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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 08/13/24 - 08/14/24.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure personal care and assistance for 1 of 5 sampled residents (#2) who required assistance with toileting care. The call bell or the bathroom push alert was activated 19 times, and the response time was 29 minutes or more including a wait time of 107 minutes. The findings are: Review of Resident #2's current FL-2 dated 06/04/24 revealed: -Diagnoses included hypertension, multiple strokes, atrial fibrillation, chronic kidney disease stage 3, history of deep vein thrombosis, and permanent pacemaker. -The resident was semi-ambulatory and required assistance with bathing and dressing. - The resident was continent of bladder and bowel. -The resident's current level of care was Assisted Living (AL).	D 269		

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D 269	Continued From page 1 Review of Resident #2's Resident Register revealed an admission date of 09/13/23. Review of Resident #2's current care plan dated 05/22/24 revealed: -She required assistance with activities of daily living such as toileting and bathing. -She was occasionally incontinent of bladder. Review of Resident #2's call bell and bathroom push alert history log dated 07-01-24 to 08-14-24 revealed: -On 07-02-24, the bathroom push alert was pushed 1 time at 8:32pm and staff responded at 9:24pm, 51 minutes later. -On 07-03-24, the call bell was pushed 14 times beginning at 6:44am and staff responded at 8:32am, 107 minutes later. -On 07-05-24, the bathroom push alert was pushed 2 times beginning at 7:38pm and staff responded at 8:09pm, 31 minutes later. -On 07-07-24, the call bell was pushed 18 times beginning at 9:22am and staff responded at 10:04am, 42 minutes later. -On 07-07-24, the call bell was pushed 2 times beginning at 2:42pm and staff responded at 3:11pm, 29 minutes later. -On 07-08-24, the call bell was pushed 3 times beginning at 10:46am and staff responded at 11:20am, 33 minutes later. -On 07-08-24, the call bell was pushed 4 times beginning at 4:48pm and staff responded at 5:27pm, 39 minutes later. -On 07-13-24, the call bell was pushed 4 times beginning at 10:49am and staff responded at 11:26am, 36 minutes later. -On 07-13-24, the call bell was pushed 3 times beginning at 6:59pm and staff responded at 7:30pm, 30 minutes later.	D 269		

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D 269	Continued From page 2 -On 07-18-24, the call bell was pushed 5 times beginning at 12:03pm and staff responded at 12:34pm, 30 minutes later. -On 07-18-24, the call bell was pushed 7 times beginning at 1:29pm and staff responded at 1:58pm, 29 minutes later. -On 07-20-24, the call bell was pushed 1 time at 10:53am and staff responded at 11:33am, 40 minutes later. -On 07-20-24, the bathroom push alert was pushed 16 times beginning at 7:52pm and staff responded at 8:24pm, 31 minutes later. -On 07-23-24, the call bell was pushed 7 times beginning at 2:35pm and staff responded at 3:17pm, 41 minutes later. -On 07-25-24, the call bell was pushed 4 times beginning at 7:02am and staff responded at 7:48am, 45 minutes later. -On 07-25-24, the bathroom push alert was pushed 3 times beginning at 6:34pm and staff responded at 7:45pm, 71 minutes later. -On 07-29-24, the call bell was pushed 3 times beginning at 6:30pm and staff responded at 7:25pm, 54 minutes later. -On 07-30-24, the call bell was pushed 5 times beginning at 2:18pm and staff responded at 2:48pm, 29 minutes later. -On 08-12-24, the call bell was pushed 12 times beginning at 7:04am and staff responded at 7:55am, 51 minutes later. Observation of a resident who pushed his call bell on 08/14/24 at 4:27pm revealed: -Staff responded to the call bell at 4:35pm, 8 minutes later. -A medication aide (MA) and a personal care aide (PCA) came into the room and helped him out of the bed into his wheelchair to give him medication and to take him to the dining hall for dinner.	D 269		

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D 269	Continued From page 3 Interview with Resident #2's on 08/13/24 at 2:15pm revealed: -She waited in the bathroom one day in July after having a bowl movement and could not get staff to assist her for about 48 minutes and she had to clean herself the best that she could because no one came to assist her. -She pushed the emergency call bell in the bathroom because no one would come after she pushed the call bell to assist her. -There were many days she had to wait at least 30 minutes after pushing the call bell and the emergency bell in the bathroom for staff to come to assist her. -She often pushed her call bell at least 5 to 6 times requesting assistance. Interview with Resident #2's family member on 08/13/24 at 2:15pm revealed: -Resident #2 called her in July, could not recall the exact date, crying that she had a bowel movement and could not get anyone to help clean her for about 48 minutes in the bathroom. -On 08/12/24, she spoke with the administrator about the issue of staff not coming to assist when her family member pushed the call bell. -The administrator stated that staff should respond in less than 10 minutes. Interview with a second Resident residing on the AL hall on 08/14/24 at 4:20pm revealed: -When he pushed the call bell for assistance it did take staff at least 20 minutes to respond to his needs such as needing assistance in the restroom. -He had not reported the late response to his call bell request to anyone at the facility. Interview with a third Resident residing on the AL hall on 08/14/24 at 4:25pm revealed:	D 269		

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D 269	Continued From page 4 -When he pushed the call bell for assistance it did take staff at least 20 to 30 minutes to respond to his needs such as needing his adult underwear changed or wishing to move from the bed to sit in his wheelchair. -Waiting for someone to respond to his call bell was daily. -The PCA would never say what took so long to come when he asked. -He had not reported the late response to his call bell request to anyone at the facility. Interview with a PCA on 08/14/24 at 3:45pm revealed: -She responded to Resident #2 call bell when it rung, to see what she needed, and would assist with personal care such as toileting care. -If she was busy, she would page the other PCAs to see if they could go to see what Resident #2 needed. -The call bell sound went to all PCAs pagers. -She responded to call bells as soon as possible and at least in 10 minutes when her pager went off. Interview with a second PCA on 08/14/24 at 4:40pm revealed: -She was assigned to the resident who pushed the call bell at 4:27pm. -She was sitting with another resident in the hall when her pager sound went off. -The call bell sound goes to other care givers, and she thought someone else would find out what the resident needed. -She normally would get up once she heard her pager go off but did not that time. -She had 10 minutes to respond to the call bell. Interview with a medication aide (MA) on 08/14/24 at 4:50pm revealed: -The PCA had 10 minutes to respond to call bell request.	D 269		

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D 269	Continued From page 5 -Once the PCA was in the room, see what the resident needed and clear the bell that staff had responded. -If the PCA was busy with another resident, they were to use their walkie talkies give the room number and ask if another PCA could go and assist the resident. Interview with the Resident Service Director (RSD) on 08/14/24 at 5:50pm revealed: -She was aware that Resident #2 had waited for staff to respond to the activated call bell. -She expected staff to respond to the call bell "as quickly as possible" to assist residents with their personal care needs but there was no set time that staff should respond to a call bell. -If the PCA was busy with another resident, they were to use their walkie talkies and express that they needed help and another PCA would go to assist the resident. -They had "daily stand up" with the staff and reported the call bell history of which resident's had the longest wait time response and encouraged staff to decrease the wait time. -During regular staff meetings she would discuss wait time response with call bells to assist with personal care and encouraged the staff to use their walkie talkies if they were busy during a resident's call bell activation. Interview with the Administrator on 08/14/24 at 6:40pm revealed: -He had a care conference with Resident #2 family member on 08/12/24. -On 08/12/24, he became aware that Resident #2 had waited for staff to respond to the activated call bell. -There are things going on in the "community" the reason it can take some time to respond to a resident's call bell.	D 269		

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D 269	Continued From page 6 -Most responses were within reason but there had been some long wait times and did not recall how many. -During a meeting with the MAs on last Thursday, 08/08/24, he instructed them to pull the call bell response time on their laptops and if notice the wait was long go and help or call a PCA to assist the resident. -His expectation was staff were to respond to a resident's call bell as soon as possible to assist residents with their personal care needs.	D 269		
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 ensure physicians' orders were implemented for 1 of 5 sampled residents (#5) with orders for thrombo-embolic deterrent hose (TED). The findings are: Review of Resident #5's current FL-2 dated 04/03/24 revealed: -Diagnoses included hemiplegia, hypertension, chronic kidney disorder, and anxiety disorder. -The resident needed assistance with bathing, dressing, toileting, and ambulation.	D 276		

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D 276	Continued From page 7 Review of Resident #5's physician orders dated 04/03/24 revealed thrombo-embolic deterrent hose (TED) hose knee high were to be applied every morning and removed at bedtime. Review of Resident #5's licensed health professional services (LHPS) form dated 07/18/24 revealed documentation that the resident wore TED hose. Review of Resident #5's August medication administration record (MAR) revealed: -There was an entry for TED hose to be applied at 8:00am and removed at 8:00pm daily. -TED hose were documented as applied and removed daily from 08/01/24 to 08/14/24. Observation of Resident #5 on 08/13/24 at various times between 12:00pm-4:00pm revealed she was not wearing TED hose. Observation of Resident #5 on 08/14/24 at 9:00am and 10:30am revealed she was not wearing TED hose. Interview with Resident #5 on 08/13/24 at 4:15pm revealed she did not wear TED hose. Interview with a medication aide (MA) on 08/14/24 at 10:40am revealed: -The MA's were responsible for applying and removing TED hose to Resident #5. -Resident #5 should have had her TED hose applied at 8:00am and removed at 8:00pm daily. -There were times the MAs put Resident #5's TED hose on in the afternoon. -She signed the eMAR that morning at 8:00am that she applied Resident #5's TED hose.	D 276		

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D 276	Continued From page 8 Interview with a second medication aide (MA) on 08/14/24 at 10:50am revealed: -The MAs were responsible to put on Resident #5's TED hose in the morning and remove them at night. -Staff members took Resident #5's TED hose off in the afternoon if she complained about them. -She put Resident #5's TED hose on at 8:00am on 08/13/24. -She did not know why Resident #5's TED hose were not on the afternoon of 08/13/24. Interview with the Resident Services Director on 08/14/24 at 3:00pm revealed: -She expected the MAs to apply Resident #5's TED hose every morning at 8:00am and remove them every night at 8:00pm. -She expected the MAs to sign the eMAR for application of TED hose after they had been applied. -If she was notified that a resident refused to wear TED hose then she attempts to get the order for the TED hose discontinued. Interview with the Administrator on 08/14/24 at 4:00pm revealed: -He expected the MAs to follow physician orders for the application and removal of thrombo-embolic deterrent hose (TED). hose. -MAs were responsible for ensuring that residents wore their TED hose daily. -He expected the MAs to sign the electronic medication administration record (eMAR) for the TED hose after they had been put on the resident. -The managers checked the eMARs regularly to ensure the MAs were following physician orders. Attempted telephone interview with Resident #5's	D 276		

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D 276	Continued From page 9 family member on 08/14/24 at 2:00pm was unsuccessful. Attempted telephone interview with Resident #5's primary care provider (PCP) on 08/14/24 at 2:00pm was unsuccessful.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (#6 and #7) observed during the medication pass including errors with a topical antifungal cream (#6), a steroidal eye drop solution and a laxative (#7); and for 2 of 3 sampled residents (#1 and #2) including errors with eye pressure reducing eye drops and topical pain relief patches (#1) and eye drop was discontinued without a doctor's order (#2). The findings are: The medication error rate was 9% as evidenced by 3 errors out of 32 opportunities during the morning medication pass on 08/14/24.	D 358		

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1. Review of Resident #7's current FL-2 dated 08/06/24 revealed diagnoses included chronic obstructive pulmonary disease, hypoxia, and respiratory failure.

Observation during the morning medication pass on 08/14/24 at 8:54am revealed:
-The medication aide (MA) prepared Resident #7's morning medications which included 9 and ½ pills, 1 topical gel, an inhaler and eye drops.
-The MA announced she was requesting refills electronically from the pharmacy for 2 medications that were not on the medication cart for Resident #7.
-The MA administered the medications to Resident #7 in his room with water (no additive).

Interview with the MA on 08/14/24 at 8:56am revealed:
-She did not know how long Resident #7's medications had been out of stock because she had been off for 2 days.
-Sometimes electronic refill requests did not always go through to the pharmacy.

a. Review of Resident #7's current FL-2 dated 08/06/24 revealed an order for prednisolone 1% ophthalmic solution 1 drop in the right eye 4 times daily. (Prednisolone ophthalmic solution is used to treat mild to moderate eye inflammation and allergies.)

Observation during the morning medication pass on 08/14/24 at 8:54am revealed Resident #7 did not receive prednisolone eye drops.

Review of Resident #7's June, July, and August 2024 electronic medication administration records (eMARs) revealed:
-There was an entry for prednisolone 1% one

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drop into the right eye 4 times daily at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation prednisolone 1% eye drops were administered from 8:00am on 06/01/24 through 08/14/24 at 8:00am.

Interview with Resident #7 on 08/14/24 at 2:55pm revealed:
-He had not been given eye drops 4 times daily for 3-4 days or a week.
-He asked the medication aide (MA) where his eye drops were and was told they had to be ordered.
-He had cataracts, and his eye doctor ordered the drops which had helped him a lot.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/14/24 at 11:32am revealed:
-The pharmacy had an order dated 07/19/23 for prednisolone 1% one eye drop to the right eye 4 times daily for Resident #7.
-The pharmacy dispensed a 10ml bottle of prednisolone eye drops for Resident #7 on 04/30/24 and 06/30/24.
-Each 10ml bottle of prednisolone contained 15-20 drops per ml or 150-200 drops per bottle which would last Resident #4 between 37 and 50 days.
-The pharmacy had not received a refill request since 06/20/24, for Resident #7's prednisolone until today.

b. Review of Resident #7's current FL-2 dated 08/06/24 revealed an order for Miralax 17 grams in 8 ounces of liquid daily with breakfast. (Miralax is used to treat constipation.)

Observation during the morning medication pass on 08/14/24 at 8:54am revealed Miralax was not

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administered to Resident #7.

Review of Resident #7's June, July, and August 2024 electronic medication administration records (eMARs) revealed:
-There was an entry for Miralax 17 grams in 8 ounces of liquid daily with breakfast at 8:00am.
-There was documentation Miralax was administered from 8:00am on 06/01/24 through 08/14/24 at 8:00am.

Interview with Resident #7 on 08/14/24 at 2:55pm revealed:
-He did not have any problems with constipation because he got Miralax every day.
-The Miralax was a powder that was mixed into his water and made the water grayish so he could see it in the water.

Interview with the medication aide (MA) on 08/14/24 at 3:04pm revealed:
-Resident #7 had his bottle of Miralax on the medication cart when she documented administering the Miralax on 08/04/24, 08/05/24, and 08/07/24 through 08/12/24.
-Resident #7's Miralax just ran out and she ordered a refill today.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/14/24 at 11:32am revealed:
-The pharmacy had an order dated 07/19/23 for Miralax 17gm daily with breakfast for Resident #7.
-The pharmacy dispensed 1 bottle of Miralax for Resident #7 on 02/06/24 and today.
-One bottle of Miralax contained 510 gm and which was a 30-day supply.
-The pharmacy had not received a refill request since February 2024, for Resident #7's Miralax

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CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

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D 358	Continued From page 13 until today. Interview with the Resident Service Director (RSD) on 08/14/24 at 4:00pm revealed: -MAs might have been borrowing Miralax for Resident #7. -MAs should not have borrowed medications. -MAs were responsible for requesting refills for residents' medications from the pharmacy. Attempted telephone interview with Resident #7's Primary Care Provider on 08/14/24 at 5:01pm was unsuccessful. Refer to interview with the Resident Service Director (RSD) on 08/14/24 at 4:00pm. Refer to interview with the Administrator on 08/14/24 at 4:45pm. c. Review of Resident #6's current FL-2 dated 05/20/24 revealed: -Diagnoses included dementia and diabetes mellitus. -Medication orders included Nystatin 100,000 grams/unit 1 application externally twice daily. (Nystatin is used to treat yeast or fungal infections.) Observation during the morning medication pass on 08/14/24 at 8:31am revealed: -The medication aide (MA) prepared Resident #6's morning medications which included 7 pills which were crushed and mixed in applesauce. -The MA assisted Resident #6 with eating the applesauce and medication mixture. -The MA documented on Resident #6's electronic medication administration record (eMAR) after administering the applesauce and medication mixture.	D 358		

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D 358	Continued From page 14 -The MA did not remove Nystatin cream from the medication cart nor apply Nystatin cream to Resident #6. Review of Resident #6's June, July and August 2024 eMARs revealed: -There was an entry for Nystatin 100,000 grams/unit topical to affected area twice daily at 8:00am and 8:00pm. -There was documentation doses of Nystatin were administered twice daily from 8:00am on 06/06/24 through 8:00am on 08/14/24. Interview with the medication aide (MA) on 08/14/24 at 3:21pm revealed: -She could not find Resident #6's Nystatin. -She thought the order for Resident #6's Nystatin might have been discontinued and that was why there was none on the medication cart. -The Nystatin cream was being applied under Resident #6's breasts and it was healed. -She thought the last time she applied the Nystatin cream under resident #6's breasts was yesterday (08/13/24). -She called the pharmacy for a refill on Resident #6's Nystatin cream and was told there were no refills available. -She did not know why she did not document the Nystatin cream was not administered today on the eMAR. -The new eMAR system required a note when a medication was not administered. -She thought she clicked administered to save time and avoid blank entries on the eMAR. Observation of Resident #6 on 08/14/24 at 3:30pm revealed there was no redness or irritation under the resident's breasts. Telephone interview with a pharmacist at the	D 358		

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facility's contracted pharmacy on 08/14/24 at 11:32am revealed:
-The pharmacy had an order dated 06/04/24 for Nystatin cream 100,000 units/gm 1 application twice daily for Resident #6.
-The Nystatin cream was ordered for Resident #6 to treat yeast dermatitis, and the application site was not specified.
-The pharmacy dispensed one 30gm tube on 06/05/24.
-It depended on where the Nystatin cream was applied for how long one 30gm tube would last; at most a 30gm tube was a 30-day supply.
-The pharmacy had not dispensed Nystatin cream for Resident #6 since 06/05/24.

Interview with the Resident Service Director (RSD) on 08/14/24 at 4:00pm revealed MAs were responsible for requesting refills for residents' medications from the pharmacy.

Attempted telephone interview with Resident #6's Primary Care Provider on 08/14/24 at 5:03pm was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.

Refer to interview with the Resident Service Director (RSD) on 08/14/24 at 4:00pm.

Refer to interview with the Administrator on 08/14/24 at 4:45pm.

2. Review of Resident #1's current FL-2 dated 02/21/24 revealed diagnoses included dementia.

a. Review of Resident #1's current FL-2 dated 02/21/24 revealed an order for lidocaine 4% apply

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D 358	Continued From page 16 2 patches to the lower back every morning and remove 12 hours later. (Lidocaine is used to treat pain.) Review of Resident #1's June, July, and August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Lidocaine 4% apply 2 patches to the lower back every morning and remove 12 hours later scheduled at 9:00am and 9:00pm. -There was documentation of Lidocaine patches application and removal daily from 06/01/24 through 08/11/24 except application on 07/20/24. Observation of Resident #1's medications on hand on 08/13/24 at 3:00pm revealed: -There was a generic box of 5 lidocaine 4% patches with a pharmacy label which had Resident #1's name and instructions for 2 patches applied to the lower back daily and removed 12 hours later. -The pharmacy label indicated there were 10 lidocaine patches dispensed on 03/23/24. Interview with the medication aide (MA) on 08/14/24 at 3:00pm revealed she did not know why Resident #1 had a box of lidocaine patches dispensed in March 2024 because the resident used the patches every day. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/13/24 at 3:20pm revealed: -The pharmacy began servicing the facility in February 2023. -Resident #1 had an existing order for lidocaine 2 patches topical to lower back every morning and remove every evening. -The pharmacy dispensed 10 lidocaine patches	D 358		

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for Resident #1 on 03/23/24 and 30 on 05/24/24.
-The pharmacy dispensed a total of 20 days' supply of lidocaine patches for Resident #1 since 03/24/24.
-Lidocaine was not on cycle fill orders; a refill had to be requested by staff.

Telephone interview with Resident #1's primary care provider (PCP) on 08/14/24 at 11:32am revealed:
-Lidocaine patches were for Resident #1's chronic arthritis pain.
-Resident #1 had advanced dementia; the PCP had not noticed any pain on examination of the resident.
-She had not thought to check for placement of lidocaine patches on resident #1.
-She expected staff to administer medications as ordered.
-She expected staff to talk to her if a medication was not administered so that she could review the medication and/or discontinue the medication.
-Staff had not contacted her regarding lidocaine patches for Resident #1.

Interview with the Memory Care Director (MCD) on 08/14/24 at 3:35pm revealed:
-MAs stocked lidocaine patches for Resident #1 by placing loose patches from plastic bags into the box.
-The Supervisor and Resident Service Director (RSD) checked for medications that were old or expired when they completed medication cart audits.

b. Review of Resident #1's current FL-2 dated 02/21/24 revealed an order for Rocklatan 0.02%-0.006% one drop into each eye daily at bedtime. (Rocklatan eye drops are used to reduce high eye pressure due to glaucoma or

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D 358	Continued From page 18 ocular hypertension.) Review of Resident #1's June, July, and August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Rocklatan 0.02%-0.006% one drop into each eye daily at bedtime scheduled at 9:00pm. -There was documentation Rocklatan was administered daily from 06/01/24 through 08/11/24. Observation of Resident #1's medications on hand on 08/14/24 at 3:00pm revealed there were no Rocklatan eye drops on the medication cart for Resident #7. Second observation of Resident #1's medications on hand on 08/14/24 at 4:09pm revealed: -The eye drops were stored in the medication refrigerator on the assisted living (AL) side. -There were 2 manufacturer's boxes of Rocklatan ophthalmic solution with pharmacy labels that had Resident #1's name and instructions for 1 drop into both eyes daily before bedtime. -The pharmacy label indicated the 3 remaining boxes were part of 5 (2.5ml each) bottles dispensed on 06/29/23. -There was a 3rd manufacturer's box of Rocklatan eye drops on the medication cart on the special care unit (SCU). -The Rocklatan box had a pharmacy label with Resident #1's name and indicated it was 1 of 5 dispensed on 06/29/23. -There was a handwritten date of "8/13" (no year) on the pharmacy label. Interview with the medication aide (MA) on 08/14/24 at 3:00pm revealed: -There were Rocklatan eye drops on the	D 358		

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medication cart that morning (08/14/24).
-The pharmacist auditing the medication cart took the bottle of Rocklatan because Resident #1's family member had provided the medication.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/13/24 at 3:20pm revealed:
-Rocklatan eye drops were not covered by Resident #1's insurance.
-The pharmacy left a message with Resident #1's ophthalmologist and faxed a notification to the facility on 05/24/24.

Telephone interview with Resident #1's mail order pharmacy on 08/14/24 at 10:55am revealed:
-The pharmacy last filled Rocklatan eye drops for Resident #1 on 04/01/23 and 06/28/23 with 12.5ml which was a 90 day supply.
-The pharmacy had not dispensed Rocklatan for Resident #1 since 06/28/23.

Interview with the Memory Care Director (MCD) on 08/13/24 at 4:01pm revealed:
-Resident #1's Rocklatan eye drops were in the facility.
-The pharmacist removed the open bottle of Rocklatan on the medication cart because she thought the open date was for (2) February 2024, but it was for (7) July 2024.
-There were 5 bottles of Rocklatan eye drops in the medication refrigerator on the assisted living (AL) side.
-New Rocklatan eye drops were placed on the medication cart today.
-He did not know why the pharmacy label indicated the Rocklatan was dispensed over one year ago.
-He only had eye drops for Resident #1 based on what the family member provided.

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D 358	Continued From page 20 Second interview with the MA on 08/13/24 at 4:17pm revealed she administered Rocklatan eye drops to Resident #1 today. c. Review of Resident #1's current FL-2 dated 02/21/24 revealed an order for Simbrinza 1%-0.2% one drop into each eye every morning. (Simbrinza eye drops are used to reduce high eye pressure due to glaucoma.) Review of Resident #1's June, July, and August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Simbrinza 1%-0.2% one drop into each eye every morning scheduled at 9:00am. -There was documentation Simbrinza was administered daily from 06/01/24 through 08/11/24 except on 07/20/24. Observation of Resident #1's medications on hand on 08/14/24 at 3:00pm revealed there were no Simbrinza eye drops on the medication cart for Resident #7. Interview with the medication aide (MA) on 08/14/24 at 3:00pm revealed: -There were Simbrinza eye drops on the medication cart that morning (08/14/24). -The pharmacist auditing the medication cart took the bottle of Simbrinza because Resident #1's family member had provided the medication. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/13/24 at 3:20pm revealed: -Simbrinza eye drops were not covered by Resident #1's insurance. -The pharmacy left a message with Resident #1's	D 358		

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ophthalmologist and faxed a notification to the facility on 05/24/24.

Telephone interview with Resident #1's mail order pharmacy on 08/14/24 at 10:55am revealed:
-The pharmacy last filled Simbrinza eye drops for Resident #1 on 04/01/23 and 07/04/23 with a 90 day supply.
-The pharmacy had not dispensed Simbrinza for Resident #1 since 07/04/23.

Second interview with the MA on 08/13/24 at 4:17pm revealed:
-She administered Simbrinza eye drops to Resident #1.
-The Simbrinza eye drops ran out today.
-She was waiting for Resident #1's family member to bring a new bottle of Simbrinza eye drops for Resident #1.

Interview with the Memory Care Director (MCD) on 08/13/24 at 4:01pm revealed he did not know there were no Simbrinza eye drops for Resident #1.

Telephone interview with a family member on 08/14/24 at 9:03am revealed:
-He called Resident #1's ophthalmologist today after the staff called and told him the resident ran out of her eye drops.
-He was on his way to the facility to figure out why Resident #1's eye drops ran out and where it was ordered from last.
-The copayment for Resident #1's eye drops was too high when the facility contracted with the new pharmacy (February 2023).
-He gave a staff (did not remember her name) information for Resident #1's pharmacy insurance plan for mail order back then.
-He did not remember exactly when that was last

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year.
-He had provided the staff with sample eye drops from the ophthalmologist's office before the mail order.
-He had not provided samples from the ophthalmologist's office since then.
-Resident #1 was legally blind in her left eye.
-The eye drops were to keep her from losing her vision in her right eye and from having any pain in her left eye.

Telephone interview with Resident #1's primary care provider (PCP) on 08/14/24 at 11:32am revealed:
-Resident #1's family member took the resident to her ophthalmologist's appointments.
-The Rocklatan and Simbrinza were used to treat glaucoma; the eye drops prevented eye pressure.
-Increased eye pressure from glaucoma could lead to headaches, eye pain, vision changes and vision loss.
-She expected staff to talk to her if a medication was not administered so that she could review the medication and/or discontinue the medication.
-Staff had not contacted her with any concerns related to Resident #1's eye drops.

Interview with the Memory Care Director (MCD) on 08/13/24 at 4:01pm revealed:
-Resident #1's family member brought her eye drops to the facility; he was supposed to bring the drops today (08/13/24).
-New orders went to the Resident Service Director (RSD) and she faxed the orders to the pharmacy.
-The pharmacy entered provider orders on the MAR; the RSD was able to enter orders on the MAR sometimes too.
-The pharmacy and the RSD were able to discontinue orders on the MAR.

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-The Supervisor and the RSD completed medication cart audits.
-A medication cart was completed yesterday (08/12/24) and the pharmacy audited the medication cart today (08/13/24).

Interview with the MCD on 08/14/24 at 3:35pm revealed:
-It was part of the medication administration process to make sure medications were on the medication cart and available for administration.
-Resident #1's family member was responsible for supplying the resident's eye drops.
-He did not know what else MAs could have been done if the family member did not supply Resident #1's eye drops.
-MAs should have documented Resident #1's eye drops were not administered due to waiting for delivery from the family member.
-He never ordered eye drops through the mail order pharmacy for Resident #1.
-The MA called Resident #1's family member when eye drop refills were needed.
-The MA did not document contacting Resident #1's family member anywhere.

Interview with the Resident Service Director (RSD) on 08/14/24 at 4:00pm revealed:
-MAs were responsible for contacting Resident #1's family member one week before a medication would run out to request a refill.
-MAs were responsible for documenting contact with the family member in the resident's progress notes.
-She, medication aides (MAs), the Memory Care Director (MCD), and the Resident Care Coordinator (RCC) were responsible for the medication order process from new orders to discontinuing medications.
-The staff member that retrieved the medication

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order from the fax machine was responsible for faxing the order to the pharmacy.
-Orders that were faxed to the pharmacy went to her or the RCC for review and approval on the electronic medication administration record (eMAR) system.
-The pharmacy entered medication orders on the eMAR and she reviewed and approved the orders on the eMAR.
-She and the MCD completed medication cart audits once weekly.
-MAs were responsible for completing medication cart audits up until May/June 2024.
-A medication cart audit in May/June 2024 showed non-oral medications were not stocked, outdated or dispensed months prior.
-MAs were retrained on medication administration and the medication cart audit process was changed.
-Checking dispense dates was part of the medication cart audit process.
-MAs were responsible for administering medications as ordered by the provider.
-She completed observations of medications passes in May 2024 and July 2024 to ensure compliance with the medication administration process.

Interview with the Administrator on 08/14/24 at 4:45pm revealed:
-MAs were responsible for contacting the family member for eye drop refills for Resident #1.
-MAs were responsible for documenting contact with the family member in the resident's progress notes.
-MAs were responsible for administering medications to residents according to the provider's order.
-MAs, the RCC, and the RSD were responsible for ensuring medications were on hand and

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D 358	Continued From page 25 available for administration. -The RSD was responsible for oversight of the medication administration process. -The RSD monitored reports generated by the electronic charting system. -Report monitoring was only as accurate as the information entered into the system. -The RSD was responsible for completing weekly medication cart audits. -The medication cart audit tool did not currently screen for discontinued medications and months old dispense dates. -Medications not on hand should have been picked up by the medication cart audit tool. -He was responsible for monitoring quality improvement reports related to the medication administration process. -He developed initiatives for improvement whenever an area of concern was identified. Attempted telephone interview with Resident #1's ophthalmologist on 08/14/24 at 10:46am was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.	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;	D 367		

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(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;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure the administration or non-administration of medications was documented on the medication administration record for 4 of 7 sampled residents (#1, #2, #6 and #7).

The findings are:

1. Review of Resident #7's current FL-2 dated 08/06/24 revealed diagnoses included chronic obstructive pulmonary disease, hypoxia, and respiratory failure.

a. Review of Resident #7's current FL-2 dated 08/06/24 revealed an order for prednisolone 1% ophthalmic solution 1 drop in the right eye 4 times daily. (Prednisolone opthalomic solution is used to treat mild to moderate eye inflammation and allergies.)

Review of Resident #7's June, July, and August 2024 electronic medication administration records (eMARs) revealed:

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D 367	Continued From page 27 -There was an entry for prednisolone 1% one drop into the right eye 4 times daily at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation prednisolone 1% eye drops were administered from 8:00am on 06/01/24 through 08/14/24 at 8:00am. -There was no documentation doses of prednisolone that were not administered. Observation during the morning medication pass on 08/14/24 at 8:54am revealed there were no prednisolone eye drops available to administer to Resident #7. Interview with Resident #7 on 08/14/24 at 2:55pm revealed: -He had not been given eye drops 4 times daily for 3-4 days or a week. -He asked the medication aide (MA) where his eye drops were and was told they had to be ordered. -He had cataracts, and his eye doctor ordered the drops which had helped him a lot. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/14/24 at 11:32am revealed: -The pharmacy had an order dated 07/19/23 for prednisolone 1% one eye drop to the right eye 4 times daily for Resident #7. -The pharmacy dispensed a 10ml bottle of prednisolone eye drops for Resident #7 on 04/30/24 and 06/30/24. -Each 10ml bottle of prednisolone contained 15-20 drops per ml or 150-200 drops per bottle which would last Resident #4 between 37 and 50 days. -The pharmacy had not received a refill request since 06/20/24, for Resident #7's prednisolone until today.	D 367		

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D 367	Continued From page 28 b. Review of Resident #7's current FL-2 dated 08/06/24 revealed an order for Miralax 17 grams in 8 ounces of liquid daily with breakfast. (Miralax is used to treat constipation.) Review of Resident #7's June, July, and August 2024 electronic medication administration records (eMARs) revealed: -There was an entry for Miralax 17gm in 8 ounces of liquid daily with breakfast at 8:00am. -There was documentation Miralax was administered from 8:00am on 06/01/24 through 08/14/24 at 8:00am. -There was no documentation of doses of Miralax that were not administered. Observation during the morning medication pass on 08/14/24 at 8:54am revealed there was no Miralax available for administration to Resident #7. Interview with Resident #7 on 08/14/24 at 2:55pm revealed: -He did not have any problems with constipation because he got Miralax every day. -The Miralax was a powder that was mixed into his water and made the water grayish so he could see it in the water. Interview with the medication aide (MA) on 08/14/24 at 3:04pm revealed: -Resident #7 had his bottle of Miralax on the medication cart when she documented administering the Miralax on 08/04/24, 08/05/24, and 08/07/24 through 08/12/24. -Resident #7's Miralax just ran out and she ordered a refill today. Telephone interview with a pharmacist at the	D 367		

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facility's contracted pharmacy on 08/14/24 at 11:32am revealed:
-The pharmacy had an order dated 07/19/23 for Miralax 17gm daily with breakfast for Resident #7.
-The pharmacy dispensed 1 bottle of Miralax for Resident #7 on 02/06/24 and today.
-One bottle of Miralax contained 510 gm and which was a 30-day supply.
-The pharmacy had not received a refill request since February 2024, for Resident #7's Miralax until today.

Interview with the Resident Service Director (RSD) on 08/14/24 at 4:00pm revealed MAs might have been borrowing Miralax for Resident #7.

Refer to interview with the Resident Service Director (RSD) on 08/14/24 at 4:00pm.

Refer to interview with the Administrator on 08/14/24 at 4:45pm.

2. Review of Resident #6's current FL-2 dated 05/20/24 revealed:
-Diagnoses included dementia and diabetes mellitus.
-Medication orders included Nystatin 100,000 grams/unit 1 application externally twice daily. (Nystatin is used to treat yeast or fungal infections.)

Review of Resident #6's June, July and August 2024 electronic medication administration records (eMARs) revealed:
-There was an entry for Nystatin 100,000 grams/unit topical to affected area twice daily at 8:00am and 8:00pm.
-There was documentation doses of Nystatin

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were administered twice daily from 8:00am on 06/06/24 through 8:00am on 08/14/24.
-There was no documentation that doses of Nystatin were not administered.

Interview with the medication aide (MA) on 08/14/24 at 3:21pm revealed:
-She could not find Resident #6's Nystatin.
-She thought the order for Resident #6's Nystatin might have been discontinued and that was why there was none on the medication cart.
-The Nystatin cream was being applied under Resident #6's breasts and it was healed.
-She thought the last time she applied the Nystatin cream under resident #6's breasts was yesterday (08/13/24).
-She called the pharmacy for a refill on Resident #6's Nystatin cream and was told there were no refills available.
-She did not know why she did not document the Nystatin cream was not given today on the eMAR.
-The new eMAR system required a note when a medication was not administered.
-She thought she clicked administered to save time and avoid blank entries on the eMAR.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/14/24 at 11:32am revealed:
-The pharmacy had an order dated 06/04/24 for Nystatin cream 100,000 units/gm 1 application twice daily for Resident #6.
-The Nystatin cream was ordered for Resident #1 to treat yeast dermatitis, and the application site was not specified.
-The pharmacy dispensed one 30gm tube on 06/05/24.
-It depended on where the Nystatin cream was applied for how long one 30gm tube would last; at

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most a 30gm tube was a 30-day supply.
-The pharmacy had not dispensed Nystatin cream for Resident #6 since 06/05/24.

Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.

Refer to interview with the Resident Service Director (RSD) on 08/14/24 at 4:00pm.

Refer to interview with the Administrator on 08/14/24 at 4:45pm.

3. Review of Resident #1's current FL-2 dated 02/21/24 revealed diagnoses included dementia.

a. Review of Resident #1's current FL-2 dated 02/21/24 revealed an order for lidocaine 4% apply 2 patches to the lower back every morning and remove 12 hours later. (Lidocaine is used to treat pain.)

Review of Resident #1's June, July, and August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Lidocaine 4% apply 2 patches to the lower back every morning and remove 12 hours later scheduled at 9:00am and 9:00pm.
-There was documentation of Lidocaine patches application and removal daily from 06/01/24 through 08/11/24 except application on 07/20/24.
-There was no documentation doses of lidocaine patches were not administered.

Observation of Resident #1's medications on hand on 08/13/24 at 3:00pm revealed:
-There was a generic box of 5 lidocaine 4% patches with a pharmacy label which had

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Resident #1's name and instructions for 2 patches applied to the lower back daily and removed 12 hours later.
-The pharmacy label indicated there were 10 lidocaine patches dispensed on 03/23/24.

Interview with the medication aide (MA) on 08/14/24 at 3:00pm revealed she did not know why Resident #1 had a box of lidocaine patches dispensed in March 2024 on the medication cart because the resident used the patches every day.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/13/24 at 3:20pm revealed:
-The pharmacy began servicing the facility in February 2023.
-Resident #1 had an existing order for lidocaine 2 patches topical to lower back every morning and remove every evening.
-The pharmacy dispensed 10 lidocaine patches for Resident #1 on 03/23/24 and 30 on 05/24/24.
-The pharmacy dispensed a total of 20 days' supply of lidocaine patches for Resident #1 since 03/24/24.
-Lidocaine was not on cycle fill orders; a refill had to be requested by staff.

b. Review of Resident #1's current FL-2 dated 02/21/24 revealed an order for Rocklatan 0.02%-0.006% one drop into each eye daily at bedtime. (Rocklatan eye drops are used to reduce high eye pressure due to glaucoma or ocular hypertension.)

Review of Resident #1's June, July, and August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Rocklatan 0.02%-0.006% one drop into each eye daily at bedtime

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scheduled at 9:00pm.
-There was documentation Rocklatan was administered daily from 06/01/24 through 08/11/24.
-There was no documentation doses of Rocklatan were not administered.

Observation of Resident #1's medications on hand on 08/14/24 at 3:00pm revealed there were no Rocklatan eye drops on the medication cart for Resident #7.

Second observation of Resident #1's medications on hand on 08/14/24 at 4:09pm revealed:
-The eye drops were stored in the medication refrigerator on the assisted living (AL) side.
-There were 2 manufacturer's boxes of Rocklatan ophthalmic solution with pharmacy labels that had Resident #1's name and instructions for 1 drop into both eyes daily before bedtime.
-The pharmacy label indicated the 3 remaining boxes were part of 5 (2.5ml each) bottles dispensed on 06/29/23.
-There was a 3rd manufacturer's box of Rocklatan eye drops on the medication cart on the special care unit (SCU).
-The Rocklatan box had a pharmacy label with Resident #1's name and indicated it was 1 of 5 dispensed on 06/29/23.
-There was a handwritten date of "8/13" (no year) on the pharmacy label.

Interview with the medication aide (MA) on 08/14/24 at 3:00pm revealed:
-There were Rocklatan eye drops on the medication cart that morning (08/14/24).
-The pharmacist auditing the medication cart took the bottle of Rocklatan because Resident #1's family member had provided the medication.

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D 367	Continued From page 34 Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/13/24 at 3:20pm revealed: -Rocklatan eye drops were not covered by Resident #1's insurance. -The pharmacy left a message with Resident #1's ophthalmologist and faxed a notification to the facility on 05/24/24. Telephone interview with Resident #1's mail order pharmacy on 08/14/24 at 10:55am revealed: -The pharmacy last filled Rocklatan eye drops for Resident #1 on 04/01/23 and 06/28/23 with 12.5ml which was a 90 day supply. -The pharmacy had not dispensed Rocklatan for Resident #1 since 06/28/23. c. Review of Resident #1's current FL-2 dated 02/21/24 revealed an order for Simbrinza 1%-0.2% one drop into each eye every morning. (Simbrinza eye drops are used to reduce high eye pressure due to glaucoma.) Review of Resident #1's June, July, and August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Simbrinza 1%-0.2% one drop into each eye every morning scheduled at 9:00am. -There was documentation Simbrinza was administered daily from 06/01/24 through 08/11/24 except on 07/20/24. -There was no documentation doses of Simbrinza were not administered. Observation of Resident #1's medications on hand on 08/14/24 at 3:00pm revealed there were no Simbrinza eye drops on the medication cart for Resident #7.	D 367		

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D 367	Continued From page 35 Interview with the medication aide (MA) on 08/14/24 at 3:00pm revealed: -There were Simbrinza eye drops on the medication cart that morning (08/14/24). -The pharmacist auditing the medication cart took the bottle of Simbrinza because Resident #1's family member had provided the medication. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/13/24 at 3:20pm revealed: -Simbrinza eye drops were not covered by Resident #1's insurance. -The pharmacy left a message with Resident #1's ophthalmologist and faxed a notification to the facility on 05/24/24. Telephone interview with Resident #1's mail order pharmacy on 08/14/24 at 10:55am revealed: -The pharmacy last filled Simbrinza eye drops for Resident #1 on 04/01/23 and 07/04/23 with a 90 day supply. -The pharmacy had not dispensed Simbrinza for Resident #1 since 07/04/24. Second interview with the MA on 08/13/24 at 4:17pm revealed: -She administered Simbrinza eye drops to Resident #1. -The Simbrinza eye drops ran out today. -She was waiting for Resident #1's family member to bring a new bottle of Simbrinza eye drops for Resident #1. Interview with the Memory Care Director (MCD) on 08/13/24 at 4:01pm revealed he did not know there were no Simbrinza eye drops for Resident #1. Telephone interview with a family member on	D 367		

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D 367	Continued From page 36 08/14/24 at 9:03am revealed: -He called Resident #1's ophthalmologist today after the staff called and told him the resident ran out of her eye drops. -He was on his way to the facility to figure out why Resident #1's eye drops ran out and where it was ordered from last. -The copayment for Resident #1's eye drops was too high when the facility contracted with the new pharmacy (February 2023). -He gave a staff (did not remember her name) information for Resident #1's pharmacy insurance plan for mail order back then. -He did not remember exactly when that was last year. -He had provided the staff with sample eye drops from the ophthalmologist's office before the mail order. -He had not provided samples from the ophthalmologist's office since then. Interview with the MCD on 08/14/24 at 3:35pm revealed: -MAs should have documented Resident #1's eye drops were not administered due to waiting for delivery from the family member. -MAs documented administering the eye drops supplied by Resident #1's family member. -The family member supplied many bottles of eye drops that lasted a long time. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. Refer to interview with the Resident Service Director (RSD) on 08/14/24 at 4:00pm. Refer to interview with the Administrator on 08/14/24 at 4:45pm.	D 367		

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D 367	Continued From page 37 4. Review of Resident #2's current FL-2 dated 06/04/24 revealed: -Diagnoses included hypertension, multiple strokes, atrial fibrillation, chronic kidney disease stage 3, history of deep vein thrombosis, and permanent pacemaker. -The resident was semi-ambulatory and required assistance with bathing and dressing. -The resident's current level of care was Assisted Living (AL). Review of Resident #2's physician order dated 07/02/24 revealed an order for Dorzolamide HCL 2% eye drop, 1 drop into each eye twice a day. Review of Resident #2's Resident Register revealed an admission date of 09/13/23. Review of Resident #2's current care plan dated 05/22/24 revealed an order for Dorzolamide HCL 2% eye drop to be given two times per day, every day at 9:00am and 9:00pm (a medication used to treat high pressure inside the eye). Review of Resident #2's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Dorzolamide HCL 2% eye drop 1 drop in each eye twice a day scheduled at 9:00am and 9:00pm. -There was an entry for Dorzolamide HCL 2% eye drop administered at 9:00am and 9:00pm on 08/01/24 and 08/02/24. -Dorzolamide HCL 2% eye drop was documented as discontinued (D/C) at 9:00am and 9:00pm on 08/03/24 to 08/12/24. Interview with Resident #2's on 08/13/24 at 2:15pm revealed:	D 367		

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-On 08/10/24, she received Dorzolamide HCL 2% eye drop in each eye at 8:00am.
-On 08/11/24, she received Dorzolamide HCL 2% eye drop in each eye at 8:00am and at 8:00pm.
-On 08/12/24, she received Dorzolamide HCL 2% eye drop in each eye at 8:00pm.

Interview with Resident #2's family member on 08/13/24 at 2:15pm revealed:
-Resident #2 called her family member on 08/10/24 and stated that she did not receive her 8:00pm eye medication.
-The MA stated that the Dorzolamide HCL 2% eye medication was discontinued but the family member had spoken with the pharmacy and confirmed that that the medication was on Resident #2's profile and was active.
-The family member called the pharmacy on 08/12/24 and re-ordered the eye medication.

Telephone interview with the facility's contracted Pharmacist on 08/14/24 at 2:30pm revealed:
-Dorzolamide HCL 2% eye drop was an active new script on for Resident #2 on 07/02/24 and it was filled and sent to the facility on 07/02/24 with 50-day supply.
-On 07/02/24, the medication was changed from 1 drop in the right eye twice a day to 1 drop in both eyes twice a day.
-There was no D/C order for this medication.

Interview with a medication aide (MA) on 08/14/24 at 4:50pm revealed:
-Resident #2's Dorzolamide had been discontinued on the eMARs.
-She did not see a stop date on the eMARs.

Interview with the Resident Service Director (RSD) on 08/14/24 at 5:50pm revealed:
-On 08/01/24, she sent a request to the pharmacy

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D 367	Continued From page 39	D 367		

that all of Resident #2's medications be changed to 8:00am and 8:00pm.
-On 08/03/24, the Resident Care Coordinator (RCC) changed the medication administration on all medication on the MARs and D/C'd the Dorzolamide by mistake.
-She was unaware of this change, and it was brought to her attention on 08/12/24 when she had a meeting with the resident's family.
-On 08/12/24, she called the pharmacy, and they confirmed that that the medication had not been D/C'd, she then added the medication back to the eMARs.
-A cart audit was done by her to look for expiration date of medication, open dates of medication, if medication was organized by residents and only used on one resident.
-She had not checked for accidental changes of physician's orders on the eMARs during this timeframe.

Interview with the Administrator on 08/14/24 at 6:40pm revealed:
-He was aware that that the RCC accidentally D/C'd the Dorzolamide on Resident #2's eMAR.
-A cart audit was done by the RSD, and it included looking for accidental changes of physician's orders weekly and then turned in to him.

Refer to interview with the Resident Service Director (RSD) on 08/14/24 at 4:00pm.

Refer to interview with the Administrator on 08/14/24 at 4:45pm.

_____

Interview with the Resident Service Director (RSD) on 08/14/24 at 4:00pm revealed:
-She and the Memory Care Director (MCD) completed medication cart audits once weekly.

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D 367	Continued From page 40 -Medication aides (MAs) were responsible for completing medication cart audits up until May/June 2024. -A medication cart audit in May/June 2024 showed non-oral medications were not stocked, outdated or dispensed months prior. -MAs were retrained on medication administration and the medication cart audit process was changed. -Checking dispense dates was part of the medication cart audit process. -MAs were responsible for administering medications as ordered by the provider and documenting medication administration accurately. -MAs were responsible for documenting medications that were not administered on the eMAR as not administered and the reason. Interview with the Administrator on 08/14/24 at 4:45pm revealed: -MAs were responsible for documenting medication administration accurately on the resident's eMAR. -MAs were responsible for documenting medications not as administered as not as administered on the eMAR. -MAs, the Resident Care Coordinator (RCC), and the RSD were responsible for ensuring medications were on hand and available for administration. -The RSD was responsible for oversight of the medication administration process. -The RSD monitored reports generated by the electronic charting system. -Report monitoring was only as accurate as the information entered into the system. -The RSD was responsible for completing weekly medication cart audits. -The medication cart audit tool did not currently	D 367		

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D 367	Continued From page 41 screen for discontinued medications and months old dispense dates. -Medications not on hand should have been picked up by the medication cart audit tool. -He was responsible for monitoring quality improvement reports related to the medication administration process. -He developed initiatives for improvement whenever an area of concern was identified.	D 367		
D 394	10A NCAC 13F .1008 (c & d) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (c) Controlled substances that are expired, discontinued or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances. (d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the	D 394		

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D 394	Continued From page 42 resident's name; the name, strength and dosage form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure discontinued controlled substances used to treat pain were returned to the pharmacy or destroyed within 90 days of being discontinued for 1 of 2 sampled residents with provider orders for controlled substances (#1). The findings are: Review of Resident #1's current FL-2 dated 02/21/24 revealed diagnoses included dementia. a. Review of Resident #1's FL-2 dated 02/21/24 revealed there was no order for morphine. (Morphine is a controlled substance used to treat pain.) Review of Resident #1's order summary report	D 394		

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D 394	Continued From page 43 dated 08/05/24 revealed there was no order for morphine. Review of Resident #1's June, July and August 2024 electronic medication administration record (eMAR) revealed there was no entry for morphine. Observation of Resident #1's medications on hand on 08/14/24 at 3:00pm revealed: -There was a plastic bag with a pharmacy label which had Resident #1's name and instructions for morphine 0.5ml (10mg) every 2 hours as needed for pain or shortness of breath. -The pharmacy label indicated 30 morphine 0.5ml prefilled syringes were dispensed on 08/25/23. -There were 30 morphine 0.5ml prefilled syringes remaining. Review of Resident #1's controlled substance record dated 08/25/23 revealed: -There was a pharmacy label with Resident #1's name and instructions for morphine 0.5ml (10mg) every 2 hours as needed for pain or shortness of breath. -The pharmacy label indicated 30 morphine 0.5ml prefilled syringes were dispensed on 08/25/23. -There was no documentation of morphine syringes being removed from the count. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/13/24 at 3:20pm revealed the pharmacy had an order dated 02/21/24 to discontinue morphine for Resident #1. Upon request on 08/13/24 and 08/14/24, the order to discontinue morphine for Resident #1 was not provided for review.	D 394		

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D 394	Continued From page 44 Interview with a medication aide (MA) on 08/13/24 at 3:56pm revealed: -She did not know when Resident #1's morphine was discontinued. -Resident #1's morphine was an as needed medication which might have been why it was missed and not removed from the medication cart since 02/21/24. Interview with the Memory Care Director (MCD) on 08/13/24 at 4:01pm revealed Resident #1's morphine might have been missed because the pharmacy return bin was full. b. Review of Resident #1's FL-2 dated 02/21/24 revealed there was no order for tramadol. (Tramadol is a controlled substance used to treat pain.) Review of Resident #1's order summary report dated 08/05/24 revealed there was no order for tramadol. Review of Resident #1's June, July and August 2024 electronic medication administration record (eMAR) revealed there was no entry for tramadol. Observation of Resident #1's medications on hand on 08/14/24 at 3:00pm revealed: -There was a bubble pack with a pharmacy label which had Resident #1's name and instructions for Tramadol 50mg one half tablet (25mg) twice daily as needed for pain. -The pharmacy label indicated 14 Tramadol 50mg tablets (28 half tablet doses) were dispensed on 08/25/23. -There were 28 tramadol 50mg half tablets remaining. Review of Resident #1's controlled substance	D 394		

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D 394	Continued From page 45 record dated 08/25/23 revealed: -There was a pharmacy label with Resident #1's name and instructions for tramadol 50mg one half tablet (25mg) twice daily as needed for pain. -The pharmacy label indicated 14 tramadol 50mg tablets (28 half tablet doses) were dispensed on 08/25/23. -There was no documentation tramadol tablets were removed from the count. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/13/24 at 3:20pm revealed the pharmacy had an order dated 02/21/24 to discontinue tramadol for Resident #1. Upon request on 08/13/24 and 08/14/24, the order to discontinue tramadol for Resident #1 was not provided for review. Interview with a medication aide (MA) on 08/13/24 at 3:56pm revealed: -She did not know when Resident #1's tramadol was discontinued. -Resident #1's tramadol was an as needed medication which might have been why it was missed and not removed from the medication cart since 02/21/24. -The Resident Service Director (RSD) was responsible for processing medication orders. -MAs were responsible for removing discontinued medications from the medication cart and placing them in the pharmacy return bin. -The Memory Care Director (MCD) would have information regarding medication cart audits. Interview with the MCD on 08/13/24 at 4:01pm revealed: -Resident #1's tramadol might have been missed because the pharmacy return bin was full.	D 394		

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D 394	Continued From page 46 -MAs did not place controlled substances in the pharmacy return bin when it was full to prevent the controlled substances from getting lost or taken. -The MAs were responsible for removing discontinued medications from the medication cart and placing them in the pharmacy return bin. -The RSD notified the MA when a medication was discontinued. Telephone interview with the Clinical Manager at Resident #1's former hospice agency on 08/14/24 at 4:38pm revealed: -Hospice did not write orders when a resident was discharged from hospice. -Resident #1 was discharged from hospice on 12/05/23. Interview with the Resident Service Director (RSD) on 08/14/24 at 4:00pm revealed: -She, MAs, the MCD, and the Resident Care Coordinator (RCC) were responsible for the medication order process from new orders to discontinuing medications. -The staff member that retrieved the medication order from the fax machine was responsible for faxing the order to the pharmacy. -Orders that were faxed to the pharmacy went to her or the RCC for review and approval on the eMAR system. -The pharmacy entered medication orders on the eMAR and she reviewed and approved the orders on the eMAR. -MAs were responsible for removing discontinued medications off the medication cart, completing a medication reconciliation form for return, and placing discontinued medications in the pharmacy return bin. -She and the MCD completed medication cart audits once weekly.	D 394		

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D 394	Continued From page 47 -MAs were responsible for completing medication cart audits up until May/June 2024. -Checking dispense dates was part of the medication cart audit process. -MAs forgot to return Resident #1's controlled substances. -Medication cart audits should have caught the discontinued controlled substances still on the cart. Interview with the Administrator on 08/14/24 at 4:45pm revealed: -The RSD was responsible for completing weekly medication cart audits. -The medication cart audit tool did not currently screen for discontinued medications and months old dispense dates. -MAs were responsible for removing discontinued medications from the medication cart the same day the discontinue order was written. -He did not know controlled substances were to be returned to the pharmacy within 90 days of being discontinued. -The RSD was responsible for ensuring discontinued controlled substances were removed from the cart by following up on the order to discontinue the controlled substance. -He was responsible for monitoring quality improvement reports related to the medication administration process. -He developed initiatives for improvement whenever an area of concern was identified.	D 394		