STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065045	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

(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 000	Initial Comments The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted a follow-up survey and a complaint investigation from May 29, 2024, to May 30, 2024. The complaint investigation was initiated by the New Hanover County Department of Social Services on May 1, 2024.	D 000		
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 observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered to of 2 of 6 residents (#6, #7) observed during the medication pass including errors with a medication used to treat pain (#6) and a medication used to treat high blood pressure and depression (#7). The findings are: The medication error rate was 12% as evidenced by the observation of 3 errors out of 25 opportunities during the morning medication pass on 05/29/24 and 05/30/24. a. Review of Resident #6's current FL-2 dated 01/03/24 revealed:	D 358		

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D 358	Continued From page 1	D 358		

-Diagnoses included depression, cellulitis, Alzheimer's disease, and hypertension.
-Level of care was the secured care unit.
-There was an order for Tylenol 325mg 2 tablets three times daily (Tylenol is used to treat mild pain).

Observation of the morning medication pass on 05/29/24 revealed that Tylenol 650mg was administered at 9:25am.

Review of Resident #6's May 2024 electronic administration record (eMARs) revealed:
-There was an entry for Tylenol 650mg, scheduled at 8:00am, 2:00pm, and 8:00pm.
-Tylenol 650mg was documented as administered on 05/01/24 through 05/28/24 at 8:00am, 2:00pm, and 8:00pm and on 05/29/24 to Resident #6 at 8:00am.

Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable.

Attempted telephone interview with the facility's contracted primary care provider on 05/30/24 at 10:56am was unsuccessful.

Refer to interview with the medication aide (MA) on 03/30/24 at 11:20am.
Refer to interview with the Director of Resident Care (DRC) on 05/30/24 at 12:00pm.
Refer to interview with the Administrator on 05/30/2024 at 2:10pm.
Refer to interview with the facility's contracted pharmacist on 05/30/24 at 10:45am.

b. Review of Resident #7's current FL-2 dated 02/23/24 revealed:
-Diagnoses included dementia, hypertension,

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D 358	Continued From page 2	D 358		

mild cognitive impairment, hyperlipidemia, and atherosclerotic heart disease.
-Level of care was the secured care unit.
-There was an order for Losartan 50mg twice daily (Losartan is used to treat hypertension).

Observation of the morning medication pass on 05/30/24 revealed Losartan 50mg was administered to Resident #7 at 8:53am.

Review of Resident #7's May 2024 electronic administration record (eMARs) revealed:
-There was an entry for Losartan 50mg, scheduled at 7:00am and 7:00pm.
-Losartan 50mg was documented as administered 05/01/24 through 05/29/24 at 7:00am and 7:00pm and 05/30/24 at 7:00am.

Attempted telephone interview with the facility's contracted primary care provider on 05/30/24 at 10:56am was unsuccessful.

Refer to interview with the medication aide (MA) on 05/30/24 at 11:20am.
Refer to interview with the Director of Resident Care (DRC) on 05/30/24 at 12:00pm.
Refer to interview with the Administrator on 05/30/2024 at 2:10pm.
Refer to interview with the facility's contracted pharmacist on 05/30/24 at 10:45am.

c. Review of Resident #7's current FL-2 dated 02/23/24 revealed the level of care was the secured care unit.

Review of Resident #7's current physician order dated 02/23/24 revealed there was an order for Quetiapine 25mg twice daily (Quetiapine is used to treat depression).

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D 358	Continued From page 3 Observation of the morning medication pass on 05/30/24 revealed Quetiapine 25mg was administered to Resident #7 at 8:53am. Review of Resident #7's May 2024 electronic administration record (eMARs) revealed: -There was an entry for Quetiapine 25mg, scheduled at 7:00am and 7:00pm. -Quetiapine 25mg was documented as administered 05/01/24 through 05/29/24 at 7:00am and 7:00pm and 05/30/24 at 7:00am. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. Attempted telephone interview with the facility's contracted primary care provider on 05/30/24 at 10:56am was unsuccessful. Refer to interview with the medication aide (MA) on 05/30/24 at 11:20am. Refer to interview with the Director of Resident (DRC) on 05/30/24 at 12:00pm. Refer to interview with the Administrator on 05/30/2024 at 2:10pm. Refer to interview with the facility's contracted pharmacist on 05/30/24 at 10:45am. _____ Interview with the medication aide (MA) on 05/30/24 at 11:20am revealed: -She had not been educated on what she should do if she was late passing medications. -She knew the medication was due at 8:00am but she had been instructed to start her medication pass on the assisted living side of the second floor. -Managers were responsible for setting the times that medications were administered.	D 358		

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D 358	Continued From page 4 -The managers did not normally come to work until 9:00am. Interview with the Director of Resident Care (DRC) on 05/30/24 at 12:00pm revealed: -She was not sure why the MA did not notify her that her medications were administered late. -She made rounds several times a day checking to see if the staff needed anything. -The medications were scheduled on the second floor to be administered at 8:00am on the assisted living side and at 9:00am on the secured side of the second floor. Interview with the Administrator on 05/30/2024 at 2:10pm revealed: -The MA should have let someone know that she was administering medications late. -There was staff available to help with the administration of medications. -The MAs had been educated on what to do if they were administering medications late. Telephone interview with the facility's contracted pharmacist on 05/30/24 at 10:45am revealed she did not have any concerns about the Tylenol 650mg that was administered late for Resident #6 and Losartan 50mg and Quetiapine 25mg that was administered late for Resident #7.	D 358		