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	HAL092219	A. BUILDING: ______ B. WING ______	R 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARINA	**6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

{D 000} Initial Comments {D 000}

The Adult Care Licensure Section conducted a follow-up survey on May 7-8, 2024.

{D 358} 10A NCAC 13F .1004(a) Medication Administration {D 358}

10A NCAC 13F .1004 Medication Administration
(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

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

Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#3, #6) observed during the medication pass related to a medication used to treat fluid retention, medication used to treat or prevent potassium deficiency, medication used to treat fungal infections, medication used to treat or prevent constipation (#6) and medication used to lower blood sugar levels (#3).

The findings are:

The medication error rate was 16% as evidenced by 5 errors out of 30 opportunities during the 8:00am medication pass on 05/08/24.

1. Review of Resident #6's current FL2 dated 10/19/23 revealed diagnoses included heart disease, atrial fibrillation, hyperlipidemia, thyroid

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{D 358}	Continued From page 1 disorder, and congestive heart failure (Congestive heart failure is a condition where the heart does not pump blood as well as it should, resulting in fluid build-up in the lungs, legs, and feet). a. Review of Resident #6's current FL2 dated 10/19/23 revealed there was an order for Furosemide 40mg one tablet daily (Furosemide is a medication used to treat fluid retention caused by congestive heart failure). Observation of the assisted living (AL) medication pass from 8:10am to 8:30am revealed: -The Memory Care Director (MCD) was working as a medication aide (MA). -The MCD prepared Resident #6's medications, which did not include Furosemide 40mg. - The MCD administered medications to Resident #6 at 8:25am. Review of Resident #6's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Furosemide 40mg, one tablet daily. -Furosemide 40mg was documented as administered at 8:00am from 03/25/24 to 03/31/24. Review of Resident #6's April 2024 eMAR revealed: -There was an entry for Furosemide 40mg, one tablet daily. -Furosemide 40mg was documented as administered at 8:00am on 28 of 30 days in April 2024. -On 04/02/24 and 04/04/24, Furosemide 40mg was documented as drug not given (DNG). -On 04/02/24, there was an entry "contact pharmacy" documented in the notes section of	{D 358}		

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Resident #6's eMAR.

Review of Resident #6's May 2024 eMAR revealed:
-There was an entry for Furosemide 40mg, one tablet daily.
-Furosemide 40mg was documented as administered at 8:00am on 7 of 8 days in May 2024.
-On 05/08/24, Furosemide 40mg was documented as drug not given (DNG).
-On 05/08/24, there was an entry "will call pharmacy on medication" documented in the notes section of Resident #6's eMAR.

Observation of Resident #6's medications on hand on 05/08/24 at 12:51pm revealed there was no Furosemide 40mg on the medication cart.

Interview with the Memory Care Director (MCD) on 05/08/024 at 12:18pm revealed:
-She did not usually work on the B hall assisted living (AL) cart, but she was helping staff this morning, 05/08/24.
-She documented DNG on Resident #'6 eMAR for Furosemide 40mg because she did not see the medication on the medication cart.
-She informed the Health and Wellness Director (HWD) this morning, 05/08/24, that Resident #6 did not have Furosemide 40mg on the medication cart.
-MAs should notify the Resident Care Coordinator (RCC), MCD, or HWD if a residents' medications were not on the medication cart.
-The RCC, MCD, or HWD notified the pharmacy if medications were needed or the residents' primary care provider (PCP) if a refill on medication was needed.
-The RCC and MCD were responsible for auditing the medication carts.

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-The medication audits were not scheduled for a certain day, but she usually audited the carts at the end of each week, usually on Thursday or Friday.
-She was unsure why Resident #6's Furosemide 40mg was not available this morning, 05/08/24.
-She was unsure how long Resident #6's Furosemide 40mg was not on the medication cart because she did not usually work as a MA on that cart.
-If there was an order from a PCP, the medication should be available for administration.

Interview with the RCC on 05/08/24 at 2:35pm revealed:
-Resident #6's medications were sent to the facility in a monthly cycle fill order from the facility's contracted pharmacy, so the staff did not have to reorder the medications.
-Resident #6's medications on cycle fill were delivered to the facility each month.
-The facility's contracted pharmacy did not notify the facility if residents needed a refill on their medications.
-The facility staff had to contact the pharmacy to inquire if a resident needed refills on their medications.
-She did not recall seeing any faxes or receiving any notification from the pharmacy informing the facility Resident #6 needed a new order for refills of Furosemide 40mg.
-She was unsure why Resident #6 did not have Furosemide 40mg on the medication cart.
-She was unsure how long Resident #6 did not have Furosemide 40mg on the medication cart but did not think it had been long.
-Resident #6 could have fluid retention if he did not take Furosemide 40mg daily.
-The MAs, RCC, MCD, and HWD did medication cart audits to make sure residents' medications

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were available.
-Medication cart audits were performed randomly by the MAs, RCC, MCD, and HWD.
-She knew Resident #6 had medications that were not in the cart during some of the audits but was not aware of any current medications that were not available.

Interview with a pharmacist at the facility's contracted pharmacy on 05/08/24 at 1:00pm revealed:
-Resident #6's Furosemide 40mg was last filled on 11/22/23 and 30 tablets were sent to the facility, which was a 30-day supply.
-Furosemide 40mg was a cycle fill medication for Resident #6 but could not be sent to the facility because he was out of refills.
-The pharmacy attempted to contact Resident #6's PCP several times to request a new order for Furosemide 40mg but had not received a new order for the medication.
-The pharmacy sent a notification via fax to the facility when a new refill for medication was needed so the facility would be aware that a refill was needed and could also notify the PCP.

Interview with Resident #6's PCP on 05/08/24 at 11:27am revealed:
-Furosemide 40mg was a significant medication and should be taken daily.
-Resident #6 had a diagnosis of congestive heart failure and was taking Furosemide 40mg for that reason.
-If Resident #6 did not take Furosemide 40mg, he would be at risk of worsening heart failure.
-All medications ordered had a reason to be administered and Resident #6 should not miss any doses of any medications.

b. Review of Resident #6's current FL2 dated

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10/19/23 revealed there was an order for Potassium Chloride ER 20mEq, take one by mouth once daily (Potassium Chloride ER is an extended-release medication used to treat or prevent potassium deficiency).

Observation of the assisted living (AL) medication pass on 05/08/24 from 8:10am to 8:30am revealed:
-The Memory Care Director (MCD) was working as a medication aide (MA).
-The MCD prepared Resident #6's medications.
-The MCD looked for Potassium Chloride ER 20mEq but was not able to locate the medication on the medication cart.
-The MCD administered medications to Resident #6 at 8:25am.

Review of Resident #6's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Potassium Chloride ER 20mEq, one tablet once daily.
-Potassium Chloride ER 20mEq was documented as administered at 8:00am from 03/25/24 to 03/31/24.

Review of Resident #6's April 2024 eMAR revealed:
-There was an entry for Potassium Chloride ER 20mEq, one tablet once daily.
- Potassium Chloride ER 20mEq was documented as administered at 8:00am on 28 of 30 days in April 2024.
-On 04/02/24 and 04/04/24, Potassium Chloride ER 20mEq was documented as drug not given (DNG).
-On 04/02/24 and 04/04/24, there was an entry "contact pharmacy" documented in the notes section of Resident #6's eMAR.

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{D 358}	Continued From page 6 Review of Resident #6's May 2024 eMAR revealed: -There was an entry for Potassium Chloride ER 20mEq, take one tablet once daily. -Potassium Chloride ER 20mEq was documented as administered at 8:00am on 7 of 8 days in May 2024. -Potassium Chloride ER 20mEq was documented as drug not given (DNG) at 8:00am on 05/08/24. -There was an entry "will call pharmacy on medication" documented in the notes section of Resident #6's eMAR on 05/08/24. Observation of Resident #6's medications on hand on 05/08/24 at 12:51pm revealed there was no Potassium Chloride ER 20mEq on the medication cart. Interview with the Memory Care Director (MCD) on 05/08/024 at 12:18pm revealed: -She did not usually work on the B hall assisted living (AL) cart, but she was helping staff this morning, 05/08/24. -She documented DNG on Resident #6's eMAR for Potassium Chloride ER 20mEq because she did not see the medication on the medication cart. -She informed the Health and Wellness Director (HWD) this morning, 05/08/24, that Resident #6 did not have Potassium Chloride ER 20mEq, on the medication cart. -MAs should notify the Resident Care Coordinator (RCC), MCD, or HWD if a residents' medications were not in the medication cart. -The RCC, MCD, or HWD notified the pharmacy if medications were needed or the residents' primary care provider (PCP) if a refill on medication was needed. -The RCC and MCD were responsible for auditing	{D 358}		

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the medication carts.
-The medication audits were not scheduled for a certain day, but she usually audited the carts at the end of each week, usually on Thursday or Friday.
-She was unsure why Resident #6's Potassium Chloride 20mEq was not available this morning, 05/08/24.
-She was unsure how long Resident #6's Potassium Chloride 20mEq was not on the medication cart because she did not usually work as a MA on that cart.
-If there was an order from a PCP, the medication should be available for administration.

Interview with the RCC on 05/08/24 at 2:35pm revealed:
-Resident #6's medications were sent to the facility in a monthly cycle fill order from the facility's contracted pharmacy, so the staff did not have to reorder the medications.
-Resident #6's medications on cycle fill were delivered to the facility each month.
-The facility's contracted pharmacy did not notify the facility if residents needed a refill on their medications.
-The facility staff had to contact the pharmacy to inquire if a resident needed refills on their medications.
-She did not recall seeing any faxes or receiving any notification from the pharmacy informing the facility Resident #6 needed a new order for refills of Potassium Chloride ER 20mEq.
-She was unsure why Resident #6 did not have Potassium Chloride ER 20mEq on the medication cart.
-She was unsure how long Resident #6 was out of Potassium Chloride ER 20mEq but did not think it had been long.
-She was unsure why Resident #6 was taking

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Potassium Chloride ER 20mEq, but if his PCP ordered it, he needed the medication.
-The MAs, RCC, MCD, and HWD did medication cart audits to make sure residents' medications were available.
-Medication cart audits were performed randomly by the MAs, RCC, MCD, and HWD.
-She knew Resident #6 had medications that were not in the cart during some of the audits but was not aware of any current medications that were not available.

Interview with a pharmacist at the facility's contracted pharmacy on 05/08/24 at 1:00pm revealed:
-Resident #6's Potassium Chloride ER 20mEq was last filled on 12/21/23 and 30 tablets were sent to the facility, which was a 30-day supply.
-Potassium Chloride ER 20mEq was a cycle fill medication for Resident #6 but could not be sent to the facility because he was out of refills.
-The pharmacy attempted to contact Resident #6's PCP several times to request a new order for Potassium Chloride ER 20mEq but had not received a new order for the medication.
-The pharmacy sent a notification via fax to the facility when a new refill for medication was needed so the facility would be aware that a refill was needed and could also notify the PCP.

Interview with Resident #6's PCP on 05/08/24 at 11:27am revealed:
-Potassium Chloride ER 20mEq was a significant medication and should be taken daily.
-Resident #6 had a diagnosis of congestive heart failure and was prescribed a medication for fluid retention that could decrease his potassium levels.
-If Resident #6 did not take Potassium Chloride ER 20mEq, he would be at risk for low potassium

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levels.
-All medications ordered had a reason to be administered and Resident #6 should not miss any doses of any medications.

c. Review of Resident #6's current FL2 dated 10/19/23 revealed there was an order for Miralax 17gm, mix 17 gm with suitable liquid and drink once daily (Miralax is a medication used to treat or prevent constipation).

Observation of the assisted living (AL) medication pass from 8:10am to 8:30am revealed:
-The Memory Care Director (MCD) was working as a medication aide (MA).
-The MCD prepared Resident #6's medications.
-The MCD looked for Miralax but was not able to locate the medication on the medication cart.
-The MCD administered medications to Resident #6 at 8:25am.

Review of Resident #6's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax 17gm, mix 17gm with suitable liquid and drink once daily.
- Miralax 17gm was documented as administered at 8:00am from 03/25/24 to 03/31/24.

Review of Resident #6's April 2024 eMAR revealed:
-There was an entry for Miralax 17gm, mix 17gm with suitable liquid and drink once daily.
- Miralax 17gm was documented as administered at 8:00am on 29 of 30 days in April 2024.
-On 04/02/24, Miralax 17 gm was documented as drug not given (DNG).
-On 04/02/24, there was an entry "contact pharmacy" documented in the notes section of Resident #6's eMAR.

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Review of Resident #6's May 2024 eMAR revealed:
-There was an entry for Miralax 17gm, mix 17gm with suitable liquid and drink once daily.
Miralax 17gm was documented as administered at 8:00am on 7 of 8 days in May 2024.
-Miralax 17gm was documented as drug not given (DNG) at 8:00am on 05/08/24.
-There was an entry "will call pharmacy on medication" documented in the notes section of Resident #6's eMAR on 05/08/24.

Observation of Resident #6's medications on hand on 05/08/24 at 12:51pm revealed there was no Miralax on the medication cart.

Interview with the Memory Care Director (MCD) on 05/08/024 at 12:18pm revealed:
-She did not usually work on the B hall assisted living (AL) cart, but she was helping staff this morning, 05/08/24.
-She documented DNG on Resident #'6 eMAR for Miralax 17gm because she did not see the medication on the medication cart.
-She informed the Health and Wellness Director (HWD) this morning, 05/08/24, that Resident #6 did not have Miralax on the medication cart.
-MAs should notify the Resident Care Coordinator (RCC), MCD, or HWD if a residents' medications were not on the medication cart.
-The RCC, MCD, or HWD notified the pharmacy if medications were needed or the residents' primary care provider (PCP) if a refill on medication was needed.
-The RCC and MCD were responsible for auditing the medication carts.
-The medication audits were not scheduled for a certain day, but she usually audited the carts at the end of each week, usually on Thursday or

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Friday.
-She was unsure why Resident #6's Miralax 17gm was not available this morning, 05/08/24.
-She was unsure how long Resident #6's Miralax was not on the medication cart because she did not usually work as a MA on that cart.
-If there was an order from a PCP, the medication should be available for administration.

Interview with the RCC on 05/08/24 at 2:35pm revealed:
-Resident #6's medications were sent to the facility in a monthly cycle fill order from the facility's contracted pharmacy, so the staff did not have to reorder the medications.
-Resident #6's medications on cycle fill were delivered to the facility each month.
-The facility's contracted pharmacy did not notify the facility if residents needed a refill on their medications.
-The facility staff had to contact the pharmacy to inquire if a resident needed refills on their medications.
-She was unsure why Resident #6 did not have Miralax on the medication cart.
-She was unsure how long Resident #6 did not have Miralax on the medication cart but did not think it had been long.
-Resident #6 could become constipated if he did not take Miralax 17gm daily.
-The MAs, RCC, MCD, and HWD did medication cart audits to make sure residents' medications were available.
-Medication cart audits were performed randomly by the MAs, RCC, MCD, and HWD.
-She knew Resident #6 had medications that were not on the cart during some of the audits but was not aware of any current medications that were not available.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 12 Interview with a pharmacist at the facility's contracted pharmacy on 05/08/24 at 1:00pm revealed: -Resident #6's Miralax was last filled on 08/16/23 and a 510 gm container was sent to the facility, which was a 30-day supply. -Miralax was not sent in the cycle fill each month and must be reordered since it was a bulk product. -Resident #6 had refills remaining on Miralax, but no refills had been requested since August 2023. Interview with Resident #6's PCP on 05/08/24 at 11:27am revealed: -Miralax was important because the medication was ordered daily. -All medications ordered had a reason to be administered and Resident #6 should not miss any doses of any medications. -Resident #6 was at risk of constipation if he missed a dose of Miralax. d. Review of Resident #6's current FL2 dated 10/19/23 revealed there was an order for Nystatin Powder 100,000 units/gm, apply to groin twice daily at 8:00am and 8:00pm (Nystatin Powder is a medication used to treat fungal infections). Observation of the assisted living (AL) medication pass from 8:10am to 8:30am revealed: -The Memory Care Director (MCD) was working as a medication aide (MA). -The MCD prepared Resident #6's medications. -She entered Resident #6's room with a medicine cup containing tablets and capsules and administered Resident #6's medications at 8:25am. -There were no topical medications administered to Resident #6.	{D 358}		

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{D 358}	Continued From page 13	{D 358}		

Review of Resident #6's May 2024 eMAR revealed:
-There was an entry for Nystatin Powder 100,000 units/gm, apply to groin twice daily at 8:00am and 8:00pm.
- Nystatin Powder 100,000 units/gm was documented as drug not given (DNG) on 05/08/24.

Observation of Resident #6's medications on hand on 05/08/24 at 12:51pm revealed Resident #6's container of Nystatin Powder 100,000 units/gm was on the medication cart in the top drawer.

Interview with the Memory Care Director (MCD) on 05/08/024 at 12:18pm revealed:
-She did not usually work on the B hall assisted living (AL) cart, but she was helping staff this morning, 05/08/24.
-She documented DNG on Resident #'6 eMAR for Nystatin Powder 100,000 units/gm because she did not see the medication on the medication cart.

Interview with the RCC on 05/08/24 at 2:35pm revealed:
-Resident #6 had Nystatin Powder on the medication cart in the top drawer.
-The MCD did not see Resident #6's Nystatin Powder on the medication cart and did not administer Resident #6's Nystatin Powder this morning, 05/08/24.

Interview with Resident #6's PCP on 05/08/24 at 11:27am revealed:
-Nystatin Powder was important because the medication was ordered daily.
-All medications ordered had a reason to be administered and Resident #6 should not miss

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{D 358}	Continued From page 14 any doses of any medications. -Resident #6 was at risk for worsening fungal infection, skin redness, and irritation of the groin if he did not have the Nystatin Powder applied. Interview with Resident #6 on 05/08/24 at 3:50pm revealed: -He was not currently having any shortness of breath. -He could not recall having any shortness of breath or swelling in his feet or legs recently. -He was not having any constipation that he was aware of at this time. -He took medications every day. -He was unsure what the names of his medications were. -He was unsure if he had been out of any medications or missed any doses of any of his medications. Interview with the HWD on 05/08/24 at 3:40pm revealed: -She started at the facility as the HWD on 03/19/24. -The facility's contracted pharmacy did not let the facility know if residents needed refills on their medications. -The facility staff had to contact the pharmacy to inquire if residents needed refills on their medications. -She did not recall seeing any notifications from the facility's contracted pharmacy notifying the facility of Resident #6 needing refills for Furosemide 40mg or Potassium Chloride ER 20mEq. -Resident #6's medications were sent in a monthly cycle fill from the facility's contracted pharmacy. -The facility's contracted pharmacy delivered all medications that were routinely administered in	{D 358}		

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{D 358}	Continued From page 15 the monthly cycle fill. -Resident #6 did not have Furosemide 40mg, Potassium Chloride ER 20mEq, or Miralax in the medication cart because he was out of refills. -Resident #6 did have a container of Nystatin Powder 100,000 units/gm in the top drawer of the medication cart. -She was unsure how long Resident #6 had been out of the medications but did not think it was for long. -She thought that she recalled seeing the medications on the cart the previous day, 05/07/24, while she was doing some training with a MA. -MAs should contact the pharmacy if a medication was not on the medication cart during the medication pass. -MAs should report any medications not available on the medication cart to the RCC, MCD, or HWD. -She contacted Resident #6's PCP today, 05/08/24, and requested refills of the medications. -She was concerned that Resident #6 could have side effects, changes in condition, or be hospitalized if he did not receive medications as ordered by his PCP. Interview with the Administrator on 05/08/24 at 2:50pm revealed: -Resident #6's medications were supposed to be sent in the monthly cycle fill and delivered to the facility by the facility's contracted pharmacy. -Resident #6 was out of refills for some of his medications, which is why the medications were not in the medication cart this morning, 05/08/24. -She was unsure if the dispensing information obtained from the facility's contracted pharmacy for Furosemide 40mg, Potassium Chloride ER 20mEq, and Miralax was accurate.	{D 358}		

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{D 358}	Continued From page 16 -She thought Resident #6's family may have brought in some medications to the facility due to the length of time it had been since the medications were filled by the facility's contracted pharmacy. -MAs should notify the RCC, MCD, or HWD if medications were not available to administer. -It was important for the residents to get their medications as ordered by their PCP. Interview with Resident #6's family member on 05/08/24 at 3:12pm revealed: -Resident #6 moved into the facility in July 2022. -Resident #6 received all his medications from the facility's contracted pharmacy. -Resident #6 had not gotten medication filled at another pharmacy since he moved into the facility. -She had not brought any medications to the facility for Resident #6. 2. Review of Resident #3's current FL2 dated 04/22/24 revealed diagnoses included cognitive communication deficit, altered mental status, type 2 diabetes, chronic obstructive pulmonary disease, and morbid obesity. Review of Resident #3's physician's order dated 04/03/24 revealed there was an order for Lantus 25 units subcutaneously every morning and Lantus 20 units subcutaneously every evening (Lantus is a long-acting insulin used to lower blood sugar levels. According to the manufacturer, the Lantus insulin pen should be primed with a 2-unit air dose before each use to ensure the insulin is flowing through the needle and to remove any air bubbles prior to administration). Observation of the Special Care Unit (SCU)	{D 358}		

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{D 358}	Continued From page 17	{D 358}		

medication pass on 05/08/24 from 8:32am to 8:43am revealed:
-The medication aide (MA) dialed 2 units on Resident #3's Lantus insulin pen.
-The MA did not perform a 2-unit air shot prior to dialing the insulin pen to 2 units to ensure no air bubbles were present and insulin was flowing from the pen.
-The MA cleaned an area on the back of Resident #3's right upper arm with an alcohol swab.
-At 8:41am, the MA injected 2 units of Lantus into Resident #3's right upper arm, pressed the button on the pen, and held the pen in place.

Interview with the MA on 05/08/24 at 8:49am revealed:
-She approached the surveyor and informed the surveyor she administered Lantus 2 units and should have administered Lantus 25 units to Resident #3.
-She had not administered the remaining 23 units of Lantus because she wanted the surveyor to be aware that she realized she did not administer enough Lantus to Resident #3.

Second observation of the SCU 8:00am medication pass on 05/08/24 from 8:51am to 9:00am revealed:
-The MA dialed 23 units on Resident #3's Lantus insulin pen.
-The MA did not perform a 2-unit air shot prior to dialing the insulin pen to 2 units to ensure no air bubbles were present and insulin was flowing from the pen.
-The MA cleaned an area on the back of Resident #3's left upper arm with an alcohol swab.
-At 8:57am, the MA injected 23 units of Lantus into Resident #3's right upper arm, pressed the button on the pen, and held the pen in place.

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{D 358}	Continued From page 18	{D 358}		

Review of Resident #3's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus Solostar Pen, inject 25 units subcutaneously every morning.
-Lantus Solostar Pen, 25 units subcutaneously was documented as administered on 05/08/24 at 8:00am.

Second interview with the MA on 05/08/24 at 12:09pm revealed:
-She started working at the facility in 2012.
-She had training on insulin pen administration sometime during her employment at the facility but was unsure of the date.
-She remembered being trained on priming the insulin pen with an air shot.
-She was unsure of the reason why the insulin pen should be primed before administering insulin.
-She did not perform the air shot prior to administering Resident #3's insulin because she forgot.

Interview with the Memory Care Director (MCD) on 05/08/24 at 12:25pm revealed:
-MAs received training on insulin administration and diabetic care yearly.
-A nurse employed with the facility's contracted pharmacy completed diabetic training with the MAs.
-She was unsure when the MA had training on insulin pen administration.
-The MA should have primed the insulin pen by doing an air shot to remove any air bubbles.
-The MA should have administered Resident #3's Lantus in one dose this morning.

Interview with the Resident Care Coordinator (RCC) on 05/08/24 at 2:27pm revealed:

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{D 358}	Continued From page 19 -The MAs had a refresher course on medication administration in March 2024. -The medication administration refresher course was conducted by a nurse from the facility's corporate office. -MAs should prime the insulin pen before giving insulin. -Priming the insulin pen was a way to make sure the resident was getting the right amount of insulin, and the insulin pen was safe for administration. Interview with the Health and Wellness Director (HWD) on 05/08/24 at 12:35pm revealed: -She was unsure when the last time the MAs had training on insulin pen administration. -The MA should have done an air shot, dialed the pen to the correct dose, then administered the insulin. -The air shot was important to ensure there were no air bubbles, the pen was working properly, and the resident received the correct dose of insulin. Interview with the Administrator on 05/08/24 at 2:50pm revealed: -She was unsure when the last time MAs had specific training on insulin pen administration. -She was not familiar with performing an air shot each time insulin was administered with an insulin pen. -She became aware of the importance of an air shot prior to administering insulin with an insulin pen today, 05/08/24, after doing some research. -She was not sure why the MA did not administer the insulin correctly unless the MA was nervous. -If Resident #3 did not get her insulin properly, she was at risk for her blood sugar to be too high or too low. ______________________ The facility failed to administer medications as	{D 358}		

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{D 358}	Continued From page 20 ordered to 2 of 3 residents observed during the medication passes on 05/08/24 resulting in a 16% medication error rate. Resident #6 was not administered a medication used to treat fluid retention and was without this medication for over four months putting him at risk for worsening congestive heart failure and was not administered a medication used to prevent or treat low potassium levels and was without this medication for more than 3 months putting him at risk for potassium deficiency. The failure of the facility to administer medications as ordered placed the resident at substantial risk of serious physical harm and constitutes a Type A2 Violation. ____________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/08/24 for this violation. CORRECTION DATE FOR TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 7, 2024.	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration;	{D 367}		

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{D 367}	Continued From page 21 (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure accuracy of the medication administration record for 1 of 3 residents observed on the medication pass (#6) related to a medication used to treat fluid retention, a medication used to treat or prevent potassium deficiency, and a medication used to treat or prevent constipation. The findings are: Review of Resident #6's current FL2 dated 10/19/23 revealed diagnoses included congestive heart failure, heart disease, atrial fibrillation, hyperlipidemia, and thyroid disorder. a. Review of Resident #6's current FL2 dated 10/19/23 revealed there was an order for Furosemide 40mg one tablet daily (Furosemide is a medication used to treat fluid retention caused by congestive heart failure). Review of Resident #6's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Furosemide 40mg, one tablet daily. -Furosemide 40mg was documented as administered at 8:00am from 03/25/24 to 03/31/24.	{D 367}		

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{D 367}	Continued From page 22 Review of Resident #6's April 2024 eMAR revealed: -There was an entry for Furosemide 40mg, one tablet daily. -Furosemide 40mg was documented as administered at 8:00am on 28 of 30 days in April 2024. -On 04/02/24 and 04/04/24, Furosemide 40mg was documented as drug not given (DNG). -On 04/02/24, there was an entry "contact pharmacy" documented in the notes section of Resident #6's eMAR. Review of Resident #6's May 2024 eMAR revealed: -There was an entry for Furosemide 40mg, one tablet daily. -Furosemide 40mg was documented as administered at 8:00am on 7 of 8 days in May 2024. -On 05/08/24, Furosemide 40mg was documented as drug not given (DNG). -On 05/08/24, there was an entry "will call pharmacy on medication" documented in the notes section of Resident #6's eMAR. Observation of Resident #6's medications on hand revealed Resident #5 had no Furosemide 40mg on the medication cart. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 05/08/24 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/08/24 at 2:35pm. Refer to interview with the Health and Wellness Director (HWD) on 05/08/24 at 3:40pm.	{D 367}		

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Refer to interview with the Administrator on 05/08/24 at 2:50pm.

Refer to telephone interview with Resident #6's family member on 05/08/24 at 3:12pm.

b. Review of Resident #6's current FL2 dated 10/19/23 revealed there was an order for Potassium Chloride ER 20mEq take one by mouth once daily (Potassium Chloride ER is an extended-release medication used to treat or prevent potassium deficiency).

Review of Resident #6's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Potassium Chloride ER 20mEq, one tablet once daily.
- Potassium Chloride ER 20mEq was documented as administered at 8:00am from 03/25/24 to 03/31/24.

Review of Resident #6's April 2024 eMAR revealed:
-There was an entry for Potassium Chloride ER 20mEq, one tablet once daily.
- Potassium Chloride ER 20mEq was documented as administered at 8:00am on 28 of 30 days in April 2024.
-On 04/02/24 and 04/04/24, Potassium Chloride ER 20mEq was documented as drug not given (DNG).
-On 04/02/24 and 04/04/24, there was an entry "contact pharmacy" documented in the notes section of Resident #6's eMAR.

Review of Resident #6's May 2024 eMAR revealed:
-There was an entry for Potassium Chloride ER 20mEq, one tablet once daily

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{D 367}	Continued From page 24 - Potassium Chloride ER 20mEq was documented as administered at 8:00am on 7 of 8 days in May 2024. -On 05/08/24, Potassium Chloride 20mEq was documented as drug not given (DNG). -On 05/08/24, there was an entry "will call pharmacy on medication" documented in the notes section of Resident #6's eMAR. Observation of Resident #6's medications on hand revealed Resident #6 had no Potassium Chloride ER 20mEq on the medication cart. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 05/08/24 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/08/24 at 2:35pm. Refer to interview with the Health and Wellness Director (HWD) on 05/08/24 at 3:40pm. Refer to interview with the Administrator on 05/08/24 at 2:50pm. Refer to telephone interview with Resident #6's family member on 05/08/24 at 3:12pm. c. Review of Resident #6's current FL2 dated 10/19/23 revealed there was an order for Miralax 17gm, mix 17 gm with suitable liquid and drink once daily (Miralax is a medication used to treat or prevent constipation). Review of Resident #6's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Miralax 17gm, mix 17gm with suitable liquid and drink once daily. - Miralax 17gm was documented as administered at 8:00am from 03/25/24 to 03/31/24.	{D 367}		

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	HAL092219	A. BUILDING: ______ B. WING ______	R 05/08/2024

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THE ADDISON OF FUQUAY VARINA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 25 Review of Resident #6's April 2024 eMAR revealed: -There was an entry for Miralax 17gm, mix 17gm with suitable liquid and drink once daily. - Miralax 17gm was documented as administered at 8:00am on 29 of 30 days in April 2024. -On 04/02/24, Miralax 17 gm was documented as drug not given (DNG). -On 04/02/24, there was an entry "contact pharmacy" documented in the notes section of Resident #6's eMAR. Review of Resident #6's May 2024 eMAR revealed: -There was an entry for Miralax 17gm, mix 17gm with suitable liquid and drink once daily. - Miralax 17gm was documented as administered at 8:00am on 7 of 8 days in May 2024. -On 05/08/24, Miralax was documented as drug not given (DNG). -On 05/08/24, there was an entry "will call pharmacy on medication" documented in the notes section of Resident #6's eMAR. Observation of Resident #6's medications on hand revealed Resident #6 had no Miralax on the medication cart. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 05/08/24 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/08/24 at 2:35pm. Refer to interview with the Health and Wellness Director (HWD) on 05/08/24 at 3:40pm. Refer to interview with the Administrator on	{D 367}		

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{D 367}	Continued From page 26	{D 367}		

05/08/24 at 2:50pm.

Refer to telephone interview with Resident #6's family member on 05/08/24 at 3:12pm.

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Telephone interview with a pharmacist from facility's contracted pharmacy on 05/08/24 at 1:00pm revealed:
-Resident #6's Furosemide 40mg was last filled on 11/22/24 and 30 tablets were sent to the facility.
-Resident #6's Potassium Chloride ER 20mEq was last filled on 12/21/24 and 30 tablets were sent to the facility.
-Resident #6's Miralax was last filled on 08/16/23 and a 510 gm container was sent to the facility, which should last 30 days.
-Furosemide 40mg and Potassium Chloride ER 20mEq were both cycle fill medications for Resident #6 but could not be sent to the facility because he was out of refills.
-The pharmacy attempted to contact Resident #6's primary care provider (PCP) several times to request a new order for Furosemide 40mg and Potassium Chloride ER 20mEq but had not received a new order for either medication.
-The pharmacy sent a notification via fax to the facility when a new refill was needed so the facility would be aware that a refill was needed and could also notify the PCP.
-Miralax was not sent on a cycle fill each month and must be reordered since it was a bulk product.
-Resident #6 had refills remaining on Miralax, but no refills had been requested since August 2023.

Interview with the Resident Care Coordinator (RCC) on 05/08/24 at 2:35pm revealed:
-Resident #6's medications were on cycle fill from the facility's contracted pharmacy, so the

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{D 367}	Continued From page 27 medications were delivered automatically to the facility each month. -The staff did not have to reorder Resident #6's scheduled medications since the medications were on cycle fill. -Resident #6's medications were delivered to the facility each month from the facility's contracted pharmacy. -The facility's contracted pharmacy did not notify the facility if a resident needed a refill on a medication. -The facility staff had to call the pharmacy to inquire if a resident needed a refill on a medication. -She was unsure why Resident #6 did not have Furosemide 40mg, Potassium Chloride ER 20mEq, Miralax in the medication cart. -MAs were instructed to document drug not given (DNG) if a medication was not available on the medication cart. -If a medication was not on the medication cart, MAs should contact the pharmacy and report to the RCC, MCD, or HWD. -The medication aides (MA), RCC, Memory Care Director (MCD), and Health and Wellness Director (HWD) were responsible for medication cart audits to make sure residents' medications were available. -The medication cart audits were conducted randomly by the MAs, RCC, MCD, and HWD. -She knew Resident #6 had medications that were not in the cart during some of the audits but was not aware of any current medications that were not available. Interview with the Health and Wellness Director (HWD) on 05/08/24 at 3:40pm revealed: -The facility's contracted pharmacy did not let the facility know if a resident needed refills on their medications.	{D 367}		

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{D 367}	Continued From page 28 -The only way the facility knew if a resident needed refills was if they contacted the facility's contracted pharmacy and asked. -Medications that were given routinely were sent to the facility in the cycle fill delivery from the facility's contracted pharmacy each month. -MAs should not document that a medication had been given if the medication was not in the medication cart. -Resident #6 did not have Furosemide 40mg, Potassium Chloride ER 20mEq, Miralax in the medication cart because he was out of refills. -She contacted Resident #6's PCP today, 05/08/24, and requested refills of the medications. Interview with the Administrator on 05/08/24 at 2:50pm revealed: -Resident #6's medications were supposed to be on cycle fill and delivered to the facility monthly by the facility's contracted pharmacy. -Resident #6 was out of refills for some of his medications, which is why the medications were not in the medication cart this morning, 05/08/24. -She was unsure if the dispensing information obtained by the facility's contracted pharmacy for Furosemide 40mg, Potassium Chloride ER 20mEq, and Miralax was accurate. -She thought Resident #6's family may have brought in some medications due to the length of time it had been since the medications were filled by the facility's contracted pharmacy. -MAs should notify the RCC, MCD, or HWD if medications were not available to administer. Telephone interview with Resident #6's family member on 05/08/24 revealed: -Resident #6 had lived at the facility since July 2022. -Resident #6 got all his medications from the	{D 367}		

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{D 367}	Continued From page 29 facility's contracted pharmacy. -Resident #6 had not gotten medication filled at another pharmacy since he moved into the facility. -She had not brought any medications to the facility for Resident #6.	{D 367}		