



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

April 27, 2022

Stephen T. Morton, Executive Officer
RSS/Durham Operations, LLC, Licensee
Carolina Reserve of Durham
5430 Wade Park Blvd
Suite 402
Raleigh, NC 27607

Email address: Julia.steingass@navionsl.com; smorton navionsl.com

Re: Receipt of Plan of Correction (RNGE11)
Facility: Carolina Reserve of Durham
Licensure Number: HAL-032-132
County: Durham

Dear Mr. Morton:

Based on the telephone conversation with the Administrator on April 27, 2022, there was an addendum to the Plan of Correction for the Statement of Deficiencies dated March 11, 2022. The pages noting the addendum are provided for your records.

Please do not hesitate to contact us at 984-202-1221, if you have questions or we may be of further assistance.

Sincerely,

Pam Dailey

Pam Dailey, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosure

cc: Matthew Thompson, Supervisor/Designee, Durham County Department of Social Services
Pamela Mayo, Administrator
Kathy Norman, Team Supervisor, Central Region, Adult Care Licensure Section
Facility File

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION
ADULT CARE LICENSURE SECTION

LOCATION: 801 Biggs Drive, Brown Building, Raleigh, NC 27603
MAILING ADDRESS: 2708 Mail Service Center, Raleigh, NC 27699-2708
<https://info.ncdhhs.gov/dhsr/> • TEL: 919-855-3765 • FAX: 919-733-9379

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER



Carolina Reserve of Durham
HAL-032-132
Pamela Mayo Executive Director
Khadijah Taylor/Director of Clinical Services
April 15, 2022

The following is a summary of the Plan of Correction for Carolina Reserve of Durham. This Plan of Correction is regarding the Corrective Action Report dated April 1, 2022, for survey competition 3/11/22. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.

D 310/ 10A NCAC 13F .0904 E4 NUTRITION AND FOOD SERVICE
10A NCAC 13F .0904 NUTRITION AND FOOD SERVICE

(e) Therapeutic Diets in Adult Care Homes

(4) All Therapeutic Diets, including nutritional supplements and thicken liquids, shall be served as ordered by the resident's physician.

To correct this: All dietary orders have been reviewed for accuracy comparing the chart to the EMAR system by the DCS and RCC on 3/11/22. Dietary was provided a copy of the diet list after accuracy was verified on 3/11/22.

To prevent recurrence:

The dietary manager will be given a copy of any diet change order and diet order on new admissions by the DCS or designee.

The dietary manager will perform an audit weekly x 4 and no less than monthly thereafter, of all diets comparing the diet extension binder to the diet list printed from the EMAR system.

Correction date of 04/01/22 P.D

10A NCAC 13F.1004 MEDICATION ADMINISTRATION

To correct this: An in-service was performed by the DCS on 3/11/22 including infection control standards with administration of medications, 8 rights of medication administration, and how to properly process and transcribe orders. The in-service also included the medication reorder process and how to ensure all ordered medications are available for administration.

To prevent recurrence:

Pamela Mayo, ED
4/15/22

Cart audits will be performed weekly x 4 and no less than monthly thereafter by the DCS or designee.

DCS or designee will observe a med tech during a med pass for accuracy of med delivery weekly and no less than monthly thereafter.

Correction date of 04/01/22 P.D

10A NCAC 13F .1005 (a) SELF-ADMINISTRATION OF MEDICATION

To correct this: A round was completed by the DCS, RCC, and ED 3/10/22 on 100% of the facility rooms removing medications without orders for self-med administration, orders were requested and if appropriate self-medication assessments were performed, otherwise medications were stored in the medication cart for staff administration.

To prevent recurrence:

Room rounds will be completed by the DCS or designee weekly x 4 and then no less than monthly thereafter, for medications with no self-administration order.

A letter was sent out, by the ED on 3/15/22, to all family members concerning the policy on medications in Resident room and Self Administer Policy.

Correction date of 04/01/22 P.D

10a NCAC 13F .1006 (a) MEDICATION STORAGE

To correct this: A round was completed by the DCS, RCC, and ED 3/10/22 on 100% of the facility rooms removing medications without orders for self-med administration, orders were requested and if appropriate self-medication assessments were performed, otherwise medications were stored in the medication cart for staff administration.

To prevent recurrence:

Room rounds will be completed by the DCS or designee weekly x 4 and then no less than monthly thereafter, for medications with no self-administration order.

To prevent recurrence:

Upon receipt self-medication order during the evaluation process the DCS or designee will be provide education to the resident/family member regarding compliance to Self-Administer including the requirement for a lock box and the need to keep all meds always locked up when out of room.

A lock box will be provided by the facility or family for locked medication storage.

Correction date of 04/01/22 P.D

Paula Mays, ED
4/15/22

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 9, 2022 to March 11, 2022.	D 000		
D 310	<p>10A NCAC 13F .0904(e)(4) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure therapeutic diet orders were served as ordered for 2 of 4 sampled residents (#1, #6) who had orders for a reduced carbohydrate diet (#1), and a low fat/low cholesterol diet (#6).</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 03/18/21 revealed: -Diagnoses included mild cognitive impairment, high blood pressure and diabetes. -There was an order for a pureed and reduced carbohydrate diet.</p> <p>Review of the reduced carbohydrate diet menu for breakfast on 03/10/22 revealed hot cereal of choice, low fat/low cholesterol eggs, diet jelly, 4 ounces of juice of choice and 8 ounces of skim</p>	D 310	<i>See attached</i>	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Camela Mayo EP TITLE *Executive Director* (X6) DATE *4/15/22*

STATE FORM 6899 RNGE11 If continuation sheet 1 of 18

Reviewed and acknowledged with addendums per telephone conversation with the Administrator on 04/27/22. Reference tag numbers D310, D358, D375 and D377. *P.D*

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D 310	<p>Continued From page 1</p> <p>milk were to be served.</p> <p>Observation of the breakfast meal service on 03/10/22 at 8:16am revealed: -Resident #1 was served pureed a half a cup of scrambled eggs, one cup of pureed oatmeal, 8 oz milk, water and half of a cup of pureed sausage. -Orange juice was served to the residents but Resident #1 was not served orange juice. -Resident #1 ate 100 percent of her meal.</p> <p>Observation of the kitchen on 03/11/22 at 8:00am revealed: -There were no low fat/low cholesterol eggs available for preparation and serving to residents. -There was no skim milk available for serving to residents.</p> <p>Interview with the personal care aide (PCA) on 03/10/22 at 8:27am revealed Resident #1 was not served orange juice or any juice because she had diabetes.</p> <p>Interview with the cook on 03/11/22 at 8:02am revealed she sent juice in bulk to the dining room for the PCAs to serve to the residents; including orange juice.</p> <p>Interview with Resident #1's primary care provider (PCP) on 03/1</p> <p>Interview with the Administrator on 03/10/22 at 9:36am revealed: -If Resident #1 was meant to have orange juice with her meal then she should have had it. -The PCA should have ask the kitchen staff if Resident #1 could have orange juice if she was not sure. -There needed to be a better training process for the staff.</p>	D 310	<p><i>See Attached</i></p>	

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D 310	<p>Continued From page 2</p> <p>-The staff needed to follow the menu.</p> <p>Refer to interview with the cook on 03/11/22 at 8:02am.</p> <p>Refer to the interview with the Dietary Manager (DM) on 03/11/22 at 2:33pm.</p> <p>Refer to the interview with the Administrator on 03/11/22 at 2:58pm.</p> <p>Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable.</p> <p>Attempted telephone interview with Resident #1's PCP on 03/10/22 at 4:47pm were unsuccessful.</p> <p>2. Review of resident #6 current FL-2 dated 03/28/21 revealed: -Diagnoses included history of venous thrombosis and emboli, primary thrombophilia, lupus anticoagulant syndrome, and deep vein thrombose. -There was a check mark by the diet under the nutritional status, but no diet was indicated.</p> <p>Review of a diet order for Resident #6 dated 02/24/22 revealed Resident #6 was ordered a low fat/low cholesterol diet.</p> <p>Review of the low fat/low cholesterol therapeutic diet menu for breakfast for 03/11/22 revealed cereal of choice, buttermilk pancakes, low fat/low cholesterol eggs, juice of choice and skim milk were to be served.</p> <p>Observation of the breakfast meal on 03/11/22 at 8:10am revealed: -Resident #6 was served half a cup of scrambled</p>	D 310	<p><i>See Attached</i></p>	
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D 310	<p>Continued From page 3</p> <p>eggs, 1 slice of French toast, 2-3 pieces of bacon and two percent milk. -Resident #6 ate 100 percent of her meal.</p> <p>Observation of the kitchen on 03/11/22 at 8:00am revealed: -There were no low fat/low cholesterol eggs available for preparation and serving to residents. -There was no skim milk available for serving to residents.</p> <p>Interview with Resident #6 on 03/11/22 revealed: -She did not think she was on a special diet. -She ate what was served to her. -She enjoyed her meal, including the bacon.</p> <p>Interview with a personal care aides (PCA) on 03/11/22 at 2:23pm revealed: -The cook prepared the plates of food and handed them to her. -The cook told her who the plate was for. -The residents sat in the same place every day. -The residents names were on the table at their seats.</p> <p>Interview with the cook on 03/11/22 at 8:02am revealed: -Resident #6 was compliant with her diet. -She plated the food for the residents and handed the plate to the PCA. -She told the PCAs who the plate was to be served to. -The Dietary Manager (DM) was new and did not know all of the residents' names.</p> <p>Telephone interview with resident #6's primary care provider (PCP) on 03/11/22 at 10:10am revealed: -Resident #6 was ordered a low fat/low cholesterol diet due to hyperlipidemia.</p>	D 310	<p><i>See Attached</i></p>	
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D 310	<p>Continued From page 4</p> <ul style="list-style-type: none"> -The low fat/low cholesterol diet should help with her cholesterol levels. -He had never been told Resident #6 was not compliant with her diet orders. -He expected his orders for diet to be followed as ordered. -A possible outcome of not following the low fat/low cholesterol diet could be increased blood cholesterol levels. <p>Refer to interview with the cook on 03/11/22 at 8:02am.</p> <p>Refer to the interview with the Dietary Manager (DM) on 03/11/22 at 2:33pm.</p> <p>Refer to the interview with the Administrator on 03/11/22 at 2:58pm.</p> <p>Interview with the cook on 03/11/22 at 8:02am revealed:</p> <ul style="list-style-type: none"> -The Dietary Manager (DM) was new and only been in the new position for a few days. -The kitchen used to serve low fat/low cholesterol eggs. -The last time low fat/low cholesterol eggs were ordered was about 4 months ago. -When there were no low fat/low cholesterol eggs available to serve to the residents she served them regular eggs. -She also cut back on the serving size for the eggs and only gave about half of a portion. -The kitchen did not have skim milk for serving to the residents on a low fat/low cholesterol diet or a reduced carbohydrate diet. -There was only two percent or whole milk available. -The last time skim milk was ordered was about two months ago. -She served two percent milk to the residents 	D 310	<p><i>See attached</i></p>	
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D 310	<p>Continued From page 5</p> <p>who were on a low fat/low cholesterol diet or a reduced carbohydrate diet. -She did not reference the therapeutic diet menu as a guide for portions sizes. -The DM was responsible for ordering food for the kitchen.</p> <p>Interview with the Dietary Manager (DM) on 03/11/22 at 2:33pm revealed: -The cooks should have been following the therapeutic diet menu. -If the cook did not have the food items she needed for service she should have told him or the Administrator. -He had only been in the position of DM for two weeks. -The Administrator was ordering the food based on needs; he would be ordering the food for the kitchen based on the menu. -There was still a lot of training that needed to be done in the kitchen.</p> <p>Interview with the Administrator on 03/11/22 at 2:58pm revealed: -The diet list and the therapeutic menus were available in the kitchen. -She had put the menu and diet list together herself because she wanted it to be correct. -She had hired the new DM because he had years of experience and she knew he would make sure things were running correctly and then train the staff correctly. -She was not aware the staff were not following the therapeutic menus and that there were items needed for the menu that they did not have. -The diets should have been followed because they were and order from the physician.</p>	D 310	<p><i>SJA Hacheo</i></p>	

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D 358	Continued From page 6	D 358		
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: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 4 residents (#7) observed during the medication pass including errors with an oral rinse and an eyelid cleanser.</p> <p>The findings are:</p> <p>The medication error rate was 7.1% as evidenced by the observation of 2 errors out of 28 opportunities during the 7:00am and 8:00am medication passes on 03/10/22.</p> <p>Review of Resident #7's current FL-2 dated 02/10/21 revealed diagnoses included unspecified glaucoma, diabetes, congestive heart failure, and high blood pressure.</p> <p>a. Review of Resident #7's primary care provider's (PCP) orders dated 06/01/21 revealed an order for chlorhexidine 0.12% rinse (an oral rinse) swish 15 milliliters (ml) by mouth four times a day after each meal and before bedtime.</p> <p>Review of Resident #7's PCP's orders dated 11/11/21 revealed an order for chlorhexidine</p>	D 358	<i>See attached</i>	

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D 358	<p>Continued From page 7</p> <p>0.12% rinse swish and spit 15ml by mouth four times a day after each meal and before bedtime.</p> <p>Observation of the 8:00am medication pass on 03/10/22 revealed: -The medication aide (MA) provided Resident #7 with chlorhexidine at 8:08am. -The resident swished and discarded the chlorhexidine as ordered. -Breakfast had not been served before Resident #7 was given the chlorhexidine.</p> <p>Interview with the MA on 03/10/22 at 8:10am revealed: -Resident #7 preferred to receive the chlorhexidine before breakfast. -Resident #7's PCP was aware Resident #7 was rinsing with the chlorhexidine before breakfast.</p> <p>Review of Resident #7's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for chlorhexidine 0.12% rinse swish and spit 15ml four times a day after each meal and before bedtime scheduled for administration at 9:00am, 2:00pm, 5:00pm, and 9:00pm. -Chlorhexidine 0.12% rinse was documented as administered on 03/10/22 at 9:00am.</p> <p>Observation of Resident #7's medications on hand on 03/10/22 at 8:00am revealed the label on the chlorhexidine indicated the rinse was ordered four times a day after each meal and before bedtime.</p> <p>Interview with Resident #7 on 03/10/22 at 12:25pm revealed: -He developed sores in his mouth and was prescribed the chlorhexidine rinse.</p>	D 358	<p><i>See Attached</i></p>	

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D 358	<p>Continued From page 8</p> <p>-He had no preference related to the time the chlorhexidine was administered. -If it was better to use the chlorhexidine after meals and was ordered for use after meals, he wanted to receive it after meals.</p> <p>Interview with the Director of Clinical Services (DCS) on 03/09/22 at 3:45pm revealed: -The MA needed re-education on administering Resident #7's chlorhexidine. -She expected the MA to read the eMAR and verify the administration time. -She did not know why Resident #7 was ordered chlorhexidine. -Medications were to be administered as ordered.</p> <p>Telephone interview with Resident #7's PCP on 03/10/22 at 4:53pm revealed: -Chlorhexidine was not very effective if it was administered before a meal. -He expected medication to be administered as ordered.</p> <p>Telephone interview with another of Resident #7's PCPs on 03/11/22 at 10:54am revealed: -Chlorhexidine was not very helpful if administered before a meal. -It was prescribed to prevent further bacterial decay. -She expected medication to be administered as ordered.</p> <p>Interview with the Administrator on 03/11/22 at 4:00pm revealed: -She expected medication to be administered as ordered. -The chlorhexidine was not administered as ordered. -Resident #7's PCP would need to be notified and asked about any negative outcome as a result of</p>	D 358	<p><i>See Attached</i></p>	

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D 358	<p>Continued From page 9</p> <p>the medication not being administered as ordered. -She held the person administering medication responsible for the accurate administration of medication.</p> <p>b. Review of Resident #7's subsequent orders revealed there was an order dated 01/12/22 by Resident #7's ophthalmologist for named brand eyelid scrubs use twice a day.</p> <p>Observation of the 8:00am medication pass on 03/10/22 revealed no eyelid scrub was provided for Resident #7.</p> <p>Interview with Resident #7 on 03/10/22 at 12:25pm revealed: -He was not having any problems with his eyes. -He did not have the eyelid scrubs available for use. -He used a washcloth when he needed to cleanse his eyelids.</p> <p>Telephone interview with a nurse at Resident #7's ophthalmologist's office on 03/10/22 at 12:34pm revealed: -Resident #7 was diagnosed with a meibomian gland dysfunction in both eyes. (Meibomian glands produce an oily substance to prevent dry eyes.) -Resident #7 may have experienced eye irritation including itchiness, running, burning, and crustiness. -The ophthalmologist ordered the eyelid scrubs and warm compresses to aid Resident #7's eyes in feeling more comfortable.</p> <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at 12:40pm revealed the pharmacy did not receive</p>	D 358	<p><i>See Attached</i></p>	

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D 358	<p>Continued From page 10</p> <p>an order for Resident #7's eyelid scrubs.</p> <p>Interviews with the Director of Clinical Services (DCS) on 03/10/22 at 3:45pm and 03/11/22 at 10:38am revealed:</p> <ul style="list-style-type: none"> -She started working at the facility on 01/18/22. -She did not know what system was in place for processing orders before she started working at the facility. -She would have expected the order from Resident #7's ophthalmologist to be sent to the pharmacy. -She would have followed-up with the ophthalmologist to clarify Resident #7's orders from the 01/12/22 appointment. -She was concerned the process was not followed. -She wanted to consistently have orders followed as written. -On 03/10/22, she called the ophthalmologist's office about Resident #7's 01/12/22 appointment. -The ophthalmologist jotted notes on the paperwork that was sent to the facility; there was no order for eyelid scrubs. -The ophthalmologist faxed a note and order to her on 03/10/22. <p>Review of a fax to the facility from Resident #7's ophthalmologist on 03/10/22 revealed:</p> <ul style="list-style-type: none"> -The fax was dated 03/10/22 and was signed by the ophthalmologist. -The ophthalmologist recommended eyelid scrubs for Resident #7 on 01/12/22 but did not send an order for the scrubs. -There was an order for named brand eyelid scrubs use to clean upper and lower eyelid margin of each eye twice a day. <p>Interview with the Administrator on 03/11/22 at 4:00pm revealed:</p>	D 358	<p><i>See Attached</i></p>	

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D 358	Continued From page 11 -She expected medication to be administered as ordered. -The DCS contacted the ophthalmologist on 03/10/22 about the eyelid scrub and was told the paperwork received after Resident #7's appointment on 01/12/22 wasn't a "real" order.	D 358		
D 375	<p>10A NCAC 13F .1005(a) Self-Administration Of Medications</p> <p>10A NCAC 13F .1005 Self -Administration Of Medications</p> <p>(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:</p> <p>(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and</p> <p>(2) specific instructions for administration of prescription medications are printed on the medication label.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 1 resident sampled (#4) had a physician's order to self-administer a medicated patch for pain, a medication for pain, and eye lubricant.</p> <p>The findings are:</p> <p>Review of Resident #4's current FL-2 dated 03/12/21 revealed diagnoses included type two diabetes, hypertension, mild cognitive</p>	D 375	<i>See Affected</i>	

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D 375	<p>Continued From page 12</p> <p>impairment, movement disorder and depression.</p> <p>Observation of Resident #4's bedroom on 003/09/22 at 10:11am revealed:</p> <ul style="list-style-type: none"> -There was medication on Resident #4's nightstand. -A bottle of acetaminophen (used to treat fever and mild to severe pain). -A bottle of eye drops (used to lubricate eyes). -There was box of lidocaine patches (used to treat pain). <p>Review of Resident #4's physician's orders dated 03/03/22 revealed:</p> <ul style="list-style-type: none"> -There was an order for acetaminophen 1gm every four hours as needed for pain. -There was not a self-administration order for acetaminophen. -There was not a self-administration order lidocaine patch or eye drops. <p>Review of Resident #4's electronic medication administration record (eMAR) for February 2022 and March 2022 revealed:</p> <ul style="list-style-type: none"> -There was an order for acetaminophen 1gm every four hours as needed for pain; the order was not for self-administration. -There was not an order for lidocaine patches or for eye drops. <p>Review of the facility's self-management of medications policy revealed:</p> <ul style="list-style-type: none"> -The facility would maintain an electronic medication administration record (eMAR) for all residents who self-administer any medications. -If there are medication in the resident room not on the current eMAR the physician would be contacted for clarification on the continued usage of the medication. -The Resident Care Coordinator (RCC) was 	D 375	<p><i>See Attached</i></p>	

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D 375	<p>Continued From page 13</p> <p>responsible for completing the self-administration assessment.</p> <p>-The RCC would obtain a physician's order for a resident to self-administer the medication once the self-administration assessment was successfully completed by the resident.</p> <p>Interview with Resident #4 on 03/09/22 at 10:11am revealed:</p> <p>-Her family took her out of the facility when they visited.</p> <p>-She had medications she purchased when she went out with her family and her family brought in medications for her.</p> <p>-She self-administered her acetaminophen when she had back pain.</p> <p>-She self-administered her eye drops when she needed them for dry eyes.</p> <p>-She could place the lidocaine patch when she had pain on her shoulder, but she would ask staff to apply it for her.</p> <p>-She had a medication aide tell her once that they could not apply her lidocaine patch for her because she did not have an order for it, and it was not listed on her electronic medication administration record (eMAR).</p> <p>-She kept the acetaminophen tablets and the eye drops on her nightstand, but she usually kept the lidocaine patches in a drawer in her nightstand.</p> <p>-She did not tell the MAs when she took any of the medications she had in her room.</p> <p>Interview with a MA on 03/10/22 at 4:02pm revealed:</p> <p>-Resident #4 kept lidocaine patches in her room.</p> <p>-Resident #4 was able to place the lidocaine patch on her shoulder herself; she had seen the patch on Resident #3's shoulder.</p> <p>-She had told Resident #4 she could not have the lidocaine patch without a physician's order.</p>	D 375	<p><i>See Attached</i></p>	

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D 375	<p>Continued From page 14</p> <ul style="list-style-type: none"> -She told someone in management about the lidocaine patch, but she could not remember who she told or when she reported it. -She had not seen the acetaminophen, or the eye drops in Resident #4's room. <p>Interview with the Resident Care Coordinator on 03/10/22 at 5:22pm revealed:</p> <ul style="list-style-type: none"> -Resident #4 went out with her family and came back with over the counter medications. -She tried to respect resident's privacy but did look around rooms for medications. -Staff were instructed to notify her or the Administrator about any medications residents might have in their rooms. -She was not aware Resident #4 had medications in her room. -Resident #4 was alert and orient so she would do a self-administer assessment on her. <p>Interview with the Administrator on 03/11/22 at 2:58pm revealed:</p> <ul style="list-style-type: none"> -She was not aware Resident #4 had over the medication in her room. -She did not know if Resident #4 had an order for self-administering the medications. -The MAs should report any medications in residents' rooms when the resident did not have a self-administer order on the eMAR. -She knew the facility had a policy for self-administration of medication, but she was not familiar with it because she had only been the Administrator for a short while. <p>Attempted telephone interview with Resident #4's primary care provider (PCP) on 03/11/ at 11:17am was unsuccessful.</p>	D 375	<p><i>See Attached</i></p>	

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D 377 D 377	<p>Continued From page 15</p> <p>10A NCAC 13F .1006(a) Medication Storage</p> <p>10a NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure that the residents' medications were stored in a safe and secure manner for 1 of 1 resident sampled (#4) who self-administered medications.</p> <p>The findings are:</p> <p>Review of the facility's policies and procedures for self-administration for medications revealed: -All residents who self-administer [medication] must secure their medications in a lock box and keep their door lock when not in their room, unless shared by another resident who is unable to use the key.</p> <p>Review of Resident #4's current FL-2 dated 03/12/21 revealed diagnoses included type two diabetes, hypertension, mild cognitive impairment, movement disorder and depression.</p> <p>Observation of Resident #4's bedroom on 003/09/22 at 10:11am revealed: -There was medication on Resident #4's nightstand. -A bottle of acetaminophen (used to treat fever and mild to severe pain).</p>	D 377 D 377	<p><i>See Attached</i></p>	

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D 377	<p>Continued From page 16</p> <ul style="list-style-type: none"> -A bottle of eye drops (used to lubricate eyes). -There was box of lidocaine patches (used to treat pain). <p>Interview with Resident #4 on 03/09/22 at 10:11am revealed:</p> <ul style="list-style-type: none"> -Her family took her out of the facility when they visited. -She had over the counter medications she purchased when she went out with her family and her family brought in medications for her. -She self-administered her acetaminophen; eye drops and lidocaine patches when she needed them. -She kept the acetaminophen tablets and the eye drops on her nightstand, but she usually kept the lidocaine patches in a drawer in her nightstand. -She was never told she could not have medications in her room. -She could lock her medications in a keyed cabinet that was in the bathroom if she needed. <p>Interview with a MA on 03/10/22 at 4:02pm revealed:</p> <ul style="list-style-type: none"> -Resident #4 kept lidocaine patches in her room. -She told someone in management about the lidocaine patch, but she could not remember who she told or when she reported it. -She had not seen the acetaminophen, or the eye drops in Resident #4's room. -Resident #4 kept her medications on the nightstand or in a drawer. -Resident #4 stayed in her room most of the time. <p>Interview with the Resident Care Coordinator on 03/10/22 at 5:22pm revealed:</p> <ul style="list-style-type: none"> -Resident #4 went out with her family and came back with over the counter medications. -She tried to respect resident's privacy but did look around rooms for medications. 	D 377	<p><i>See Attached</i></p>	
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D 377	<p>Continued From page 17</p> <ul style="list-style-type: none"> -Staff were instructed to notify her or the Administrator about any medication's residents might have in their rooms. -She was not aware Resident #4 had medications in her room. -Resident #4 was alert and orient and did not leave her room very often. -There was a locking cabinet in the bathroom; she would have Resident #4 lock the over the counter medications in the bathroom cabinet. <p>Interview with the Administrator on 03/11/22 at 2:58pm revealed:</p> <ul style="list-style-type: none"> -She was not aware Resident #4 had over the medication in her room. -She knew the facility had a policy for self-administration of medication storage, but she was not familiar with it because she had only been the Administrator for a short while. -She knew the over the counter medication was required to be kept locked up at all times. 	D 377	<p><i>See Attached</i></p>	