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D 000	Initial Comments The Adult Care Licensure Section Conducted an annual and a complaint investigation on 02/20/24 to 02/22/24.	D 000		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure foods stored and prepared in the kitchen were free from contamination related to dirty food storage containers, shelves and walls in the walk-in cooler and a dirty stove with a buildup of grease on the surrounding equipment. The findings are: Observation of the walk-in cooler in the kitchen on 02/21/24 at 10:36am revealed:	D 283		

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D 283	Continued From page 1 -There were multiple assorted containers of food items and bottles of sauces and condiments with black and gray spots of various sizes on the lids, sides and handles of the containers. -There was a white, gray, black and greenish buildup on the rungs and legs of the shelves where the food was stored. -There were black and white spots of various sizes on the walls. -There was a black plastic cart with boxes food stored on it in the walk-in cooler. -There were small to large brownish, white and gray spots on the cart. Observation of the stove, the deep fryer and the flat top grill on 02/21/24 at 10:40am revealed: -There was a large black and brownish area with a yellow boarder on the back of the stove. -The area was sticky to the touch. -There was a thick build-up of a black and yellow substance with food particles stuck in it on the burners on the stove. -There was a thick yellow build up and long drips of the yellow build up that was sticky to the touch on the sides of the stove. -There was a deep fryer on one side of the stove and a flat top grill setting on a small table on the other side of the stove. -There was a thick yellow build-up and long drips of a yellow substance on the sides and the top of the deep fryer. -There was a thick build up and long drips of a yellow substance that was sticky to the touch on the table where the flat top grill was setting. -There was a large puddle of build up of debris and a thick yellow and brown substance on the top of the table under the flat top grill. Review of the local Environmental Health Services (EHS) Inspection Report dated 09/01/23	D 283		

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revealed:
-The kitchen received a score of 97.
-The outside walk-in freezer and cooler had split gaskets.
-The inspector instructed the facility to replace the split gaskets on the outside walk-in freezer and cooler.
-The inspector noted gaskets were ordered per maintenance staff for the outside walk-in freezer and cooler.
-This was a repeat violation.

Review of the weekly cleaning log posted in the kitchen on 02/21/24 at 10:51am revealed:
-There was a clip board with a stack of completed cleaning logs in the kitchen.
-There was a place to record the date and to circle the days of the week across the top of the daily cleaning log.
-There was a list of equipment and various task on the log.
-There were checkmarks, a date, a circle around the day of the week and a signature on the completed daily cleaning logs.
-The list included checking the temperatures for the walk-in cooler.
-The walk-in cooler shelves and walls, the stove, the deep fryer and the flat top grill were not included on the list.

Interview with the Kitchen Manager (KM) on 02/21/24 at 10:36am revealed:
-There was a split in the gasket on the door to the walk-in cooler located inside the kitchen.
-Because of the split in the gasket the door did not get a good seal when closed and allowed extra moisture to come into the walk-in cooler.
-The Maintenance Director (MD) had ordered a new gasket for the door after the EHS inspection in September 2023.

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-She had been told by the MD that the door gasket was on back order.
-She checked the walk-in cooler every day.
-She checked for dates on food items and checked or mold because of the moisture in the walk-in cooler.
-She threw away food items that appeared to have mold on them when she did her checks.
-She had just thrown food items away two to three days ago.
-The shelving, cart and walls had been wiped clean about one week ago.
-These shelves, cart and walls had not been deep cleaned in about a month.
-She did not want the staff to serve the food that appeared to have a build up of mold on them.
-She had the staff remove the grates off the stove and soak them about once a week.
-The staff had attempted to clean the food and grease build up on the front, backs and side of the stove during their weekly cleaning, but it could not all be removed.
-The deep fryer and the flat top grill had grease and food build up because they were beside the stove and the build up was from prior use.
-The deep fryer and the flat top grill did not work, and she had requested for them to be removed.
-She was told they could not be removed from the kitchen because the facility could not find an outside company or anyone to remove them.
-The kitchen staff cleaned the sides of the deep fryer and the flat top grill after they used the stove.

Interview with the MD on 02/22/24 at 3:20pm revealed:
-He had ordered the replacement gaskets for the cooler about a month ago and they were delivered about two weeks ago.
-He had not replaced them because they had

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D 283	Continued From page 4 slipped his mind. Interview with the Administrator on 02/22/24 at 10:00am revealed: -He passed through the kitchen every day. -He monitored the kitchen every day when he passed through it. -He did not have a list he used to monitor; if he saw something, he was concerned about he would tell the KM. -The Maintenance Director (MD) had a list he used when he monitored the kitchen. -He had not looked at the gaskets for the walk-in coolers. -The local EHS inspector had referenced the gasket for the outside walk-in cooler on the inspection last report. -If the KM had noticed something needed to be repaired, she should have notified him or the MD. -The build up on the items in the walk-in cooler did not happen overnight and were unacceptable. -He should have noticed the build up on the stove, the deep fryer and the flat top grill himself when he walked through the kitchen. -He thought the flat top grill was used when preparing meals, he did not know it was not used. -There needed to be a detailed cleaning schedule developed and staff training done to make sure equipment was deep cleaned and daily cleaning maintained.	D 283		
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	D 344		

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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 record.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to clarify an order for 1 of 5 sampled residents for a medication inhaled by nebulizer (#3).

The findings are:

Review of Resident #3's current FL-2 dated 02/13/24 revealed:
-Diagnosis included delirium.
-There was no order for ipratropium-albuterol (used to treat air flow blockage in the lungs) 0.5-2.5mg/3ml nebulizer solution; there was no frequency documented.

Review of Resident #3's electronic medication administration record (eMAR) for February 2024 from 02/01/24 to 02/20/24 revealed:
-There was an entry for polyethylene glycol 17gm once daily and hold for loose stools; scheduled at 8:00am.
-Polyethylene glycol was documented as administered once daily from 12/01/23 to 12/31/23.

Observation of Resident #3's room on 02/21/24 at 11:28am revealed there was no nebulizer machine in her room.

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Observation of Resident #3's medication on hand on 02/20/24 at 4:28pm revealed there was no ipratropium-albuterol 0.5-2.5mg/3ml available for administration.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 02/02/22/24 at 8:40am revealed:
-The pharmacy had not received Resident #3's FL-2 dated 02/13/24 from the facility.
-The pharmacy did not have an order for ipratropium-albuterol 0.5-2.5mg/3ml nebulizer solution for Resident #3.
-The pharmacy would attempt to clarify an order with the physician and then reach out to the facility if they did not get a response from the physician.
-The pharmacy did not have any documentation of a clarification request for the ipratropium-albuterol.
-Ipratropium-albuterol was used to as a breathing treatment and was typically ordered as needed for shortness of breath.

Telephone interview with Resident #3's primary care provider (PCP) on 02/21/24 at 3:20pm revealed:
-He was not aware of an order for ipratropium-albuterol 0.5-2.5mg/3ml nebulizer solution for Resident #3.
-Resident #3 had been in the hospital for a recent stay and he did not know if her medications had changed after the visit.
-He did not sign the FL-2 dated 02/13/24.
-Resident #3 was admitted to hospice recently and he was allowing hospice to manager her medications.

Interview with Resident #3 on 02/21/24 at 3:50pm revealed she did not use a nebulizer machine.

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D 344	Continued From page 7 Interview with the medication aide (MA) on 02/21/24 at 11:35am revealed Resident #3 did not have an order for a medication administered via nebulizer machine. Interview with the Health and Wellness Director (HWD) on 02/22/24 at 11:30am revealed: -She was responsible for ensuring the residents' most recent FL-2 was correct and sent to the pharmacy. -She reviewed the FL-2s before she sent them to the pharmacy. -She checked the eMAR to the FL-2 within 24 hours of receiving the new FL-2. -Resident #3 had a lot of medications. -Resident #3 had a recent hospital stay and a new FL-2 and a discharge summary that were submitted to the facility the same day. -The pharmacy sent clarification request to the physician when there was a question with a medication order; the facility would receive a copy of the clarification request via fax. -When she knew the pharmacy was requesting a clarification on a medication dose or frequency she would follow-up within three days with the physician herself to get the clarification. -She never got a fax from the pharmacy or was contacted about a clarification request. -She thought she had done a thorough job when she compared the FL-2 and the discharge summary; she must have missed the ipratropium-albuterol 0.5-2.5mg/3ml nebulizer solution. Interview with the Administrator on 02/22/24 at 12:35pm revealed: -The HWD was responsible for clarification of medication orders. -The HWD usually consulted with the hospital	D 344		

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D 344	Continued From page 8 discharge planners over the telephone to make sure the orders on the FL-2 and the discharge summary are complete. -The facility then sends the FL-2 to the pharmacy after the HWD has reviewed it. -He could not say what happened to the order for Resident #3's ipratropium-albuterol nebulizer solution without speaking to the HWD. Attempted telephone interview with Resident #3's hospice nurse on 02/22/24 at 10:40am 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: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents who had an inhaler, (#3) a topical pain medication (#4) and a laxative (#3 and #4). The findings are: 1. Review of Resident #3's current FL-2 dated 02/13/24 revealed diagnosis included delirium. a. Review of Resident #3's current FL -2 dated	D 358		

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02/13/24 revealed there was an order for fluticasone furoate-vilanterol (used to treat asthma) 100-25mcg per dose; there was no dosage or frequency documented.

Review of Resident #3's electronic medication administration record (eMAR) for December 2023 revealed there was no entry for fluticasone furoate-vilanterol 100-25mcg.

Review of Resident #3's eMAR for January 2024 revealed there was no entry for fluticasone furoate-vilanterol 100-25mcg.

Review of Resident #3's eMAR for February 2024 from 02/01/24 to 02/20/24 revealed there was no entry for fluticasone furoate-vilanterol 100-25mcg.

Observations of Resident #3's medication on hand on 02/20/24 at 4:28pm revealed there was no fluticasone furoate-vilanterol 100-25mcg available for administration.

Interview with Resident #3 on 02/21/24 at 3:50pm revealed:
-She did not have a problem with constipation.
-She did not take polyethylene glycol everyday or twice a day.

Interview with the medication aide (MA) on 02/21/24 at 11:35am revealed:
-Resident #3 did not have an order for fluticasone furoate-vilanterol 100-25mcg.
-If there was an order for the fluticasone furoate-vilanterol 100-25mcg it would have been placed on the eMAR and dispensed by the pharmacy.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 02/02/22/24 at

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8:40am revealed:
-The pharmacy had not received Resident #3's FL-2 dated 02/13/24 from the facility.
-The pharmacy did not have an order for fluticasone furoate-vilanterol 100-25mcg for Resident #3.
-The facility was responsible for faxing Resident #3's current FL-2 to the pharmacy.
-The pharmacy had not dispensed fluticasone furoate-vilanterol 100-25mcg for Resident #3 because they did not have an order.
-Fluticasone furoate-vilanterol was used as a preventative treatment for asthma.
-A possible outcome of not administering fluticasone furoate-vilanterol could be asthmatic exasperation.

Telephone interview with Resident #3's primary care provider (PCP) on 02/21/24 at 3:20pm revealed:
-He was not aware of an order for fluticasone furoate-vilanterol for Resident #3.
-Resident #3 had been in the hospital for a recent stay and he did not know if her medications had changed after the visit.
-Resident #3 was admitted to hospice recently and he was allowing hospice to manager her medications.

Interview with the Health and Wellness Director (HWD) on 02/22/24 at 11:30am revealed:
-She was responsible for ensuring the residents' most recent FL-2 was complete and sent to the pharmacy.
-She reviewed the FL-2s before she sent them to the pharmacy.
-She checked the eMAR to the FL-2 within 24 hours of receiving the new FL-2.
-Resident #3 had a lot of medications and a discharge summary that were submitted to the

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facility the same day.
-She thought she had done a thorough job when she compared the FL-2 to the eMAR but she must have missed the fluticasone inhaler.

Interview with the Administrator on 02/22/24 at 12:35pm revealed:
-The pharmacy did quarterly medication cart audits.
-The HWD and the staff conducted medication cart audits but, he was not sure how often.
-He was not sure of the process, but he thought medication inventory levels were looked at during the reviews.
-The HWD was responsible for sending the new FL-2s to the pharmacy after reviewed.
-Someone should have caught the missing fluticasone furoate-vilanterol was not on the eMAR or on the medications cart.
-He was not sure of the steps the MAs followed when they administered medications.

Attempted telephone interview with Resident #3's hospice nurse on 02/22/24 at 10:40am was unsuccessful.

b. Review of Resident #3's current FL -2 dated 02/13/24 revealed there was an order for polyethylene glycol (used to treat constipation) 17gm twice daily.

Review of Resident #3's electronic medication administration record (eMAR) for December 2023 revealed:
-There was an entry for polyethylene glycol 17gm once daily and hold for loose stools; scheduled at 8:00am.
-Polyethylene glycol was documented as administered once daily from 12/01/23 to

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D 358	Continued From page 12 12/31/23. Review of Resident #3's eMAR for January 2024 revealed: -There was an entry for polyethylene glycol 17gm once daily and hold for loose stools; scheduled at 8:00am. -Polyethylene glycol was documented as administered once daily from 01/01/24 to 01/31/24. Review of Resident #3's eMAR for February 2024 from 02/01/24 to 02/20/24 revealed: -There was an entry for polyethylene glycol 17gm once daily and hold for loose stools; scheduled at 8:00am. -There was documentation Resident #3 was in the hospital from 02/09/24 to 02/13/24. -Polyethylene glycol was documented as administered once daily for sixteen of sixteen opportunities from 02/01/24 to 02/20/24. Observations of Resident #3's medication on hand on 02/20/24 at 4:28pm revealed there was a half of a bottle of polyethylene glycol 17gm administer once daily dispensed on 10/18/23 available for administration. Interview with Resident #3 on 02/21/24 at 3:50pm revealed: -She kept an inhaler in her room for times when she was not able to breath. -She did not think she had an order for any other inhalers. Interview with the medication aide (MA) on 02/21/24 at 11:35am revealed: -Resident #3 was administered her polyethylene glycol 17gm one a day in the mornings. -Resident #3 was good about taking her	D 358		

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polyethylene glycol as ordered and never refused it.
-She did not know Resident #3's polyethylene glycol was changed to once daily because it was on the eMAR to be administered only one time a day.
-Resident #3 had complained of any constipation to her.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 02/02/22/24 at 8:40am revealed:
-The pharmacy had not received Resident #3's FL-2 dated 02/13/24 from the facility.
-Resident #3 had on order for polyethylene glycol 17gm once daily dated October 2023.
-The pharmacy did not have an order for polyethylene glycol 17gm twice daily for Resident #3.
-The facility was responsible for faxing Resident #3's current FL-2 to the pharmacy.
-A thirty-day supply of polyethylene glycol was last dispensed on 10/18/23 for Resident #3.
-Polyethylene glycol was used to treat constipation and a possible out come of not administering it as ordered could include trouble with bowel movements and constipation.

Telephone interview with Resident #3's primary care provider (PCP) on 02/21/24 at 3:20pm revealed:
-She was ordered the polyethylene glycol 17gm because of a chronic history of constipation.
-Resident #3 had not complained of constipation at his last visit on 02/08/24.
-Resident #3 had experienced constipation during a recent hospital stay; her order for polyethylene glycol may have been changed to twice daily after the hospital stay.

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D 358	Continued From page 14 Interview with the Health and Wellness Director (HWD) on 02/22/24 at 11:30am revealed: -She was responsible for ensuring the residents' most recent FL-2 was complete and sent to the pharmacy. -She reviewed the FL-2s before she sent them to the pharmacy. -She checked the eMAR to the FL-2 within 24 hours of receiving the new FL-2. -Resident #3 had a lot of medications and a discharge summary that were submitted to the facility the same day. -She thought she had done a thorough job when she compared the FL-2 to the eMAR but she must have missed the order change for the polyethylene glycol from once daily to twice daily. -Resident #3 knew her medications and knew if she was not getting a medication. -She wondered if the MAs were administering the polyethylene glycol as ordered to Resident #3 but was using another resident's bottle and that was why she still had a bottle that was dispensed on 10/18/23. -The MAs should not have been using other residents medications unless there was an emergency. Interview with the Administrator on 02/22/24 at 12:35pm revealed: -The pharmacy did quarterly medication cart audits. -The HWD and the staff conducted medication cart audits but, he was not sure how often. -He was not sure of the process, but he thought medication inventory levels were looked at during the audits. -The HWD was responsible for sending the new FL-2s to the pharmacy after reviewed. -The dosage changes for Resident #3's polyethylene glycol should have been discovered	D 358		

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before the FL-2 was sent to the pharmacy.
-He was not sure of the steps the MAs followed when they administered medications.
-Resident #3's polyethylene glycol should not have lasted from 10/18/23 if it was administered as ordered.
-He thought maybe the reason Resident #3 had a bottle of polyethylene glycol dispensed from 10/18/23 was because the MAs were sharing other residents' bottles.
-The MAs should not have sharing medications; they should have only administered polyethylene glycol to Resident #3 from her bottle.

Attempted telephone interview with Resident #3's hospice nurse on 02/22/24 at 10:40am was unsuccessful.
2. Review of Resident #4's current FL-2 dated 09/19/23 revealed diagnoses included osteoarthritis, alzheimers, diabetes mellitus type 2, hypertension, hyperlipidemia, and glaucoma.

a. Review of Resident #4's current FL-2 dated 09/19/23 revealed there was an order for biofreeze topically to each knee twice a day.

Review of Resident #4's signed physician's orders dated 02/05/24 revealed there was an order for biofreeze 4 percent gel spread topically to each knee twice a day.

Review of Resident #4's December 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for biofreeze 4 percent gel spread topically to each knee twice daily.
-There was documentation biofreeze 4 percent gel was administered twice daily from 12/01/23 to 12/31/23.

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D 358	Continued From page 16 Review of Resident #4's January 2024 eMAR revealed: -There was an entry for biofreeze 4 percent gel spread topically to each knee twice daily. -There was documentation biofreeze 4 percent gel was administered twice daily from 01/01/24 to 01/31/24. Review of Resident #4's February 2024 eMAR from 02/01/24 to 02/20/24 at 8:00am revealed: -There was an entry for biofreeze 4 percent gel spread topically to each knee twice daily. -There was documentation biofreeze 4 percent gel was administered twice daily from 22/01/24 to 02/20/24 at 8:00am. Observation of Resident #4's medications on hand on 02/20/24 at 4:20pm revealed: -There was a tube of biofreeze gel 4 percent available for administration. -There was no other tube of biofreeze available for administration. -The prescription label had a dispensed date of 05/19/23. -There tube was half-full. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 02/21/24 at 8:45am revealed: -There was an active order on Resident #4's profile for biofreeze 4 percent gel topically to each knee twice a day dated 07/13/22. -The pharmacy last dispensed biofreeze 4 percent gel on 05/19/23. -The biofreeze would have to be reordered by the facility staff when needed. -If the facility was applying a dime to nickel size amount twice a day to both knees, the medication would last a month or two.	D 358		

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Based on interviews, record reviews, and medication on hand, there would not have been enough biofreeze dispensed for administration to Resident #4 from 12/01/23 to 02/20/24.

Interview with Resident #4 on 02/20/24 at 9:30am revealed:
-He had pain in both of his knees sometimes.
-He did not know if he got biofreeze applied.
-He got his medications daily.

Interview with a medication aide (MA) on 02/21/24 at 8:30am revealed:
-Resident #4 gets his medications as ordered.
-Resident #4 never refused his medications.
-She did not borrow medications from other residents.
-She applied biofreeze to Resident #4's knees as ordered.
-She did not know why there was still medication in the tube of biofreeze that was dispensed on 05/19/23.

Telephone interview with Resident #4's primary care provider (PCP) on 02/21/24 at 3:15pm revealed:
-Resident #4 had chronic arthritis in both of his knees.
-Resident #4 was able to express his needs and would let the staff know when he was in pain.
- He reviewed the eMAR's when he saw residents and expected them to be accurate to make appropriate treatment decisions
-He was concerned staff were not giving medication as ordered.

Interview with the Resident Care Coordinator (RCC) on 02/21/24 at 3:50pm revealed:
-Resident #4 did not have as much knee pain as he used to have.

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D 358	Continued From page 18 -She did not conduct audits of the medication carts; the pharmacy came in and did audits. b. Review of Resident #4's current FL-2 dated 09/19/23 revealed there was an order for miralax 17 Gm in liquid every other day. Review of Resident #4's signed physician's orders dated 02/05/24 revealed there was an order for miralax 17 Gm in liquid every other day. Review of Resident #4's December 2023 electronic medication administration record (eMAR) revealed: -There was an entry for miralax 17 Gm in liquid every other day. -There was documentation miralax 17 Gm was administered every other day from 12/01/23 to 12/31/23. Review of Resident #4's January 2024 eMAR revealed: -There was an entry for miralax 17 Gm in liquid every other day. -There was documentation miralax 17 Gm in liquid was administered every other day from 01/01/24 to 01/31/24. Review of Resident #4's February 2024 eMAR from 02/01/24 to 02/20/24 at 8:00am revealed: -There was an entry for miralax 17 Gm in liquid every other day. -There was documentation miralax 17 Gm in liquid was administered every other day from 22/01/24 to 02/20/24 at 8:00am. Observation of Resident #4's medications on hand on 02/20/24 at 4:20pm revealed: -There was a bottle of miralax that contained a scant amount.	D 358		

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-There was no bottle of miralax available for administration.
-The prescription label had a dispensed date of 03/16/23.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/21/24 at 8:45am revealed:
-There was an active order on Resident #4's profile for miralax 17 Gm.
-Miralax was used to treat constipation.
-Not getting miralax as ordered could cause an increase in constipation or could cause bowel impaction.
-The pharmacy last dispensed miralax on 03/15/23.
-The miralax would have to be reordered by the facility staff when needed.
-If the facility was using the miralax as ordered every other day, the bottle would last 14 days.

Based on interviews, record reviews, and medication on hand, there would not have been enough miralax dispensed for administration to Resident #4 from 12/01/23 to 02/20/24.

Interview with Resident #4 on 02/20/24 at 9:30am revealed:
-He thought he got his medications as he should.
-He did not know if he took miralax every other day.

Interview with a medication aide (MA) on 02/21/24 at 8:30am revealed:
-Resident #4 gets his medications as ordered.
-Resident #4 never refused his medications.
-She did not borrow medications from other residents.
-She administered miralax per the order.
-She did not know why there was still medication

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in the bottle of miralax that was dispensed on 03/15/23.

Telephone interview with Resident #4's primary care provider (PCP) on 02/21/24 at 3:15pm revealed:
-Resident #4 had several gastrointestinal issues.
-Staff would let him know if Resident #4 did not have a bowel movement in 3 days.
-He reviewed the eMAR's when he saw residents and expected them to be accurate to make appropriate treatment decisions.
-Miralax was used to treat constipation.
-It was important Resident #4 got his miralax as orderd.

Interview with the Resident Care Coordinator (RCC) on 02/21/24 at 3:50pm revealed:
-She did not conduct audits of the medication carts; the pharmacy came in and did audits.
-She did not know why there was still miralax on the cart from 03/15/23 or why it had not been reordered.

Interview with the Health Wellness Director (HWD) on 02/22/24 at 10:40am revealed:
-She did not do medication cart audits.
-A nurse from the pharmacy came into the facility and checked each cart quarterly.
-She was not sure what the audits consisted of.
-She was shocked to hear the miralax was still on the medication cart from 03/15/23.
-She did not know how Resident #4 could still have medication from 03/15/23 unless staff shared medications which they should not do.
-She expected the MA's to administer the medications as ordered.

Interview with the Executive Director on 02/22/24 at 12:30pm revealed:

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D 358	Continued From page 21 -He thought the HWD did medication cart audits. -He was unaware what the audits consisted of. -He was concerned if medications were not being given as ordered. -He hoped the staff did not share medications between residents. -He expected the MA's to take their time and administer the medications as ordered. -It was important to provide accurate information for the physician to make informed decisions.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (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. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 2 sampled residents had physician's orders to self-administer Symbicort inhaler used to treat shortness of breath associated with chronic obstructive pulmonary disease (COPD), and Voltaren gel used to treat pain (#5), and	D 375		

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fluticasone inhaler used to treat shortness of breath (#3).

The findings are:

1.Observation of Resident #5's bedroom on 02/21/24 at 11:00am revealed:
-There was a Symbicort inhaler (budesonide 160mcg and formoterol fumarate 4.5mcg) on the nightstand beside Resident #5's bed.
-There was still some medication remaining in the Symbicort inhaler.
-There was a tube of Voltaren gel in Resident #5's nightstand drawer.
-The tube of Voltaren gel was approximately one-half empty.

Interview with Resident #5 on 02/21/24 at 11:00am revealed:
-She had COPD and got short of breath and used the Symbicort inhaler for that.
-She kept the Symbicort inhaler at her bedside.
-She used the Symbicort order as ordered.
-She used voltaren gel for knee pain.
-She couldn't reach her back to apply the voltaren gel to her back.
-Her needs bothered her more than her back.
-The staff did not apply the voltaren gel to her back.
-She was independent and did not need a lot of care, so the staff left her alone unless she asked for help.
-The Medication Aide was aware she kept the Symbicort inhaler and voltaren gel in her room at the bedside.

Review of Resident #5's current FL-2 dated 01/26/24 revealed:
-Diagnoses included COPD, diabetes mellitus type 2 and hypertension.

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D 375	Continued From page 23 -She was admitted to the facility on 10/14/20. -There was an order for Symbicort 160-4.5mcg 2 puffs twice a day. -There was an order for voltaren gel 1 percent spread 2GM topically to lower back three times a day. -There was not an order for Resident #5 to self-administer medications. Review of Resident #5's physician's orders dated 02/06/24 revealed: -There was an order for Symbicort 160-4.5mcg inhale 2 puffs twice a day. -There was an order for voltaren gel 1 percent spread 2GM topically to low back three times a day. -There was not an order for Resident #5 to self-administer her medications. Interview with a Medication Aide (MA) on 02/21/24 at 3:10pm revealed: -Resident #5 kept her Symbicort inhaler and voltaren gel in her room at the bedside. -She applied voltaren gel to Resident #5's lower back three times a day. -Resident #5 used the Symbicort inhaler independently. -Resident #5 did not have an order to self-administer her medications. -Resident #5 should have an order to self-administer her medications. -She should have noticed there was not an order and notified the primary care provider (PCP). Interview with the Resident Care Coordinator (RCC) on 02/21/24 at 3:50pm revealed: -Resident #5 was oriented and very independent and able to self-administer her own medications. -She did not know if Resident #5 had an order to self-administer her medications.	D 375		

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D 375	Continued From page 24 -The MA's should let her know if a resident has medications at the bedside so she can let the PCP know. Interview with the Health Wellness Director (HWD) on 02/22/24 at 10:40am revealed: - Residents' medications should be kept on the medication cart unless there was an order to sef-administer and an assessment completed. -Resident #5 did not have an order to self-administer her medications. -All staff were responsible for checking resident rooms to ensure no medications were left at the bedside. Interview with Resident #5's PCP on 02/21/24 at 3:15pm revealed: -He was not aware Resident #5 had medications at the bedside. -Resident #5 did not have an order to self-administer her medications. -He was only comfortable with rescue inhalers being left at the bedside. -Symbicort was not a rescue inhaler. -Symbicort should be kept on the medication cart and administered by the MA to monitor usage. -He was not aware Resident #5 was not using her voltaren gel as ordered. -Facility staff should be aware of residents that have medications at the bedside and let him know via the HWD to obtain an order if appropriate. Interview with the Executive Director (ED) on 02/23/24 at 12:30pm revealed: -Residents should not have medications at the bedside unless there is a physician's order to do so. -Staff should let the HWD know if medications are found at the bedside.	D 375		

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2. Review of Resident #3's current FL-2 dated 02/13/24 revealed:
-Diagnosis included delirium.
-There was no order for fluticasone-salmeterol (used to treat asthma attacks) 232-14mcg.

Observation of Resident #3's medication on hand on 02/20/24 at 4:28pm revealed there was there was a box of fluticasone-salmeterol 232-14mcg dispensed on 12/28/23; the inhaler was not in the box or on the medication cart.

Observation of Resident #3's room on 02/21/24 at 11:28am revealed:
-There were two fluticasone-salmeterol 232-14mcg inhalers in a cup in Resident #3's in an open drawer in Resident #3's room.
-One of the inhalers was empty and the counter on the second inhaler indicated two to four puffs were available for administration.

Review of Resident #3's record on revealed there was no self-administration evaluation available for review.

Review of Resident #3's electronic medication administration record (eMAR) for December 2023 and January 2024 revealed:
-There was an entry for fluticasone-salmeterol 232-14mcg inhale one puff twice daily scheduled at 8:00am and 8:00pm.
-There was documentation Resident #3 was administered fluticasone-salmeterol twice daily 62 of 62 opportunities for December 2023 and January 2024.
-There was nothing documented about self-administration of fluticasone-salmeterol 232-14mcg on the eMARs.

Review of Resident #3's eMAR for February 2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019019	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE HILLS OF PITTSBORO	P O BOX 1209 PITTSBORO, NC 27312

(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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from 02/01/24 to 02/20/24 revealed:
-There was an entry for fluticasone-salmeterol 232-14mcg inhale one puff twice daily scheduled at 8:00am and 8:00pm.
-There was documentation Resident #3 was in the hospital from 02/09/24 to 02/13/24.
-Fluticasone-salmeterol 232-14mcg was documented as administered twice daily for 32 of 32 opportunities from 02/01/24 to 02/20/24.

Interview with Resident #3 on 02/21/24 at 3:50pm revealed:
-She kept the fluticasone-salmeterol inhaler in her room for times when she was not able to breath.
-She knew one of the inhalers was empty and one still had medication in it.
-She did not know the last time she had used the inhaler.
-She thought the staff knew the inhaler was in her room because they gave it to her.

Interview with the medication aide (MA) on 02/21/24 at 11:35am revealed:
-There was an empty box of Resident #3's fluticasone-salmeterol 232-14mcg because the inhaler was in the resident's room.
-The primary care provider (PCP) would write an order for a resident to self-administer medications.
-Resident #3 did not have an order to keep her fluticasone-salmeterol in her room and self-administer it.
-Resident #3 had insisted on keeping the inhaler in her room with her.
-She had let the Health and Wellness Director (HWD) know Resident #3 insisted on having her fluticasone-salmeterol inhaler in her room about the middle of last month.
-When she told the HWD Resident #3 insisted on keeping the inhaler in her room, she was told to

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get it out.
-Resident #3 would scream and yell and fight so she gave up and allowed her to have the inhaler in her room.
-Resident #3 had kept the inhaler in her room for a couple of weeks.

Telephone interview with Resident #3's PCP on 02/21/24 at 3:20pm revealed:
-He did not have a self-administer order for Resident #3's fluticasone-salmeterol because it was to control asthma and he wanted it to be administered by the MA.
-He did not think Resident #3 could administer the fluticasone-salmeterol correctly herself.
-She had a recent hospital stay and seemed more confused after returning to the facility.

Interview with the HWD on 02/22/24 at 11:40am revealed:
-The MAs were supposed to administer Resident #3's medications including her inhalers.
-Resident #3 had her inhaler in her room once before and she had told the MAs to place it back on the medication cart.
-She was not aware Resident #3 had her fluticasone-salmeterol in her room again until the day before, 02/21/24.
-She told the MA to put the fluticasone-salmeterol back on the medication cart.
-The PCP did not want Resident #3 to administer her own fluticasone-salmeterol because she could administer too much.
-If she had been told Resident #3 insisted on keeping her fluticasone-salmeterol she would have removed it from the resident's room herself.

Interview with the Administrator on 02/22/24 at 12:35pm revealed:
-Residents were not allowed to have medications

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D 375	Continued From page 28 in their room; it was a "hard no". -Emergency inhalers were one of the only medications that could be self-administered. -He had sent emails to families reminding them about not providing medications to residents to keep in their rooms. -Staff were instructed to notify the HWD and to remove medications from the residents' rooms when they observed them. -Residents could not demand to keep medications in their rooms; the PCP had to do a self-administration evaluation prior to the resident having a self-administered medication. -Residents could not have medication in their rooms without the facility's knowledge because it could put another resident at risk of taking the medication by accident. Attempted telephone interview with Resident #3's hospice nurse on 02/22/24 at 10:40am was unsuccessful.	D 375		