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	HAL032001	A. BUILDING: _____ B. WING _____	R 08/25/2022

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ENO POINTE ASSISTED LIVING	5600 N ROXBORO ROAD DURHAM, NC 27712

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, a follow-up survey and a complaint investigation on August 23, 2022 to August 25, 2022.	D 000		
D 229	10A NCAC 13F .0702 (e) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (e) The facility shall assure the following requirements for written notice are met before discharging a resident: (1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Medical Assistance, 2505 Mail Service Center, Raleigh, NC 27699-2505. (2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative on the same day the Adult Care Home Notice of Discharge is dated. (3) Failure to use and simultaneously provide the specific forms according to Subparagraphs (e)(1) and (e)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge unless the facility has been previously notified of a change in the forms and been provided a copy of the latest forms by the Department of Health and Human Services. (4) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home	D 229		

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D 229	Continued From page 1	D 229		

Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed ensure requirements for written discharge notice were met by one of one resident (#8) whose discharge had been initiated by the facility.

The findings are:

Review of Resident #8's current FL2 dated 01/31/22 revealed:
-Diagnosis included major neurocognitive disorder, weight loss, and vitamin D deficiency.
-The recommended level of care was domiciliary (rest home).

Review of Resident #8's record revealed:
-There was documentation Resident #8 was discharged on 04/13/22; including progress notes, notice of discharge and hearing request forms.
-There was no documentation to indicate Resident #8's responsible party had received a copy of the discharge notice in hand or by return receipt.

Interview with Resident #8's responsible party on 08/22/22 at 10:27am revealed:
-Resident #8 moved into the facility in the fall of 2021.
-Resident #8 exhibited aggressive behaviors and was transferred from the facility to the local hospital via emergency medical transport on

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D 229	Continued From page 2 04/13/22. -The Administrator called her on 04/13/22 and informed her via telephone that Resident #8 was being discharged from the facility. -Resident #8 was discharged because of his aggressive behaviors and for his safety and the safety of the other residents. -She was not giving paperwork or sent discharge papers or paperwork for a hearing for appeal via return or certified mail or when she went into the facility after he was discharged. -She signed papers for Resident #8's personal belongings when she went to pick his things up later in the month; she was unsure of the date. Interview with the Administrator on 08/24/22 at 5:10pm revealed: -On the morning of 04/13/22 Resident #8 hit staff, pulled a chandelier from the ceiling and threw chairs around the dining room while other residents were in the room. -She called Resident #8's responsible party that day and explained why he had to be discharged from the facility. -Resident #8's responsible party said they understood he was being discharged due to aggressive behaviors. -She sent Resident #8's responsible party the notice of discharge and the hearing appeal forms via mail on the same day he was sent to the local hospital. -She sent the discharge papers and the hearing form via regular mail without a return receipt.	D 229		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes:	D 310		

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D 310	Continued From page 3 (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to ensure therapeutic diets were served as ordered for 2 of 5 sampled residents, (#1, #2) with an order for a mechanic soft, carbohydrate-controlled diet (#1); and an order for mechanical soft diet (#2).

The findings are:

Review of the therapeutic diet menu for lunch on 08/23/22 revealed:
-The mechanical soft diet menu listed ground chicken with honey mustard sauce, rice, cooked broccoli and peaches with a scoop of ice cream were to be served.
-The carbohydrate-controlled diet menu listed grilled chicken breast with honey mustard sauce, rice broccoli and peaches were to be served.

Review of the therapeutic diet menu for breakfast on 08/24/22 revealed:
-The mechanical soft diet menu listed ground breakfast meat with gravy, eggs, 2 slices of French toast with syrup was to be served.
-The carbohydrate-controlled diet menu listed breakfast meat, egg, 1 slice of French toast with diet syrup was to be served.

1. Review of Resident #1's current FL-2 dated 05/01/22 revealed:

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-Diagnoses included dementia, hemiplegia, dysarthria of dominant side, cerebral infarct and chronic kidney disease.
-There was a diet order for mechanical soft, carbohydrate-controlled diet.

Review of Resident #1's physician's orders dated 07/26/22 revealed an order for mechanical soft, carbohydrate-controlled diet.

Observation of the lunch meal served on 08/23/22 at 11:55am revealed Resident #1 was served chopped chicken and rice with honey mustard sauce, broccoli, a wheat roll broken into 4 pieces and a cup of ice cream with two slices of peaches.

Observation of the breakfast meal served on 08/24/22 at 8:10pm revealed Resident #1 was served scrambled eggs, two sausage links torn in half, and French toast torn in 6 pieces.

Review of Resident #1's laboratory values dated 010/05/21 revealed a hemoglobin A1C (HbA1C) value of 6.9. (The hemoglobin A1C measures the average level of blood sugar over the previous 3 months. The normal A1C level is below 5.7%).

Review of Resident #1's laboratory values dated 06/29/22 revealed a HbA1C value of 8.0.

Telephone interview with Resident #1's primary care provider (PCP) on 08/25/22 at 4:00pm revealed:
-Resident #1 was ordered a carbohydrate-controlled diet because he was diabetic, and the diet order was the first step in controlling blood sugar levels as apposed to or with medications alone.
-A mechanical soft diet consisted of ground

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meats moistened with gravy.
-Resident #1 had dementia causing dysphagia which difficulties in swallowing.
-Resident #1 had not had an episode of strangling or chocking; the mechanical soft diet was supposed to prevent those incidents from happening.
-He expected his orders to be followed as written.

Based on observations, interviews and record review it was determined Resident #1 was not interviewable.

Refer to the interview with the cook on 08/24/22 at 2:31pm.

Refer to the interview with the assistant cook on 08/24/22 at 2:50pm.

Refer to the telephone interview with the Kitchen Manager on 08/25/22 at 4:42pm.

Refer to the interview with the Administrator on 08/25/22 at 5:47pm.

2. Review of Resident #2's current FL2 dated 04/19/22 revealed:
-Diagnoses included Alzheimer's Disease, osteoarthritis, and recurrent urinary tract infections.
-There was an order for a mechanical soft diet.

Observation of the lunch meal on 08/23/22 at 12:05pm revealed Resident #2 was served chopped chicken and rice, broccoli, a wheat roll torn into 5 pieces and ice cream with peach slices.

Observation of the breakfast meal on 08/24/22 at

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8:11am revealed Resident #2 was served French toast, and a sausage link cut into five sections.

Telephone interview with Resident #2's primary care provider (PCP) on 08/25/22 at 4:00pm revealed:
-Resident #2 had dementia causing dysphagia which difficulties in swallowing.
-Resident #2 had not had an episode of strangling or chocking; the mechanical soft diet was supposed to prevent those incidents from happening.
-An outcome of not following the mechanical soft diet could be aspiration.
-He expected his orders to be followed as written.

Based on observations, interviews and record review it was determined Resident #2 was not interviewable.

Refer to the interview with the cook on 08/24/22 at 2:31pm.

Refer to the interview with the assistant cook on 08/24/22 at 2:50pm.

Refer to the telephone interview with the Kitchen Manager on 08/25/22 at 4:42pm.

Refer to the interview with the Administrator on 08/25/22 at 5:47pm.

_____

Interview with the cook on 08/24/22 at 2:31pm revealed:
-Another cook would instruct her on what and how to prepare the meals for the day.
-Ground meats were not the same as chopped meats.
-She chopped the chicken for lunch on 08/23/22 and cut up the sausage on 08/24/22 for breakfast

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because that was all she needed to do.
-The carbohydrate-controlled diet was the same as the regular diet except for the unsweetened iced tea and the sugar free jellies and sugar free syrups.
-She did not know if the residents who were ordered the carbohydrate-controlled diet got the peaches and ice cream or not because she did not prepare them.

Interview with the assistant cook on 08/24/22 at 2:50pm revealed:
-She told the main cook what to prepare for the meals.
-She also cooked some of the meals; she cut up foods and chopped meats, but she did not serve ground meats to anyone.
-There was a therapeutic diet menu, but she knew the mechanical soft diet was chopped meat.
-She also knew the carbohydrate-controlled diet was basically sugar free items.
-There were sugar free condiments available for serving to residents, including sugar free jellies, sugar free syrups and artificial sweeteners.
-She had prepared the peaches and ice cream the day before, 08/23/22, she had forgotten and did not prepare peaches without ice cream for the carbohydrate-controlled diets.

Telephone interview with the Kitchen Manager on 08/25/22 at 4:42pm revealed:
-She had only worked at the facility for one week.
-The mechanical soft diet was supposed to be a ground diet; foods were supposed to be easy to chew or require little to no chewing.
-Mechanical soft diets were usually ordered for residents who had dysphagia and had difficulty chewing.
-She had not seen how the chicken, or the

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D 310	Continued From page 8 sausage were prepared for the mechanical soft diets. -She knew carbohydrate-controlled diets were ordered for diabetics to help control their blood sugars. -There were sugar free jellies, syrups, beverages and artificial sweeteners available. -The cooks should have followed the therapeutic diet menu for the carbohydrate-controlled diet. Interview with the Administrator on 08/25/22 at 5:47pm revealed: -The cooks were supposed to follow the therapeutic diet menus when preparing and serving the mechanical soft and the carbohydrate-controlled meals for the residents. -The facility's consistency for the mechanical soft diet was supposed to be a chopped foods consistency. -The therapeutic menu was incorrect it should have been chopped not ground for the mechanical soft diets. -None of the residents had swallowing difficulties so they could be served chopped foods. -The cooks should have followed the carbohydrate-controlled diet menu..	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.	D 312		

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D 312	Continued From page 9 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 5 of 5 residents (#2, #3, #5, #6 & #7) sampled was treated with respect, consideration and dignity as evidence by rushing meals and staff standing while providing feeding assistance to the residents. The findings are: Observation of the breakfast meal on 08/23/22 from 8:14am until 8:38am revealed: -There were five residents seated at a table and were being fed by one personal care aide (PCA). -The PCA moved around the table assisting the five residents to eat. -The PCA stood to feed the five residents. -The PCA reached across the table and feed a resident while standing between two other residents. -The PCA stood between two residents and fed them. -She used her left hand and arm to reach around the head of the resident on her left side to feed the resident. -She told one resident at the table to "to get busy and eat" and she told another to not to take all day to eat. -A second PCA came to the table and sat next to a resident and began to feed her; the PCA fed the resident and removed her from the dining room. -The first PCA continued to feed the four remaining residents; she continued to stand as she fed them. -She stood in one position between two residents; she reached around one resident's head and leaned across the table to feed two others. -She left the table twice to go to another table and assist other residents.	D 312		

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D 312	Continued From page 10 -She cut a hard-boiled egg in half and used a fork to place the half of the egg into the resident's mouth. Observation of the lunch meal on 08/23/22 from 12:08pm to 12:28pm revealed: -There were five residents seated at a table; there were three PCAs at the table to assist with feeding the residents. -Two of the residents were being fed by two of the PCAs; each PCA was seated beside the resident they were feeding. -A third PCA stood at the end of the table between two residents and assisted them with eating by feeding them. -The third PCA reached across the table and fed a resident while feeding a resident to her right and her left. -She was feeding the resident to her left by reaching around the back of the resident's head and feeding her with her left hand. -The PCA walked away from the table to assist a resident at another table, she returned to the first table and began to feed the three residents again. -The PCA moved around the table opposite side of the table to cut up food but continued to stand and feed the residents. -None of the residents at the table fed themselves. -Th PCA continued to move around the table and feed the three residents; she cut up food and instructed them to "open your mouth wide". -The PCA placed large amounts of food on the spoons. -While one resident was chewing her food, she fed another resident; she alternated from resident to resident while they chewed their food. -The PCA told one resident to "hurry and open your mouth" and to "come on and open up".	D 312		

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D 312	Continued From page 11 1. Review of Resident #2's current FL2 dated 04/19/22 revealed: -Diagnoses included Alzheimer's Disease, osteoarthritis, and recurrent urinary tract infections. -There was an order for a mechanical soft diet. Refer to interview with the personal care aide (PCA) on 08/23/22 at 4:29pm. Refer to interview with the Resident Care Coordinator on 08/25/22 at 11:19am. Refer to interview with the Administrator on 08/25/22 at 5:30pm. 2. Review of Resident #3's current FL-2 dated 10/03/21 revealed: -Diagnoses included Alzheimer's disease, hypertension and gastroesophageal reflux disease. -There was an order for a pureed diet. -Resident #3 required assistance with feeding. Refer to interview with the personal care aide (PCA) on 08/23/22 at 4:29pm. Refer to interview with the Resident Care Coordinator on 08/25/22 at 11:19am. Refer to interview with the Administrator on 08/25/22 at 5:30pm. 3. Review of Resident #5's current FL-2 dated 08/02/22 revealed: -Diagnosis included history of gastrointestinal bleed, acute renal failure, bladder tumor and cute encephalopathy. -There was an order for a pureed diet. -Resident #5 required assistance with feeding.	D 312		

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D 312	Continued From page 12 Refer to interview with the personal care aide (PCA) on 08/23/22 at 4:29pm. Refer to interview with the Resident Care Coordinator on 08/25/22 at 11:19am. Refer to interview with the Administrator on 08/25/22 at 5:30pm. 4. Review of Resident #6's current FL2 dated 07/07/22 revealed: -Diagnoses included dementia, hypertension, hyperlipidemia, coronary artery disease (CAD), and chronic kidney disease. -There was an order for a carbohydrate-controlled diet. Refer to interview with the personal care aide (PCA) on 08/23/22 at 4:29pm. Refer to interview with the Resident Care Coordinator on 08/25/22 at 11:19am. Refer to interview with the Administrator on 08/25/22 at 5:30pm. 5. Review of Resident #7's current FL-2 dated 09/02/21 revealed: -Diagnoses included dementia and depression. -There was an order for finger foods. Refer to interview with the personal care aide (PCA) on 08/23/22 at 4:29pm. Refer to interview with the Resident Care Coordinator on 08/25/22 at 11:19am. Refer to interview with the Administrator on 08/25/22 at 5:30pm.	D 312		

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D 312	Continued From page 13 _____ Interview with the personal care aide (PCA) on 08/23/22 at 4:29pm revealed: -She was told to just looked around the dining room to see who needed help with eating. -There was one table where residents who needed help while eating sat together. -Some of the residents she was feeding today, 08/23/22, just needed help because they would stop eating and not finish their meals. -She was told at her orientation who needed assistance with eating, but she was not trained on how to feed residents. -She was an "expert" and skilled at feeding residents because she had worked at other facilities and at a day care. -She knew how to "trick" a resident into eating vegetables by placing another food on top of the vegetables. -She was not told to sit while feeding residents or to only feed one resident at a time. -She moved around the table while the residents were chewing and eating to "keep the flow going". Interview with the Resident Care Coordinator on 08/25/22 at 11:19am revealed: -There were five residents who sat together at a table because they required some form of feeding assistance; some of them only required queuing and prompting while eating. -Staff trained each other when they were hired on feeding techniques. -She expected the staff to have the resident sitting up, to offer bite size portions and not put too much in their mouths, to watch the resident to ensure they swallow and do not pocket any food. -She had not monitored the dining room to see if the PCAs were seated while feeding the residents. -Staff were allowed to feed more than one	D 312		

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D 312	Continued From page 14 resident at a time by sitting between them. -Staff were to speak to the resident and encourage chewing and drinking, to also ask how the food taste and if they liked it. -The resident should never be rushed while eating. -She was not aware the PCA was moving from resident to residents and standing while feeding them. Interview with the Administrator on 08/25/22 at 5:30pm revealed: -All of the residents could feed themselves, staff only needed to encourage them to eat. -One of the residents was pocketing her food but could eat on her own. -Another resident could eat on her own but depending on her physical abilities on any given day she would need assistance and prompting to eat. -Two PCAs were assigned to the table to encourage the five residents at the table to eat because no one needed to be fed. -She assisted the PCAs and served residents in the dining room during the breakfast meals and most of the time during the lunch meal as well. -She expected the two PCAs assigned to the table to sit while they assisted the residents; she had never seen the PCAs stand. -She and the RCC usually trained the staff on feeding techniques including hand under the utensil, small bites, waiting until they finished chewing, encouraging conversation and non-rushed meals.	D 312		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 15 (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: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 residents, (#2, #6, and #7) related to a medication used for memory and dementia, a medication for mood, a medication for depression and anxiety, an antibiotic to treat urinary tract infections, a prophylactic antibiotic to prevent urinary tract infections and an eye drop for dry eyes (#7); a medication used for depression and a medication used to treat behaviors (#2); three medications used to treat hypertension and a medication used to treat high cholesterol (#6). The findings are: 1. Review of Resident #7's current FL-2 dated 09/02/21 revealed diagnoses included dementia and depression. a. Review of Resident #7's incident report dated 08/14/22 revealed: -Resident #7 had an incident that required an Emergency Department (ED) visit on 08/14/22 at 9:15am. -Resident #7 had "a seizure" while in the dining room. -Hospice was notified and instructed to send	D 358		

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Resident #7 to the ED.
-Emergency Medical Services (EMS) was called and Resident #7 was taken to the hospital.

Review of Resident #7's hospital discharge summary dated 08/14/22 revealed:
-She was seen in the ED on 08/14/22 for seizure activity.
-She was diagnosed with a urinary tract infection (UTI) and ordered cefpodoxime (used to treat infections) 200mg twice daily for 10 days.
-The seizure was most likely provoked by a UTI.

Review of Resident #7's physician's orders dated 08/16/22 revealed there was an order for cefpodoxime 200mg twice daily for 10 days.

Review of Resident #7's August 2022 electronic medication administration record (eMAR) from 08/01/22 to 08/24/22 revealed:
-There was an entry for cefpodoxime 200mg twice daily for 10 days with a scheduled administration time of 9:00am and 9:00pm.
-There was documentation that cefpodoxime was administered twice daily at 9:00am and 9:00pm from 08/16/22 to 08/23/22 and at 9:00am on 08/24/22.

Observation of Resident #7's medication on hand on 08/24/22 at 3:55pm revealed there was a bubble pack labeled cefpodoxime 200mg dispensed on 08/14/22 with 9 of 20 tablets remaining.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/25/22 at 9:25am revealed:
-The pharmacy had an order for cefpodoxime 200mg twice daily for 10 days dated 08/14/22.
-The pharmacy dispensed 20 cefpodoxime (a 10

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day supply) on 08/14/22.
-Resident #7 could have a continuation of UTI if she did not receive the antibiotic as ordered.

Based on observations, interviews, and record reviews, there should have been 5 cefpodoxime 200mg available to administered from 08/23/22 at 9:00pm to 08/25/22, but there were 9 cefpodoxime remaining for administration.

Interview with a medication aide (MA) on 08/25/22 at 11:40am revealed:
-Resident #7 was transferred to the hospital on 08/14/22.
-She was not sure why Resident #7 was taken to the hospital.
-She did not know Resident #7 had a seizure on 08/14/22.
-Resident #7 did not have a history of seizures.
-She knew Resident #7 was ordered an antibiotic but did not know why Resident #7 was being administered an antibiotic.
-She did not know why Resident #7 had extra cefpodoxime available to be administered.
-Resident #7 rarely refused her medications.
-Any missed dosages due to refusal would be documented on the eMAR.

Interview with a second MA on 08/25/22 at 12:12pm revealed:
-Resident #7 was seated in the wheelchair in the dining room on 08/14/22.
-She heard Resident #7 hollering and she ran toward Resident #7.
-Resident #7 was shaking, with legs and arms extended straight out and eyes rolled back; it lasted about 5 to 7 minutes.
-Resident #7 was stiff and slipping out of the wheelchair.
-Resident #7 was sent to the ED as directed by

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the hospice nurse.
-Resident #7 returned to the facility with a diagnosis of UTI and an order for an antibiotic.
-She administered Resident #7 her medication without difficulty.
-Resident #7 did not refuse her medications when she administered them.
-She did not know why Resident #7 had extra cefpodoxime tablets on hand.

Interview with Resident #7's Primary Care Provider (PCP) on 08/25/22 at 3:45pm revealed:
-Resident #7 was ordered cefpodoxime 200mg for a UTI upon discharge for the ED.
-Cefpodoxime was an antibiotic to treat UTIs.
-Resident #7 would be at a high risk of the UTI continuing if she did not receive the cefpodoxime as ordered.
-Resident #7 could possibly go back to the hospital if the cefpodoxime was not administered as ordered.
-He expected orders to be followed as written and medication to be administered as ordered.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

Refer to the interview with a MA on 08/25/22 at 11:02am.

Refer to the interview with the Resident Care Coordinator (RCC) on 08/25/22 at 4:50pm.

b. Review of Resident #7's current FL-2 dated 09/02/21 revealed there was an order for nitrofurantoin (used to treat urinary tract infections) 100mg at bedtime.

Review of Resident #7's June 2022 electronic

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medication administration record (eMAR) revealed:
-There was an entry for nitrofurantoin 100mg at bedtime with a scheduled administration time of 9:00pm.
-There was documentation nitrofurantoin was administered nightly at 9:00pm from 06/01/22 to 06/30/22.
-There was an exception documented that Resident #4 refused administration of nitrofurantoin on 06/15/22 at 9:16pm.

Review of Resident #7's July 2022 eMAR revealed:
-There was an entry for nitrofurantoin 100mg at bedtime with a scheduled administration time of 9:00pm.
-There was documentation nitrofurantoin was administered nightly at 9:00pm from 07/01/22 to 07/31/22.

Review of Resident #7's August 2022 eMAR from 08/01/22 to 08/25/22 revealed:
-There was an entry for nitrofurantoin 100mg at bedtime with a scheduled administration time of 9:00pm.
-There was documentation nitrofurantoin was administered nightly at 9:00pm from 08/01/22 to 08/15/22.
-Nitrofurantoin was placed on hold from 08/16/22 to 08/25/22 while cefpodoxime was being administered.

Observation of Resident #7's medication on hand on 08/24/22 at 3:55pm revealed there was a bubble pack labeled nitrofurantoin 100mg with a dispense date of 08/04/22 with 25 of 30 capsules remaining.

Telephone interview with the Pharmacist at the

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facility's contracted pharmacy on 08/25/22 at 9:25am and 3:04pm revealed:
-The pharmacy had an order for nitrofurantoin 100mg at bedtime dated 09/02/21.
-The pharmacy dispensed 30 nitrofurantoin (a 30 day supply) on 04/25/22, 05/20/22, and 08/04/22.
-The pharmacy did not receive a refill request for nitrofurantoin 100mg from the facility for June 2022 or July 2022.
-The facility was not on cycle fill; the staff re-ordered medication when needed.
-The facility staff could call in a re-fill order or fax the sticker from the bubble pack.
-Nitrofurantoin was an antibiotic used prophylactically to prevent urinary tract infections (UTI).
-Resident #7 would have been more susceptible for having a UTI if not receiving nitrofurantoin as ordered.

Based on observations, interviews, and record reviews, the total number of doses of nitrofurantoin documented as administered exceeded the total number of doses dispensed by the pharmacy and would not have been available for administration as ordered in June 2022 and July 2022.

Interview with a medication aide (MA) on 08/25/22 at 11:40am revealed:
-She administered nitrofurantoin to Resident #7.
-Resident #7 had frequent UTIs.
-Resident #7 rarely refused her medications.
-She did not know why Resident #7's nitrofurantoin refills were not ordered monthly.
-The MAs were responsible for re-ordering medication when there were 5 to 8 tablets remaining in the bubble pack.
-The MAs re-ordered all medications when needed.

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-All missed doses and the reason why the medication was not given would be documented on the eMAR.

Interview with a second MA on 08/25/22 at 12:12pm revealed:
-She administered nitrofurantoin to Resident #7.
-Resident #7 did not refuse her medications when she administered them.
-She did not know why Resident #7's nitrofurantoin refills were not ordered monthly.

Interview with Resident #7's Primary Care Provider (PCP) on 08/25/22 at 3:45pm revealed:
-Resident #7 was ordered nitrofurantoin due to history of frequent UTIs.
-Resident #7 would be at a high risk of getting a UTI if she did not receive her nitrofurantoin as ordered.
-Resident #7's seizure on 08/14/22 was provoked by the UTI.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

Refer to the interview with a MA on 08/25/22 at 11:02am.

Refer to the interview with the RCC on 08/25/22 at 4:50pm.

c. Review of Resident #7's current FL-2 dated 09/02/21 revealed there was an order for memantine (used to treat moderate to severe Alzheimer's disease) 10mg twice daily.

Review of Resident #7's physician's orders dated 08/16/22 revealed there was an order for memantine 10mg twice daily.

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D 358	Continued From page 22 Review of Resident #7's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for memantine 10mg 1 tablet twice daily with a scheduled administration time of 9:00am and 9:00pm. -There was documentation that memantine 10mg was administered twice daily at 9:00am and 9:00pm from 06/01/22 to 06/30/22. -There was an exception documented that Resident #4 refused administration of memantine 10mg on 06/15/22 at 9:16pm. Review of Resident #7's July 2022 eMAR revealed: -There was an entry for memantine 10mg 1 tablet twice daily with a scheduled administration time of 9:00am and 9:00pm. -There was documentation that memantine 10mg was administered twice daily at 9:00am and 9:00pm from 07/01/22 to 07/31/22. Review of Resident #7's August 2022 eMAR from 08/01/22 to 08/24/22 revealed: -There was an entry for memantine 10mg 1 tablet twice daily with a scheduled administration time of 9:00am and 9:00pm. -There was documentation that memantine 10mg was administered twice daily at 9:00am and 9:00pm from 08/01/22 to 08/23/22 and at 9:00am on 08/24/22. Observation of Resident #7's medication on hand on 08/24/22 at 3:55pm revealed there was a bubble pack labeled memantine 10mg with 21 of 60 tablets remaining with a dispense dated of 06/01/22. Telephone interview with the Pharmacist at the	D 358		

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facility's contracted pharmacy on 08/25/22 at 9:25am revealed:
-The pharmacy had an order for memantine 10mg twice daily dated 09/02/21.
-The pharmacy dispensed 60 memantine 10mg (a 30 day supply) on 03/03/22, 04/25/22 and 06/15/22.
-The pharmacy did not receive a refill request for memantine 20mg from the facility for May 2022, July 2022 or August 2022.
-The facility was not on cycle fill; the staff re-ordered medication when needed.
-The facility staff could call in a re-fill order or fax the sticker from the bubble pack.
-Memantine was used in residents who were diagnosed with dementia or Alzheimer's disease to help with behaviors and to slow down the progression of the disease process.

Based on observations, interviews, and record reviews, the total number of doses of memantine documented as administered exceeded the total number of doses dispensed by the pharmacy and would not have been available for administration as ordered in July 2022 and August 2022.

Interview with a medication aide (MA) on 08/25/22 at 11:40am revealed:
-She administered memantine to Resident #7.
-Resident #7 had calmed down a lot over the past three months; she was no longer throwing her food, utensils, and glasses.
-Resident #7 rarely refused her medications.
-She did not know why Resident #7's memantine refills were not ordered monthly.
-All missed doses and the reason why the medication was not given would be documented on the eMAR.
-The MAs were responsible for re-ordering medication when there were 5 to 8 tablets

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remaining in the bubble pack.
-The MAs re-ordered all medications when needed.

Interview with a second MA on 08/25/22 at 12:12pm revealed:
-She administered memantine to Resident #7.
-Resident #7 did not refuse her medications when she administered them.
-She did not know why Resident #7's memantine refills were not ordered monthly.

Interview with Resident #7's Primary Care Provider (PCP) on 08/25/22 at 3:45pm revealed:
-Resident #7 was ordered memantine 20mg twice daily for diagnosis of dementia.
-Memantine was a medication that had to be tapered to prevent sudden side effects.
-Resident #7 could become increasingly agitated if memantine was stopped abruptly.
-The staff had not reported any increase in agitation for Resident #7.
-He expected all orders to be followed as written and all medication to be administered as ordered.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

Refer to the interview with a MA on 08/25/22 at 11:02am.

Refer to the interview with the RCC on 08/25/22 at 4:50pm.

d. Review of Resident #7's current FL-2 dated 09/02/21 revealed there was an order for citalopram (used to treat depression) 20mg daily.

Review of Resident #7's physician's orders dated

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D 358	Continued From page 25 08/16/22 revealed there was an order for citalopram 20mg daily. Review of the manufacturer's prescribing information for citalopram revealed: -A gradual reduction in dosage was recommended rather than abrupt discontinuation. -Adverse reactions of abrupt discontinuation include nausea, irritability, agitation, anxiety, dizziness, confusion, lethargy, emotional labiliity, seizures and tinnitis. Review of Resident #7's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for citalopram 20mg daily with a scheduled administration time of 9:00am. -There was documentation that citalopram was administered daily at 9:00am from 06/01/22 to 06/30/22. Review of Resident #7's July 2022 eMAR revealed: -There was an entry for citalopram 20mg daily with a scheduled administration time of 9:00am. -There was documentation that citalopram was administered daily at 9:00am from 07/01/22 to 07/31/22. Review of Resident #7's August 2022 eMAR from 08/01/22 to 0/24/2 revealed: -There was an entry for citalopram 20mg daily with a scheduled administration time of 9:00am. -There was documentation that citalopram was administered daily at 9:00am from 08/01/22 to 08/24/22. Observation of Resident #7's medication on hand on 08/24/22 at 3:55pm revealed there was a bubble pack of citalopram 20mg with a dispense	D 358		

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ENO POINTE ASSISTED LIVING	5600 N ROXBORO ROAD DURHAM, NC 27712

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D 358	Continued From page 26 dated of 08/20/22 with 14 of 15 tablets remaining. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/25/22 at 9:25am revealed: -The pharmacy had an order for citalopram 20mg daily dated 09/02/21. -The pharmacy dispensed 15 citalopram (a 15 day supply) on 04/18/22, 06/13/22, and 08/20/22. -The pharmacy did not receive a refill request for citalopram 20mg from the facility for July 2022. -The facility was not on cycle fill; the staff re-ordered medication when needed. -The facility staff could call in a re-fill order or fax the sticker from the bubble pack. -Resident #7 could experience an increase in signs of depression such as crying, and an increase in anxiety. Based on observations, interviews, and record reviews, the total number of doses of citalopram documented as administered exceeded the total number of doses dispensed by the pharmacy and would not have been available for administration as ordered in June 2022, July 2022 and August 2022. Interview with a medication aide (MA) on 08/25/22 at 11:40am revealed: -She administered citalopram to Resident #7. -She had not noticed increased agitation or crying with Resident #7. -She did not know why Resident #7's citalopram refills were not ordered monthly. -Resident #7 rarely refused her medications. -All missed doses and the reason why the medication was not given would be documented on the eMAR . -The MAs were responsible for re-ordering medication when there were 5 to 8 tablets	D 358		

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remaining in the bubble pack.
-The MAs re-ordered all medications when needed.

Interview with a second MA on 08/25/22 at 12:12pm revealed:
-She administered citalopram to Resident #7.
-Resident #7 did not refuse her medications when she administered them.
-She did not know why Resident #7 had extra citalopram tablets on hand.

Interview with Resident #7's Primary Care Provider (PCP) on 08/25/22 at 3:45pm revealed:
-Resident #7 was ordered citalopram for depression and anxiety.
-Resident #7 could become more anxious and depressed if citalopram was not administered as ordered.
-The staff had not reported any increase in anxiety or depression for Resident #7.
-He expected all orders to be followed as written and all medication to be administered as ordered.

Interview with Resident #7's Mental Health Provider on 08/25/22 at 4:27pm revealed:
-She managed Resident #7's citalopram.
-Resident #7 was ordered citalopram 20mg daily.
-Resident #7 was started on citalopram due to anxiety and depression.
-She had not been notified of any crying episodes or increase in anxiety in several months.
-She reviewed Resident #7's eMARs with each visit to see if Resident #7 was receiving her medications as ordered; she expected the eMARs to be accurate.
-According to the documentation of the eMARs, Resident #7 took medications as ordered.
-She was not aware that Resident #7 was not being administered her medication as ordered.

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-If Resident #7's behaviors were not being controlled, she could possibly increase Resident #7's medication, which would not be an appropriated adjustment in the medication since she was not receiving citalopram as ordered.
-She expected all orders to be followed as written and all medication to be administered as ordered.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

Refer to the interview with a MA on 08/25/22 at 11:02am.

Refer to the interview with the RCC on 08/25/22 at 4:50pm.

e. Review of Resident #7's current FL-2 dated 09/02/21 revealed there was an order for divalproex (used to help with mood) 125mg twice daily.

Review of Resident #7's physician's orders dated 08/16/22 revealed there was an order for divalproex 125mg twice daily.

Review of the manufacturer's prescribing information for divalproex revealed abrupt cessation of the medication could lead to serious problems including seizures that will not stop.

Review of Resident #7's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for divalproex 125mg twice daily with a scheduled administration time of 9:00am and 9:00pm.
-There was documentation that divalproex was administered twice daily at 9:00am and 9:00pm

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from 06/01/22 to 06/30/22.
-There was an exception documented that Resident #4 refused administration of divalproex on 06/15/22 at 9:16pm.

Review of Resident #7's July 2022 eMAR revealed:
-There was an entry for divalproex 125mg twice daily with a scheduled administration time of 9:00am and 9:00pm.
-There was documentation that divalproex was administered twice daily at 9:00am and 9:00pm from 07/01/22 to 07/31/22.

Review of Resident #7's August 2022 eMAR from 08/01/22 to 08/24/22 revealed:
-There was an entry for divalproex 125mg twice daily with a scheduled administration time of 9:00am and 9:00pm.
-There was documentation that divalproex was administered twice daily at 9:00am and 9:00pm from 08/01/22 to 08/23/22 and at 9:00am on 08/24/22.

Observation of Resident #7's medication on hand on 08/24/22 at 3:55pm revealed:
-There was a bubble pack labeled divalproex 125mg with 13 of 30 capsules remaining with a dispense dated of 08/01/22.
-There was a second bubble pack labeled divalproex 125mg with 30 of 30 capsules remaining with a dispense dated of 08/01/22.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/25/22 at 9:25am and 3:04pm revealed:
-The pharmacy had an order for divalproex 125mg twice daily dated 09/02/21.
-The pharmacy dispensed 60 divalproex 125mg (a 30-day supply) on 03/02/22, 04/13/22, and

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08/01/22.
-The pharmacy did not receive a refill request for divalproex 125mg from the facility for May 2022, June 2022, or July 2022.
-The facility was not on cycle fill; the staff re-ordered medication when needed.
-The facility staff could call in a re-fill order or fax the sticker from the bubble pack.-Resident #1 possibly could have a seizure and increase in agitation.
-Divalproex should be tapered; if not, the resident could experience racing heart, irritable behaviors, headaches and dizziness.

Based on observations, interviews, and record reviews, the total number of doses of divalproex documented as administered exceeded the total number of doses dispensed by the pharmacy and would not have been available for administration as ordered in June 2022 and July 2022.

Interview with a medication aide (MA) on 08/25/22 at 11:40am revealed:
-She administered divalproex to Resident #7.
-Resident #7 had calmed down a lot over the past three months, she was not throwing her food, plates and utensils.
-Resident #7 rarely refused her medications.
-She did not know why Resident #7's divalproex refills were not ordered monthly.
-All missed doses and the reason why the medication was not given would be documented on the eMAR.
-The MAs were responsible for re-ordering medication when there were 5 to 8 tablets remaining in the bubble pack.
-The MAs re-ordered all medications when needed.

Interview with a second MA on 08/25/22 at

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D 358	Continued From page 31 12:12pm revealed: -She administered divalproex to Resident #7. -Resident #7 did not refuse her medications when she administered them. -She did not know why Resident #7's divalproex refills were not ordered monthly. Telephone interview with Resident #7's Primary Care Provider (PCP) on 08/25/22 at 3:45pm revealed: -Resident #7 was ordered divalproex for mood; she did not have a history of seizures. -Divalproex was a medication that had to be tapered to prevent sudden side effects. -Resident #7 could become increasingly agitated and crying if divalproex was stopped suddenly. -The staff had not reported any increase in agitation or crying for Resident #7. -He expected all orders to be followed as written and all medication to be administered as ordered. Telephone interview with Resident #7's Mental Health Provider on 08/25/22 at 4:27pm revealed: -She managed Resident #7's divalproex. -Resident #7 was ordered divalproex 125mg twice daily. -Resident #7 was started on divalproex due to mood instability and impulse. -She reviewed Resident #7's eMARs with each visit to see if Resident #7 was receiving her medications as ordered; she expected the eMARs to be accurate. -According to the documentation of the eMARs, Resident #7 took medications as ordered. -She was not aware that Resident #7 was not being administered her medication as ordered. -If Resident #7's behaviors were not being controlled, she could possibly increase Resident #7's medication, which would not be an appropriate adjustment in the medication since	D 358		

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she was not receiving divalproex as ordered.
-She expected all orders to be followed as written and all medication to be administered as ordered.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

Refer to the interview with a MA on 08/25/22 at 11:02am.

Refer to the interview with the RCC on 08/25/22 at 4:50pm.

f. Review of Resident #7's current FL-2 dated 09/02/21 revealed there was an order for cyclosporine (used to increase tear production) 0.05% eye drops 1 drop in each eye twice daily.

Review of Resident #7's physician's orders dated 08/16/22 revealed there was an order for cyclosporine 0.05% eye drops 1 drop in each eye twice daily.

Review of Resident #7's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for cyclosporine 0.05% 1 drop in each eye twice daily with a scheduled administration time of 10:00am and 9:00pm.
-There was documentation that cyclosporine 0.05% was administered twice daily at 10:00am and 9:00pm from 06/01/22 to 06/30/22.
-There was an exception documented that Resident #4 refused administration of cyclosporine on 06/15/22 at 9:16pm.

Review of Resident #7's July 2022 eMAR revealed:
-There was an entry for cyclosporine 0.05% 1

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drop in each eye twice daily with a scheduled administration time of 10:00am and 9:00pm.
-There was documentation that cyclosporine 0.05% was administered twice daily at 10:00am and 9:00pm from 07/01/22 to 07/31/22.

Review of Resident #7's August 2022 eMAR from 08/01/22 to 08/24/22 revealed:
-There was an entry for cyclosporine 0.05% 1 drop in each eye twice daily with a scheduled administration time of 10:00am and 9:00pm.
-There was documentation that cyclosporine 0.05% was administered twice daily at 10:00am and 9:00pm from 08/01/22 to 08/23/22 and at 10:00am on 08/24/22.

Observation of Resident #7's medication on hand on 08/24/22 at 3:55pm revealed:
-There was a container labeled cyclosporine 0.05%.
-The dispensed date on the prescription label was 08/01/22, with 30 of 60 single use vials dispensed.
-There was a hand-written date of 08/13/22 on the container.
-There were 25 single-use vials remaining.
-There was a second, sealed container labeled cyclosporine 0.05% with 30-single use vials.
-The dispense dated on the prescription label was 08/01/22, with 30 of 60 single use vials dispensed.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/25/22 at 9:25am revealed:
-The pharmacy had an order for cyclosporine 0.05% 1 drop in each eye twice daily dated 09/02/21.
-The pharmacy dispensed 60 single unit vials of cyclosporine (a 30-day supply) on 12/14/21,

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3/16/22, and 08/01/22.
-The pharmacy did not receive a refill request for cyclosporine 0.05% from the facility for April 2022, May 2022, June 2022, or July 2022.
-The facility was not on cycle fill; the staff re-ordered medication when needed.
-The facility staff could call in a re-fill order or fax the sticker from the bubble pack.
-Cyclosporine was intended for single use; any remainder of solution should be discarded if not administered.
-Cyclosporine did not have a preservative in it; it could potentially become contaminated and cause an eye infection if the remainder of solution was saved for another administration.

Based on observations, interviews, and record reviews, the total number of doses of memantine documented as administered exceeded the total number of doses dispensed by the pharmacy and would not have been available for administration as ordered in June 2022 July 2022.

Interview with a medication aide (MA) on 08/25/22 at 11:40am revealed:
-She administered cyclosporine 0.05% eye drops to Resident #7.
-She would save the single use vial if there was any solution left in the vial and administer if during the next medication pass.
-Resident #7 rarely refused her medications.
-Resident #7 had extra single-use vials of cyclosporine because she would save the vials and use for the next administration if there was solution remaining in the vial.
-All missed doses and the reason why the medication was not given would be documented on the eMAR.
-The MAs were responsible for re-ordering medication when there were 5 to 8 single use

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vials remaining in the container.
-The MAs re-ordered all medications when needed.

Interview with a second MA on 08/25/22 at 12:12pm revealed:
-She had administered cyclosporine 0.05% eye drops to Resident #7.
-The eye drops were in a single use vial.
-She would dispose of the vial after administration of eye drops.
-She had never saved a single use vial to be used for a second administration.
-There was no way to recap the single dose vial.

Telephone interview with Resident #7's Primary Care Provider (PCP) on 08/25/22 at 3:45pm revealed:
-Resident #7 was ordered cyclosporine 0.05% twice daily for dry eyes.
-Resident #7's eye could become more uncomfortable related to itching and dryness.
-The staff had not reported any problems with increasing in eye irritation for Resident #7.
-He expected all orders to be followed as written and all medication to be administered as ordered.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

Refer to the interview with a MA on 08/25/22 at 11:02am.

Refer to the interview with the RCC on 08/25/22 at 4:50pm.

2. Review of Resident #2's current FL2 dated 04/19/22 revealed:

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-Diagnoses included Alzheimer's Disease, osteoarthritis, and recurrent urinary tract infections.
-Resident #2 was constantly confused.
-Resident #2 had wandering behaviors.

Review of Resident #2's care notes from 07/12/22-08/22/22 revealed:
-On 07/12/22, 07/13/22, and 07/16/22, Resident #2 was on the floor in her room.
-On 08/11/22, Resident #2 fell out of her wheelchair onto the floor.
-On 08/18/22, Resident #2 was repeatedly crawling out of chairs and yelling. Combative with staff. The physician ordered new medication.
-On 08/19/22, Resident #2 was again disruptive, yelling, crawling, hallucinating, and picking up things from the floor that were not there.
-On 08/20/22, at 11:45pm, Resident #2 was balled up on the floor, naked in between the bed and the dresser. Resident #2 continued to get out of bed and get on the floor.
-On 08/22/22, at 12:30am, Resident #2 moved the dresser and chairs, and was on the floor naked. She had urinated all over the floor and at 1:30am, Resident #2 was up again and on the floor. She had taken her incontinence brief off.

a. Review of Resident #2's Mental Health (MH) Provider's after visit summary dated 06/29/22 revealed there was an order to start Quetiapine 25mg, (an antipsychotic) one half a tablet at 2:00pm and one whole tablet once daily for a total of 37.5mg daily.

Review of Resident #2's Primary Care Provider's (PCP) after-visit summary dated 07/20/22 revealed there was an order to start Quetiapine 25mg at bedtime and continue all other Quetiapine for a daily total of 62.5mg.

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D 358	Continued From page 37 Review of Resident #2's electronic medication administration record (eMAR) for July 2022 revealed: -There was an entry for Quetiapine 25mg take one tablet once daily. -There was documentation Quetiapine 25mg was administered at 8:00am from 07/01/22-07/31/22. -There was a second entry for Quetiapine 25mg, take ½ tablet at 2:00pm. -There was documentation Quetiapine 25mg, ½ tablet was administered at 2:00pm from 07/01/22-07/31/22. -There was a third entry for Quetiapine 25mg take one tablet at bedtime. -There was documentation Quetiapine 25mg was administered at 8:00pm from 07/20/22-07/31/22. Telephone interview with a Pharmacist at Resident #2's pharmacy on 08/24/22 at 9:25am revealed: -Fifteen tablets of Quetiapine 25mg were dispensed on 06/29/22 and 07/15/22. -He did not receive an order on 07/20/22 for 25mg at bedtime and no additional Quetiapine was dispensed. Based on interview and record review the total doses of Quetiapine documented from 07/01/22-07/31/22 as administered (1437.5mg) exceeded the total dosage dispensed from the pharmacy on 06/29/22 (375mg) and on 07/15/22 (375mg) and would not have been available for administration as ordered in July 2022. Third interview with the MA on 08/24/22 at 3:03pm revealed: -She administered Resident #2's medications as ordered, based on the eMAR and medications on hand.	D 358		

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D 358	Continued From page 38 -She had not cut any whole tablets in half for Resident #2. -Resident #2 had not used any other pharmacy since she had been working at the facility; she had been working at the facility for 5-6 years. Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 4:35pm revealed: -The MAs had "never not given" Resident #2 her medication. -She did not know how it could have happened that Resident #2 did not have enough tablets of Quetiapine dispensed to administer daily as ordered. -When Resident #2 had behaviors, she would ask the MA if the medication had been administered and the MAs were saying they had administered the medication. -She looked at Resident #2's eMAR and it was documented the medication had been administered. -She thought Resident #2's medication had been administered as ordered based on the MA saying it was administered and it was documented it was administered. -If the medication had been administered like it was ordered, she wondered if the medication would have helped with Resident #2's behaviors. Telephone interview with Resident #2's PCP on 08/25/22 at 3:51pm revealed: -He had made a referral to a MH provider because of Resident #2's ongoing behaviors. -The staff "kept talking" about Resident #2's behaviors so the MH provider kept increasing the medication based on the behaviors. -He was concerned Resident #2 was not getting her medications correctly for the MH provider to know what was effective or not before increasing the medication.	D 358		

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-Quetiapine was a medication that was typically tapered off and not stopped abruptly.
-If Resident #2's Quetiapine had been stopped abruptly, she would have been more anxious and more agitated.

Telephone interview with Resident #2's MH provider on 08/25/22 at 4:27pm revealed:
-She looked at Resident #2's eMAR when she made visits.
-Based on the documentation, she thought Resident #2 was taking the dosage ordered and was still having behaviors.
-If Resident #2 was not taking the medication as ordered, she was adjusting the medication based on the incorrect dosage.
-When she adjusted Resident #2's Quetiapine, she adjusted it based on the resident still having behaviors at that dosage, so she increased the medication.
-She made changes to Resident #2's medication based on the eMAR documentation and trusted the MAs were documenting what was being administered.
-She was being told Resident #2 was agitated, exhibiting behaviors, and disruptive to her roommate.
-When she started Resident #2 on Quetiapine, she started on a low dose and was gradually increasing to avoid over-sedation.
-She did not make any changes to Resident #2's medication when she saw her on 08/17/22 and later that day she received a call from the facility staff and was told Resident #2 was "off the wall" and she added in a prn medication for agitation.
-She based all her increases in the dosage of Quetiapine ordered for Resident #2 on the ongoing report of behaviors.
-It was very concerning Resident #2's Quetiapine had not been administered as ordered.

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D 358	Continued From page 40 -She expected Resident #2's medication to be administered as ordered. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Refer to the interview with the MA on 08/25/22 at 11:02am. Refer to the interview with the RCC on 08/25/22 at 4:50pm. b. Review of Resident #2's after-visit summary with a geriatric provider dated 08/04/22 revealed an order to decrease bedtime Trazadone from 100mg to 50mg (used to treat behaviors and depression) because of falls in the overnight period and over sedation. Review of Resident #2's electronic medication administration record (eMAR) for 08/04/22-08/25/22 revealed: -There was an entry for Trazadone 50mg take 2 tablets (100mg) at bedtime; the entry was discontinued on 08/03/22. -There was a second entry for Trazadone 50mg take 1 tablet at bedtime; the entry started on 08/04/22. -Trazadone 50mg was documented as administered at 8:00pm from 08/04/22-08/24/22. Observation of Resident #2's medication on hand on 08/24/22 at 3:56pm revealed: -There was a punch card dated 07/15/22 for Trazadone 50mg with directions to administer two tablets every night; 60 Trazadone 50mg tablets were dispensed. -There were 2 tablets in each of the 30 individual bubbles.	D 358		

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D 358	Continued From page 41 -There were 5 individual bubbles available for administration for a total of 10 tablets. Telephone interview with a Pharmacist at Resident #2's pharmacy on 08/24/22 at 9:25am revealed: -The last order he had received for Resident #2's Trazadone was for the 07/15/22 dispensing. -Sixty tablets of Trazadone 50mg were dispensed on 07/15/22 with the directions to take 2 tablets at bedtime. -He had not received an order dated 08/04//22 to decrease Resident #2's Trazadone to 50mg at bedtime. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/24/22 at 4:27pm revealed: -An order was received on 08/04/22 for Resident #2's Trazadone 50mg at bedtime. -The pharmacy did not fill the order for Resident #2, but they did profile the new order, so the medication was on the resident's eMAR. Interview with the medication aide (MA) on 08/24/22 at 3:48pm revealed: -She administered Resident #2's Trazadone at bedtime. -She administered 2 tablets at bedtime. -Resident #2's punch card had the directions to give 2 tablets to equal 50mg, so she gave two tablets. -She did not know that Trazadone 50mg meant each tablet was 50mg. -She thought each tablet of Trazadone was 25mg to equal to 50mg. Interview with the Resident Care Coordinator on 03/24/22 at 4:35pm revealed: -She processed new orders.	D 358		

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D 358	Continued From page 42 -If a resident used a different pharmacy, she faxed the order to the facility's contracted pharmacy for the eMAR and to the outside pharmacy to be filled. -All medication was placed into the resident's individual cubby in the medication room. -When the MA administered medication, if the medication was not on the cart, she would know to check the resident's cubby for the medication. -The eMAR was always the most current order and medications should be administered based on the resident's eMAR. -Resident #2 had a lot of medication changes recently so the medication label did not match the eMAR, but the eMAR was correct. -If the medication label did not match the eMAR she expected the MA to tell her or to fix it themselves by clarifying the order and adding a label change to the medication package. -She expected the MA to tell her so she could follow up if she needed to. -If Resident #2's eMAR had the directions to take 1 tablet, she expected the MA to punch 1 tablet and to waste the other tablet until the correct punch card had been dispensed. -She had seen a MA punch one tablet and waste the other tablet when administering medications to Resident #2; she was not sure which MA she had seen. -When she knew there was a label change, she would write "LC" on the punch card. -She had not documented a label change on Resident #2's Trazadone. -When she faxed new orders to the pharmacy, she would know it was received because she would get a confirmation; she did not keep the confirmation. -She thought Resident #2's last cart audit was completed at the end of July 2022. -Today, 08/24/22, was the first time she had seen	D 358		

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D 358	Continued From page 43 Resident #2 sleepy "like this." Telephone interview with Resident #2's primary care provider (PCP) on 08/25/22 at 3:51pm revealed Resident #2's Trazadone had been decreased because Resident #2 had a history of falls. Telephone interview with Resident #2's geriatric provider on 08/26/22 at 12:36pm revealed: -He had decreased Resident #2's Trazadone because the resident's family member had reported Resident #2 had been sedated. -Resident #2 was at risk for ongoing over-sedation and falls if the Trazadone had not been decreased as ordered. -He expected the medication order to have been followed. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Refer to the interview with the MA on 08/25/22 at 11:02am. Refer to the interview with the RCC on 08/25/22 at 4:50pm. 3. Review of Resident #6's current FL2 dated 07/07/22 revealed: -Diagnoses included dementia, hypertension, hyperlipidemia, coronary artery disease (CAD), and chronic kidney disease. -Resident #2 was constantly confused. Review of Resident #6's after visit summaries and physician's orders revealed: -On 03/24/22, Resident #6's blood pressure (BP) order was to check BP and heart rate (HR) once	D 358		

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a week and notify the primary care provider (PCP) if systolic BP was less than 100 or greater than 180 and HR less than 50 or greater than 100.
-On 05/19/22, Resident #6's BP was persistently above goal over the past month. Increased BP checks to daily for one week. Will check labs and follow-up to adjust antihypertensives were needed.
-On 05/26/22, Resident #6's BP was above goal yesterday, however near goal today. Staff to check BP every other day for 2 weeks.
-On 06/02/22, there was an order to check BP on Monday, Wednesday, and Friday for 2 weeks.
-On 06/09/22, Resident #6's BP was better.
-On 08/18/22, Resident #6's BP was maintaining.

Review of Resident #6's March 2022, April 2022, May 2022, June 2022, July 2022 and 08/01/22-08/24/22 electronic medication administration records (eMAR) revealed:
-There was an entry check BP and HR once a week and notify the PCP if systolic BP was less than 100 or greater than 180 and HR less than 50 or greater than 100.
-In March 2022, Resident #6's BP was documented as 101/71, 177/115, and 173/89.
-In April 2022, Resident #6's BP was documented as 162/82, 163/83, 154/80, and 182/102.
-In May 2022, Resident #6's BP was documented as 174/96, 170/114, 169/98, and 155/105.
-In June 2022, Resident #6's BP was documented as 116/78, 144/78, 161/88, 152/93, 151/99, 135/73, and 132/70.
-In July 2022, Resident #6's BP was documented as 138/68, 133/72, 144/74, and 134/72.
-In August 2022, Resident #6's BP was documented as 133/68, 135/70, and 130/70.

a. Review of Resident #6's physician's order

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dated 03/24/22 revealed an order Aspirin 81mg once daily (a nonsteroidal anti-inflammatory drug used to treat inflammation and reduce the risk of heart attack in people with CAD).

Review of Resident #6's June 2022 electronic administration record (eMAR) revealed:
-There was an entry for Aspirin 81mg take 1 tablet daily with a scheduled administration time of 9:00am.
-Aspirin 81mg was documented as administered at 9:00am from 06/01/22-06/30/22.

Review of Resident #6's July 2022 eMAR revealed:
-There was an entry for Aspirin 81mg take 1 tablet daily with a scheduled administration time of 9:00am.
-Aspirin 81mg was documented as administered at 9:00am from 07/01/22-07/31/22.

Review of Resident #6's eMAR for 08/01/22-08/25/22 revealed:
-There was an entry for Aspirin 81mg take 1 tablet daily with a scheduled administration time of 9:00am.
-Aspirin 81mg was documented as administered at 9:00am from 08/01/22-08/24/22.

Observation of Resident #6's medications on hand on 08/24/22 at 2:18pm revealed:
-There was a punch card of Aspirin 81mg dispensed on 03/22/22 for 30 tablets.
-There were 2 of 30 tablets available for administration.
-There was a second punch card of Aspirin 81mg dispensed on 08/18/22 for 30 tablets.
-There were 30 of 30 tablets of Aspirin 81mg available for administration.

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Telephone interview with a Pharmacist with the facility's contracted pharmacy on 08/24/22 at 2:28pm revealed:
-Resident #6's Aspirin 81mg was dispensed on 03/22/22 and 08/18/22; thirty tablets were dispensed for a one-month supply at each dispensing.
-There was no Aspirin dispensed between 03/22/22 and 08/18/22.
-There had been no request from the facility to refill Resident #6's Aspirin 81mg at any time between 03/22/22 and 08/18/22.
-The facility was not on cycle fill; staff re-ordered medication when needed.
-The facility staff could call in a re-fill order or fax the sticker from the bubble pack.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 08/25/22 at 10:03am revealed Resident #6 was at increased risk of heart attack or stroke if her Aspirin was not administered as ordered.

Based on observations, interviews, and record reviews, the total number of doses of Aspirin documented as administered exceeded the total number of doses dispensed by the pharmacy and would not have been available for administration as ordered.

Interview with a medication aide (MA) on 08/25/22 at 11:02am revealed:
-She did not know why she was administering Resident #6's Aspirin from a March 2022 punch card.
-She did not know why Resident #6's March 2022 punch card of Aspirin still had tablets remaining.
-She did not know why Resident #6's Aspirin was not ordered monthly.
-The MAs were responsible for re-ordering

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medication when there were 5 to 8 tablets remaining in the bubble pack.
-The MAs re-ordered all medications when needed.
-All missed doses and the reason why the medication was not given would be documented on the eMAR.

Telephone interview with Resident #6's Primary Care Provider (PCP) on 08/25/22 at 3:45pm revealed:
-He had ordered Aspirin 81mg for Resident #6 to treat hypertension.
-If Resident #6's medication was not administered as ordered it increased the resident's risk of high BP and high BP increased her risk of heart attack and stroke.
-Resident #6's BP had been running high from May 2022-June 2022 and it could have been because her medication had not been administered correctly.

Interview with the Resident Care Coordinator (RCC) on 08/25/22 at 4:50pm revealed:
-She did not know the current punch card for Resident #6's Aspirin was dispensed in March 2022.
-She did not know why Resident #6 would still have medication from March 2022 on hand.

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

Refer to the interview with the MA on 08/25/22 at 11:02am.

Refer to the interview with the RCC on 08/25/22 at 4:50pm.

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b. Review of Resident #6's physician's orders dated 03/24/22 revealed an order for Atorvastatin 20mg take one and a half tablet to equal 30mg once daily (used to treat high cholesterol).

Review of Resident #6's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Atorvastatin 20mg take one and a half tablet to equal 30mg once daily with a scheduled administration time of 9:00pm.
-Atorvastatin 30mg was documented as administered at 9:00pm from 06/01/22-06/30/22.

Review of Resident #6's July 2022 eMAR revealed:
-There was an entry for Atorvastatin 20mg take one and a half tablet to equal 30mg once daily with a scheduled administration time of 9:00pm.
-Atorvastatin 30mg was documented as administered at 9:00pm from 07/01/22-07/31/22.

Review of Resident #6's eMAR for 08/01/22-08/25/22 revealed:
-There was an entry for Atorvastatin 20mg take one and a half tablet to equal 30mg once daily with a scheduled administration time of 9:00pm.
-Atorvastatin 30mg was documented as administered at 9:00pm from 08/01/22-08/24/22.

Observation of Resident #6's medications on hand on 08/24/22 at 2:18pm revealed:
-There was a punch card of Atorvastatin 20mg take one and a half tablets dispensed on 06/02/22; 45 tablets were dispensed.
-Each individual bubble contained one whole and one half a tablet; there were 4 unpunched bubbles.

Telephone with a Pharmacist with the facility's

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contracted pharmacy on 08/24/22 at 2:28pm revealed:
-Resident #6's Atorvastatin 20mg take one and a half tablets was dispensed on 01/27/22, 04/19/22, and 06/02/22 for a one-month supply at each dispensing.
-There was no other Atorvastatin dispensed in 2022.
-There had been no request from the facility to refill Resident #6's Atorvastatin since 06/02/22.
-The facility was not on cycle fill; staff re-ordered medication when needed.
-The facility staff could call in a re-fill order or fax the sticker from the bubble pack.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 08/25/22 at 10:03am revealed Atorvastatin was used to lower cholesterol and if the medication was missed for extended periods of time and Resident #6's cholesterol went up, it could increase her risk of a heart attack or stroke.

Interview with a medication aide (MA) on 08/25/22 at 11:02am revealed:
-She did not know why she was administering Resident #6's Atorvastatin from a June 2022 punch card.
-She did not know why Resident #6's June 2022 punch card of Atorvastatin still had tablets remaining.
-She did not know why Resident #6's Atorvastatin was not ordered monthly.
-The MAs were responsible for re-ordering medication when there were 5 to 8 tablets remaining in the bubble pack.
-The MAs re-ordered all medications when needed.
-All missed doses and the reason why the medication was not given would be documented

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on the eMAR.

Telephone interview with Resident #6's Primary Care Provider (PCP) on 08/25/22 at 3:45pm revealed:
-He had ordered Atorvastatin for Resident #6 to treat high cholesterol.
-Untreated high cholesterol could cause heart issues.

Interview with the Resident Care Coordinator (RCC) on 08/25/22 at 4:50pm revealed:
-She did not know the current punch card for Resident #6's Atorvastatin was dispensed in June 2022.
-She did not know why Resident #6 would still have medication from June 2022 on hand.

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

Refer to the interview with the MA on 08/25/22 at 11:02am.

Refer to the interview with the RCC on 08/25/22 at 4:50pm.

c. Review of Resident #6's physician's orders dated 03/24/22 revealed an order for Amlodipine 5mg take once daily (used to treat high blood pressure).

Review of Resident #6's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Amlodipine 5mg once daily with a scheduled administration time of 9:00am.
-Amlodipine 5mg was documented as

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ENO POINTE ASSISTED LIVING	5600 N ROXBORO ROAD DURHAM, NC 27712

(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	Continued From page 51 administered at 9:00am from 06/01/22-06/30/22. Review of Resident #6's July 2022 eMAR revealed: There was an entry for Amlodipine 5mg once daily with a scheduled administration time of 9:00am. -Amlodipine 5mg was documented as administered at 9:00am from 07/01/22-07/31/22. Review of Resident #6's eMAR for 08/01/22-08/25/22 revealed: - There was an entry for Amlodipine 5mg once daily with a scheduled administration time of 9:00am. -Amlodipine 5mg was documented as administered at 9:00am from 08/01/22-08/24/22. Observation of Resident #6's medications on hand on 08/24/22 at 2:18pm revealed: -There was a punch card of Amlodipine 5mg dispensed on 04/04/22; 30 tablets were dispensed. -There were 24 of 30 tablets available to be administered. Telephone with a Pharmacist with the facility's contracted pharmacy on 08/24/22 at 2:28pm revealed: -Resident #6's Amlodipine 5mg was dispensed on 12/03/21 and 04/04/22 for a one-month supply at each dispensing. -There was no other Amlodipine 5mg dispensed in 2022. -There had been no request from the facility to refill Resident #6's Amlodipine since 04/04/22. -The facility was not on cycle fill; staff re-ordered medication when needed. -The facility staff could call in a re-fill order or fax the sticker from the bubble pack.	D 358		

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D 358	Continued From page 52 Telephone interview with a Pharmacist with the facility's contracted pharmacy on 08/25/22 at 10:03am revealed Resident #6 was at increased risk of heart attack or stroke if her Amlodipine was not administered as ordered. Interview with a medication aide (MA) on 08/25/22 at 11:02am revealed: -She did not know why she was administering Resident #6's Amlodipine from an April 2022 punch card. -She did not know why Resident #6's April 2022 punch card of Amlodipine still had tablets remaining. -She did not know why Resident #6's Amlodipine was not ordered monthly. -The MAs were responsible for re-ordering medication when there were 5 to 8 tablets remaining in the bubble pack. -The MAs re-ordered all medications when needed. -All missed doses and the reason why the medication was not given would be documented on the eMAR. Telephone interview with Resident #6's Primary Care Provider (PCP) on 08/25/22 at 3:45pm revealed: -He had ordered Amlodipine for Resident #6 to treat high blood pressure. -If Resident #6's medication was not administered as ordered it increased the resident's risk of high BP and high BP increased her risk of heart attack and stroke. -Resident #6's BP had been running high from May 2022-June 2022 and it could have been because her medication had not been administered correctly.	D 358		

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D 358	Continued From page 53 Interview with the Resident Care Coordinator (RCC) on 08/25/22 at 4:50pm revealed: -She did not know the current punch card for Resident #6's Amlodipine was dispensed in April 2022. -She did not know why Resident #6 would still have medication from April 2022 on hand. Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable. Refer to the interview with the MA on 08/25/22 at 11:02am. Refer to the interview with the RCC on 08/25/22 at 4:50pm. d. Review of Resident #6's physician's orders dated 03/24/22 revealed an order for Isosorbide mononitrate ER 60mg take one at bedtime (used to prevent chest pain and treat elevated BP). Review of the manufacturer's prescribing information revealed abruptly stopping the medication could cause a severe angina attack. Review of Resident #6's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Isosorbide mononitrate ER 60mg with a scheduled administration time of 9:00pm. - Isosorbide mononitrate ER 60mg was documented as administered at 9:00pm from 06/01/22-06/30/22. Review of Resident #6's July 2022 eMAR revealed: There was an entry for Isosorbide mononitrate	D 358		

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ER 60mg with a scheduled administration time of 9:00pm.
-Isosorbide mononitrate ER 60mg was documented as administered at 9:00pm from 07/01/22-07/31/22.

Review of Resident #6's eMAR for 08/01/22-08/25/22 revealed:
-There was an entry for Isosorbide mononitrate ER 60mg with a scheduled administration time of 9:00pm.
-Isosorbide mononitrate ER 60mg was documented as administered at 9:00pm from 08/01/22-08/24/22.

Observation of Resident #6's medications on hand on 08/24/22 at 2:18pm revealed:
-There was a punch card of Isosorbide mononitrate ER 60mg dispensed on 05/09/22; 30 tablets were dispensed.
-There were 2 of 30 tablets available to be administered.

Telephone with a Pharmacist with the facility's contracted pharmacy on 08/24/22 at 2:28pm revealed:
-Resident #6's Isosorbide mononitrate ER 60mg was dispensed on 03/16/22, 05/09/22, and 06/06/22 for a one-month supply at each dispensing.
-There was no other Isosorbide dispensed in 2022.
-There had been no request from the facility to refill Resident #6's Isosorbide since 06/06/22.
-The facility was not on cycle fill; staff re-ordered medication when needed.
-The facility staff could call in a re-fill order or fax the sticker from the bubble pack.

Telephone interview with a Pharmacist with the

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facility's contracted pharmacy on 08/25/22 at 10:03am revealed Resident #6 was at increased risk of chest pain if her Isosorbide was not administered as ordered.

Interview with a medication aide (MA) on 08/25/22 at 11:02am revealed:
-She did not know why she was administering Resident #6's Isosorbide from a May 2022 punch card.
-She did not know why Resident #6's May 2022 punch card of Isosorbide still had tablets remaining.
-She did not know if the Isosorbide from Resident #6's June 2022 punch card had been administered.
-She did not know why Resident #6's Isosorbide was not ordered monthly.
-The MAs were responsible for re-ordering medication when there were 5 to 8 tablets remaining in the bubble pack.
-The MAs re-ordered all medications when needed.
-All missed doses and the reason why the medication was not given would be documented on the eMAR.

Telephone interview with Resident #6's Primary Care Provider (PCP) on 08/25/22 at 3:45pm revealed
-He had ordered Isosorbide for Resident #6 as an antihypertensive to treat high blood pressure.
-If Resident #6's medication was not administered as ordered it increased the resident's risk of high BP and high BP increased her risk of heart attack and stroke.
-Resident #6's BP had been running high from May 2022-June 2022 and it could have been because her medication had not been administered correctly.

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D 358	Continued From page 56 Interview with the Resident Care Coordinator (RCC) on 08/25/22 at 4:50pm revealed: -She did not know the current punch card for Resident #6's Isosorbide was dispensed in May 2022. -She did not know why Resident #6 would still have medication from May 2022 on hand. Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable. Refer to the interview with the MA on 08/25/22 at 11:02am. Refer to the interview with the RCC on 08/25/22 at 4:50pm. _____ Interview with a MA on 08/25/22 at 11:02am revealed: -They had just recently started back doing cart audits (in the past month) because they had been short staffed. -When cart audits were done, they only checked to make sure medication was on hand to be administered, and not the dates of when the medication was dispensed. -The MAs would reorder medication when there were between 5 and 8 tablets left in the bubble packs. Interview with the RCC on 08/25/22 at 4:50pm revealed: -She did not know why resident's medication were not ordered monthly when the pharmacy only sent a 30 day supply. -The MAs knew the importance of administering medication as ordered. -She was concerned that the residents were not	D 358		

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D 358	Continued From page 57 getting their medications as ordered. -If she had seen punch cards were still on hand, when they should have been used, it would have raised a red flag for her. -The MAs were responsible for reordering medications when needed. -If a medication was not available on the medication cart to be administered, the MA should call the pharmacy and reorder the medication. _____ The facility failed to ensure medications were available and administered as ordered. The facility staff did not request monthly medication refills from the pharmacy resulting in Resident #7 having at least 5 medications that did not have enough medication dispensed to meet the doses ordered; Resident #6 having at least four medications that did not have enough doses dispensed to meet the number of doses ordered; and Resident #2 having 1 medication that did not have enough medication dispensed to meet the number of doses ordered. Resident #7 was ordered memantine twice daily for the treatment of Alzheimer's disease which was last dispensed by the pharmacy on 06/15/22; divalproex ordered twice daily for mood stabilization that was not dispensed from 04/13/22-08/01/22; and Nitrofurantoin (an antibiotic prescribed as a prophylaxis due to a history of urinary tract infections) and did not have the medication dispensed and available for administration between 05/20/22 and 08/04/22 resulting in the resident having a hospital visit for a seizure on 08/14/22 that was provoked by a UTI. The resident was ordered another antibiotic (cefpodoxime) twice daily for 10 days and did not receive the antibiotic twice daily as ordered. Resident #2 was ordered quetiapine for behaviors and was not administered the medication as	D 358		

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D 358	Continued From page 58 ordered resulting in the resident having ongoing behaviors and the provider increasing the quetiapine. Resident #6, who had a diagnoses of hypertension and coronary artery disease, was ordered amlodipine daily for treatment of hypertension that was last dispensed by the pharmacy on 04/04/22 and ordered isosorbide mononitrate (used to treat elevated blood pressure) daily at bedtime that was last dispensed by the pharmacy on 06/06/22. Not receiving amlodipine and isosorbide mononitrate resulted in Resident #6 having elevated blood pressure and increased risk for a heart attack. The facility's failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/25/22 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2022.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.	D 366		

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D 366	Continued From page 59 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure a medication aide (MA) observed residents take their morning medications prior to the administration of medications to another resident for 2 of 3 sampled residents (#9, #10). The findings are: Review of the Medication Administration Policy revealed: -There was no date noted on the policy. -The MA should remain with the resident until the medication had been swallowed. -The MA should not record the administration of a medication unless the MA is positive the resident swallowed the dose of medication. 1. Observation of the medication aide (MA) during the morning medication pass on 08/23/22 at 7:56am revealed: -The MA prepared 3 medications for Resident #9 while in the medication room by placing the 3 tablets in a medication cup with applesauce. -The MA walked out of the medication room and into the dining room and handed Rsident #9 the medication cup, with the 3 medications in applesauce and a spoon. (The medication room was directly off the dining room.) -The MA returned to the medication room and documented Resident #9 was administered her medications. -The MA did not observe Resident #9 take her medications. Review of Resident #9's current FL-2 dated 04/01/22 revealed diagnoses of mental retardation, vitamin D deficiency and depression.	D 366		

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D 366	Continued From page 60 Review of Resident #9's assessment and care plan dated 04/01/22 revealed: -Resident #9 was forgetful and needed reminders. -Resident #9 needed limited assistance with eating. Interview with Resident #9 on 08/23/22 at 1:59pm revealed: -The MA would give her a cup of medications each morning in applesauce. -She would feed herself her medications. -The MA did not stay with her while she took her medications. -She always took her medications. Interview with the MA on 08/23/22 at 8:15am revealed: -She prepared 3 medications for Resident #9 and placed them in applesauce. -She handed Resident #9 a medication cup with her medications in applesauce and a spoon. -She returned to the medication room, signed Resident #9's eMAR that medications were administered, without observing Resident #9 take her medications during the morning medication pass. Interview with the RCC on 08/23/22 at 8:59am revealed: -Resident #9 was very independent and took her medications. -She would hold the cup of medications in her hand until she had taken them. Refer to the interview with the MA on 08/23/22 at 8:15am. Refer to the interview with the RCC on 08/23/22 at 8:59am.	D 366		

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D 366	Continued From page 61 Refer to the interview with the Administrator on 08/23/22 at 4:04pm. 2. Observation of the medication aide (MA) during the morning medication pass on 08/23/22 at 8:01am revealed: -The MA prepared 8 medications for Resident #10 while in the medication room by crushing 7 tablets and placing them, along with one capsule, in a medication cup with applesauce. -The MA walked out of the medication room and into the dining room and handed resident #10 the medication cup with the 8 medications in applesauce and a spoon. (The medication room was directly off the dining room.) -The MA returned to the medication room and documented Resident #10 was administered her medications. -The MA did not observe Resident #9 take her medications. Review of Resident #10's current FL-2 dated 10/03/21 revealed: -Diagnoses of acute cystitis, onychogryphosis, tremors, basal cell cancer, carcinoma of the central portion of right breast, memory loss, dementia, and bipolar disorder. -Resident #19 was intermittently confused. Review of Resident #10's assessment and care plan dated 10/03/21 revealed: -The resident was sometimes disoriented, forgetful, and needed reminders. -Resident #10 required supervision while eating. Interview with Resident #10 on 08/23/22 at 12:30pm revealed: -Her medications were always crushed and placed in applesauce. -The MA would hand me my cup of medications	D 366		

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D 366	Continued From page 62 and walk away. -She would take her medications. Interview with the MA on 08/23/22 at 8:15am revealed: -She prepared 8 medications for Resident #10 by crushing 7 tablets and placing them and one capsule in applesauce. -She handed Resident #10 a medication cup with her medications in applesauce and a spoon. -She returned to the medication room, signed Resident #10's eMAR that medications were administered, without observing Resident #10 take her medications during the morning medication pass. Refer to the interview with the MA on 08/23/22 at 8:15am. Refer to the interview with the RCC on 08/23/22 at 8:59am. Refer to the interview with the Administrator on 08/23/22 at 4:04pm. _____ Interview with the MA on 08/23/22 at 8:15am revealed: -She knew the residents would take their medications. -The residents did not want to be watched when taking their medications. -She should watch the residents take their medication before signing the eMAR. Interview with the RCC on 08/23/22 at 8:59am revealed: -The MA should locate the medications on the cart for the resident she was preparing to administer medications.	D 366		

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D 366	Continued From page 63 -The MA should follow the six rights of medications administration when administering medications. -The MA should stay with the residents until they swallow their medications. -The MA should sign the eMAR that medications were administered after observing the residents taking their medication. Interview with the Administrator on 08/23/22 at 4:04pm revealed: -The MA should observe residents swallow their medications. -The residents felt like we do not trust them if we stand over them and watch them take their medications.	D 366		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.	D 612		

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D 612	Continued From page 64 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to staff not properly wearing personal protective equipment (PPE), a mask/ face covering while on duty in the facility, and staff and residents not being screened daily for fever, signs and symptoms of COVID-19.. The findings are: 1. Review of the CDC Interim Infection Prevention and Control Recommendations to prevent SARs-CoV-2 spread in Nursing Homes dated 02/22/22 revealed residents should be evaluated daily for symptoms of COVID-19 and actively monitor residents for fever. Review of the North Carolina Department of Health and Human Services COVID-19 Post Acute Care Setting Infection Control Assessment and Response (ICAR) tool dated 10/2021 revealed staff and residents should be actively screened daily for fever, signs and symptoms of COVID-19. Interview with a MA on 08/24/22 at 11:41am revealed: -A few resident had their temperature check daily, but not all of the residents. -She did not ask residents questions about how they were feeling each day. -She could look at the residents and see if they were not feeling well.	D 612		

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-Temperatures are checked daily on residents who test positive for COVID-19.
-She knew resident's temperatures had not been taken daily for the past 3 months.

Interviews with three residents on 08/23/22 between 8:49am-9:00am revealed:
-One resident stated her temperature was not checked daily by staff. The Primary Care Provider (PCP) checked her temperature when he made rounds.
-A second resident stated his temperature was checked "maybe once a week."
-A third resident stated her temperature was not checked very often. She did not recall the last time her temperature was checked.

Interview with a fourth resident on 08/24/22 at 11:19am revealed:
-The staff did not take her temperature daily or ask her questions about how she felt.
-She did not recall the last time her temperature was taken.

Interview with a fifth resident on 08/24/22 at 11:21am revealed:
-His PCP would take his temperature every 2 weeks when he visited.
-The staff did not take his temperature daily or ask him questions about how he felt.

Telephone interview with the Registered Nurse from the local health department on 08/25/22 at 9:10am revealed:
-She was part of the COVID-19 infection control team for the local health department.
-CDC guidance for long term care facilities was to screen residents daily for fever equal to or greater than 100 degrees Fahrenheit.
-To monitor residents daily for symptoms of

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D 612	Continued From page 66 COVID-19 by asking residents questions about symptoms as well as visually monitoring for symptoms; including temperature checks. Interview with the Resident Care Coordinator (RCC) on 08/23/22 at 9:36am revealed: -The facility was not taking the residents' temperatures daily and were only taking them when they did not feel well. -They had never taken daily temperatures of the residents; only during an outbreak. -The staff monitored the residents for signs and symptoms of COVID on a daily basis. -The staff looked for shortness of breath, and coughing. Interview with the Administrator on 08/24/22 at 10:07am revealed: -The facility did not do daily screening of residents for signs and symptoms of COVID-19, including daily temperature checks. -The facility stopped daily screening of residents after rapid test were available; about three months into the pandemic. -The residents could verbalize symptoms, so they relied on a symptom-based screening process; when staff observed residents with symptoms or residents reported symptoms then they were tested for COVID-19. -When a resident looked like or said they did not feel good then they were screened for one of sixteen symptoms. -They learned early on that temperatures were not an indicator of COVID-19, so they switched to symptom based. 2. Review of the North Carolina Department of Health and Human Services COVID-19 Post Acute Care Setting Infection Control Assessment and Response (ICAR) tool dated 10/2021	D 612		

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revealed:
-Staff and residents should be actively screened daily for fever, signs and symptoms of COVID-19.
-Facilities should establish a process to identify anyone entering the facility, regardless of vaccination status, who has any one of the following three criteria so that they can be managed: a positive viral test for COVID-19, symptoms of COVID-19, or close contact with someone with COVID-19 infection.
-The options could include (but were not limited to): individual screening upon arrival to the facility or implement an electronic monitoring system in which individuals can self-report any of the above before entering the facility.

Review of the North Carolina Department of Health and Human Services COVID-19 Post Acute Care Setting Infection Control Assessment and Response (ICAR) tool dated 10/2021 revealed staff and residents should be actively screened daily for fever, signs and symptoms of COVID-19.

Interview with a MA on 08/24/22 at 11:41am revealed:
-She did not check her temperature or complete a health questionnaire daily when entering the facility.
-She knew the staff stopped checking their temperatures daily about 3 months ago.
-She could not recall if she had previously completed a health questionnaire.

Telephone interview with the Registered Nurse from the local department of health on 08/25/22 at 9:10am revealed:
-She was part of the COVID-19 infection control team for the local health department.
-CDC guidance for long term care facilities was to

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screen staff prior to the start of their shift.
-To monitor staff daily for symptoms of COVID-19 by using a questionnaire about symptoms; screening for fever equal to or greater than 100 degrees Fahrenheit should be part of the monitoring process.

Interview with the Resident Care Coordinator (RCC) on 08/23/22 at 9:36am revealed:
-The facility was monitoring staff temperatures and symptoms on a daily basis until about two months ago.
-She thought things were settling down with COVID.
-Staff were to report symptoms to her or the Administrator.

Interview with the Administrator on 08/24/22 at 10:07am revealed:
-The staff stopped screening a couple of month ago.
-They were to report symptoms to management without filling out a screening form or temperature checks before reporting to work.
-Staff were to reference a signage with symptoms and to report if they had symptoms.
-She felt confident the staff would report symptoms if they did not feel well.
-Nothing was documented.

3. Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) during the COVID-19 Pandemic dated 02/02/22 revealed:
-Source control measures were to be implemented for HCP.
-Source control referred to the use of a well-fitting face mask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they were breathing, talking, sneezing, or

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coughing.
-Cloth facemasks were not personal protective equipment (PPE) appropriate for use by HCP.
-Fully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents.

Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention for Long-Term Care Facilities dated 11/19/21 revealed:
-Source control referred to the use of well-fitting face masks to cover a person's mouth and nose.
-Cloth masks were not considered PPE and should not be worn by staff.

Observation of staff member on 08/23/22 at 7:45am revealed she was wearing a cloth facemask when she opened the door to allow surveyors to enter the facilty.

Observation of a second staff member on 08/23/22 at 9:48am revealed:
-He was in the dining room cleaning the floor.
-There was an activity being conducted in the dining room while he cleaned; there were 12 residents participating in the activity.
-He did not have a facemask on.

Observation of a housekeeper on 08/23/22 at 12:36pm revealed:
-She was sweeping a resident's room while the resident was sitting on the bed.
-She had her facemask below her chin while she was in the resident's room talking to him.
-She pulled the facemask up when she left the resident's room but did not cover her nose.
-He facemask was cloth and not a surgical facemask or KN95.

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D 612	Continued From page 70 Interview with a MA on 08/24/22 at 11:41am revealed: -She wore a facemask to enter the facility each day she worked. -She would change her mask when she entered the medication room. -She would ask staff to pull their mask up and over their nose and mouth if she saw the mask below their nose and mouth. Interview with the staff on 08/23/22 at 9:50am revealed: -He did not wear his facemask all the time because it got hot. -He had a facemask in his pocket. -He was trained by another staff and he was told he only had to wear his facemask when he was in a hallway or in resident rooms. -He was not wearing a facemask while he cleaned the floors because there were not a lot of residents in the room. Interview with a housekeeper on 08/23/22 at 12:40pm revealed: -She wore her facemask all the time while at work. -She only removed her facemask to eat. -The facility provided surgical facemask. -She wore the cloth facemask because someone made them for her; no one had ever told her to wear a surgical facemask. -She always wore her facemask over her nose and mouth but she had moved it under her chin to talk to the resident so he could understand her. -She had been instructed in daily meeting to wear her facemask at all times and to cover her mouth and nose with the mask. Telephone interview with the Registered Nurse from the local health department on 08/25/22 at	D 612		

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D 612	Continued From page 71 9:10am revealed: -She was part of the COVID-19 infection control team for the local health department -CDC guidance for health care personnel regarding facemask was an N95 was preferred but a surgical facemask was also acceptable. -Cloth facemask were not effective to avoid wearing them. Interview with the Administrator on 08/24/22 at 10:07am revealed: -Staff were instructed to wear facemask at all times when around residents. -The only time staff were allowed to remove their facemask were when they were eating. -The staff were provided surgical facemask and N95 facemask by the facility. -Staff were allowed to wear cloth facemask; they had started to wear cloth facemask about 2 or 3 months ago. -The last guidance she was aware of recommended surgical but did not require them. -Facemask should always cover the mouth and nose of the staff wearing them. -Everyone was responsible for reminding each other to properly wear their facemask.	D 612		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents	D914		

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D914	Continued From page 72 were free of mental and physical abuse, neglect, and exploitation related to medication administration. The findings are: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 residents, (#2, #6, and #7) related to a medication used for memory and dementia, a medication for mood, a medication for depression and anxiety, an antibiotic to treat urinary tract infections, a prophylactic antibiotic to prevent urinary tract infections and an eye drop for dry eyes (#7); a medication used for depression and a medication used to treat behaviors (#2); three medications used to treat hypertension and a medication used to treat high cholesterol (#6). [Refer to Tag 358 10A NCAC 13F .1004a Medication Administration(Type A1 Violation)].	D914		