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CADENCE GARNER	**200 MINGLEWOOD DRIVE GARNER, NC 27529**

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 8-9, 2023.	D 000		
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 B VIOLATION Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 2 of 5 residents (#6, #7) observed during the medication pass, including a medication used to treat high blood pressure and chest pain, a supplement used to prevent/treat urinary tract infection (#6), a dietary supplement, and a medication used to reduce the risk of a stroke and a heart attack (#7); and 1 of 5 sampled residents for record review (#2) including a medication used to treat mental and mood disorders (#2). The findings are: The medication error rate was 12% as evidenced by the observation of 4 errors out of 31 opportunities during the medication pass on 03/08/23.	D 358		

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1. Review of Resident #6's current FL-2 dated 11/23/22 revealed:
-Diagnoses included urinary tract infection, dementia, and hypertension.
-The level of care was the memory care unit.
-She was constantly disoriented.

a. Review of a physician visit progress note dated 03/06/23 revealed an order for Amlodipine 10mg daily. (Amlodipine is a medication used to treat high blood pressure and chest pain).

Observation of Resident #6's 7:00am medication pass on 03/08/23 revealed:
-Amlodipine 5mg was administered instead of 10mg as ordered at 9:35am.
-The bubble card dated 03/01/23 contained Amlodipine 5 mg, 1 tablet daily with 26 remaining out of 31 tablets.

Review of Resident #6's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Amlodipine Besylate 10mg, 1 tablet once daily to be administered at 7:00am.
-There was documentation that Amlodipine Besylate 10mg, 1 tablet was administered on 03/08/23 at 9:35am.

Interview with the facility's contracted pharmacist on 03/09/23 at 2:50pm revealed:
-This pharmacy was the facility's current contracted pharmacy starting 03/01/23.
-There was an order for Amlodipine 5mg, 1 tablet dated 01/30/ 23.
-There was a new order for Amlodipine 10mg, 1 tablet last dispensed on 02/23/23 for 31 tablets.

Interview with the Special Care Director (SCD) on

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03/08/23 at 4:00pm revealed:
-She normally was not on the medication cart to administer medications in the memory care unit.
-She administered Resident #6's medications at the 7:00am medication pass on 03/08/23.
-She did not notice Resident #6's bubble card contained Amlodipine 5mg instead of 10mg as ordered and displayed on the eMAR.
-She thought she administered Amlodipine 10mg to Resident #6.

A second interview with the SCD on 03/09/23 at 10:30am revealed:
-She later found another bubble card in the medication cart for Resident #6 for Amlodipine 10mg, 1 tablet daily, which was the correct dose.
-The Amlodipine 5mg bubble card should have been removed from the medication cart.

Interview with the RSD (Resident Services Director) on 03/08/23 at 4:30pm revealed:
-She was responsible for conducting medication cart audits weekly.
-Medication cart audits included ensuring medications had not expired, and checking the bubble cards against the eMAR for accuracy.
-She did not know why the Amlodipine 5mg bubble card had not been caught and removed from the medication cart.

Interview with the Executive Director (ED) on 03/09/23 at 5:00pm revealed:
-Amlodipine 10mg should have been administered to Resident #6 as ordered.
-The RSD was responsible for conducting medication cart audits and ensuring medication orders were accurate, including the correct dose.

Interview with the primary care provider (PCP) on 03/09/23 at 11:10 revealed:

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-The current medication order for Resident #6 was for Amlodipine 10mg, 1 tablet once daily.
-Amlodipine was ordered for Resident #6 because of her hypertension (high blood pressure).
-The incorrect dose of Amlodipine could cause Resident #6's blood pressure to be elevated.

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

b. Review of Resident #6's medication orders dated 02/16/23 revealed an order for D-Mannose 500mg, 4 capsules (2000mg) daily. (D-Mannose is a supplement used to prevent/treat urinary tract infection).

Interview with the facility's contracted pharmacist on 03/09/23 at 2:50pm revealed.
-There was a physician order received on 02/16/23 for D-Mannose 500mg, 4 capsules (4000mg "pharmacy entry error") daily.
-D-Mannose was last dispensed on 02/20/23 for a quantity of 124 pills.

Observation of Resident #6's 7:00am medication pass on 03/08/23 revealed:
- D-Mannose 500mg, 1 capsule was administered instead of 4 capsules (2000mg) on 03/08/23 at 9:35am.
-There were 4 bubble cards that contained D-Mannose with the instructions to administer 500mg, 4 capsules (4000mg "pharmacy entry error") dated 02/20/23 with a total of 118 of 124 pills remaining.

Review of Resident #6's March 2023 eMAR revealed:
-There was an entry for D-Mannose 500mg, 4

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capsules (4000 mg "pharmacy entry error") once daily for urinary tract infection prevention on 03/08/23 to be administered at 7:00am.
-There was documentation that D-Mannose 500mg, 4 capsules (4000mg "pharmacy entry error") was administered at 7:00am on 03/08/23.

Interview with the SCD (Special Care Director) on 03/08/23 at 4:00pm revealed:
-She normally was not on the medication cart to administered medications.
-She administered Resident #6's 7:00am medications on 03/08/23.
-She had not noticed the instructions on the eMAR and bubble card was for D-Mannose 500mg, 4 capsules.
-She administered D-Mannose 500mg, 1 tablet to Resident #6.

Interview with the RSD (Resident Services Director) on 03/09/23 at 4:30pm revealed D-Mannose 500mg, 4 tablets should have been administered to Resident #6.

Interview with the Executive Director (ED) on 03/09/23 at 5:00pm revealed D-Mannose 500mg, 4 tablets should have been administered to Resident #6 as ordered.

Interview with the primary care provider on 03/09/23 at 2:50pm revealed.
-She wrote an order for D-Mannose 500mg, 4 capsules daily (2000mg) for Resident #6 in February 2023 for urinary tract infection.
-She expected 4 capsules to be administered to Resident #6 instead of the 1 capsule because the resident was prone to urinary tract infections and the D-Mannose was prescribed as a prophylactic to prevent urinary tract infections.
-The lower dose of D-Mannose could cause

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Resident #6 to have a higher risk of developing a urinary tract infection.

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

2. Review of Resident #7's current FL-2 dated 01/29/23 revealed:
-Diagnoses included dementia/Alzheimer's, hypertension, stroke, and high cholesterol.
-The level of care was the memory care unit.
-She was constantly disoriented.

a. Review of a physician visit progress note dated 01/23/23 revealed an order for Cyanocobalamin (Vitamin B-12) 100mcg, take 1/2 tablet (50mcg) daily. (Cyanocobalamin (Vitamin B-12) is used as a dietary supplement).

Review of Resident #7's hospital discharge summary dated 01/29/23 revealed an order for Cyanocobalamin (Vitamin B-12) 1,000mcg/ml, take 50mcg (0.05ml) daily as needed. (Liquid Form).

Review of a physician visit order dated 01/30/23 revealed an order for Cyanocobalamin (Vitamin B-12) 100mcg, take 1/2 tablet (50mcg) daily.

Observation of Resident #7's 7:00am medication pass on 03/08/23 revealed Cyanocobalamin (Vitamin B-12) 100mcg, 1/2 tablet (50mcg) was not administered when she received her other medications at 9:50am..

Review of Resident #7's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for B-12 1,000 mcg/ml SL

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D 358	Continued From page 6 Liquid, take 50mcg (0.05ml) daily as needed. -There was no documentation that Resident #7 was administered B-12, 50mcg (0.05ml) on 03/08/23 at the 7:00am medication pass. Interview with the pharmacist on 03/09/23 at 2:50pm revealed: -They were the facility's contracted pharmacy starting 03/01/23. -The previous facility's contracted pharmacy sent them the profiles of all residents but not the prescriptions. -There was an order dated 02/03/23 for Vitamin B-12 100mcg, 1/2 tab 50mcg daily. -There was an order dated 02/22/23 for Vitamin B-12 0.05ml/solution as needed. Interview with the Special Care Director (SCD) on 03/08/23 at 4:00pm revealed: -Resident #7 had some recent hospital stays in January 2023. -Vitamin B-12 was discontinued on the hospital discharge summary as a scheduled daily medication and ordered as needed with no paremeters. -The hospital discharge summary order was sent to the facility's contracted pharmacy to be processed and placed on the eMAR. -The hospital discharge summary was placed in a folder for the Resident #7's primary care provider (PCP) for review when she visited the facility once a week to approve the changes in medications on the hospital discharge summary or to reinstate the previous order. -The PCP order dated 01/30/23 for Cyanocobalamin (Vitamin B-12) 100mcg, 1/2 tablet (50mcg) was not submitted to the facility's contracted pharmacy for processing. -She did not know why the PCP order dated 01/30/23 was not sent to pharmacy.	D 358		

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-She and the Resident Services Director (RSD) were responsible for ensuring orders were sent to the pharmacy for processing.

Interview with the RSD (Resident Services Director) on 03/08/23 at 4:30pm revealed:
-Resident #7 had some hospital stays in January 2023.
-The hospital visit summary included some medication changes for the resident.
-Resident #7's Vitamin B-12 was changed to as needed instead of a scheduled medication as previously ordered by the PCP.
-The process was for the PCP to review the hospital orders on her next visit to the facility to approve the changes or reinstate the previous order.
-The PCP visit medication order dated 01/30/23 was not sent to the pharmacy for processing.
-She did not why the order was not sent.
-The SCD or the RCD were responsible for ensuring medication orders were sent to pharmacy for processing.

Interview with the Executive Director on 03/09/23 at 5:00pm revealed:
-When a resident's discharge hospital summary had a change in a medication, the order was sent to the facility's contracted pharmacy for processing and becomes the active order until the PCP comes in and approves the changes or reinstate the previous order.
-The PCP visit progress note dated 01/30/23 reinstating Resident #7's for Vitamin B-12 to a scheduled medication should have been faxed to the facility's contracted pharmacy for processing and to be placed on the eMAR.
-The RSD and the SCD were responsible for ensuring medication orders were faxed to the pharmacy for processing.

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Interview with Resident #7's primary care provider (PCP) on 03/09/23 at 11:10pm revealed:
-She prescribed Cyanocobalamin (Vitamin B-12) 100mcg, 1/2 tablet (50mcg) for Resident #7 based on a review of her laboratory values for Vitamin B-12.
-Resident #7 should be receiving Cyanocobalamin (Vitamin B-12) 100mcg, 1/2 tablet (50-mcg) once a day as a scheduled dietary supplement.

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

b. Review of Resident #7's physician visit progress note dated 01/23/23 revealed an order for Aspirin 81mg chewable, 1 tablet daily. (Aspirin is a medication used to reduce the risk of a stroke or heart attack).

Review of Resident #7's hospital visit report dated 01/29/23 revealed an order for Aspirin 81mg chewable, 1 tablet as needed.

Review of Resident 7's physician visit progress note dated 01/30/23 revealed an order for Aspirin 81mg chewable, 1 tablet daily.

Observation of the 7:00am medication pass on 03/08/23 revealed Aspirin 81mg chewable was not administered to Resident #7 when she received her other medications at 9:50am.

Review of Resident #7's March 2023 eMAR revealed:
-There was an entry for Aspirin 81mg chewable tablet, chew and swallow 1 tablet once daily as needed.

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-There was no documentation that Aspirin 81mg, 1 tablet was administered to Resident #7 on 03/08/23 when she received her other medications.

Interview with the facility's contracted pharmacist on 03/09/23 at 2:50pm revealed:
-They were the facility's contracted pharmacy starting 03/01/23.
-They received the profiles of residents from the previous facilty's contracted pharmacy but not the prescriptions.
-There was an order dated 01/29/23 for Aspirin 81mg chewable as needed from the hospital physician.
-They did not receive an order for Aspirin 81mg chewable tablet, 1 tablet daily dated 01/30/23 from Resident 7's physician.

Interview with the Special Care Director (SCD) on 03/08/23 at 4:00pm revealed:
-Resident #7 had some recent hospital stays in January 2023.
-Aspirin 81mg daily was discontinued on the hospital discharge summary as a scheduled daily medication and ordered as needed.
-The hospital discharge summary order was sent to the facility's contracted pharmacy to be processed and placed on the eMAR.
-The hospital discharge summary was placed in a folder for the Resident #7's primary care provider (PCP) for review when she visited the facility once a week to approve the changes in medications on the discharge summary or to reinstate the previous order.
-The PCP order dated 01/30/23 for Aspirin 81mg daily was not submitted to the facility's contracted pharmacy for processing.
-She did not know why the PCP order dated 01/30/23 was not sent to pharmacy.

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-She and the Resident Services Director (RSD) were responsible for ensuring orders were sent to the pharmacy for processing.

Interview with the RSD on 03/08/23 at 4:30pm revealed:
-Resident #7 had some hospital stays in January 2023.
-The hospital visit summary may include some medication changes for the resident.
-Resident #7's Aspirin 81mg daily was changed to as needed instead of a scheduled medication as previously ordered by the PCP.
-The process was for the PCP to review the hospital orders on her next visit to the facility to approve the changes or reinstate the previous order.
-The PCP visit medication order dated 01/30/23 was not sent to the pharmacy for processing.
-She did not why the order was not sent.
-The SCD or she were responsible for ensuring medication orders were sent to pharmacy for processing.

Interview with the Executive Director (ED) on 03/09/23 at 5:00pm revealed:
-When a resident's discharge hospital summary have a change in medications, the order was sent to the facility's contracted pharmacy for processing and becomes the active order until the PCP comes in and approve the changes or reinstates the previous order.
-The PCP visit progress note reinstating Resident #7's Aspirin 81mg daily to a scheduled medication should have been faxed to the facility's contracted pharmacy for processing and to be placed on the eMAR.
-The RSD and the SCD were responsible for ensuring medication orders were faxed to the pharmacy for processing.

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Interview with Resident#7's primary care provider (PCP) on 03/09/23 at 11:10am revealed:
-She prescribed Aspirin 81mg chewable, 1 tablet daily for Resident #7 as a scheduled medication.
-Resident #7 should be receiving Aspirin 81mg chewable, 1 tablet daily to reduce the risk of a stroke or heart attack.

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

3. Review of Resident #2's current FL-2 dated 01/01/23 revealed:
-Diagnoses included vascular dementia with behavioral disturbances and hypertension.
-An order for aripiprazole 15mg one half tablet (7.5mg) daily and aripiprazole 2mg daily at bedtime. (Aripiprazole is an antipsychotic used to treat mental and mood disorders.)

Observations of Resident #2's medications on hand on 03/09/23 at 10:47am revealed:
-There was a bubble pack with a pharmacy label that had the resident's name, instructions for "aripiprazole 15mg, one and one half tablets (7.5mg)" every morning.
-The pharmacy label did not indicate that the total dosage of 15mg one and one half tablets was 22.5mg.
-The pharmacy label indicated 47 aripiprazole 15mg tablets were dispensed on 03/01/23.
-There were 31 individually packaged doses in the bubble pack, of which 7 were empty and the remaining 24 had one whole and one-half tablet.
-The pharmacy label and dosage dispensed did not match the order for aripiprazole 15mg one half tablet (7.5mg).

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Interview with the medication aide (MA) on 03/09/23 at 10:47am revealed:
-The aripiprazole dosage of one whole and one half tablet in the bubble pack was what she administered that morning (03/09/23) to Resident #2.
-She checked the medication bubble pack against the electronic medication administration record (eMAR), punched the medication from the pack and administered the medication to the resident.

Review of Resident #2's March 2023 eMAR revealed:
-There was an entry for aripiprazole 15mg one half tablet (7.5mg) every morning with asterisk before and after, "NOTE DOSE AND STRENGTH".
-There was documentation aripiprazole 15mg one half tablet (7.5mg) was administered at 7:00am on 03/01/23.
-There was a second entry for aripiprazole 15mg one- and one-half tablet (7.5mg) every morning.
-The eMAR did not indicate the total dosage of 15mg one and one half tablets was 22.5mg.
-There was documentation aripiprazole 15mg one- and one-half tablet (7.5mg) was administered at 7:00am from 03/02/23 through 03/09/23.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/09/23 at 4:53pm revealed:
-The pharmacy started providing service to the facility on 03/01/23.
-The pharmacy had an order dated 01/03/23 for aripiprazole 15mg one half tablet (7.5mg) every morning for Resident #2.
-The pharmacy dispensed 47 tablets of aripiprazole on 02/20/23 for 31 doses of

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aripiprazole 15mg one- and one-half tablets (22.5mg).
-The order was entered in the electronic system incorrectly as aripiprazole 15mg one- and one-half tablets every morning instead of the correct dosage of 15mg one half tablet (7.5mg).
-She was going to contact the resident's primary care provider (PCP) regarding the error in the increased dosage sent.
-Potential side effects to taking an increased dose depended on each individual person.

Telephone interview with Resident #2's mental health provider (MHP) on 03/09/23 at 4:35pm revealed:
-She last saw Resident #2 on 02/20/23 and was responsible for managing her psychiatric medications.
-The resident should have been receiving aripiprazole 7.5mg every morning.
-One and one half tablets was 3 times the ordered dose which was concerning because Resident #2 was elderly, "tiny" in size and frail.
-There was a potential for altered mental status, involuntary movements, and tremors with higher doses.

Interview with the Special Care Director (SCD) on 03/09/23 at 5:11pm revealed:
-The Resident Care Director (RCD) was responsible for processing new and changed medication orders.
-She or the Resident Care Coordinator (RCC) were responsible for putting medications on the medication carts after pharmacy deliveries.
-The RCD was responsible for checking the medications delivered against the order before giving the medications to her or the RCC to load on the medication carts.
-The current medication cart had not yet been

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audited because the facility just got them from new pharmacy on 03/01/23.

Interview with the RCD on 03/09/23 at 5:25pm revealed:
-The third shift MA was responsible for checking medications and stocking the medication carts when the pharmacy delivered medications.
-There had been issues with medications she was working to resolve since the new pharmacy took over services on 03/01/23.

Interview with the Administrator on 03/09/23 at 5:40pm revealed:
-He had just started as the Administrator one month ago and was working to strengthen systems for care and services.
-He was going to follow up on identifying why the dosage error for Resident #2's aripiprazole delivered by pharmacy occurred.
-Staff were responsible for checking orders, medications against PCP orders when delivered and medications against the MAR prior to administration.

Upon request on 03/08/23 and 03/09/23, there were no subsequent orders changing the dosage of Resident #2's aripiprazole provided for review.

Attempted interview with Resident #2's Hospice Care Provider on 03/09/23 at 5:10pm was unsuccessful.

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

____
The facility failed to administer medications as ordered for 2 of 5 residents (#6, #7) observed during the medication pass as evidenced by the

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administration of the wrong dose of medications used for urinary tract infection and high blood pressure for a resident diagnosed with urinary tract infections and high blood pressure (#6) and medications administered as needed without parameters instead of scheduled as ordered that were used as a supplement and to reduce the risk of a stroke and a heart attack for a resident with a history of a stroke and a diagnosis of high blood pressure. (#7) This failure is detrimental to the health, welfare and safety of the residents and constitutes a type B Violation.

____

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 03/09/23.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 23, 2023.

D 376 | 10A NCAC 13F .1005 (b) Self-Administration Of Medications | D 376

10A NCAC 13F .1005 Self-Administration Of Medications

(b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.

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This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations and interviews, the facility failed to ensure 1 of 1 sampled resident (#4) with a self-administering medication order was compliant with self-administering her own medications as evidence by the resident taking medications from a third party provider without the facility's knowledge and the resident not taking medications prescribed by her primary care provider.

The findings are:

Review of Resident #4's FL-2 dated 01/10/23 revealed:
-Diagnoses included chronic obstruction pulmonary disease (COPD), hypertension, emphysema, and a history of deep vein thrombosis.
-The resident was semi-ambulatory.

Review of Resident #4's signed physician orders dated 01/18/23 revealed the resident may self-administer medications.

Observation of Resident #4's medications stored in her room on 03/08/23 at 3:50pm revealed:
-The medications were kept in an unlocked nightstand drawer next to the resident's room.
-There was a bottle of Alprazolam (Xanax) in the nightstand drawer that was not on the electronic medication administration record (eMAR). (Xanax is a controlled substance used to treat anxiety and panic disorder).
-There was a bottle of potassium chloride in the nightstand drawer that was not on the eMAR. (Potassium chloride is used to treat and prevent low blood potassium).

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-There was a bottle of prednisone in the nightstand drawer that was not on the eMAR. (Prednisone is used to treat inflammation).
-There was a total of 13 bottles of medications in the nightstand drawer.

Review of Resident #4's signed physician orders dated 03/09/23 revealed:
-An order for Amlodipine Benazepril 5-20mg, take 1 tablet by mouth once daily. (Amlodipine is used to treat high blood pressure).
-An order for Aspirin EC 81mg tablet, take 1 tablet by mouth once daily. (Aspirin is used to reduce the risk of a heart attack).
-An order for Hydrochlorothiazide (HCTZ) 50mg tablet, take 1 tablet by mouth once daily. (HCTZ is used to treat high blood pressure and edema).

Review of Resident #4's signed pulmonologist orders dated 01/30/23 revealed:
-Continue prednisone 10mg, take 4 tablets by mouth for 3 days, 3 tablets daily for 3 days, 2 tablets daily for 3 days and 1 tablet daily for 3 days, then stop.
-An order for Alprazolam 0.25mg by mouth once a day as needed for anxiety.

Review of Resident #4's pulmonologist patient face sheet revealed:
-The resident was previously prescribed potassium citrate ER 10meq tablet.
-The resident was previously prescribed prednisone 10mg tablet.

Review of Resident #4's progress notes dated 01/23/23 revealed:
-She had hypertension that was managed by Amlodipine, HCTZ and metoprolol.
-She had a history of a deep vein thrombosis (DVT) and was taking Eliquis for clot prevention.

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Interview with Resident #4 on 03/08/23 at 3:50pm revealed:
-She took a ½ tablet of Metoprolol for her blood pressure and no other medications related to her blood pressure.
-She was taken off other blood pressure related medications about 4 months ago when she was in rehab.
-She did not take her prescribed Aspirin because she was on a blood thinner.
-She was self-administering Xanax, prednisone, and potassium chloride tablets.

Review of Resident #4's January 2023 eMAR revealed:
-From 01/13/23 to 01/31/23, the resident's medications were noted as self-administer medications.
-There was an entry for Amlodipine/Benazepril 5-20mg capsules, take 1 capsule by mouth once daily for blood pressure.
-There was an entry for Aspirin low tab 81mg, take 1 tablet by mouth daily.
-There was an entry for Hydrochlorothiazide (HCTZ) tab 50mg, take 1 tablet by mouth daily for blood pressure.
-There was not an entry for Alprazolam (Xanax) 0.25mg by mouth once a day as needed for anxiety.
-There was not an entry for Prednisone 10mg by mouth one tablet daily.
-There was not an entry for Potassium Chloride 10meq.

Review of Resident #4's February 2023 eMAR revealed:
-From 02/01/23 to 02/28/23, the resident's medications were noted as self-administer medications.

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-There was an entry for Amlodipine/Benazepril 5-20mg capsules, take 1 capsule by mouth once daily for blood pressure.
-There was an entry for Aspirin low tab 81mg, take 1 tablet by mouth daily.
-There was an entry for Hydrochlorothiazide (HCTZ) tab 50mg, take 1 tablet by mouth daily for blood pressure.
-There was not an entry for Alprazolam (Xanax) 0.25mg by mouth once a day as needed for anxiety.
-There was not an entry for Prednisone 10mg by mouth one tablet daily.
-There was not an entry for Potassium Chloride 10meq.

Review of Resident #4's March 2023 eMAR revealed:
-From 03/01/23 to 03/08/23, the resident's medications were noted as self-administer medications.
-There was an entry for Amlodipine/Benazepril 5-20mg capsules, take 1 capsule by mouth once daily for blood pressure.
-There was an entry for Aspirin low tab 81mg, take 1 tablet by mouth daily.
-There was an entry for Hydrochlorothiazide (HCTZ) tab 50mg, take 1 tablet by mouth daily for blood pressure.
-There was not an entry for Alprazolam (Xanax) 0.25mg by mouth once a day as needed for anxiety.
-There was not an entry for Prednisone 10mg by mouth one tablet daily.
-There was not an entry for Potassium Chloride 10meq.

Review of Resident #4's Primary Care Provider's (PCP) progress notes dated 03/06/23 revealed:
-The resident was self-administering her

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medications.
-She was concerned with her memory and her forgetting recent events.
-She was concerned the resident would not remember she took her Xanax and readminister doses which could lead to an adverse event due to her diagnosis of COPD.

Interview with the Resident Service Director (RSD) on 03/09/23 at 12:30pm revealed:
-On 03/06/23, the facility was aware Resident #4 had Xanax in her room.
-Resident #4 obtained the order from a third party provider without the facility's knowledge.
-The facility notified the PCP, Resident #4 had the Xanax and she stated the resident could not have it in her room.
-She was not aware Resident #4 was not taking all of her blood pressure medications.
-She reconciled Resident #4's medications upon admission but did not reconcile them the next 30 days per the facility's protocol.

Interview with the PCP on 03/09/23 at 11:49am revealed:
-She had seen Resident #4 three times since her admission in January 2023 and the facility nor the resident notified her the resident was self-administering her medications.
-On 03/06/23 the facility notified her Resident #4 had prednisone, potassium chloride and Xanax in her room prescribed by a third-party provider and self- administered her medications.
-Resident #4 refused to give the facility the medication until they could obtain a prescription from the third-party provider.
-Resident #4 did not remember she had been seen by her or other third-party providers in the past.
-She was concerned Resident #4 had Xanax in

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her room without her knowledge and the facility's knowledge due to her not being able to remember some things.
-She was concerned Resident #4 would double up on doses of Xanax due to memory loss which could put the resident into respiratory depression or overdoes which could lead to death.
-She addressed her concerns with the family member.
-Resident #4 had an infection, which she was going to prescribe an antibiotic, but she did not because the potassium chloride could have caused hyperkalemia which could have led to a heart attack, if taken with blood pressure medications.
-She was not aware Resident #4 had not been taking her Amlodipine medication for her blood pressure which could have caused her blood pressure to be elevated and could have led to a stroke, heart attack, altered mental status and renal failure.
She was not aware Resident #4 had not been taking her HCTZ medication for her blood pressure which could have caused her edema to decrease and could have prevented her wound from healing and caused a decrease in her blood pressure.

Interview with the Executive Director on 03/09/23 at 12:46pm revealed:
-He was not aware Resident #4 had the Xanax, prednisone, and potassium chloride in her room without a prescription on file in the facility until 03/06/23.
-He was not aware Resident #4 had stopped taking her blood pressure medications.
-He expected the staff to ask Resident #4 about the medications she took before they sign off as self-administered.
-He expected the staff to notify the PCP

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immediately with any concerns related to Resident #4 self-administering medications.

____

The failure of the facility to ensure a Resident who self-administered her medications was taking her prescribed medications placed the Resident at substantial risk of serious injury for a stroke, heart attack, renal failure, altered mental status as evidence by not being aware the resident had stopped taking her medications for blood pressure that were prescribed by her Primary Care Provider and was taking medications prescribed by a third-party provider. This failure resulted in substantial risk of physical harm and constitutes a Type 2 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/09/23 for this violation.

THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 8, 2023.

D 377 — 10A NCAC 13F .1006(a) Medication Storage — D 377

10A NCAC 13F .1006 Medication Storage
(a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures.

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure that medications stored in a resident's room (#4) were safe and secured, as evidence by a controlled substance being left in an unlocked nightstand drawer.

Review of the facility's Resident Self-Management and Storage of Medications revealed:
-If a resident is allowed to keep his/her own medications, the Resident Services Director ensures all medications are kept in a secure environment that is accessible only to the resident and community staff.
-If a resident is in a shared apartment with another resident, the resident must agree to keep their medication in a secured area not accessible to their roommate.

The findings are:

Review of Resident #4's FL-2 dated 01/10/23 revealed:
-Diagnoses included chronic obstruction pulmonary disease (COPD), hypertension, emphysema and a history of deep vein thrombosis.
-The resident was semi-ambulatory.

Review of the facility's Resident Self-Management and Storage of Medications

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revealed:
-If a resident is allowed to keep his/her own medications, the Resident Services Director ensures all medications are kept in a secure environment that is accessible only to the resident and community staff.
- If a resident is in a shared apartment with another resident, the resident must agree to keep their medication in a secured area not accessible to their roommate.

Observation of Resident #4's medications stored in her room on 03/08/23 at 3:50pm revealed:
-There were 13 bottles of medications in the nightstand drawer.
-The medications were kept in an unlocked nightstand drawer next to the resident's room.
-There was a bottle of Alprazolam, a controlled substance in the nightstand drawer.

Interview with Resident #4 on 03/08/23 at 3:50pm revealed:
-She did not lock her nightstand drawer when she was out of her room.
-There was not a lock attached to the nightstand drawer.

Interview with the Resident Service Director (RSD) on 03/09/23 at 12:30pm revealed:
-The family inquired about what type of medication lock box Resident #4 needed upon admission.
-She thought Resident #4's medications were locked in her room.
-She was responsible to ensure resident's who self-administered medications had their medications in a secure location.

Interview with the Executive Director on 03/09/23 at 12:46pm revealed he did not know Resident

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D 377	Continued From page 25 #4's medications were not stored in a locked space.	D 377		