

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL055009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>02/17/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE ADDISON OF LINCOLNTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SALEM CHURCH ROAD</b> <b>LINCOLNTON, NC 28092</b>
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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
{D 000}	Initial Comments  The Adult Care Licensure Section conducted a follow-up survey on February 15 - 17, 2022.	{D 000}		
{D 358}	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>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.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION</p> <p>The Type A2 Violation is abated. Non-compliance continues.</p> <p>TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 4 of 5 sampled residents (#1, #2, #4, and #5) related to not administering medications for dementia, vitamin D deficiency, stroke prevention and depression (Resident #4); for anxiety, mild to moderate pain, high blood pressure, dementia, and high cholesterol (Resident #5); for anxiety and insomnia (Resident #2); and for mild to moderate pain (Resident #1).</p> <p>The findings are:</p>	{D 358}		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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{D 358}	<p>Continued From page 1</p> <p>Review of the facility's medication policy revealed: -It was the policy of the community to administer all medications that the residents receive as ordered by their physician. -The licensed nurse or designee will fax new orders and reorders for medications to the pharmacy. -Medications will be ordered on demand and will be requested when 5 days of medications are left in the package.</p> <p>1. Review of Resident #4's current FL2 dated 02/10/22 revealed diagnoses included Alzheimer's dementia, acute diastolic congestive heart failure, and type II diabetes.</p> <p>a. Review of Resident #4's current FL2 dated 02/10/22 revealed an order for donepezil 10mg (used to treat dementia) take 1 tablet daily at bedtime, scheduled for 8:00pm.</p> <p>Review of Resident #4's physician order dated 11/11/21 revealed an order for donepezil 10mg take 1 tablet daily at bedtime.</p> <p>Review of Resident #4's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for donepezil 10mg, take 1 tablet daily at bedtime, scheduled for 8:00pm. -Donepezil 10mg was documented as not administered at 8:00pm on 12/11/21, 12/20/21, 12/21/21, 12/22/21, 12/24/21, 12/30/21, and 12/31/21. -The reason the medication was not administered was documented as DNG (drug not given) for 12/20/21, 12/21/21, and 12/22/21, and OTH (other) for 12/24/21, and with a dash (-) on 12/11/21, 12/30/21, and 12/31/21.</p>	{D 358}		

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{D 358}	<p>Continued From page 2</p> <p>Review of Resident #4's January 2022 eMAR revealed: -There was an entry for donepezil 10mg, take 1 tablet daily at bedtime, scheduled for 8:00pm. -Donepezil 10mg was documented as not administered at 8:00pm on 01/02/22, 01/28/22, 01/29/22, 01/30/22 and 01/31/22. -The reason the medication was not administered was documented as DNG (drug not given) for 01/02/22 and 01/30/22, and DNA (drug not available) on 01/28/22 and 01/29/22, and with CE (charted in error) on 01/31/22.</p> <p>Review of Resident #4's February 2022 eMAR revealed: -There was an entry for donepezil 10mg, take 1 tablet daily at bedtime, scheduled for 8:00pm. -Donepezil 10mg was documented as not administered at 8:00pm on 2/03/22, 02/04/22, 02/10/22, 02/11/22, 02/12/22, 02/14/22, 02/15/22, 02/16/22, and 02/17/22. -The reason the medication was not administered was documented as DNA (drug not available) for 02/03/22, 02/04/22, 02/10/22, 02/11/22, and 02/14/22, and with a dash (-) on 02/12/22, 02/15/22, 02/16/22, and 02/17/22.</p> <p>Telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy revealed Resident #4's donepezil 10mg was dispensed to the facility on 11/23/21, quantity 30 tablets and on 01/02/22, quantity 30 tablets.</p> <p>Observation on 02/17/22 at 10:30am of Resident #4's medications available for administration revealed there was no donepezil 10mg available for administration on the medication cart.</p> <p>Interview on 02/17/22 at 10:30am with the</p>	{D 358}		

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{D 358}	<p>Continued From page 3</p> <p>medication aide (MA) revealed Resident #4 had been out of her donepezil for the past 3 days.</p> <p>Interview on 02/17/22 at 11:30am with the Health and Wellness Director (HWD) revealed Resident #4's donepezil would be delivered today from the back-up pharmacy.</p> <p>Telephone interview on 02/17/22 at 12:10pm with the Pharmacist at the facility's contracted pharmacy revealed when a resident was not administered donepezil 10mg for 14 days, they may have increased mood changes.</p> <p>b. Review of Resident #4's current FL2 dated 02/10/22 revealed an order for Vitamin D 1.25mg (used to treat vitamin D deficiency) take 1 capsule by mouth once weekly, scheduled for 8:00am.</p> <p>Review of Resident #4's physician order dated 11/19/21 revealed an order for Vitamin D 1.25mg take 1 capsule by mouth once weekly.</p> <p>Review of Resident #4's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D 1.25mg take 1 capsule once weekly, scheduled for 8:00am. -Vitamin D 1.25mg was not documented as administered at 8:00am on 12/27/21. -The reason the medication was not administered was documented as DNA (drug not available) for 12/27/21.</p> <p>Review of Resident #4's January 2022 eMAR revealed: -There was an entry for Vitamin D 1.25mg take 1 capsule once weekly, scheduled for 8:00am. - Vitamin D 1.25mg was not documented as</p>	{D 358}		

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{D 358}	<p>Continued From page 4</p> <p>administered at 8:00am on 01/03/22 and 01/31/22.</p> <p>-The reason the medication was not administered was documented as DNG (drug not given) on 01/03/22 and DNA (drug not available) on 01/31/22.</p> <p>Review of Resident #4's February 2022 eMAR revealed:</p> <p>-There was an entry for Vitamin D 1.25mg take 1 capsule once weekly, scheduled for 8:00am.</p> <p>-Vitamin D 125mg was documented as not administered at 8:00am on 02/14/22.</p> <p>-The reason the medication was not administered was documented as DNG (drug not given) on 02/14/22.</p> <p>Telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy revealed:</p> <p>-Resident #4's Vitamin D 1.25mg was dispensed to the facility on 11/18/21, quantity 4 capsules and on 01/12/22, quantity 4 capsules.</p> <p>-The Vitamin D that was dispensed to the facility on 01/12/22 was returned to the pharmacy by the facility.</p> <p>Observation on 02/17/22 at 10:30am of Resident #4's medications available for administration revealed there was no Vitamin D 1.25mg available for administration on the medication cart.</p> <p>Interview on 02/17/22 at 10:30am with the medication aide (MA) revealed Resident #4 did not have Vitamin D on the medication cart, because it was a once weekly medication and was sent by the pharmacy right before it was due.</p> <p>Interview on 02/17/22 at 11:30am with the Health</p>	{D 358}		

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{D 358}	<p>Continued From page 5</p> <p>and Wellness Director (HWD) revealed Resident #4's Vitamin D would be delivered on Friday, 02/18/22, from the pharmacy.</p> <p>Telephone interview on 02/17/22 at 12:10pm with the Pharmacist at the facility's contracted pharmacy revealed when a resident was not administered Vitamin D 1.25mg for 3 weeks, they may have decreased vitamin D levels.</p> <p>c. Review of Resident #4's current FL2 dated 02/10/22 revealed an order for aspirin 81mg (used to prevent stroke and heart attacks) take 1 tablet daily, scheduled for 8:00am.</p> <p>Review of Resident #4's physician order dated 11/11/21 revealed an order for aspirin 81mg take 1 tablet daily.</p> <p>Review of Resident #4's February 2022 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for aspirin 81mg, take 1 tablet daily, scheduled for 8:00am.</li> <li>-Aspirin 81mg was not documented as administered at 8:00am on 02/01/22, 02/04/22, 02/05/22, 02/11/22, 02/12/22, and 02/14/22.</li> <li>-The reason documented on the eMAR regarding why the medication was not administered was listed as DNG (drug not given) for 02/01/22 and 02/04/22 and DNA (drug not available) for 02/05/22, 02/11/22, 02/12/22, and 02/14/22.</li> </ul> <p>Telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy revealed Resident #4's aspirin 81mg was dispensed to the facility on 01/03/22 for quantity 30 tablets and on 02/12/22 for quantity 30 tablets.</p>	{D 358}		

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{D 358}	<p>Continued From page 6</p> <p>Observation on 02/17/22 at 10:30am of Resident #4's medications available for administration revealed there was a bubble pack of aspirin 81mg with a pharmacy label dated 02/12/22 and directions to take 1 tablet daily.</p> <p>Telephone interview on 02/17/22 at 12:10pm with the Pharmacist at the facility's contracted pharmacy revealed when a resident was not administered aspirin 81mg for several days, they have an increased risk for heart attacks and stroke.</p> <p>d. Review of Resident #4's current FL2 dated 02/10/22 revealed an order for sertraline 50mg (used to treat depression) take 0.5 tablet daily (25mg), scheduled for 8:00am.</p> <p>Review of Resident #4's physician order dated 11/11/21 revealed an order for sertraline 50mg take 0.5 tablet (25mg) daily.</p> <p>Review of Resident #4's February 2022 electronic medication administration record (eMAR) revealed:                      -There was an entry for sertraline 50mg take 0.5 tablet daily (25mg), scheduled for 8:00am.                      -Sertraline 50mg was not documented as administered at 8:00am on 02/01/22, 02/04/22, 02/11/22, 02/12/22, and 02/14/22.                      -The reason the medication was not administered was documented as DNG (drug not given) on 02/01/22, 02/04/22, and 02/14/22 and DNA (drug not available) on 02/11/22 and 02/12/22.</p> <p>Telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy revealed Resident #4's sertraline 50mg was dispensed to the facility on 12/15/21 for quantity 30 tablets and on 02/12/22 for quantity</p>	{D 358}		

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{D 358}	<p>Continued From page 7</p> <p>30 tablets.</p> <p>Observation on 02/17/22 at 10:30am of Resident #4's medications available for administration revealed there was a bubble pack of sertraline 50mg with a pharmacy label dated 02/12/22 and directions to take 0.5 tablet daily.</p> <p>Telephone interview on 02/17/22 at 12:10pm with the Pharmacist at the facility's contracted pharmacy revealed when a resident was not administered sertraline 75mg for five days, they may have increased anxiety and mood changes.</p> <p>Interview on 02/17/22 at 1:00pm with a medication aide (MA) revealed Resident #4 had not had any recent behavioral or mood changes.</p> <p>Attempted telephone interview with Resident #4's Physician Assistant (PA) on 02/17/22 at 8:29am was unsuccessful.</p> <p>Interview on 02/17/22 at 10:50am with Resident #4 revealed: -She took the medications that were given to her by the MAs. -She was not aware if she had missed any medications in the past 3 months. -She did not feel like she had missed any of her regular medications and felt like her "normal self."</p> <p>Refer to interview on 02/15/22 at 10:25am with the Health and Wellness Director (HWD).</p> <p>Refer to telephone interview on 02/15/22 at 11:01am with the pharmacy technician from the facility's contracted pharmacy.</p> <p>Refer to interview on 02/16/22 at 2:30pm with a medication aide (MA).</p>	{D 358}		

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{D 358}	<p>Continued From page 8</p> <p>Refer to telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy.</p> <p>Refer to interview on 02/17/22 at 10:30am with another medication aide (MA).</p> <p>Refer to the interview on 02/17/22 at 12:22pm with the Health and Wellness Director (HWD).</p> <p>Refer to interview on 02/17/22 at 12:45pm with the Resident Care Coordinator (RCC).</p> <p>Refer to the telephone interview on 02/17/22 at 12:48pm with the Administrator.</p> <p>Refer to interview on 02/17/22 at 2:40pm with a third medication aide (MA)</p> <p>2. Review of Resident #5's current FL2 dated 06/18/21 revealed diagnoses included dementia with behavioral changes, high blood pressure, morbid obesity, and depression.</p> <p>a. Review of Resident #5's current FL2 dated 06/18/21 revealed an order for Seroquel 50mg (used to treat anxiety) take 1.5 tablets (75mg) twice daily.</p> <p>Review of Resident #5's December 2021 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for Seroquel 50mg take 1.5 tablets (75mg) twice daily, scheduled for 8:00am and 8:00pm.</li> <li>-Seroquel 50mg (1.5 tablets) was not documented as administered at 8:00am on 12/08/21 and 12/30/21.</li> <li>-The reason the medication was not administered</li> </ul>	{D 358}		

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{D 358}	<p>Continued From page 9</p> <p>was documented with a dash (-) mark for 12/08/21 and 12/30/21.</p> <p>Review of Resident #5's February 2022 eMAR revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for Seroquel 50mg take 1.5 tablets (75mg) twice daily, scheduled for 8:00am and 8:00pm.</li> <li>-Seroquel 50mg (1.5 tablets) was documented as not administered at 8:00am on 02/04/22 and 02/05/22, and at 8:00pm on 02/04/22, 02/06/22 and 02/09/22.</li> <li>-The reason the medication was not administered was documented as DNG (drug not given) on 02/04/22 and 02/06/22 and DNA (drug not available) on 02/04/22, 02/05/22 and 02/09/22.</li> </ul> <p>Observation on 02/16/22 at 3:23pm of Resident #5's medications available for administration revealed there was a bubble pack of Seroquel 50mg with a pharmacy label dated 02/08/22 and directions to take 1.5 tablets twice daily.</p> <p>Telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy revealed Resident #5's Seroquel 50mg (1.5 tablets) was dispensed to the facility on 11/22/21, 12/15/21, and on 02/08/22 for a 30 day supply each time.</p> <p>Telephone interview on 02/17/22 at 12:10pm with the Pharmacist at the facility contracted pharmacy revealed when a resident was not administered Seroquel 50mg for several days, they may have increased mood changes.</p> <p>Interview on 02/17/22 at 1:00pm with a medication aide (MA) revealed Resident #5 had not had any recent behavioral or mood changes.</p>	{D 358}		

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{D 358}	<p>Continued From page 10</p> <p>b. Review of Resident #5's physician order dated 08/03/21 revealed an order for Tylenol 325mg (used to treat mild to moderate pain) take 2 tablets three times daily.</p> <p>Review of Resident #5's December 2021 electronic medication administration record (eMAR) revealed:                      -There was an entry for Tylenol 325mg take 2 tablets three times daily, scheduled for 8:00am, 2:00pm and 8:00pm.                      -Tylenol 325mg was documented as not administered at 2:00pm on 12/09/21, 12/17/21, and 12/19/21.                      -Tylenol 325mg was documented as not administered at 8:00pm on 12/08/21, 12/10/21, and 12/30/21.                      -The reason the medication was not administered was documented with a dash (-) mark for 12/08/21 and 12/30/21, and as DNG (drug not given) on 12/09/21, 12/17/21, and 12/19/21, and as DNA (drug not available) on 12/10/21.</p> <p>Review of Resident #5's January 2022 eMAR revealed:                      -There was an entry for Tylenol 325mg take 2 tablets three times daily, scheduled for 8:00am, 2:00pm and 8:00pm.                      -Tylenol 325mg was documented as not administered at 8:00am on 01/11/22 and 01/13/22.                      -Tylenol 325mg was documented as not administered at 2:00pm on 01/04/22, 01/11/22, and 01/13/22.                      -Tylenol 325mg was documented as not administered at 8:00pm on 01/10/22, 01/11/22, 01/12/22, and 01/13/22.                      -The reason the medication was not administered was documented as DNG (drug not given) on 01/04/22, 01/11/22 at 8am and 2pm, and</p>	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL055009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>02/17/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE ADDISON OF LINCOLNTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SALEM CHURCH ROAD LINCOLNTON, NC 28092</b>
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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
{D 358}	<p>Continued From page 11</p> <p>01/13/22 at 8am and 2pm, and as DNA (drug not available) on 01/10/22, 01/11/22, 01/12/22, and 01/13/22.</p> <p>Observation on 02/16/22 at 3:23pm of Resident #5's medications available for administration revealed there were 3 bubble packs of Tylenol 325mg with a pharmacy label dated 02/06/22 and directions to take 2 tablets three times daily.</p> <p>Telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy revealed Resident #5's Tylenol 325mg was dispensed to the facility on 11/29/21, 01/13/22, and on 02/06/22 for a 30 day supply each time.</p> <p>Telephone interview on 02/17/22 at 12:10pm with the Pharmacist at the facility's contracted pharmacy revealed when a resident was not administered Tylenol 325mg for several days, they may have increased pain.</p> <p>c. Review of Resident #5's current FL2 dated 06/18/21 revealed an order for carvedilol 3.125mg (used to treat high blood pressure) take 1 tablet twice daily.</p> <p>Review of Resident #5's February 2022 electronic medication record (eMAR) revealed: -There was an entry for carvedilol 3.125mg take 1 tablet twice daily, scheduled for 8:00am and 5:00pm. -Carvedilol 3.125mg was documented as not administered at 8:00am on 02/14/22, and at 5:00pm on 02/14/22. -The reason the medication was not administered was documented as DNG (drug not given) on 02/14/22 at 8am and 5pm.</p>	{D 358}		

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{D 358}	<p>Continued From page 12</p> <p>Observation on 02/16/22 at 3:23pm of Resident #5's medications available for administration revealed there was a bubble pack of carvedilol 3.125mg with a pharmacy label dated 02/14/22 and directions to take 1 tablet twice daily.</p> <p>Telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy revealed Resident #5's carvedilol 3.125mg was dispensed to the facility on 01/03/22 quantity 60 tablets, and on 02/14/22 quantity 32 tablets.</p> <p>Telephone interview on 02/17/22 at 12:10pm with the Pharmacist at the facility's contracted pharmacy revealed when a resident was not administered carvedilol 3.125mg for several days, they may have increased blood pressure and heart rate.</p> <p>d. Review of Resident #5's current FL2 dated 06/18/21 revealed an order for donepezil 10mg (used to treat dementia) take 1 tablet at bedtime.</p> <p>Review of Resident #5's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for donepezil 10mg take 1 tablet at bedtime -Donepezil 10mg was documented as not administered at 8:00pm on 12/08/21, 12/20/21, 12/22/21, 12/23/21, 12/24/21, 12/27/21, 12/29/21, 12/30/21 and 12/31/21. -The reason the medication was not administered was documented with a dash (-) mark on 12/08/21 and 12/30/21, and as DNA (drug not available) on 12/20/21, 12/22/21, 12/23/21, 12/24/21, 12/27/21, 12/29/21, and 12/31/21.</p> <p>Review of Resident #5's January 2022 eMAR</p>	{D 358}		

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{D 358}	<p>Continued From page 13</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for donepezil 10mg take 1 tablet at bedtime.</li> <li>-Donepezil 10mg was documented as not administered at 8:00pm on 01/3/22, 01/4/22, 01/05/22, 01/06/22, 01/08/22, 01/09/22, 01/10/22, 01/11/22, 01/12/22 and 01/13/22.</li> <li>-The reason the medication was not administered was documented as DNA (drug not available) on 01/3/22, 01/4/22, 01/05/22, 01/06/22, 01/08/22, 01/09/22, 01/10/22, 01/11/22, 01/12/22 and 01/13/22.</li> </ul> <p>Observation on 02/16/22 at 3:23pm of Resident #5's medications available for administration revealed there was a bubble pack of donepezil 10mg with a pharmacy label dated 02/04/22 and directions to take 1 tablet at bedtime.</p> <p>Telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy revealed Resident #5's donepezil 10mg was dispensed to the facility on 11/11/21, 01/13/22, and on 02/05/22 for a 30 day supply each time.</p> <p>Telephone interview on 02/17/22 at 12:10pm with the Pharmacist at the facility's contracted pharmacy revealed when a resident was not administered donepezil 10mg for 19 days, they may have increased mood changes.</p> <p>e. Review of Resident #5's current FL2 dated 06/18/21 revealed an order for simvastatin 10mg (used to treat high cholesterol) take 1 tablet at bedtime.</p> <p>Review of Resident #5's December 2021 electronic medication administration record (eMAR) revealed:</p>	{D 358}		

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NAME OF PROVIDER OR SUPPLIER  <b>THE ADDISON OF LINCOLNTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SALEM CHURCH ROAD</b> <b>LINCOLNTON, NC 28092</b>
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{D 358}	<p>Continued From page 14</p> <p>-There was an entry for simvastatin 10mg take 1 tablet at bedtime.</p> <p>-Simvastatin 10mg was documented as not administered at 8:00pm on 12/08/21, 12/20/21, 12/22/21, 12/23/21, 12/24/21, 12/25/21, 12/26/21, 12/27/21, 12/28/21, 12/29/21, 12/30/21 and 12/31/21.</p> <p>-The reason the medication was not administered was documented with a dash (-) mark on 12/08/21 and 12/30/21, and as DNA (drug not available) on 12/20/21, 12/22/21, 12/23/21, 12/24/21, 12/25/21, 12/26/21, 12/27/21, 12/28/21, 12/29/21, and 12/31/21.</p> <p>Review of Resident #5's January 2022 eMAR revealed:</p> <p>-There was an entry for simvastatin 10mg take 1 tablet at bedtime.</p> <p>-Simvastatin 10mg was documented as not administered at 8:00pm on 01/01/22, 01/3/22, 01/4/22, 01/06/22, 01/08/22, 01/09/22, 01/10/22, 01/11/22, 01/12/22 and 01/13/22.</p> <p>-The reason the medication was not administered was documented as DNA (drug not available) on 01/01/22, 01/3/22, 01/4/22, 01/06/22, 01/08/22, 01/09/22, 01/10/22, 01/11/22, 01/12/22 and 01/13/22.</p> <p>Observation on 02/16/22 at 3:23pm of Resident #5's medications available for administration revealed there was a bubble pack of simvastatin 10mg with a pharmacy label dated 02/04/22 and directions to take 1 tablet at bedtime.</p> <p>Telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy revealed Resident #5's simvastatin 10mg was dispensed to the facility on 11/15/21, 01/13/22, and on 02/05/22 for a 30 day supply each time.</p>	{D 358}		

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{D 358}	<p>Continued From page 15</p> <p>Telephone interview on 02/17/22 at 12:10pm with the Pharmacist from the facility's contracted pharmacy revealed when a resident was not administered simvastatin 10mg for 22 days, they may have increased lipid levels.</p> <p>Attempted telephone interview with Resident #5's Physician Assistant (PA) on 02/17/22 at 8:29am was unsuccessful.</p> <p>Refer to interview on 02/15/22 at 10:25am with the Health and Wellness Director (HWD).</p> <p>Refer to telephone interview on 02/15/22 at 11:01am with the pharmacy technician from the facility's contracted pharmacy.</p> <p>Refer to interview on 02/16/22 at 2:30pm with a medication aide (MA).</p> <p>Refer to telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy.</p> <p>Refer to interview on 02/17/22 at 10:30am with another medication aide (MA).</p> <p>Refer to the interview on 02/17/22 at 12:22pm with the Health and Wellness Director (HWD).</p> <p>Refer to interview on 02/17/22 at 12:45pm with the Resident Care Coordinator (RCC).</p> <p>Refer to the telephone interview on 02/17/22 at 12:48pm with the Administrator.</p> <p>Refer to interview on 02/17/22 at 2:40pm with a third medication aide (MA)</p>	{D 358}		

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{D 358}	<p>Continued From page 16</p> <p>3. Review of Resident #2's current FL2 dated 08/15/21 revealed a diagnosis of improved hypersomnolence.</p> <p>Review of Resident #2's Physician's order dated 12/22/21 revealed an order for Doxepin 10mg (used to treat insomnia and anxiety) scheduled at bedtime.</p> <p>Review of Resident #2's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Doxepin HCl 10mg, take at bedtime, scheduled for 9:00pm. -Doxepin HCl 10mg had a start date of 12/29/21. -Doxepin HCl 10mg was documented as administered at 9:00pm from 12/29/21-12/31/21.</p> <p>Review of Resident #2's January 2022 eMAR revealed: -There was an entry for Doxepin HCl 10mg, take at bedtime, scheduled for 9:00pm. -Doxepin HCl 10mg was documented as administered at 9:00pm from 01/01/22-01/18/22. -Doxepin HCl 10mg was documented as held from 01/19/22-01/31/22.</p> <p>Review of Resident #2's February 2022 eMAR revealed: -An entry for Doxepin HCl 10mg, take at bedtime, scheduled for 9:00pm. -Doxepin HCl 10mg was documented as held from 02/01/22-02/15/22.</p> <p>Interview on 02/15/22 at 9:30am with Resident #2 revealed she could not recall all the medications she took because she had many medications.</p> <p>Observation on 02/16/22 at 3:42pm of Resident #2's medications available for administration</p>	{D 358}		

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{D 358}	<p>Continued From page 17</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-There was a bubble pack of Doxepin HCl 10mg with a pharmacy label and instructions to take one capsule at bedtime.</li> <li>-There were 30 capsules in the bubble pack.</li> </ul> <p>Interview on 02/16/22 at 4:00pm with a medication aide (MA) revealed:</p> <ul style="list-style-type: none"> <li>-She was from a staffing agency and started working at the facility about 2 weeks ago.</li> <li>-She could not find Doxepin HCl 10mg scheduled on the eMAR and decided to ask the Health and Wellness Director (HWD) for assistance.</li> </ul> <p>Interview on 02/16/22 at 4:45pm with the HWD revealed:</p> <ul style="list-style-type: none"> <li>-She called the pharmacy to investigate why Doxepin HCl 10mg did not show up on the eMAR.</li> <li>-The pharmacy informed her Doxepin HCl 10mg was scheduled once daily at bedtime and recommended she refresh her computer screen.</li> <li>-The HWD was able to see Doxepin HCl on the eMAR, after refreshing her computer screen, but was unsure why the medication had been held from 02/01/22-02/15/22.</li> </ul> <p>Telephone interview on 02/17/22 at 12:00pm with the Pharmacist at the facility's contracted pharmacy revealed:</p> <ul style="list-style-type: none"> <li>-Doxepin HCl 10mg was dispensed on 12/28/21 and 01/23/22 for 30 tablets each time.</li> <li>-The pharmacy did not have an order to hold the medication from Resident #2's Physician and was not aware that Resident #2's Doxepin HCl 10mg had been held for 28 days.</li> <li>-The pharmacy was not able to see what the facility documented on their eMARs.</li> <li>-The order was written on 12/23/21 due to increased anxiety at night and insomnia.</li> <li>-Resident #2 could have experienced increased</li> </ul>	{D 358}		

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{D 358}	<p>Continued From page 18</p> <p>anxiety or loss of sleep due to the missed medication.</p> <p>Interview on 02/17/22 at 10:30am with Resident #2 revealed she had not slept well for the last 3-4 nights.</p> <p>Interview on 02/17/22 at 1:00pm with a MA revealed Resident #2 appeared more tired this week.</p> <p>Interview on 02/17/22 at 12:40pm with the HWD revealed: -She was not aware Resident #2's Doxepin HCl 10mg was held for 28 days. -The Doxepin HCl 10mg did not show up as a missed medication on her daily medication report. -The facility did not have a Physician's order to hold the medication. -She was not sure who put the hold order on the eMAR.</p> <p>Interview on 02/17/22 at 12:45pm with the Resident Care Coordinator (RCC) revealed: -She did a medication cart audit approximately once a month. -She was not aware Resident #2's Doxepin HCl 10mg was held for 28 days.</p> <p>Attempted telephone interview on 02/17/22 at 9:50am with Resident #2's Physician was unsuccessful.</p> <p>Refer to interview on 02/15/22 at 10:25am with the Health and Wellness Director (HWD).</p> <p>Refer to telephone interview on 02/15/22 at 11:01am with the pharmacy technician from the facility's contracted pharmacy.</p>	{D 358}		

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{D 358}	<p>Continued From page 19</p> <p>Refer to interview on 02/16/22 at 2:30pm with a medication aide (MA).</p> <p>Refer to telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy.</p> <p>Refer to interview on 02/17/22 at 10:30am with a medication aide (MA).</p> <p>Refer to the interview on 02/17/22 at 12:22pm with the Health and Wellness Director (HWD).</p> <p>Refer to interview on 02/17/22 at 12:45pm with the Resident Care Coordinator (RCC).</p> <p>Refer to the telephone interview on 02/17/22 at 12:48pm with the Administrator.</p> <p>Refer to interview on 02/17/22 at 2:40pm with a medication aide (MA)</p> <p>4. Review of Resident #1's current FL2 dated 02/09/22 revealed diagnoses included compression fracture of the L3 vertebra and an unsteady gait.</p> <p>a. Review of Resident #1's Physician's order dated 01/10/22 revealed an order for lidocaine HCl cream 4% (used to treat pain), spread topically to left leg three times per day.</p> <p>Review of Resident #1's February 2022 eMAR revealed: -There was an entry for lidocaine HCl cream 4% spread topically to left leg three times per day scheduled at 8:00am, 2:00pm and 8:00pm. -Lidocaine HCl cream 4% was documented as not administered 8 times between 02/01/22 and 02/15/22, due to medication not being available.</p>	{D 358}		

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{D 358}	<p>Continued From page 20</p> <p>-The medication was not administered on 02/01/22 at 8:00am, 02/03/22 at 2:00pm, 02/04/22 at 8:00pm, 02/05/22 at 8:00am and 8:00pm, 02/06/22 at 8:00pm, 02/07/22 at 8:00am and 2:00pm.</p> <p>Interview on 02/17/22 at 10:50am with Resident #1 revealed: -He experienced a lot of pain and tight muscles due to a fall in January 2022. -He could not remember refusing or missing applications of lidocaine HCl cream.</p> <p>Telephone interview on 02/16/22 at 11:01am with a pharmacy technician at the facility's contracted pharmacy revealed lidocaine HCl cream 4% with instructions to spread topically to left leg three times per day was dispensed on 01/10/22 and 02/04/22 for 2.7 oz bottle each time.</p> <p>Interview on 02/16/22 at 4:00pm with a medication aide (MA) revealed: -She recalled some residents being out of medications in the beginning of February 2022 but did not remember if Resident #1 was out of the lidocaine HCl cream at that time. -She called the pharmacy to request a refill when a resident was out of a medication.</p> <p>Telephone interview on 02/17/22 at 12:00pm with a Pharmacist at the facility's contracted pharmacy revealed the lidocaine HCl cream 4% was prescribed to treat pain and missing this medication could have caused the resident increased pain.</p> <p>Attempted telephone interview on 02/17/22 at 8:44am with Resident #1's Physician was unsuccessful.</p>	{D 358}		

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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
{D 358}	<p>Continued From page 21</p> <p>b. Review of Resident #1's Physician's order dated 01/20/22 revealed an order for Salonpas Pain Relief Gel-Patch Hot Patch 0.025-1.25%, apply 1 patch externally to back area for pain daily at 7:00am and remove at 7:00pm.</p> <p>Review of Resident #1's January 2022 electronic medication administration record (eMAR) revealed:                      -There was an entry for Salonpas Gel-Patch Hot External Patch 0.025-1.25%, apply 1 patch to area of pain on back once daily at 7:00am and remove at 7:00pm.                      -Salonpas Gel-Patch Hot External Patch 0.025-1.25% had a start date of 01/22/22.                      -Salonpas Gel-Patch Hot External Patch 0.025-1.25% was documented as administered on 01/24/22 and 01/27/22.                      -Salonpas Gel-Patch Hot External Patch 0.025-1.25% was documented as not administered on 01/22/22, 01/23/22, 01/25/22, 01/26/22, 01/28/22-01/31/22 due to not being available to administer.</p> <p>Review of Resident #1's February 2022 eMAR revealed:                      -There was an entry for Salonpas Gel-Patch Hot External Patch 0.025-1.25%, apply 1 patch to area of pain on back once daily at 7:00am and remove at 7:00pm.                      -Salonpas Gel-Patch Hot External Patch 0.025-1.25% was documented as not administered on 02/01/22 due to not being available to administer.                      -Salonpas Gel-Patch Hot External Patch 0.025-1.25% was documented as administered from 02/02/22-02/03/22.                      -Salonpas Gel-Patch Hot External Patch 0.025-1.25% application instructions were modified to apply 1 patch to area of pain on back</p>	{D 358}		

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{D 358}	<p>Continued From page 22</p> <p>once daily at 8:00pm and remove at 8:00am on 02/04/22. -Salonpas Gel-Patch Hot External Patch 0.025-1.25% was documented as administered 02/04/22-02/14/22.</p> <p>Interview on 02/17/22 at 10:50am with Resident #1 revealed: -He experienced a lot of pain and tight muscles due to a fall in January 2022. -He could not remember when he started using the Salonpas Gel-Patches.</p> <p>Telephone interview on 02/16/22 at 11:01am with a pharmacy technician at the facility's contracted pharmacy revealed: -The pharmacy received an order dated 01/20/22 for Salonpas Gel-Patch Hot External Patch 0.025-1.25%, apply 1 patch to area of pain on back once daily at 7:00am and remove at 7:00pm. -The medication was dispensed on 01/29/22 for 36 patches. -She thought the medication was dispensed late due to supply issues.</p> <p>Attempted telephone interview on 02/17/22 at 8:44am with Resident #1's Physician was unsuccessful.</p> <p>Refer to interview on 02/15/22 at 10:25am with the Health and Wellness Director (HWD).</p> <p>Refer to telephone interview on 02/15/22 at 11:01am with the pharmacy technician from the facility's contracted pharmacy.</p> <p>Refer to interview on 02/16/22 at 2:30pm with a medication aide (MA).</p>	{D 358}		

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{D 358}	<p>Continued From page 23</p> <p>Refer to telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy.</p> <p>Refer to interview on 02/17/22 at 10:30am with another medication aide (MA).</p> <p>Refer to the interview on 02/17/22 at 12:22pm with the Health and Wellness Director (HWD).</p> <p>Refer to interview on 02/17/22 at 12:45pm with the Resident Care Coordinator (RCC).</p> <p>Refer to the telephone interview on 02/17/22 at 12:48pm with the Administrator.</p> <p>Refer to interview on 02/17/22 at 2:40pm with a third medication aide (MA)</p> <p>_____</p> <p>Interview on 02/15/22 at 10:25am with the Health and Wellness Director (HWD) revealed:                      -A dash in the column on the eMAR was typically for as needed (PRN) medications not given.                      -When a medication was grayed out it was discontinued or replaced by a new order.                      -The facility could enter medications on the eMARs during the weekend then the pharmacy would discontinue the facility's entry and create an "official one" on the eMAR.</p> <p>Telephone interview on 02/15/22 at 11:01am with the pharmacy technician from the facility's contracted pharmacy revealed:                      -The pharmacy was not able to view the facility's eMAR.                      -The pharmacy entered the medications on the eMAR and the facility verified them.                      -The facility was able to edit their eMARs.                      -The facility should fax a discontinue order for the</p>	{D 358}		

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{D 358}	<p>Continued From page 24</p> <p>pharmacy to remove a medication from the eMAR. -Sometimes the physician's office would fax the pharmacy directly with orders.</p> <p>Interview on 02/16/22 at 2:30pm with a medication aide (MA) revealed: -She had worked in the facility for 2 years. -The MAs were responsible to fax refill requests to the pharmacy or physician. -DNA and DNG on the eMAR meant the resident was out of a medication and that a refill was needed. -A refill should be sent to the facility within 12-24 hours, if there was a delay beyond 24 hours, the MAs would follow-up with the pharmacy, and then notify the RCC of the delay.</p> <p>Telephone interview on 02/17/22 at 8:43am with a pharmacy technician from the facility's contracted pharmacy revealed: -The facility was not currently on cycle fill. -The facility had to manually fax request for refills to the pharmacy for all residents' medications.</p> <p>Interview on 02/17/22 at 10:30am with a another MA revealed -The MAs were responsible to request refills from the pharmacy when there were 5-7 doses left on the bubble packs. -The MA was to remove a pharmacy label from the bubble pack and place it on a sheet of paper to be faxed to the pharmacy as a refill request.</p> <p>Interview on 02/17/22 at 12:22pm with the HWD revealed: -The HWD, RCC and MAs were responsible for auditing the medication carts. -The MAs were expected to do them when they are on the cart and the HWD or RCC are</p>	{D 358}		

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{D 358}	<p>Continued From page 25</p> <p>expected to audit once a week.</p> <p>-During a medication cart audit staff looked at the dates medications were opened, made sure medications were labeled correctly, looked at the expiration dates of medications and compared the medications on the cart to the medications that were scheduled on the electronic medication administration record (eMAR).</p> <p>-The medication cart audit forms were kept in a binder and the HWD looked at the forms frequently to review findings and follow up with the pharmacy, if needed.</p> <p>-The MAs were expected to refill medications, by calling the pharmacy, whenever there was a need.</p> <p>-If a resident was out of a medication, the MA was expected to contact the pharmacy for a refill and ask for medication from the back up pharmacy before documenting "did not administer".</p> <p>-The MA was also expected to alert the supervisor if the medication was not available to administer and send a message to the residents' Physician to alert them of the missed medication.</p> <p>-The HWD had not been made aware of any recent missed medications for anyone in the facility.</p> <p>-She checked a missed medication report daily and did not recall seeing any recent missed medications on that report.</p> <p>Interview on 02/17/22 at 12:45pm with the RCC revealed:</p> <p>-She had been doing cart audits only about once a month secondary to "being busy".</p> <p>-The Lead MA and other MAs were expected to complete cart audits weekly.</p> <p>-When an issue was found during her cart audit she would correct the issue at the time of audit.</p> <p>Telephone interview on 02/17/22 at 12:48pm with</p>	{D 358}		

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{D 358}	<p>Continued From page 26</p> <p>the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-The HWD and the RCC were responsible for completing cart audits.</li> <li>-There was no set schedule for the cart audits.</li> <li>-The contracted pharmacy's Registered Nurse (RN) performed cart audits each month, but she was not sure when they had been completed.</li> <li>-The HWD was responsible to keep up with those audits.</li> <li>-She was not aware of medications being unavailable for administration for the sampled residents.</li> <li>-There had been some supply issues with the pharmacy related to obtaining medications.</li> <li>-She expected her staff to keep records of cart audits.</li> <li>-She expected the MAs, RCC, and HWD to request refills when there was a two week supply left on the medication carts.</li> <li>-She was not aware if the physician had been notified of the missed medications.</li> </ul> <p>Interview on 02/17/22 at 2:40pm with a third MA revealed the MAs should request a refill when there was one week of medications left on the bubble pack.</p> <p>_____</p> <p>The facility failed to ensure medications were administered as ordered by a licensed prescribing provider for 4 of 5 sampled residents (Resident #1, #2, #4, and #5) which resulted in a resident not administered medications for dementia, increasing the risk for cognitive changes; vitamin D deficiency, increasing the risk for decreased vitamin D levels; stroke prevention, increasing the risk for stroke and a heart attack; and depression, which could result in increased depression (#4); a resident not administered medications for anxiety, increasing the risk for mood changes; mild to</p>	{D 358}		

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{D 358}	Continued From page 27  moderate pain, which could result in increased pain levels; high blood pressure, increasing the risk for high blood pressure and changes in heart rate; dementia, increasing the risk for cognitive changes; and high cholesterol which could result in increased lipid levels (#5); a resident not administered a medication for anxiety and insomnia, which could have resulted in increased anxiety or loss of sleep (#2); and a resident not administered medications for pain, which could result in increased pain levels (#1). This failure was detrimental to the health, welfare and safety of the residents and constitutes a Type B violation.  The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/16/22 for this violation.  CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 3, 2022.	{D 358}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights  G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.  This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration.	{D912}		

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{D912}	<p>Continued From page 28</p> <p>The findings are:</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 4 of 5 sampled residents (#1, #2, #4, and #5) related to not administering medications for dementia, vitamin D deficiency, stroke prevention and depression (Resident #4); for anxiety, mild to moderate pain, high blood pressure, dementia, and high cholesterol (Resident #5); for anxiety and insomnia (Resident #2); and for mild to moderate pain (Resident #1). [Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].</p>	{D912}		