STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and a complaint investigation survey from February 14 - 15, 2023. The complaint investigation was initiated by the Wake County Department of Social Services on February 2, 2023.	D 000		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure quarterly pharmacy reviews with recommendations were completed by following up with the primary care provider (PCP) for 2 of 5 sampled residents (#2 and #3) for the past 3 quarters. The findings are: 1. Review of Resident #3's current FL-2 dated 11/14/22 revealed: -Diagnoses included depression and dementia. -There was an order for Rosuvastatin (used to treat high cholesterol) 20 mg to be administered every day in the morning. Review of Resident #3's Resident Register revealed an admission date of 10/21/21.	D 406		

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D 406	Continued From page 1 Review of Resident #3's December 2022 electronic Medication Administration Record (eMAR) revealed: -There were electronic entries for Rosuvastatin 20 mg to be administered once daily at 9:00am. -There was documentation that the Rosuvastatin 20 mg was administered daily at 9:00am. Review of Resident #3's January 2023 eMAR revealed: -There were electronic entries for Rosuvastatin 20 mg to be administered once daily at 9:00am. -There was documentation that the Rosuvastatin 20 mg was administered daily at 9:00am. Review of Resident #3's February 2023 eMAR revealed: -There were electronic entries for Rosuvastatin 20 mg to be administered once daily at 9:00am. -There was documentation that the Rosuvastatin 20 mg was administered daily at 9:00am. Review of Resident #3's pharmacy reviews revealed: -The last pharmacy review was completed on 01/10/23 by a pharmacist with a consulting pharmacy provider. -The previous pharmacy review was completed on 10/19/22 by a pharmacist with a consulting pharmacy provider. -The prior pharmacy review was completed on 08/24/22 by a pharmacist with a consulting pharmacy provider. -On all these dates of 08/24/22, 10/19/22 and 01/10/23, the recommendations were to ensure the primary care provider (PCP) was aware the Rosuvastatin 20 mg was being given in the morning when the best effects for the medication was when it was given before bedtime.	D 406		

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Interview with the facility's contracted pharmacist on 02/15/23 at 9:42am revealed:
-The body's normal release of cholesterol happened at nighttime.
-The resident's Rosuvastatin was recommended to be administered a night to treat the resident's high cholesterol more effectively.
-If the resident's cholesterol was not treated effectively, the resident was at risk for heart attacks and strokes.

Interview with Resident #2's primary care provider (PCP) on 02/15/23 at 12:25pm revealed she was not aware of the pharmacy recommendations to change the administration time of the Rosuvastatin to the evening.

Refer to interview with the facility's contracted pharmacist on 02/15/23 at 9:42am.

Refer to interview with the Special Care Coordinator (SCC) on 02/15/23 at 8:49am.

Refer to interview with the Resident Care Director (RCD) on 02/15/23 at 8:53am.

Refer to interview with the RCD on 02/15/23 at 11:16am.

Refer to interview with the Executive Director (ED) on 02/15/23 at 10:40am.

Refer to second interview with the ED on 02/15/23 at 10:48am.

Refer to third interview with the ED on 02/15/23 at 11:54am.

Refer to interview with the facility's contracted primary care provider (PCP) on 02/15/23 at

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D 406	Continued From page 3 12:25pm. 2. Review of Resident #2's current FL-2 dated 03/23/22 revealed: -Diagnoses included history of a cardiovascular accident with residual deficit, weakness in her legs, neuropathy in both feet, frequent falls, and arthritis in both knees. -The resident was semi-ambulatory and used a walker and cane to ambulate. -There was a handwritten note to see attached visit note dated 03/23/22. -There was not a visit note attached to the FL-2 dated 03/23/22. a. Review of Resident #2's physician orders dated 09/26/22 revealed: -There was an order for Gabapentin (used to treat nerve pain) 100mg, take one capsule every night before bed. -There was an order to crush medications and administer in applesauce if needed. Review of Resident #3's pharmacy review dated 07/11/22 revealed there was a recommendation to add "do not crush" to the Gabapentin. Review of Resident #3's pharmacy review dated 10/19/22 revealed there was a recommendation to add "do not crush" to the Gabapentin. Review of Resident #3's pharmacy review dated 01/10/23 revealed there was a recommendation to add "do not crush" to the Gabapentin. Review of Resident #2's December 2022, January 2023, and February 2023 electronic medication administration records (eMARs) revealed: -There was an entry for Gabapentin 100mg, take	D 406		

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one capsule at bedtime.
-The Gabapentin was documented as administered daily at bedtime.
-There was an entry to crush medications and administer in applesauce if needed.
-There were no documentation medications had been crushed.
-There was no documentation to not crush the Gabapentin capsules.

Interview with Resident #2 on 02/15/23 at 1:00pm revealed she did not have trouble swallowing her medications and the facility had never administered medications to her crushed.

Interview with the facility's contracted pharmacist on 02/15/23 at 9:42am revealed:
-It was important for staff who were administering Gabapentin to know that the medication should not be crushed because capsules released the medication in the body evenly over time.
-If the Gabapentin capsules were to be crushed the resident would not receive the proper dose causing all the medication to be release at once, to not work properly, and could cause side effects that included dizziness, drowsiness, and an increased risk of falls.

Interview with Resident #2's primary care provider (PCP) on 02/15/23 at 12:25pm revealed:
-She agreed with the pharmacist's recommendation and reasoning to not crush the Gabapentin due to the medication being time released.
-She was not made aware of the quarterly recommendations to add a "do not crush" to the Gabapentin or crush order.

Refer to interview with the facility's contracted pharmacist on 02/15/23 at 9:42am.

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D 406	Continued From page 5 Refer to interview with the Special Care Coordinator (SCC) on 02/15/23 at 8:49am. Refer to interview with the Resident Care Director (RCD) on 02/15/23 at 8:53am. Refer to interview with the RCD on 02/15/23 at 11:16am. Refer to interview with the Executive Director (ED) on 02/15/23 at 10:40am. Refer to second interview with the ED on 02/15/23 at 10:48am. Refer to third interview with the ED on 02/15/23 at 11:54am. Refer to interview with the facility's contracted primary care provider (PCP) on 02/15/23 at 12:25pm. b. Review of Resident #2's physician orders dated 09/26/22 revealed: -There was an order for Vitamin D 125mcg, take capsules once daily. -There was an order to crush medications and administer in applesauce if needed. Review of Resident #3's pharmacy review dated 07/11/22 revealed there was a recommendation to add "do not crush" to the Vitamin D. Review of Resident #3's pharmacy review dated 10/19/22 revealed there was a recommendation to add "do not crush" to the Vitamin D. Review of Resident #3's pharmacy review dated 01/10/23 revealed there was a recommendation	D 406		

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to add "do not crush" to the Vitamin D.

Review of Resident #2's December 2022, January 2023, and February 2023 electronic medication administration records (eMARs) revealed:
-There was an entry for Vitamin D 125 mg, take 2 capsules once daily.
-The Vitamin D was documented as administered daily.
-There was an entry to crush medications and administer in applesauce if needed.
-There were no documentation medications had been crushed.
-There was no documentation to not crush the Vitamin D capsules.

Interview with Resident #2 on 02/15/23 at 1:00pm revealed she did not have trouble swallowing her medications and the facility had never administered her medications to her crushed.

Interview with the facility's contracted pharmacist on 02/15/23 at 9:42am revealed:
-It was important for staff who were administering Vitamin D to know that the medication should not be crushed because capsules released the medication in the body evenly over time.
-If the Vitamin D capsules were to be crushed the resident would not receive the proper dose causing all the medication to be release at once, to not work properly, and could cause side effects of constipation and stomach upset.

Interview with Resident #2's primary care provider (PCP) on 02/15/23 at 12:25pm revealed:
-She agreed with the pharmacist's recommendation and reasoning to not crush the Vitamin D due to the medication being time released.

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-She was not made aware of the quarterly recommendations to add a "do not crush" to the Vitamin D or crush order.

Refer to interview with the facility's contracted pharmacist on 02/15/23.

Refer to interview with the Special Care Coordinator (SCC) on 02/15/23 at 8:49am.

Refer to interview with the Resident Care Director (RCD) on 02/15/23 at 8:53am.

Refer to interview with the RCD on 02/15/23 at 11:16am.

Refer to interview with the Executive Director (ED) on 02/15/23 at 10:40am.

Refer to second interview with the ED on 02/15/23 at 10:48am.

Refer to third interview with the ED on 02/15/23 at 11:54am.

Refer to interview with the facility's contracted primary care provider (PCP) on 02/15/23 at 12:25pm.

c. Review of Resident #3's pharmacy review dated 07/11/22 revealed there was a recommendation to attach a copy of the visit note dated 03/23/22.

Review of Resident #3's pharmacy review dated 10/19/22 revealed there was a recommendation to attach a copy of the visit note dated 03/23/22.

Review of Resident #3's pharmacy review dated 01/10/23 revealed there was a recommendation

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to attach a copy of the visit note dated 03/23/22 or obtain an updated FL-2.

Review of Resident #2's current FL-2 dated 03/23/22 revealed:
-There was a handwritten note to see attached visit note dated 03/23/22.
-There was not a visit note attached to the FL-2 dated 03/23/22.

Interview with the facility's contracted pharmacist on 02/15/23 at 9:42am revealed:
-The recommendation to attach the resident's visit note dated 03/23/22 to her FL-2 was important because the FL-2 was incomplete without it.
-If a provider was ordering medications without referencing a complete FL-2 they did not have all the diagnoses and medical history on the resident to ensure medications were prescribed safely.

Refer to interview with the facility's contracted pharmacist on 02/15/23.

Refer to interview with the Special Care Coordinator (SCC) on 02/15/23 at 8:49am.

Refer to interview with the Resident Care Director (RCD) on 02/15/23 at 8:53am.

Refer to interview with the RCD on 02/15/23 at 11:16am.

Refer to interview with the Executive Director (ED) on 02/15/23 at 10:40am.

Refer to second interview with the ED on 02/15/23 at 10:48am.

Refer to third interview with the ED on 02/15/23 at

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D 406	Continued From page 9 11:54am. Refer to interview with the facility's contracted primary care provider (PCP) on 02/15/23 at 12:25pm. _____ Interview with the facility's contracted pharmacist on 02/15/23 at 9:42am revealed: -She came to the facility quarterly to perform pharmacy reviews on all the residents. -She will repeat recommendations for medications on her quarterly reports if the previous recommendations had not been implemented. -She provided the facility with progress notes for resident medication recommendations via email along with an attachment in the same email to send to the resident's primary care provider (PCP) to sign off on the recommendation. -She expected the recommendations to be sent to the resident's PCP and followed up on within one week of receipt. Interview with the Special Care Coordinator (SCC) on 02/15/23 at 8:49am revealed: -The facility had an order form which would be sent to the PCP to be signed as to what they wanted to do based on the pharmacy recommendations. -The Resident Care Director (RCD) received the pharmacy recommendations. -The RCD would forward the pharmacy recommendations to the PCP if recommendations were provided and need to be followed up by the PCP. -She was not sure why the recommendations for the Rosuvastatin were not followed up with the PCP. Interview with the RCD on 02/15/23 at 8:53am	D 406		

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revealed:
-She received the pharmacy recommendations from the pharmacy consultant via email.
-When there were recommendations, there was a second sheet which was an order form.
-She would forward that second form (the order form) to the PCP for her follow up on the recommendations.
-She was not sure why the facility did not receive the second form for the last 3 quarters of pharmacy reviews for Resident #3.

Second interview with the RCD on 02/15/23 at 11:16am revealed:
-She was the RCD but also acting at the Resident Care Coordinator (RCC) because the facility currently had a vacancy in that position.
-She reviewed pharmacy recommendations but did not have a formal process to audit resident records and follow-up to ensure orders were implemented or reviewed by the provider as expected.
-She had not sent any of these recommendations to the primary care provider (PCP) via email because she did not think she received the attached form to send to the provider.
-If she had received the attachment, she thought she placed the form in the PCP's folder to review when the PCP visited the facility on a weekly basis.
-It was important that recommendations and orders were followed-up on to ensure the well-being of the resident's and for resident care.

Interview with the Executive Director (ED) on 02/15/23 at 10:40am revealed:
-The RCD received the pharmacy recommendations.
-The RCD followed up with the PCP by e-mail or a fax with the pharmacy recommendations.

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-There was a purple folder the facility would place information to be followed up by the PCP when she made her weekly visits.
-No one in the facility "made rounds" (accompanies the PCP when she examined residents) with the PCP.
-The PCP would verbally let the RCD or SCC, or lead medication aide (MA) know, if there was an order to be carried out for a resident from the information left in the purple folder or while she had made rounds and would sign the form with orders if she received the pharmacy recommendation.

Second interview with the ED on 02/15/23 at 10:48am revealed:
-Pharmacy reviews with recommendations were received via email with provider attachments from the contracted pharmacist quarterly once completed.
-If the recommendations were urgent, they were to be faxed to the resident's PCP immediately by the RCC, SCC or the RCD.
-If the recommendations were not urgent, they were to be placed in a folder for the PCP to review by the RCC, SCC, or RCD who visited the facility weekly.
-He expected the RCC, SCC, or RCD to follow up with the resident's PCP within one week of receipt of the pharmacy recommendations to ensure timely implementation of the recommendations for the best interest of the resident's care.
-Even if the physician attachment had not accompanied the pharmacist's quarterly email of recommendations, he expected the RCC, SCC, or RCD to provide the PCP with the quarterly report of recommendations for follow-up.
-He was not aware the PCP did not receive the pharmacy recommendations and did not know why the RCC, SCC, or RCD did not follow up to

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D 406	Continued From page 12 ensure they had been received and followed-up on. Third interview with the ED on 02/15/23 at 11:54am revealed: -The Regional Nurse did weekly reviews of charts and looks for recommendations or clarifications. -He was not sure why the recommendations from the pharmacy reviews were not given to the PCP for the past three quarters. Interview with the facility's contracted PCP on 02/15/23 at 12:25pm revealed: -If pharmacy recommendations were urgent, she expected the facility to call her or email her the recommendations that needed to be reviewed. -If the recommendations were not urgent, she expected to have the recommendations provided to her in her folder when she visited the facility each week. -She had not received any pharmacy recommendations for Resident #2 or Resident #3 via email, phone call, or in her purple folder and she was not sure why. -The pharmacist knew medications better than she did and she would have signed off and provided orders per the pharmacist's quarterly review recommendations if she had received the recommendations due to the same potential side effects and concerns that the pharmacist expressed.	D 406		