STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR ASSISTED LIVING #5	416 NORTH PARKER STREET ELM CITY, NC 27822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 03/20/23 through 03/22/23.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews and interviews, the facility failed to implement physician's orders for 1 of 6 sampled residents related to an order for daily dressing changes that were not completed for a resident which lead to the resident being sent to the local hospital emergency department for evaluation and subsequently admitted to the hospital (#7) for 8 days. The findings are: Review of Resident #7's current FL-2 dated 11/16/23 revealed: -Diagnoses included moderate intellectual development disability, unspecified dementia with behavioral disturbance and type II diabetes. -He was intermittently disoriented. Review of Resident #7's current care plan dated	D 276		

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11/16/23 revealed:
-The resident was injurious to himself and received medications for self-injurious behaviors.
-The resident was totally dependent for dressing, grooming, bathing, and toileting.
-The resident required extensive assistance with transferring and limited assistance with eating.

Review of Resident #7's physician's order dated 11/16/22 revealed there was an order for gauze pad sterile 4 x 4 non sticky dressing to be applied daily to right hand and change daily until wound was healed.

Review of Resident #7's electronic medication administration record (eMAR) for January 2023 revealed:
-There was a computerized entry for Gauze pad sterile 4 x 4 non sticky dressing to be applied daily to right hand and change daily until wound was healed.
-There was documentation a gauze pad sterile 4 x 4 non-sticky dressing was applied and changed to right hand daily from 01/01/23 through 01/25/23.
-There was documentation a gauze pad sterile 4 x 4 non-sticky dressing was not applied and changed to right hand on 01/26/23 because Resident #7 was in the hospital.
-There was documentation Resident #7 remained in the hospital from 01/27/23 through 01/31/23.

Review of Resident #7's physician's visit note dated 01/25/23 revealed:
-Resident #7 had an order for non-sticky dressing to right hand and change daily for a wound on the back of his right hand.
-Resident #7 was found to have a foul smelling wound to his right index finger on the edge of the dressing.

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-There was foul smelling discharge, redness and swelling distally to the index finger.
-The primary care provider (PCP) found an ulcerated wound with a depth possibly to the bone with purulent discharge when she removed the dressing. (Purulent means consisting of, containing or discharging pus.)
-Resident #7 was sent to the local hospital emergency department (ED) for emergent evaluation and testing.

Review of Resident #7's Emergency Provider record from the local hospital emergency department (ED) dated 01/25/23 revealed:
-Resident #7 presented to the ED with pain, swelling, redness to his index finger.
-Resident #7 was transported via emergency management services (EMS) who reported the facility had placed a bandage on Resident #7's finger a few weeks prior, took it off that day, 01/25/23, and noticed erosion to the base of his finger, purulent drainage, redness and swelling to the end of the finger.
-The wound appeared to be eroding to the bone around the finger.
-There was surrounding cellulitis. (Cellulitis is an infection of the skin that occurs when bacteria enters the body through an open cut or wound.)
-The right index finger was warm, red, and tender.
-Resident #7 required admission the hospital for antibiotics and possible debridement. (Debridement is a medical removal of dead, damaged or infected tissue to improve the healing potential of the remaining healthy tissue.)

Review of Resident #7's hospital discharge summary for admission date of 01/25/23 with discharge date of 02/02/23 revealed:
-Resident was transported to the ED by

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emergency management services (EMS)
-There was report that Resident #7 had a bandage to his first digit on his right hand that was removed for evaluation that day and there was erosion of the skin all the way down to the bone.
-Osteomyelitis (inflammation of the bone caused by infection) was likely given the degree to which his bandages eroded into his right first finger.
-Resident #7 was unable to sit still for preferred diagnostic MRI testing due to his cognition so a CT with contrast was performed with no evidence of osteomyelitis.
-Orthopedic surgery and Infectious Disease were consulted and recommended treating with intravenous (IV) antibiotics while in the hospital.
-Resident was placed on NPO after midnight for possible surgical incision and drainage.

Review of Resident #7's orthopedic consultation report dated 01/26/23 revealed:
-Resident #7 had contractures of his right hand.
-There was a wound noted around his right index finger with some surrounding cellulitis.
-Recommendations were made to attempt local wound care and antibiotics in efforts to avoid surgery but could perform an irrigation and debridement if condition of the wound worsened or did not improve.

Review of Resident #7's Infectious Disease consult report dated 01/30/23 revealed:
-Resident #7 presented to the ED due to a wound on his right first finger that tracked all the way down to the bone with some surrounding cellulitis.
-Resident #7 was receiving Zosyn and Vancomycin by IV. (Zozyn is broad spectrum antibiotic that works against many types of bacteria and is often used for people who are very sick or have serious injury. Vancomycin is an

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D 276	Continued From page 4 antibiotic that treats multi drug-resistant infections.) Interview with Resident #7's primary care provider (PCP) on 03/22/23 at 11:37am revealed: -Resident #7 had a history of biting himself on the hand when he felt anxious and had an order in place for dressing changes to the wound on his right hand to be completed daily until it was healed. -During one of her visits to the facility in January, she checked in on Resident #7 and found him with a dirty dressing on his right hand. -The dressing was a stretchy self adhesive dressing used to hold gauze in place over the wound. -The stretchy material was very tight and his finger was red and swollen. -She removed the dressing to find the gauze next to his skin dark, soiled and there was a foul odor. -There was a cut around his finger where the adhesive bandage was pressing into his skin because it was so tight. -The cut on his index finger went to the bone and she was concerned he may need surgery. -She sent him to the local hospital ED for evaluation where he was admitted and stayed for several days on IV antibiotic. -She expected orders to be carried out daily as ordered to prevent infection. -If staff had completed the dressing changes each day as ordered, Resident #7 would not have had the injury, possibility of surgery, or needed the hospital stay for IV antibiotics. Interview with a personal care aide (PCA) on 03/22/23 at 3:55pm revealed: -PCAs completed skin assessment forms if they observed a bruise on a resident, redness, scabs, marks, or any changes. -The PCAs signed the skin assessment form and	D 276		

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reviewed with the MA that worked during their shift.
-After the MA reviewed and signed the skin assessment form the PCA slid the skin assessment form under the RCC's door.
-Resident #7 was unable to use his right arm and when he was given showers, he preferred to put his right arm in a sling when he received showers.

Interview with a MA on 03/22/23 at 4:09pm revealed:
-When Resident #7 bit his hand she and MAs would bandage his right hand.
-She would provide the oncoming MA with a verbal report of how his hand looked during her shift and also document the report in a shift report in the electronic progress notes.
-MAs would document that the resident's bandage had been changed by initialing the eMAR.
-She changed Resident #7's bandage on his right hand daily during her shift and more often if needed.
-When she changed the residents bandage on his right hand she checked for any color change, drainage, and odor.
-She had not noticed any color change, drainage, or odor.
-If the bandage to his right hand became wet when staff provided him with a shower, the MA on duty would place a new bandage on his right hand.
-She documented her initials in the eMAR when she changed the resident's bandage.
-MAs were expected to notify the Resident Care Coordinator (RCC) if they noticed any changes in Resident #7's wound when they changed his bandage.

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Telephone interview with a second MA on 03/22/23 at 5:26pm revealed:
-She was at the facility on 01/25/23 when the PCP found Resident #7 with an old dressing on his right hand.
-She saw the dressing on the resident's right hand on 01/25/23 with the PCP present and observed it looked like the dressing was too tight.
-There was an order on the resident's eMAR to change the dressing on his right hand daily and as needed.
-She and MAs were expected to follow all PCP orders.
-She documented that she changed the residents bandage on the eMAR, however she only changed the bandage when it looked dirty.
-She should have changed the bandage when she documented that she changed it.
-She did not follow the PCP orders to change the bandage daily and as needed and regrets she did not follow the PCP orders.
-All MAs were held accountable for not following PCP orders to change his bandage daily and as needed.
-The RCC and BM met with all MAs on 01/25/23 or the following day to discuss false documentation.

Interview with the Resident Care Coordinator (RCC) on 03/22/23 at 5:33pm revealed:
-She was at the facility on 01/25/23 when the Building Manager (BM) made rounds with the PCP.
-She observed the dressing to Resident #7's right hand and noticed that the bandage was wrapped too tight, it looked like it had been on his hand a few days, it was dirty and scuffed up with discoloration to the bandage.
-Resident #7's bandage on his right hand was soiled with food stains.

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-She could tell the bandage was dirty and she knew it had been on his hand a few days due to the discoloration of his right index finger.
-She observed a deep indentation on his right index finger where the bandage was wrapped too tight.
-MAs were supposed to follow the PCP orders and change the bandage daily and as needed.
-She and the BM held a meeting with the MAs on that week and found out that the MAs were checking off on the eMAR that they had changed Resident #7's bandage, when they explained they had not changed his bandage.
-The MAs should have informed her that they were not changing the resident's bandage instead of documenting on the eMAR that they were changing his bandage.
-The failure of the MAs not changing the resident's bandage as ordered caused the resident to be hospitalized due to an infection of his index finger on his right hand.

Interview with the BM on 03/22/23 at 5:50pm revealed:
-Resident #7 had a history of biting his right hand when he became angry or upset.
-He could not remember a time that the resident did not have a bite on his right hand because he always had a wound on that hand from biting it.
-He made rounds with the PCP at the facility on 01/25/23.
-He observed the bandage on Resident #7's right hand with the PCP present.
-He observed an indentation to the resident's right index finger and it looked inflamed, swollen and red.
-After the PCP removed the resident's bandage from his right hand she directed him to immediately notify EMS so he could be evaluated at the local hospital.

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-He and the RCC met with the MAs that week at the facility to identify how the resident's right index finger and the bandage were neglected.
-The MAs that falsely documented that they changed Resident #7's bandage daily and as needed were written up and he held an inservice on false documentation with all MAs.
-He was upset that some MAs had lied and falsely documented on the eMAR that they had changed the resident's bandage.

Telephone interview with Resident #7's PCP on 03/22/23 at 3:40pm revealed:
-She had a regular visit with Resident #7 at the facility on 01/25/23.
-The BM made rounds with her on 01/25/23.
-The BM observed Resident #7's right hand with her present.
-The resident's hand was swollen at the right index finger where the elastic bandage wrap was too tight.
-The BM was shocked when she removed the bandage from the resident's right hand.
-She met with the BM and the Resident Care Coordinator (RCC) on 01/25/23 to inform them of her concerns about the severe damage to Resident #7's right index finger.
-She instructed the BM and RCC to investigate and find out when the resident's bandage was last changed.
-She communicated her concern that MAs were documenting on the electronic medication administration record (eMAR) that they changed the resident's bandage on his right hand daily.
-She was concerned that MAs were documenting that they changed the bandage daily, however observation of Resident #7's hand and bandage were evidence that the MAs were not following her orders to change his bandage daily and as needed.

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-The severity of the bandage wrapped too tightly for too long on the resident's right hand caused his skin to be cut down to the bone on his right index finger.
-The cut from the pressure of the bandage on his right hand had caused so much damage that she was concerned his right index finger would be amputated.
-She spoke with staff at the local emergency department (ED) and asked them to provide her with an update as soon as possible due to the severity of the inflammation and open wound of Resident #7's right index finger.
-Staff were "clearly neglecting the resident's care" by not changing his bandage on his right hand as ordered.
-The resident was at risk of losing his finger due to amputation which would result in the resident requiring rehabilitation services at a skilled nursing home, a higher level of care.
-The lack of care to the resident's bandage on his right hand placed him at risk of an extended hospitalization, risk of becoming septic and risk of death.

Interview with the Administrator/Owner on 03/22/23 at 2:00pm revealed:
-She expected and trusted the medication aides (MA)to carry out physicians orders for dressing changes.
-There was no process in place prior to the event with Resident #7 to ensure dressing changes were completed.

Attempted interview with Resident #7 on 03/22/23 at 4:06pm revealed the resident was not interviewable.

____

The facility failed to ensure the implementation of physician orders for a resident with moderate

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D 276	Continued From page 10 intellectual development disability, unspecified dementia with behavioral disturbance and type II diabetes with a history of biting his right hand causing a wound (#7) who had orders for daily and as needed dressing changes to his right hand, and was found by the primary care provider (PCP) with a soiled bandage wrapped too tightly to his right hand which resulted in a wound which was eroded down to the bone, required an 8 day hospitalization with orthopedic and infectious disease consults and IV antibiotics administered to treat the infection. The failure resulted in serious physical harm and serious neglect to the resident and constitutes a Type A1 violation. ______________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/22/23 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 21, 2023.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's	D 344		

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record.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to notify the primary care provider (PCP) for medication order clarification for 2 of 5 sampled residents (#3, #4) who received dialysis, including medications used to treat high levels of phosphorus in the blood, shortness of breath, and dry eyes (#3) and medications used to treat an eye condition that can cause vision loss, fluid retention, an antibiotic for eye infection, shortness of breath, heart failure, and high levels of potassium in the blood (#4).

The findings are:

1. Review of Resident #3's current FL-2 dated 03/16/23 revealed:
- Diagnoses included left first toe osteomyelitis, end stage renal disease and on hemodialysis, schizophrenia, essential primary hypertension, hyperkalemia, chronic pain, arthritis, diabetes mellitus type II, major depressive disorder, chronic obstructive pulmonary disease (COPD), diabetic neuropathy, underlying peripheral arterial disease (PAD) and dysfunctional uterine bleeding.
-Additional information included Resident #3 had left great toe amputation on 03/09/23 and to resume dialysis. (Dialysis is a type of treatment that helps your body remove extra fluids and waste products from your blood when the kidneys are not able to).

Review of Resident #3's Resident Register revealed an admission date of 04/12/21.

a. Review of Resident #3's physician order report

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dated 12/14/22 revealed:
-There was an order for Sevelamer Carbonate 800mg, 2 tablets twice a day with meals to be administered at 8:00am and 7:00pm.(Sevelamer Carbonate is a medication used to treat a high phosphorus level in individuals with chronic kidney disease).
-There was an order for Sevelamer Carbonate 800mg, 1 tablet with snacks to be administered at 10:00am, 4:00pm and 8:00pm.

Review of Resident #3's medication order dated 03/16/23 revealed:
-There was an order for Sevelamer Carbonate 800mg, 2 tablets twice daily with meals.
-There was an order for Sevelamer Carbonate 800mg, 1 tablet with snacks.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Sevelamer Carbonate 800mg, 2 tablets twice daily with meals to be administered at 8:00am and 7:00pm.
-There was an entry for Sevelamer Carbonate 800mg, 1 tablet to be administered with snacks at 10:00am, 4:00pm, and 8:00pm.
-There was documentation Sevelamer Carbonate 800mg, 2 tablets was not administered at 8:00am on 01/07/23, 01/10/23, 01/17/23, and 01/19/23 due to the resident being out of the facility for dialysis.
-There was documentation Sevelamer Carbonate 800mg, 1 tablet was not administered at 10:00am on 01/05/23, 01/23/23, and 01/31/23 due to the resident being out of the facility for dialysis.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for Sevelamer Carbonate

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MORNING STAR ASSISTED LIVING #5	416 NORTH PARKER STREET ELM CITY, NC 27822

(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 344	Continued From page 13 800mg, 2 tablets twice daily with meals to be administered at 8:00am and 7:00pm. -There was an entry for Sevelamer Carbonate 800mg, 1 tablet to be administered with snacks at 10:00am, 4:00pm, and 8:00pm -There was documentation Sevelamer Carbonate 800mg, 2 tablet was not administered at 8:00am on 02/02/23, 02/07/23 due to the resident being out of the facility at dialysis. -There was documentation Sevelamer Carbonate 800mg, 1 tablet was not administered at 10:00am on 02/04/23, 02/09/23, 02/14/23 due to the resident being out of the facility at dialysis. Review of Resident #3's March 2023 eMAR revealed: -There was an entry for Sevelamer Carbonate 800mg, 2 tablets twice daily with meals to be administered at 8:00am and 7:00pm. -There was an entry for Sevelamer Carbonate 800mg, 1 tablet to be administered with snacks at 10:00am, 4:00pm and 8:00pm. -There was documentation Sevelamer Carbonate 800mg, 2 tablets was not administered at 8:00am on 03/02/23 and 03/04/23 due to the resident being out of the facility at dialysis. -There was documentation Sevelamer Carbonate 800mg, 1 tablet was not administered at 10:00am on 03/11/23 and 03/18/23 due to the resident being out of the facility at dialysis. Refer to interview with the medication aide (MA) on 03/21/23 at 9:30am Refer to interview with a second MA on 03/21/23 at 9:50am. Refer to telephone interview with the facility's contracted pharmacy on 03/21/23 at 10:05am.	D 344		

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Refer to interview with the Resident Care Coordinator (RCC) 03/21/23 at 11:00am and 03/22/23 at 9:00am.

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the Primary Care Provider (PCP) on 03/22/23 at 11:30am.

b. Review of Resident #3's physician order report dated 12/14/22 revealed there was an order for Advair HFA 230-21 mcg, inhale 2 puffs twice a day, use with spacer, scheduled for 8:00am and 8:00pm. (Advair HFA is a steroid medication used to treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung disease).

Review of Resident #3's medication order dated 03/16/23 revealed there was an order for Advair HFA 230-21mcg, inhale 2 puffs twice a day.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Advair HFA 230-21mcg, inhale 2 puffs twice daily, use with spacer to be administered at 8:00am and 8:00pm.
-There was documentation Advair HFA 230-21mcg was not administered at 8:00am on 01/17/23 and 01/19/23 due to the resident being out of the facility at dialysis.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for Advair HFA 230-21mcg,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 15 inhale 2 puffs twice daily, use with spacer to be administered at 8:00am and 8:00pm -There was documentation Advair HFA 230-21mcg, inhale 2 puffs was not administered at 8:00am on 02/02/23 and 02/07/23 due to the resident being out of the facility at dialysis. Review of Resident #3's March 2023 eMAR revealed: -There was an entry for Advair HFA 230-21mcg, inhale 2 puffs twice daily, use with spacer, to be administered at 8:00am and 8:00pm. -There was documentation Advair HFA 230-21mcg, 2 puffs was not administered at 8:00am on 03/03/23 due to the resident being out of the facility at dialysis. Refer to interview with the MA on 03/21/23 at 9:30am Refer to interview with a second MA on 03/21/23 at 9:50am. Refer to telephone interview with the facility's contracted pharmacy on 03/21/23 at 10:05am. Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am. Refer to interview with the Building Manager 03/22/23 at 10:05am Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am. Refer to interview with the PCP on 03/22/23 at 11:30am. c. Review of Resident #3's physician order report dated 01/14/23 revealed there was an order for	D 344		

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Artificial Tears Drops, 1 drop into left eye four times a day scheduled for 8:00am, 12:00pm, 4:00pm and 8:00pm. (Artificial Tears is used to lubricate dry eyes).

Review of Resident #3's medication order dated 03/16/23 revealed there was an order for Artificial Tears Drops, 1 drop into left eye four times a day.

Review of Resident #3's January 2023 eMAR revealed:
-There was an entry for Artificial Tears Drops, 1 drop into left eye four times a day to be administered at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation Artificial Tears Drops, 1 drop into left eye was not administered at 8:00am on 01/17/23, 01/19/23 due to the resident being out of the facility for dialysis.
-There was documentation Artificial Tears Drops, 1 drop into left eye was not administered at 12:00pm on 01/03/23, 01/05/23, 01/12/23, 01/13/23, 01/17/23, 01/19/23, 01/21/23, 01/24/23, 01/28/23, 01/31/23 due to the resident being out of the facility for dialysis.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for Artificial Tears Drops, 1 drop into left eye four times day to be administered at 8:00am, 12:00pm, and 4:00pm.
-There was documentation Artificial Tears Drops, 1 drop into left eye was not administered at 8:00am on 02/02/23, 02/07/23, 02/21/23 due to the resident being out of the facility for dialysis.

Review of Resident #3's March 2023 eMAR revealed:
-There was an entry for Artificial Tears Drops, 1 drop into left eye four times a day to be

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administered at 8:00am, 12:00pm and 4:00pm.
-There was documentation Artificial Tears Drops, 1 drop into left eye was not administered 8:00am on 03/04/23 due to the resident being out of the facility at dialysis.
-There was documentation Artificial ears Drops, 1 drop into left eye was not administered 12:00pm on 03/02/23, 03/18/23, and 03/21/23 due to the resident being out of the facility at dialysis.

Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with the facility's contracted pharmacy on 03/21/23 at 10:05am.

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am.

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am

____

Interview with MA on 03/21/23 at 9:30am revealed:
-Resident #3 went to dialysis "around" 6:00am on Tuesday, Thursday, and Saturday.
-The night shift was responsible for getting Resident #3 dressed and serving him an early breakfast.
-There were no medications administered to Resident #3 before dialysis.

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Interview with a second MA on 03/21/23 at 9:50am revealed:
-Resident #3 went to dialysis at 6:00am in the morning on Tuesday, Thursday, and Saturday.
-The night shift was responsible for getting him up and dressed, serving him breakfast and getting him ready to be picked up by the county van.
-Sometimes the night shift administered his 8:00am medications.

Telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05 am revealed:
-The pharmacist entered residents' medications and times of administration in the system and sent them to the facility for approval.
-The facility was responsible for approving the times the medications were administered or making changes regarding the times to suit the needs of the resident.
-The pharmacy did not know the times of dialysis sessions for the residents at the facility who were scheduled for dialysis.

Interview with the RCC on 03/21/23 at 11:00am and 03/22/23 at 9:00am revealed:
-She was not aware Resident #3 was not receiving his 8:00am and 12:00pm medications due to early dialysis sessions.
-The facility did not have a medication administration policy or protocol for residents who went to dialysis.
-Medication orders from the dialysis facility were submitted directly to pharmacy for processing.
-The pharmacist entered the medication orders and times of administration in the system and sent the orders to the facility for review and approval.
-The facilty did not make changes to the times of

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administration of medications for residents.

Interview with the Building Manager 03/22/23 at 10:05am revealed:
-He was not aware Resident #3 was not getting her 8:00am and 12:00pm medications on the days she goes to dialysis.
-He had concerns with Resident #3 not getting her blood pressure medications because her blood pressure had "bottomed out" (dropped low) in the past during dialysis.
-He expected the MA's to have caught that Resident #3 was not getting her medications at 8:00am before dialysis and informed the RCC and the Building Manager.
-He expected the RCC to notify the PCP for clarification on how to handle the 8:00am and 12:00pm medications for Resident #3 on dialysis days.

Interview with the Administrator/Owner on 03/22/23 at 10:55am revealed:
-She was not aware Resident #3 went to dialysis three times a week and was not receiving her 8:00am and 12:00pm medications.
-She expected the RCC to reach out to the PCP for clarification regarding the times of medication administration.
-It was a major concern that Resident #3 did not receive her 8:00am and 12:00pm medications because it could cause other health problems.

Interview with the PCP on 03/22/23 at 11:30am revealed:
-She was not aware Resident #3 was scheduled for dialysis at 6:00am and was not receiving her 8:00am and 12:00pm medications as ordered.
-Resident #3 should have received her morning medications prior to dialysis.
-Had the RCC or the MAs reached out to her for

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clarification regarding the time of dialysis, she could have adjusted the medication administration times.

Attempted telephone interview with Resident #4's Nephrologist on 03/22/23 at 9:15am was unsuccessful.

2. Review of Resident #4's current FL-2 dated 11/09/22 revealed diagnoses included osteomylitis of left foot, acute kidney injury, polysubstance, and diabetes mellitus type II.

a. Review of Resident #4's medication orders dated 11/16/22 revealed there was an order for Acetazolamide 250mg, 2 tablets (500mg) three times a week at 8:00am. (Acetazolamide is a medication used to treat fluid retention and glaucoma, an eye condition that can cause blindness).

Review of Resident #4's physician visit report dated 01/25/23 revealed an order for Acetazolamide 250mg, 2 tablets (500mg) three times weekly.

Review of Resident #4's January 2023 electronic medication administration record revealed:
-There was an entry for Acetazolamide 250mg, 2 tablets (500mg) three times a week to be administered at 8:00am.
-There was documentation that Acetazolamide 250mg, 2 tablets (500mg) was not administered at 8:00am on 01/10/23, 01/17/23, and 01/19/23 due to resident being out of the facility for dialysis.

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for Acetazolamide 250mg, 2 tablets (500mg) three times a week to be

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administered at 8:00am.
-There was documentation that Acetazolamide 250mg, 2 tablets (500mg) was not administered at 8:00am on 02/02/23 and 02/07/23 at 8:00am due to the resident being at dialysis.

Review of Resident #4's March 2023 eMAR revealed:
-There was an entry for Acetazolamide 250mg, 2 tablets (500mg) thee times a week to be administered at 8:00am.
-There was documentation that Acetazolamide 250mg, 2 tablets (500mg) was not administered on 03/04/23 at 8:00am due to resident being out of the facility for dialysis.

Refer to interview with the medication aide (MA) on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with the facility's contracted pharmacy on 03/21/23 at 10:05am.

Refer to interview with the Resident Care Coordinator (RCC) 03/21/23 at 11:00am and 03/22/23 at 9:00am.

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the Primary Care Provider (PCP) on 03/22/23 at 11:30am.

b. Review of Resident #4's physician order dated 03/01/23 revealed:

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-There was an order for Besivance 0.6% suspension, place 1 drop in right eye three times daily at 8:00am, 12:00pm and 8:00pm. (Besivance is an antibiotic used to treat eye infection).

Review of Resident #4's March 2023 eMAR revealed:
-There was an entry for Besivance 0.6% suspension, place 1 drop in right eye three times daily at 8:00am, 12:00pm and 8:00pm.
-There was documentation that Besivance 0.6% Suspension was not administered at 8:00am on 03/04/23 and 03/08/23 due to the resident being out of the facility for dialysis.
-There was documentation that Besivance 0.6% suspension was not administered at 12:00pm on 03/02/23, 03/04/23, 03/08/23, 03/11/23, and 03/18/23 due to the resident being out of the facility for dialysis.

Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with the facility's contracted pharmacy on 03/21/23 at 10:05am.

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at

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D 344	Continued From page 23 11:30am. c. Review of Resident #4's medication order dated 11/09/22 revealed there was an order for Breo Ellipta 200-25mcg, inhale 1 puff every day at 8:00am. (Breo Ellipta is a medication used to treat shortness of breath caused by lung disease). Review of a physician visit report dated 03/15/23 revealed an order for Breo Ellipta 200-25mcg, inhale 1 puff daily for 28 days. Review of Resident #4's February eMAR revealed: -There was an entry for Breo Ellipta 200-25 mcg, inhale 1 puff every day at 8:00am. -There was documentation that Breo Ellipta 100-25 mcg was not administered at 8:00am on 02/02/23 and 02/07/23 due to the resident being out of the facility for dialysis. Review of Resident #4's March eMAR revealed: -There was an entry for Breo Ellipta 200-25mcg, inhale 1 puff every day at 8:00am. -There was documentation that Breo Ellipta 100-25mcg was not administered at 8:00am on 03/04/23 due to the resident being out of the facility at dialysis. Refer to interview with the MA on 03/21/23 at 9:30am Refer to interview with a second MA on 03/21/23 at 9:50am. Refer to telephone interview with the facility's contracted pharmacy on 03/21/23 at 10:05am. Refer to interview with the RCC 03/21/23 at	D 344		

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11:00am and 03/22/23 at 9:00am

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

d. Review of Resident #4's medication order dated 11/09/22 revealed there was an order for Carvedilol (Coreg) 3.125mg, take 1 tablet twice daily at 8:00am and 8:00pm. (Carvedilol is a medication used to treat high blood pressure and heart failure).

Review of Resident #4's discharge hospital visit summary dated 02/27/23 revealed:
-There was an an order to increase Carvedilol 3.125, 4 tablets (12.5mg) two times a day.
-Resident #4 was admitted to the hospital for an abnormal stress test and chest pain.
-Resident #4's blood pressure was 166/91.
-Resident #4's potassium was 5.2 millimoles per liter(mmol/L) with a normal range of 3.5-5.0 mmol/L
-Resident #4's phosphorus was 5.3 milligrams per deciliter (mg/dl) with a normal range of 2.5-4.5 mg/dl.
Review of a physician visit report dated 03/15/23 revealed an order for Carvedilol 3.125mg, 1 tablet twice daily.

Review of the American Heart Association guidelines regarding blood pressure and potassium levels revealed:
-A normal BP reading was 120/80 (the top number called the systolic number was less than

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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120 and the bottom number called the diastolic number was less than 80).
-Elevated blood pressure was when the systolic was between 120-129 and diastolic was greater than 80.
-High blood pressure (hypertension) stage 1 was when the systolic was between 130-139 and diastolic was between 80-89.
-High blood pressure (hypertension) stage 2 was when the systolic was 140 or higher or the diastolic 90 or higher.
-High Blood pressure could cause a stroke, vision loss, heart attack/failure and kidney disease/failure.
-Hyperkalemia was a higher than normal level of potassium in the blood.
-Higher than normal potassium levels in the blood can lead to abnormal heart rhythms.

Review of Resident #4's January eMAR revealed:
-There was an entry for Carvedilol 3.125mg, 1 tablet twice daily at 8:00am and 8:00pm.
-There was documentation that Carvedilol 3.125mg, 1 tablet was not administered at 8:00am on 01/10/23, 01/17/23, 01/19/23 due to the resident being out of the facility for dialysis.

Review of Resident #4's February eMAR revealed:
-There was an entry for Carvedilol 3.125mg, 1 tablet twice daily at 8:00am and 8:00pm.
-There was documentation that Carvedilol 3.125mg, 1 tablet was not administered at 8:00am on 02/02/23 and 02/07/23 due to the resident being out of the facility for dialysis.

Review of Resident #4's March eMAR revealed:
-There was an entry for Carvedilol 3.125mg, 1 tablet twice daily at 8:00am and 8:00pm.
-There was no entry for Carvedilol 3.125, 4

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tablets (12.5mg) a day.
-There was documentation Carvedilol 3.125, 1 tablet was administered at 8:00am on 03/02/23, 03/03/23, 03/05/23, 03/07/23 and 03/09/23 through 03/20/23.
-There was documentation Carvedilol 3.125mg. 1 tablet was administered at 8:00pm on 03/01/23 through 03/19/23.
-There was documentation that Carvedilol 3.125mg, 1 tablet was not administered at 8:00am on 03/04/23 due to the resident being out of the facility at dialysis.

Telephone interview with the facility's contracted pharmacist on 03/22/23 at 9:30am revealed:
-The current order for Carvedilol was 3.125mg., 1 tablet two times daily.
-Carvedilol 3.125mg was last dispensed on 03/20/23 for 43 tablets.
-The pharmacy did not receive an order from the facility for Carvedilol 3.125, 4 tablets a day.

Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to interview with the facility's contracted pharmacy on 03/21/23 at 10:05am.

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator on 03/22/23 at 10:55am.

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Refer to interview with the PCP on 03/22/23 at 11:30am.

e. Review of Resident #4's medication order dated 11/29/22 revealed there was an order for Clonidine 0.1mg, take 1 tablet every morning and at bedtime at 8:00am and 8:00pm. (Clonidine is a medication used to treat high blood pressure).

Review of a physician visit report dated 03/15/23 revealed an order for Clonidine Hydrochloride 0.1mg, 1 tablet twice daily.

Review of Resident #4's January 2023 eMAR revealed:
-There was an entry for Clonidine 0.1 mg, 1 tablet every morning and at bedtime at 8:00am and 8:00pm.
-There was documentation that Clonidine 0.1mg, 1 tablet was not administered at 8:00am on 01/10/23, 01/17/23, and 01/19/23 due to the resident being out of the facility for dialysis.

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for Clonidine 0.1mg, 1 tablet every morning and at bedtime at 8:00am and 8:00pm.
-There was documentation that Clonidine 0.1mg, tablet was not administered at 8:00am on 02/02/23, and 02/07/23 due to the resident being out of the facility for dialysis.

Review of Resident #4's March 2023 eMAR revealed:
-There was an entry for Clonidine 0.1mg, 1 tablet every morning and at bedtime at 8:00am and 8:00pm.
-There was documentation Clonidine 0.1mg, 1 tablet was not administered at 8:00am on

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03/04/23 due to the resident being out of the facility for dialysis.

Refer to interview with the MA 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with the facility's contracted pharmacy on 03/21/23 at 10:05am.

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

f. Review of Resident #4's medication order dated 11/09/22 revealed there was an order for Dorzol-Timolol Eye Drops, 1 drop to both eyes twice daily. (Dorsol/Timolol is an eye drop used to treat eye conditions that can lead to loss of vision.

Review of Resident #4's medication order dated 01/16/23 revealed there was an order for Dorzol/Timolol Eye Drops, 1 drop to both eyes twice daily, at 8:00am and 8:00pm.

Review of Resident #4's January 2023 eMAR revealed:
-There was an entry for Dorzol/Timolol Eye Drops, 1 drop to both eyes twice day at 8:00 and 8:00pm.

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-There was documentation that Dorzol/Timolol Eyedrops, 1 drop to both eyes was not administered at 8:00am on 01/10/23, 01/17/23, 01/19/23 due to Resident #4 being out of the facility for dialysis.

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for Dorzol/Timolol Eye Drops, 1 drop to both eyes twice a day at 8:00am and 8:00pm.
-There was documentation that Dorzol/Timolol Eyedrops, 1 drop to both eyes was not administered at 8:00am on 02/02/23, 02/07/23, 02/11/23 due to Resident #4 being out of the facility for dialysis.
-There was documentation Dorzol/Timolol Eye Drops, 1 drop was not administered at 8:00am on 02/24/23 due to Resident #4 being out of the facility at the hospital.
-There was documentation Resident #4 was out of the facility at the hospital on 02/24/23 to 03/01/23.

Review of Resident #4 March 2023 eMAR revealed:
-There was an entry for Dorzol/Timolol Eye Drops, 1 drop to both eyes twice a day at 8:00am and 8:00pm.
-There was documentation that that Dorzol/Timolol Eye drops, 1 drop to both eyes was not administered at 8:00am on 03/04/23 due to Resident #4 being out of the facility for dialysis.

Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

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Refer to telephone interview with the facility's contracted pharmacy on 03/21/23 at 10:05am.

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

g. Review of Resident #4's medication order dated 11/09/22 revealed there was an order for Isosorbide-Hydralazine 20-37.5, 1 tablet three times daily at 8:00am, 12:00pm, and 8:00pm. (Isosorbide-Hydralazine is a medication used to treat high blood pressure and heart failure).

Review of a physician visit report dated 03/15/23 revealed an order for Isosorbide-Hydralazine 20-37.5, 1 tablet three times daily

Review of Resident #4's January 2023 eMAR revealed:
-There was an entry for Isosorbide-Hydralazine 20-37.5, 1 tablet three times daily at 8:00am, 12:00pm, and 8:00pm.
-There was documentation Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered at 8:00am on 01/10/23, 01/17/23, 01/19/23 due to the resident being out of the facility for dialysis.
-There was documentation Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered at 12:00pm on 01/03/23, 01/05/23,

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01/07/23, 01/12/23, 01/17/23, 01/19/23, 01/21/23, 01/24/23, 01/31/23 due to the resident being out of the facility for dialysis.

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for Isosorbide-Hydralazine 20-37.5, 1 tablet three times daily at 8:00am, 12:00pm, and 8:00pm.
-There was documentation Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered at 8:00am on 02/02/23, 02/07/23 due to the resident being out of the facility for dialysis.
-There was documentation Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered at 12:00pm on 02/02/23, 02/04/23, 02/07/23, 02/11/23, 02/16/23, 02/18/23, 02/22/23 due to the resident being out of the facility at dialysis..

Review of Resident #4's March 2023 eMAR revealed:
-There was an entry for Isosorbide-Hydralazine 20-37.5, 1 tablet three times daily at 8:00am, 12:00pm, and 8:00pm.
-There was documentation Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered to Resident #4 at 8:00am on 03/04/23 due to the resident being out of the facility having a procedure done.
-There was documentation Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered to Resident #4 at 12:00pm on 03/02/23, 03/04/23, 03/11/23, 03/18/23 due to the resident being out of the facility dialysis.

Refer to interview with MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23

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D 344	Continued From page 32 at 9:50am. Refer to telephone interview with the facility's contracted pharmacy on 03/21/23 at 10:05am. Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am Refer to interview with the Building Manager 03/22/23 at 10:05am Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am. Refer to interview with the PCP on 03/22/23 at 11:30am. h. Review of Resident #4's medication order dated 11/09/22 revealed there was an order for Sevelamer Carbonate 800mg, take 3 tablets (2400mg) three times daily with meals at 8:00am, 12:00pm, and 5:00pm. (Sevelamer Carbonate is a medication used to treat high potassium levels in individuals with chronic kidney disease or individuals receiving hemodialysis). Review of a physician visit report dated 03/15/23 revealed an order for Sevelamer Carbonate 800mg, 3 tablets (2400mg) three times day with meals. Review of Resident #4's January 2023 eMAR revealed: -There was an entry for Sevelamer Carbonate 800mg, 3 tablets (2400mg) three times daily with meals at 8:00am, 12:00pm, and 5:00pm. -There was documentation Sevelamer Carbonate 800mg, 3 tablets (2400mg) was not administered at 8:00am on 01/10/23, 01/17/23, and 01/19/23 due to the resident being out of the facility for	D 344		

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dialysis.
-There was documentation Sevelamer Carbonate 800mg, 3 tablets (2400mg) was not administered at 12:00pm on 01/03/23, 01/05/23, 01/12/23, 01/17/23, 01/19,23, 01/21/23, 01/24/23, and 01/31/23 due to the resident being out of the facility for dialysis.

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for Sevelamer Carbonate 800mg, 3 tablets (2400mg) three times daily with meals at 8:00am, 12:00pm, and 5:00pm.
-There was documentation Sevelamer Carbonate 800mg, 2 tablets (2400mg) was not administered at 8:00am on 02/02/23, and 02/07/23 due to Resident #4 being out of the facility for dialysis.

Review of Resident #4's March 2023 eMAR revealed:
-There was an entry for Sevelamer Carbonate 800mg, 3 tablets (2400mg) three times daily with meals at 8:00am, 12:00pm, and 5:00pm.
-There was documentation Sevelamer Carbonate 800mg, 3 tablets (2400) was not administered at 8:00am at 03/04/23 and 03/08/23 due to Resident #4 being out of the facility at the dialysis.
-There was documentation Sevelamer Carbonate 800mg, 3 tablets (2400mg) was not administered at 12:00pm on 03/02/23, 03/04/23, 03/11/23, and 03/18/23 due to the resident being out of the facility at dialysis.

Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with the facility's

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contracted pharmacy on 03/21/23 at 10:05am.

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

____

Interview with MA on 03/21/23 at 9:30am revealed:
-Resident #4 went to dialysis "around" 6:00am on Tuesday, Thursday, and Saturday.
-The night shift was responsible for getting Resident #4 dressed and serving him an early breakfast.
-There were no medications administered to Resident #4 before dialysis.

Interview with a second MA on 03/21/23 at 9:50am revealed:
-Resident #4 went to dialysis at 6:00am in the morning on Tuesday, Thursday, and Saturday.
-The night shift was responsible for getting him up and dressed, serving him breakfast and getting him ready to be picked up by the county van.
-Sometimes the night shift administered his 8:00am medications.

Telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05 am revealed:
-The pharmacist entered residents' medications and times of administration in the system and

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D 344	Continued From page 35 sent them to the facility for approval. -The facility was responsible for approving the times the medications were scheduled to be administered or making changes regarding the times to suit the needs of the resident. -The pharmacy did not know the times of dialysis sessions for the residents at the facility who were scheduled for dialysis. Interview with the RCC on 03/21/23 at 11:00am and 03/22/23 at 9:00am revealed: -She was not aware Resident #4 was not receiving his 8:00am and 12:00pm medications due to early dialysis sessions. -The facility did not have a medication administration policy or protocol for residents who go to dialysis. -Medication orders from the dialysis facility were submitted directly to pharmacy for processing. -The pharmacist entered the medication orders and times of administration in the system and sends the orders to the facility for review and approval. -The facilty did not make changes to the times of administration of medications for residents. Interview with the Building Manager 03/22/23 at 10:05am revealed: -He thought Resident #4 was receiving his 8:00am and 12:00pm medications on the days he goes to dialysis. -He expected the MA's to have caught that Resident #4 was not getting his medications at 8:00am before dialysis and inform the RCC and the Building Manager. -He expected the RCC to notify the PCP for clarification on how to handle the 8:00am and 12:00pm medications for Resident #4 on dialysis days.	D 344		

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D 344	Continued From page 36 Interview with the Administrator/Owner on 03/22/23 at 10:55am revealed: -She was not aware Resident #4 went to dialysis three times a week and was not receiving his 8:00am and 12:00pm medications. -She expected the RCC to notify the PCP for clarification. -It was a major concern that Resident #4 did not receive his 8:00am and 12:00pm medications because it could cause other health problems. Interview with the PCP on 03/22/23 at 11:30am revealed: -She was not aware Resident #4 was scheduled for dialysis at 6:00am and was not receiving his 8:00am and 12:00pm medications as ordered. -Had the facility notified her for clarification regarding the time of dialysis, she could have adjusted the medication administration times. Attempted telephone interview with Resident #4's Nephrologist on 03/22/23 at 9:15am was unsuccessful.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 358		

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Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#5 and #8) observed during the medication pass including errors with a medication used to support adequate thyroid function (#5) and medication used to relieve pain (#8) and 3 of 6 sampled residents (#3, #4, and #5) regarding a medication used to support thyroid function (#5), medications used to treat low blood pressure, high levels of potassium in the blood (hyperkalemia), high levels of phosphorous in the blood, shortness of breath, pain, and fluid retention, (#3) and medications used to treat an eye condition that can cause vision loss, an antibiotic for eye infection, depression, shortness of breath, heart failure, high levels of potassium in the blood, schizophrenia, and depression. (#4).

The findings are:

1. The medication error rate was 6% as evidenced by 2 errors out of 32 opportunities during the 8:00am morning medication pass on 03/20/23.

a. Review of Resident #5's current FL2 dated 11/02/23 revealed:
-Diagnoses included dementia, pain in joints, muscle weakness, and muscle spasms.
-There was an order for levothyroxine 137 mcg to be administered Monday through Saturday.
-There was an order for levothyroxine 137 mcg, one half tab (68.5 mcg) to be administered on Sunday.

Review of Resident #5's signed physician's order dated 11/10/23 revealed levothyroxine was to be increased to 137mcg every day in the morning on

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an empty stomach.

Observation of the morning medication pass on 03/20/23 at 8:39am revealed:
-The morning medication aide (MA) in special care unit prepared 9 oral medications for administration to Resident #5.
-The MA administered 7 oral medications and documented administration on the electronic Medication administration record (eMAR) after watching the resident take the medications.
-Resident #5 said that he had already eaten breakfast that morning.

Review of Resident #7's electronic medication administration record (eMAR) for March 2023 revealed:
-There was an entry for levothyroxine 137mcg to be administered each morning on an empty stomach and scheduled for administration at 8:00am.
-There was documentation levothyroxine 137mcg was administered at 8:00am on 03/20/23.

Observation of medication on hand for administration for Resident #5 on 03/20/23 at 4:34pm revealed there was a medication dispensing card labeled for levothyroxine 137mcg to be administered each morning on an empty stomach with tablets available for administration.

Telephone interview with the facility's contracted pharmacy on 03/21/23 at 9:57am revealed:
-Levothyroxine should be given on an empty stomach 30 minutes to 60 minutes prior to breakfast and other medications.
-Levothyroxine can bind to food or other medications making it less effective.

Interview with a medication aide (MA) on

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03/20/23 at 1:35pm revealed:
-She knew the levothyroxine was to be administered on an empty stomach as instructed.
-The levothyroxine was on the eMAR to be given at 9:00am and the residents were served breakfast was around 7:30am.
-She had not brought the time of administration to the attention of management or Resident #5's primary care provider.

Interview with Resident #5's primary care provider (PCP) on 03/22/23 at 11:37am revealed:
-Levothyroxine should be given on an empty stomach because food could decrease the absorption of the medication.
-She had difficulty managing Resident #5's thyroid stimulating hormone (TSH) level and had referred him to endocrinology for evaluation.
-Receiving the levothyroxine after breakfast could have been a contributing factor to being unable to manage his TSH level.

Interview with the Resident Care Coordinator (RCC) on 03/21/23 at 5:08pm revealed:
-Residents were served breakfast between 7:00am and 8:00am each morning.
-She was not aware the levothyroxine for Resident #7 was timed to be given after breakfast instead of before as ordered.

Refer to interview with the RCC on 03/21/23 at 5:08pm.

Refer to interview with the Building Manager (BM) on 03/22/23 at 10:19am.

Refer to interview with the Administrator/Owner on 03/22/23 at 10:58am.

b. Review of Resident #8's current FL-2 dated

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D 358	Continued From page 40 06/30/22 revealed: -Diagnoses included type II diabetes, stroke and chronic stable angina. -He was semi ambulatory and had contractures. Review of Resident #8's physician's order dated 12/15/22 revealed diclofenac topical gel for joint pain, apply twice daily and at bedtime to painful joints. (Diclofenac is topically medication used to treat pain.) Review of Resident #8's physician's order dated 01/26/23 revealed diclofenac 1% gel, apply 2GM's twice daily for joint pain. Observation of the 8:00am medication pass on 03/20/23 at 8:27 am revealed the MA donned gloves and squeezed the diclofenac gel directly on to her hand and rubbed the gel onto Resident #8's lower back. Review of Resident #8's eMAR for March 2023 revealed: -There was an entry for diclofenac 1% gel 2GM to be applied twice daily for joint pain at 8:am and 4:00pm. -There was documentation diclofenac 1% gel 2GM was applied at 8:00am on 03/20/23. Interview with the medication aide (MA) on 03/20/23 at 10:20am revealed: -She knew she should measure the topical gel to ensure 2 GM of the medication was applied. -She is usually in a hurry and did not measure the gel. Telephone interview with a pharmacist on 03/21/23 at 9:57am revealed: -Diclofenac should be measured by using the clear plastic tool that comes with the medication.	D 358		

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-A ribbon of gel is to be squeeze down the measuring tool to the ordered dose.
-There was little risk of a resident receiving too much medication but too little could cause pain to not be as well controlled.

Refer to interview with the RCC on 03/21/23 at 5:08pm.

Refer to interview with the Building Manager (BM) on 03/22/23 at 10:19am.

Refer to interview with the Administrator/Owner on 03/22/23 at 10:58am.
2. Review of Resident #3's current FL-2 dated 03/16/23 revealed diagnoses included left first toe osteomyelitis, end stage renal disease and on hemodialysis, schizophrenia, essential primary hypertension, hyperkalemia, chronic pain, arthritis, diabetes mellitus type II, major depressive disorder, chronic obstructive pulmonary disease (COPD), diabetic neuropathy, underlying peripheral arterial disease (PAD) and dysfunctional uterine bleeding.

a. Review of Resident #3's medication order dated 03/16/23 revealed there was an order for Incruse Ellipta 62.5 mcg INH, inhale 1 puff daily as directed every morning. (Incruse Ellipta is a medication used to treat wheezing, coughing, chest tightness and shortness of breath due to lung disease).

Review of Resident #3's physician order report dated 12/14/22 revealed there was an order for Incruse Ellipta 62.5 mcg INH, inhale 1 puff daily scheduled at 8:00am.

Review of Resident #3's January 2023 electronic medication administration record (eMAR)

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revealed:
-There was an entry for Incruse Ellipta 62.5 mcg INH, inhale 1 puff daily as directed to be administered at 8:00am.
-There was documentation Incruse Ellipta was not administered to Resident #3 at 8:00am on 01/17/23 and 01/19/23 due to the resident being out of the facility for dialysis.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for Incruse Ellipta 62.5 mcg INH, inhale 1 puff every day as directed to be administered at 8:00am.
-There was documentation Incruse Ellipta 62.5 mcg, 1 puff was not administered at 8:00am on 02/02/23, 02/07/23, and 02/11/23 due to resident being out of the facility for dialysis.

Review of Resident #3's March 2023 eMAR revealed:
-There was an entry for Incruse Ellipta 62.5 mcg INH, inhale 1 puff every day as directed to be administered at 8:00am.
-There was documentation Incruse Ellipta 62.5mcg, 1 puff was not administered at 8:00am on 03/04/23 due to the resident being out of the facility for dialysis.
-There was documentation Resident #3 was out of the facility at the hospital from 03/07/23 to 03/16/23.

Observation of medications on hand for Resident #3 on 03/21/23 at 2:00pm revealed Incruse Ellipta 62.5 mg INH, with 24 puffs left.

Refer to interview with the medication aide (MA) on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23

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at 9:50am.

Refer to telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the Resident Care Coordinator (RCC) 03/21/23 at 11:00am and 03/22/23 at 9:00am.

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the Primary Care Provider (PCP) on 03/22/23 at 11:30am.

b. Review of Resident #3's medication order dated 01/25/23 revealed there was an order for Metaxalone 800mg , 1/2 tablet (400mg) daily. (Metaxalone is a medication used to treat muscle cramps and relieve pain).

Review of Resident #3's medication order dated 03/16/23 revealed there was an order for Metaxalone 800mg, take 1/2 tablet (400mg) daily every morning.

Review of Resident #3's January 2023 eMAR revealed:
-There was an entry for Metaxalone 800mg, 1/2 tablet (400mg) daily for muscle cramps to be administered at 8:00am.
-There was documentation Metaxalone 800mg, 1/2 tablet (400mg) was not administered at 8:00am on 01/27/23 due to awaiting prescription for authorization from the physician.

Review of Resident #3's February 2023 eMAR

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D 358	Continued From page 44 revealed: -There was an entry for Metaxalone 800mg, 1/2 tablet (400mg) daily for muscle cramps to be administered at 8:00am. -There was documentation Metaxalone 800mg, 1/2 tablet (400mg) was not administered at 8:00am on 02/02/23, 02/07/23 due to the resident being out of the facility for dialysis. -There was documentation Metaxalone 800mg, 1/2 tablet (400mg) was administered at 8:00am on 02/11/23 by the 3rd shift medication aide (MA), time documented on eMAR 9:39am. -There was documentation Metaxalone 800mg, 1/2 tablet (400mg) was administered at 8:00am on 02/18/23 early due to resident going to dialysis. Review of Resident #3's March 2023 eMAR revealed: -There was an entry for Metaxalone 800mg, 1/2 tablet (400mg) daily for muscle cramps to be administered at 8:00am. -There was documentation Mataxalone 800mg 1/2 tablet (400mg) was not administered at 8:00am on 03/04/23 due to the resident being out of the facility for dialysis. -There was documentation Resident #3 was out of the facility at the hospital from 03/07/23 through 03/16/23. Observation of Resident #3's medications on hand on 03/21/23 at 2:30pm revealed a bubble card containing 26 (1/2) tablets of Mataxalone 800mg. Refer to interview with the the MA on 03/21/23 at 9:30am Refer to interview with a second MA on 03/21/23 at 9:50am.	D 358		

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Refer to telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the RCC on 03/21/23 at 11:00am and 03/22/23 at 9:00am.

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

c. Review of Resident #3's physician order report dated 12/14/22 revealed there was an order for Midodrine 5 mg, 1 tablet prior to Hemodialysis on Tuesday, Thursday, and Saturday to be administered at 8:00am. (Midodrine is a medication used to treat low blood pressure).

Review of Resident #3's medication order dated 03/16/23 revealed there was an order for Midodrine 5mg, take 1 tablet prior to hemodialysis on Tuesday, Thursday, and Saturday.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Midodrine 5mg, 1 tablet prior to hemodialysis on Tuesday, Thursday, and Saturday to be administered at 8:00am.
-There was documentation Midodrine 5mg, 1 tablet was not administered at 8:00am on 01/17/23 and 01/19 /23 due to the resident being out of the facility for dialysis.

Review of Resident #3's February 2023 eMAR

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revealed:
-There was an entry for Midodrine 5mg, 1 tablet prior to hemodialysis on Tuesday, Thursday, and Saturday to be administered at 8:00am.
-There was documentation Midodrine 5mg, 1 tablet was not administered at 8:00am on 02/02/23 and 02/07/23 due to the resident being out of the facility for dialysis.
-There was documentation Midodrine 5mg, 1 tablet was not administered at 8:00am on 02/21/23 due to awaiting physician authorization.
-There was documentation Midodrine 5mg, 1 tablet was not administered at 8:00am on 02/28/23 due to being held per physician order.
-There was documentation Midodrine 5mg, 1 tablet was administered at 8:00am by the 3rd shift MA on 02/11/23, time documented on the eMAR at 9:39am.
-There was documentation Midodrine 5mg, 1 tablet was administered early at 8:00am due to Resident #3 going to dialysis on 02/18/23.

Review of Resident #3's March 2023 eMAR revealed:
-There was an entry for Midodrine 5mg, 1 tablet prior to Hemodialysis on Tuesday, Thursday, and Saturday to be administered at 8:00am.
-There was documentation Resident #3 was out of the facility at the hospital from 03/07/23 to 03/16/23.

Observation of Resident #3's medications on hand on 03/21/23 at 2:30pm revealed no Midodrine 5mg was not in the medication cart, but pharmacy will deliver the medication today.

Telephone interview with the facility's contracted pharmacist on 03/21/23 at 10:05 revealed:
- Midodrine was a medication prescribed to keep Resident #3 blood pressure from getting too low

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(orthostatic hypotension) during dialysis.
-If the blood pressure gets to low it could cause severe dizziness and fainting and could place the resident at risk for falls.

Interview with the PCP on 03/22/23 at 11:30am revealed Resident #3 could experience low blood pressure during dialysis causing sweating, dizziness, high risk for falls, and not feeling well if she did not get her Midodrine before dialysis.

Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am.

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

d. Review of Resident #3's medication order dated 12/14/22 revealed there was an order for Pantoprazole 40mg, 1 tablet every morning. (Pantoprazole was a medication used for acid reflux).

Review of Resident #3's January 2023 eMAR revealed:

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-There was an order for Pantoprazole 40mg, 1 tablet to be administered at 8:00am.
-There was documentation Pantoprazole 40mg, 1 tablet was not administered at 8:00am on 01/19/23 due to the resident being out of the facility for dialysis.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for Pantoprazole 40mg, 1 tablet every morning to be administered at 8:00am.
-There was documentation Pantoprazole 40mg, 1 tablet was not administered at 8:00am on 02/02/23 and 02/07/23 due to the resident being out of the facility for dialysis.
-There was documentation Pantoprazole 40mg, 1 tablet 8:00am medication was administered early on 02/18/23 due to the resident going to dialysis.

Review of Resident #3's March 2023 eMAR revealed:
-There was an entry for Pantoprazole 40mg, 1 tablet every morning to be administered at 8:00am.
-There was documentation Pantoprazole 40mg, 1 tablet was not administered at 8:00am on 03/04/23 due to Resident #3 being out of the facility for dialysis.
-There was documentation Resident #3 was out of the facility at the hospital from 03/07/23 to 03/16/23.

Observation of Resident #3's medications on hand on 03/21/23 at 2:30pm revealed a bubble card containing 26 tablets of Pantoprazole 40mg.

Refer to interview with the MA on 03/21/23 at 9:30am

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Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am.

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

e. Review of Resident #3's physician order report dated 12/14/22 revealed there was an order for Rena-Vite, 1 tablet every day to be administered at 8:00am. (Rena-Vite RX is a dietary supplement for individuals on dialysis).

Review of Resident #3's medication order dated 03/16/23 revealed there was an order for Rena-Vite RX, take 1 tablet every morning.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Rena-Vite RX, take 1 tablet every day to be administered at 8:00am.
-There was documentation Rena-Vite RX, 1 tablet was not administered at 01/17/23 and 01/19/23.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for Rena-Vite RX, 1 tablet every day to be administered at 8:00am.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR ASSISTED LIVING #5	**416 NORTH PARKER STREET ELM CITY, NC 27822**

(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
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-There was documentation Rena-Vite RX, 1 tablet was not administered at 8:00am on 02/02/23 and 02/07/23 due to Resident #3 going to dialysis.
-There was documentation Rena-Vite RX, 1 tablet was administered by the 3rd shift on 02/11/23, time documented on the eMAR at 9:39am.
-There was documentation Rena-Vite Rx, 1 tablet was administered early on 02/18/23 due to Resident #3 going to dialysis, documented on eMAR at 8:10am.

Review of Resident #3's March 2023 eMAR revealed:
-There was an entry for Rena-Vite RX 1 tablet every day be administered at 8:00am.
-There was documentation Rena-Vite RX was not administered at 8:00am on 03/04/23 due to Resident # 3 being out of the facility for dialysis.
-There was documentation Resident #3 was out of the facility at the hospital from 03/07/23 to 03/16/23.

Observation of Resident #3's medications on hand on 03/21/23 at 2:30pm revealed a bubble card with 26 tablets of Rena-Vite RX.

Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am.

Refer to interview with the Building Manager 03/22/23 at 10:05am

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

f. Review of Resident #3's physician order report dated 12/14/22 revealed an order for Sertraline 50mg, 4 tablets (200mg) every day to be administered at 8:00am. (Sertraline is a medication used for depression, obsessive-compulsive disorder, social anxiety and panic disorder).

Review of Resident #3's medication order dated 03/16/23 revealed there was an order for Sertraline 50mg, take 4 tablets (200mg) every morning.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Sertraline 50mg, take 4 tablets (200mg) every day for depression to be administered at 8:00am.
-There was documentation Sertraline 50mg, 4 tablets was not administered at 8:00 on 01/17/23 and 01/19/23 due to Resident #3 being out of the facility for dialysis.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for Sertraline 50mg, 4 tablet (200mg) every day for depression to be administered at 8:00am.
-There was documentation Sertraline 50mg, 4 tablets (200mg) was not administered at 8:00am on 02/02/23 and 02/07/23 due to Resident #3 being out of the facility for dialysis.

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-There was documentation Sertraline 50mg, 4 tablet (200mg) was administered early on 02/18/23 due to Resident #3 going to dialysis, documented at 8:10am.

Review of Resident #3's March 2023 eMAR revealed:
-There was an entry for Sertraline 50mg, 4 tablets (200mg) every day for depression to be administered at 8:00am.
-There was documentation Sertraline 50mg, 4 tablets (200mg) was not administered at 8:00am on 03/04/23 due to Resident #3 being out of the hospital at dialysis.
-There was documentation Resident #3 was out of the facility at the hospital from 03/07/23 to 03/1/6/23.

Observation of Resident #3's medications on hand on 03/21/23 at 2:30pm revealed a bubble card containing 26 tablets of Sertraline 50mg.

Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am.

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

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Refer to interview with the PCP on 03/22/23 at 11:30am.

g. Review of Resident #3's physician order report dated 12/14/22 revealed:
-There was an order for Sevelamer Carbonate 800mg, 2 tablets twice a day with meals to be administered at 8:00am and 7:00pm.(Sevelamer Carbonate is a medication used to treat a high phosphorus level in individuals with chronic kidney disease).
-There was an order for Sevelamer Carbonate 800mg, 1 tablet with snacks to be administered at 10:00am, 4:00am and 8:00pm.

Review of Resident #3's medication order dated 03/16/23 revealed:
-There was an order for Sevelamer Carbonate 800mg, take 2 tablets twice daily with meals.
-There was an order for Sevelamer Carbonate 800mg with snacks.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Sevelamer Carbonate 800mg, take 2 tablets twice daily with meals to be administered at 8:00am and 7:00pm.
-There was documentation that Sevelamer Carbonate 800mg, 2 tablets was not administered at 8:00am on 01/05/23, 01/07/23, 01/10/23, 01/12/23, 01/17/23, 01/19/23, and 01/31/23 due to Resident #3 being out of the facility for dialysis.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for Sevelamer Carbonate 800mg, take 2 tablets twice daily with meals to be administered at 8:00am and 7:00pm.
-There was documentation Sevelamer Carbonate

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800mg, 1 tablets was not administered at 8:00am on 02/02/23, 02/04/23, 02/07/23, 02/09/23, 02/14/23 due to Resident #3 being out of the facility for dialysis.
-There was documentation Sevelamer Carbonate 800mg, 1 tablet was administered early on 02/18/23, documented on the eMAR at 8:00am.

Review of Resident #3's March 2023 eMAR revealed:
-There was an entry for Sevelamer Carbonate 800mg, take 2 tablets twice daily with meals to be administered at 8:00am and 7:00pm.
-There was documentation Resident #3 was out of the facility at the hospital from 03/07/23 to 03/16/23.

Observation of Resident #3's medications on hand on 03/21/23 at 2:00pm revealed bubble cards containing 78 tablets of Sevelamer Carbonate 800mg.

Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am.

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

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Refer to interview with the PCP on 03/22/23 at 11:30am.

h. Review of Resident #3's physician order report dated 12/14/22 revealed there was an order for Torsemide 20mg, 2 tablets (40mg) every day to be administered at 8:00am. (Torsemide is a medication used to treat fluid retention and high blood pressure)

Review of Resident #3's medication order dated 03/16/23 revealed there was an order for Torsemide 20mg, take 2 tablets (40mg) every morning.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Torsemide 20mg, take 2 tablets (40mg) every day to be administered at 8:00am.
-There was documentation Torsemide 20mg, 2 tablets was not administered at 8:00am on 01/17/23, 01/19/23, due to Resident #3 being out of the facility for dialysis.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for Torsemide 20mg, take 2 tablets (40mg) every day to be administered at 8:00am.
-There was documentation Torsemide 20mg, 2 tablets was not administered at 8:00am on 02/02/23 02/07/23 due to Resident #3 being out of the facility at dialysis.
-There was documentation Torsemide 20mg, 2 tablets was administered early on 02/18/23, due to Resident #3 going to dialysis, documented on eMAR at 8:10am.

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Review of Resident #3's March 2023 eMAR revealed there was documentation Resident #3 was out of the facility at the hospital from 03/07/23 to 03/16/23.

Observation of Resident #3's medications on hand on 03/22/23 at 2:00pm revealed a bubble card containing 26 tablets of Torsemide 20mg.

Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am.

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

i. Review of Resident #3's medication order dated 12/14/22 revealed there was a order for Veltassa 8.4 gm powder packet, mix 1 packet with water as directed and drink on an empty stomach every day (Veltassa is a medication used to treat high potassium levels in the blood).

Review of Resident #3's medication order dated 03/16/23 revealed there was an order for Veltassa 8.4 gm powder packet, mix 1 packet

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with water as directed and drink on an empty stomach every day.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Veltassa 8.4 gm powder packet, mix 1 packet with water as directed and drink on an empty stomach every day to be administered at 8:00am.
-There was documentation Veltassa 8. 4gm, 1 packet was not administered at 8:00am on 01/17/23 and 01/19/23 due to Resident #3 being out of the facilty at dialysis.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for Veltassa 8.4 gm powder packet, mix 1 packet with water as directed and rink on an empty stomach every day to be administered at 8:00am.
-There was documentation Veltassa 8.4 gm powder packet, 1 packet was not administered at 8:00am on 02/02/23, 02/07/23 due to Resident #3 being out of the facility at dialysis.
-There was documentation Veltassa 8.4 gm powder packed, 1 packet was administered on 02/11/23 by the 3rd shift MA due to Resident #3 going to dialysis.
-There was documentation Veltassa 8.4 gm powder packet, 1 packet was administered early on 02/18/23 dur to Resident #3 going to dialysis, documented on the eMAR at 8:10am.

Review of Resident #3's March 2023 eMAR revealed:
-There was an entry for Veltassa 8.4 gm powder packet, mix 1 packet with water as directed and drink on an empty stomach every day to be administered at 8:00am.

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-There was documentation Veltassa 8.4 gm powder packet, 1 packet was not administered at 8:00am on 03/02/23 due to Resident #3 being out of the facility at dialysis.
-There was documentation Resident #3 was out of the facility at the hospital from 03/07/23 through 03/16/23.

Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with the facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am.

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

j. Review of Resident #3's physician order report dated 12/14/22 revealed there was an order for Advair HFA 230-21 mcg, inhale 2 puffs twice a day, use with spacer, scheduled for 8:00am and 8:00pm. (Advair HFA is a steroid medication used to treat wheezing, shortness of breath, coughing, and chest tightness caused by lung disease).

Review of Resident #3's medication order dated 03/16/23 revealed there was an order for Advair HFA 230-21mcg, inhale 2 puffs twice a day.

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Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Advair HFA 230-21mcg, inhale 2 puffs twice daily, use with spacer to be administered at 8:00am and 8:00pm.
-There was documentation Advair HFA 230-21mcg was not administered at 8:00am on 01/17/23 and 01/19/23 due to Resident #3 being out of the facility for dialysis.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for Advair HFA 230-21mcg, inhale 2 puffs twice daily, use with spacer to be administered at 8:00am and 8:00pm
-There was documentation Advair HFA 230-21mcg, inhale 2 puffs was not administered at 8:00am on 02/02/23 02/07/23 due to Resident #3 being out of the facility at dialysis.
-There was documentation Advair HFA was administered early on 02/18/23 due to Resident #3 going to dialysis, time documented on eMAR at 8:10am.

Review of Resident #3's March 2023 eMAR revealed:
-There was an entry for Advair HFA 230-21mcg, inhale 2 puffs twice daily, use with spacer to be administered at 8:00am and 8:00pm.
-There was documentation Advair HFA 230-21mc, inhale 2 puffs was not administered at 8:00am on 03/04/23 due to Resident #3 being out of the facility for dialysis.
-There was documentation Resident #3 was out of the facility at the hospital from 03/07/23 through 03/16/23.

Refer to interview with the MA on 03/21/23 at

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9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am.

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

k. Review of Resident #3's physician order report dated 01/14/22 revealed there was an order for Artificial Tears Drops, 1 drop into left eye four times a day scheduled for 8:00am, 12:00pm, 4:00pm and 8:00pm. (Artificial Tears is used to lubricate dry eyes).

Review of Resident #3's medication order dated 03/16/23 revealed there was an order for Artificial Tears Drops, 1 drop into left eye four times a day.

Review of Resident #3's January 2023 eMAR revealed:
-There was an entry for Artificial Tears Drops, 1 drop into left eye four times a day to be administered at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation Artificial Tears Drops, 1 drop into left eye was not administered at 8:00am on 01/17/23, 01/19/23 due to Resident #3

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being out of the facility at dialysis.
-There was documentation Artificial Tears Drops, 1 drop into left eye was not administered at 12:00pm on 01/03/23, 01/05/23, 01/12/23, 01/13/23, 02/17/23, 01/19/23, 01/21/23, 01/24/23, 01/28/23, 01/31/23 due to Resident #3 being out of the facility at dialysis.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for Artificial Tears Drops, 1 drop into left eye four times day to be administered at 8:00am, 12:00pm, and 4:00pm.
-There was documentation Artificial Tears Drops, 1 drop into left eye was not administered at 8:00am on 02/02/23, 02/07/23, 02/21/23 due to Resident #3 being out of the facility at dialysis.
-There was documentation Tears Drops, 1 drop into let eyes was administered early on 02/18/23 due to Resident #3 going to dialysis, documented on eMAR at 8:10am.

Review of Resident #3's March 2023 eMAR revealed:
-There was an entry for Artificial Tears Drops, 1 drop into left eye four times a day to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was documentation Artificial Tears Drops, 1 drop was not administered at 8:00am on 03/04/23 due to Resident #3 being out of the facility at dialysis.
-There was documentation Artificial Tears Drops, 1 drop was not administered at 12:00pm on 03/02/23, 03/21/23 due to Resident #3 being out of the facility at dialysis.
-There was documentation Resident #3 was out of the facility at the hospital from 03/07/23 to 03/16/23.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with the facilty's contracted pharmacist on 03/21/23 at 10:05am.

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am

____

Interview with MA on 03/21/23 at 9:30am revealed:
-Resident #3 went to dialysis "around" 6:00am on Tuesday, Thursday, and Saturday.
-The night shift was responsible for getting Resident #3 dressed and serving him an early breakfast.
-There were no medications administered to Resident #3 before dialysis.

Interview with a second MA on 03/21/23 at 9:50am revealed:
-Resident #3 went to dialysis at 6:00am in the morning on Tuesday, Thursday, and Saturday.
-The night shift was responsible for getting him up and dressed, serving him breakfast and getting him ready to be picked up by the county van.
-Sometimes the night shift administered his

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D 358	Continued From page 63 8:00am medications. Telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05 am revealed: -The pharmacist entered residents' medications and times of administration in the system and sent them to the facility for approval. -The facility was responsible for approving the times the medications were scheduled to be administered or making changes regarding the times to suit the needs of the resident. -The pharmacy did not know the times of dialysis sessions for the residents at the facility who were scheduled for dialysis. Interview with the RCC on 03/21/23 at 11:00am and 03/22/23 at 9:00am revealed: -She was not aware Resident #3 was not receiving his 8:00am and 12:00pm medications due to early dialysis sessions. -The facility did not have a medication administration policy or protocol for residents who go to dialysis. -Medication orders from the dialysis facility were submitted directly to pharmacy for processing. -The pharmacist entered the medication orders and times of administration in the system and sends the orders to the facility for review and approval. -The facilty could make changes to the times but did not make changes to the times of administration of medications for the residents on dialysis. Interview with the Building Manager 03/22/23 at 10:05am revealed: -He was not aware Resident #3 did not receive her 8:00am and 12:00pm -He had concerns with Resident #3 not getting her blood pressure medications because her	D 358		

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blood pressure had "bottomed out" (dropped low) in the past during dialysis.
-He expected the MA's to have caught that Resident #3 was not getting her medications at 8:00 am before dialysis and informed the RCC and the Building Manager.
-He expected the RCC to notify the PCP for clarification on how to handle the 8:00am and 12:00pm medications for Resident #3 on dialysis days.

Interview with the Administrator/Owner on 03/22/23 at 10:55am revealed:
-She was not aware Resident #3 went to dialysis three times a week and was not receiving his 8:00am and 12:00pm medications.
-She expected the RCC to notify the PCP for clarification.
-It was a major concern that Resident #4 did not receive his 8:00am and 12:00pm medications because it could cause other health problems.

Interview with the PCP on 03/22/23 at 11:30am revealed:
-She was not aware Resident #3 was scheduled for dialysis at 6:00am and was not receiving his 8:00am and 12:00pm medications as ordered.
-Had the facility reached out to her regarding the time of dialysis, she could have adjusted the medication administration times.

Attempted telephone interview with the Mental Health Provider on 03/22/23 at 9:00am was unsuccessful.

Attempted telephone interview with Resident #4's Nephrologist on 03/22/23 at 03/22/23 at 9:15am was unsuccessful.

3. Review of Resident #4's current FL-2 dated

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11/09/22 revealed diagnoses included osteomylitis of left foot, acute kidney injury, polysubstance, and diabetes mellitus type II.

Review of Resident #4's hospital discharge summary dated 02/27/23 revealed Resident #4 was admitted to the hospital for an abnormal stress test. (A stress test is used to determine how the heart works during physical activity and can show problems with blood flow within the heart).

a. Review of Resident #4's medication orders dated 11/09/22 revealed there was an order for Acetazolamide 250mg, take 2 tablets (500mg) three times a week at 8:00am. (Acetazolamide is a medication used to treat fluid retention and glaucoma (an eye condition that can cause blindness).

Review of Resident #4's January 2023 electronic medication administration record (eMAR)revealed:
-There was an order for Acetazolamide 250mg, 2 tablets (500mg) three times a week to be administered at 8:00am.
-There was documentation that Acetazolamide 250mg, 2 tablets (500mg) was not administered on 01/10/23, 01/17/23, and 01/19/23 due to resident being out of the facility for dialysis.

Review of Resident #4's February 2023 eMAR revealed:
-There was an order for Acetazolamide 250mg, 2 tablets (500mg) three times a week to be administered at 8:00am.
-There was documentation that Acetazolamide 250mg, 2 tablets (500mg) was not administered on 02/02/23 and 02/07/23 at 8:00am due to resident being at dialysis.

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D 358	Continued From page 66 -There was documentation that Acetazolamide 250mg 2 tablets (500mg) was not administered on 02/16/23, 02/21/23, 02/23/23 because of waiting on prescription authorization from physician. -There was documentation that Resident #4 was out of the facility from 02/24/23 through 03/01/23 due to hospitalization. Review of Resident #4's March 2023 eMAR revealed: -There was an order for Acetazolamide 250mg, 2 tablets (500mg) thee times a week. -There was documentation that Acetazolamide 250mg, 2 tablets (500mg) was not administered on 03/04/23 at 8:00am due to resident being out of the facility for dialysis. Observation of Resident #4's medications on hand on 03/21/23 at 2:30pm revealed a bubble card containing 9 tablets of Acetazolamide 250mg. Refer to interview with the medication aide (MA) on 03/21/23 at 9:30am Refer to interview with a second MA on 03/21/23 at 9:50am. Refer to telephone interview with the facilty's contracted pharmacist on 03/21/23 at 10:05am Refer to interview with the Resident Care Coordinator (RCC) 03/21/23 at 11:00am and 03/22/23 at 9:00am. Refer to interview with the Building Manager 03/22/23 at 10:05am Refer to interview with the Administrator/Owner	D 358		

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D 358	Continued From page 67 on 03/22/23 at 10:55am. Refer to interview with the Primary Care Provider (PCP) on 03/22/23 at 11:30am. b. Review of Resident #4's physician order dated 03/01/23 revealed: -There was an order for Besivance 0.6% suspension, place 1 drop in right eye three times daily at 8:00am, 12:00pm and 8:00pm. (Besivance is an antibiotic used to treat eye infection). Review of Resident #4's March 2023 eMAR revealed: -There was an entry for Besivance 0.6% suspension, place 1 drop in right eye three times daily at 8:00am, 12:00pm and 8:00pm. -There was documentation that Besivance 0.6% suspension was not administered at 8:00am on 03/04/23, 03/08/23 due to the resident being out of the facility for dialysis. -There was documentation that Besivance 0.6% suspension was not administered at 12:00pm on 03/02/23, 03/04/23, 03/08/23, 03/11/23, 03/18/23 due to the resident being out of the facility for dialysis. Refer to interview with the MA on 03/21/23 at 9:30am Refer to interview with a second MA on 03/21/23 at 9:50am. Refer to telephone interview with the facilty's contracted pharmacist on 03/21/23 at 10:05am Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am	D 358		

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Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

c. Review of Resident #4's medication order dated 11/09/22 revealed there was an order for Breo Ellipta 100-25mcg, inhale 1 puff every day at 8:00am. (Breo Ellipta is a medication used to treat shortness of breath caused by lung disease).

Review of Resident #4's January 2023 eMAR revealed:
-There was an entry for Breo Ellipta 200-25 mcg INH, 1 puff every day for 28 days.
-There was documentation Breo Ellipta 200-25 mcg INH, 1 puff every day for 28 days was discontinued.

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for Breo Ellipta 200-25 mcg, inhale 1 puff every day at 8:00am.
-There was documentation that Breo Ellipta 200-25 mcg was not administered at 8:00am on 02/02/23, 02/07/23 due to the resident being out of the facility at dialysis.
-There was documentation that Breo Ellipta 200-25mcg was not administered at 8:00am on 02/24/23 due to Resident #4 being out of the facility at the hospital.
-There was documentation that Resident #4 was out of the facility from 02/24/23 to 03/01/23 at the hospital.

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D 358	Continued From page 69 Review of Resident #4's March 2023 eMAR revealed: -There was an entry for Breo Ellipta 200-25 mcg, inhale 1 puff every dat at 8:00am. -There was documentation that Breo Ellipta 200-25mcg was not administered at 8:00am on 03/04/23 due to the resident being out of the facility at dialysis. -There was documentation that Breo Ellipta 200-25 mcg was not administered at 8:00am on 03/08/23 due to resident being out of the facility having a procedure done. Observation of Resident #4's medications on hand on 03/21/23 at 2:30pm revealed Breo Ellipta 200-25mcg with a count of 25 puffs left. Refer to interview with the MA on 03/21/23 at 9:30am Refer to interview with a second MA on 03/21/23 at 9:50am. Refer to telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05am Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am Refer to interview with the Building Manager 03/22/23 at 10:05am Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am. Refer to interview with the PCP on 03/22/23 at 11:30am. d. Review of Resident #4's medication order dated 11/09/22 revealed there was an order for	D 358		

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Carvedilol (Coreg) 3.125mg, take 1 tablet twice daily at 8:00am and 8:00pm. (Carvedilol is a medication used to treat high blood pressure and heart failure).

Review of Resident #4's discharge hospital visit summary dated 02/27/23 revealed:
-There was an an order to increase Carvedilol 3.125, 4 tablets (12.5mg) two times a day.
-Resident #4 was admitted to the hospital for an abnormal stress test.
-Resident #4's blood pressure was 166/91.
-Resident #4's potassium was 5.2 millimoles per litter ((mmol/L) with a normal range of 3.5-5.0 mmol/L
-Resident #4's phosphorus was 5.3 milligrams per deciliter (mg/dl) with a normal range of 2.5-4.5 mg/dl.

Review of the American Heart Association guidelines regarding blood pressure and potassium levels revealed:
-A normal BP reading was 120/80 (the top number called the systolic number was less than 120 and the bottom number called the diastolic number was less than 80).
-Elevated blood pressure was when the systolic was between 120-129 and diastolic was greater than 80.
-High blood pressure (hypertension) stage 1 was when the systolic was between 130-139 and diastolic was between 80-89.
-High blood pressure (hypertension) stage 2 was when the systolic was 140 or higher or the diastolic 90 or higher.
-High Blood pressure could cause a stroke, vision loss, heart attack/failure and kidney disease/failure.
-Hyperkalemia was a higher than normal level of potassium in the blood.

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-Higher than normal potassium levels in the blood can lead to abnormal heart rhythms.

Review of Resident #4's January 2023 eMAR revealed:
-There was an entry for Carvedilol 3.125mg, 1 tablet twice daily at 8:00am and 8:00pm.
-There was documentation that Carvedilol 3.125mg, 1 tablet was not administered at 8:00am on 01/10/23, 01/17/23, 01/19/23 due to Resident #4 being out of the facility for dialysis.

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for Carvedilol 3.125mg, 1 tablet twice daily at 8:00am and 8:00pm.
-There was documentation that Carvedilol 3.125mg, 1 tablet was not administered at 8:00am on 02/02/23, 02/07/23 due to Resident #4 being out of the facility for dialysis.
-There was documentation that Carvedilol 3.125mg was not administered at 8:00am on 02/24/23 due to Resident #4 being out of the facility at the hospital.
-There was documentation that Resident #4 was out of the facility at the hospital from 02/24/23 to 03/01/23.

Review of Resident #4's March 2023 eMAR revealed:
-There was an entry for Carvedilol 3.125mg, 1 tablet twice daily at 8:00am and 8:00pm.
-There was no entry for Carvedilol 3.125, 4 tablets (12.5mg) a day.
-There was documentation Carvedilol 3.125, 1 tablet was administered at 8:00am on 03/02/23, 03/03/23, 03/05/23, 03/07/23 and 03/09/23 through 03/20/23.
-There was documentation Carvedilol 3.125mg. 1 tablet was administered at 8:00pm on 03/01/23

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through 03/19/23.
-There was documentation that Carvedilol 3.125mg, 1 tablet was not administered at 8:00am on 03/04/23 due to Resident #4 being out of the facility at dialysis.
-There was documentation that Carvedilol 3.125mg, 1 tablet was not administered at 8:00am on 03/08/23 due to Resident #4 being out of the facility having a procedure done.

Observation of Resident #4's medications on hand on 03/21/23 at 2:30pm revealed a bubble card containing 50 tablets of Carvedilol 3.125mg.

Telephone interview with the facility's contracted pharmacist on 03/22/23 at 9:30am revealed:
-The current order for Carvedilol was 3.125mg., 1 tablet two times daily.
-Carvedilol 3.125mg was last dispensed on 03/20/23 for 43 tablets.
-The pharmacy did not receive an order from the facility for Carvedilol 3.125, 4 tablets a day.

Interview with the PCP on 03/22/23 at 11:30am revealed Resident #4 could experience a hypertensive crisis (a sudden and severe increase in high blood pressure) that could cause him to be hospitalized if he did not receive his blood pressure medication as ordered..

Refer to interview with the MA 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with the facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am

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D 358	Continued From page 73 Refer to interview with the Building Manager 03/22/23 at 10:05am Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am. e. Review of Resident #4's medication order dated 11/29/22 revealed there was an order for Clonidine 0.1mg, take 1 tablet every morning and at bedtime at 8:00am and 8:00pm. (Clonidine is a medication used to treat high blood pressure). Review of Resident #4's January 2023 eMAR revealed: -There was an entry for Clonidine 0.1 mg, 1 tablet every morning and at bedtime at 8:00am and 8:00pm. -There was documentation that Clonidine 0.1mg, 1 tablet was not administered at 8:00am on 01/10/23, 01/17/23, 01/19/23 due to Resident #4 being out of the facility at dialysis. Review of Resident #4's February 2023 eMAR revealed: -There was an entry for Clonidine 0.1mg, 1 tablet every morning and at bedtime at 8:00am and 8:00pm. -There was documentation that Clonidine 0.1mg, tablet was not administered at 8:00am on 02/02/23, 02/07/23 due to Resident #4 being out of the facility for dialysis. -There was documentation that Clonidine 0.1mg, 1 tablet was not administered on 8:00am 02/04/23, 02/05/23, 02/08/23, 02/15/23 02/16/23, 02/19/23, 02/21/23, and 02/23/23 due to awaiting prescription authorization from physician. -There was documentation Clonidine 0.1mg, 1 tablet was not administered on 8:00pm on 02/24/23 due to Resident #4 being out of the	D 358		

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facility at the hospital.
-There was documentation that Resident #4 was out of the facility at the hospital from 02/24/23 to 03/01/23.

Review of Resident #4's March 2023 eMAR revealed:
-There was an entry for Clonidine 0.1mg, 1 tablet every morning and at bedtime at 8:00am and 8:00pm.
-There was documentation Clonidine 0.1mg, 1 tablet was not administered at 8:00am on 03/04/23 due to Resident #4 being out of the facility for dialysis.
-There was documentation Clonidine 0.1mg, 1 tablet was not administered at 8:00pm on 03/04/23, 03/05/23, 03/06/23, 03/08/23, 03/09/23 due to awaiting prescription authorization from physician.

Interview with the PCP on 03/22/23 at 11:30am revealed Resident #4 could experience a hypertensive crisis (a sudden and severe increase in high blood pressure) that could cause him to be hospitalized if he did not receive his blood pressure medication as ordered.

Refer to interview with the MA 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am

Refer to interview with the Building Manager 03/22/23 at 10:05am

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MORNING STAR ASSISTED LIVING #5	416 NORTH PARKER STREET ELM CITY, NC 27822

(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
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Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

f. Review of Resident #4's medication order dated 11/09/22 revealed there was an order for Dorzol-Timolol Eye Drops, 1 drop to both eyes twice daily. (Dorzol/Timolol is an eye drop used to treat eye conditions that can lead to loss of vision.

Review of Resident #4's medication order dated 01/16/23 revealed there was an order Dorzol/Timolol Eye Drops, 1 drop to both eyes twice daily, at 8:00am and 8:00pm.

Review of Resident #4's January 2023 eMAR revealed:
-There was an entry for Dorzol/Timolol Eye Drops, 1 drop to both eyes twice day at 8:00 and 8:00pm.
-There was documentation that Dorzol/Timolol Eye drops, 1 drop to both eyes was not administered at 8:00am on 01/10/23, 01/17/23, 01/19/23 due to Resident #4 being out of the facility for dialysis.

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for Dorzol/Timolol Eye Drops, 1 drop to both eyes twice a day at 8:00am and 8:00pm.
-There was documentation that Dorzol/Timolol Eye drops, 1 drop to both eyes was not administered at 8:00am on 02/02/23, 02/07/23, 02/11/23 due to resident being out of the facility for dialysis.
-There was documentation Dorzol/Timolol Eye Drops, 1 drop was not administered at 8:00am on 02/24/23 due to the resident being out of the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 76 facility at the hospital. -There was documentation Resident #4 was out of the facility at the hospital on 02/24/23 through 03/01/23. Review of Resident #4 March 2023 eMAR revealed: -There was an entry for Dorzol/Timolol Eye Drops, 1 drop to both eyes twice a day at 8:00am and 8:00pm. -There was documentation that that Dorzol/Timolol Eye drops, 1 drop to both eyes was not administered at 8:00am on 03/04/23 due to the resident being out of the facility for dialysis. -There was documentation that Dorzol/Timolol Eye drops, 1 drop to both eyes was not administered at 8:00am on 03/08/23 due to the resident being out of the facility having a procedure done. -There was documentation that the Dorzol/Timolol Eye droops, 1 drop to both eyes was not administered at 8:00am on 03/09/23 due to awaiting prescription authorization from physician. Observation of Resident #4's medications on hand on 03/21/23 at 2:30pm revealed 2 small bottles of Dorzol/Timolol Eye Drops. Refer to interview with the MA on 03/21/23 at 9:30am Refer to interview with a second MA on 03/21/23 at 9:50am. Refer to telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05am Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am	D 358		

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Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

g. Review of Resident #4's medication order dated 11/09/22 revealed there was an order for Isosorbide-Hydralazine 20-37.5, 1 tablet three times daily at 8:00am, 12:00pm, and 8:00pm. (Isosorbide-Hydralazine is a medication used to treat high blood pressure and heart failure).

Review of Resident #4's January 2023 eMAR revealed:
-There was an entry for Isosorbide-Hydralazine 20-37.5, 1 tablet three times daily at 8:00am, 12:00pm, and 8:00pm.
-There was documentation Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered at 8:00am on 01/10/23, 01/17/23, 01/19/23 due to the resident being out of the facility for dialysis.
-There was documentation Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered at 12:00pm on 01/03/23, 01/05/23, 01/07/23, 01/12/23, 01/16/23, 01/17/23, 01/19/23, 01/21/23, 01/24/23, and 01/31/23 due to the resident being out of the facility for dialysis.

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for Isosorbide-Hydralazine 20-37.5, 1 tablet three times daily at 8:00am, 12:00pm, and 8:00pm.
-There was documentation

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Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered at 8:00am on 02/02/23, 02/07/23 due to the resident being out of the facility for dialysis.
-There was documentation Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered at 12:00pm on 02/02/23, 02/04/23, 02/07/23, 02/11/23, 02/16/23, 02/18/23, 02/22/23 due to the resident being out of the facility at dialysis.
-There was documentation Isosorbide-Hydralazine 20-375, 1 tablet was not administered at 8:00am on 02/20/23 due to the resident being out of the facility having surgery.
-There was documentation Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered at 8:00am due to the resident being out of the facility at the hospital.
-There was documentation Resident #4 was out of the facility at the hospital from 02/24/23 to 03/01/23.

Review of Resident #4's March 2023 eMAR revealed:
-There was an order for Isosorbide-Hydralazine 20-37.5, 1 tablet three times daily at 8:00am, 12:00pm, and 8:00pm.
-There was documentation Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered to Resident #4 at 8:00am on 03/04/23 due to the resident being out of the facility having a procedure done.
-There was documentation Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered to Resident #4 at 12:00pm on 03/02/23, 03/04/23, 03/11/23, 03/18/23 due to the resident being out of the facility at dialysis.
-There was documentation Isosorbide-Hydralazine 20-37.5, 1 tablet was not administered to Resident #5 at 8:00am on

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03/08/23 due to the resident being out of the facility having a procedure done.

Observation of Resident #4's medications on hand on 03/21/23 at 2:30pm revealed bubble cards containing 53 tablets of Isosorbide-Hydralazine 20-37.5.

Interview with the PCP on 03/22/23 at 11:30am revealed Resident #4 could experience a hypertensive crisis (a sudden and severe increase in high blood pressure) that could cause him to be hospitalized if he did not receive his blood pressure medication as ordered.

Refer to interview with MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with the facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

h. Review of Resident #4's hospital visit summary report dated 02/27/23 revealed there was an order for Lokelma 10gm powder packet, take 1 packet every day for hyperkalemia (high potassium) at 8:00am. (Lokelma is a medication used to treat high potassium levels in the blood).

Review of Resident #4's March 2023 eMAR

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revealed:
There was an entry for Lokelma 10gm powder packet, take 1 packet every day for hyperkalemia (high potassium) at 8:00am.
-There was documentation Lokelma 10gm power packet, 1 packet was not administered at 8:00am on 03/13/23 because awaiting prescription authorization from physician.

Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

i. Review of Resident #4's medication order dated 11/09/22 revealed there was an order for Sevelamer Carbonate 800 mg, take 3 tablets (2400) three times daily with meals at 8:00am, 12:00pm, and 5:00pm. (Sevelamer Carbonate is a medication used to treat high potassium levels in individuals with chronic kidney disease or individuals receiving hemodialysis).

Review of a physician visit report dated 03/15/23

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D 358	Continued From page 81 revealed an order for Sevelamer Carbonate 800mg, 3 tablets (2400mg) three times a day with meals. Review of Resident #4's January 2023 eMAR revealed: -There was an entry for Sevelamer Carbonate 800mg, 3 tablets (2400) three times daily with meals at 8:00am, 12:00pm, and 5:00pm. -There was documentation Sevelamer Carbonate 800mg, 3 tablets (2400) was not administered at 8:00am on 01/10/23, 01/17/23, and 01/19/23 due to the resident being out of the facility for dialysis. -There was documentation Sevelamer Carbonate 800mg, 3 tablets (2400) was not administered at 12:00pm on 01/03/23, 01/05/23, 01/12/23, 01/17/23, 01/19/23, 01/21/23, 01/24/23, and 01/31/23 due to the resident being out of the facility for dialysis. Review of Resident #4's February 2023 eMAR revealed: -There was an entry for Sevelamer Carbonate 800mg, 3 tablets (2400) three times daily with meals at 8:00am, 12:00pm, and 5:00pm. -There was documentation Sevelamer Carbonate 800mg, 2 tablets (2400mg) was not administered at 8:00am on 02/02/23, and 02/07/23 due to the resident being out of the facility for dialysis. -There was documentation Sevelamer Carbonate 800mg, 2 tablets (2400mg) was not administered at 8:00am on 02/24/23 due to the resident being out of the facility at the hospital. -There was documentation Resident #4 was out of the facility at the hospital from 02/24/23 through 03/01/23. Review of Resident #4's March 2023 eMAR revealed: -There was an entry for Sevelamer Carbonate	D 358		

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800mg, 3 tablets (2400) three times daily with meals at 8:00am, 12:00pm, and 5:00pm.
-There was documentation Sevelamer Carbonate 800mg, 3 tablets (2400) was not administered at 8:00am at 03/04/23, 03/08/23 due to the resident being out of the facility at the dialysis.
-There was documentation Sevelamer Carbonate 800mg, 3 tablets (2400) was not administered at 12:00pm on 03/02/23, 03/04/23, 03/11/23, 03/18/23 due to the resident being out of the facility at dialysis.

Observation of Resident #4's medications on hand on 03/21/23 at 2:30pm revealed bubble cards containing 66 tablets of Sevelamer Carbonate 800mg.

Refer to interview with the MA on 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with the facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Refer to interview with the PCP on 03/22/23 at 11:30am.

j. Review of Resident #4's medication order dated 11/29/22 revealed there was an order for Abilify

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Maintena ER 300mg VL, inject 300mg IM every month (no scheduled day). (Abilify is a medication used to treat schizophrenia, bipolar disorder, and depression).

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for Abilify Maintena ER 300mg VL, inject 300mg IM every month.
-There was no documentation that Abilify Maintena ER 300mg VL was administered in February 2023.
-There was documentation that Resident #4 was out of the facility from 02/24/23 to 03/01/23 at the hospital.

Interview with the RCC on 03/21/23 at 7:55am revealed:
-Resident #4's mental health provider usually administered his Abilify medication.
-Resident #4 was out of the facility and at the hospital in February when the mental health provider came to give him his Abilify injection.
-She did not contact the mental health provider when Resident #4 was discharged from the hospital on 02/27/23 to reschedule the February Abilify injection.
-Resident #4 was out of the facility from 02/24/23 through 02/27/23.

Interview with the Administrator on 03/22/23 at 10:55am revealed she expected the RCC to notify the mental health provider when Resident #4 was discharged from the hospital to schedule his February Ability injection.

Interview with the PCP on 03/22/23 at 11:30am revealed:
-She was not aware that Resident #4 did not receive his February Abilify injection due to the

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resident being in the hospital from 02/24/23 to 02/27/23.
-She became aware that the resident did not receive his February Abilify injection when she came to the facilty on 03/15/23 for her weekly visit.
-The Abilify injection was usually administered by the mental health provider.
-The Abilify medication was in the facility and the PCP administered Resident #4's Abilify on 03/15/23.
-It was concerning that Resident #4 missed his February Abilify injection because dialysis reported the resident exhibited aggressive behaviors at dialysis in February, that could result in him being discharged from the dialysis facility that could lead to a poor prognosis for the resident.
-The resident had been banned from other dialysis facilities due to his behaviors.

k. Review of Resident #4's physician medication report dated 11/09/22 revealed an order for Lipitor 40mg, 1 tablet at bedtime. (Lipitor is a medication used to treat high cholesterol levels in the blood and may reduce the risk of angina, stroke, heart attack and heart and blood vessel problems).

Review of Resident #4's hospital discharge summary dated 02/27/23 revealed there was an order to increase Lipitor 40mg, 2 tablets (80mg) at bedtime.

Review of Resident #4's January 2023 e MAR revealed there was an entry for Lipitor 40mg, 1 tablet at bedtime.
-There was an entry for Lipitor 40mg, 1 tablet at bedtime.
-There was documentation Resident #4 Lipitor 40mg, 1 tablet was administered from 01/01/23

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thorough 1/31/23.

Review of Resident #4's February 2023 eMAR revealed:
-There was an entry for Lipitor 40mg, 1 tablet at bedtime.
-There was documentation Lipitor 40mg, 1 tablet was administered at 10:00pm from 02/01/23 through 02/23/23.
-There was documentation Resident #4 was out of the facility at the hospital from 02/24/23 through 03/01/23.

Review of Resident #4's March 2023 eMAR revealed:
-There was an entry for Lipitor 40mg, 1 tablet at bedtime to be administered at 10:00pm.
-There was no entry for Lipitor 40mg, 2 tablets (80mg) at bedtime.
-There was documentation Lipitor 40mg, 1 tablet was administered on 03/02/23, 03/03/23, 03/07/23, 03/10/23, 03/11/23, 03/12/23, 03/14/23 through 03/19/23.
-There was documentation Lipitor 40mg, 1 tablet was not administered on 03/04/23, 03/05/23, 03/08/23, 03/09/23 and 03/13/23 due to prescription/MD prior authorization.

Interview with the facility contracted pharmacist on 03/22/23 at 9:30am revealed:
-The current order on file for Resident #4 was Lipitor 40mg, 1 tablet daily at bedtime.
-The last dispense date for Lipitor 40mg was 03/13/23 for 30 tablets.
-The pharmacy did not receive a medication order from the facility for Lipitor 40mg, 2 tablets (80mg) daily.

Observations of Resident #4's medications on hand on 03/21/23 at 2:30pm revealed a bubble

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card containing 24 tablets of Lipitor 40mg.

Refer to interview with the MA 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with the facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

Interview with the PCP on 03/22/12 at 11:30am.

I. Review of Resident #4's hospital discharge summary dated 02/27/23 revealed there was a new medication order for Aspirin 81mg, 1 tablet daily. (Aspirin is a medication that can treat pain, fever, headache, and inflammation. It can also reduce the risk of heart attack and stroke).

Review of Resident #4's March 2023 eMAR revealed there was no entry for Aspirin 81mg, 1 tablet daily.

Telephone interview with the facility's contracted pharmacist on 03/22/23 at 9:30am revealed the pharmacy did not receive an order for Aspirin 81mg, 1 tablet from the facility.

Observations of Resident #4's medications on hand on 03/21/23 at 2:30pm revealed there was no Aspirin 81mg in the medication cart for the

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	HAL098031	A. BUILDING: ______ B. WING ______	R 03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR ASSISTED LIVING #5	416 NORTH PARKER STREET ELM CITY, NC 27822

(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
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resident.

Refer to interview with the MA 03/21/23 at 9:30am

Refer to interview with a second MA on 03/21/23 at 9:50am.

Refer to telephone interview with the facilty's contracted pharmacist on 03/21/23 at 10:05am

Refer to interview with the RCC 03/21/23 at 11:00am and 03/22/23 at 9:00am

Refer to interview with the Building Manager 03/22/23 at 10:05am

Refer to interview with the Administrator/Owner on 03/22/23 at 10:55am.

____

Interview with MA on 03/21/23 at 9:30am revealed:
-Resident #4 went to dialysis "around" 6:00am on Tuesday, Thursday, and Saturday.
-The night shift was responsible for getting Resident #4 dressed and serving him an early breakfast.
-There were no medications administered to Resident #4 before dialysis.

Interview with a second MA on 03/21/23 at 9:50am revealed:
-Resident #4 went to dialysis at 6:00am in the morning on Tuesday, Thursday, and Saturday.
-The night shift was responsible for getting him up and dressed, serving him breakfast and getting him ready to be picked up by the county van.
-Sometimes the night shift administered his 8:00am medications.

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D 358	Continued From page 88 Telephone interview with facilty's contracted pharmacist on 03/21/23 at 10:05 am revealed: -The pharmacist entered residents' medications and times of administration in the system and sends them to the facility for approval. -The facility was responsible for approving the times the medications were administered or making changes regarding the times to suit the needs of the resident. -The pharmacy did not know the times of dialysis sessions for the residents at the facility who were scheduled for dialysis. Interview with the RCC on 03/21/23 at 11:00am and 03/22/23 at 9:00am revealed: -She was not aware Resident #4 was not receiving his 8:00am and 12:00pm medications due to early dialysis sessions. -The facility did not have a medication administration policy or protocol for residents who go to dialysis. -Medication orders from the dialysis facility were submitted directly to pharmacy for processing. -The pharmacist entered the medication orders and times of administration in the system and sends the orders to the facility for review and approval. -The facilty did not make changes to the times of administration of medications for residents. Interview with the Building Manager 03/22/23 at 10:05am revealed: -The eMAR system did not allow a medication to "pop up" to be administered until an hour before the scheduled administration time. -He expected the MA's to have caught that Resident #4 was not getting his medications at 8:00 am before dialysis and inform the RCC and the Building Manager. -He expected the RCC to notify the PCP for	D 358		

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clarification on how to handle the 8:00am and 12:00pm medications for Resident #4 on dialysis days.

Interview with the Administrator/ Owner on 03/22/23 at 10:55am revealed:
-She was not aware Resident #4 went to dialysis three times a week and was not receiving his 8:00am and 12:00pm medications.
-She expected the RCC to reach out to the PCP for clarification.
-It was a major concern that Resident #4 did not receive his 8:00am and 12:00pm medications because it could cause other health problems.

Interview with the primary care provider on 03/22/23 at 11:30am revealed:
-She was not aware Resident #4 was scheduled for dialysis at 6:00am and was not receiving his 8:00am and 12:00pm medications as ordered.
-Had the facility reached out to her regarding the time of dialysis, she could have adjusted the medication administration times.

Attempted telephone interview with the Mental Health Provider on 03/22/23 at 9:00am was unsuccessful.

Attempted telephone interview with Resident #4's Nephrologist on 03/22/23 at 03/22/23 at 9:15am was unsuccessful.

4. Review of Resident #5's current FL2 dated 11/02/23 revealed:
-Diagnoses included dementia, pain in joints, muscle weakness, and muscle spasms.
-There was an order for for levothyroxine 137 mcg to be administered Monday through Saturday.
-There was an order for for levothyroxine 137

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mcg, on half tab (68.5 mcg to be administered on Sunday.

Review of Resident #7's a signed signed physician's order dated 11/10/23 revealed Levothyroxine was to be increased to 137mcg every day on the morning on an empty stomach.

Review of Resident #7's electronic medication administration record (eMAR) for January 2023 revealed:
-There was an entry for levothyroxine 137mcg to be administered every morning on an empty stomach and timed for 9:00am.
-There was documentation of administration each day from 01/01/23 through 01/31/23.

Review of Resident #7's electronic medication administration record (eMAR) for February 2023 revealed:
-There was an entry for levothyroxine 137mcg to be administered every morning on an empty stomach and timed for 9:00am.
-There was documentation of administration each day from 02/01/23 through 02/28/23.

Review of Resident #7's electronic medication administration record (eMAR) for March 2023 revealed:
-There was an entry for levothyroxine 137 mcg to be administered every morning on an empty stomach and timed for 9:00am.
-There was documentation of administration each day from 03/01/23 through 03/20/23.

Observation of medication on hand for administration for Resident #7 on 03/20/23 4:34pm there was a medication dispensing card labeled for Levothyroxine 137mcg to be administered each morning on an empty stomach

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D 358	Continued From page 91 with tablets available for administration. Telephone interview with the facility's contracted pharmacy on 03/21/23 at 9:57am revealed: -Levothyroxine should be given on an empty stomach 30 minutes to 60 minutes prior to breakfast an other medications. -Levothyroxine can bind to food or other medications making it less effective. Interview with a medication aide (MA) on 03/20/23 at 1:35pm revealed: -She knew the levothyroxine was to be administered on an empty stomach as instructed. -The Levothyroxine was on the eMAR to be given at 9:00am and the residents were served breakfast was around 7:30am. -She had not brought the time of administration to the attention of management or Resident #7's primary care provider. Interview with Resident #7's primary care provider (PCP) on 03/22/23 at 11:37am revealed: -Levothyroxine should be given on an empty stomach because food will decrease the absorption of the medication. -She had difficulty managing Resident #7's thyroid stimulating hormone (TSH) level and had referred him to endocrinology for evaluation. -Receiving the levothyroxine after breakfast could have been a contributing factor to being unable to manage his TSH level. Interview with the Resident Care Coordinator (RCC) on 03/21/23 at 5:08pm revealed: -Residents were served breakfast between 7:00am and 8:00am each morning. -She was not aware the levothyroxine for Resident #7 was timed to be given after breakfast instead of before as ordered.	D 358		

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____
The facility failed to administer medications as ordered for 2 of 3 residents (#5, #8) observed during the medication pass including a medication used for thyroid function support that was not administered on an empty stomach as ordered and resulted in an endocrinology referral by the PCP due to difficulty in regulating the resident's stimulating thyroid hormone (#5) and 2 of 6 sampled residents (#3, #4) who received dialysis three times a week, as evidenced by their scheduled 8:00am and 12:00pm medications not being administered as ordered on dialysis days due to the residents leaving the facility at 6:00am; including medications used to treat low blood pressure during dialysis, high levels of potassium in the blood (hyperkalemia) due to kidney failure, high levels of phosphorus in the blood due to kidney failure, shortness of breath, pain, and fluid retention, (#3) and medications used to treat an eye condition that can cause vision loss, an antibiotic for eye infection, depression, shortness of breath, heart failure, high levels of potassium in the blood due to kidney failure, schizophrenia, and depression for a resident with significant vision loss and high blood pressure (#4). This failure placed the residents at serious physical harm and constitutes a A2 Violation.
____
The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 03/21/23.

THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 21, 2023.