PRINTED: 08/01/2024
FORM APPROVED

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
	HAL092219	A. BUILDING: _____ B. WING _____	R 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARINA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 conducted a follow-up survey on 07/10/24 - 07/11/24.	D 000		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 6 sampled residents (#7) as related to crushing medications for a resident (#7) with a diagnosis of dysphagia (difficulty swallowing). The findings are: Review of Resident #7's current FL-2 dated 06/18/24 revealed: -Diagnoses included non-traumatic intracerebral hemorrhage (stroke), dysphagia (difficulty swallowing), internal jugular vein thromboembolism (blood clot), hyponatremia (low sodium levels), and dyslipidemia (elevated cholesterol).	D 344	D344 The Health and Wellness Director (HWD) and Medical Care Director (MCD) will review each resident's FL2 form to identify and resolve any discrepancies. FL2 addendum form will be signed by the resident PCP prior moving in. In cases where discrepancies are found, staff will utilize the AFL2 Verification Form and promptly request the resident's Primary Care Provider (PCP) to sign off on the corrections. Additionally, all orders will be verified to ensure they are accurately reflected on the Medication Administration Record (MAR) prior to or immediately upon the resident's move-in.	8/1/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE [signature] (X6) DATE 8/28/24

Reviewed and Acknowledged
WW 8/30/24

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D 344	Continued From page 1 -The FL-2 was from a rehabilitation hospital the resident was admitted to on 06/07/24. -The FL-2 was signed by a care provider at the rehabilitation hospital on 06/18/24. -The nutritional section indicated the resident needed an easy to chew (NDD3) diet with nectar thickened liquids. -The resident had a percutaneous endoscopic gastrostomy (PEG) (a feeding tube) that was removed on 06/17/24. -Notes in the medication section indicated for final discharge and medication reconciliation, see attached discharge form. -The care provider at the rehabilitation hospital handwrote an order in the medication section for "meds crushed in puree" (a pureed diet is a texture modified diet that consists of foods that do not require chewing before swallowing). Review of Resident #7's facility diet order sheet dated 06/18/24 revealed: -The diet order was for mechanical soft diet with nectar thick liquids. -There was no information on the order sheet related to crushing the resident's medications. -The order was signed and dated on 06/18/24 by the same rehabilitation hospital provider. Review of Resident #7's rehabilitation hospital provider's progress note dated 06/23/24 revealed: -The resident's diagnoses included dysphagia. -The provider noted the resident would be discharged to an assisted living facility tomorrow, 06/24/24. -There was an order for Vitamin D3 2,000 units 1 tablet daily. (Vitamin D3 is a supplement used for Vitamin D deficiency.) -There was an order for Sertraline 50mg 1 tablet daily. (Sertraline is used to treat depression.) -There was an order for Pantoprazole 40mg 1	D 344	HWD, MCD, RCC will clarify orders within 24 hours of receiving the order. HWD, MCD, RCC will do weekly chart audits to ensure accuracy of orders	8/1/2024 8/1/2024

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D 344	Continued From page 2 tablet daily. (Pantoprazole is used to treat acid reflux. Pantoprazole is enteric-coated and should not be crushed or chewed.) -There was an order for Doxazosin 2mg 1 tablet daily. (Doxazosin is used to treat high blood pressure and/or urinary retention.) -There was an order for Eliquis 5mg 1 tablet every 12 hours. (Eliquis is a blood thinner used to treat and prevent blood clots.) -There was no order or documentation regarding whether Resident #7's medications should be crushed. Review of Resident #7's physician's orders revealed no documentation to clarify whether the resident's medications should be crushed. Review of Resident #7's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D3 2,000 units 1 tablet once daily scheduled at 8:00am -There was an entry for Sertraline 50mg 1 tablet once daily scheduled at 8:00am. -There was an entry for Pantoprazole 40mg 1 tablet once daily scheduled at 8:00am. -There was an entry for Doxazosin 2mg 1 tablet once daily scheduled at 8:00am. -There was an entry for Eliquis 5mg 1 tablet every 12 hours scheduled at 8:00am and 8:00pm. -There was no entry on the eMAR with instructions to crush the resident's medications. Observation of the 8:00am medication pass on 07/10/24 revealed: -The medication aide (MA) prepared Vitamin D3 2,000 units, Sertraline 50mg, Pantoprazole 40mg, Doxazosin 2mg, and Eliquis 5mg for Resident #7. -The MA did not crush any of the medications. -The MA assisted the resident with pulling the	D 344		

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D 344	Continued From page 3 whole pills in the resident's mouth at 9:55am. -The resident chewed the pills and then swallowed them. -The resident was provided pre-thickened nectar thick water to drink with the medications. -After swallowing the chewed pills and drinking some water, the resident coughed twice. Interview with Resident #7 on 07/11/24 at 1:37pm revealed: -The resident's speech was slurred and difficult to understand at times. -He could swallow his medications better if he chewed them or if they were crushed. -He denied any side effects from his medications. -When asked about coughing or choking, the resident did not answer. Interview with the MA on 07/10/24 at 1:12pm revealed: -She usually administered Resident #7's medication whole. -The resident usually chewed the medications before swallowing them. -She was not sure if Resident #7 had an order to crush his medications. -The resident coughed "every so often" when he took his medications and when he was in the dining room eating his meals or drinking liquids. -If a resident had an order to crush medications, there was usually a message that would come up on the eMAR to crush the medications. -She had not seen a message on the eMAR to crush Resident #7's medications. Interview with the Resident Care Coordinator (RCC) on 07/10/24 at 1:40pm revealed: -She was not aware of the order on the FL-2 dated 06/18/24 to crush medications for Resident #7.	D 344		

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D 344	Continued From page 4 -Resident #7 had swallowing problems and he was on a list to be seen by facility's contracted primary care provider (PCP). -She was not aware there was no order to crush medications on the resident's medication orders dated 06/24/24. -She had not clarified any orders for crushing the resident's medications because she was not aware the resident had an order to crush medications. -There was usually a message on the eMAR if a resident's medications were supposed to be crushed. -The management team, which included the RCC, the Special Care Director (SCD), or the Health and Wellness Director (HWD) were responsible for clarifying orders. Interviews with the HWD on 07/11/24 at 10:07am and 4:16pm revealed: -She had reminded and trained the MAs on 06/25/24 to crush Resident #7's medications because of his dysphagia. -She usually reviewed admission orders and contacted the provider for clarification if needed. -She was off duty on 06/24/24 when Resident #7 was admitted so she did not review his admission orders. -The RCC would have been responsible for reviewing the orders and getting clarification in her absence. -She spoke with the facility's contracted PCP today, 07/11/24, and Resident #7's medications should be crushed if appropriate to crush. Attempted telephone interview with the Interim Administrator on 07/11/24 at 4:35pm was unsuccessful. Attempted telephone interview with Resident #7's	D 344		

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D 344	Continued From page 6 provider at the rehabilitation hospital on 07/11/24 at 12:01pm was unsuccessful. Interview with the facility's contracted PCP on 07/11/24 at 10:33am revealed: -Resident #7 was a new admission and she had not seen the resident yet. -She had spoken with the HWD about Resident #7 and wrote an order today that appropriate medications may be crushed. -The resident could aspirate (accidentally inhale food, liquids or other objects into the lungs) if his medications were not crushed due to his diagnosis of dysphagia. -She was not as concerned about the resident aspirating since the resident had been chewing his medications before swallowing them.	D 344	HWD, MCD, and RCC will conduct weekly chart audits to ensure all medications are documented in the chart and accurately reflected in the eMAR.	8/1/2024
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: FOLLOW-UP TO TYPE A2 VIOLATION. The Type A2 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications	D 358		

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D 359	Continued From page 6 were administered as ordered for 2 of 5 residents (#6, #8) observed during the medication pass including errors with a medication for high blood pressure (#6), a medication that may prevent heart attack or stroke (#6), and a medication for high cholesterol (#8); and for 1 of 5 residents (#1) sampled for record review for a medication for allergies (#1) and a medication used to treat heartburn and acid reflux (#1). The findings are: 1. The medication error rate was 11% as evidenced by 3 errors out of 26 opportunities during the 8:00am medication passes on 07/10/24 and 07/11/24. a. Review of Resident #6's current FL-2 dated 05/26/24 revealed: -Diagnoses included moderate vascular dementia without behavioral disturbance, recent cerebrovascular accident (stroke), hypertensive emergency, and peptic ulcer disease. -The medication section noted to see After Visit Summary (AVS) report. Review of Resident #6's hospital AVS report dated 05/26/24 revealed: -The medication list included instructions to start taking Hydralazine 50mg 2 tablets (100mg) 3 times a day. (Hydralazine is used to treat high blood pressure.) -The resident last received Hydralazine on 05/26/24 at 6:42am. Review of Resident #6's hospital discharge summary dated 05/26/24 revealed: -The resident was admitted to the hospital on 05/24/24 for evaluation after a fall. -The resident was diagnosed with acute renal	D 359		

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D 358	Continued From page 7 failure superimposed on stage 3 chronic kidney disease. -Due to poor blood pressure control, the resident was started on Hydralazine. -The resident's blood pressure was documented as high as 171/88. -There was an order to start taking Hydralazine 50mg 2 tablets (100mg) 3 times a day. Review of Resident #6's prescription dated 05/26/24 revealed an order for Hydralazine 50mg 2 tablets (100mg total) 3 times a day. Review of Resident #6's primary care provider (PCP) visit note dated 07/08/24 revealed: -The PCP had a conference with the resident's family members, who expressed desire to have the resident's blood pressure allowed to be high, 180 systolic blood pressure, believing that allowed the resident to be less lethargic. -The family members verbalized understanding to increased risk of heart attack or stroke with elevated blood pressures. -There was an order to discontinue Hydralazine 50mg 2 tablets 3 times a day. -There was an order to start Hydralazine 50mg 1 tablet 3 times a day for 7 days, then discontinue. Review of Resident #6's PCP physician order form dated 07/08/24 revealed: -There was an order to discontinue Hydralazine 50mg 2 tablets 3 times a day. -There was an order to start Hydralazine 50mg 1 tablet 3 times a day for 7 days, then discontinue. -The order was electronically signed by the PCP on 07/08/24 at 3:30pm. -There was computer printed documentation on the form that a copy of the order was sent via fax to the facility's contracted pharmacy and via email to the facility's Health and Wellness Director	D 358		

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D 358	Continued From page 8 (HWD), the Resident Care Coordinator (RCC), and the Special Care Director (SCD). Observation of the 8:00am medication pass on 07/10/24 revealed: -The medication aide (MA) prepared and administered Resident #6's 8:00am medications, including Hydralazine 50mg 2 tablets (100mg) at 9:49am. -Resident #6 received 2 Hydralazine 50mg tablets instead of 1 Hydralazine 50mg tablet as ordered on 07/08/24. -The resident received Hydralazine at 9:49am, 49 minutes beyond the allowable time frame for medications scheduled to be administered at 8:00am. Review of Resident #6's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Hydralazine 50mg take 2 tablets (100mg) 3 times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -Hydralazine 50mg 2 tablets was documented as administered from 8:00am on 07/01/24 through 8:00am on 07/10/24. -There was no entry to discontinue Hydralazine 50mg 2 tablets 3 times a day on the eMAR. -There was no entry on the eMAR to start Hydralazine 50mg 1 tablet 3 times a day then discontinue as ordered on 07/08/24. Observation of Resident #6's medications on hand on 07/10/24 at 1:06pm revealed: -There was a supply of Hydralazine 50mg tablets dispensed on 06/18/24 with 2 tablets packaged in each bubble. -There were 90 of 180 tablets remaining. -The instructions on the label were to take 2 tablets (100mg) 3 times daily.	D 358	D358 The order will be faxed directly to the community and then forwarded to the pharmacy. HWD, MCD, RCC, or MCC will verify the order within 24 hours to ensure that it is accurately reflected on the Medication Administration Record (MAR). Additionally, the clinical staff will follow up with a phone call to confirm receipt of the order by both the community and the pharmacy. Staff have received training on safe medication administration practices. Medication administration times will be adjusted as necessary to ensure both accuracy and safety.	7/17/2024

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D 358	Continued From page 9 -There was no supply of Hydralazine 50mg with instructions to take 1 tablet 3 times daily for 7 days then discontinue. Interview with the MA on 07/10/24 at 1:05pm revealed: -The MAs did not enter orders into the eMAR system, so she was not aware Resident #6's Hydralazine order had changed. -She administered the Hydralazine according to the instructions on the eMAR and the medication label. -She usually started the morning medication pass at 7:30am and usually finished between 10:00am and 10:30am. -She was assigned to administer medication for 2 of 3 medication carts in the assisted living AL) side of the facility. -The MAs were not allowed to administer medications in the dining room, so she had to wait for residents to finish eating breakfast and come out of the dining room, which sometimes caused her to run late on the medication pass. Telephone interview with a pharmacist with the facility's contracted pharmacy on 07/11/24 at 12:25pm revealed: -The pharmacy did not receive an order for Resident #6's Hydralazine on 07/08/24. -The pharmacy received the order dated 07/08/24 for Hydralazine on 07/10/24 at 3:57pm via fax. -She was not sure who faxed the order to the pharmacy. -The pharmacy processed the order on the day they received it, 07/10/24. Interview with the RCC on 07/10/24 at 1:40pm revealed: -The facility's contracted PCP usually sent medication orders to the pharmacy and to the	D 358		

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D 358	Continued From page 10 facility. -The pharmacy usually entered orders into the eMAR system and then the facility had to verify the orders in the eMAR system. -Either she, the SCD, or the HWD had access to verify and approve orders in the eMAR system. -She checked her emails today, and the order change for Hydralazine was sent to her email on 07/08/24 at 3:45pm. -She was unsure why she did not see the order. -She checked emailed orders every day. -She must have overlooked Resident #6's order to change the Hydralazine on 07/08/24. -The MAs had been trained to administer medications within 1 hour before or 1 hour after the scheduled time. -She was not aware of any issues with medications being administered late. -The MAs were not allowed to administer medications in the dining room per facility policy. -The MAs should notify her if they were running late with administering medications. Interview with the HWD on 07/10/24 at 2:30pm revealed: -The pharmacy usually entered medication orders into the eMAR system. -Either she, the RCC, the SCD, or the Special Care Coordinator (SCC) also had access to and could enter orders into the eMAR system if needed. -Resident #6's Hydralazine orders dated 07/08/24 should have been implemented when ordered on 07/08/24. -The morning medication pass usually started around 7:00am and the medications should be administered within 1 hour before or after the scheduled time. -The facility's policy was no medications should be administered in the dining room.	D 358		

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D 358	Continued From page 11 -She had noticed last week when reviewing medication reports there had been some issues with late medications. -They started staggering scheduled medication times last week to help with administering medications on time. Attempted telephone interview with the Interim Administrator on 07/11/24 at 4:35pm was unsuccessful. Interview with Resident #6's PCP on 07/11/24 at 10:33am revealed: -When she wrote an order, she sent it to the pharmacy and the facility. -The pharmacy usually put the orders into the eMAR system. -The facility also received orders and should check with the pharmacy if an order was not in the eMAR system. -Resident #6's family said the resident's cognition was better if her blood pressure was higher, so she changed the order for Hydralazine after speaking with the family. -She was not concerned about the resident continuing to receive the Hydralazine 50mg 2 tablets because the resident had been taking that amount for a while and the resident's blood pressure was still high. -Administering Hydralazine too close together could cause low blood pressure but the resident's blood pressure had been running high, so she was not concerned. Review of Resident #6's vital signs sheet for May 2024 - July 2024 revealed: -The resident's blood pressure was 138/70 on 06/10/24. -The resident's blood pressure was 170/82 on 06/05/24.	D 358		

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D 358	Continued From page 12 -The resident's blood pressure was 171/81 on 07/10/24. Based on observations, interviews, and record review, it was determined that Resident #6 was not interviewable. b. Review of Resident #6's hospital After Visit Summary (AVS) dated 05/20/24 revealed: -The hospital visit was dated from 05/17/24 - 05/20/24. -The resident's diagnoses included right-sided cerebrovascular accident (stroke). -The instructions included to start taking Aspirin 81mg 1 tablet daily. (Aspirin is used to prevent heart attack and stroke.) -The resident last received Aspirin 81mg on 05/20/24 at 8:53am. Review of Resident #6's current FL-2 dated 05/26/24 revealed the medication section noted to see AVS report. Review of Resident #6's hospital AVS report dated 05/26/24 revealed: -The medication list included instructions to continue taking Aspirin 81mg 1 tablet daily. -The resident last received Aspirin 81mg on 05/26/24 at 8:09am. Review of Resident #6's hospital discharge summary dated 05/26/24 revealed: -The resident was admitted to the hospital on 05/24/24 for evaluation after a fall. -The resident was diagnosed with acute renal failure superimposed on stage 3 chronic kidney disease. -The resident's diagnoses also included recent cerebrovascular accident (stroke). -There was an order to continue taking Aspirin	D 358	D358 The Health and Wellness Director (HWD), Medical Care Director (MCD), Resident Care Coordinator (RCC), or Medication Care Coordinator (MCC) will review the resident's After Visit Summary (AVS) to ensure that the medication list matches the resident's current medication list. The AVS will then be faxed to the pharmacy for verification and updates.	8/1/2024

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	R 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARINA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

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D 359	Continued From page 13 81mg 1 tablet daily. Review of Resident #6's primary care provider (PCP) visit note dated 07/08/24 revealed the resident's current medication list included Aspirin 81mg 1 tablet daily. Observation of the 8:00am medication pass on 07/10/24 revealed: -The medication aide (MA) prepared and administered Resident #6's 8:00am medications at 9:48am. -The MA did not prepare or administer Aspirin 81mg to the resident as ordered. Review of Resident #6's July 2024 electronic medication administration record (eMAR) revealed: There was no entry for Aspirin 81mg 1 tablet daily as ordered. -There was no documentation Aspirin 81mg had been administered in July 2024. Observation of Resident #6's medications on hand on 07/10/24 at 1:08pm revealed there was no supply of Aspirin 81mg available for administration. Interview with the MA on 07/10/24 at 1:05pm revealed: -The MAs did not enter orders into the eMAR system, so she was not aware of Resident #6's order for Aspirin. -She administered the medications according to the instructions on the eMAR and the medication label. -Resident #6 did not have any Aspirin 81mg on hand. Telephone interview with a pharmacist with the	D 359		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092210	A. BUILDING: _____ B. WING _____	R 07/11/2024

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D 355	Continued From page 14 facility's contracted pharmacy on 07/11/24 at 12:29pm revealed: -The pharmacy did not receive Resident #6's FL-2 dated 05/26/24. -The pharmacy received only the first page of Resident #6's AVS form dated 05/26/24, which did not include information regarding Aspirin on that page. -The pharmacy had not dispensed any Aspirin for Resident #6 because they did not have an order on file for Aspirin. Interview with the Resident Care Coordinator (RCC) on 07/10/24 at 1:40pm revealed: -The pharmacy usually entered orders into the eMAR system and then the facility had to verify the orders in the eMAR system. -Either she, the Special Care Director (SCD), or the Health and Wellness Director (HWD) had access to verify and approve orders in the eMAR system. -She must have overlooked Resident #6's order for Aspirin. Interview with the HWD on 07/11/24 at 10:07am revealed: -She contacted Resident #6's PCP regarding the Aspirin and the PCP stated the resident should have been receiving the Aspirin. -The PCP was going to send a new order for Aspirin to the pharmacy today, 07/11/24. Attempted telephone interview with the Interim Administrator on 07/11/24 at 4:35pm was unsuccessful. Interview with Resident #6's PCP on 07/11/24 at 10:33am revealed: -Resident #6 was prescribed Aspirin because of her age and health benefits associated with it.	D 355		

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	HAL092218	A. BUILDING: _____ B. WING _____	R 07/11/2024

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D 358	Continued From page 15 -The resident should be receiving Aspirin 81mg 1 tablet daily. -She was not concerned about or aware of any outcomes due to the resident not receiving the Aspirin as ordered. Review of Resident #8's PCP order dated 07/11/24 at 8:13am revealed the resident was to be on Aspirin 81mg daily. Based on observations, interviews, and record review, it was determined that Resident #8 was not interviewable. c. Review of Resident #8's current FL-2 dated 01/17/24 revealed: -Diagnoses included hyperlipemia (high cholesterol) and vascular dementia. -There was an order for Crestor 5mg daily. (Crestor is used to lower cholesterol.) Review of Resident #8's primary care provider (PCP) order dated 06/10/24 revealed an order to discontinue Crestor. Observation of the 8:00am medication pass on 07/11/24 revealed the medication aide (MA) prepared and administered Crestor 5mg to Resident #8 when she received her other morning medications at 7:45am. Review of Resident #8's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Crestor 5mg take 1 tablet once daily scheduled at 8:00am. -Crestor 5mg was documented as administered daily from 06/01/24 - 06/30/24. -There was no entry to discontinue Crestor 5mg as ordered on 06/10/24.	D 358		

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D 358	Continued From page 16 Review of Resident #8's July 2024 eMAR dated 07/01/24 - 07/11/24 revealed: -There was an entry for Crestor 5mg take 1 tablet once daily scheduled at 8:00am. -Crestor 5mg was documented as administered daily from 07/01/24 - 07/11/24. -Crestor continued to be administered after it was discontinued on 06/10/24. Observation of Resident #8's medications on hand on 07/11/24 at 1:59pm revealed: -There was a supply of Crestor 5mg dispensed on 06/18/24. -There were 17 of 30 tablets remaining in the bubble card. Interview with the MA on 07/11/24 at 10:45am revealed: -She was not aware Resident #8's Crestor had been discontinued. -She administered Crestor to Resident #8 because it was on the eMAR to be administered. Interview with the Special Care Director (SCD) on 07/11/24 at 2:07pm revealed: -She remembered Resident #8's Crestor being discontinued because she had pulled the medication card from the medication cart when it was discontinued. -One of the MAs must have put it back on the medication cart since it was still on the eMAR. -She recalled seeing the Crestor on the eMAR after it was discontinued so she called the pharmacy (not sure date and time). -The pharmacy staff told her the PCP had restarted the Crestor. -The facility did not have an order to restart the Crestor. -She should have contacted the PCP to clarify the	D 358	D358 The Health and Wellness Director (HWD), Medical Care Director (MCD), Resident Care Coordinator (RCC), and Medication Care Coordinator (MCC) will ensure that all orders are verified within 24 hours and accurately reflected in the Medication Administration Record (MAR) daily. Once verification is completed, the order will be filed in the resident's chart.	8/1/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 17 Crestor. Interview with the Health and Wellness Director (HWD) on 07/11/24 at 4:16pm revealed: -The SCD, Resident Care Coordinator (RCC), Special Care Coordinator (SCC), or herself would be responsible for verifying and clarifying orders. -The Resident #8's Crestor should have been clarified. Interview with Resident #8's PCP on 07/11/24 at 10:45am revealed: -She discontinued Resident #8's Crestor because due to the resident's age and mental status, it was not beneficial due to risk of side effects. -She was not concerned about Resident #8 continuing to receive Crestor after it was discontinued since it was just not beneficial due to her age. Telephone interview with a pharmacist with the facility's contracted pharmacy on 07/11/24 at 12:29pm revealed: -The pharmacy did not have an order to discontinue Resident #8's Crestor on file. -The pharmacy sent a refill request to the PCP and they received an electronic prescription on 06/13/24 with authorized refills for the Crestor so the pharmacy continued to dispense Crestor. 2. Review of Resident #1's FL-2 dated 05/28/24 revealed diagnoses included myelofibrosis, sleep apnea, chronic kidney disease stage 3, atrial fibrillation, congestive heart failure, history of prostate cancer, glaucoma, and biventricular cardiac pacemaker. Review of Resident #1's Resident Register revealed he was admitted from home on 05/28/24.	D 358		

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D 358	Continued From page 18 s. Review of Resident #1's physician order review dated 06/10/24 revealed there was a handwritten order to start Cetirizine 10mg daily. (Cetirizine is used to treat allergy symptoms.) Review of Resident #1's June 2024 electronic medication administration record (eMAR) revealed there was no entry for Cetirizine 10mg daily. Review of Resident #1's July 2024 eMAR revealed there was no entry for Cetirizine 10mg daily. Observation of Resident #1's medications on hand on 07/11/24 at 1:31pm revealed there was a 12-day supply of Cetirizine 10mg tablets dispensed on 07/10/24 with 11 tablets remaining. Interview with Resident #1 on 07/11/24 at 2:50pm revealed: -He was admitted from home the last part of May. -He had brought his medications from home. -The facility was supposed to be giving him the medications he brought with him. -He had asked about getting Zyrtec (Cetirizine) when he first arrived at the facility, but he did not think he had received it yet. -He had forgotten to ask about it again. Interview with a medication aide (MA) on 07/11/24 at 1:31pm revealed she was not aware of an order for Cetirizine 10mg for Resident #1 until yesterday (07/10/24). Interview with the Resident Care Coordinator (RCC) on 07/11/24 at 2:30pm revealed: -She had reached out to Resident #1's primary care provider (PCP) yesterday, 07/10/24, when it	D 358		

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D 358	Continued From page 19 had been brought to her attention that the facility had overlooked the physician's orders from the physician order review dated 06/10/24. -The PCP ordered the Cetirizine 10mg once a day. -She was not sure how she had missed the orders that were handwritten on the physician order review dated 06/10/24. -She was responsible for carrying out the orders and faxing them to the pharmacy. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/11/24 at 12:29pm revealed: -The pharmacy did not receive an order on 06/10/24 for Cetirizine for Resident #1. -The pharmacy received an order for Cetirizine 10mg on 07/10/24. -The pharmacy dispensed a 12-day supply of Cetirizine 10mg on 07/10/24 to finish out the monthly cycle fill. -Not receiving Cetirizine could cause the resident to have increased allergy symptoms. Interview with Resident #1's PCP on 07/11/24 at 10:33am revealed: -Facility staff asked her on 07/10/24 to order Resident #1's Cetirizine 10mg once daily. -She was not concerned about Resident #1 not getting the Cetirizine 10mg once a day as he had not complained about any allergy symptoms when she saw him last. Attempted telephone interview with the Interim Administrator on 07/11/24 at 4:35pm was unsuccessful. b. Review of Resident #1's physician order review dated 06/10/24 revealed: -There was an electronic entry for Famotidine	D 358		

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D 359	Continued From page 20 10mg daily. (Famotidine is used to treat acid reflux and heartburn). -There was a handwritten order to start Famotidine 10mg twice daily. Review of Resident #1's June 2024 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Famotidine 10mg daily. -There was no entry for Famotidine10mg twice daily. -There was documentation Famotidine 10mg was administered daily at 8:00am 06/01/24-06/30/24. -There was no documentation Famotidine 10mg was administered twice daily from 06/10/24-06/30/24. Review of Resident #1's July 2024 eMAR revealed: -There was an electronic entry for Famotidine 10mg daily. -There was documentation Famotidine 10mg was administered daily at 8:00am 07/01/24-07/11/24. -There was an entry for Famotidine10mg twice daily beginning on 07/10/24 to be administered at 8:00am and 8:00pm. Observation of Resident #1's medications on hand on 07/11/24 at 1:31pm revealed: -There was a supply of Famotidine 10mg tablets dispensed on 06/18/24. -There were 7 of 30 Famotidine tablets remaining. -The directions were to take 1 tablet once daily. -There was a white sticker with red lettering placed in the upper left-hand corner of the bubble pack that noted "DIRECTIONS CHANGED REFER TO CHART". -There was a supply of Famotidine 10mg tablets	D 359		

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D 358	Continued From page 21	D 359		

dispensed on 07/10/24.
-There were 24 of 24 Famotidine tablets remaining.
-The directions were to take 1 tablet twice daily.

Interview with Resident #1 on 07/11/24 at 2:50pm revealed:
-He was admitted from home the last part of May.
-He had brought his medications from home.
-The facility was supposed to be giving him the medications he brought with him.
-He was receiving his 'Pepcid' (Famotidine) once a day.
-He had forgotten to ask about it again.

Interview with a medication aide (MA) on 07/11/24 at 1:31pm revealed:
-She had been administering Resident #1 his Famotidine once daily from his personal medications he had brought from home.
-She was not aware that he had an order for Famotidine twice daily until yesterday, 07/10/24.
-She received a new bubble pack of Famotidine today, 07/11/24, with directions to give it twice a day and had placed the sticker on his old bubble pack of Famotidine that the directions had changed.

Interview with the Resident Care Coordinator (RCC) on 07/11/24 at 2:30pm revealed:
-She had reached out to Resident #1's primary care provider (PCP) yesterday 07/10/24 when it had been brought to her attention that the facility had overlooked the physician's orders from the physician order review dated 06/10/24.
-The PCP ordered the Famotidine 10mg to be administered twice a day now instead of once daily.
-She was not sure how she had missed the orders that were handwritten on the physician

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D 358	Continued From page 22 order review dated 06/10/24. -She was responsible for carrying out the orders and faxing them to the pharmacy. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/11/24 at 12:29pm revealed: -The pharmacy did not receive an order on 06/10/24 for Famotidine for Resident #1. -The pharmacy received an order for Famotidine 10mg on 07/10/24. -The pharmacy dispensed a 12-day supply of Famotidine 10mg on 07/10/24 to finish out the monthly cycle fill. -Not receiving Famotidine could cause the resident to have increased stomach acid. Interview with Resident #1's PCP on 07/11/24 at 10:33am revealed: -Facility staff asked her on 07/10/24 to order Resident #1's Famotidine twice daily. -Resident #1 was a little forgetful. -She was not concerned about Resident #1 not getting the Famotidine twice a day as he had been getting it once daily and had not complained about it not being effective when she saw him last. Attempted telephone interview with the Interim Administrator on 07/11/24 at 4:35pm was unsuccessful.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development	D 371		

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D 371	Continued From page 23 and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control measures were implemented during the medication pass on 07/10/24 by 1 of 1 medication aides observed who failed to wash or sanitize their hands prior to preparing and after administering medications to 2 residents, including multiple oral medications, an antibiotic eye ointment for infection, and a liquid oral medication. The findings are: Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 07/10/24 from 9:45am - 9:55am revealed: -There was no hand sanitizer on the B Hall medication cart. -At 7:45am, the MA started preparing medications for a resident who lived on the B Hall. -The MA did not wash or sanitize her hands prior to preparing the resident's medications. -The MA administered oral solid medications to the resident at 9:49am. -The MA put on gloves and administered an antibiotic eye ointment (for infection) to the same resident at 9:51am. -The MA returned to the medication cart, removed the gloves, and entered documentation into the computer system. -The MA did not sanitize or wash her hands after administering the medications, removing the gloves, or prior to preparing medications for the next resident. -The MA prepared medication for a second	D 371	D371 RCC will ensure that hand sanitizer is available on each medication cart (A, B, C, and D). Additionally, medtech's will receive education on the importance of infection control, proper handwashing techniques, and infection control practices during medication administration. HWD and MCD will conduct daily spot checks to ensure proper handwashing and sanitizing practices are being followed.	8/1/2024 8/1/2024

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THE ARMISON OF FUQUAY VARINA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 371	Continued From page 24 resident who resided on the B Hall, including pouring and measuring a liquid medication and mixing it in water. -The MA assisted the resident by putting the medication cup to the resident's mouth and handing the water cup to the resident. -The resident took the medications and drank the medication mixed in water at 9:55am. -The MA returned to the medication cart and entered documentation into the computer system. -The MA did not sanitize or wash her hands after administering the medications. -The MA continued with the medication cart to administer more medications without sanitizing or washing her hands. Interview with the MA on 07/10/24 at 1:05pm revealed: -There was no hand sanitizer on the medication carts today, 07/10/24. -They usually had hand sanitizer spray but she did not like to use the spray. -She thought the hand sanitizer with a pump dispenser was better. -There was a big container of hand sanitizer in the nurses' station near the medication carts for A and B Halls, but the hand pump was missing from the bottle and she would have to pick up the bottle in order to use the sanitizer. -She usually tried to sanitize her hands after she administered medications like eye drops or insulin or she would put gloves on for those type of medications. -She did not recall the facility's policy for hand hygiene for the medication pass. Interview with the Resident Care Coordinator (RCC) on 07/10/24 at 1:40pm revealed: -The MAs were supposed to sanitize their hands between each resident during the medication	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	R 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARINA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

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D 371	Continued From page 25 pass. -There should be hand sanitizer on each medication cart. -If they run out of hand sanitizer on the medication cart, there was enough hand sanitizer in the facility to restock the medication carts. -She was concerned the MA did not use hand sanitizer for proper infection control during the medication pass because of cross-contamination between the residents. Interview with the Health and Wellness Director (HWD) on 07/10/24 at 2:30pm revealed: -The MAs were supposed to sanitize their hands before and after administering medications to each resident. -There should be hand sanitizer on each medication cart. -There was also a hand sanitizer wall dispenser near the nurses' station beside the medication carts. -She was concerned the MA not sanitizing or washing her hands could potentially transmit infections to other residents. Interview with the facility's contracted primary care provider (PCP) on 07/11/24 at 10:33am revealed: -The MAs should sanitize or wash their hands between each resident when administering medications. -If the MAs did not sanitize or wash their hands, there was potential for cross-contamination. Attempted telephone interview with the Interim Administrator on 07/11/24 at 4:35pm was unsuccessful.	D 371		