.
-She did not recall seeing a new order for Resident #5 for vitamin D2.
-She did not recall seeing vitamin D2 on the medication cart for administration.
-Resident #5's had problems with his memory.

Telephone interview with a second MA on 04/07/22 at 9:15am revealed:
-Medications from the pharmacy were usually delivered between midnight and 1:00am.
-The medications delivered were confirmed to make sure the medications in the tote matched the delivery list from the pharmacy.
-The medication was then scanned into the eMAR system.
-If there was no order in the eMAR for the medication the system would alert you and the order would have to be entered into the eMAR manually.
-She had never had a medication that when scanned, was not already in the eMAR.
-She did not recall vitamin D being delivered for Resident #5.

Interview with the Resident Care Coordinator (RCC) on 04/06/22 at 9:13am revealed:
-New prescriptions were faxed to the pharmacy, a copy was placed in the new order book and the original would be filed in the resident's record.
-The MAs should check the new order book for new orders at the beginning of their shift.
-If there were new orders, the MA would check to see if the medication was on the medication cart.
-If the medication was on the medication cart, the

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copy of the new order would be removed from the new order book; if the medication was not on the medication cart, the MA would check the pharmacy packing slip to verify the medication was delivered; if the medication was not delivered, the MA would call the pharmacy.
-It was the responsibility of the MA and the RCC to check the new order book for new orders.
-She did not recall seeing an order for vitamin D2 for Resident #5 in the new order book.
-The third shift MA would receive and sign for medications delivered.
-The MA should compare the packing slip with the medications.
-She did not know if the MA compared the packing slip with the medications by scanning the medication into the eMAR.
-The MA would place the medications on the correct medication cart.
-All new medications would be written down on the 24-hour shift report.
-If the medication was not on the eMAR the MA should call the pharmacy and question why the medication was not on the eMAR.
-The pharmacy would not dispense medication without an order.

Interview with the Primary Care Provider (PCP) on 04/07/22 at 11:34am revealed:
-He did not know Resident #5 had been ordered vitamin D2 by the neurologist.
-He expected the staff to notify him when new orders were written.
-He was unaware of a low vitamin D level.
-Resident #5 could have an increase in fatigue and depression due to a low vitamin D level leading to an increase in falls.
-Resident #5 would need all 8 doses of vitamin D to pull his level up to the therapeutic range.

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| D 358 | Continued From page 39<br><br>Interview with the facility's Registered Nurse (RN) on 04/06/22 at 4:16pm revealed:<br>-Medications were delivered by the pharmacy during third shift.<br>-They were received and checked in by the third shift MA.<br>-The MA would sign the medication packing list after all medications had been received and checked.<br>-The signed packing lists were kept on file in the RN's office.<br><br>Interview with the facility's RN on 04/07/22 at 2:04pm revealed:<br>-Resident #5's room was on hall A.<br>-The medication cart for hall A was audited in late February 2022 to early March 2022.<br>-The RCC was responsible for the medication cart audits.<br>-The RN would occasionally do the medication cart audits.<br>-Staff should look for expiration dates, medications are separated by routes, look at the date medications were opened, compare medications on the cart with the eMAR to ensure all medications are available for administration.<br>-If a medication was on the medication cart but was not on the eMAR, the staff should look for a discontinue order.<br>-If a discontinued order was found, the medication would be pulled and returned to the pharmacy.<br>-The staff should communicate discrepancies with their supervisor.<br>-She did not recall seeing an order for vitamin D2 for Resident #5.<br>-She did not know who faxed the vitamin D2 order to the pharmacy.<br>-The third shift MA received medications from the pharmacy. | D 358 | | |

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-The third shift MA compared medications received with the packing slip.
-If there was a discrepancy, the MA should notify the pharmacy and the RCC.
-The MA placed the new medications on the medication cart.
-New orders were placed on the 24-hour shift report so all MAs would know of the new order.
-A copy of the new order should be placed in the new order book.
-When a new medication was scanned into the eMAR, it would be accepted or rejected.
-If it was rejected there would be a beeping sound, alerting the staff there was a problem.
-The MA should call the pharmacy and notified the RCC that the medication was not accepted into the eMAR.
-If there was no entry for vitamin D on the eMAR, the system should not have accepted the medications when it was scanned into the system.
-She was unaware of Resident #5's low vitamin D level.
-A low vitamin D level could contribute to Resident #5's confusion and fatigue.
-She did not know if a vitamin D level had been drawn since 01/24/22.

Interview with the Administrator on 04/07/22 at 2:47pm revealed:
-The third shift MA received the medications from the pharmacy.
-The MA would scan the medications into the eMAR.
-Once scanned, if the medication was not excepted, she expected the MA to notify the RCC or the pharmacy.
-The MA or RCC should find out why the medication was not accepted into the system.
-She was concerned that Resident #5 did not

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receive his vitamin D as ordered.
-She expected the MAs to follow the PCP orders.

Attempted telephone interview with the Neurologist Physician's Assistant on 04/07/22 at 8:30am and 1:30 was unsuccessful.

Attempted telephone interview with the Neurologist Physician's Assistant on 04/08/22 at 8:30am was unsuccessful.

3. Review of Resident #1's current FL-2 dated 06/24/21 revealed diagnoses included mixed hyperlipidemia, dementia without behaviors, hypertension, emphysema, chronic kidney disease and congestive heart failure.

Review of a physician's order for Resident #1 dated 07/03/21 revealed there was an order for sucralfate (used to treat and prevent ulcers) 1 gram four times daily.

Review of a physician's order for Resident #1 dated 07/14/21 revealed there was on order to crush sucralfate 1g and put into water four times daily.

Review of a physician's after-visit summary for Resident #1 dated 03/07/22 revealed:
-The summary was electronically signed by Resident #1's physician.
-The list of current medication included sucralfate 1g four times daily.

Review of a physician's after-visit summary for Resident #1 dated 04/04/22 revealed:
-The summary was electronically signed by Resident #1's physician.
-The list of current medication included sucralfate 1g four times daily.

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| D 358 | Continued From page 42<br><br>Review of Resident #1's electronic medication administration records (eMARs) dated February 2022, March 2022 and April 2022 revealed there was not an entry for sucralfate 1g four times daily and no documentation of administration.<br><br>Observation of Resident #1's medication on hand on 04/05/22 at 2:56pm revealed sucralfate 1g was not available for administration.<br><br>Interview with Resident #1 on 04/06/22 at 10:54am revealed:<br>-She was not familiar with all her medications and why she took them.<br>-She had complained of abdominal pain in the past.<br><br>Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/05/22 at 3:52pm revealed:<br>-Resident #1 did not have an order on file for sucralfate 1g take four times daily.<br>-They had only been the facility's contracted pharmacy since September 2021.<br>-Resident #1 had not had an order for sucralfate since they started dispensing her medications in September 2021.<br>-Uses of sucralfate included treatment and prevention of ulcers in the intestine and stomach and abdominal discomfort.<br>-Possible outcomes of not administering sucralfate as ordered could include increased abdominal pain and discomfort due to ulcers.<br><br>Telephone interview with a certified medical assistant (CMA) from Resident #1's physician's office on 04/06/22 at 10:37am revealed:<br>-Resident #1 was ordered sucralfate by the physician after she complained of abdominal | D 358 | | |

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discomfort most likely due to medications she was ordered.
-Resident #1 had been to emergency department at the local hospital in August 2021 for abdominal pain.
-Resident #1 visited the physician on 04/04/22.
-The physician provided a list of medication to continue on the after-visit reports and he expected Resident #1 to continue with the medication that were on the list.

Interview with the medication aide (MA) on 04/06/22 at 1:58pm revealed:
-She did not remember an order for sucralfate for Resident #1.
-She did not crush any of Resident #1's medications.
-She had not complained of stomach or abdominal pain in a long time.

Interview with a second MA on 04/06/22 at 4:04pm revealed:
-He did know if Resident #1 had an order for sucralfate; he would have to reference the eMAR.
-He did not recall administering her medications in water.
-Resident #1 did not complain of stomach or abdominal pain or discomfort to him.

Interview with the Resident Care Coordinator (RCC) on 04/06/22 at 2:23pm revealed:
-She saw Resident #1's sucralfate entry on the July 2021 eMAR, but that was the last time she saw the order anywhere in the eMAR.
-She was responsible for auditing the eMAR.
-The MAs reviewed the physician's visit-summary's for changes in medication orders and then faxes them to the pharmacy.
-She and the facility's Registered Nurse (RN) review the orders from physicians' visits to ensure

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| D 358 | Continued From page 44<br>the medication orders were carried out correctly.<br><br>Interview with the facility's RN on 04/06/22 at 2:51pm revealed:<br>-The MAs were responsible for faxing any medication orders to the pharmacy.<br>-She and the RCC monitored the eMAR for accuracy.<br>-She had a form that was used by the MAs, the RCC and herself to ensure medication orders were correct.<br>-She thought Resident #1's order for sucralfate was only for fifteen days.<br>-She thought there was an order to discontinue the medication on 07/21/21.<br>-She could not find the discontinued order.<br>-Resident #1 complained of abdominal discomfort but it was usually from constipation.<br><br>Interview with the Administrator on 04/07/22 at 11:18am revealed:<br>-She was not aware Resident #1 had not received her sucralfate as ordered.<br>-The RCC and the RN should have caught the missing medication when they conducted eMAR audits.<br>-She expected medication orders from physicians to be followed as ordered.<br><br>4. Review of Resident #3's current FL-2 dated 07/14/21 revealed:<br>-Diagnoses included constipation, femur fracture, and dementia.<br>-There was an order for Miralax (used to treat constipation) 17 grams in 4-8 ounces of fluid daily.<br><br>Review of Resident #3's primary care provider's (PCP) after visit summary dated 03/24/22 revealed: | D 358 | | |

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| D 358 | Continued From page 45<br>-Resident #3 was seen by her primary care provider for chronic constipation.<br>-Resident #3 complained of recent difficulty with constipation and straining.<br>-The plan was to continue Resident #3's Miralax and other stool softeners.<br>-An additional Miralax to be used as needed in addition to the scheduled Miralax was added to Resident #3's medications.<br><br>Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for Miralax 17 grams (1 capful) in 8 ounces of liquid of choice with a scheduled administration time of 8:00am.<br>-There was documentation Miralax was administered at 8:00am from 02/01/22-02/28/22.<br>-There was an exception documented on 02/22/22 Resident #3 was out of the facility.<br><br>Review of Resident #3's March 2022 eMAR revealed:<br>-There was an entry for Miralax 17 grams (1 capful) in 8 ounces of liquid of choice with a scheduled administration time of 8:00am.<br>-There was documentation Miralax was administered at 8:00am from 03/02/01/22-03/31/22.<br>-There was a second entry for Miralax 17grams to be administered twice a day as needed (prn) for constipation.<br>-There was no documentation Miralax had been administered prn.<br><br>Review of Resident #3's April 2022 eMAR revealed:<br>-There was an entry for Miralax 17 grams (1 capful) in 8 ounces of liquid of choice with a scheduled administration time of 8:00am. | D 358 | | |

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| D 358 | Continued From page 46<br>-There was documentation Miralax was administered at 8:00am from 04/01/22-04/05/22.<br>-There was a second entry for Miralax 17grams to be administered twice a day as needed (prn) for constipation.<br>-There was no documentation Miralax had been administered prn.<br><br>Observation of Resident #3's medications on hand on 04/05/22 at 4:14pm revealed:<br>-There was a bottle of Miralax dispensed on 12/05/21.<br>-The bottle contained 510 grams of Miralax and there was documentation the bottle was opened on 12/07/21.<br>-The bottle contained multiple doses of Miralax.<br>-There was a second bottle of Miralax (238 grams) with a dispense date of 11/22/21; the bottle had not been opened.<br>-There was a third bottle of Miralax (510 grams) with a dispense date of 03/17/22; the bottle had not been opened.<br><br>Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/06/22 at 9:03am revealed:<br>-Resident #3 was dispensed a small bottle (238 grams) of Miralax on 11/22/21 that would have lasted for 14-days if administered 17 grams daily as ordered.<br>-Resident #3 was dispensed a large bottle (510 grams) of Miralax on 12/05/22 that would have lasted for 30 days if the resident was administered 17 grams daily as ordered.<br>-Resident #3 was dispensed a large bottle of Miralax on 03/17/22 with directions to administer Miralax twice daily as needed for constipation; the bottle would have lasted for 30 doses.<br><br>Telephone interview with Resident #3's PCP on | D 358 | | |

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| D 358 | Continued From page 47<br><br>04/06/22 at 9:45am revealed:<br>-Miralax was used to make stools softer and easier to pass.<br>-He was not aware Resident #3's Miralax had not been administered as ordered.<br>-He had ordered Miralax for Resident #3 due to the resident's slow bowel.<br>-Resident #3 was administered a lot of pain medication which could slow her bowels even further and it was important for the resident to be administered Miralax.<br>-The resident could experience perforation of the colon if extremely constipated.<br><br>Interview with Resident #3 on 04/06/22 at 11:50am revealed:<br>-She had a bowel movement (BM) yesterday, 04/05/22.<br>-She had to push hard, and it was painful to have the BM on 04/05/22.<br>-Before she "started taking all these pills" she had been regular, but she was not regular now.<br>-When she had to push hard to have a BM, it made her rectum area hurt.<br>-She did not know if she was administered Miralax every day.<br>-She was given water to drink in a cup every morning to take medications, but she did not know if the water contained Miralax.<br>-She had not told anyone her BM on 04/05/22 had been painful.<br><br>Interview with a medication aide (MA) on 04/06/22 at 1:54pm revealed:<br>-She administered Resident #3's Miralax every day she worked.<br>-She administered 1 capful of Miralax in a disposable cup with water.<br>-She did not know why there would still be Miralax available to be administered in a bottle that was | D 358 | | |

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| D 358 | Continued From page 48<br>opened on 12/07/21.<br>-She knew she administered Resident #3's Miralax but did not know if Resident #3 may have missed doses when she was not working.<br><br>Interview with the Resident Care Director-Assisted Living on 04/06/22 at 2:13pm revealed:<br>-Resident #3's Miralax was ordered to be administered every day.<br>-If Resident #3's bottle of Miralax was opened 12/07/21, she would expect the bottle to have been empty.<br>-She did not know if Resident #3 had refused the Miralax or if the medication had not been administered.<br>-If Resident #3 was refusing the Miralax it should have been documented.<br>-She was concerned Resident #3's Miralax had not been administered as ordered because the medication needed to be administered consistently to keep the resident's BMs regular.<br>-Resident #3 would get constipated "pretty easy" because the resident's pain medications could cause constipation.<br>-Resident #3 was seen by the PCP in March 2022 because the resident had complained of stomach pain and not feeling well.<br><br>Interview with the facility's Registered Nurse (RN) on 04/07/22 at 1:46pm revealed:<br>-She did not know how long a large bottle of Miralax would last if administered a cap full daily but would think a bottle opened in December 2022 would "be out by now."<br>-If Resident #3's Miralax was administered daily as ordered, the resident would most likely not have been constipated.<br>-She expected Resident #3's Miralax to have been administered as ordered. | D 358 | | |

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| D 358 | Continued From page 49<br><br>Interview with the Administrator on 04/07/22 at 2:49pm revealed:<br>-She expected the MAs to follow the PCP's orders as written.<br>-She was concerned Resident #3's Miralax was not administered as ordered and the resident's BMs would not be "regular."<br><br>The facility failed to ensure medications were administered as ordered for 1 resident observed during the medications pass including a resident who was administered three medications crushed in applesauce when the medications should not been crushed (#5) and 3 sampled residents for record review including a resident who did not receive their vitamin D supplement based on a lab result of 9 (normal range 30-100) which could cause increase in fatigue leading to falls and a medication that should have been discontinued but was administered, which could lead to increased confusion (#5); a resident (#1) who had been to the emergency department in August 2021 for abdominal pain and was ordered a medication to treat and prevent stomach ulcers, but was not receiving the medication; and a resident (#5) who was not administered a stool softener as ordered and who complained of constipation and discomfort with her bowel movements. The facility's failure to administer medication as ordered was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/07/22 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 22, | D 358 | | |

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|---|---|---|---|
| | HAL001159 | A. BUILDING: _____ B. WING _____ | 04/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MEBANE RIDGE ASSISTED LIVING | 1999 SOUTH NC HWY 119 MEBANE, NC 27302 |

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| D 358 | Continued From page 50<br>2022. | D 358 | | |
| D 378 | 10a NCAC 13F .1006 (b) Medication Storage<br><br>10A NCAC 13F .1006 Medication Storage<br><br>(b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure medications were under locked security related to the medication cart being left unlocked and unattended by a medication aide (MA).<br><br>The findings are:<br><br>Review of the facility's medication storage policy and procedure dated 07/15/20 revealed:<br>-The policy was to maintain and ensure the quality, efficacy, and safety of medications in accordance with state and federal guidelines.<br>-The procedure was for the community to ensure medications were stored in accordance with the following guidelines: Medication was to be stored in an orderly manner in locked cabinets, drawers, medication cards, or in a designated room.<br><br>Observation of the B hall on 04/05/22 at various times between 7:53am-8:24am revealed:<br>-The medication cart was located inside a room labeled as a storage room.<br>-The door to the storage room was open. | D 378 | | |

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| D 378 | Continued From page 51<br>-The medication cart was not locked.<br>-A drawer on the medication cart was not closed.<br>-The other drawers on the medication cart opened when pulled.<br>-At 7:57am, a resident in a wheelchair rolled himself by the storage room.<br>-At 8:00am, two staff were delivering meals to residents' rooms.<br>-There was no MA in the hallway.<br>-At 8:27am, the Maintenance Director and a personal care aide walked by the storage room where the medication cart was located.<br>-At 8:29am, a MA returned to the hallway, locked the medication cart, cut the light off to the storage room, and pulled the door closed.<br><br>Observation of a sign on the storage room at 8:29am revealed:<br>-Please be sure to keep the medication room doors shut when not in use.<br>-This was a state regulation in which that need to adhere to for the safety of the residents.<br>-Please take time to make sure they are shut upon exiting the room.<br>-The sign was signed by a previous Executive Director.<br><br>Observation of the B hall on 04/07/22 at 11:10am revealed:<br>-The medication cart was located inside a room labeled as a storage room.<br>-The door to the storage room was open.<br>-The medication cart was not locked.<br>-The drawers on the medication cart opened when pulled.<br>-There was no MA in the hallway.<br><br>Observation of the main hallway on 04/07/22 at 11:11am revealed the MA was walking toward the B hall holding a medication punch card. | D 378 | | |

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| D 378 | Continued From page 52<br><br>Interview with a medication aide (MA) on 04/07/22 at 11:26am revealed:<br>-The medication cart was supposed to be locked when she was away from the medication cart.<br>-She had left the medication cart on the B Hall on 04/07/22 to go to the nurse's office to cut a pill because they were not allowed to cut pills at the medication cart.<br>-The RCC reminded her to lock the medication cart when she returned to the B Hall.<br><br>Interview with the Resident Care Coordinator (RCC) on 04/07/22 at 11:53am revealed:<br>-The MA was supposed to make sure the medication cart was locked, and the storage room door was closed.<br>-If the MA left the medication cart, even for 2 seconds, she expected the medication cart to be locked.<br>-The medication cart was locked because it contained medications and she would not want residents to have access to the medications because a resident might take something that could be dangerous to them.<br><br>Interview with another MA on 04/07/22 at 12:13pm revealed:<br>-She knew she was supposed to lock the medication cart, close the computer screen and close the door to the storage room.<br>-She had seen the B Hall storage room open and the medication cart unlocked on 04/05/22.<br>-She did not know why the door was open and when she saw it, she wondered why the door was open.<br>-She had finished her medication count with the 3rd shift MA on 04/05/22, left the room and when she returned, she saw the door was open and the medication cart was unlocked. | D 378 | | |

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| D 378 | Continued From page 53<br>-She was not the last one to leave the room after the medication count, so she did not know what happened.<br><br>Interview with the facility's Registered Nurse (RN) on 04/07/22 at 1:46pm revealed:<br>-The medication cart should be locked at all times.<br>-She expected the MAs to lock the medication cart, close the screen to the computer for confidentiality, and close the door to the medication room.<br>-She was concerned the cart was not locked because someone could wander into the room and get medications that could be very dangerous depending on what medications they got.<br><br>Interview with the Administrator on 04/07/22 at 2:49pm revealed:<br>-The medication carts should always be locked when the MA was away from the cart.<br>-She was concerned the medication cart was unlocked because someone could have gotten into the cart, "anything could have happened." | D 378 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure residents | D912 | | |

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| D912 | Continued From page 54<br>received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration.<br><br>The findings are:<br><br>Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#5) observed during the morning medication pass including errors with the administration of medication used to treat an enlarged prostate, an iron supplement, and a medication used to treat an overactive bladder (#5); and for 3 of 5 sampled residents (#1, #3, #5) for record review including errors with a vitamin D supplement and medication used to treat migraines (#5); and a medication used to treat and prevent ulcers in the small intestine (#1); and a stool softner (#3). [Refer to Tag D 0358, 10A NCAC 13 F .1004(a) Medication Administration (Type B Violation)] | D912 | | |