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{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from December 12, 2023 through December 13, 2023.	{C 000}		
{C 249}	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .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: FOLLOW-UP TO TYPE B VIOLATION. Based on these findings, the previous B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure physician orders were implemented for 2 of 3 sampled residents by ensuring an order for a wound dressing changes three times a week, an order to apply a compression sock and an ankle compression wrap daily, and an order to elevate the resident's legs daily (#1), and an order for compression stockings to be worn daily and weight checked daily (#2) were implemented. The findings are: 1. Review of Resident #1's current FL-2 dated 10/26/23 revealed diagnosis included diabetes type II, stasis ulcer on the inside of his left ankle	{C 249}		

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(a statis ulcer is a vascular ulcer that develops due to problems with blood circulation), coronary artery disease, and a history of deep vein thrombosis (DVT) and pulmonary embolism.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 09/21/23.

Review of Resident #1's Care Plan dated 09/25/23 revealed the resident received wound care to his left ankle.

Review of Resident #1's Licensed Health Professional Support (LHPS) evaluation dated 09/28/23 revealed wound care was listed and checked off as an LHPS task.

Review of Resident #1's LHPS evaluation dated 11/04/23 revealed wound care was listed and checked off as an LHPS task.

a. Review of a physician order for Resident #1 dated 10/10/23 revealed:
-The resident was seen at a local wound clinic for a wound on the inside of his left ankle.
-There was an order to clean the wound with Vashe (Vashe is a wound solution that was used for irrigating and moistening a wound); moisten gauze with Vashe, apply the wound solution to a gauze, place the gauze to the wound for five minutes, then remove and dress the wound with a non-adherent dressing, change three times a week.

Review of a physician order for Resident #1 dated 10/24/23 revealed:
-The resident was seen at a local wound clinic for a wound on his left ankle.
-There was an order to continue to change the

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{C 249}	Continued From page 2 resident's wound dressing three times a week. Review of a physician order for Resident #1 dated 11/21/23 revealed: -The resident was seen at a local wound clinic for a wound on his left ankle. -There was an order to cleanse the wound with Vashe, moisten gauze with Vashe and apply to the wound for five minutes, apply a non-adherent dressing, change three times a week. Review of Resident #1's electronic medication administration record (eMAR) for November 2023 revealed there was no documentation that wound care was provided to the resident's left ankle three times a week. Review of Resident #1's eMAR for December 2023 revealed there was no documentation that wound care was provided to the resident's left ankle three times a week. Observation of Resident #1's left foot on 12/12/23 at 11:32am revealed: -The medication aide (MA) provided a dressing change to the resident's left foot. -There was white gauze that was wrapped around the middle portion of his left foot and ankle. -There was dark brown drainage that seeped through the white gauze from the inside of his left ankle that was 2 ½ inches in diameter. -The MA removed the white gauze from the resident's left foot. -There was a wound on the resident's left ankle that was 2 ½ inches in diameter. -There was a brown crusted area around the wound to the left, right and above the wound. -There was not a crusted area at the bottom of the wound. -There was clear drainage from the wound on the	{C 249}		

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resident's left ankle.
-After the MA removed the gauze wrap from the resident's left ankle, the resident told the MA "you forgot the peroxide."
-The MA asked the Administrator to bring her the peroxide.
-The Administrator returned to the MA with a bottle of peroxide.
-The MA poured peroxide directly to the resident's wound on the inside of his left ankle and blotted the wound with a piece of gauze.
-The MA poured the Vashe directly to the wound on the resident's left ankle, placed a non-adherent dressing to the wound, and wrapped it with gauze.

Interview with Resident #1 on 12/13/23 at 4:04pm revealed:
-The MA completed his dressing change to his left foot and ankle about every other day.
-The MA usually changed the dressing to his left foot and ankle a few times a week.
-The MA always poured peroxide on his wound to help remove the dead skin.
-He suffered from pain in his left foot and ankle every night.
-Most nights he woke up with "real sharp throbbing pain from the top of his left foot up to his mid-calf."
-The pain woke him up "out of a dead sleep" and he rated the pain a 10 from a scale of 1 to 10 with 10 being the worse pain.

Interview with the MA on 12/12/23 at 11:35am revealed:
-She poured peroxide onto the resident's wound and applied the Vashe directly to the wound because that is how she observed the staff at the wound clinic do when they changed the resident's bandage.

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-She did not know that she should not apply peroxide directly to the resident's wound on his left ankle.
-She was not aware that pouring peroxide directly to the resident's wound on his left ankle killed the good and bad bacteria of the resident's wound.
-She had always applied Vashe directly to the resident's wound on his left ankle.
-She did not realize that the order was to apply the Vashe to gauze and hold the gauze with the Vashe to the wound.
-She changed the resident's dressing for his wound three times a week but had never documented that she changed his dressing.

Telephone interview with a nurse at the wound clinic on 12/13/23 at 8:05am revealed:
-The MAs should never pour peroxide directly to the resident's open wound because there was not an order for it, the peroxide kills the good and bad bacteria.
-Peroxide should not be used on chronic wounds because using peroxide can harm the tissue and delay healing.

Interview with the Administrator on 12/13/23 at 4:14pm revealed:
-She was not aware that the MA should not pour peroxide onto the resident's open wound.
-She thought the MA was following what she observed the staff at the wound clinic when they changed his dressing.
-She and the MA had missed these orders and did not implement them correctly.
-She should have paid closer attention to the resident's orders and visit notes.
-She was ultimately responsible for ensuring that orders were implemented correctly to ensure the proper care of residents.

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b. Review of a physician order for Resident #1 dated 10/24/23 revealed:
-The resident was seen at a local wound clinic for a wound on his left ankle.
-There was an order to continue to wear an ankle compression wrap on the left ankle (the ankle compression wrap is a medical compression sleeve that reduces swelling).

Review of a physician order for Resident #1 dated 11/21/23 revealed:
-The resident was seen at a local wound clinic for a wound on his left ankle.
-There was an order for the resident to continue to wear an ankle compression wrap on the left ankle daily.

Review of Resident #1's electronic medication administration record (eMAR) for November 2023 revealed there was no documentation and no entry that the ankle compression wrap was applied to the resident's left ankle daily.

Review of Resident #1's eMAR for December 2023 revealed there was no documentation and no entry that the ankle compression wrap was applied to the resident's left ankle daily.

Observation of Resident #1 on 12/12/23 at 10:46am revealed the resident did not have an ankle compression wrap on his left foot.

Observation of Resident #1's dresser on 12/12/23 at 10:49am revealed there was an ankle compression wrap on top of his dresser.

Interview with Resident #1 on 12/12/23 at 10:48am revealed:
-His left foot felt better when the medication aide (MA) placed the ankle compression wrap on his

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left foot because it reduced the swelling in his left foot and ankle and decreased the pain in his left foot and ankle.
-The MA placed the ankle compression wrap on his left foot when she changed his bandage.
-The MA usually changed his bandage a few times a week.
-He took a bath this morning and thought had last worn his ankle compression wrap two days ago.
-He did not know why the MA had not placed his ankle compression wrap on his left ankle today.

Interview with a medication aide (MA) on 12/12/23 at 11:00am revealed:
-She applied the resident's ankle compression wrap to his left ankle every morning.
-Resident #1 was supposed to wear his ankle compression wrap daily and remove at night.
-She forgot to place the resident's ankle compression wrap this morning (12/12/23).

Interview with the Administrator on 12/13/23 at 4:14pm revealed she was not aware that the resident had an order for an ankle compression wrap to be worn daily.

c. Review of a physician order for Resident #1 dated 10/10/23 revealed:
-The resident was seen at a local wound clinic for a wound on the inside of his left ankle.
-There was an order for the resident to wear compression sock daily.

Review of Resident #1's electronic medication administration record (eMAR) for November 2023 revealed there was no documentation and no entry that a compression sock was applied to the resident's left foot daily.

Review of Resident #1's eMAR for December

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2023 revealed there was no documentation and no entry that a compression sock was applied to the resident's left foot daily.

Observation of Resident #1 on 12/12/23 at 10:46am revealed the resident did not have a compression sock on his left foot.

Interview with Resident #1 on 12/12/23 at 10:48am revealed:
-His left foot felt better when the medication aide (MA) placed the compression sock on his left foot because it reduced the swelling in his left foot and ankle and decreased the pain in his left foot and ankle.
-He usually slept in his compression sock because it helped reduce the pain in his left foot and ankle; if he did not wear the compression sock at night, he woke up with throbbing pain that made it hard for him to sleep.
-The MA placed the compression sock on his left foot when she changed his bandage.
-He took a bath this morning and thought had last worn his compression sock two days ago.
-He was not wearing his compression sock because he thought it was in the laundry.

Interview with a medication aide (MA) on 12/12/23 at 11:00am revealed:
-The resident placed his compression sock on independently after she completed his dressing change to his left ankle.
-The resident removed his compression sock before he went to bed.
-She checked daily to be sure the resident wore his compression sock.
-Resident #1 was supposed to wear his compression sock daily and remove it at night.
-She forgot to remind Resident #1 to put on his compression sock this morning (12/12/23).

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Observation of the Administrator on 12/13/23 at 4:13pm revealed:
-She gave Resident #1 his compression sock and told him to place it on his left foot.
-The resident was having difficulties placing the compression sock on his left foot and the Administrator applied the compression sock.
-The Administrator placed the compression sock on the resident's left foot.

Interview with the Administrator on 12/13/23 at 4:14pm revealed:
-She thought the resident was able to put the compression sock on himself and did not realize he needed assistance.
-She and the MAs needed to put the resident's compression sock on for him.
-She was not aware that the resident had an order for a compression sock to be worn daily.

d. Review of a physician order for Resident #1 dated 10/10/23 revealed:
-The resident was seen at a local wound clinic for a wound on the inside of his left ankle.
-There was an order to elevate legs daily.

Review of a physician order for Resident #1 dated 11/21/23 revealed:
-The resident was seen at a local wound clinic for a wound on his left ankle.
-There was an order to elevate the residents' legs daily.

Review of Resident #1's electronic medication administration record (eMAR) for November 2023 revealed there was no documentation and no entry that the resident's legs were elevated daily.

Review of Resident #1's eMAR for December

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2023 revealed there was no documentation and no entry that the resident's legs were elevated daily.

Observation of Resident #1 on 12/12/23 at 8:30am revealed the resident was sitting in the family room on the couch without his feet elevated.

Interview with Resident #1 on 12/12/23 at 10:48am revealed he was not aware that he needed to elevate his left foot during the day.

Telephone interview with a nurse at the wound clinic on 12/12/23 at 11:17am revealed:
-There was a physician order on 10/10/23 for Resident #1 to wear a compression sock and ankle compression wrap on his left foot and ankle every day.
-The ankle compression wrap and compression sock helped prevent the resident's foot and ankle from swelling.
-When the resident had swelling of his left ankle and foot it made the wound on the inside of his left ankle worse.
-Resident #1 had a history of a DVT and it was important to reduce swelling of his left foot and ankle to prevent another DVT.
-The physician order specifically instructed facility staff to place the compression sock and ankle compression wrap to the resident's left foot and ankle every morning.

Interview with a MA on 12/12/23 at 11:00am revealed:
-She reviewed orders when the resident returned from an appointment because she was supposed to follow physician orders to help the resident get better.
-She was not sure how she missed the wound

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clinic physician's orders to apply the ankle compression wrap and compression sock daily and to elevate Resident #1's feet during the day.

Interview with the Administrator on 12/13/23 at 4:14pm revealed she was not aware that the resident had an order to elevate his feet daily.

Attempted telephone interviews with Resident #1's primary care physician (PCP) on 12/12/23 at 4:06pm and 12/13/23 at 1:48pm were unsuccessful.

2. Review of Resident #2's current FL-2 dated 06/15/23 revealed diagnoses included hypertension and obesity.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 05/01/23.

Review of an internal medicine physician visit note for Resident #2 dated 11/06/23 revealed:
-Resident #2 was diagnosed with swelling of both legs and weight gain.
-There was an order for Resident #2 to weigh herself daily; there were no parameters listed.

Review of an internal medicine physician visit note for Resident #2 dated 11/20/23 revealed:
-Resident #2 had swelling of both legs.
-There was an order for Resident #2 to wear compression stockings daily and to elevate her legs daily.

Review of Resident #2's electronic medication administration record (eMAR) for November 2023 revealed there was no documentation and no entry to apply compression stockings to the resident's legs in the morning and to remove at

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{C 249}	Continued From page 11 8:00pm. Review of Resident #2's eMAR for December 2023 revealed there was documentation to apply compression stockings to the resident's legs in the morning at 8:00am and to remove at 8:00pm. -There was an entry from 12/7/23 to 12/12/23 at 8:00am to apply compression stockings to the resident's legs and at 8:00pm to remove the compression stockings. -There was no documentation or entry that compression stockings were applied to the resident's legs or removed from 12/01/23 to 12/06/23. Observation of Resident #2 on 12/12/23 at 3:45pm revealed she was not wearing compression stockings. Observation of Resident #2 on 12/13/23 at 3:30pm revealed she was not wearing compression stockings. Interview with Resident #2 on 12/13/23 at 3:30pm revealed: -She usually placed her compression stockings on each morning. -Staff at the facility had never put compression stockings on her feet. -She weighed herself each morning before breakfast and told the MA what her weight was each day. -When she wore her compression stockings it helped her legs and feet feel better because they were not swollen. -She had one pair of compression stockings. -She thought her compression stockings were in the laundry, so she did not wear them yesterday or today. -She found her compression stockings on her	{C 249}		

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nightstand next to her bed today at 3:30pm.

Telephone interview with a medication aide (MA) on 12/13/23 at 2:15pm revealed:
-Resident #2 put her compression stockings on each morning.
-She was not aware that the resident did not have compression stockings yesterday and today.
-She had not checked with the resident to ensure she was wearing compression stockings as ordered by her physician.
-She had not asked the resident to elevate her legs as ordered by her physician, she had missed reading that in the physician orders and had not implemented the order.
-She and the Administrator were responsible for reviewing physician orders to ensure orders were implemented for residents.
-She had overlooked the orders for Resident #2 to weigh herself daily, wear compression stockings and elevate her legs daily.

Interview with the Administrator on 12/13/23 at 11:50am revealed:
-She was not aware that Resident #2's PCP had ordered her weight to be checked daily.
-She missed the order and should have implemented the daily weight checks for the resident.
-She and the MAs were responsible for reviewing orders when a resident returned from an appointment.
-It was her responsibility to ensure that any orders for a resident were implemented and the MAs understood they are expected to follow physician orders.

Attempted telephone interviews with Resident #2's internal medicine physician on 12/13/23 at 2:00pm was unsuccessful.

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{C 249}	Continued From page 13 ______________________________ The facility failed to ensure a order to provide wound dressing changes three times a week, wear an ankle compression wrap and compression sock daily, and elevate legs daily were implemented for a resident diagnosed with diabetes type II, coronary artery disease, and a history of deep vein thrombosis and pulmonary embolism and a resident with a diagnosis of hypertension with a bilateral edema and weight gain order was implemented to wear compression stockings and elevate legs daily. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/13/23 for this violation.	{C 249}		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#1, #2) related to medications used to treat	C 330		

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hypertension, insomnia, pain, and paranoid schizophrenia (#1) and hypertension (#2).

The findings are:

1. Review of Resident #1's current FL-2 dated 10/26/23 revealed diagnosis included paranoid schizophrenia and hypertension.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 09/21/23.

a. Review of Resident #1's physician order sheet dated 10/26/23 revealed there was an order for Tylenol Extra Strength 500mg caplet, take one caplet two times a day (Tylenol Extra Strength is used to treat minor aches and pains).

Review of Resident #1's November 2023 eMAR revealed there was no entry for Tylenol Extra Strength 500mg listed on the eMAR.

Review of Resident #1's December 2023 eMAR revealed there was no entry for Tylenol Extra Strength 500mg listed on the eMAR.

Observation of medications on hand on 12/13/23 at 11:30am revealed Tylenol Extra Strength 500mg was not available for administration.

Interview with Resident #1 on 12/13/23 at 4:04pm revealed:
-He suffered from pain in his left foot and ankle every night.
-Most nights he woke up with "real sharp throbbing pain from the top of his left foot up to his mid-calf."
-The pain woke him up "out of a dead sleep" and he rated the pain a 10 from a scale of 1 to 10 with

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10 being the worse pain.
-He recently had an appointment with a pain doctor to help manage his foot and ankle pain with a different medication.

b. Review of a physician order dated 09/22/23 revealed there was an order for Trazodone 100mg, take one tablet at 8:00am every day for mood (Trazodone is used to treat depression and anxiety).

Review of Resident #1's physician order sheet dated 10/26/23 revealed there was an order for Trazodone 150mg, take one tablet at 8:00pm.

Review of Resident #1's November 2023 eMAR revealed:
-There was an entry for Trazodone 100mg, take one tablet at 8:00am every day for mood.
-Trazodone 100mg was documented as administered on 11/01/23 to 11/30/23 at 8:00am.
-There was no entry for Trazodone 150mg listed on the eMAR.

Review of Resident #1's December 2023 eMAR revealed:
-There was an entry for Trazodone 100mg, take one tablet at 8:00am every day for mood.
-Trazodone 100mg was documented as administered on 12/01/23 to 12/12/23 at 8:00am.
-There was no entry for Trazodone 150mg listed on the eMAR.

Observation of medications on hand on 12/13/23 at 11:30am revealed Trazodone 100mg was available for administration but Trazodone 150mg was not available for administration.

c. Review of Resident #1's physician order dated 09/22/23 revealed there was an order for Ferrous

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Sulfate 325mg, take one tablet every day at 8:00am (Ferrous Sulfate is used to treat iron deficiency).

Review of Resident #1's physician order sheet dated 10/26/23 revealed there was an order for Ferrous Sulfate 325mg tablet, take one tablet every 48 hours.
Review of Resident #1's November 2023 eMAR revealed:
-There was an entry for Ferrous Sulfate 325mg, take one tablet every day at 8:00am.
-Ferrous Sulfate 325mg was documented as administered on 11/01/23 to 11/30/23 at 8:00am.
-There was no entry for Ferrous Sulfate 325mg, take one tablet every 48 hours.

Review of Resident #1's December 2023 eMAR revealed:
-There was an entry for Ferrous Sulfate 325mg, take one tablet at 8:00am every at 8:00am.
-Ferrous Sulfate 325mg was documented as administered on 12/01/23 to 12/12/23 at 8:00am.
-There was no entry for Ferrous Sulfate 325mg, take one tablet every 48 hours.

Observation of medications on hand on 12/13/23 at 11:30am revealed Ferrous Sulfate 325mg was available for administration.

Interview with the medication aide (MA) on 12/13/23 at 8:15am revealed she had administered Resident #1 Ferrous Sulfate 325mg every morning at 8:00am.

d. Review of Resident #1's physician order sheet dated 10/26/23 revealed there was an order for Melatonin 5mg, take one tablet at 8:00pm (Melatonin is used to treat insomnia).

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C 330	Continued From page 17 Review of a physician order dated 11/17/23 revealed there was an order for Melatonin 10mg, take one tablet at 8:00pm. Review of Resident #1's November 2023 eMAR revealed: -There was an entry for Melatonin 5mg, take one tablet at 8:00pm as needed for sleep. -Melatonin 5mg was documented as administered at 8:00pm on 11/15/23. Review of Resident #1's December 2023 eMAR revealed: -There was an entry for Melatonin 5mg, take one tablet at 8:00pm as needed for sleep. -There was no documentation Melatonin 5mg was documented as administered. Observation of medications on hand on 12/13/23 at 11:30am revealed Melatonin 5mg was available for administration but Melatonin 10mg was not available for administration. Interview with a MA on 12/13/23 at 8:15am revealed: -She thought she was administering medications as ordered for Resident #1. -She was not aware that his primary care physician (PCP) had updated his orders on 10/26/23. -She always reviewed PCP orders after a resident returned from an appointment. -She was not sure why she did not fax the new orders to the facility's contracted pharmacy. -She was responsible to fax any new orders to the pharmacy and to check medications with the order once medications were delivered. -She had just assumed that she was administering the correct medications to Resident #1.	C 330		

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C 330	Continued From page 18 Interview with the Administrator on 12/13/23 at 9:47am revealed: -She thought that Resident #1's medications on the eMAR were the correct orders. -She completed an audit of resident medications about a week ago but did not compare Resident #1's physician orders with the eMAR and medications on hand. -She had not sent orders from the resident's primary care physician (PCP) to the pharmacy because she thought the resident's PCP had sent them to the pharmacy. -She did not realize that she was responsible for sending new orders to the pharmacy. -She should have done a better job with reviewing physician orders with the eMAR. -She had not noticed that Resident #1's medications were changed on his most recent FL-2 dated 10/26/23. -She and the MA were responsible for ensuring that Resident #1 received his medications as ordered by his PCP. -She and the MA were responsible for ensuring that Resident #1 received his medications as ordered. -It was ultimately her responsibility to ensure that Resident #1 had the correct medications at the facility and was administered medications as ordered by the PCP. Attempted telephone interviews with Resident #1's primary care physician (PCP) on 12/12/23 at 4:06pm and 12/13/23 at 1:48pm were unsuccessful. 2. Review of Resident #2's current FL-2 dated 06/15/23 revealed diagnoses included hypertension and obesity.	C 330		

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Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 05/01/23.

Review of a physician order dated 10/18/23 revealed there was an order for Furosemide 40mg, take one tablet every day at 8:00am (Furosemide is a diuretic used to treat hypertension, heart failure and edema).

Review of an internal medicine physician visit note for Resident #2 dated 11/20/23 revealed:
-Resident #2 had swelling of both legs.
-There was an order to increase the resident's Furosemide from to 60mg, take one tablet at 8:00am for three days, then return to taking one Furosemide 40mg every day at 8:00am.

Review of Resident #2's November 2023 eMAR revealed:
-There was an entry for Furosemide 40mg, take one tablet at 8:00am every day.
-Furosemide 40mg was documented as administered on 11/20/23 to 11/23/23 at 8:00am.
-There was no documentation Furosemide 60mg was listed on the eMAR from 11/20/23 to 11/23/23.
-There was no documentation that Furosemide 60mg was administered at 8:00am on 11/20/23 to 11/23/23.

Observation of medications on hand on 12/13/23 at 11:30am revealed Furosemide 40mg was available for administration.

Interview with Resident #2 on 12/1323 at 3:30pm revealed:
-She had been to the doctor for swelling in her legs and pain in her legs.
-Her legs ached and throbbed when her legs

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became swollen.
-She had gained some weight and the doctor encouraged her to weigh herself each morning.

Telephone interview with a medication aide (MA) on 12/13/23 at 2:15pm revealed:
-She was not sure why she did not send Resident #2's order to the pharmacy when her Furosemide was increased from 40mg to 60mg for three days.
-Resident #2 had problems with bilateral edema for a few weeks, she did not realize Furosemide would have helped decrease her edema.
-She thought she had sent the order to the pharmacy but evidently just forgot.
-She was responsible for ensuring that Resident #2 received medications as ordered.

Interview with the Administrator on 12/13/23 at 11:50am revealed:
-Resident #2 had experienced swelling of her legs and weight gain.
-She did not realize Resident #2's PCP had ordered an increase in the resident's Furosemide from 40mg daily to 60mg for three days.
-She and the MAs were responsible for reviewing orders when a resident returned from an appointment.
-She and the MA should have sent the new order for Furosemide 60mg to the facility's contracted pharmacy.
-She and the MA reviewed PCP notes and orders when residents returned from an appointment, but they had missed the order to increase the resident's Furosemide.
-It was her responsibility to ensure that physician orders were implemented to ensure residents received medications as prescribed by their physician.

Attempted telephone interviews with Resident

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C 330	Continued From page 21 #2's internal medicine physician on 12/13/23 at 2:00pm was unsuccessful.	C 330		
C 350	10A NCAC 13G .1005 (a and b) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) The facility shall notify the physician when: (1) there is a change in the resident's mental or physical ability to self-administer; (2) the resident is non-compliant with the physician's orders; or (3) the resident is non-compliant with the facility's medication policies and procedures. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure an assessment and physician's order was in place for 1 of 3 sampled residents (#2) who self-administered a medication used to treat	C 350		

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nerve pain.

The findings are:

Review of Resident #2's current FL-2 dated 06/15/23 revealed:
-Diagnoses included hypertension and obesity.
-There was no information documented for orientation status.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 05/01/23.

Review of Resident #2's current assessment and care plan dated 06/02/23 revealed:
-Resident #2 required total assistance from staff for bathing and grooming.
-Resident #2 required limited assistance with dressing and ambulation.

Review of Resident #2's resident record revealed there was no documentation of a physician's order for self-administration of any medication.

Review of Resident #2's physician order dated 12/01/23 revealed a physician's order for Lidocaine 5% patch, apply one patch topically to the affected area every morning and remove in 12 hours at bedtime for pain (Lidocaine is used to treat nerve pain).

Review of Resident #2's electronic medication administration record (eMAR) for December 2023 revealed:
-There was an entry for Lidocaine 5% patch apply one patch topically to affected area every morning and remove in 12 hours at bedtime for pain.
-There was documentation of administration each day at 8:00am and 8:00pm from 12/02/23 to

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12/11/23.
-There was documentation of administration at 8:00am on 12/12/23.

Interview with Resident #2 on 12/13/23 at 3:30pm revealed:
-She asked the medication aide (MA) for a Lidocaine patch every morning.
-Once she received the Lidocaine patch from the MA each morning, she opened the package, removed the Lidocaine patch and placed it on her lower back.
-She removed the Lidocaine patch every night around 8:00pm and placed a new Lidocaine patch on every morning.

Telephone interview with a medication aide (MA) on 12/13/23 at 2:15pm revealed:
-Resident #2 was able to place her Lidocaine patch on herself every morning.
-She had not applied the patch to Resident #2 because she felt the resident could apply the patch independently.
-There was not a physician order for the resident to self-administer the Lidocaine patch.
-She was not aware that she needed an order from a physician for the resident to self-administer the Lidocaine patch.

Interview with the Administrator on 12/13/23 at 12:12pm revealed:
-She had given Resident #2 her Lidocaine patch to place on her lower back because the resident was able to apply the patch independently.
-She wanted to respect the resident's privacy and allow the resident to place the Lidocaine patch to her lower back by herself.
-She made a mistake and should not have allowed Resident #2 to self-administer her Lidocaine patch since there was not a physician

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C 350	Continued From page 24 order to self-administer the patch. Attempted telephone interviews with Resident #2's internal medicine physician on 12/13/23 at 2:00pm was unsuccessful.	C 350		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the retrievable record of controlled substances were maintained and reconciled accurately with the documented receipt and administration of a medication used to control pain for 1 of 1 sampled resident (#1) with an order for a controlled substance medication. The findings are: Review of Resident #1's current FL-2 dated 10/26/23 revealed diagnosis included diabetes type II, stasis ulcer on the inside of his left ankle (a statis ulcer is a vascular ulcer that develops due to problems with blood circulation), coronary artery disease, hypertension, and a history of deep vein thrombosis (DVT) and pulmonary embolism. Review of Resident #1's physician order sheet	C 367		

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dated 12/08/23 revealed there was an order for Xtampza ER 13.5mg capsule sprinkle, take one tablet every 12 hours for pain (Xtampza is used to treat severe pain).

Review of a controlled drug record for Xtampza ER 13.5mg for Resident #1 revealed:
-A quantity of 14 tablets of Xtampza ER 13.5mg was filled on 12/08/23.
-There was a circle around the number 14 on the controlled drug record for doses present.
-There was no signature documented on the controlled drug record.
-There was no documentation on the controlled drug record that Xtampza ER 13.5mg was administered.

Review of Resident #1's December 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Xtampza 13.5mg take one tablet every 12 hours for lumbar radiculopathy at 8:00am and 8:00pm (lumbar radiculopathy is an inflammation of a nerve root in the lower back).
-Xtampza 13.5mg was documented as administered at 8:00am and 8:00pm on 12/11/23.

Observation of Resident #1's medications on hand on 12/12/23 at 4:56pm revealed:
-Fourteen tablets of Xtampza 13.5mg was filled on 12/08/23.
-The medication card contained 12 tablets of Xtampza 13.5mg.

Interview with the Administrator on 12/12/23 at 4:59pm revealed:
-She forgot to date and sign her name on the controlled drug record for 14 Xtampza 13.5mg capsules received from the facility's contracted

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CLEMMIE'S FAMILY CARE HOME II	110 PEARL DR GREENVILLE, NC 27834

(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
C 367	Continued From page 26 pharmacy. -She did not realize that she forgot to document on the controlled drug record that she administered Xtampza 13.5mg to Resident #1 on 12/11/23. -She should have caught her mistake because she needed to provide documentation of any controlled substance that was administered at the facility. -She was ultimately responsible for the oversight of medications for residents to ensure medications were administered as ordered and there was no drug diversion. Attempted telephone interviews with Resident #1's primary care physician (PCP) on 12/12/23 at 4:06pm and 12/13/23 at 1:48pm were unsuccessful.	C 367		