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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 19, 2022 to April 21, 2022.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure therapeutic diets were served as ordered for 3 of 9 sampled residents (#1, #4, #8) with orders for a carbohydrate-controlled diet (#1), a finger food diet (#4) and a 2gram sodium diet (#8). The findings are: 1. Review of Resident #1's current FL-2 dated 02/08/22 revealed: -Diagnoses included Alzheimer's disease with late onset, major depressive disorder, diabetes mellitus type 2, essential hypertensive, osteoarthritis, vitamin B12 deficiency anemia. -There was no diet order listed under nutritional status. Review of Resident #1's physician's diet order dated 04/05/22 revealed an order for a carbohydrate-controlled diet. (A	D 310		

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carbohydrate-controlled diet offers consistent amounts of carbohydrates at meals and snacks. Foods containing sugar may be allowed when planned into the total carbohydrate allowance of the meal.)

Review of the resident diet list posted in the kitchen revealed Resident #1 was on a carbohydrate-controlled diet.

Review of the breakfast therapeutic menu for 04/20/22 revealed a carbohydrate-controlled diet consisted of 3 ounces of scrambled eggs, ½ ounce of bacon strips, 1 ounce of white toast, 1 teaspoon of margarine, 1 cup of fresh peach slices, 1 cup of corn flakes, 1 cup of milk, 6 ounces of coffee and 4 ounces of orange juice.

Observation of the breakfast meal on 04/20/22 at 8:21am revealed:
-Resident #1 was served a bowl of cereal and milk, scrambled eggs, pineapple chunks, 2 strips of bacon, 1 slice of toast with grape jelly, coffee, milk and 6-ounces of orange juice.
-Resident #1 consumed 100% of her breakfast including grape jelly on her toast and 6 ounces of orange juice.

Interview with Resident #1 on 04/20/22 at 8:45am revealed:
-She always had jelly on her toast.
-She did not know if the grape jelly was sugar-free or not.
-She always received a glass of orange juice.
-She did not know how many ounces of juice she received.
-She usually ate all her meals and drank all her orange juice.

Review of the lunch therapeutic menu for

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04/20/22 revealed a carbohydrate-controlled diet consisted of ¾ cup of chicken vegetable soup, 7-ounce breaded chicken sandwich, ½ cup of broccoli, bacon and onion salad, 2 sugar free cookies, 1 cup of low-fat milk and 6 ounces of coffee.

Observation of the lunch meal on 04/20/22 at 12:15pm revealed:
-Resident #1 was served a bowl of chicken vegetable soup, a chicken sandwich, broccoli and onion salad, 2 cookies, a glass of sugar free fruit punch, water and coffee.
-Resident #1 consumed 100% of her lunch.

Interview with Resident #1 on 04/20/22 at 12:35pm revealed:
-She received two cookies today for lunch.
-She did not know if they were sugar-free or not.

Review of the breakfast therapeutic menu for 04/21/22 revealed a carbohydrate-controlled diet consisted of 1 homemade waffle with diet syrup, 2 ounce sausage patty, 1 teaspoon of margarine, 1 cup of pineapple cubes, ¾ cup of corn flakes, 4-ounces of orange juice, 1 cup of milk and 6 ounces of coffee.

Observation of the breakfast meal on 04/21/22 at 8:13am revealed:
-Resident #1 was served a bowl of cereal and milk, a waffle with syrup, a sausage patty, scrambled eggs, peach slices, coffee, water and 6-ounces of orange juice.
-Resident #1 consumed 100% of her diet, including a waffle with syrup and 6 ounces of orange juice.

Interview with Resident #1 on 04/21/22 at 8:35am revealed:

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-The syrup was poured onto her waffles in the kitchen before being served.
-She did not know if the syrup on the waffle was sugar-free or not.
-She always received a glass of orange juice.
-She did not know how many ounces of juice she received.
-She usually ate all her meals and drank all her orange juice.

Observation of the kitchen on 04/21/22 at 8:25 revealed there was no sugar-free syrup, sugar-free jelly and sugar-free cookies available to be served to Resident #1.

Interview with the cook on 04/21/22 at 8:22am and 8:26am revealed:
-Resident #1 received grape jelly on her toast for breakfast.
-There was no sugar free grape jelly in the kitchen for residents.
-He had not requested sugar free grape jelly for the kitchen; he did not realize he needed sugar free jelly.
-Resident #1 received syrup on her waffle for breakfast on 04/21/22.
-The syrup was not sugar free.
-There was no sugar free syrup in the kitchen for residents.
-He had not requested sugar free syrup for the kitchen.
-He baked frozen sugar cookies for lunch on 04/21/22.
-He did not have any sugar free cookies to serve Resident #1.
-He did not know he needed sugar free cookies to serve to Resident #1.
-He had not requested any sugar free cookies for the kitchen.

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Interview with a Medication aide (MA) on 04/20/22 at 12:32pm revealed:
-She did not know the jelly and syrup where not sugar free.
-The MAs and PCAs would serve the juice to the residents.
-She did not know Resident #1 was to be served 4-ounces of orange juice.
-She served all residents 6-ounces of orange juice.
-She served 2 freshly baked sugar cookies to Resident #1 for lunch on 04/21/22.
-She did not know if there were any sugar free cookies available to serve Resident #1.

Review of Resident #1's February 2022 electronic medication administration record (eMAR) revealed
fingerstick blood sugar (FSBS) readings ranged from 74 to 269.

Review of Resident #1's March 2022 EMAR revealed FSBS readings ranged from 70 to 220.

Review of Resident #1's April 2022 EMAR revealed FSBS readings ranged from 78 - 217.

Interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 9:00am revealed:
-Resident #1 was on a modified diet for her diabetes.
-Resident #1 should receive sugar free products as specified on the modified diet menu.
-She expected the dietary cook to be knowledgeable and follow the modified diet as ordered.
-She was concerned that Resident #1's fingerstick blood sugars could become elevated.

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Interview with the Dietary Manager (DM) on 04/21/22 at 9:25am revealed:
-Residents on carbohydrate-controlled diets should only receive 4 ounces of orange juice at breakfast.
-Resident #1 should have received sugar free grape jelly at breakfast on 04/20/22, sugar free syrup at breakfast on 04/21/22 and sugar free cookies at lunch on 04/21/22.
-She was concerned that Resident #1's blood sugar would become elevated.
-She expected the cook to ask for sugar free items if they were not in the kitchen.

Interview with the Administrator-in- Charge on 04/21/22 at 10:58am revealed:
-The kitchen should always have sugar free products for residents on carbohydrate-controlled diets.
-If sugar-free products were not available, the cook needed to let the DM know.
-He was concerned that Resident #1's blood sugar would be elevated.

Attempted telephone interview Resident #4's PCP on 04/20/22 at 10:01 was unsuccessful.

Refer to the interview with a Medication aide (MA) on 04/20/22 at 12:32pm.

Refer to the interview with another MA on 04/21/22 at 8:22am.

Refer to the interview with the dietary cook on 04/21/22 at 8:26am.

Refer to the interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 9:00am.

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Refer to the interview with the Dietary Manager (DM) on 04/21/22 at 9:25am.

Refer to the interview with the Administrator-in-Charge on 04/21/22 at 10:58am.

2. Review of Resident #4's current FL-2 dated 09/27/21 revealed:
-Diagnoses included vascular dementia, fractured femur, difficulty walking, constipation, chronic pharyngitis, dysphagia, hyperlipidemia, vitamin deficiency, heart disease and age-related osteoporosis.
-There was an order for mechanical soft diet.

Review of Resident #4's physician's diet order dated 03/25/22 revealed a diet order for texture modified diet.

Review of Resident #4's physician's order dated 04/19/22 revealed a diet order for finger foods.

Review of Resident #4's physician's order dated 04/20/22 revealed a diet order for texture modified diet (A texture modified diet is when foods are softened to make it easier and safer to eat) with soft sandwiches like grilled cheese and peanut butter and jelly sandwiches.

Review of the resident diet list posted in the kitchen revealed Resident #4 was on a finger food diet.

Review of the breakfast modified menu for 04/20/22 revealed a finger food diet consisted of 3 ounces of scrambled eggs served as a sandwich cut into fourths, ½ ounce of bacon strips, 1 ounce of white toast, 1 teaspoon of margarine, 1 cup of fresh peach slices cut into 2 inch pieces, ½ cup of oatmeal thin with milk and

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served in a mug, 1 cup of milk, 6 ounces of coffee and 6 ounces of orange juice.

Observation of the finger food diet served at the breakfast meal on 04/20/22 at 8:10am revealed:
-Resident #4 was served a bowl of oatmeal with grape jelly, a boiled egg cut in half, 2 strips of bacon, a whole banana cut in 5 pieces, toast with grape jelly cut in half and orange juice.
-Resident #4 was served a bowl of oatmeal which should have been served in a mug.
-Resident #4 attempted to eat the strips of bacon; he would bite and chew the bacon then spit it out on his plate; he was unable to chew the bacon.

Review of the lunch modified menu for 04/20/22 revealed a finger food diet consisted of ¾ cup of chicken vegetable soup with chunks of meat and vegetable must be ½ inch or less in size and served in a mug, 7-ounce breaded chicken sandwich cut in fourths, ½ cup of broccoli, tomato and mushrooms plated, 2 sugar cookies, ½ cup of mandarin oranges drained well, 1 cup of low-fat milk and 6 ounces of coffee.

Observation of the finger food diet served at the lunch meal on 04/20/22 at 12:15pm revealed:
-Resident #4 was served a chicken sandwich, broccoli and onion salad, potato chips, sugar cookies and fruit punch.
-Resident #4's chicken sandwich was cut in half; not in our fourths as indicated on the modified diet sheet.
-Resident #4 consumed about 1/3 of the chicken sandwich.
-Resident #4 had difficulty chewing the chicken sandwich.
-He asked for a grilled cheese sandwich.
-He received a grilled cheese sandwich cut in half.

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-Resident #4's broccoli and onion salad were served in a mayonnaise-based dressing.
-Resident #4 did not eat the broccoli and onion salad.
-Resident #4 did not receive tomatoes, broccoli and mushrooms or chicken vegetable soup.

Interview with a personal care assistant (PCA) on 04/20/22 at 12:30pm revealed:
-She removed Resident #4's plate because he could not chew the chicken sandwich and he would not eat the broccoli and onion salad.
-She was going to get him a grilled cheese sandwich at his request.

Interview with the medication aide (MA) on 04/20/22 at 10:45am revealed:
-The hospice nurse had suggested a finger food diet because he was having difficulty using utensils.
-The facility received an order from Resident #4's Primary Care Provider (PCP) for finger foods yesterday afternoon, 04/20/22.
-She did not realize that Resident #4 had oatmeal with grape jelly and ate with a spoon this morning, 04/20/22, for breakfast.

Interview with the dietary cook on 04/21/22 at 8:35am revealed:
-Resident #4's diet order had change daily for the past 2 days.
-He was served a bowl of oatmeal this morning to be eaten with a spoon.
-He did not know Resident #4's oatmeal should have been served in a mug.

Telephone interview with the Registered Nurse (RN) from Hospice on 04/20/22 at 9:25am revealed:
-She saw Resident #4 weekly and more often

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when needed.
-Resident #4 was ordered a texture modified diet in March 2022.
-She had conversations with facility staff on 04/05/22 and 04/14/22 regarding a change in diet for Resident #4.
-She observed Resident #4 at a mealtime on 04/14/22; he was noted to have a tremor of his hand, making it difficult for him to use silverware.
-The facility requested a finger food diet for Resident #4 because he was not eating well.
-The PCP signed the new order for finger food diet on 04/19/22.

Interview with the same MA on 04/20/22 at 12:32pm revealed:
-Resident #4 was on a ground diet and was changed to finger foods yesterday, 04/19/22.
-Resident #4 did not chew his food well.
-Resident #4 asked for oatmeal this morning for breakfast.
-She knew it was not a finger food but since he asked for the oatmeal, she gave it to him.
-Resident #4 ate his oatmeal with a spoon; he consumed 100% of his oatmeal.
-She did not follow the menu for a finger food diet.
-She should have placed the oatmeal in a cup as directed on the modified menu.

Interview with the Health and Wellness Coordinator (HWC) on 04/20/22 at 10:53am revealed:
-She observed a meal about once a week.
-The staff reported that Resident #4 had problems using utensils.
-The facility received an order yesterday, 04/19/22, to change Resident #4 from a texture modified diet to a finger food diet.
-She did not observe Resident #4 at breakfast

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this morning, 04/20/22.
-She did not know that Resident #4 had difficulty chewing his bacon at breakfast this morning, 04/20/22.
-She would observe Resident #4 at lunch on 04/20/22 to see if his diet needed to be changed again.

Interview with the HWC on 04/21/22 at 9:00am revealed:
-She observed Resident #4 at lunch on 04/20/22.
-Resident #4 had difficulty with his chicken sandwich and his broccoli.
-She had notified the RN at Hospice to discuss Resident #4's diet.
-The facility received a new order to return to texture modification diet with soft sandwiches such as peanut butter and jelly and grilled cheese.
-She was concerned that Resident #4 could choke if he was not served the diet ordered by the PCP.

Interview with the Administrator-in- Charge on 04/21/22 at 10:58am revealed:
-The cook should prepare the plate based on the modified diet menu.
-He was concerned that Resident #4 may lose weight if he was unable to eat the food that was served him.

Attempted telephone interview Resident #4's PCP on 04/20/22 at 10:01 was unsuccessful.

Refer to the interview with a Medication aide (MA) on 04/20/22 at 12:32pm.

Refer to the interview with another MA on 04/21/22 at 8:22am.

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D 310	Continued From page 11 Refer to the interview with the dietary cook on 04/21/22 at 8:26am. Refer to the interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 9:00am. Refer to the interview with the Dietary Manager (DM) on 04/21/22 at 9:25am. Refer to the interview with the Administrator-in-Charge on 04/21/22 at 10:58am. 3. Review of Resident #8's current FL-2 dated 02/15/22 revealed diagnoses included dementia, hypertension, and atrial fibrillation. Review of Resident #8's facility's diet order form dated 03/01/22 revealed she was ordered a 2gram sodium diet. Review of the diet list posted in the kitchen dated 03/11/22 revealed Resident #8's diet was listed as a 2gram sodium diet. Observation of the lunch meal service on 04/20/22 at 12:00pm revealed: -Resident #8 was served chicken vegetable soup with saltine crackers, and a breaded chicken breast on a bun. -Resident #8 ate 100 percent of her meal. Review of the facility's diet menu for the lunch meal on 04/20/22 revealed: -The 2gram sodium diet included a 6-ounce low sodium breaded chicken breast. -The chicken vegetable soup was listed as omitted; not to be served to residents who were ordered the 2gram sodium diet.	D 310		

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Observation of the breakfast meal service on 04/21/22 at 8:21am revealed:
-Resident #8 was served scrambled eggs, a waffle, syrup, and a sausage patty.
-Resident #8 ate 100 percent of her meal.

Review of the facility's diet menu for the breakfast meal for 04/21/22 revealed:
-The 2gram sodium diet included a low sodium waffle, a beef patty.
-Eggs were not listed as a menu item on the low sodium diet menu.

Observation of the kitchen storage areas on 04/20/22 at 11:30am revealed there were no low sodium items available for service to the residents.

Interview with a personal care aide (PCA) on 04/20/22 at 12:06pm revealed:
-She crumbled up a two pack of saltine crackers and put them into Resident #8's soup.
-She thought Resident #8 was on a regular diet, so she served her what was on the regular menu.

Interview with a medication aide (MA) on 04/21/22 at 8:45am revealed:
-Resident #8 was ordered a regular diet.
-She considered a 2gram sodium diet a regular diet with just less salt.
-She told the cook to plate a low sodium diet for Resident #8, but she was served what the residents on a regular diet were served.

Interview with the cook on 04/21/22 at 8:35am revealed:
-He was not familiar with a 2gram sodium diet; he thought the 2gram sodium was served the same menu as a regular diet.
-He did not know if any of there were any low

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sodium foods available for service.

Interview with the Dietary Manager (DM) on 04/20/22 at 11:35am revealed:
-There were no low sodium items available for service to residents who were ordered a 2gram sodium diet.
-She did not know of any residents who were ordered a 2gram sodium diet.

Interview with the Dietary Manager (DM) on 04/21/22 at 9:34am revealed:
-She did the food orders for the kitchen the week before.
-She did not order any low sodium items for service.
-She did not know she needed to order any low sodium items.
-It was brought to her attention the day before, 04/20/22 that there were residents who were ordered 2gram sodium diets.

Attempted telephone interview with Resident #8's primary care provider (PCP) on 04/20/22 at 4:27pm was unsuccessful.

Refer to the interview with a Medication aide (MA) on 04/20/22 at 12:32pm.

Refer to the interview with another MA on 04/21/22 at 8:22am.

Refer to the interview with the dietary cook on 04/21/22 at 8:26am.

Refer to the interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 9:00am.

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D 310	Continued From page 14 Refer to the interview with the Dietary Manager (DM) on 04/21/22 at 9:25am. Refer to the interview with the Administrator-in-Charge on 04/21/22 at 10:58am. Based on observations, record reviews and interviews it was determined Resident #8 was not interviewable. _____ Interview with a Medication aide (MA) on 04/20/22 at 12:32pm revealed: -The MAs assisted with plating the meals and serving the meals. -She did not refer to a therapeutic diet menu when assisting the cook with plating the meals. -She knew which residents were on therapeutic diets, and she would tell the cook what type of diet to prepare. Interview with another MA on 04/21/22 at 8:22am revealed: -The meal plates were plated in the kitchen by the cook and a MA; another MA served the plates. -She knew which residents were on modified diets without looking at the modified diet list. Interview with the dietary cook on 04/21/22 at 8:26am revealed: -He and a MA would work together to plate the food at each meal. -The MAs would request the plates by diet name, not by resident name. -He did not refer to the therapeutic menu when serving. -He depended on the MAs to tell him what could and could not go on the plates for residents with therapeutic diets Interview with the Health and Wellness	D 310		

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D 310	Continued From page 15 Coordinator (HWC) on 04/21/22 at 9:00am revealed: -The cook should be aware of new diet orders -The cook should be plating the food for each meal; the MA should deliver the plates to the residents. -She expected the diet ordered to be followed and served at each meal. Interview with the Dietary Manager (DM) on 04/21/22 at 9:25am revealed: -The MAs referred to the colored-coded diet chart to see what type of diet each resident was ordered. -The MAs would tell the cook if the resident was on a modified diet. -The cook plated the meal based on the modified diet the MA told him. -The cook should be referring to the modified diet menu when plating a modified diet meal. -She did not know if the cook referred to the modified diet menu when plating the residents' meal. -She expected the cook to follow the modified diet menu at each meal for each modified diet. Interview with the Administrator-in-Charge on 04/21/22 at 10:58am revealed: -He was not familiar with the different type of modified diets that were offered. -The cook was responsible for plating the meals; the MAs were responsible for serving the meals. -The cook and the MAs should have access to the modified diet menu when plating the meals. -The dietary staff was expected to serve modified diets as written on the modified diet menu. -He was ultimately responsible for the modified diets to be served as ordered.	D 310		

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#4 and #10) observed during the 8:00am medication pass, including errors with two pain medications, a multivitamin, a decongestant (#4), and a nasal spray (#10). The findings are: 1. The medication error rate was 21% as evidenced by the observation of 6 errors out of 28 opportunities during the 8:00am medication pass on 04/19/22. a. Review of Resident #4's current FL-2 dated 09/27/21 revealed: -Diagnoses included vascular dementia, fracture of the femur, difficulty walking, constipation, chronic pharyngitis, dysphagia, hyperlipidemia, vitamin deficiency, heart disease and age-related osteoporosis. -There was no order to crush medication. 1. Review of Resident #4's current FL-2 revealed there was an order for Tylenol (used for pain)	D 358		

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325mg 2 tablets four times a day.

Observation during the medication pass on 04/19/22 at 8:00am revealed:
-The medication aide (MA) prepared 5 pills for administration to Resident #4.
-The MA prepared 2 Tylenol tablets for administration to Resident #4.
-The MA placed the Tylenol in a clear, small bag with 3 other pills and crushed them.
-The MA placed the crushed medication in 2 teaspoonfuls of yogurt and administered to Resident #4.

Interview with the MA on 04/19/22 at 12:08pm revealed:
-She crushed Resident #4's Tylenol the morning of 04/19/22 during the 8:00am medication pass and placed in yogurt for administration.
-She administered the crushed medication to Resident #4 in yogurt.
-She had been crushing Resident #4's medications for months.
-Resident #4 would not swallow his pills; he would spit them out.
-She thought Resident #4 had an order for crushed medications.

Review of Resident #4's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Tylenol 325mg 2 tablets four times a day to be administered at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation that Tylenol was administered on 04/19/22 at 8:00am.

Observation of medications on hand on 04/19/22 at 8:21am revealed a bottle of Tylenol 325mg with a prescription label that read "take 2 tablets every

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day."

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/20/22 at 11:26am revealed:
-Resident #4 had an order for Tylenol 325mg 2 tablets four times a day dated 09/30/21.
-Tylenol was used to treat chronic pain.
-Tylenol may be crushed if ordered.

Telephone interview with the Registered Nurse (RN) from Hospice on 04/20/22 at 9:25am revealed:
-She saw Resident #4 weekly and more often when needed.
-Resident #4 did not have a "may crush medications" order.
-She received a call yesterday, 04/19/22, regarding an order to crush medications.
-The was the first request for an order to crush medications.
-They requested the order to crush medications because Resident #4 tried to chew his pills.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

Attempted telephone interview Resident #4's PCP on 04/20/22 at 10:01 was unsuccessful.

Refer to the interview with the Resident Care Coordinator (RCC) on 04/21/22 at 8:04am.

Refer to the interview with the Administrator-in-Charge (AIC) on 04/21/22 at 8:57am.

2. Review of Resident #4's current FL-2 dated 09/27/21 revealed there was an order for Mucinex

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(used for a cough and congestion) 600mg 2 tablets twice a day.

Observation during the medication pass on 04/05/22 at 8:00am revealed:
-The medication aide (MA) prepared 5 pills for administration to Resident #4.
-The MA prepared 1 Mucinex 600mg for administration to Resident #4.
-The MA placed the Mucinex in a clear, small bag with 4 other pills and crushed them.
-The MA placed the crushed medication in two teaspoonfuls of yogurt and administered to Resident #4.

Interview with the MA on 04/19/22 at 12:08pm revealed:
-She only administered 1 Mucinex the morning of 04/19/22 during the 8:00am medication pass.
-She usually administered 2 Mucinex.
-She did not know why she only administered one Mucinex; she was nervous because she was being observed during the medication administration pass.
-She crushed the Mucinex the morning of 04/19/22 during the 8:00am medication pass and placed in yogurt for administration.
-She administered the crushed Mucinex in yogurt to Resident #4.
-She had been crushing Resident #4's medications for months.
-She thought Resident #4 had an order for crushed medications.
-She did not notice that the prescription label read "Do Not Crush."
-Resident #4 would not swallow his pills; he would spit them out.

Review of Resident #4's April 2022 electronic medication administration record (eMAR)

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revealed:
-There was an entry for Mucinex 600mg 2 tablets twice a day to be administered at 8:00am and 8:00pm.
-There was documentation that Mucinex was administered on 04/19/22 at 8:00am.

Observation of medications on hand on 04/19/22 at 8:21am revealed a bubble pack of Mucinex 600mg with a prescription label that read "take 2 tablets (1200mg) twice a day" (do not crush).

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/20/22 at 11:26am revealed:
-Resident #4 had an order for Mucinex 600mg 2 tablets twice a day, do not crush, dated 09/30/21.
-Mucinex was used to treat cough and congestion.
-Mucinex was an extended release medication and could not be crushed.
-If the medication was crushed it would be released at the same time instead over the 24-hour period and could cause abdominal discomfort.

Telephone interview with the Registered Nurse (RN) from Hospice on 04/20/22 at 9:25am revealed:
-She saw Resident #4 weekly and more often when needed.
-Resident #4 did not have a "may crush medications" order.
-She received a call yesterday, 04/19/22, regarding an order to crush medications.
-The was the first request for an order to crush medications.
-They requested the order to crush medications because Resident #4 tried to chew his pills.

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D 358	Continued From page 21 Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Attempted telephone interview Resident #4's PCP on 04/20/22 at 10:01 was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 04/21/22 at 8:04am. Refer to the interview with the Administrator-in-Charge (AIC) on 04/21/22 at 8:57am. 3. Review of Resident #4's current FL-2 dated 09/27/21 revealed there was an order for a multivitamin (used as a supplement) daily. Observation during the medication pass on 04/05/22 at 8:00am revealed: -The medication aide (MA) prepared 5 pills for administration to Resident #4. -The MA prepared 1 multivitamin for administration to Resident #4. -The MA placed the multivitamin in a clear, small bag with 4 other pills and crushed them. -The MA placed the crushed medication in 2 teaspoonfuls of yogurt and administered to Resident #4. Interview with the MA on 04/19/22 at 11:26am revealed: -She crushed Resident #4's multivitamin the morning of 04/19/22 during the 8:00am medication pass and placed in yogurt for administration. -She administered the crushed multivitamin in yogurt to Resident #4. -She had been crushing Resident #4's medications for months.	D 358		

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D 358	Continued From page 22 -She thought Resident #4 had an order for crushed medications. -Resident #4 would not swallow his pills; he would spit them out. Review of Resident #4's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for a multivitamin daily to be administered at 8:00am. -There was documentation that a multivitamin was administered on 04/19/22 at 8:00am. Observation of medications on hand on 04/19/22 at 8:21am revealed a bubble pack of multivitamins with a prescription label that read "take 1 tablet by mouth every day." Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/20/22 at 11:26am revealed: -Resident #4 had an order for a multivitamin daily dated 09/30/21. -Multivitamin was used as a supplement. -Multivitamin may be crushed if ordered. Telephone interview with the Registered Nurse (RN) from Hospice on 04/20/22 at 9:25am revealed: -She saw Resident #4 weekly and more often when needed. -Resident #4 did not have a "may crush medications" order. -She received a call yesterday, 04/19/22, regarding an order to crush medications. -The was the first request for an order to crush medications. -They requested the order to crush medications because Resident #4 tried to chew his pills.	D 358		

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D 358	Continued From page 23 Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Attempted telephone interview Resident #4's PCP on 04/20/22 at 10:01 was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 04/21/22 at 8:04am. Refer to the interview with the Administrator-in-Charge (AIC) on 04/21/22 at 8:57am. 4. Review of Resident #4 physician's orders dated 03/24/22 revealed an order for tramadol (used for moderate to severe pain) 50mg one-half tablet twice a day. Observation during the medication pass on 04/05/22 at 8:00am revealed: -The medication aide (MA) prepared 5 pills for administration to Resident #4. -The MA prepared tramadol 1/2 tablet for administration to Resident #4. -The MA placed the tramadol in a clear, small bag with 4 other pills and crushed them. -The MA placed the crushed medication in 2 teaspoonfuls of yogurt and administered to Resident #4. Interview with the MA on 04/19/22 at 11:26am revealed: -She crushed Resident #4's tramadol the morning of 04/19/22 during the 8:00am medication pass and placed in yogurt for administration. -She administered the crushed tramadol in yogurt to Resident #4. -She had been crushing Resident #4's medications for months.	D 358		

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-Resident #4 would not swallow his pills; he would spit them out.
-She thought Resident #4 had an order for crushed medications.

Review of Resident #4's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for tramadol 50mg one-half tablet twice a day to be administered at 8:00am and 8:00pm.
-There was documentation that tramadol was administered on 04/19/22 at 8:00am.

Observation of medications on hand on 04/19/22 at 9:28am revealed a bubble pack of tramadol 50mg with a prescription label that read "take ½ tablet every day."

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/20/22 at 11:26am revealed:
-Resident #4 had an order for tramadol 50mg ½ tablet twice a day dated 03/24/22.
-Tramadol was used to treat pain.
-Tramadol may be crushed if ordered.

Telephone interview with the Registered Nurse (RN) from Hospice on 04/20/22 at 9:25am revealed:
-She saw Resident #4 weekly and more often when needed.
-Resident #4 did not have a "may crush medications" order.
-She received a call yesterday, 04/19/22, regarding an order to crush medications.
-The was the first request for an order to crush medications.
-They requested the order to crush medications because Resident #4 tried to chew his pills.

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D 358	Continued From page 25 Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Attempted telephone interview Resident #4's PCP on 04/20/22 at 10:01 was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 04/21/22 at 8:04am. Refer to the interview with the Administrator-in-Charge (AIC) on 04/21/22 at 8:57am. b. Review of Resident #10's current FL-2 dated 04/19/22 revealed: -Diagnoses included asthma, essential hypertension, Alzheimer's disease with late onset, hyperlipidemia, gastro-esophageal reflux disease without esophagitis, osteoarthritis, and other seizures. -Flonase suspension 50mcg/act (used to relieve seasonal allergies and non-allergic nasal symptoms) 1 spray both nostrils twice daily for allergy. Observation of the morning medication pass on 04/19/22 at 9:40am revealed: -The MA prepared the oral medications first and then retrieved Resident #10's Flonase suspension and a inhaler from plastic bags with pharmacy labels. -She carried the medications to Resident #10's room and administered the oral medication first. -She then administered the inhaler and the last medication administered was Flonase. -The resident was provided with verbal cues when pressing the actuator for the Flonase. -The residents administered two sprays into each nostril and the MA told the resident how many to	D 358		

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administer per nostril.

Interview with the MA on 04/19/22 at 9:43am revealed:
-Resident #10 always had two sprays of Flonase administered into each nostril.
-She read the label attached to Resident #10's bottle of Flonase and saw that it instructed for one spray per nostril.
-She did not work often as the MA for Resident #10's hallway.
-She was not as familiar with Resident #10's medications as the residents on another hallway.
-She did not know Resident #10's Flonase was ordered for one spray per nostril.

Review of Resident #10's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Flonase suspension 50mcg/act one spray in both nostrils twice daily for allergy congestion, scheduled for 9:00am and 9:00pm.
-There was documentation of administration of Flonase from 04/01/22 to 04/18/22 at 9:00am and 9:00pm and on 04/19/22 at 9:00am.

Review of Resident #10's Flonase bottle revealed there was a label attached with instructions to administer one spray in each nostril twice daily.

Interview with Resident #10 on 04/20/22 at 10:55am revealed:
-He used Flonase for allergies, and it worked well for him.
-He always sprayed two sprays per nostril and took two puffs of his inhaler.
-He thought his physician ordered two sprays of Flonase per nostril.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001028	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BURLINGTON	3619 SOUTH MEBANE STREET BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 27 Interview with a representative at Resident #10's physician's office on 04/20/22 at 11:05am revealed: -Resident #10 had an order for Flonase suspension 50 mcg/act one spray per nostril. -Resident #10 began seeing the physician on 12/2021 and there was documentation that Flonase was used to control his asthma. -His Flonase was already on his medication list. -The last visit Resident #10 had with the physician was on 03/15/22. Refer to the interview with the Resident Care Coordinator (RCC) on 04/21/22 at 8:04am. Refer to the interview with the Administrator-in-Charge (AIC) on 04/21/22 at 8:57am. _____ Interview with the Resident Care Coordinator (RCC) on 04/21/22 at 8:04am revealed: -The MA told her about the medication error made during the medication pass on 04/19/22. -An incident report was completed and Resident #10's family member and physician were notified. -She expected the MAs to read the eMAR and check the medication prior to administering medications. -She held the MAs responsible for administering medications accurately. Interview with the Administrator-in-Charge (AIC) on 04/21/22 at 8:57am revealed: -He expected the MAs to follow the seven medication rights (right resident, right medication, right dose, right route, right time, right documentation and right reason). -He expected the MAs to stay focused during medication passes.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001028	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BURLINGTON	3619 SOUTH MEBANE STREET BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 28 -He was made aware of the medication error that occurred with Resident #10 during the morning medication pass on 04/19/22. -He held himself the RCC, and the MA responsible for administering medications accurately.	D 358		