Received via electronic mail 4/18/24

D358

10A NCAC 13F .1004(a) Medication Administration

The following is the Plan of Correction for Integrity Patriot Living regarding the Statement of Deficiencies cited March 27, 2024, during a complaint investigation. This Plan of Corrections is not to be construed as an admission of or agreement with the conclusions in the statement, but rather as the confirmation of our continuing efforts to comply with statutory and regulatory requirements.

The facility will assure that the preparation and administration of medication, 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.

All errors have been reviewed and have been found to be corrected. Resident Care Coordinator and/or Designee will match all Veteran Administration medication labels upon arrival with their orders to confirm that they are matching. Any discrepancies will be immediately reported to the Veteran Administration for corrections. The Operational Manager and/or Designee will review all physician orders against all medications on the carts to ensure accuracy between the orders and the medications monthly.

The facility will continue to use Order Logs to track all orders from start to completion. Resident Care Coordinator and/or Designee will log, verify, and clear orders daily. The Operational Manager and/or Designee will daily follow, tracking orders as second verification until completion.

Report on completion of Order Logs to be reviewed by Administrator and/or Designee monthly.

Completion Date: 4/5/2024

Reviewed and acknowledged 04/18/24. SG

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	HAL099018	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation from 03/26/24 through 03/27/24.	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: Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 3 of 6 sampled residents who had orders for an antihypertensive medication (#1), an acid reflux medication (#3), and an antihistamine medication (#6). The findings are: 1. Review of Resident #1's current FL2 dated 12/19/23 revealed: -Diagnoses included hypertension. -There was an order for losartan potassium (a medication used to treat high blood pressure) 1 tablet daily (dose not specified). Review of Resident #1's signed physician's orders dated 07/12/23 and 01/17/24 revealed orders for losartan potassium 50mg daily.	D 358		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janet C. Bush — TITLE: Administrator — (X6) DATE: 4/18/24

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D 358	Continued From page 1 Review of Resident #1's January, February, and March 2024 (from 03/01/24 to 03/26/24) electronic medication administration records (eMAR) revealed: -There was an entry for losartan potassium 50mg take 1 tablet daily scheduled at 6:00am. -There was documentation the medication was administered daily from 01/01/24 through 01/31/24, from 02/01/24 through 02/29/24, and from 03/01/24 through 03/26/24. Observation of medications on hand for Resident #1 on 03/26/24 at 2:36pm revealed: -There was one bottle containing losartan potassium 100mg tablets labeled to take 1 tablet daily. -The dispensed date was 11/14/23 and there were 86 out of 90 tablets remaining in the bottle. -There were no half tablets in the bottle. -The tablets were tear shaped and did not have a score on them to allow for cutting the tablets in half. Observation of the facility's overstock medications on 03/27/24 at 3:37pm revealed: -There was one bottle containing losartan potassium 100mg tablets labeled to take 1 tablet daily. -The dispensed date was 02/13/24 and there were 90 out of 90 tablets remaining in the bottle. -There were no half tablets in the bottle. -The tablets were tear shaped and did not have a score on them to allow for cutting the tablets in half. Interview with a medication aide (MA) on 03/26/24 at 2:45pm revealed: -The only losartan available for Resident #1 was what was on the medication cart. -Since the losartan was dispensed from the	D 358		

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pharmacy to take one 100mg tablet daily, the MAs cut the tablet in half lengthwise to try to make it an even cut.
-She did not know if anyone at the facility had contacted the Veteran's Administration (VA) pharmacy to request 50mg tablets be sent to the facility instead of the 100mg tablets.

Interview with Resident #1 on 03/27/24 at 8:53am revealed he was not familiar with his dose of losartan or if he received any half tablets with his morning medications.

Telephone interview with a representative from the VA pharmacy on 03/27/24 at 2:15pm revealed:
-Resident #1's current order for losartan potassium was 100mg daily.
-The pharmacy dispensed a 90-day supply of losartan potassium 100mg on 11/14/23 and on 02/13/24.
-There was no history of Resident #1 being ordered or dispensed losartan potassium 50mg tablets.

Interview with the Operations Manager (OM) on 03/27/24 at 2:55pm revealed:
-Resident #1's losartan potassium 50mg order had been active and current since 2020.
-The VA provider signed Resident #1's FL2 and physician's orders every 6 months for losartan potassium 50mg daily.
-When she administered Resident #1's losartan to him she cut the tablet in half lengthwise.
-The MAs should have placed a change of order sticker on Resident #1's losartan bottle to alert them to check the dose against the eMAR so they did not administer a full 100mg tablet.
-Resident #1 did not have blood pressure checks ordered but he never complained of symptoms of

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D 358	Continued From page 3 high or low blood pressure. Interview with the Resident Care Coordinator (RCC) on 03/27/24 at 10:22am revealed: -She was aware Resident #1's losartan potassium medication bottle did not match his dose order on the eMAR. -She had not done anything differently with Resident #1's losartan medication bottle because it was easy to get the ordered dose of 50mg by cutting the 100mg tablet in half. -She had administered Resident #1's losartan to him a few times and always cut the tablet in half. Interview with a second MA on 03/27/24 at 4:07pm revealed: -She did not cut any of Resident #1's medications in half when administering his morning medications. -Resident #1's losartan pill bottle was labeled to take one full tablet daily so that was what she administered to him. -She was not aware the dose on the eMAR was for 50mg daily. Interview with the Administrator on 03/27/24 at 4:15pm revealed -She was not aware that Resident #1's losartan on the medication cart was for 100mg tablets and his order was 50mg. -She expected the MAs to administer medications based on the order on the eMAR rather than the medication bottles since orders sometimes changed. -The RCC and OM were responsible for ensuring the medications on the medication cart matched the orders on the eMAR and the physician's orders every month for all residents. Attempted telephone interview with Resident #1's	D 358		

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D 358	Continued From page 4 VA primary care provider (PCP) on 03/27/24 at 2:25pm was unsuccessful. 2. Review of Resident #3's current FL2 dated 12/24/23 revealed: -Diagnoses included diabetes type 2, hyperlipidemia, inguinal hernia, history of stroke, and hypertension. -There was an order for pantoprazole (a medication used to treat heartburn and acid reflux) 40mg daily. Review of Resident #3's January, February, and March 2024 (from 03/01/24 to 03/26/24) electronic medication administration records (eMAR) revealed there were no entries for pantoprazole 40mg daily. Observation of medications on hand for Resident #3 on 03/26/24 at 2:43pm revealed there was no pantoprazole available on the medication cart. Interview with Resident #3 on 03/27/24 at 9:30am revealed: -He was not familiar with each medication he took. -He did not have symptoms of heartburn or reflux in the previous 3 months. Interview with the Resident Care Coordinator (RCC) on 03/27/24 at 10:05am revealed: -Resident #3's pantoprazole order was discontinued in the eMAR on 12/27/23. -She did not have a discontinue order from Resident #3's primary care provider (PCP) for pantoprazole. -She and the Operations Manager (OM) had access to discontinuing orders in the eMAR. -She audited the eMARs and the medication carts monthly, and the OM audited the eMARs to the	D 358		

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D 358	Continued From page 5 physician's orders monthly. -Resident #3's last cycle-fill date for pantoprazole was in February 2024, but the facility returned the pantoprazole back to the pharmacy. -She had noticed Resident #3's pantoprazole was not on the medication cart, but she had not checked to see if it had been discontinued by the PCP. Telephone interview with a representative from the facility's contracted pharmacy on 03/27/24 at 1:30pm revealed: -Resident #3 had a current order for pantoprazole 40mg daily. -The pharmacy had not received an order to discontinue pantoprazole 40mg for Resident #3. -The pharmacy dispensed pantoprazole 40mg for Resident #3 on 03/08/24 for a 28-day supply, on 02/09/24 for a 28-day supply, on 01/12/24 for a 28-day supply and they had all been returned to the pharmacy. -The pharmacy dispensed pantoprazole 40mg for Resident #3 on 12/15/23, and it had not been returned to the pharmacy. Interview with a medication aide (MA) on 03/27/24 at 2:00pm revealed: -She had noticed Resident #3 did not have pantoprazole on the medication cart for the previous few months, but assumed it had been discontinued. -She did not administer any medication that was not due to be administered according to the eMAR. -Resident #3 had not complained of having symptoms of heartburn or reflux. Telephone interview with Resident #3's PCP on 03/27/24 at 3:08pm revealed: -She had not discontinued Resident #3's	D 358		

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D 358	Continued From page 6 pantoprazole order. -Resident #3 should have been receiving pantoprazole 40mg daily for the previous three months. -Resident #3 had not reported symptoms of heartburn, belching, or bloating to her but those would be the possible side effects for not taking pantoprazole. -She would expect the facility staff to only discontinue a medication order if she wrote an order to have it discontinued. Interview with the OM on 03/27/24 at 4:00pm revealed: -She had erroneously discontinued Resident #3's pantoprazole order from the eMAR in December 2023. -She would have caught her error during an eMAR audit if pantoprazole was a high-risk medication, but since most residents were not prescribed pantoprazole long-term, she had not questioned that it was discontinued. -When medications were received from the pharmacy, she scanned each medication card and if there was no matching order on the eMAR for the medication that was scanned, the scanner made an alert and she would set that medication aside. -She had sent pantoprazole back to the pharmacy in January, February and March 2024 since it was not showing as an active medication on his eMAR. -Resident #3 had not complained of acid reflux symptoms in the previous three months Interview with the Administrator on 03/27/24 at 4:15pm revealed. -She was not aware Resident #3's pantoprazole had been discontinued and he should have been receiving it.	D 358		

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D 358	Continued From page 7 -There should have been a double-check between the OM and the RCC for each medication discontinued to prevent errors. -The discontinued pantoprazole should have been caught during the OM's audit of the eMAR compared to the current physician's orders. -No medication should be discontinued without a physician's order. 3. Review of Resident #6's current FL2 dated 12/05/23 revealed: -Diagnoses included mental disability, dementia, and schizoaffective disorder. -There was an order for hydroxyzine HCL (used to help control anxiety and tension caused by nervous and emotional conditions) 50mg daily twice a day. -There was an order for hydroxyzine HCL 25mg twice a day as needed for anxiety. Review of Resident #6' psychiatry progress notes dated 01/23/24 revealed: -Resident #6 had not used hydroxyzine ordered as needed in several months. -There was an order to discontinue hydroxyzine 25mg used as needed. -No additional changes to Resident #6's medications were recommended. Review of Resident #6's Pharmacist's Quarterly Medication Review dated 03/05/24 revealed there was an entry for discontinued hydroxyzine (as needed) in January 2024. Observation of medication administration for Resident #6 on 03/27/24 at 7:40am revealed: -The morning medication aide (MA) prepared and administered 11 oral medications to Resident #6. -Resident #6 did not receive hydroxyzine 50mg.	D 358		

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D 358	Continued From page 8 Observation of medications on hand for Resident #3 on 03/27/24 at 12:00pm revealed there was no hydroxyzine 50mg available on the medication cart. Review of Resident #6's March 2024 (from 03/01/24 to 03/27/24) electronic medication administration records (eMAR) revealed: -There was an entry for hydroxyzine HCL 50mg one tablet twice a day scheduled for administration at 8:00am and 8:00pm. -There was documentation hydroxyzine HCL 50mg was administered twice daily from 8:00am on 03/01/24 to 8:00am on 03/06/24. -Hydroxyzine 50mg was marked discontinue on 03/06/24 on the eMAR. Interview with the Resident Care Coordinator (RCC) on 03/27/24 at 9:30am revealed: -The pharmacy medication staff routinely entered all orders for medications at the contracted pharmacy. -The Operations Manager (OM) and the RCC could enter or discontinue orders on the eMAR at the facility also. -Resident #6's hydroxyzine HCL 50mg was discontinued on the March 2024 eMAR by the Operations Manager (OM). -There was no order to discontinue Resident #6's hydroxyzine 50mg twice a day available for review. Telephone interview with the order entry representative at the contracted pharmacy on 03/27/24 at 9:40am revealed: -The pharmacy did not have an order to discontinue Resident #6's hydroxyzine 50mg at the pharmacy. -The pharmacy's eMAR system had Resident #6's hydroxyzine 50mg as a current medication.	D 358		

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D 358	Continued From page 9 Interview with the a MA on 03/27/24 at 10:00am revealed: -She did not enter medications on residents' eMARs. -She administered medications according to the medications listed on the eMAR at a scheduled time. -She did not have an active entry for hydroxyzine 50mg for Resident #6 on the current eMAR, therefore she did not administer hydroxyzine HCL 50mg to Resident #6 during medication administration on 03/27/24. Interview with Resident #6 on 03/27/24 at 11:45am revealed: -He took a lot of medications. -He had not felt any increased anxiety or stresses recently. Telephone interview with a representative from the facility's contracted pharmacy on 03/27/24 at 1:30pm revealed: -Resident #6 was dispensed hydroxyzine HCL 50mg quantity of 28 tablets on cycle fill on 03/08/24. -The hydroxyzine HCL 50mg dispensed 03/08/24 was returned to the pharmacy for credit back to Resident #6. Interview with the OM on 03/27/24 at 2:45pm revealed: -Medications filled on cycle fill were added to the medication carts by scanning the bar code on the packaging to ensure the medication was still active on a resident's eMAR. -If a cycle fill medication was not listed as current on a resident's eMAR, the medication was returned to the contracted pharmacy unopened for credit back to the resident's medication	D 358		

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D 358	Continued From page 10 account. -She routinely processed recommendations and reviewed pharmacy reviews generated during the Quarterly Pharmacy Reviews. -She was not sure why she discontinued Resident #6's hydroxyzine HCL 50mg on 03/06/24 -She may have confused the Pharmacist's documentation that Resident #6's hydroxyzine used as needed was discontinued in January 2024 noted on the pharmacy review, and hydroxyzine HCL 50mg still active on Resident #6's eMAR, somehow overlooking the hydroxyzine HCL 50mg was scheduled and not as needed. -She was not able to locate an order to discontinue hydroxyzine HCL 50mg for Resident #6. -She would notify the mental health provider (MHP) that hydroxyzine 50mg was discontinued inadvertently on 03/06/24 and verify the resident should still be receiving the medication. Interview with the Administrator on 03/27/24 at 4:15pm revealed: -She was not aware Resident #6's hydroxyzine HCL was discontinued on 03/06/24. -There should have been a double-check between the OM and the RCC for each medication discontinued to prevent errors. -The discontinued hydroxyzine should have been caught during the OM's audit of the eMAR compared to the current physician's orders. -No medication should be discontinued without a physician's order. Attempted telephone interview with Resident #6's MHP on 03/27/24 at 10:20am and 3:30pm was unsuccessful. Review of Resident #6's triage note dated	D 358		

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D 358	Continued From page 11 03/27/24, and provided by the OM at 4:20pm, revealed Resident #6 was supposed to be on hydroxyzine HCL 50mg twice a day and a new order was sent electronically to the contracted pharmacy.	D 358		