STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092212	A. BUILDING: _____ B. WING _____	R 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY HOUSE OF ZEBULON	1205 W GANNON AVENUE ZEBULON, NC 27597

(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 The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on June 18-20, 2024. The complaint investigation was initiated by the Wake County Department of Social Services on May 31, 2024.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures at 6 of 16 fixtures accessible to residents were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F. The findings are: Review of the facility's environmental health inspection report dated 12/08/23 revealed: -The facility's score was 96 with 4 total demerits. -There were 1.5 demerits for hot water temperatures with a range of 97 degrees Fahrenheit (F) on one side of the building and 127 degrees F on the other side of the building. Observations of resident room 207 on 06/18/24 from 9:43am to 9:52am revealed:	D 113	hot water mixing value has been replaced regulating water temps throughout facility. housekeeping supervisor to perform weekly temps	8/04/24

Reviewed and acknowledged on 08/01/24 by JL

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D 113	Continued From page 1 -A resident exited the bathroom at 9:43am. -The hot water temperature at the bathroom sink was 121.1 degrees F at 9:50am. -The hot water temperature at the bathroom shower was 119 degrees F at 9:52am. Observations of resident room 209 on 06/18/24 at 10:00am revealed the water temperature at the bathroom shower was 118.5 degrees F. Recheck of hot water temperatures, after calibration of thermometers, with the Administrator on 06/18/24 from 10:08am to 10:13am revealed: -The hot water temperature at the bathroom sink in room 207 was 120.2 degrees F with the surveyor thermometer and 121.1 degrees F with the facility thermometer at 10:10am. -The hot water temperature at the bathroom shower in room 207 was 118 degrees F with the surveyor thermometer and 120 degrees F with the facility thermometer at 10:13am. Interview with maintenance person on 06/18/24 at 10:16am revealed: -He had just turned the thermostat down. -There was a problem with regulating hot water temperatures because a mixing valve was messed up. -The hot water temperatures went up and down. Observations of resident room 211 on 06/19/24 from 9:19am to 9:24am revealed: -Two residents were seated in the room watching television. -The hot water temperature at the bathroom sink was 120.5 degrees F at 9:21am. -The hot water temperature at the bathroom shower was 119.3 degrees F at 9:24am.	D 113		

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D 113	Continued From page 2 Observations of resident room 202 on 06/19/24 at 9:31am revealed the hot water temperature at the bathroom sink was 117.4 degrees F. Interview with a resident on 06/18/24 at 9:24am revealed: -The hot water temperature was hot when the water was first turned on. -If the water temperature was hot, she mixed the water with cold water. -She had never gotten burned by the hot water, but the hot water temperature did get "really hot". Interview with a second resident on 06/18/24 at 9:54am revealed: -The hot water sometimes got hot. -She had to let the hot water cool. -She had never gotten burned by the hot water, but the hot water temperature did get "really hot". Interview with a third resident on 06/18/24 at 9:55am revealed: -She thought the hot water temperatures cooled down. -She did not feel heat like everybody else because her hands were "messed up". -She saw the maintenance person check the water temperatures in the bathroom last week (no specific date provided). Interview with a personal care aide (PCA) on 06/18/24 at 10:00am revealed: -The hot water temperature was warm and not "hot, hot, hot". -The water temperature was just right for the residents when the residents showered. -Staff stayed with the residents when the residents showered. Interview with the Administrator on 06/18/24	D 113		

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D 113	Continued From page 3 between 10:04am to 10:14am revealed: -There was a bad mixing valve at the facility. -The facility had been waiting for someone to get time in their schedule to fix the mixing valve. -Hot water temperature checks were being performed weekly by the maintenance person. Interview with the maintenance person on 06/19/24 at 9:39am revealed: -The mixing valve on the 200-hall was not working. -The 200-hall mixing valve was shut off prior to new management of the facility and had not been turned back on because the mixing valve was not replaced. -He adjusted the hot water temperature when staff notified him the water temperature was too hot. -He performed hot water temperature checks at random fixtures daily from 05/01/24 through 06/07/24 but had not performed any water temperature checks since 06/10/24 until 06/18/24 after becoming aware of surveyor water temperature findings. Interview with the Administrator on 06/20/24 at 9:19am revealed: -She had contacted the corporate office about the need for a plumber visit to repair the mixing valve. -The corporate office was responsible for contacting a plumber to repair the mixing valve. -To her knowledge, the last plumber to visit the facility prior to the 06/19/24 plumber visit, was when the facility was under different management and was a couple months ago (no specific date provided).	D 113		
D 273	10A NCAC 13F .0902(b) Health Care	D 273		

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D 273	Continued From page 4 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure notification to the primary care provider (PCP) for 1 of 5 sampled residents (#2) related to blood sugar levels outside the parameters established by the residents' PCP. The findings are: Review of Resident #2's current FL2 dated 02/28/24 revealed: -Diagnoses included essential hypertension, diabetes mellitus, systolic congestive heart failure, chronic obstructive pulmonary disease, and cognitive communication deficit. -There was an order to check blood sugar every morning before breakfast, notify primary care provider (PCP) for blood sugar less than 100 or greater than 140. Review of Resident #2's May 2024 electronic medication administration record (eMAR) from 05/15/24 to 05/31/24 revealed: -There was an entry to check blood sugar every morning before breakfast, notify PCP for blood sugar less than 100 or greater than 140 scheduled daily at 7:30am. -On 05/16/24, Resident #2's blood sugar was documented as 145 at 7:30am. -On 05/17/24, Resident #2's blood sugar was documented as 142 at 7:30am. -On 05/27/24, Resident #2's blood sugar was documented as 90 at 7:30am. Review of Resident #2's June 2024 eMAR	D 273	RCC will review any blood sugars with perimeters daily and notify PCP when out range.	8/4/24

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D 273	Continued From page 5 revealed: -There was an entry to check blood sugar every morning before breakfast, notify PCP for blood sugar less than 100 or greater than 140 scheduled daily at 7:30am. -On 06/01/24, Resident #2's blood sugar was documented as 171 at 7:30am. -On 06/03/24, Resident #2's blood sugar was documented as 141 at 7:30am. -On 06/04/24, Resident #2's blood sugar was documented as 181 at 7:30am. -On 06/05/24, Resident #2's blood sugar was documented as 98 at 7:30am. -On 06/11/24, Resident #2's blood sugar was documented as 169 at 7:30am. -On 06/14/24, Resident #2's blood sugar was documented as 148 at 7:30am. -On 06/15/24, Resident #2's blood sugar was documented as 150 at 7:30am. -On 06/17/24, Resident #2's blood sugar was documented as 150 at 7:30am. -On 06/18/24, Resident #2's blood sugar was documented as 168 at 7:30am. Review of Resident #2's facility charting notes revealed: -There were no entries of notification to Resident #2's PCP regarding blood sugars outside of the established parameters on 05/16/24, 05/17/24, or 05/27/24. There were no entries of notification to Resident #2's PCP regarding blood sugars outside of the established parameters on 06/01/24, 06/03/24, 06/04/24, 06/05/24, 06/11/24, 06/14/24, 06/15/24, 06/17/24, or 06/18/24. Interview with Resident #2 on 06/19/24 at 11:16am revealed: -The staff checked his blood sugar every day before breakfast.	D 273		

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D 273	Continued From page 6 -He did not recall having any symptoms of his blood sugar being too high or too low. Interview with a medication aide (MA) on 06/19/24 at 1:35pm revealed: -Resident #2's blood sugars were usually checked by the third shift (11:00pm-7:00am) MA. -She usually worked on first shift (7:00am-3:00pm) but had worked third shift occasionally. -She had not checked Resident #2's blood sugar recently. -She was unsure if Resident #2's blood sugar was out of the parameters on the eMAR when she checked his blood sugar. -If Resident #2's blood sugar was lower or higher than the parameters on the eMAR, she would have contacted Resident #2's PCP. -She was unsure if she had ever needed to contact Resident #2's PCP regarding his blood sugar. Interview with the Resident Care Coordinator (RCC) on 06/20/24 at 12:48pm revealed: -MAs should follow instructions on each resident's eMAR. -MAs were responsible for contacting Resident #2's PCP about any blood sugars outside of the parameters on his eMAR, -If Resident #2's blood sugars were out of the parameters on the eMAR, MAs should notify his PCP. -MAs should also report to her when Resident #2's blood sugars were outside the parameters on the eMAR. -She was not notified of Resident #2's blood sugars being outside of the parameters on the eMAR in May 2024 or June 2024. -Resident #2 did not see the PCP that came to the facility, so contacting his PCP was more	D 273		

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D 273	Continued From page 7 difficult. -MAs could not send faxes to the PCP because the fax line was not working. -The fax line had not worked since January 2024. -Any notifications of Resident #2's blood sugar levels should have been documented in the facility charting notes. -She was unsure why the MAs did not contact Resident #2's PCP when his blood sugar was less than 100 or greater than 140. Interview with the Administrator on 06/20/24 at 11:30am revealed: -MAs should follow orders as written on the eMAR. -MAs were responsible for notifying a resident's PCP if there were instructions to notify the PCP for low or high blood sugar readings. -MAs should also report low or high blood sugar readings to the RCC. -Any attempts to contact a resident's PCP should be documented in the charting notes. -The facility could not send faxes because the fax line did not work. -The facility had not been able to send faxes since the facility was transferred to new management in January 2024. -She was unsure if MAs contacted Resident #2's PCP when his blood sugar was outside of the parameters on the eMAR. -MAs should have notified Resident #2's PCP about low and high blood sugar readings and documented in Resident #2's charting notes.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support	D 280	LHPS nurse from our contracted pharmacy will be coming to facility quarterly to ensure all LHPS are	8/04/24

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D 280	Continued From page 8 (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a licensed health professional support (LHPS) assessment was completed quarterly for 3 of 5 sampled residents (#2, #3, and #5). The findings are: 1. Review of Resident #2's current FL2 dated 02/28/24 revealed: -Diagnoses included essential hypertension, diabetes mellitus, systolic congestive heart failure, chronic obstructive pulmonary disease, and cognitive communication deficit. -There was an order to check blood sugar every morning before breakfast, notify primary care	D 280	up to date	

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D 280	Continued From page 9 provider (PCP) for blood sugar less than 100 or greater than 140. -There was an order for Semglee insulin pen, inject 5 units subcutaneously nightly. Increase by 2 units if morning blood sugar is greater than 140. (Semglee insulin pen is a long-acting injectable medication used to help control blood sugars) Review of Resident #2 May 2024 electronic medication administration record (eMAR) revealed: -There was an entry to check blood sugar every morning before breakfast, notify primary care provider (PCP) for blood sugar less than 100 or greater than 140. -There was an entry for Semglee insulin pen, inject 5 units subcutaneously nightly. Increase by 2 units if morning blood sugar is greater than 140. -Resident #2's blood sugar was documented as being checked daily at 7:30am and ranged 90-145 from 05/15/24 to 05/31/24. -Semglee insulin pen was documented as administered nightly at 8:00pm from 05/15/24 to 05/31/24 at 8:00pm. Review of Resident #2 June 2024 eMAR revealed: -There was an entry to check blood sugar every morning before breakfast, notify primary care provider (PCP) for blood sugar less than 100 or greater than 140. -There was an entry for Semglee insulin pen, inject 5 units subcutaneously nightly. Increase by 2 units if morning blood sugar is greater than 140. -Resident #2's blood sugar was documented as being checked daily at 7:30am and ranged 98-171. -Semglee insulin pen was documented as administered nightly at 8:00pm.	D 280		

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D 280	Continued From page 10 Review of Resident #2's record revealed there were no licensed health professional support (LHPS) assessments for review. Interview with Resident #2 on 06/19/24 at 11:16am revealed: -The staff checked his blood sugar every day before breakfast. -He received an insulin injection every night. Interview with a medication aide (MA) on 06/19/24 at 1:35pm revealed: -Resident #2's blood sugar was usually checked by the third shift MA. -Resident #2's insulin was scheduled for 8:00pm and was given by the second shift MA. Refer to interview with the Resident Care Coordinator (RCC) on 06/20/24 at 12:58pm. Refer to interview with the Administrator on 06/20/24 at 11:35am. 2. Review of Resident #3's current FL2 dated 01/30/24 revealed diagnoses included essential hypertension, type 2 diabetes mellitus, cardiomyopathy, and history of transient ischemic attack. Review of Resident #3's primary care provider's (PCP) order dated 03/04/24 revealed an order to check blood sugar every week on Monday before breakfast. Review of Resident #3 May 2024 electronic medication administration record (eMAR) revealed: -There was an entry to check blood sugar every week on Monday before breakfast. -Resident #3's blood sugar was documented as	D 280		

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D 280	Continued From page 11 being checked at 7:30am every Monday and ranged from 97-100 from 05/15/24 to 05/31/24. Review of Resident #3's June 2024 eMAR revealed: -There was an entry to check blood sugar every week on Monday before breakfast. -Resident #3's blood sugar was documented as being checked every Monday at 7:30am and ranged from 101-185. Review of Resident #2's record revealed there were no licensed health professional support (LHPS) assessments for review. Interview with Resident #3 on 06/19/24 at 2:40pm revealed the staff checked his blood sugar every week on Monday. Interview with a medication aide (MA) on 06/19/24 at 1:25pm revealed: -Resident #3's blood sugar was scheduled once a week on Mondays. -Resident #3's blood sugar was usually checked by the third shift medication aide (MA). Refer to interview with the Resident Care Coordinator (RCC) on 06/20/24 at 12:58pm. Refer to interview with the Administrator on 06/20/24 at 11:35am. 3. Review of Resident #5's current FL2 dated 01/09/24 revealed diagnoses included hypothyroidism and type 2 diabetes mellitus. Review of Resident #5's primary care provider's (PCP) orders dated 04/16/24 revealed: -There was an order for Thrombo-embolic deterrent (TED) hose, apply every morning and	D 280		

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D 280	Continued From page 12 remove in evening once daily as needed for leg swelling. (TED hose are used to prevent or minimize swelling in the legs) -There was an order to check blood sugar 3 times a day before meals. -There was an order for Basaglar Kwikpen inject 12 units subcutaneously every evening. (Basaglar Kwikpen is a long-acting injectable medication used to help control blood sugars) -There was an order for Insulin Aspart Pen inject 3 units subcutaneously twice daily with breakfast and dinner. (Insulin Aspart is a rapid-acting injectable medication used to help control blood sugars) -There was an order for Insulin Aspart Pen inject 4 units subcutaneously daily with lunch, do not give is blood sugar is less than 200. Review of Resident #5's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for TED hose, apply every morning and remove in evening once daily as needed for leg swelling. -There was an entry to check blood sugar 3 times a day before meals scheduled for 8:00am, 12:00pm, and 5:00pm. -There was an entry for Basaglar Kwikpen inject 12 units subcutaneously every evening scheduled for 5:00pm. -There was an entry for Insulin Aspart Pen inject 3 units subcutaneously twice daily with breakfast and dinner scheduled for 8:00am and 5:00pm. -There was an entry for Insulin Aspart Pen inject 4 units subcutaneously daily with lunch scheduled for 12:00pm, do not give if blood sugar is less than 200. -There was no documentation of Resident #5's TED hose being applied or removed from 05/15/24 to 05/31/24.	D 280		

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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 280	Continued From page 13 -Resident #5's blood sugar was documented 3 times daily at 8:00am, 12:00pm, and 5:00pm from 05/15/24 to 05/31/24 and ranged from 92-480. -Basaglar Kwikpen was documented as administered daily at 5:00pm from 05/15/24 to 05/31/24. -Insulin Aspart Pen 3 units was documented as administered twice daily at 8:00am and 5:00pm from 05/15/24 to 05/31/24. -Insulin Aspart Pen 4 units was documented as administered at 12:00pm on 11 of 17 days from 05/15/24 to 05/31/24. Review of Resident #5's June 2024 eMAR revealed: -There was an entry for TED hose, apply every morning and remove in evening once daily as needed for leg swelling. -There was an entry to check blood sugar 3 times a day before meals at 8:00am, 12:00pm, and 5:00pm. -There was an entry for Basaglar Kwikpen inject 12 units subcutaneously every evening scheduled for 5:00pm. -There was an entry for Insulin Aspart Pen inject 3 units subcutaneously twice daily with breakfast and dinner scheduled for 8:00am and 5:00pm. -There was an entry for Insulin Aspart Pen inject 4 units subcutaneously daily with lunch scheduled for 12:00pm, do not give if blood sugar is less than 200. -There was no documentation of Resident #5's TED hose being applied or removed. -Resident #5's blood sugar was documented 3 times daily at 8:00am, 12:00pm, and 5:00pm and ranged from 113-424. -Basaglar Kwikpen was documented as administered daily at 5:00pm. -Insulin Aspart Pen 3 units was documented as administered twice daily at 8:00am and 5:00pm.	D 280		

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D 280	Continued From page 14 -Insulin Aspart Pen 4 units was documented as administered at 12:00pm on 15 of 18 days. Review of Resident #5's record revealed: -The last licensed health professional support (LHPS) assessment was dated 05/18/22 and tasks included fingerstick blood samples, medication administration through injections, and applying and removing TED hose. -There were no other LHPS assessments for review. Interview with Resident #5 on 06/19/24 at 2:58pm revealed: -The staff checked her blood sugar around the time of every meal. -The staff administered her insulin 3 times each day. -She did not currently have any leg swelling. -She was unsure if she needed TED hose but could ask for them if she thought her legs were swollen. Interview with a medication aide (MA) on 06/19/24 at 1:18pm revealed: -She did not recall Resident #5 needing TED hose, so she had not applied or removed TED hose for Resident #5. -She usually worked from 7:00am to 3:00pm and checked Resident #5's blood sugar at breakfast and lunch. -She administered insulin to Resident #5 at breakfast and lunch unless the eMAR instructed her not to give the insulin. Refer to interview with the Resident Care Coordinator (RCC) on 06/20/24 at 12:58pm. Refer to interview with the Administrator on 06/20/24 at 11:35am.	D 280		

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D 280	Continued From page 15 Interview with the Resident Care Coordinator (RCC) on 06/20/24 at 12:58pm revealed: -The nurse responsible for completing licensed health professional support (LHPS) was employed by the facility's contracted pharmacy. -The nurse came to the facility 2 times in April 2024 and then went on medical leave. -She was aware the LHPS assessments should be completed quarterly. -The Administrator had been trying to find someone to complete LHPS assessments but had not been able to find a nurse. Interview with the Administrator on 06/20/24 at 11:35am revealed: -LHPS assessments for residents should be completed quarterly. -The facility's contracted pharmacy sent a nurse to the facility to complete LHPS assessments on 04/10/24 and 04/17/24. -The nurse was unable to complete all the LHPS assessments on those dates. -The nurse had to go on medical leave, and she did not know when the nurse would return from medical leave. -She had asked the facility's contracted pharmacy if another nurse could come to the facility to complete LHPS assessments, but the pharmacy did not send anyone else, and she had not heard anything else from the pharmacy.	D 280		
D 324	10A NCAC 13F .0906 (d) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (d) Telephone.	D 324	A designated phone has been established just for residents and placed in area that provides privacy.	8/4/24

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D 324	Continued From page 16 (1) A telephone shall be available in a location providing privacy for residents to make and receive calls. (2) A pay station telephone is not acceptable for local calls; and (3) It is not the home's obligation to pay for a resident's toll calls This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents had a telephone available in a private location for residents to make and receive telephone calls. The findings are: Observation of the facility from 06/18/24 to 06/20/24 revealed: -The current census of the facility was 43 residents. -Some residents had personal cell phones. -There was not a telephone in any common areas throughout the facility. -There was a cordless telephone at the desk in the nurses' station. Interview with a resident on 06/18/24 at 9:13am revealed: -He did not have a personal cell phone. -He made telephone calls occasionally. -When he needed to use the telephone, he used the telephone located in one of the staff member's offices. Interview with a second resident on 06/18/24 at 9:40am revealed: -He did not have a personal cell phone. -He used a telephone in the Business Office	D 324		

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D 324	Continued From page 17 Manager's (BOM) office when he needed to make a telephone call. Interview with a medication aide (MA) on 06/20/24 revealed: -The cordless telephone located in the nurses' station did not work. -The cordless telephone had not worked for at least a month. -If a resident needed to use the telephone, they could use the telephone located in the BOM's office, Resident Care Coordinator's (RCC) office, or the Administrator's office. -The residents and staff did not have access to a telephone in the facility when the managers were not there. -The staff had to use their personal cell phone to call the pharmacy, physician's offices, and resident's family members when the managers were not there. -Residents had to use a staff member's cell phone if they needed to make a telephone call after the managers left for the day and on weekends. Interview with the BOM on 06/20/24 at 11:50am revealed: -Residents used to have access to a cordless telephone, but the telephone had not worked for several weeks. -The facility had changed telephone service providers, and the cordless telephone stopped working. -Residents could use the telephones in any of the management offices. -Many of the residents had personal cell phones, but there were a few residents that asked to use her office telephone. -After the managers left the facility for the day, residents used their roommate's cell phones or	D 324		

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D 324	Continued From page 18 the staff's cell phones if they needed to make a telephone call. Interview with the Administrator on 06/19/24 at 3:40pm revealed: -Residents had a cordless telephone at the nurses' station that could be used for personal telephone calls. -The cordless telephone had stopped working a few weeks ago because the facility changed telephone service providers. -The other telephones in the manager's offices were working properly, but the cordless telephone did not work anymore, and she did not know why it was not working. -Residents could use the telephone in any manager's office and the manager would leave the office so the resident could speak privately. -There was no other telephone available for residents to use after the managers left the facility for the day. -Staff members let the residents use their personal cell phones to make telephone calls. -She was aware that residents should have access to a telephone in a private location.	D 324		
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.	D 358	Pharmacy will delivery multidose medication packs to facility on Tuesday. RCC will match physician orders to meds, and will be responsible for contacting pharmacy /MD for any missed meds. The medications go on cart on Wed. ED is working with pharmacy to transition multi dose packs to single dose monthly packs beginning Sept.	8/4/24

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D 358	Continued From page 19 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered to 1 of 6 residents (#6) observed during the medication pass including errors with an eye drop for glaucoma and an oral medication used for hypertension, and for 2 of 5 sampled residents (#1, #4) who had orders for a blood thinner (#1) , heart disorder medications (#1, #4), pain medication (#1, #4), anti-seizure medication (#1), dietary supplements (#1) blood pressure medication (#1, #4), a stomach disorder medication (#1), a laxative medication (#1), and a mood stabilizer (#1,#4). The findings are: 1. The medication error rate was 5% as evidenced by 2 errors out of 34 opportunities during the 2:00pm medication pass on 06/18/24 and the 8:00am medication pass on 06/19/24. Review of Resident #6's current FL-2 dated 01/23/24 revealed diagnoses included hypertension, benign prostatic hyperplasia, hyperlipidemia, insomnia, chronic pain, cerebral infarction, and visual impairment. a. Review of a physician order for Resident #6 dated 04/23/24 revealed an order for Lisinopril 30mg tablet daily. (Lisinopril is used to treat hypertension.) Observation of the 8:00am medication pass on 06/19/24 revealed:	D 358	RCC will be responsible that all meds are in facility.	

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D 358	Continued From page 20 -The medication aide (MA) removed 9 oral medications from Resident #6's medication packaged multidose unit (MDU) bubble package after comparing the medications listed on the MDU with medications displayed on the electronic medication administration record (eMAR). -There was no Lisinopril 30mg tablet included in the MDU packaged medications for Resident #6. -Resident #6 requested a pain pill which was added to the medications prepared for administration to the resident. -The MA administered 10 pills to Resident #6 with water in the hall outside the dining room. -The MA did not administer the Lisinopril 30mg tablet to Resident #6. Review of Resident #6's June 2024 eMAR revealed: -There was an entry for Lisinopril 30mg tablet daily scheduled at 8:00am. -Lisinopril 30mg tablet was documented as administered from 06/01/24 - 06/18/24. -The MA documented the Lisinopril 30mg tablet was unavailable and supplier contacted on 06/19/24 at 8:16am. Interview with the MA on 06/19/24 at 10:55am revealed: -The Lisinopril 30mg tablet for Resident #6 was not delivered to the facility and was not included in the MDU medication packaging for Resident #6. -She did not document administration of the Lisinopril for Resident #6 on 06/19/24. Telephone interview with the contracted pharmacy provider on 06/19/24 at 12:30pm revealed: -Lisinopril 30mg tablets were last dispensed to the facility on 06/12/24 quantity of seven tablets	D 358		

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for a 7-day supply.
-Resident #6 was out of refills for the Lisinopril 30mg tablets daily.
-A new prescription was needed for Resident #6's Lisinopril 30mg tablet.
-The contracted pharmacy manager contacted the facility administrator when refill prescriptions were needed.

Interview with Resident #6 on 06/20/24 at 11:50am revealed:
-He did not know if he was administered Lisinopril.
-The resident denied any feelings of dizziness.
-His blood pressure was checked "every so often" and it was good.

Refer to interview with a MA on 06/19/24 at 10:49am.

Refer to interview with the Resident Care Coordinator (RCC) on 06/19/24 at 2:46pm.

Refer to interview with the Administrator on 06/19/24 at 2:32pm.

Refer to interview with the Primary Care Provider (PCP) on 06/20/24 at 12:49pm.

b. Review of a physician order for Resident #6 dated 05/01/24 revealed an order for Dorzolamide / Timolol 2-0.5% instill 1 drop into right eye twice a day. (Dorzolamide / Timolol is a combination eye drop that contains two medications used to treat increased pressure in the eye caused by glaucoma.)

Observation of the 8:00am medication pass on 06/19/24 revealed:
-The medication aide (MA) administered 10 pills

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D 358	Continued From page 22 to Resident #6 with water in the hall outside the dining room. -The MA did not administer any eye drops to Resident #6. -The MA did not administer Dorzolamide / Timolol 2-0.5% eye drops as ordered. Review of Resident #6's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Dorzolamide / Timolol eye drops 22.3-6.8/1 (2-0.5%) instill 1 drop into right eye twice daily scheduled at 8:00am and 8:00pm. -Dorzolamide / Timolol was documented as administered from 06/01/24 - 06/18/24. -There was no documentation of administration for 06/19/24. Interview with the MA on 06/19/24 at 11:00am revealed: -The Dorzolamide/Timolol eye drops for Resident #6 were not in the facility. -She had been reordering the Dorzolamide/Timolol eye drops. -Another MA last requested a reorder of the eye drops on 06/10/24. -She thought the contracted provider pharmacy may need a new prescription and Resident #6 would have to revisit the eye doctor. Interview with the Administrator on 06/19/24 at 1:59pm revealed she found Resident #6's Dorzolamide/Timolol eye drops in another drawer of the medication cart where Resident #6 resided. Observations of the Dorzolamide/Timolol Maleate 2/0.5% eye drops for Resident #6 on 06/19/24 at 1:59pm revealed: -There was a pharmacy labeled 10ml bottle	D 358		

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D 358	Continued From page 23 container for Dorzolamide/Timolol Maleate for Resident #6. -The dispense date was not legible on the label. Interview with Resident #6 on 06/20/24 at 11:50am revealed: -He was supposed to have eye drops administered in the mornings. -He was not getting the morning eye drops. -He thought the eye drops were supposed to be placed in his right eye. -The MA told him the eye drops were lost. -He went to the eye doctor about one month ago. Telephone interview with the Primary Care Provider (PCP) for Resident #6 on 06/20/24 at 12:58pm revealed: -The Dorzolamide/Timolol eye drops for Resident #6 were prescribed by the eye doctor. -Resident #6 was already blind. -She did not know if Resident #6's condition would get worse by missing the administration of the eye drops. Interview with the Resident Care Coordinator (RCC) on 06/20/24 at 1:15pm revealed: -She did not have a telephone number for the eye doctor that prescribed the Dorzolamide/Timolol eye drops for Resident #6. -Resident #6's family member took the resident to the eye doctor appointment. Refer to interview with a MA on 06/19/24 at 10:49am. Refer to interview with the RCC on 06/19/24 at 2:46pm. Refer to interview with the Administrator on 06/19/24 at 2:32pm.	D 358		

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D 358	Continued From page 24 Refer to interview with the PCP on 06/20/24 at 12:49pm. 2. Review of Resident #1's current FL-2 dated 01/09/24 revealed diagnoses included atrial fibrillation, defibrillator, rheumatoid arthritis, gout, history of transient ischemic attack, cerebral infarction without residual deficits, gastro-esophageal reflux disease, serum neuropathy, history of chronic pain syndrome, hypertension, gastric ulcer, and hyperlipidemia. Review of physician orders for Resident #1 revealed: -There was a physician's order dated 01/09/24 for Amiodarone 200mg tablet once daily scheduled at 9:00am. (Amiodarone is used to treat heart arrhythmias.) -There was a physician's order dated 01/09/24 for Amlodipine 10mg tablet once daily scheduled at 9:00am. (Amlodipine is used to treat high blood pressure.) -There was a physician's order dated 01/09/24 for Metoprolol Succinate extended release 24-hour 50mg tablet once daily scheduled at 9:00am. (Metoprolol Succinate is used to treat high blood pressure.) -There was a physician's order dated 01/09/24 for Hydralazine 50mg tablet every eight hours scheduled at 6:00am, 2:00pm, and 10:00pm. (Hydralazine is used to treat high blood pressure.) -There was a physician's order dated 01/09/24 for Leflunomide 10mg tablet once daily scheduled at 8:00am. (Leflunomide is used to treat rheumatoid arthritis.) -There was a physician's order dated 01/09/24 for Allopurinol 100mg tablet once daily scheduled at 9:00am. (Allopurinol is used to treat gout.) -There was a physician's order dated 01/09/24 for	D 358		

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D 358	Continued From page 25 Duloxetine Delay Release 60mg capsule once daily scheduled at 9:00am. (Duloxetine is used to treat mood disorders.) -There was a physician's order dated 01/09/24 for Vitamin B-12 1000mcg tablet once daily scheduled at 8:00am. (Vitamin B-12 is used as a dietary supplement.) -There was a physician's order for dated 01/09/24 FeroSul 325mg tablet twice daily scheduled at 8:00am and 8:00pm. (FeroSul is a dietary supplement.) -There was a physician's order dated 01/09/24 for Eliquis 5mg tablet twice daily scheduled at 9:00am and 9:00pm. (Eliquis is used to thin the blood and prevent clot formation.) -There was a physician's order dated 01/09/24 for Levetiracetam 1000mg tablet twice daily scheduled at 8:00am and 8:00pm. (Levetiracetam is generic for Keppra which is used to control seizures.) -There was a physician's order dated 01/09/24 for Potassium Chloride 10 meq tablet twice daily scheduled at 8:00am and 5:00pm. (Potassium Chloride is a dietary supplement.) -There was a physician's order dated 01/09/24 for Sodium Chloride 5% ophthalmic eye drops instill one drop in both eyes twice daily scheduled at 8:00am and 8:00pm. (Sodium Chloride eye drops are used to is used to add moisture to dry eyes.) -There was a physician's order dated 01/09/24 for Omeprazole 20mg delayed release capsule twice daily scheduled at 8:00am and 8:00pm. (Omeprazole is used to treat stomach acid reflux.) -There was a physician's order dated 01/09/24 for Vitamin D-3 50mcg capsule daily scheduled at 8:00am. (Vitamin D-3 is a dietary supplement.) -There was a physician's order dated 01/09/24 for Folic Acid 1mg tablet daily scheduled at 9:00am.	D 358		

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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 26 (Folic Acid is a dietary supplement.) -There was a physician's order dated 01/09/24 for Stool Softener-Laxative 8.6-50mg tablet daily scheduled at 5:00pm. (Stool Softener-Laxative is used to treat constipation.) -There was a physician's order dated 04/30/24 for Biofreeze 4% topical gel apply small amount to both knees, neck, and both shoulders twice daily scheduled at 8:00am and 8:00pm. (Biofreeze is a topical get used to treat pain.) Review of the May 2024 electronic medication administration records (eMARs) for Resident #1 revealed: -There was an entry for Potassium Chloride ER 10meq tablet twice daily. -Potassium Chloride ER 10meq was documented as unavailable, supplier contacted on 05/19/24 at 4:04pm, 05/20/24 at 4:01pm, 05/21/24 at 4:11pm, 05/23/24 at 4:13pm, 05/24/24 at 4:45pm, 05/27/24 at 4:44pm, and 05/28/24 at 4:05pm. Review of the June 2024 eMARs for Resident #1 revealed: -There was an entry for Amiodarone 200mg tablet once daily scheduled at 9:00am; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted. -There was an entry for Amlodipine 10mg tablet once daily scheduled at 9:00am; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted. -There was an entry for Metoprolol Succinate extended release 24-hour 50mg tablet once daily scheduled at 9:00am; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted. -There was an entry for Hydralazine 50mg tablet every eight hours scheduled at 6:00am, 2:00pm,	D 358		

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D 358	Continued From page 27 and 10:00pm; there was documentation on 06/13/24 at 6:11am and 06/19/24 at 10:14am the medication was unavailable, supplier contacted. -There was an entry for Leflunomide 10mg tablet once daily scheduled at 8:00am; there was documentation on 06/19/24 at 10:14am and 06/20/24 at 10:03am the medication was unavailable, supplier contacted. -There was an entry for Allopurinol 100mg tablet once daily scheduled at 9:00am; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted. -There was an entry for Duloxetine Delay Release 60mg capsule once daily scheduled at 9:00am; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted. -There was an entry for Vitamin B-12 1000mcg tablet once daily scheduled at 8:00am; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted. -There was an entry for FeroSul 325mg tablet twice daily scheduled at 8:00am and 8:00pm; there was documentation on 06/19/24 at 10:14am and 7:13pm the medication was unavailable, supplier contacted. -There was an entry for Eliquis 5mg tablet twice daily scheduled at 9:00am and 9:00pm; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted. -There was an entry for Levetiracetam 1000mg tablet twice daily scheduled at 8:00am and 8:00pm; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted. -There was an entry for Potassium Chloride10meq tablet twice daily scheduled at 8:00am and 5:00pm; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted.	D 358		

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D 358	Continued From page 28 -There was an entry for Sodium Chloride 5% ophthalmic eye drops instill one drop in both eyes twice daily scheduled at 8:00am and 8:00pm; there was documentation on 06/19/24 at 10:14am and 06/20/24 at 10:03am the medication was unavailable, supplier contacted. -There was an entry for Omeprazole 20mg delayed release capsule twice daily scheduled at 8:00am and 8:00pm; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted. -There was an entry for Vitamin D-3 50mcg capsule daily scheduled at 8:00am; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted. -There was an entry for Folic Acid 1mg tablet daily scheduled at 9:00am; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted. -There was an entry for Stool Softener-Laxative 8.6-50mg tablet daily scheduled at 5:00pm; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted. -There was an entry for Biofreeze 4% topical gel apply small amount to both knees, neck, and both shoulders twice daily scheduled at 8:00am and 8:00pm; there was documentation on 06/19/24 at 10:14am the medication was unavailable, supplier contacted. Interview with Resident #1 on 06/19/24 at 9:11am revealed: -She had been administered some of her medications and had a few more to take. -She took a blood pressure pill before breakfast. Interview with the MA on 06/19/24 at 11:13am revealed: -Resident #1's medications were not delivered to the facility on 06/18/24 with the batch delivery of	D 358		

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D 358	Continued From page 29 medications. -She did not know why Resident #1's medications were not delivered to the facility on 06/18/24. -She informed the Administrator this morning (06/19/4) that Resident #1's medications were not delivered to the facility on 06/18/24 with the contracted pharmacy provider batch delivery of resident medications. Observation of medications on hand for Resident #1 on 06/19/24 at 11:37am revealed there was no Amiodarone, Amlodipine, Eliquis, FeroSul, Leflunomide, Levetiracetam, Potassium Chloride, Omeprazole, Stool Softener-Laxative, Vitamin D-3, Folic Acid, Metoprolol Succinate, Allopurinol, Vitamin B-12, and Duloxetine 60mg capsule on the medication cart. Observation of medications on hand for Resident #4 on 06/20/24 at 11:41am revealed: -Amiodarone 200mg tablet once daily was dispensed on 06/19/24 quantity 6. There were 5 tablets remaining on hand. -Amlodipine 10mg tablet daily was dispensed on 06/19/24 quantity 6. There were 5 tablets remaining on hand. -Metoprolol Succinate 50mg extend release 24-hour 50mg tablet daily was dispensed on 06/19/24 quantity 6. There were 5 tablets remaining on hand. -Hydralazine 50mg tablet every eight hours was dispensed on 06/18/24 quantity 105. There were 87 tablets remaining on hand. -Allopurinol 100mg tablet once daily was dispensed on 06/19/24 quantity 6. There were 5 tablets remaining on hand. -Duloxetine Delay Release 60mg capsule once daily was dispensed on 06/19/24 quantity 6. There were 5 tablets remaining on hand. -Vitamin B-12 1000mcg tablet once daily was	D 358		

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D 358	Continued From page 30 dispensed on 06/19/24 quantity 6. There were 5 tablets remaining on hand. -FeroSul 325mg tablet twice daily was dispensed on 06/19/24 quantity 12. There were 11 tablets remaining on hand. -Eliquis 5mg tablet twice daily was dispensed on 06/19/24 quantity 12. There were 11 tablets remaining on hand. -Levetiracetam 1000mg tablet twice daily was dispensed on 06/19/24 quantity 12. There were 11 tablets remaining on hand. -Potassium Chloride10meq tablet twice daily was dispensed on 06/19/24 quantity 12. There were 11 tablets remaining on hand. -Omeprazole 20mg delayed release capsule twice daily was dispensed on 05/16/24 quantity 60. There were 2 tablets remaining on hand. -Vitamin D-3 50mcg capsule daily was dispensed on 06/19/24 quantity 6. There were 5 tablets remaining on hand. -Folic Acid 1mg tablet daily was dispensed on 06/19/24 quantity 6. There were 5 tablets remaining on hand. -Stool Softener-Laxative 8.6-50mg tablet daily was dispensed on 06/19/24 quantity 6. There were 6 tablets remaining on hand. Observation of medications on hand for Resident #1 on 06/20/24 at 11:41am revealed the Leflunomide10mg tablet once daily remained unavailable for administration. Telephone interview with the contracted pharmacy provider on 06/19/24 at 12:43pm revealed: -There was a "computer glitch" and Resident #1's medications were not processed for delivery on 06/18/24 with the recent facility batch delivery of medications. -She did not know how the pharmacy became	D 358		

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D 358	Continued From page 31 aware that Resident #1's medications were not delivered with the facility batch delivery of medications on 06/18/24. Interview with Resident #1 on 06/18/24 at 9:38am revealed: -She was not administered blood pressure medicine on Thursday (06/13/24) because the medication was not in the facility. -Her blood pressure medication arrived at the facility and she only missed one dose. -She had "blood pressure trouble". -Her blood pressure was elevated when she visited a doctor last Friday (06/14/24) and she was not able to receive an injection because the blood pressure was too high. Observations of Resident #1 on 06/18/24 at 9:49am revealed: -An attendant entered the resident's room, who identified herself as the medical assistant for the nurse practitioner. -The resident informed the medical assistant that her (Resident #1) blood pressure was "up" last week. -A blood pressure reading for Resident #1 of 130/59 was obtained by the medical assistant. Interview with the Primary Care Provider (PCP) for Resident #1 on 06/18/24 at 12:05pm revealed: -She would not know if the resident's blood pressure was up unless the facility notified her. -She did not know why Resident #1 missed her blood pressure medication. -She found out today (06/18/24) when Resident #1 informed her, that the resident missed her blood pressure medication. -Resident #1's blood pressure is high at baseline and is hard to treat. -She was not too worried about the resident	D 358		

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D 358	Continued From page 32 missing one dose of her blood pressure medication. -Resident #1 is prescribed multiple blood pressure medications. Telephone interview with Resident #1's Primary Care Provider (PCP) on 06/20/24 at 12:49pm revealed: -She would not want Resident #1 to miss any doses of medications. -All of Resident #1's medications were "pretty concerning" because any of her medications could affect her heart. -If Resident #1's medications were not administered, her cardiac status could be affected causing a stroke or seizures. Refer to interview with a MA on 06/19/24 at 10:49am. Refer to interview with the Resident Care Coordinator (RCC) on 06/19/24 at 2:46pm. Refer to interview with the Administrator on 06/19/24 at 2:32pm. Refer to interview with the PCP on 06/20/24 at 12:49pm. 3. Review of Resident #4's current FL-2 dated 04/23/24 revealed diagnoses included lactic acidosis, tachycardia, vomiting and diarrhea, urinary tract infection (prior to admission), coronavirus (not Covid-19), primary hypertension, and Alzheimer's disease. Review of physician orders for Resident #4 revealed: -There was a physician's order dated 04/23/24 for Aspirin enteric coated (ASA EC) 81mg tablet	D 358		

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D 358	Continued From page 33 daily. (Aspirin 81mg EC is used to treat pain and heart disorders.) -There was a physician's order dated 04/23/24 for Zestril 2.5mg tablet daily. (Zestril is used to treat high blood pressure. -There was a physician's order dated 04/23/24 for Toprol XL 24-hour 50mg tablet daily. (Toprol is used to treat high blood pressure.) -There was a physician's order dated 04/2324 for Zoloft 12.5mg tablet daily. (Zoloft is used to treat mood disorders.) -There was a physician's order dated 04/23/24 for Lyrica 25mg capsule every night. (Lyrica is used to treat nerve pain.) -There was a physician's order dated 04/23/24 for Salonpas 4% two patches topically daily. (Salonpas Patches (Lidocaine) are topical medication patches used to treat pain.) Review of the May 2024 electronic medication administration records (eMARs) for Resident #4 revealed: -There was an entry for Lidocaine Pain Relief 4% Patch apply 2 patches transdermally daily to affected area(s) and remove at bedtime daily scheduled at 8:00am and 8:00pm. -There was documentation the Lidocaine Pain Relief 4% Patch was unavailable, supplier contacted on 05/08/24 at 7:17pm, 05/09/24 at 7:05pm, 05/10/24 at 7:03pm, 05/13/24 at 7:17pm, 05/14/24 at 7:07pm, 05/15/24 at 7:56pm, 05/16/24 at 8:08pm, 05/18/24 at 9:49pm, 05/19/24 at 8:51am, 05/19/24 at 8:08pm, 05/20/24 at 8:01pm, 05/22/24 at 7:25pm, 05/23/24 at 9:05pm, 05/24/24 at 7:02pm, and 05/28/24 at 7:07pm. Review of the June 2024 eMARs for Resident #4 revealed: -There was an entry for Pregabalin (equivalent to	D 358		

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D 358	Continued From page 34 Lyrica) 25mg tablet at bedtime scheduled at 8:00pm; there was documentation on 06/11/24 at 7:09pm and 06/12/24 at 7:04pm the medication was unavailable, supplier contacted. -There was an entry for Aspirin EC 81mg tablet daily scheduled at 8:00am; there was documentation on 06/19/24 at 10:10am the medication was unavailable, supplier contacted. -There was an entry for Lisinopril (equivalent to Zestril) 2.5mg tablet daily scheduled at 8:00am; there was documentation on 06/19/24 at 10:10am the medication was unavailable, supplier contacted. -There was an entry for Zoloft 25mg tablet take 0.5 tablet (12.5mg) daily scheduled at 8:00am; there was documentation on 06/19/24 at 10:10am the medication was unavailable, supplier contacted. -There was an entry for Metoprolol Succ ER (equivalent to Toprol XL) 50mg tablet daily scheduled at 8:00am; there was documentation on 06/19/24 at 10:10am the medication was unavailable, supplier contacted. Observation of medications on hand for Resident #4 on 06/19/24 at 11:15am revealed: -Resident #4's Aspirin 81mg tablet, Zestril 2.5mg tablet, Toprol XL 50mg tablet, and Zoloft 12.5mg tablet were not in the medication cart for administration. -There was a supply of ASA 81mg tablets removed by the Administrator from the overstock cabinet in the medication room. -There were two pharmacy labeled blister pack of Zestril 2.5mg tablets dated 03/27/24 and 04/23/24 for a total quantity on hand of 12 tablets removed by the Administrator from the overstock cabinet in the medication room. -There was a pharmacy labeled blister pack of Zoloft 12.5mg tablets dated 04/29/24 with a	D 358		

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D 358	Continued From page 35 quantity on hand of 5 tablets removed by the Administrator from the overstock cabinet in the medication room. -There was a pharmacy labeled blister pack of Lyrica 25mg capsule one capsule at bedtime with documentation for receipt at the facility on 06/12/24, quantity of 30 capsules. There were 24 capsules remaining on hand. Observation of medications on hand for Resident #4 on 06/20/24 at 11:31am revealed there was no Toprol XL available for administration. Interview with Resident #4 on 06/19/24 at 11:44am revealed: -Her legs were hurting earlier, but she was doing better now. -She had a headache this morning (Wednesday). -She thought the headache was because cold air was blowing on her head. -She was administered 3 or 4 pills in a cup this morning. -She knew she was administered a pain pill this morning and "a little capsule looking thing". Interview with the Medication Aide (MA) on 06/19/24 at 11:19am revealed: -She knew there were medications for Resident #4 in the overstock supply of medications. -She did not look in the overstock supply for Resident #4's scheduled 8:00am medications. -She administered Resident #4 those medications that were in the medication cart this morning (06/19/24). -She administered only the Vitamin B-12 capsule to Resident #4 thus far this morning (06/19/24). -The Administrator just provided her with medications for Resident #4 that were in the overstock medication supply.	D 358		

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D 358	Continued From page 36 Second interview with the MA on 06/19/24 at 11:41am revealed: -Resident #4's medications were not delivered to the facility on 06/18/24 with the batch delivery of medications. -She did not know why Resident #4's medications were not delivered to the facility on 06/18/24. -She informed the Administrator this morning (06/19/24) that Resident #4's medications were not delivered to the facility on 06/18/24 with the contracted pharmacy provider batch delivery of resident medications. -She had not checked the overstock medication supply today because she had not had time to do that. Telephone interview with the contracted pharmacy provider on 06/19/24 at 12:49pm revealed: -Resident #4 needed refill prescriptions from the Primary Care Provider (PCP) for the Aspirin EC 81mg tablet, Metoprolol 50mg tablet, Lisinopril 2.5mg tablet, and Zoloft 25mg tablet. -The facility was notified on 06/16/24 that refill prescriptions were needed for the medications. Telephone interview with Resident #4's Primary Care Provider (PCP) on 06/20/24 at 12:55pm revealed: -She would be worried about a stroke or heart attack for Resident #1 if the resident missed administration of Zestril and Toprol. -By missing one day of other medications such as Aspirin, would be "okay". Refer to interview with a MA on 06/19/24 at 10:49am. Refer to interview with the RCC on 06/19/24 at 2:46pm.	D 358		

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D 358	Continued From page 37 Refer to interview with the Administrator on 06/19/24 at 2:32pm. Refer to interview with the PCP on 06/20/24 at 12:49pm. Interview with a MA on 06/19/24 at 10:49am revealed: -She administered medication according to what was on the eMARs. -Any of the facility MAs were responsible for re-ordering resident's medications. -Resident medications were delivered to the facility from the contracted provider pharmacy every Tuesday for cart change out. -If a medication was not delivered with the weekly batch delivery on Tuesday, the MA should call the pharmacy. Interview with the Resident Care Coordinator (RCC) on 06/19/24 at 2:46pm revealed: -She was responsible for calling the contracted pharmacy provider for missing medications. -She had never used the backup pharmacy for medication delivery because most of the time there were medications in the overstock medication cabinet for residents. -All MAs knew to check the overstock medication cabinet for medications if the medication was not in the medication cart. Interview with the Administrator on 06/19/24 at 2:32pm revealed: -The facility called the contracted provider pharmacy when residents medications were not available in the facility for administration. -The contracted provider pharmacy should call the back-up pharmacy when residents medications were needed from the back-up	D 358		

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COVENTRY HOUSE OF ZEBULON	1205 W GANNON AVENUE ZEBULON, NC 27597

(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 38 pharmacy. -She did not know why the MAs did not call the backup pharmacy for missing medications but thought it may have something to do with payment. -The MAs did not realize medications were not available until the MAs started their medication pass the morning after the batch delivery of medications occurred. -The MA working the 11:00pm - 7:00am shift stocked the medication carts with the batch delivered medications. -The RCC was responsible to perform a medication cart audit the Wednesday morning following the Tuesday night batch delivered medications being placed in the medication carts. -The facility would need to start conducting a medication cart audit when batch delivered medications are stocked in the medication carts. -Medications had not been available for administration on another occasion. Telephone interview with the Primary Care Provider (PCP) on 06/20/24 at 12:49pm revealed: -She would want to be notified if a resident missed their medications. -She was concerned about any resident who missed their medications. -If medications were missed, she would tell the facility to make every effort to get the medication and administer the mediation the same day as soon as possible.	D 358		