Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL001159 | A. BUILDING: _____ B. WING _____ | 01/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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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 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and follow up survey from January 17, 2024 to January 18, 2024. | D 000 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews, the facility failed to assure referral and follow-up for 1 of 2 sampled residents (#4) related to the care of an indwelling catheter.<br><br>The findings are:<br><br>Review of Resident #4's current FL-2 dated 12/29/23 revealed:<br>-Diagnoses included history of prostate cancer.<br>-Resident #4 had an indwelling catheter.<br><br>Interview with the Business Office Manager (BOM) on 01/18/24 at 10:25am revealed Resident #4 was admitted to the facility on 01/02/24.<br><br>Review of Resident #4's record revealed no physician's orders for catheter care or home health services.<br><br>Observation of Resident #4 and his room on 01/17/24 at 8:15am revealed:<br>-There was a suprapubic catheter in place with a leg bag attached for drainage.<br>-There was a supply of syringes in the bathroom and a small bottle of sterile water and a bottle of | D 273 | Resident in sample had physician referral and follow up completed 1/29/24. Facility will conduct a full audit by RCC, ED, or designee of all resident physician orders to ensure compliance with referral and follow up. All staff will be trained to complete tasks, if appropriate under LHPS.<br><br>The facility to ensure that home health services are set up prior to admission or re-admission and all admission orders are followed. Follow up on-going to be completed by RCC, nurse consultant or designee through routine audits.<br><br>To be completed by 3/3/2024. | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D Foster — TITLE: Director — (X6) DATE: 2/14/2024



Reviewed and acknowledged 02/15/24 KC Kathleen C Lawson

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| D 273 | Continued From page 1<br>normal saline in the bathroom.<br><br>Interview with Resident #4 on 01/17/24 at 8:15am revealed:<br>-He had a suprapubic catheter in place.<br>-He had the catheter prior to being admitted to the facility.<br>-He was concerned the catheter leaked at times.<br>-Home health had not been in to see him about the catheter.<br>-One of the male staff members flushed the catheter sometimes.<br><br>Interview with Resident #4's family member on 01/18/24 2:00pm revealed:<br>-Resident #4 was seen by a urologist for his catheter prior to his admission to the facility.<br>-He went to the urologist's office monthly for a tube change.<br>-He had not been to see the urologist since being admitted to the facility.<br>-The catheter was to be flushed three times a week with 50cc's of saline for increase sediment per the recommendation of the urologist.<br>-He had not been seen by home health at the facility yet. She thought it might be because there was a mix up of who his primary care provider (PCP) was.<br>-She gave the facility a list of his medications and the prescription to flush the catheter on admission.<br>-She had not instructed the PCA's or MA's to flush the catheter.<br>-She flushed the catheter when she visited Resident #4 because he had not been seen by home health yet.<br><br>Interview with a personal care aide (PCA) on 01/17/24 at 3:40pm revealed:<br>-He worked the second shift from 3:00pm to | D 273 | | |

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| D 273 | Continued From page 2<br><br>11:00pm.<br>-He provided care to Resident #4's care by cleaning around the catheter insertion site and he changed the drainage bag from a leg bag to a larger bag for overnight.<br>-He flushed Resident #4's catheter with 50cc's of sterile water about once a week when it was clogged or did not drain well.<br>-Resident #4 did not voice any concerns to him about his catheter.<br><br>Interview with a medication aide (MA) on 01/18/24 at 2:40pm revealed:<br>-Home health came to the facility when a resident was admitted with a catheter.<br>-She had not seen home health come to the facility for Resident #4 yet.<br>-The PCA's were responsible for cleaning around the catheter site and empty the drainage bag.<br>-She did not flush Resident #4's catheter and was unaware staff were doing that.<br>-There was not an order to flush Resident #4's catheter.<br><br>Interview with Resident #4's PCP on 01/18/24 at 11:31am revealed:<br>-Home health was to handle the care for Resident #4's catheter.<br>-She met Resident #4 on 01/16/24 and wrote an order for home health to begin care of Resident #4's catheter.<br>-Resident #4's daughter was very involved in his care and managed the catheter when she visited.<br>-There was not a current order to flush Resident #4's catheter.<br>-PCA's and MA's could clean the catheter site and empty the drainage bag but should not flush the catheter.<br>-She was not aware a PCA was flushing Resident #4's catheter and was not comfortable with that | D 273 | | |

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| D 273 | Continued From page 3<br>as they were not trained and could cause injury or other complications.<br><br>Interview with the Resident Care Coordinator on 01/18/24 at 2:45pm revealed:<br>-When a resident was admitted with a catheter, home health would be called to come and manage it.<br>-When Resident #4 was admitted, there was no order obtained for home health.<br>-When Resident #4 was admitted, the facility was unsure who the PCP would be because his daughter wanted his previous physician to continue to manage his care and she then decided the facility's PCP could manage his care.<br>-Resident #4's PCP saw him on 01/16/24 and wrote an order for home health to manage his catheter.<br>-Resident #4 had not been seen by home health yet.<br>-PCA's and MA's could clean the catheter site and empty the drainage bag.<br>-PCA's were not trained to flush catheters and should not be doing it.<br>-She was not aware a staff member was flushing Resident #4's catheter.<br><br>Interview with the Regional Director of Clinical Services (RDCS) on 01/18/24 at 3:40pm revealed she was concerned who instructed the PCA to flush Resident #4's catheter and would need more information. | D 273 | | |
| 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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| D 344 | Continued From page 4<br>medications and treatments:<br>(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;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or clarification is documented in the resident's record.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#3) for an insulin order with a fingerstick blood sugar range.<br><br>The findings are :<br><br>Review of Resident #3's current FL-2 dated 05/31/25 revealed:<br>-Diagnosis included diabetes mellitus.<br>-There was an order for Levemir 16 units (used to control high blood sugars) every morning and 10 units at bedtime, hold insulin if fingerstick blood sugar (FSBS) less than 100.<br><br>Review of Resident #3's signed physician's order dated 12/18/23 revealed there was an order to increase Levemir to 12 units at bedtime.<br><br>Review of Resident #3's December 2023 electronic medication administration record (eMAR) from 12/19/23 to 12/31/23 revealed:<br>-There was an entry for Levemir 16 units every morning with a scheduled administration time of 8:00am (prime pen with 2 units prior to use). | D 344 | All current insulin orders have been reviewed to ensure parameters are in place. Insulin training was completed on 1/18/24, 1/25/24 and 2/8/24. On-going training to be completed monthly with a focus on all medication orders.<br><br>The facility will ensure that all physician orders are clarified at admission and re-admission with prescribing practitioner. All existing and new insulin orders will be reviewed for parameters by RCC, nurse consultant or designee by routine audits and monitoring.<br><br>To be completed by 3/3/2024. | |

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| D 344 | Continued From page 5<br>-There was no entry to hold insulin for FSBS readings less than 100.<br>-There was documentation Levemir 16 units was administered on 12/20/23 with a FSBS reading of 67, on 12/21/23 with a FSBS readings of 96, on 12/24/23 with a FSBS reading of 65, on 12/27/23 with a FSBS reading of 68, and on 12/03/23 with a FSBS reading of 98.<br>-There was documentation Levemir 16 units was not administered on 12/25/23 with to FSBS reading of 61.<br>-There was an entry for Levemir insulin 12 units with a scheduled administration time of 8:00pm from 12/20/23 to 12/31/23 (prime pen with 2 units prior to use).<br>-There was documentation Levemir 12 units was administered on 01/24/24 for a FSBS readings of 95.<br>-There was documentation Levemir 12 units was not administered on 12/28/23 due to FSBS reading of 82.<br><br>Review of Resident #3 January 2024 eMAR from 01/01/24 to 01/17/24 revealed:<br>-There was an entry for Levemir insulin 16 units every morning with a scheduled administration time of 8:00am (prime pen with 2 units prior to use).<br>-There was no entry to hold insulin for FSBS readings less than 100.<br>-There was documentation Levemir 16 units was administered on 01/02/24 with a FSBS reading of 97, on 01/06/24 with a FSBS reading of 69, and on 01/17/24 with a FSBS reading of 83.<br>-There was documentation Levemir 16 units was not administered on 01/08/24 with a FSBS reading of 47 and on 01/13/24 with a FSBS reading of 83.<br>-There was an entry for Levemir insulin 12 units with a scheduled administration time of 8:00pm | D 344 | | |

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| D 344 | Continued From page 6<br>(prime pen with 2 units prior to use).<br>-There was documentation Levemir 12 units was administered on 01/09/24 with a FSBS reading of 89 and on 01/16/24 with a FSBS readings of 66.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/17/24 at 12:12pm revealed:<br>-There was a change in the evening dose of Levemir insulin from 10 units to 12 units each night.<br>-Although the morning dose of 16 units did not change, the entry had to be discontinued on the eMAR and re-entered on 12/19/23 when the change in the evening Levemir was increase so the medication could be billed through the insurance.<br>-All entries on the eMAR by the pharmacy had to be approved by a staff member before the medication could be administered.<br><br>Interview with a medication aide (MA) on 01/18/24 at 9:40am revealed:<br>-She had checked Resident #3's FSBS readings and administered his Levemir insulin.<br>-She did not administer Levemir insulin to Resident #3 on 12/02/23, 12/03/23, 12/05/23, 12/16/23, 12/17/23, 01/08/24, and 01/13/24 because his FSBS readings were below 100.<br>-She knew the current order did not include to hold insulin for FSBS readings less than 100, but the previous order did state to hold insulin for FSBS readings less than 100.<br>-She knew if she administered the insulin with the blood sugar being below 60 that Resident #3's blood sugar may drop even more and then there may be an emergency situation for Resident #3.<br>-She had not mentioned to management for clarification regarding the FSBS range to hold the insulin was not entered on the eMAR when the | D 344 | | |

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| D 344 | Continued From page 7<br>new order was written.<br><br>Interview with a second MA on 01/18/24 at 10:56am revealed:<br>-She knew Resident #3 had a new order for the Levemir insulin at bedtime.<br>-She did not know why the Levemir insulin for the morning was discontinued and re-entered.<br>-She did not realize the FSBS range was not re-entered for the morning dose of Levemir insulin.<br>-She administered the Levemir insulin when Resident #3's FSBS was less than 100 because there was no order to hold the insulin for FSBS readings less than 100.<br>-She had not spoken to management regarding the FSBS reading not being re-entered on the most recent entry on eMAR.<br><br>Telephone interview with Resident #3's Primary Care Provider on 01/18/24 at 11:55am revealed:<br>-She did not know the order to hold the insulin for FSBS readings less than 100 would fall off the eMAR when she wrote the new order.<br>-She would have liked to have been notified for clarification of the FSBS range and when to hold the insulin.<br><br>Interview with the Resident Care Coordinator (RCC) on 01/18/24 at 2:47pm revealed:<br>-She was not aware the FSBS range to hold insulin for FSBS readings less than 100 was no longer on the eMAR.<br>-She would expect the MAs to hold the insulin for FSBS readings less than 100.<br>-She would expect the MAs to ask for clarification when things have changed.<br>-She or a MA had to approve orders before the medications can be administered.<br>-The staff member approving the order should | D 344 | | |

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| D 344 | Continued From page 8<br>have noticed the FSBS range to hold the insulin was not on the new order and reached out to the PCP for clarification.<br><br>Interview with the Regional Director of Clinical Services (RDCS) on 01/18/24 at 3:40pm revealed:<br>-Administering insulin when FSBS readings were below 100 could potentially cause further hypoglycemia.<br>-She would have expected the MAs to question why there were no parameters and to notify the PCP for clarification. | 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, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 3 of 5 residents (#2, #3, and #4), including insulin (#2); two insulings and a nasal spray (#3); and an anti-hypertensive and anticoagulant (#4).<br><br>The findings are: | D 358 | | |

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| D 358 | Continued From page 9<br><br>1. Review of Resident #2's current FL-2 dated 01/25/23 revealed diagnoses included diabetes mellitus type 2, chronic kidney disease, and depression.<br>Review of Resident #2's record revealed:<br>-There was an order for Humalog 3 units subcutaneously (sq) before meals.<br>-There was an order for Humulin N 35 units sq twice a day.<br>-There was an order to change Humulin N 30 units on 12/07/23.<br>-There was an order to check finger stick blood sugar (FSBS) three times a day before meals.<br><br>Review of Resident #2's November 2023 electronic medication administration record (eMar) revealed:<br>-There was an entry for Humalog 3 units sq before breakfast scheduled at 6:00am.<br>-Humalog 3 units was documented as administered from 11/01/23 to 11/30/23.<br>-There was an entry for FSBS scheduled at 6:30am, 11:30am, and 5:00pm.<br>-FSBS checks were documented daily with results from 44-411.<br>-There was an entry for Humulin N 35 units sq twice a day.<br>-Humulin N was documented as administered from 11/01/23 to 11/30/23.<br><br>Review of Resident #2's December 2023 eMar revealed:<br>- There was an entry for Humalog 3 units sq before breakfast scheduled at 6:00am.<br>-Humalog 3 units was documented as administered from 12/01/23 to 12/31/23.<br>-There was an entry for FSBS scheduled at 6:30am, 11:30am, and 5:00pm.<br>-FSBS checks were documented daily with | D 358 | Immediate training with Med-Techs on the different types of insulin and diabetes was held on 1/19/24 and 2/8/2024. The facility ensured that all nasal sprays were standing upright in the carts. Med tech retraining on this was completed on 2/8/2024.<br><br>Medication Pass Observations with a focus on insulin and retraining to be completed on all med techs by nurse consultant by 3/3/24.<br><br>Pharmacy Qmar and med cart audits completed on 1/31/2024.<br><br>Facility increased weekly med cart audits on 1/23/24 to two times a week for 30 days, and then weekly thereafter conducted on-going by RCC, Nurse Consultant or designee.<br><br>ED and nurse consultant provided education to resident on making good and appropriate food choices according to physician's prescribed diet.<br><br>Facility will be in communication with the pharmacy for any orders requiring clarification. The pharmacy team will provide reeducation on the order clarification process for Med Techs and Clinical managers.<br><br>The facility to ensure that team members are trained appropriately in diabetic management and orientation to the med cart and processes upon hire, and monitored for completion by RCC, Nurse Consultant or designee.<br><br>The facility will ensure that all FL-2 will be cross-matched to orders for all admissions and re-admission.<br><br>All new admits have all completed documents in their health record. This is to be monitored by RCC, nurse consultant and designee within 48 hours of move-in.<br><br>To be completed by 3/3/2024. | |

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| D 358 | Continued From page 10<br>results from 74-381.<br>-There was an entry for Humulin N 35 units sq twice a day.<br>-Humulin N 35 units sq was documented as administered from 12/01/23 to 12/07/23.<br>-Humulin N 30 units sq was documented as administered from 12/07/23 to 12/31/23.<br><br>Review of Resident #2's January 2024 eMar for January 1, 2024, to January 17, 2024 revealed:<br>- There was an entry for Humalog 3 units sq before breakfast scheduled at 6:00am.<br>-Humalog 3 units was documented as administered from 01/01/24 to 01/17/24.<br>-There was an entry for FSBS scheduled at 6:30am, 11:30am, and 5:00pm.<br>-FSBS checks were documented daily with results from 143-382.<br>-There was an entry for Humulin N 30 units sq twice a day.<br>-Humulin N 30 units sq was documented as administered from 01/01/24 to 01/17/24.<br><br>Observations of Resident #2's medications on hand on 01/17/24 a 2:15pm revealed:<br>-There was one Humalog pen available for administration.<br>-There were two Humulin N insulin pens available for administration.<br><br>Interview with a representative with the facility's contracted pharmacy on 01/17/24 at 3:52pm revealed:<br>-There was an active order for Humalog 3 units sq before breakfast.<br>-The pharmacy dispensed 1 pen of Humalog 300 units/ml on 01/11/24.<br>-Humalog was a fast-acting insulin that acted quickly to bring down blood sugar but would not stay in the system long. | D 358 | | |

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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 11<br>-There was an active order for Humulin N 30 units twice a day.<br>-The pharmacy dispensed 5 pens of Humulin N on 01/12/24.<br>-Humulin insulin took longer to act and lasted longer.<br><br>Interview with Resident #2 on 01/17/24 at 8:15am revealed:<br>-He took insulin daily.<br>-He did not have any problems with the way his medications were administered.<br><br>Interview with a medication aide (MA) on 01/17/24 at 2:30pm revealed:<br>-She started work as a MA in December 2023.<br>-She had not taken her MA test yet; she had until March 2024 to get it done.<br>-She was trained by another MA in the facility.<br>-She never used the Humulin N pen to give Resident #2 his insulin.<br>-She always used the Humalog blue pen to give Resident #1 both of his insulin doses, Humalog 3 units and Humulin N 30 units daily.<br>-The staff member that trained her always used the blue pen so that was what she continued doing.<br>-She did not realize there was a difference in the insulin pens and thanked the surveyor for bringing it to her attention.<br><br>Interview with Resident #2's primary care provider (PCP) on 01/18/24 at 2:40pm revealed:<br>-Resident #2 had FSBS's that varied greatly, and she was concerned if he received the incorrect insulin he could have hyper or hypoglycemia.<br>-Resident #2 was non-compliant with his diet; he had many snacks in his room.<br>-She was very concerned Resident #2 had not had his medications as ordered. | D 358 | | |

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| D 358 | Continued From page 12<br>-She was concerned she made changes to Resident #2's orders that may not be necessary.<br><br>Interview with the Resident Care Coordinator (RCC) on 01/18/24 at 2:45pm revealed:<br>-The MA was new to her role.<br>-MA's were expected to complete the 3 checks of medication administration; if they completed the 3 checks, there was no room for error.<br>-MA's should scan all medication to decrease the chance of errors.<br>-She could not explain why the MA administered the incorrect insulin to Resident #2.<br>-If a medication was unavailable, it should be documented and ordered from the pharmacy.<br>-She was concerned Resident #2's medications were adjusted and did not need to be.<br><br>Interview with the Regional Director of Clinical Services (RDCS) on 01/18/24 at 3:40pm revealed:<br>-She was concerned Resident #2 was not getting his medications as ordered.<br>-Resident #2 could experience higher or lower blood sugars if his medications weren't given as ordered.<br><br>Refer to the interview with the RCC on 01/18/24 at 2:48pm.<br><br>Refer to the interview with the Regional Director of Clinical Services (RDCS) on 01/18/24 at 3:40pm.<br><br>2. Review of Resident #4's current FL-2 dated 12/19/23 revealed:<br>-Diagnoses included atrial fibrillation, congestive heart failure (CHF), diabetes mellitus type 2, hypothyroidism, history of prostate cancer, and chronic obstructive pulmonary disease (COPD). | D 358 | | |

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| D 358 | Continued From page 13<br>-There was an order for Eliquis 5mg daily.<br>-There was an order for metoprolol 25mg daily.<br><br>Review of Resident #4's Resident Register revealed there was no admission date.<br><br>Review of Resident #4's January 2024 (eMAR) for 01/02/24 to 01/17/24 revealed:<br>-There was no entry for Eliquis 5mg daily.<br>-There was no entry for metoprolol 25mg daily.<br><br>Observation of Resident #4's medications on hand on 01/18/24 at 7:42am revealed:<br>-There was no Eliquis available to administer for Resident #4.<br>-There was no metoprolol available to administer for Resident #4.<br><br>Interview with the Business Office Manager (BOM) on 01/18/24 at 11:30am revealed Resident #4 was not admitted to the facility until 01/02/24.<br>Interview with a pharmacist from the facility's contracted pharmacy on 01/18/24 at 2:15pm revealed:<br>-The pharmacy received Resident #4's FL-2 on 12/29/23.<br>-The pharmacy sent a request for clarification for the Eliquis and metoprolol orders via fax on 12/29/23 and got no response.<br>-The pharmacy called the facility and left a voicemail to clarify the medication orders on 01/01/24 and got no response.<br>-The pharmacy sent a second request for clarification for the Eliquis and metoprolol via fax on 01/11/24 and received no response.<br>-Eliquis was a medication used to treat atrial fibrillation.<br>-Metoprolol was a medication used to treat high blood pressure and regulate heart rate. | D 358 | | |

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| D 358 | Continued From page 14<br><br>Interview with a Medication Aide (MA) on 01/18/24 at 7:45am revealed:<br>-She had not administered Eliquis or metoprolol to Resident #4.<br>-Eliquis and metoprolol were not on Resident #4's eMAR.<br>-There was no Eliquis or metoprolol available to administer to Resident #4.<br>-The Resident Care Coordinator (RCC) faxed the FL-2's to the pharmacy on admission<br><br>Interview with Resident #4 on 01/18/24 at 3:00pm revealed:<br>-He could not list all the medications he took.<br>-He did take a blood thinner but could not recall the name.<br>-He was prescribed metoprolol.<br>-He took medications daily and did not have any concerns.<br><br>Interview with Resident #4's primary care provider (PCP) on 01/18/24 at 2:40pm revealed:<br>-She was not aware Resident #4 had not received his Eliquis or metoprolol since admission.<br>-She was concerned Resident #4 did not receive his Eliquis and metoprolol.<br>-She expected the staff to clarify orders on admission and compare the eMar to the FL-2 to make sure all the medications were ordered and available to administer.<br>-She spoke to a pharmacist at the facility's contracted pharmacy 01/18/24 and was made aware there was a problem getting the mediation orders clarified.<br>-Resident #2 had atrial fibrillation and at risk for stroke; it was important for him to have his medications as ordered.<br>-She checked Resident #2's blood pressure (132/78) and pulse (72) when she saw him at the facility on 01/16/24. | D 358 | | |

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| D 358 | Continued From page 15<br><br>Interview with the RCC on 01/18/24 at 8:48am and at 2:45pm revealed:<br>-Resident #4 was admitted to the facility on 01/02/24.<br>-When a resident was admitted to the facility, she faxed the FL-2 to the pharmacy.<br>-Medications usually arrived from the pharmacy at night and the night shift MA was responsible to check the FL-2 against the eMAR for accuracy.<br>-She tried to also check the FL-2's against the eMAR on admission but did not always get to them all.<br>-She was not aware Resident #4's Eliquis and metoprolol were not on the eMAR.<br>-She called the pharmacy 01/18/24 and was informed the pharmacy had sent request for clarification for the Eliquis and metoprolol several times.<br>-She never received the clarification request.<br><br>Interview with the Regional Director of Clinical Services (RDCS) on 01/18/24 at 3:40pm revealed:<br>-She was not aware Resident #4 did not receive Eliquis and metoprolol since his admission.<br>-She was concerned there was a system breakdown.<br><br>Refer to the interview with the RCC on 01/18/24 at 2:48pm.<br><br>Refer to the interview with the Regional Director of Clinical Services (RDCS) on 01/18/24 at 3:40pm.<br><br>_____<br>_____<br>3. Review of Resident #3's current FL-2 dated 05/31/25 revealed diagnosis included diabetes | D 358 | | |

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| D 358 | Continued From page 16<br>mellitus.<br><br>a. Review of Resident #3's signed physician's order dated 10/18/23 revealed there was an order for Levemir 16 units (used to control high blood sugars) every morning and 10 units at bedtime.<br><br>Review of Resident #3's signed physician's order dated 12/18/23 revealed there was an order to increase Levemir to 12 units at bedtime.<br><br>Review of Resident #3's laboratory values dated 07/13/23 revealed a hemoglobin A1C (HbA1C) value of 8.5. (The hemoglobin A1C measures the average level of blood sugar over the previous 3 months. The normal A1C level is below 5.7%).<br><br>Review of Resident #3's September 2023 electronic medication administration record (eMAR) from 09/10/23 to 09/30/23 revealed:<br>-There was an entry for Levemir insulin 16 units every morning with a scheduled administration time of 8:00am (prime pen with 2 units prior to use).<br>-There was documentation Levemir 16 units was administered from 09/10/23 to 09/11/23, from 09/13/23 to 09/22/23, on 09/25/23, from 09/27/23 to 09/28/23 and on 09/30/23.<br>-There was documentation Levemir 16 units was not administered on 09/12/23, 09/23/23, 09/24/23, 09/26/23, and 09/29/23 due to fingerstick blood sugar (FSBS) reading below 100.<br>-There was an entry for Levemir insulin 10 units at bedtime with a scheduled administration time of 8:00pm (prime pen with 2 units prior to use).<br>-There was documentation Levemir 10 units was administered from 09/10/23 to 09/21/23 and from 09/23/23 to 09/30/23.<br>-There was documentation Levemir 10 units was | D 358 | | |

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| D 358 | Continued From page 17<br>not administered on 09/22/23 due to FSBS reading below 100.<br><br>Review of Resident #3's October 2023 eMAR revealed:<br>-There was an entry for Levemir insulin 16 units every morning with a scheduled administration time of 8:00am (prime pen with 2 units prior to use).<br>-There was documentation Levemir 16 units was administered every morning from 10/01/23 to 10/09/23 and from 10/11/23 to 10/31/23.<br>-There was documentation Levemir 16 units was not administered on 10/10/23 due to FSBS reading below 100.<br>-There was an entry for Levemir 10 units at bedtime with a scheduled administration time of 8:00pm (prime pen with 2 units prior to use).<br>-There was documentation Levemir 10 units was administered at bedtime from 10/01/23 to 10/06/23 and from 10/08/23 to 10/31/23.<br>-There was documentation Levemir 10 units was not administered on 10/07/23 due to FSBS reading below 100.<br><br>Review of Resident #3 November 2023 eMAR revealed:<br>-There was an entry for Levemir insulin 16 units every morning with a scheduled administration time of 8:00am (prime pen with 2 units prior to use).<br>-There was documentation Levemir 16 units was administered each morning from 11/01/23 to 11/08/23, on 11/10/23, from 11/12/23 to 11/19/23, from 11/21/23 to 11/22/23, and from 11/24/23 to 11/30/23.<br>-There was documentation Levemir 16 units was not administered on 11/09/23, 11/11/23, 11/20/23, and 11/23/23 due to FSBS reading below 100.<br>-There was an entry for Levemir insulin 10 units | D 358 | | |

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| D 358 | Continued From page 18<br>every morning with a schedule administration time of 8:00pm (prime pen with 2 units prior to use).<br>-There was documentation Levemir 10 units was administered at bedtime from 11/01/23 to 11/03/23 and from 11/04/23 to 11/30/23.<br><br>Review of Resident #3 December 2023 eMAR revealed:<br>-There was an entry for Levemir insulin 16 units every morning with a schedule administration time of 8:00am (prime pen with 2 units prior to use).<br>-There was documentation Levemir 16 units was administered on 12/01/23, on 12/04/23, from 12/06/23 to 12/15/23, and from 12/18/23 to 12/19/23.<br>-There was documentation Levemir 16 units was not administered on 12/02/23, 12/03/23, 12/05/23, 12/16/17, and 12/18/23 due to FSBS reading below 100.<br>-There was a second entry for Levemir 16 units every morning with a scheduled administration time of 8:00am (prime pen with 2 units prior to use).<br>-There was documentation Levemir 16 units was administered on 12/20/23 to 12/24/23, and from 12/26/23 to 12/31/23.<br>-There was documentation Levemir 16 units was not administered on 12/25/23 due to FSBS reading below 100.<br>-There was an entry for Levemir insulin 10 units with a scheduled administration time at 8:00pm from 12/01/23 to 12/18/23.<br>-There was documentation Levemir 10 units was administered from 12/01/23 to 12/18/23.<br>-There was an entry for Levemir insulin 12 units with a scheduled administration time of 8:00pm from 12/20/23 to 12/31/23 (prime pen with 2 units prior to use). | D 358 | | |

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| D 358 | Continued From page 19<br>-There was documentation Levemir 12 units was administered from 12/19/23 to 12/27/23, and 12/29/23 to 12/31/23.<br>-There was documentation Levemir 12 units was not administered on 12/28/23 due to FSBS reading below 100.<br><br>Review of Resident #3 January 2024 eMAR from 01/01/24 to 01/16/24 revealed:<br>-There was an entry for Levemir insulin 16 units every morning with a scheduled administration time of 8:00am (prime pen with 2 units prior to use).<br>-There was documentation Levemir 16 units was administered from 01/01/24 to 01/07/24, from 01/09/24 to 01/12/24, and from 01/14/24 to 01/16/24.<br>-There was documentation Levemir 16 units was not administered on 01/08/24 and 01/13/24 due to FSBS below 100.<br>-There was an entry for Levemir insulin 12 units with a scheduled administration time of 8:00pm (prime pen with 2 units prior to use).<br>-There was documentation Levemir 12 units was administered from 01/01/24 to 01/16/24.<br><br>Observation of medication on hand on 01/17/24 at 11:12am revealed:<br>-There was an opened Levemir insulin pen on the medication cart containing 50 units of insulin for Resident #3.<br>-There was a sealed 3ml (300 units) Levemir insulin pen in the refrigerator for Resident #3 with a dispensed date of 12/19/23.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/17/24 at 12:12pm revealed:<br>-Resident # 3 had a current order for Levemir insulin 16 units every morning and 12 units every | D 358 | | |

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| D 358 | Continued From page 20<br><br>night with an order date of 12/19/23.<br>-Resident #3's previous order was Levemir insulin 16 units every morning and 10 units every night with an order date of 09/09/23.<br>-The pharmacy dispensed three 3ml Levemir insulin pens (1ml = 300 units) on 09/09/23, 10/03/23, and 12/19/23.<br>-Each 3ml pen contained 300 units of Levemir insulin; there were 3 pens with 900 units of insulin dispensed each time.<br>-When preparing the medication for administration, the medication aide (MA) would use an additional 2 units of insulin to prime the needle before administering the medication.<br>-From 09/09/23 to 12/18/23, Resident #3 should have been administered 16 units in the morning plus 2 units to prime the needle and 10 units in the evening with 2 units to prime the needle for a total of 30 units of Levemir insulin administered daily.<br>-From 12/19/23 to present day, Resident #3 should have been administered 16 units in the morning plus 2 units to prime the needle and 12 units in the evening with 2 units to prime the needed for a total of 32 units of Levemir insulin administered daily.<br>-The Levemir insulin was not on cycle fill; the facility staff would re-order the medication when needed.<br>-The facility staff reordered medication through the eMAR by clicking the reorder tab, by faxing the sticker on the prescription label, or by calling the pharmacy.<br><br>Based on record review, interviews, and medications on hand, Resident #3 had 2700 units of Levemir dispensed since 09/09/23 and documentation Resident #3 was administered a total of 3394 units from 09/09/23 to 01/16/24, including 2 units to prime needle with each | D 358 | | |

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| D 358 | Continued From page 21<br>administration, being 694 units short and with 350 units still available for administration as of 01/17/24.<br><br>Interview with a medication aide (MA) on 01/18/24 at 9:40am revealed:<br>-Resident #3 never refused his insulin.<br>-She did not understand why Resident #3's insulin was not re-ordered in November and why there was an extra pen on hand from the dispense date of 12/19/24.<br><br>Interview with a second MA on 01/18/24 at 3:55pm revealed:<br>-She administered Levemir insulin to Resident #3.<br>-Resident #3 did not refuse his medication.<br><br>Telephone interview with the Primary Care Provider (PCP) on 01/18/24 at 11:55am revealed:<br>-She expected the MAs to administer Resident #3's medication as ordered.<br>-She adjusted Resident #3's insulin based on his FSBS readings, thinking he was being administered insulin as ordered.<br>-She was concerned that Resident #3's FSBS would increase to critical levels if he was not being administered his insulin as ordered.<br><br>Interview with the Resident Care Coordinator (RCC) on 01/18/24 at 2:47pm revealed<br>-She was concerned about Resident #3's FSBS increasing if he did not receive his Levemir as ordered.<br>-The PCP changes the dosage of insulin based on the FSBS readings, and if Resident #3 did not receive his insulin as ordered, then the PCP did not have the accurate information when changing insulin dosages.<br><br>Interview with the Regional Director of Clinical | D 358 | | |

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| D 358 | Continued From page 22<br>Services (RDCS) on 01/18/24 at 3:40pm revealed she was concerned Resident #7 did not get his Levemir insulin as ordered, and he may have complications with hyperglycemia.<br><br>Attempted interview with the Administrator on 01/18/24 at 3:35pm was unsuccessful.<br><br>Refer to the interview with the RCC on 01/18/24 at 2:48pm.<br><br>Refer to the interview with the RDCS on 01/18/24 at 3:40pm.<br><br>b. Review of Resident #3's signed physician's order dated 11/27/23 revealed there was an order for Novolog insulin 5 units (used to lower blood sugar) as needed (PRN) for fingerstick blood sugars (FSBS) greater than 400.<br><br>Review of Resident #3's Review of Resident #3 December 2023 electronic medication administration record (eMAR) revealed:<br>-There was an entry for FSBS checks twice daily with a scheduled time of 8:00am and 8:00pm.<br>-There was documentation Resident #3's FSBS was 449 on 12/06/23 and 439 on 12/27/23.<br>-There was an entry for Novolog 5 units PRN for FSBS readings greater than 400.<br>-There was no documentation Novolog was administered on 12/06/23 and 12/27/23 for FSBS greater than 400.<br><br>Review of Resident #3 January 2024 eMAR from 01/01/24 to 01/13/24 revealed:<br>-There was an entry for FSBS checks twice daily with a scheduled time of 8:00am and 8:00pm.<br>-There was documentation Resident #3's FSBS was 439 on 01/10/24.<br>-There was an entry for Novolog 5 units PRN for | D 358 | | |

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

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| D 358 | Continued From page 23<br>FSBS readings greater than 400.<br>-There was no documentation Novolog was administered on 01/10/24 for FSBS greater than 400.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/18/24 at 2:05pm revealed:<br>-The pharmacy had an order dated 11/27/23 for Novolog Insulin 5 units as needed for FSBS readings greater than 400.<br>-The pharmacy dispensed one 3ml pen of Novolog Insulin on 11/28/23.<br>-The 3ml Novolog Insulin pen contained 300 units of insulin.<br><br>Interview with a medication aide (MA) on 01/18/24 at 2:54pm revealed:<br>-She had checked Resident #3's FSBS and it was greater than 400.<br>-She did not realize Resident #3 had a PRN order for Novolog when his FSBS readings were greater than 400.<br>-The PRN order for Novolog did not appear on the eMAR screen to administer the medication for FSBS readings greater than 400; the PRN order was under the PRN tab.<br>-She was informed about a week ago that Resident #3 had a PRN order for FSBS readings greater than 400.<br><br>Telephone interview with Resident #3's Primary Care Provider (PCP) on 01/18/24 at 11:55am revealed:<br>-He expected the MAs to administer Novolog insulin when his FSBS reading was greater than 400 as ordered.<br>-Resident #3's FSBS readings could continue to increase causing concerns for a coma if the FSBS reading increased to high. | D 358 | | |

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| D 358 | Continued From page 24<br><br>Interview with the Resident Care Coordinator (RCC) on 01/18/24 at 2:47pm revealed:<br>-The eMAR should have been audited to see if the medications were being administered correctly.<br>-If the eMAR had been audited, management would have known the PRN Novolog Insulin was not being administered as ordered.<br><br>Attempted interview with the Administrator on 01/18/24 at 3:35pm was unsuccessful.<br><br>Refer to the interview with the RCC on 01/18/24 at 2:48pm.<br><br>Refer to the interview with the Regional Director of Clinical Services (RDCS) on 01/18/24 at 3:40pm.<br><br>c. Review of Resident #3's signed physician's order dated 10/18/23 revealed there was an order for fluticasone 50mcg (used to treat allergies) instill 2 sprays in each nostril daily.<br><br>Review of Resident #3's October 2023 electronic medication administration record (eMAR) revealed:<br>-There was an entry for fluticasone nasal spray instill 2 sprays in each nostril daily with a scheduled administration time of 6:00am.<br>-There was documentation fluticasone was administered daily from 10/01/23 to 10/31/23.<br><br>Review of Resident #3's November 2023 eMAR revealed:<br>-There was an entry for fluticasone nasal spray instill 2 sprays in each nostril daily with a scheduled administration time of 6:00am.<br>-There was documentation fluticasone was | D 358 | | |

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| D 358 | Continued From page 25<br>administered daily from 11/01/23 to 11/22/23 and from 11/29/23 to 11/30/23.<br>-There was documentation fluticasone was not administered daily from 11/23/23 to 11/28/23 due to medication not being available.<br><br>Review of Resident #3's December 2023 eMAR revealed:<br>-There was an entry for fluticasone nasal spray instill 2 sprays in each nostril daily with a scheduled administration time of 6:00am.<br>-There was documentation fluticasone was administered daily from 12/01/23 to 12/05/23, on 12/07/23, on 12/09/23, from 12/12/23 to 12/15/23, and from 12/17/23 to 12/31/23.<br>-There was documentation fluticasone was not administered on 12/06/23, 12/08/23, from 12/10/23 to 12/11/23, and on 12/06/23 due to medications not available.<br><br>Review of Resident #3's January 2024 eMAR revealed:<br>-There was an entry for fluticasone nasal spray instill 2 sprays in each nostril daily with a scheduled administration time of 6:00am.<br>-There was documentation fluticasone was administered daily from 01/01/24 to 01/17/24.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/17/24 at 12:12pm revealed:<br>-Resident #3 had an order for fluticasone nasal spray, 2 sprays in each nostril daily.<br>-The pharmacy dispensed 1 bottle of fluticasone nasal spray on 09/28/23 and 12/16/23.<br>-One bottle should last 30 days.<br>-The pharmacy always has fluticasone nasal spray in stock to dispense when needed.<br>-If the pharmacy did not have fluticasone nasal spray in stock, it would be obtained from the | D 358 | | |

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| D 358 | Continued From page 26<br><br>backup pharmacy.<br>-The fluticasone nasal spray was not on cycle fill; the facility staff would re-order the medication when needed.<br>-The facility staff reordered medication through the eMAR by clicking the reorder tab, by faxing the sticker on the prescription label, or by calling the pharmacy.<br><br>Based on interviews, record reviews and medication on hand, Resident #3 had 2 bottles of fluticasone nasal spray dispensed since 09/09/28, each bottle lasting 30 days if administered as ordered, leaving 38 days documented as administered with no available medications to administer.<br><br>Interview with a medication aide (MA) on 01/18/24 at 3:55pm revealed:<br>-Resident #7 did not refuse his fluticasone nasal spray when she administered medications.<br>-She did not know why the fluticasone nasal spray was not ordered monthly.<br><br>Telephone interview with the Primary Care Provider (PCP) on 01/18/24 at 11:30am revealed:<br>-Resident #3 could have worsening allergy symptoms of runny nose and watery eyes.<br>-She expected medication to be administered as ordered.<br><br>Interview with the Resident Care Coordinator (RCC) on 01/18/24 at 2:47pm revealed:<br>-If the fluticasone nasal spray has only been dispensed twice since September 2023, it appeared the medication had not been administered as ordered.<br><br>Attempted interview with the Administrator on 01/18/24 at 3:35pm was unsuccessful. | D 358 | | |

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| D 358 | Continued From page 27<br><br>Refer to the interview with the RCC on 01/18/24 at 2:48pm.<br><br>Refer to the interview with the Regional Director of Clinical Services (RDCS) on 01/18/24 at 3:40pm.<br><br>_____<br>Interview with the Resident Care Coordinator (RCC) on 01/18/24 at 2:47pm revealed:<br>-She expected the MAs to administer medications as ordered.<br>-Medication carts were audited weekly on Wednesday for loose pills in the medication cart, medications were dated with "open dates", and expired medications.<br><br>Interview with the Regional Director of Clinical Services (RDCS) on 01/18/24 at 3:40pm revealed:<br>-MAs were expected to administer medications as ordered.<br>-MAs were expected to complete medication cart audits weekly.<br><br>The facility failed to ensure medications were administered as ordered for a resident that received insulin (#2); a resident that received an antihypertensive and anticoagulant (#4); and a resident who did not received his Levemir and Novolog insulin as ordered which resulted in the resident continuing to have elevated fingerstick blood sugar reading as high as 533 (#3) which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.<br><br>_____<br>_____<br><br>The facility provided a plan of protection in | D 358 | | |

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| D 358 | Continued From page 28<br>accordance with G.S. 131D-34 on 01/17/24.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 03/03/24. | D 358 | | |
| D 375 | 10A NCAC 13F .1005(a) Self-Administration Of Medications<br><br>10A NCAC 13F .1005 Self -Administration Of Medications<br>(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:<br>(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and<br>(2) specific instructions for administration of prescription medications are printed on the medication label.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record reviews, and interviews, the facility failed to ensure 2 of 3 sampled residents (#6, #7) had a physician's order to self-administer medications, including an acid reducer (#6) and a laxative (#7).<br><br>The findings are:<br><br>Review of the facility's self-administration of medications policy revealed: | D 375 | Staff training to be conducted by 3/3/24 on the difference between self-administration and facility administration along with appropriate techniques. A review of all residents who self-administer medications will be completed to ensure that physician's orders are in place correctly, and self-administration assessments completed for all that have self-administration orders.<br><br>The facility to ensure that all staff are trained to report to the RCC, Nurse Consultant or designee if they see a medication in a resident room to ensure the resident is self-administrating, and to confirm that all medications are to be always keep in a safe and secure place per regulations.<br><br>On going med observation and room sweeps to be completed monthly by the RCC, nurse consultant or designee.<br><br>To be completed by 3/3/2024. | |

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| D 375 | Continued From page 29<br>-An order should be obtained for self-administration from the Primary Care Provider (PCP).<br>-A self-administration of medications assessment would be required upon admission, quarterly or per state guideline.<br>-The resident's care plan must be updated to include the resident's ability to self-administer medications.<br><br>1. Observation of Resident #6's bedroom on 01/17/24 at 8:15am revealed:<br>-There was a bottle of Pepcid Complete on the nightstand beside Resident #6's recliner.<br>-The bottle was approximately half-full.<br><br>Interview with Resident #6 on 01/17/24 at 8:15am revealed:<br>-He used the medication when he had heartburn.<br>-He only took the medication once in a while.<br>-He did not know if the staff knew it was there.<br>-He got the medication from his brother who visited him daily.<br><br>Review of Resident #6's current FL-2 dated 05/30/23 revealed:<br>-Diagnoses included hyperlipidemia, pacemaker, atrial fibrillation, and coronary artery disease.<br>-There was not an order for Pepcid Complete.<br><br>Review of Resident #6's signed physician's orders dated 09/21/23 revealed:<br>-There was not an order for Pepcid Complete.<br>-There was not an order for Resident #6 to self-administer medications.<br><br>Interview with Resident #6's primary care provider (PCP) on 01/18/24 at 2:40pm revealed:<br>-Resident #6 was a candidate to self-administer his medication. | D 375 | | |

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| D 375 | Continued From page 30<br>-Resident #6 should not have any medications without an order.<br>-Resident #6 should not have medications at the bedside without an order to self -administer; medications left at the bedside should also be locked in a storage container.<br><br>Interview with the medication aide (MA) on 01/18/24 at 10:00am revealed:<br>-She did not have any residents on her hall that self-administered medications.<br>-Resident #6 did not have an order to self-administer his medications.<br>-Resident #6 did not have an order for Pepcid Complete.<br>-She did not know Resident #6 had a bottle of Pepcid Complete in his room.<br>-Resident #6 should not have medications at the bedside.<br><br>Interview with the Resident Care Coordinator (RCC) on 01/18/24 at 2:45pm revealed:<br>-Resident #6 did not have an order for Pepcid Complete.<br>-Resident #6 did not have an order to self-administer his medications.<br>-Resident #6 had a brother that visited daily and brought him over the counter medication.<br>-She makes regular room sweeps on his room because she has found medication in his room before.<br>-She talked to Resident #6 before about medications at the bedside; he was aware of the rules.<br>-She had not spoken to Resident #6 about the medications left at the bedside.<br><br>Refer to the interview with the RCC on 01/18/24 at 2:47pm. | D 375 | | |

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| D 375 | Continued From page 31<br>Refer to interview with the Regional Director of Clinical Services (RDCS) on 01/18/24 at 3:40pm.<br><br>2. Review of Resident #7's current FL-2 dated 10/09/23 revealed:<br>-Diagnoses included anorexia, acute kidney failure, chronic kidney disease stage 3, atrial fibrillation, and diastolic congestive heart failure.<br>-There was no order for Miralax (used as a laxative).<br>-There was no order for self-administration for administration.<br><br>Review of Resident #7's signed physician's orders dated 01/03/24 revealed:<br>-There was no order for Miralax.<br>-There was no order for self-administration for administration.<br><br>Observation of Resident #7's room on 01/17/24 at 9:04am revealed:<br>-Resident #7 was seated in his recliner next to his bedside table.<br>-There was a 4.1-ounce bottle Miralax on his bedside table.<br>-There was no prescription label on the bottle of Miralax.<br><br>Interview with Resident #7 on 01/17/24 at revealed:<br>-His family member brought it to him yesterday, 01/16/24.<br>-He needed to have a bowel movement, and he took some of the Miralax last night, 01/16/24.<br>-The staff had not given him any medication for his bowels.<br>-He had not asked the staff to give him medication for his bowels.<br><br>Review of Resident #7's record on 01/17/23 | D 375 | | |

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| D 375 | Continued From page 32<br>revealed there was no self-administration assessment available for review.<br><br>Interview with a personal care aide (PCA) on 01/18/24 at 1:59pm revealed:<br>-She had not seen medications in Resident #7's room.<br>-If she saw medications in a resident's room, she would remove the medications and take it to the medication aide (MA) or the Resident Care Coordinator (RCC).<br><br>Interview with Resident #7 on 01/18/24 at 2:02pm revealed:<br>-The Miralax was not in his room.<br>-He did not know what happened to the Miralax.<br>-He thought someone removed the Miralax from his room.<br><br>Interview with the MA on 01/18/24 at 2:24pm revealed:<br>-She saw the Miralax in Resident #7's room yesterday and removed the medication.<br>-She thought a relative brought the medication to Resident #7.<br>-Resident #7 had not asked for medication for his bowels.<br>-Resident #7 did not have an order to self-administer medications.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/18/24 at 2:05pm revealed:<br>-The pharmacy received an order on 01/17/24 for Resident #7 for Miralax 17gms in 8 ounces of water daily yesterday.<br>-Resident #7 did not have a self-administration order to self-administer medications.<br><br>Telephone interview with the Primary Care | D 375 | | |

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| D 375 | Continued From page 33<br>Provider (PCP) on 01/18/24 at 11:30am revealed:<br>-Resident #7 was not able to self-administer his medications.<br>-Resident #7 should not have medications at his bedside.<br>-She had not written a self-administration order for Resident #7.<br>-She was notified by the staff yesterday, 01/17/24, that Resident #7 needed an order for Miralax.<br><br>Interview with the RCC on 01/18/24 at 2:47pm revealed:<br>-Resident #7 should not have medications in his room.<br>-Resident #7 has family that visit daily who may have brought the medication to him.<br><br>Attempted telephone interview with Resident #7's family member on 01/18/24 at 2:24pm was unsuccessful.<br><br>Attempted interview with the Administrator on 01/18/24 at 3:35pm was unsuccessful.<br><br>Refer to the interview with the RCC on 01/18/24 at 2:47pm.<br><br>Refer to interview with the Regional Director of Clinical Services (RDCS) on 01/18/24 at 3:40pm.<br><br>_____<br>Interview with the Resident Care Coordinator (RCC) on 01/18/24 at 2:47pm revealed:<br>-The resident's doctor must write an order for self-administration.<br>-Residents must have a successful self-administration assessment completed to self-administer medications.<br>-The staff and the RCC would check the resident's room twice weekly for medication that should not be in their rooms. | D 375 | | |

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| (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 375 | Continued From page 34<br>-She expected MA's and personal care assistants (PCA's) to make daily checks of the residents' rooms.<br><br>Interview with the Regional Director of Clinical Services (RDCS) on 01/18/24 at 3:40pm revealed:<br>-Residents who wanted to self-administer their own medications had to be assessed first and an order obtained.<br>-She was concerned that residents might take too much medication if left at the bedside and not monitored. | D 375 | | |