STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MEADOW LAKES OF STATESVILLE	1372 EUFOLA ROAD STATESVILLE, NC 28677

(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 a complaint investigation from 07/22/24 through 07/24/24. The complaint investigation was initiated by Iredell County Department of Social Services on 07/12/24.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to implement physician's orders for 1 of 3 sampled residents (#2) related to compression stockings. The findings are: Review of Resident #2's current FL2 dated 09/21/23 revealed diagnoses included peripheral vascular disease, muscle weakness and dementia. Review of Resident #2's record revealed: -There was an order dated 07/03/24 for compression stockings to be applied in the morning and removed at night. -There was a copy of a fax that was received at the facility from the pharmacy on 07/03/24 at 2:30pm requesting leg measurements before compression stockings could be dispensed.	D 276		

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D 276	Continued From page 1 Review of Resident #2's Primary Care Provider (PCP) progress note dated 07/03/24 revealed: -Resident #2 was experiencing pain due to bilateral lower leg edema (fluid buildup). -Two weeks prior, Resident #2 started receiving a medication to reduce edema. -Due to continued edema the medication would be increased and compression stockings ordered. Review of Resident #2's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for compression stockings to be applied in the morning and removed at night with a note documenting pending confirmation of measurements for stockings. -There was no documentation compression stockings were applied. Interview with the Resident Care Coordinator (RCC) on 07/22/24 at 11:09am revealed: -She had been employed at the facility for one week. -She had not started conducting chart audits yet or she would have found the order for compression stockings and had the facility's contracted Registered Nurse (RN) obtain the measurements so the compression stockings could be ordered. Interview with the facility's contracted RN on 07/22/24 at 11:18am revealed: -She had been hired in May 2024 to conduct chart reviews. -She was at the facility once a week. -She did not know how she missed the order for compression stockings when she was conducting chart audits.	D 276		

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D 276	Continued From page 2 -She expected the RCC to inform her when orders were received that needed attention like leg measurements. -She did not know why the RCC who no longer worked at the facility, did not inform her of the order. Interview with the Administrator on 07/22/24 at 11:21am and 07/24/24 at 10:18am revealed: -The current RCC started work a week ago after the previous RCC resigned a few weeks ago. -She expected the RCC to inform the RN when leg measurements were needed. -There had been 2 RCCs and an RN in the facility conducting chart audits since the 07/03/24 order was received and did not know how the order was missed. -When orders were received from the PCP the medication aide (MA) was responsible for faxing the order to the pharmacy and then informing the RCC about the order. -The RCC or RN was responsible for verifying the order on the eMAR. Attempted telephone interview with Resident #2's PCP on 07/22/24 at 4:47pm was unsuccessful. Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the	D 344		

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resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

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

Based on observations, interviews and record reviews, the facility failed to clarify medications orders for 1 of 3 sampled residents (#3) regarding an order for a medication to treat seizures.

The findings are:

1. Resident #3's current FL2 dated 04/05/24 revealed:
-Diagnoses included dementia, other seizures, chronic kidney disease and bipolar disorder (mental illness associated with episodes of mood swings from depressive lows to manic highs).
-He was intermittently disoriented.

Review of Resident #3's signed physician orders dated 05/13/24 revealed an order for levetiracetam (a medication to treat seizures) 1000mg 1.5 tablet (1500mg) two times a day.

Review of Resident #3's June 2024 electronic Medication Administration Record (eMAR) from 06/01/24 to 06/28/24 revealed:
-There was an entry for levetiracetam 1000mg 1.5 tablets (1500mg) twice daily.
-Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as administered from

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06/01/24 to 06/24/24 at 9:00am and 9:00pm.
-Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as not administered from 06/25/24 to 06/27/24 at 9:00am and 9:00pm with a reason code of hospitalized.
-Levetiracetam 1000mg 1.5 tablets (1500mg) was documented as not administered on 06/28/24 at 9:00am with a reason code of hospitalized.

Review of Resident #3's hospital discharge summary dated 06/28/24 revealed:
-Resident #3 was diagnosed with partial complex seizures.
-An order for levetiracetam 750mg one tablet twice daily.

Review of Resident #3's June 2024 electronic Medication Administration Record (eMAR) from 06/28/24 to 06/30/24 revealed:
-Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as administered from 06/28/24 at 9:00pm to 06/30/24 at 9:00pm.
-There was an entry for levetiracetam 750mg one tablet twice daily beginning 06/28/24.
-Levetiracetam 750mg was documented as administered from 06/29/24 to 06/30/24 at 9:00am and 9:00pm.

Review of Resident #3's July 2024 eMAR from 07/01/24 to 07/03/24 revealed:
-There was an entry for levetiracetam 1000mg 1.5 tablets (1500mg) twice daily.
-Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as administered from 07/01/24 to 07/21/24 at 9:00am and 9:00pm.
-Levetiracetam 1000mg 1.5 tablets twice (1500mg) daily was documented as administered on 07/22/24 at 9:00am.
-There was entry for levetiracetam 750mg one tablet twice daily.

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-Levetiracetam 750mg 1 tablet twice daily was documented as administered on 07/01/24 and 07/02/24 at 9:00am and 9:00pm.
-Levetiracetam 750mg 1 tablet twice daily was documented as administered on 07/03/24 at 9:00am.

Review of Resident #3 signed physician orders dated 07/03/24 revealed an order to discontinue levetiracetam 1000mg 1.5 tablets (1500mg) twice daily.

Review of Resident #3's July 2024 eMAR from 07/03/24 to 07/22/24 revealed:
-There was an entry to D/C (discontinue) levetiracetam 750mg one tablet twice daily beginning 07/03/24 at 9:00am.
-There was no documentation levetiracetam 750mg one tablet twice daily was administered from 07/03/24 at 9:00pm to 07/22/24 at 9:00am.
-Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as administered from 07/03/24 through 07/22/24 and not discontinued per the physician orders dated 07/03/24.

Interview with a medication aide (MA) on 07/23/24 revealed:
-When a resident came back from the hospital with new medication orders the MA was responsible for faxing the new order to the pharmacy and follows up with a phone call to ensure the pharmacy received the order.
-MAs were responsible for ensuring medications are off the cart and discontinued.
-The Residential Care Coordinator (RCC) was responsible for sending the discontinued medication back to the pharmacy.
-She did not recall seeing the discontinued order in Resident #3's record.
-She had not been notified of any changes

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regarding Resident #3 levetiracetam order or that it had been discontinued.
-She acknowledged that Resident #3 should not have been given the Levetiracetam 1500mg after 07/03/24.
-If she knew Resident #3 there were two orders for levetiracetam she would need to call the primary care provider (PCP) to clarify which order was correct.
-She would have given Resident #3 the levetiracetam 750mg and clarified with the Administrator.

Observation of Resident #3's medications on hand on 07/23/24 at 11:13am revealed:
-There was one bubble pack of levetiracetam 1000mg halved tablets (500mg) with 1 tablet of 90 tablets remaining labeled with the resident's name and a dispense date of 04/23/24 take 1.5 tablets (1500mg) by mouth twice daily.
-There was one bubble pack of levetiracetam 1000mg halved tablets (500mg) with 25 tablets of 90 tablets remaining labeled with the resident's name and a dispense date of 04/23/24 take 1.5 tablets (1500mg) by mouth twice daily and instructions to refill after 05/17/24.
-There was one bubble pack of levetiracetam 1000mg with 25 tablets of 90 tablets remaining labeled with the resident's name and a dispense date of 04/23/24 take 1.5 tablets (1500mg) by mouth twice daily and instructions to refill after 05/17/24.
-There was a drawer on the bottom right-hand side of the medication cart with a cardboard divider titled overstock.
-There was one bubble pack of levetiracetam 750mg with 21 tablets of 60 tablets remaining labeled with the resident's name and a dispense date of 06/28/24 take one tablet by mouth twice daily and instructions to refill after 07/22/24.

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D 344	Continued From page 7 -There was one bubble pack of levetiracetam 750mg with 30 tablets of 60 tablets remaining labeled with the resident's name and a dispense date of 06/28/24 take 1.5 tabs by mouth twice daily and instructions to refill after 07/22/24. Interview with the RCC on 07/23/24 at 1:28pm revealed: -She began working at the facility on 07/15/24 after this error was made. -The expectation was when a resident was discharged from the hospital, the discharge paperwork should have been put in the PCP folder by the RCC. -The RCC should make the PCP aware of the new medication orders and clarify if he was agreeable to the new orders. -The RCC was expected to document the change in medication in the communication book. -The RCC or MA should fax the new orders to the pharmacy, then call the pharmacy and confirm the order. -The RCC and the MA should verify the new orders were entered correctly in the eMAR system. Interview with the facility's contracted Registered Nurse (RN) consultant on 07/23/24 at 11:22am revealed: -When a medication order was changed, added or discontinued the order should be faxed to the pharmacy. -Staff who sent the fax were supposed to document the date and time faxed on the order and put in in the 24-hour report book. -The RCC was responsible for faxing the changes to the pharmacy and follow up to make sure the medications were entered correctly on the eMAR. -The RCC was responsible for returning	D 344		

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medications to the pharmacy.
-The RCC would communicate the change in the 24-hour report book.
-She and the RCC were responsible for ensuring medication changes were correct.
-She acknowledged the provider should have been notified Resident #3 received both doses.
-The pharmacy was responsible for entering the orders on the eMAR.
-She acknowledged all medications need to be confirmed from the pharmacy to ensure the medication and orders were all correct.

Telephone interview with the facility's contracted Pharmacist on 07/23/24 at 12:49pm revealed:
-The pharmacy had a signed physician order dated 05/13/24 for levetiracetam 1000mg 1.5 tablets two times a day.
-The pharmacy received an order dated 06/28/24 for Resident #3 that was written upon discharge from the hospital for levetiracetam 750mg one tablet twice daily.
-On 07/03/24 the pharmacy received an order to discontinue levetiracetam 1000mg 1.5 tablets twice daily.
-The pharmacy technician entered the medication orders into the eMAR, and the pharmacist verified the orders.
-She did not know why the resident received both levetiracetam 750mg and levetiracetam 1500mg continued twice daily.

Telephone interview with the facility's contracted primary care provider (PCP) on 07/24/24 at 10:37am revealed:
-He wrote an order to discontinue the levetiracetam 1500mg twice daily on 07/03/24 because when Resident #3 was discharged from the hospital on 06/28/24 his levetiracetam was changed to levetiracetam 750mg twice daily and

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Depakote (a medication to treat bipolar) was started due to his kidney function.
-Resident #3 should not have been administered the levetiracetam 1500mg twice daily after 07/03/24.
-The orders on the resident's hospital discharge did not include an order to discontinue the levetiracetam 1500mg twice daily.
-Both orders for levetiracetam 1500mg twice daily and levetiracetam 750mg twice daily continued.
-He was notified yesterday (07/23/24) that Resident #3 received both doses of levetiracetam 1500mg twice daily and the levetiracetam 750mg twice daily on 07/01/24, 07/02/24 and the 8:00am dose on 07/03/24.
-The maximum dose of levetiracetam was 3000mg, could be given in higher doses, but he would not initiate a dose of 4500mg.
-A higher dose could cause Resident #3 to experience fatigue, dizziness, memory loss and could impact his kidney function.
-He was confused as to why the pharmacy would have entered the wrong medication (levetiracetam 750mg) on the eMAR as discontinued on 07/03/24 when levetiracetam 1500mg twice daily was to be discontinued.

Interview with the Administrator on 07/24/24 at 1:22pm revealed:
-The RCC was responsible to fax the new medication order to the pharmacy, save the fax confirmation and call the pharmacy to ensure the order was received and accurate.
-The RCC was responsible for confirmation of the new medication order and ensure the order is correct on the eMAR.
-The RCC should communicate any changes to medication orders to the MA and document the change in the internal communication book.
-She was not aware that Resident #3 had

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D 344	Continued From page 10 received both doses of the Levetiracetam 1500mg twice daily and the 750mg 1 tablet twice daily on 07/01/24, 07/02/24 and the morning of 07/03/24. -She was not aware that Resident #3 had received the 1500mg twice daily after it had been discontinued on 07/03/24. -It was her expectation that all orders were clarified and confirmed with the physician. _____ The facility failed to clarify a new physician order for a seizure medication when Resident #3 was discharged from the hospital resulting in the resident being administered 4500mg daily of the seizure medication from 06/30/24 to 07/03/24, and on 07/03/24 when an order to discontinue 3000mg continued when the resident was to receive 1500mg daily increasing the resident's risks for kidney problems, dizziness, fatigue and memory loss. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/23/24 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 7, 2024.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:	D 358		

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D 358	Continued From page 11 (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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (#1, #3) related to medications used to treat seizures (#3) and a medication to treat anxiety (#1). The findings are: 1. Resident #3's current FL2 dated 04/05/24 revealed: -Diagnoses included dementia, other seizures, chronic kidney disease and bipolar disorder (mental illness associated with episodes of mood swings from depressive lows to manic highs). -He was intermittently disoriented. Review of Resident #3's signed physician orders dated 05/13/24 revealed an order for levetiracetam (a medication to treat seizures) 1000mg 1.5 tablet (1500mg) two times a day. Review of Resident #3's hospital discharge medication orders dated 06/28/24 revealed an order for levetiracetam 750mg one tablet twice daily. Review of Resident #3's July 2024 eMAR from 07/01/24 to 07/03/24 revealed:	D 358		

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-There was an entry for levetiracetam 1000mg 1.5 tablets (1500mg) twice daily.
-Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as administered from 07/01/24 to 07/21/24 at 9:00am and 9:00pm.
-Levetiracetam 1000mg 1.5 tablets twice (1500mg) daily was documented as administered on 07/22/24 at 9:00am.
-There was entry for levetiracetam 750mg one tablet twice daily.
-Levetiracetam 750mg 1 tablet twice daily was documented as administered on 07/01/24 and 07/02/24 at 9:00am and 9:00pm.
-Levetiracetam 750mg 1 tablet twice daily was documented as administered on 07/03/24 at 9:00am.

Review of Resident #3 signed physician orders dated 07/03/24 revealed an order to discontinue levetiracetam 1000mg 1.5 tablets (1500mg) twice daily.

Review of Resident #3's July 2024 eMAR from 07/03/24 to 07/22/24 revealed:
-There was an entry to D/C (discontinue) levetiracetam 750mg one tablet twice daily beginning 07/03/24 at 9:00am.
-There was no documentation levetiracetam 750mg one tablet twice daily was administered from 07/03/24 at 9:00pm to 07/22/24 at 9:00am.
-Levetiracetam 1000mg 1.5 tablets (1500mg) twice daily was documented as administered from 07/03/24 through 07/22/24 and not discontinued per the physician orders dated 07/03/24.

Observation of Resident #3's medications on hand on 07/23/24 at 11:13am revealed:
-There was one bubble pack of levetiracetam 1000mg halved tablets (500mg) with 1 tablet of 90 tablets remaining labeled with the resident's

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name and a dispense date of 04/23/24 take 1.5 tablets (1500mg) by mouth twice daily.
-There was one bubble pack of levetiracetam 1000mg halved tablets (500mg) with 25 tablets of 90 tablets remaining labeled with the resident's name and a dispense date of 04/23/24 take 1.5 tablets (1500mg) by mouth twice daily and instructions to refill after 05/17/24.
-There was one bubble pack of levetiracetam 1000mg with 25 tablets of 90 tablets remaining labeled with the resident's name and a dispense date of 04/23/24 take 1.5 tablets (1500mg) by mouth twice daily and instructions to refill after 05/17/24.
-There was a drawer on the bottom right-hand side of the medication cart with a cardboard divider titled overstock.
-There was one bubble pack of levetiracetam 750mg with 21 tablets of 60 tablets remaining labeled with the resident's name and a dispense date of 06/28/24 take one tablet by mouth twice daily and instructions to refill after 07/22/24.
-There was one bubble pack of levetiracetam 750mg with 30 tablets of 60 tablets remaining labeled with the resident's name and a dispense date of 06/28/24 take 1.5 tabs by mouth twice daily and instructions to refill after 07/22/24.

Interview with a medication aide (MA) on 07/23/24 revealed:
-When a resident came back from the hospital with new medication orders the MA was responsible for faxing the new order to the pharmacy and following up with a phone call to ensure the pharmacy received the order.
-MAs are responsible for ensuring medications are off the cart and discontinued.
-The Residential Care Coordinator (RCC) was responsible for sending the discontinued medication back to the pharmacy.

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D 358	Continued From page 14 -She did not recall seeing the discontinued order in Resident #3's record. -She had not been notified of any changes regarding Resident #3 levetiracetam order or that it had been discontinued. -She administered Resident #3's levetiracetam on eight occasions from 07/04/24 through 07/22/24 as documented on the July eMAR. -She had followed the order on the eMAR which showed levetiracetam 750mg twice daily was discontinued and she administered levetiracetam 1500mg twice daily during her shift. Interview with the RCC on 07/23/24 at 1:28pm revealed: -She began working at the facility on 07/15/24 after this error was made. -The expectation was when a resident was discharged from the hospital, the discharge paperwork should have been put in the PCP folder by the RCC. -The RCC was expected to make the PCP aware of the new medication orders and clarify if he was agreeable to the new orders. -The RCC was expected to document the change in medication in the communication book. -The RCC or MA should fax the new orders to the pharmacy, then call the pharmacy and confirm the order. -The RCC and the MA should verify the new orders were entered correctly in the eMAR system. Interview with the facility's contracted Registered Nurse (RN) Consultant on 07/23/24 at 11:22am revealed: -When a medication order is changed, added or discontinued the order should be faxed to the pharmacy and document the date and the time it was faxed and put the information in the internal	D 358		

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D 358	Continued From page 15 24-hour report book. -The RCC was responsible for faxing the changes to the pharmacy. -The orders for the levetiracetam 1500mg twice daily and 750mg twice daily were not clarified. -Because the orders were not clarified Resident #3 continued to receive 4500mg of levetiracetam twice daily. -The MAs administered what was ordered according to the eMAR. Telephone interview with the facility's contracted Pharmacist on 07/23/24 at 12:49pm revealed: -The pharmacy had a signed physician order dated 05/13/24 for levetiracetam 1000mg 1.5 tablets two times a day. -The pharmacy received an order dated 06/28/24 for Resident #3 that was written upon discharge from the hospital for levetiracetam 750mg one tablet twice daily. -On 07/03/24 the pharmacy received an order to discontinue levetiracetam 1000mg 1.5 tablets twice daily. -The pharmacy technician entered the medication orders into the eMAR, and the pharmacist verified the orders. -She did not know why the resident received both levetiracetam 750mg and levetiracetam 1500mg twice daily. Telephone interview with the facility's contracted primary care provider (PCP) on 07/24/24 at 10:37am revealed: -He wrote an order to discontinue the levetiracetam 1500mg twice daily on 07/03/24 because when Resident #3 was discharged from the hospital on 06/28/24 his levetiracetam was changed to levetiracetam 750mg twice daily and Depakote (a medication to treat bipolar) was started due to his kidney function.	D 358		

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D 358	Continued From page 16 -Resident #3 should not have been administered the levetiracetam 1500mg twice daily after 07/03/24. -The orders on the resident's hospital discharge did not include an order to discontinue the levetiracetam 1500mg twice daily. -Both orders for levetiracetam 1500mg twice daily and levetiracetam 750mg twice daily continued. -He was notified yesterday (07/23/24) that Resident #3 received both doses of levetiracetam 1500mg twice daily and the levetiracetam 750mg twice daily on 07/01/24, 07/02/24 and the 8:00am dose on 07/03/24. -The maximum dose of levetiracetam was 3000mg, it could be given in higher doses, but he would not initiate a dose of 4500mg. -The higher doses could cause Resident #3 to experience fatigue, dizziness, memory loss and could impact his renal function. -He was confused as to why the pharmacy would have entered the wrong medication (levetiracetam 750mg) on the eMAR as discontinued on 07/03/24 when it should have been the levetiracetam 1500mg twice daily as discontinued. Interview with the Administrator on 07/24/24 at 1:22pm revealed: -The RCC was responsible to fax the new medication order to the pharmacy, save the fax confirmation and call the pharmacy to ensure the order was received and accurate. -The RCC was responsible for confirmation of the new medication order and ensure the order is correct on the eMAR. -The RCC should communicate any changes in medication orders to the MA and document the change in the internal communication book. -She was not aware that Resident #3 had received both doses of the Levetiracetam	D 358		

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1500mg twice daily and the 750mg one tablet twice daily on 07/01/24, 07/02/24 and the morning of 07/03/24.
-She was not aware that Resident #3 had received the 1500mg twice daily after it had been discontinued on 07/03/24.
-It was her expectation that all medication orders were clarified and confirmed to ensure they were administered correctly.

Based on record reviews and observations it was determined Resident #3 was not interviewable.

2. Review of Resident #1's current FL2 dated 04/10/24 revealed:
-Diagnoses included mood disturbance, psychotic disturbance (mental illness that affects the mind), and anxiety disorder.
-There was an order for divalproex (a medication to treat anxiety) 125mg, two capsules daily.

Review of Resident 1's hospice provider's note dated 04/17/24 revealed:
-There was an order for divalproex 125mg, two capsules daily in the morning.
-There was an order for divalproex 125mg, four capsules daily at bedtime.

Review of Resident #1's July 2024 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for divalproex 125mg, two capsules daily at 8:00am.
-There was documentation divalproex 125mg, two capsules were administered daily at 8:00am from 07/01/24 through 07/22/24 except on 07/04/24 due to Resident #1 being hospitalized.
-There was an entry for divalproex 125mg, four capsules daily at 8:00pm.
-There was documentation divalproex 125mg,

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D 358	Continued From page 18 four capsules were administered daily at 8:00pm from 07/01/24 through 07/21/24. Observation on 07/22/24 at 2:05pm of medications on hand for Resident #1 revealed there was no divalproex 125mg available for administration. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 07/24/24 at 12:24pm revealed: -Resident #1 had a current order for divalproex 125mg, two capsules in the morning and four capsules in the evening. -The facility faxed a refill request to the pharmacy on 07/22/24 for Resident #1's divalproex 125mg. -On 05/22/24, divalproex 125mg, 150 tablets (25 day supply) were last dispensed to the facility. -Divalproex 125mg was not dispensed for Resident #1 in June 2024 because there were no refills remaining. -Resident #1 could experience mood deterioration if divalproex 125mg was not administered as ordered. -The facility requested a refill for Resident #1's divalproex 125mg on 07/22/24. Telephone interview with a medication aide (MA) on 07/23/24 at 10:45am revealed: -She worked the night shift on 07/20/24 and 07/21/24. -There was no divalproex 125mg to administer to Resident #1, so she borrowed medication from another resident and wrote it in the notebook kept on the medication cart. -She could not recall which resident she borrowed the medication from. -She told the first shift MA coming on duty on 07/21/24 and 07/22/24 that Resident #1 was out of divalproex 125mg, and it needed to be	D 358		

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reordered.
-MAs were responsible to contact pharmacy if a medication was not available but it was hard to reach the pharmacy on night shift.

Interview with the Resident Care Coordinator (RCC) on 07/23/24 at 1:05pm revealed:
-She started working at the facility as the RCC last Monday (07/15/24).
-She was not aware of any notebook kept on the medication cart.
-A note was left on her desk yesterday morning (07/22/24) from the night shift MA informing her Resident #1 was out of his divalproex 125mg.
-She contacted the pharmacy and was told Resident #1 needed a new order to be faxed to the pharmacy.
-Resident #1's divalproex was delivered to the facility yesterday evening (07/22/24).

Interview with the Administrator on 07/24/22 at 1:25pm revealed:
-The RCC and the MAs were responsible for ordering the residents' medications when there were seven doses remaining.
-If a medication was not available to administer, she expected the MA to reach out to the pharmacy and order it "stat" (immediately).
-The previous RCC who left approximately two weeks ago and the current RCC were responsible for performing cart audits weekly to ensure all medications were available for administration.
-She was not aware Resident #1 did not receive his divalproex 125mg as ordered.

Attempted telephone interview on 07/24/24 at 1:55pm with Resident #1's hospice provider was unsuccessful.

Based on observations, interviews and record

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D 358	Continued From page 20 reviews it was determined Resident #1 was not interviewable. _____ The facility failed to administer a medication to treat seizures properly when Resident #3 was discharged from the hospital with an order to decrease his seizure medication dosage to 3000mg daily, but the resident received 4500mg. The 4500mg daily dose was not discontinued, increasing the residents' risks for renal issues, dizziness, fatigue and memory loss. Resident #1's anxiety medications was not refilled by the pharmacy in June 2024 which could cause the resident to experience mood deterioration. These failures were detrimental to the health, safety and welfare of the residents and constitutes a Type Unabated B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/23/24 for this violation.	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 interviews, and record reviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 3 residents relating to inaccurate documentation of a medication to treat anxiety (Resident #1). The findings are: Review of Resident #1's current FL2 dated 04/10/24 revealed: -Diagnoses included mood disturbance, psychotic disturbance (mental illness that affects the mind), and anxiety disorder. -There was an order for divalproex (a medication to treat anxiety) 125mg, two capsules daily. Review of Resident 1's hospice provider's note dated 04/17/24 revealed: -There was an order for divalproex 125mg, two capsules daily in the morning. -There was an order for divalproex 125mg, four capsules daily at bedtime. Review of Resident #1's July 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for divalproex 125mg, two capsules daily at 8:00am. -There was documentation divalproex 125mg,	D 367		

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two capsules were administered daily at 8:00am from 07/01/24 through 07/22/24 except on 07/04/24 due to Resident #1 being hospitalized.
-There was an entry for divalproex 125mg, four capsules daily at 8:00pm.
-There was documentation divalproex 125mg, four capsules were administered daily at 8:00pm from 07/01/24 through 07/21/24.

Observation on 07/22/24 at 2:05pm of medications on hand for Resident #1 revealed there was no divalproex 125mg available for administration.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 07/24/24 at 12:24pm revealed:
-Resident #1 had a current order for divalproex 125mg, two capsules in the morning and four capsules in the evening.
-The facility faxed a refill request to the pharmacy on 07/22/24 for Resident #1's divalproex 125mg.
-On 05/22/24, divalproex 125mg, 150 tablets (25 day supply) were last dispensed to the facility.
-Divalproex 125mg was not dispensed for Resident #1 in June 2024 because there were no refills remaining.
-Resident #1 could experience mood deterioration if divalproex 125mg was not administered as ordered.
-The facility requested a refill for Resident #1's divalproex 125mg on 07/22/24.

Telephone interview with a medication aide (MA) on 07/23/24 at 10:45am revealed:
-She worked the night shift on 07/20/24 and 07/21/24.
-There was no divalproex 125mg to administer to Resident #1, so she borrowed medication from another resident.

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D 367	Continued From page 23 Interview with the Resident Care Coordinator (RCC) on 07/23/24 at 1:05pm revealed: -She started working at the facility as the RCC last Monday (07/15/24). -A note was left on her desk yesterday morning (07/22/24) from the night shift MA informing her Resident #1 was out of his divalproex 125mg. -She contacted the pharmacy and was told Resident #1 needed a new order to be faxed to the pharmacy. -When a medication was not available on the medication cart, it was the responsibility of the MA to document on the eMAR that the medication was not given and the reason. -She did not know why a medication was documented as administered when it was not available for administration. Interview with the Administrator on 07/24/22 at 1:25pm revealed: -It was the responsibility of the MA to accurately document in the eMAR system when a medication was not administered. -The corporate Registered Nurse (RN) completed cart audits monthly comparing medications on hand to the eMAR. -The RCC was responsible for completing cart audits weekly comparing medications on hand to the eMAR. -She was not aware Resident #1's divalproex 125mg was not available for administration.	D 367		
D 467	10A NCAC 13F .1308 (c) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (c) In units of 16 or more residents and any units	D 467		

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D 467	Continued From page 24 that are freestanding facilities, there shall be a care coordinator as required in Paragraph (b) of this Rule in addition to the staff required in Paragraph (a) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure there was a Special Care Coordinator (SCC) on duty at least eight hours a day, five days a week. The findings are: Review of the facility's census on 07/22/24 revealed there were 30 residents who lived at the facility. Interview with the Administrator on 07/22/24 at 9:46am revealed the SCC was also the Activity Director (AD). Interview with the AD on 07/22/24 at 11:38am and 2:45pm revealed: -She started last Monday (07/15/24) as the AD. -Her job duties consisted of making the activity calendar, facilitating resident activities, and encouraging residents to participate in activities. -"Activities are my sole roll". -She worked Monday through Friday from 9:00am-5:00pm. -She did not do anything clinical. Review of the AD's personnel file revealed: -She applied for the AD position in July 2024. -There was documentation she signed the AD job duties descriptions upon hire.	D 467		

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D 467	Continued From page 25 Interview with the Administrator on 07/22/24 at 2:24pm revealed: -The AD was the back-up to the Resident Care Coordinator (RCC). -The SCC was responsible for monitoring the residents and generally worked Monday through Friday from 9:00am-5:00pm. -The SCC did not do anything clinical. Interview with the RCC on 07/23/24 at 1:05pm revealed: -The AD only did activities and nothing clinical. -The AD was not her assistant or back-up. Interview with the Administrator on 07/23/24 at 4:10pm revealed: -The AD was not hired to be the SCC but they talked about her fulfilling that role in the future. -She, as the Administrator, did all the duties a SCC would do and was technically the SCC. -The RCCs were counted in staffing hours and therefore could not be considered the SCC. Interview with the facility's Vice President of Operations on 07/24/24 at 8:55am revealed: -The facility only employed RCCs, not a SCC. -The Administrator acted as a SCC.	D 467		