STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R-C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation from 07/09/24 to 07/10/24. The complaint investigation was initiated by the Lee County Department of Social Services on 06/11/24.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 10 residents (#4) observed during the afternoon medication pass including an error with a nebulizer treatment for chronic obstructive pulmonary disease. The findings are: The medication error rate was 3% as evidenced by 1 error out of 26 opportunities during the morning medication pass on 02/22/24. Review of Resident #4's current FL-2 dated 09/28/23 revealed diagnoses included chronic obstructive pulmonary disease (COPD). Review of Resident #4's hospice telephone/verbal	D 358		

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order dated 05/21/24 revealed an order for ipratropium/albuterol 3ml every 6 hours and ipratropium/albuterol 3ml every 2 hours as needed for shortness of breath or wheezing. (Ipratropium/albuterol is used to treat airway narrowing that happens with COPD.)

Observation of the medication pass on 07/09/24 at 1:48pm revealed:
-The medication aide (MA) prepared one tablet and one capsule and administered those to Resident #4 with a cup of water in his room.
-The MA did not administer ipratropium/albuterol nebulizer treatment to Resident #4.

Review of Resident #4's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for ipratropium/albuterol 1 vial every 6 hours scheduled for 2:00am, 8:00am, 2:00pm, and 8:00pm.
-Ipratropium/albuterol was not documented as administered on 05/22/24, 05/23/24, 05/24/24 and at 2:00am, 8:00am, and 2:00pm on 05/25/24 (15 doses).
-There was documentation 25 doses of ipratropium/albuterol were administered from 8:00pm on 05/25/24 through 8:00pm on 05/31/24.
-There was an entry for ipratropium/albuterol 1 vial every 2 hours as needed for shortness of breath or wheezing.
-There was documentation 3 doses of ipratropium/albuterol were administered as needed.

Review of Resident #4's June 2024 eMAR revealed:
-There was an entry for ipratropium/albuterol 1 vial every 6 hours scheduled for 2:00am, 8:00am, 2:00pm, and 8:00pm.

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-There was documentation 120 doses of ipratropium/albuterol were administered from 06/01/24 until 06/30/24.
-There was an entry for ipratropium/albuterol 1 vial every 2 hours as needed for shortness of breath or wheezing.
-There was no documentation ipratropium/albuterol was administered as needed.

Review of Resident #4's July 2024 eMAR revealed:
-There was an entry for ipratropium/albuterol 1 vial every 6 hours scheduled for 2:00am, 8:00am, 2:00pm, and 8:00pm.
-There was documentation 35 doses of ipratropium/albuterol were administered from 07/01/24 until 07/09/24.
-There was an entry for ipratropium/albuterol 1 vial every 2 hours as needed for shortness of breath or wheezing.
-There was no documentation ipratropium/albuterol was administered as needed.

Observation of Resident #4's medications on hand on 07/10/24 at 10:25am revealed:
-There was a plastic bag with a pharmacy label containing loose and packaged ipratropium/albuterol vials.
-The pharmacy label had Resident #4's name and instructions for ipratropium/albuterol 1 vial every 6 hours.
-The pharmacy label indicated 90ml (30 vials) were dispensed on 05/21/24.
-There were 4 unopened packages which contained (5) 3ml vials each for a total of 20 vials.
-There were 2 unopened 3ml vials in an open package of ipratropium/albuterol, 4 unopened vials in a second open package, and 1 unopened

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vial in the plastic bag (7 total).
-There were no vials or packages of ipratropium/albuterol as needed.

Interview with Resident #4 on 07/09/24 at 3:15pm revealed:
-He did not receive a nebulizer treatment today (07/09/24).
-He rarely received nebulizer treatments.
-The last time he received a nebulizer treatment was one week ago.
-He always had shortness of breath.
-The nebulizer treatments helped decrease his shortness of breath when he received them.

Interview with the MA on 07/09/24 at 3:21pm revealed:
-She administered Resident #4's nebulizers according to the order on the eMAR.
-She administered a nebulizer treatment to Resident #4 in the morning and around lunch time today (07/09/24).
-She administered the nebulizer treatment scheduled for 2:00pm early because Resident #4 was wheezing around lunch time (12:00pm).
-There were 4 doses of nebulizer treatments in Resident #4's room because she opened a new package, used one and accidentally left the others in the room.
-Resident #4 did not self-administer his nebulizer treatments.

Interview with the Resident Care Manager (RCM) on 07/09/24 at 4:13pm revealed:
-Resident #4 received his nebulizer treatments because he had an order and MAs administered medications as ordered by the provider.
-She did not know why Resident #4 would say nebulizer treatments were not administered.
-Resident #4 was forgetful at times and might

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D 358	Continued From page 4 have forgotten he received a nebulizer treatment today (07/09/24). Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/24 at 9:00am revealed: -The pharmacy had a hospice verbal order dated 05/21/24 for ipratropium/albuterol 3ml nebulizers every 6 hours and every 2 hours as needed for shortness of breath or wheezing. -The pharmacy dispensed a 7-day supply for all hospice verbal orders. -The pharmacy dispensed 90ml of ipratropium/albuterol every 6 hours and 90ml of ipratropium/albuterol as needed. -90ml of ipratropium/albuterol was 30 doses of 3ml vials which would last 7.5 days being administered every 6 hours. -The pharmacy dispensed a total of 60 doses or 15 days if administered every 6 hours and if no as needed doses were administered every 2 hours. Telephone interview with Resident #4's Hospice Director on 07/10/24 at 10:36am revealed: -The hospice provider used the facility's contracted pharmacy for medication orders. -Hospice covered a total of 15 day supply for all medications before a new order was required. -Staff called and requested a refill order or the hospice nurse documented a verbal order for a refill while at the facility. -She did not know if a refill order for Resident #4's ipratropium/albuterol nebulizers was requested or written since 05/21/24. -Ipratropium/albuterol nebulizers were ordered for Resident #4 to treat symptoms of COPD. -The provider ordered scheduled dosing of ipratropium/albuterol nebulizers in addition to as needed because Resident #4 must have needed treatments every 6 hours.	D 358		

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D 358	Continued From page 5 Second interview with the RCM on 07/10/24 at 10:14am revealed: -All Resident #4's medications came from the facility's contracted pharmacy. -She was not aware of hospice refilling Resident #4's nebulizer treatment from a back-up pharmacy. -She completed weekly medication cart audits where she primarily checked for missing medications, expired medications and accuracy of controlled substance counts. Interviews with the Administrator on 07/10/24 at 10:14am and 10:50am revealed: -The pharmacy dispensing history and the documentation on the eMAR for Resident #4's nebulizer treatments did not add up. -MAs were responsible for administering nebulizer treatments to Resident #4 as ordered by the provider and documenting accurately on the eMAR medications that were or were not given. -MAs were responsible for completing medication cart audits daily. -Medication cart audits were documented by the MA and reviewed by the RCM. -The RCM completed a medication cart audit weekly. -Additionally, a corporate nurse conducted medication cart audit ensuring medications were on the medication cart. -The corporate nurse audited Resident #4's medications last on 06/25/24. Attempted telephone interview with Resident #4's hospice provider on 07/10/24 at 10:36am was unsuccessful.	D 358		

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D 367	Continued From page 6	D 367		
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; (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 accurate documentation on the electronic medication administration record (eMAR) for 1 of 4 sampled residents (#4) including a nebulizer treatment.. The findings are: Review of Resident #4's current FL-2 dated 09/28/23 revealed diagnoses included chronic obstructive pulmonary disease (COPD). Review of Resident #4's hospice telephone/verbal	D 367		

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D 367	Continued From page 7	D 367		

order dated 05/21/24 revealed an order for ipratropium/albuterol 3ml every 6 hours and ipratropium/albuterol 3ml every 2 hours as needed for shortness of breath or wheezing. (Ipratropium/albuterol is used to treat airway narrowing that happens with COPD.)

Review of Resident #4's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for ipratropium/albuterol 1 vial every 6 hours scheduled for 2:00am, 8:00am, 2:00pm, and 8:00pm.
-Ipratropium/albuterol was not documented as administered on 05/22/24, 05/23/24, 05/24/24 and at 2:00am, 8:00am, and 2:00pm on 05/25/24 (15 doses).
-There was documentation 25 doses of ipratropium/albuterol were administered from 8:00pm on 05/25/24 through 8:00pm on 05/31/24.
-There was an entry for ipratropium/albuterol 1 vial every 2 hours as needed for shortness of breath or wheezing.
-There was documentation 3 doses of ipratropium/albuterol were administered as needed.

Review of Resident #4's June 2024 eMAR revealed:
-There was an entry for ipratropium/albuterol 1 vial every 6 hours scheduled for 2:00am, 8:00am, 2:00pm, and 8:00pm.
-There was documentation 120 doses of ipratropium/albuterol were administered from 06/01/24 until 06/30/24.
-There was an entry for ipratropium/albuterol 1 vial every 2 hours as needed for shortness of breath or wheezing.
-There was no documentation ipratropium/albuterol was administered as

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D 367	Continued From page 8 needed. Review of Resident #4's July 2024 eMAR revealed: -There was an entry for ipratropium/albuterol 1 vial every 6 hours scheduled for 2:00am, 8:00am, 2:00pm, and 8:00pm. -There was documentation 35 doses of ipratropium/albuterol were administered from 07/01/24 until 07/09/24. -There was an entry for ipratropium/albuterol 1 vial every 2 hours as needed for shortness of breath or wheezing. -There was no documentation ipratropium/albuterol was administered as needed. Observation of Resident #4's medications on hand on 07/10/24 at 10:25am revealed: -There was a plastic bag with a pharmacy label containing loose and packaged ipratropium/albuterol vials. -The pharmacy label had Resident #4's name and instructions for ipratropium/albuterol 1 vial every 6 hours. -The pharmacy label indicated 90ml (30 vials) were dispensed on 05/21/24. -There were 4 unopened packages which contained (5) 3ml vials each for a total of 20 vials. -There were 2 unopened 3ml vials in an open package of ipratropium/albuterol, 4 unopened vials in a second open package, and 1 unopened vial in the plastic bag (7 total). -There were no vials or packages of ipratropium/albuterol as needed. Based on review of Resident #4's May 2024, June 2024 and July 2024 eMARs there was a total of 183 doses documented as administered over 48 days.	D 367		

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D 367	Continued From page 9 Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/24 at 9:00am revealed: -The pharmacy had a hospice verbal order dated 05/21/24 for ipratropium/albuterol 3ml nebulizers every 6 hours and every 2 hours as needed for shortness of breath or wheezing. -The pharmacy dispensed a 7-day supply for all hospice verbal orders. -The pharmacy dispensed 90ml of ipratropium/albuterol every 6 hours and 90ml of ipratropium/albuterol as needed. -90ml of ipratropium/albuterol was 30 doses of 3ml vials which would last 7.5 days being administered every 6 hours. -The pharmacy dispensed a total of 60 doses or 15 days if administered every 6 hours and if no as needed doses were administered every 2 hours. Telephone interview with Resident #4's Hospice Director on 07/10/24 at 10:36am revealed: -The hospice provider used the facility's contracted pharmacy for medication orders. -Hospice covered a total of 15 day supply for all medications before a new order was required. -Staff called and requested a refill order or the hospice nurse documented a verbal order for a refill while at the facility. -She did not know if a refill order for Resident #4's ipratropium/albuterol nebulizers was requested or written since 05/21/24. Interview with the Resident Care Manager (RCM) on 07/10/24 at 10:14am revealed: -All Resident #4's medications came from the facility's contracted pharmacy. -She was not aware of hospice refilling Resident #4's nebulizer treatment from a back-up pharmacy.	D 367		

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D 367	Continued From page 10 Interviews with the Administrator on 07/10/24 at 10:14am and 10:50am revealed: -The pharmacy dispensing history and the documentation on the eMAR for Resident #4's nebulizer treatments did not add up. -MAs were responsible for documenting accurately on the eMAR medications that were or were not given.	D 367		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an accident and incident report was sent to the department of social services (DSS) for 1 of 2 sampled residents (#2) who required emergency room evaluation and treatment after a fall. The findings are: Review of Resident #2's current FL-2 dated 03/20/24 revealed diagnoses included hypotension, urinary tract infection, and weakness.	D 451		

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D 451	Continued From page 11 Review of Resident #2's incident report dated 06/19/24 revealed: -At 2:50pm, Resident #4 was found on the floor in the hall with blood on the back of his head and a cut on his left index finger. -Resident #4 was sent to the emergency room (ER) via emergency medical services (EMS) at 3:00pm. -The Resident Care Manager (RCM) signed the management section of the report on 06/20/24. -There was no documentation the medication aide (MA) or the RCM notified department of social services (DSS). Review of Resident #4's ER discharge instructions dated 06/19/24 revealed the resident diagnoses included fall, closed head injury and scalp abrasion. Telephone interview with the DSS Supervisor on 07/09/24 at 2:41pm revealed he did not receive an incident report dated 06/19/24 for Resident #2. Interview with the RCM on 07/09/24 at 2:22pm revealed: -Resident #2's accident/incident report dated 06/19/24 was not sent to the county DSS. -The previous Administrator sent accident/incident reports to DSS. -She was not clear on the process of which accident/incident reports were sent to DSS and by whom since the change in Administrators (May 2024). Interview with the Administrator 07/09/24 at 4:05pm revealed: -She evaluated the previous process for accident/incident reports when she started as the Administrator in early May 2024.	D 451		

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D 451	Continued From page 12 -There were gaps in the previous process, so she immediately retrained the RCM and MAs. -MAs were responsible to complete accident/incident reports immediately following any resident involved accidents or incidents. -MAs were responsible to fax completed accident/incident reports DSS when instructed to by the RCM or her. -The MA attached the fax confirmation and gave completed accident/incident reports to the RCM for review. -The RCM was responsible for reviewing completed accident/incident reports and ensure fax confirmation to DSS when appropriate. -The RCM then forwarded reviewed accident/incident reports to her for a second review. -She was not previously aware of every accident and incident to ensure reportable accident/incident reports were sent to DSS. Attempted telephone interview on 07/10/24 at 10:41am with the MA was unsuccessful.	D 451		