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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted a follow-up survey and complaint investigation on 11/05/24-11/08/24. The complaint investigation was initiated by the Buncombe County Department of Social Services on 09/16/24.	D 000		
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Facility & 10A NCAC 13F .0704 Resident Contract, Information On Facility, And Resident Register (b) The administrator or their management designee and the resident or the resident's representative shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following: (1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address; (2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status; (3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests; (4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail;	D 248		

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D 248	Continued From page 1 (5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D-4.8; and (6) resident's consent including a signature confirming the review and receipt of information contained in the form. The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf at no charge. The facility may use a resident information form other than the Resident Register as long as it contains the same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Resident Register was signed and dated by the Administrator and the resident or responsible party for 3 of 8 sampled residents (#1, #5, & #8). The findings are: 1. Review of Resident #5's current FL2 dated 05/29/24 revealed diagnoses included Parkinson's disease, generalized pain, and restless leg syndrome. Review of Resident #5's Resident Register revealed: -There was not an admission date listed for Resident #5.	D 248		

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-Resident #5 had a Power of Attorney (POA) listed on the Resident Register.
-Resident #5 had signed the Resident Register in Section E entitled Receipt of Materials, but there was no date.
-Resident #5 nor his POA had signed or dated the Resident Register in Section F entitled Signatures.
-The administrator or their management designee had not signed the Resident Register.

Refer to interview with the Administrator on 11/07/24 at 2:00pm.

2. Review of Resident #1's current FL2 dated 02/12/24 revealed diagnoses included Alzheimer's Disease and Sjogren's syndrome.

Review of Resident #1's Resident Register on 11/05/24 revealed:
-There was an admission date of 08/11/20.
-Resident #1's Power of Attorney (POA) signed the Resident Register on 08/11/20.
-The administrator or their management designee had not signed the Resident Register.

Refer to the interview with the Administrator on 11/07/24 at 2:00pm.

3. Review of Resident #8's current FL2 dated 05/15/24 revealed diagnoses including periprosthetic fracture of femur and osteoporosis.

Review of Resident #8's Resident Register on 11/06/24 revealed:
-There was an admission date of 08/31/23.
-Resident #8 did not sign or date the Resident Register.
-The administrator or their management designee had not signed the Resident Register.

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D 248	Continued From page 3 Refer to the interview with the Administrator on 11/07/24 at 2:00pm. ____________________ Interview with the Administrator on 11/07/24 at 2:00pm revealed: -The Health and Wellness Director (HWD) was responsible for completing the Resident Register. -The current HWD was new and had been working only a few weeks. -There had been several staff in the HWD position.	D 248		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;	D 255		

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(G) threat to life such as stroke, heart condition, or metastatic cancer;
(H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher;
(I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes;
(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to complete an assessment within 10 days related to significant changes in status for 2 of 2 sampled residents (#4 and #7) after they were admitted into hospice care.

The findings are:

1. Review of Resident #7's current FL2 dated 04/30/24 revealed diagnoses included diabetes, high blood pressure, and chronic lung disease.

Review of Resident #7's Hospice Care Facesheet revealed Resident #7 was admitted to hospice care on 07/25/24.

Review of the initial Hospice Certification for

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Resident #7 dated 08/01/24 revealed:
-Resident #7 required total assistance with toileting.
-Resident #7 required extensive assistance with bathing, transfers, grooming, and hygiene.

Review of Resident #7's care plan dated 09/04/24 revealed:
-There was no information regarding hospice services on the care plan.
-Resident #7 required minimal assistance with transfers, grooming, and hygiene.
-Resident #7 required moderate assistance with bathing and toileting.

Review of Resident #7's care plan history revealed a significant change in status care plan had not been completed after Resident #7 was admitted to hospice care on 07/25/24.

Interview with a personal care aide (PCA) on 11/06/24 at 12:43pm revealed:
-Resident #7 was totally dependent for bathing, toileting, transfers, grooming, and hygiene.
-Resident #7 was only able to feed herself if her meal was set up for her.
-Resident #7 has been steadily declining in the past several weeks since she was placed on hospice care.
-Resident #7 received 2 bed baths a week from a hospice certified nursing aide (CNA).
-There were days that Resident #7 required two-person assistance for her personal care needs.

Refer to interview with the Executive Director on 11/06/24 at 10:10am.

Refer to interview with the Administrator on 11/07/24 at 1:16pm.

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2. Review of Resident #4's current FL2 dated 03/15/24 revealed diagnoses included dysphagia (swallowing difficulty) and cerebral infarction (stroke).

Review of Resident #4's Care Plan dated 05/01/24 revealed:
-She needed supervision with eating, ambulating, grooming and transferring.
-She needed limited assistance with toileting, bathing and dressing

Review of Resident #4's Hospice Care Facesheet dated 09/18/24 revealed:
-She was admitted to hospice care on 05/19/24.
-She needed total care for mobility, bathing, dressing, toileting and feeding.

Review of Resident #4's care plan history revealed a significant change in status care plan had not been completed after Resident #4 was admitted to hospice care on 05/19/24.

Refer to interview with the Executive Director on 11/06/24 at 10:10am.

Refer to interview with the Administrator on 11/07/24 at 1:16pm.

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Interview with the Executive Director on 11/06/24 at 10:10am revealed:
-Care plans should be updated annually or within a week after a change in condition.
-Resident #4's care plan should have been updated within a week after she transitioned to hospice care on 05/19/24.
-She did not know why the Health and Wellness Director (HWD) at that time did not update the care plan.

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D 255	Continued From page 7 -The new HWD started 4 weeks ago and she did not have time yet to review all the records to determine if care plans needed to be updated but she ultimately would responsible for all updates. Interview with the Administrator on 11/07/24 at 1:16pm revealed: -Care plans should be updated after a change in condition and transferring to hospice was considered a change in condition. -The HWD was usually responsible for updating care plans. -The HWD that was employed in May 2024 was no longer employed with the facility. The facility hired a nurse consultant to review all the charts to see what needed to be updated but evidently the need for an updated care plan was not identified.	D 255		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care for 1 of 5 residents (#7) who was dependent for staff assistance related to incontinence care. The findings are:	D 269		

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Review of Resident #7's current FL2 dated 04/30/24 revealed:
-Diagnoses included diabetes, high blood pressure, and chronic lung disease.
-She was continent of bowel and bladder.

Review of Resident #7's physician Hospice Recertification note dated 10/11/24 revealed Resident #7 required total assistance with toileting, bathing, dressing, and mobility.

Review of Resident #7's Hospice Plan of Care dated 10/16/24 revealed:
-Resident #7 was at risk for skin breakdown due to bowel and bladder incontinence.
-A goal for staff was to verbalize understanding of factors influencing skin integrity and demonstrating measures to implement in prevention of skin breakdown.

Interview with Resident #7 on initial tour on 11/05/24 at 9:51am revealed:
-She was incontinent of bowel and bladder.
-She required assistance with incontinence care.
-She did not get out of bed.

Interview with a MA on 11/06/24 at 12:35pm revealed:
-Resident #7 was incontinent of bowel and bladder.
-Resident #7 required total assistance with incontinence care.
-Resident #7 was not aware when her incontinence episodes occurred.
-When she came into work on 11/06/24, there was one PCA assigned to provide care for residents on all 3 floors.
-She was assigned to the second floor as a MA and there was another MA who was assigned to

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the first and third floors.
-She went in to Resident #7's room once this morning to administer medication.
-She did not provide incontinence care or check to see if Resident #7 needed incontinence care.

Observation of Resident #7 on 11/06/24 at 12:51pm revealed she was lying in bed with the head of the bed elevated, eating lunch.

Interview with Resident #7 on 11/06/24 at 12:51pm revealed:
-Staff had not provided incontinence care for her the morning of 11/06/24.
-She told the medication aide (MA) at 12:51pm she did not want to be checked for incontinence care until she finished eating her lunch.

Interview with a first shift personal care aide (PCA) on 11/06/24 at 12:18pm revealed:
-She worked as agency staff at the facility.
-She was not scheduled to work at the facility on 11/06/24 but was called in to work by her agency representative.
-She arrived at the facility between 11:00am and 11:15am on 11/06/24.
-When she arrived, she went to the second floor and observed the MA was in the middle of administering the residents' medication.
-The PCA who was assigned to the floor was now working on another floor.
-She did not receive an update on what care was needed or had already been provided or already provided for any of the residents.
-Even though she was agency staff, she had been assigned to the residents before and knew who needed assistance.
-She assisted with care of residents who used their call lights to request assistance.
-Resident #7 was able to use her call light to

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request assistance.
-She had not checked on or provided care to Resident #7 since her arrival at work on 11/06/24.

Interview with a second PCA on 11/06/24 at 12:43pm revealed:
-He came to work at 7:00am on 11/06/24.
-He was the only PCA present to provide care for the residents on the first, second and third floors.
-Resident #7 was totally incontinent of bowel and bladder and required total assistance with incontinence care.
-Sometimes Resident #7 required two people to assist with her care.
-He did not know if Resident #7 needed incontinence care during his shift on 11/06/24 because he had not checked on her.
-He was supposed to check on residents every two hours but that was not possible the morning of 11/06/24 because of staffing issues.

A second interview with the MA on 11/06/24 at 12:48pm revealed:
-She assumed the PCA checked on Resident #7 the morning of 11/06/24.
-Resident #7 should have been checked on at least every 2 hours and provided incontinence care.
-Resident #7 was not aware when she had incontinence episodes.

Interview with the Health and Wellness Director (HWD) on 11/06/24 at 1:18pm revealed:
-Staff should be checking on the residents every two hours.
-There was one PCA assigned to the first, second and third floors on the morning of 11/06/24.
-She assisted the PCA with answering call lights on second floor.
-Resident #7 was incontinent of bowel and

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bladder.
-She did not check on or provide incontinence care for Resident #7 because she was only answering residents that used their call lights to request assistance.

A third interview with the MA on 11/06/24 at 1:32pm revealed:
-She went to Resident #7's room at 1:15pm and asked Resident #7 if she could check to see if she needed incontinence care.
-Resident #7 refused because she was still eating her lunch and did not want to be interrupted.

A second interview with the first PCA on 11/06/24 at 3:08pm revealed:
-Residents were supposed to be checked on every two hours.
-Resident #7 had bowel and bladder incontinence.
-She checked on Resident #7 at 1:52pm, but Resident #7 told her to go away because she was still eating her lunch.
-She told Resident #7 to use her call light when she was finished with lunch, and she would come back to provide incontinence care.
-Resident #7 was provided with incontinence care after she used her call light at 2:32pm.

Interview with the Executive Director on 11/06/24 at 4:06pm revealed:
-Staff should be checking on all residents at least every 2 hours.
-She had been made aware there were some staffing challenges in the morning of 11/06/24.
-She had been assured by her HWD that everything was being covered.
-Residents should never go 2 hours or longer without being checked and provided with necessary care.

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Telephone interview with Resident #7's hospice provider on 11/07/24 at 10:30am revealed:
-Resident #7 began hospice care on 07/25/24.
-Resident #7 was totally incontinent of bowel and bladder.
-Staff should be checking on Resident #7 every two hours.
-She had a history of some skin issues which included breakdown in her gluteal crease and buttocks, along with a stage one pressure ulcer.
-Resident #7 was at high risk for skin breakdown due to incontinence and mobility issues.

Interview with the Administrator on 11/07/24 at 11:17am revealed:
-She knew there was a staffing issue on 11/06/24.
-She did not know the residents were not being checked on every two hours until agency staff arrived at the facility.
-Staff had been told multiple times that they needed to check on each resident a minimum of every two hours.
-Staff had training they needed to check on residents every two hours and needed to be held accountable when they did not.

____

The facility failed to provide incontinence care for Resident #7, who was incontinent of bowel and bladder, for over seven hours. The failure of the facility to provide incontinence care resulted in an increased risk for skin breakdown which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/07/24 for this violation.

THE CORRECTION DATE FOR THE TYPE B

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D 269	Continued From page 13 VIOLATION SHALL NOT EXCEED DECEMBER 23, 2024.	D 269		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the implementation of the most recent therapeutic diet orders for 2 of 6 sampled (#3 and #4) residents who had multiple therapeutic diet orders in their record. The findings are: 1. Review of Resident #4's current FL2 dated 03/15/24 revealed: -Diagnoses included dysphagia (swallowing difficulty) and cerebral infarction (stroke). -There was an order for a no added salt, pureed diet. Review of Resident #4's record revealed: -An order dated 04/12/24 for a mechanical soft diet with regular liquids signed by the palliative care provider. -An order dated 05/15/24 for a no added salt, pureed diet with nectar thickened liquids signed by the primary care provider (PCP). Review of Resident #4's 04/12/24 diet order	D 310		

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posted in the kitchen revealed Resident #4 was ordered a mechanical soft diet.

Interview with Resident #4 on 11/06/24 at 12:02pm revealed:
-She was on a pureed diet at one time because she did not have very many teeth.
-She did not want to receive pureed food and thought she managed soft foods fine.
-She never remembered receiving thickened liquids.

Telephone interview with Resident #4's Power of Attorney (POA) on 11/08/24 at 11:12am revealed:
-Resident #4 was on a pureed diet with thickened liquids in the Spring of 2024 but she requested it be changed to mechanical soft.
-Resident #4 was receiving hospice care and she wanted her to have what ever soft foods she wanted.

Interview with the Executive Director (ED) on 11/06/24 at 10:10am revealed:
-The Administrator, the food service director and the Health and Wellness Director (HWD) reviewed diet orders about a month ago to confirm residents were receiving the correct diet.
-They reviewed the orders that were on paper and did not look at the electronic physician order summary.
-She did not know why they only looked at the orders that were on paper and not at the electronic orders in the record.
-She discovered a discrepancy in Resident #4's diet orders earlier in the morning (11/06/24).

Interview with the Administrator on 11/07/24 at 1:16pm revealed:
-She and the Food Service Director reviewed diet

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D 310	Continued From page 15 orders to confirm Residents were receiving the correct diets. -They did not look at the electronic orders, only the orders that were written on paper. -A contracted nurse consultant audited the records also and she did not know why the error was not identified. -She would have contacted the Resident #4's provider for clarification if the error had been identified. Interview with the Food Service Director on 11/08/24 at 8:20am revealed: -About a month ago he and the Administrator reviewed all the diet orders on file. -He did not have access to any electronic orders so the only diet orders he accepted in the kitchen were the ones written on the facility's diet order form. -The most recent diet order he received was for a mechanical soft diet dated 04/12/24. Interview with Resident #4's PCP on 11/08/24 at 9:45am revealed: -Resident #4 returned to the facility from a rehabilitation facility in March 2024 on a pureed diet with nectar thickened liquids. -The family requested the resident be changed to a mechanical soft diet and they planned to consult with the palliative care team. -When she signed the diet order dated 05/15/24 she was not sure if the palliative team had evaluated Resident #4 yet and if the diet had been officially changed. -The facility should have clarified the diet order because she agreed with the family requesting a mechanical soft diet. -Resident #4 transitioned to hospice care on 05/17/24.	D 310		

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2. Review of Resident #3's current FL2 dated 09/19/24 revealed:
-Diagnoses included agitation or violent behavior.
-There was no diet order.

Review of Resident #3's diet order available in the kitchen on 11/05/24 revealed regular house diet low concentrated sweets dated 08/08/24.

Review of Resident #3's primary care provider (PCP) order dated 10/09/24 revealed the diet as low concentrated sweets, nectar texture, thin consistency.

Review of Resident #3's PCP order dated 10/23/24 revealed the diet as low concentrated sweets, nectar texture, thin consistency.

Observation of the lunch meal and beverage service on 11/05/24 at 12:15pm revealed Resident #3 received a regular diet including a pulled pork BBQ sandwich, fried okra, pasta salad, fruit parfait, carbonated soda, and water.

Observation of Resident #3 in the dining room on 11/05/24 from 12:15pm to 12:52pm revealed:
-She did not appear to have any difficulty eating or drinking any of the items provided to her.
-She ate 50% of the BBQ sandwich and 100% of the okra and pasta salad.

Review of Resident #3's November 2024 electronic medication administration record (eMAR) from 11/01/24-11/05/24 revealed the blood sugar range was 84-242.

Review of Resident #3's Speech Language Pathology (SLP) swallowing evaluation results dated 11/07/24 revealed the recommendation was for regular textures diet and thin liquids.

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Interview with the Health and Wellness Director (HWD) on 11/06/24 at 9:15am revealed:
-She did not start her employment at the facility until 10/07/24.
-She was not aware there was not a diet order on Resident #3's FL2 dated 09/19/24.

Interview with the Administrator on 11/07/24 at 1:35pm revealed the medication aides (MAs) and HWD were responsible for clarifying the diet order on Resident #3's FL2 with the PCP.

D 344 | 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 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:
Based on observations, record reviews and interviews, the facility failed to ensure contact with the prescribing practitioner for clarification of medication orders for 1 of 7 sampled residents (#3) related to orders for two medications for diabetes, and a medication for dementia.

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The findings are:

Review of Resident #3's current FL2 dated 09/19/24 revealed diagnoses included agitation or violent behavior.

1. Review of Resident #3's current FL2 dated 09/19/24 revealed there was an order for Fiasp (a rapid-acting insulin used to control blood sugar) flextouch 100 unit/ml with no additional instructions.

Review of Resident #3's primary care provider (PCP) order dated 10/09/24 revealed Fiasp flextouch 100 unit/ml check fingerstick blood sugar (FSBS) before meals and inject per sliding scale: If 200-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, if above 400 call MD.

Review of Resident #3's PCP order dated 10/23/24 revealed Fiasp flextouch 100 unit/ml check fingerstick blood sugar (FSBS) before meals and inject per sliding scale: If 200-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, if above 400 call MD.

Review of Resident #3's September, October, and November 2024 electronic medication administration records (eMAR) revealed there was an entry for Fiasp flextouch 100 unit/ml check FSBS and inject per sliding scale: If 200-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, if above 400 call MD scheduled at 8:00am, 12:00pm, and 5:00pm.

Interview with the Health and Wellness Director (HWD) on 11/06/24 at 9:15am revealed:
-She did not start her employment at the facility until 10/07/24.

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-She was not aware there were medication orders on Resident #3's FL2 dated 09/19/24 which were incomplete.
-She had not yet had a chance to "clean up" all the FL2's.

Interview with the Administrator on 11/07/24 at 1:35pm revealed the medication aides (MAs) and HWD were responsible for clarifying the orders on Resident #3's FL2 with the PCP.

Interview with Resident #3's PCP on 11/08/24 at 9:25am revealed:
-Resident #3 was supposed to receive Fiasp insulin per sliding scale at meals if her FSBS was 200 or greater.
-She did not recall being contacted by facility staff to clarify the Fiasp order, nor had she seen an entry in the communication book about the Fiasp order.

2. Review of Resident #3's current FL2 dated 09/19/24 revealed there was an order for memantine (used to treat moderate to severe Alzheimer's disease) 5mg one tablet daily.

Review of Resident #3's primary care provider (PCP) order dated 09/03/24 revealed memantine 5mg one tablet twice daily for memory "profile only."

Review of Resident #3's PCP order dated 10/09/24 revealed memantine 5mg one tablet two times a day.

Review of Resident #3's PCP order dated 10/23/24 revealed memantine 5mg one tablet two times a day.

Review of Resident #3's September, October,

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and November 2024 electronic medication administration records (eMARs) revealed there were entries for memantine 5mg one tablet two times a day scheduled at 8:00am and 8:00pm.

Interview with the Health and Wellness Director (HWD) on 11/06/24 at 9:15am revealed:
-She did not start her employment at the facility until 10/07/24.
-She was not aware there were medication orders on Resident #3's FL2 dated 09/19/24 which needed to be clarified.

Interview with the Administrator on 11/07/24 at 1:35pm revealed the medication aides (MAs) and HWD were responsible for clarifying the orders on Resident #3's FL2 with the PCP.

Telephone interview with Resident #3's PCP on 11/08/24 at 9:25am revealed:
-The order for memantine was 5mg one tablet two times a day.
-She did not recall being contacted by facility staff to clarify the memantine order.

3. Review of Resident #3's current FL2 dated 09/19/24 revealed there was an order for Tresiba (a long-acting insulin used to control blood sugar) 100 units/ml inject 26 units daily.

Review of Resident #3's primary care provider (PCP) order dated 10/09/24 revealed Tresiba 100 units/ml inject 25 units daily.

Review of Resident #3's PCP order dated 10/23/24 revealed Tresiba 100 units/ml inject 25 units daily.

Review of Resident #3's September, October, and November 2024 electronic medication

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D 344	Continued From page 21 administration records (eMARs) revealed there were entries for Tresiba 100 units/ml inject 25 units daily. Interview with the Health and Wellness Director (HWD) on 11/06/24 at 9:15am revealed: -She did not start her employment at the facility until 10/07/24. -She was not aware there were medication orders on Resident #3's FL2 dated 09/19/24 which needed to be clarified. Interview with the Administrator on 11/07/24 at 1:35pm revealed the medication aides (MAs) and HWD were responsible for clarifying the orders on Resident #3's FL2 with the PCP.	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: (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 A2 VIOLATION The Type A2 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record	D 358		

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reviews, the facility failed to ensure medications were administered as ordered for 2 of 7 sampled residents (#3 and #4) related to medications used to treat behaviors and dementia (#3), a long-acting insulin used to treat diabetes (#3), and a medication used to treat anxiety (#4).

The findings are:

1. Review of Resident #3's current FL2 dated 09/19/24 revealed:
-Diagnoses included agitation or violent behavior.
-The current level of care was hospital.
-The requested level of care was assisted living memory care.
-The resident was documented as constantly disoriented, semi-ambulatory, verbally abusive, with a history of wandering behaviors.

Review of Resident #3's Resident Register revealed an admission date of 08/06/24.

Review of Resident #3's Care Plan dated 10/23/24 revealed the resident was documented to have significant memory loss.

a. Review of Resident #3's current FL2 dated 09/19/24 revealed there was an order for Seroquel (used to balance the levels of dopamine and serotonin in the brain, hormones that help regulate mood, behaviors, and thoughts) 25mg one tablet daily at bedtime.

Review of a subsequent primary care provider (PCP) order for Resident #3 dated 09/25/24 revealed Seroquel 25mg one tablet daily at bedtime.

Review of Resident #3's PCP orders dated 10/09/24 revealed there was no order for

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Seroquel.

Review of Resident #3's PCP order dated 10/23/24 revealed Seroquel 25mg one tablet daily at bedtime for mood.

Review of Resident #3's September 2024 electronic medication administration record (eMAR) from 09/19/24 to 09/30/24 revealed:
-There was no entry for Seroquel 25mg one tablet daily at bedtime.
-There were no documentation Seroquel 25mg was administered at bedtime.

Review of Resident #3's October 2024 eMAR revealed:
-There was an entry for Seroquel 25mg one tablet by mouth daily at bedtime for mood scheduled at 8:00pm.
-The Seroquel was documented as administered 15 occurrences out of 30 opportunities.
-The Seroquel was documented as not administered with a note "not due" from 10/01/24-10/14/24.
-On 10/23/24, the Seroquel was documented as not administered due to leave of absence.

Review of Resident #3's November 2024 eMAR from 11/01/24-11/04/24 revealed:
-There was an entry for Seroquel 25mg one tablet by mouth daily at bedtime for mood scheduled at 8:00pm.
-The Seroquel was documented as administered 4 occurrences out of 4 opportunities.

Observation of Resident #3's medications on hand on 11/07/24 at 10:27am revealed:
-There was one bubble pack of Seroquel 25mg tablets with ten tablets remaining in the pack.
-The directions on the label were Seroquel 25mg

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take one tablet daily at bedtime.
-The bubble pack of Seroquel was dispensed on 10/17/24 in a quantity 30.

Telephone interview with the facility's contracted pharmacy on 11/07/24 at 11:16am revealed:
-They dispensed 32 Seroquel 25mg tablets for Resident #3 for the first time on 10/17/24.
-The Seroquel was filled from the order dated 09/25/24 written by Resident #3's PCP.

Interview with Resident #3's family member on 11/05/24 at 10:25am revealed:
-Resident #3 had recently been hospitalized due to a change in condition.
-Resident #3 had increased agitation and had become combative with staff.
-There had been an order for Seroquel, but it "disappeared" from Resident #3's medication list.

Interview with the Health and Wellness Director (HWD) on 11/07/24 at 11:05am revealed:
-She was responsible for ensuring orders for new medications were processed and available for administration.
-She did not know why Resident #3's Seroquel order was not started until 10/17/24 and would have to "look it up."

Interview with the Administrator on 11/07/24 at 1:35pm revealed:
-The HWD was responsible for entering new medication orders into the eMAR.
-It was the HWD's responsibility to ensure new medication orders were followed-up and the medication was available for administration.
-The pharmacy received the order entered by the HWD through the eMAR.
-The pharmacy delivered medications to the facility "daily."

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-Their third shift MAs had been conducting medication cart audits starting in mid-September 2024.
-They also had a contracted nurse consultant come in and perform medication cart audits.

Telephone interview with Resident #3's PCP on 11/08/24 at 9:25am revealed:
-Resident #3 was in the hospital in September to get her behaviors stabilized.
-Resident #3 was discharged from the hospital with an order to start Seroquel.
-The hospital did not provide a prescription for the Seroquel upon discharge on 09/19/24.
-She had written an order to start the Seroquel on 09/25/24.
-Having missed the doses of Seroquel could have caused an increase in Resident #3's behaviors.
-Behaviors would include anxiety, agitation, and a possible increase in aggressive behaviors towards staff when they attempted to assist the resident with activities of daily living.
-She observed Resident #3 to be agitated in the mornings.

b. Review of Resident #3's current FL2 dated 09/19/24 revealed there was an order for memantine (used to treat dementia) 5mg one tablet daily.

Review of a previous primary care provider (PCP) order for Resident #3 dated 09/03/24 revealed memantine 5mg one tablet twice daily for memory "profile only."

Review of Resident #3's PCP order dated 10/09/24 revealed memantine 5mg one tablet two times a day.

Review of Resident #3's PCP order dated

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10/23/24 revealed memantine 5mg one tablet two times a day.

Review of Resident #3's September 2024 electronic medication administration record (eMAR) from 09/19/24-09/27/24 revealed:
-There was an entry for memantine 5mg one tablet two times a day scheduled at 8:00am and 8:00pm.
-The memantine was documented as not administered for 6 occurrences out of 14 opportunities.
-On 09/20/24 at 5:00pm, the memantine was documented as not administered due to "on order."
-On 09/21/24 at 8:00am, the memantine was documented as not administered due to "waiting on pharmacy."
-On 09/21/24 at 8:00pm, the memantine was documented as not administered due to "not in cart."
-On 09/22/24 at 8:00am, the memantine was documented as not administered due to "patient refused medication."
-On 09/24/24 at 8:00am, the memantine was documented as not administered due to "patient refused medication."
-On 09/27/24 at 8:00am, the memantine was documented as not administered due to "patient refused medication."

Review of Resident #3's October 2024 eMAR from 10/04/24-10/31/24 revealed:
-There was an entry for memantine 5mg one tablet two times a day scheduled at 8:00am and 8:00pm.
-The memantine was documented as not administered 6 occurrences out of 55 opportunities.
-On 10/09/24 at 8:00am, the memantine was

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D 358	Continued From page 27 documented as not administered due to "patient refused medication." -On 10/12/24 at 8:00am, the memantine was documented as not administered due to "patient refused medication." -On 10/12/24 at 8:00pm, the memantine was documented as not administered due to "not in cart." -On 10/16/24 at 8:00pm, the memantine was documented as missed dose no reason documented. -On 10/23/24 at 8:00pm, the memantine was documented as not administered due to resident on leave of absence. -On 10/26/24 at 8:00am, the memantine was documented as not administered due to "patient refused medication." Review of Resident #3's November 2024 eMAR from 11/01/24-11/05/24 revealed: -There was an entry for memantine 5mg one tablet two times a day scheduled at 8:00am and 8:00pm. -The memantine was documented as not administered 1 occurrence out of 9 opportunities. -On 11/01/24 at 8:00am, the memantine was documented as not administered due to "patient refused medication." Observation of Resident #3's medications on hand on 11/07/24 at 10:27am revealed: -There were two bubble packs of memantine 5mg tablets available. -One bubble pack was labeled "morning" memantine 5mg one tablet two times a day with ten tablets remaining dispensed on 10/18/24. -A second bubble pack was labeled " bedtime" memantine 5mg one table two times a day with 19 tablets remaining dispensed on 10/18/24.	D 358		

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Telephone interview with the facility's contracted pharmacy on 11/07/24 at 11:16am revealed they dispensed 60 tablets of memantine for the first time for Resident #3 on 09/23/24.

Telephone interview with the facility's contracted pharmacy on 11/07/24 at 2:25pm revealed:
-They received an order for Resident #3 on 09/03/24 for memantine 5mg one tablet two times a day to add as "profile only" to the eMAR.
-The resident brought in their own supply of the memantine.
-On 10/14/24, the facility requested a refill of memantine for Resident #3 and they dispensed and delivered four memantine 5mg tablets.
-On 10/18/24, the facility received an additional 56 tablets of memantine for Resident #3 in with their batch supply of medications.

Interview with Resident #3's family member on 11/05/24 at 10:25am revealed:
-Resident #3 ran out of memantine on a Friday night.
-The MA staff reordered the memantine on the same day.
-The MA staff told her the memantine would not be delivered from the pharmacy until Monday.
-She did not understand why the pharmacy did not deliver the medication over the weekend.

Interview with a medication aide (MA) on 11/07/24 at 10:42am revealed:
-At first the family was going to supply the memantine for Resident #3.
-Then the family found out their pharmacy could send the memantine directly to the facility's contracted pharmacy for repackaging and labeling.

Interview with the Administrator on 11/07/24 at

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1:35pm revealed:
-It was the responsibility of the MAs and Health and Wellness Director to ensure new medication orders were followed-up and the medication was available for administration.
-The pharmacy received the order entered by the HWD through the eMAR.
-The pharmacy delivered medications to the facility "daily."
-Their third shift MAs had conducted medication cart audits starting in mid-September 2024.
-They also had a contracted nurse consultant come in and perform medication cart audits.

Telephone interview with Resident #3's PCP on 11/08/24 at 9:25am revealed:
-The memantine was originally prescribed during an emergency room visit for Resident #3.
-The prescription for the memantine was sent to a local pharmacy and Resident #3's family picked it up.
-The order was memantine 5mg one tablet two times a day.

c. Review of Resident #3's current FL2 dated 09/19/24 revealed there was an order for Tresiba flextouch (a long-acting insulin used to control blood sugar) 100 units/ml inject 26 units daily.

Review of Resident #3's primary care provider (PCP) order dated 10/09/24 revealed Tresiba flextouch 100 units/ml inject 25 units daily.

Review of Resident #3's PCP order dated 10/23/24 revealed Tresiba flextouch 100 units/ml inject 25 units daily.

Review of Resident #3's September 2024 electronic medication administration record (eMAR) from 09/19/24-09/30/24 revealed:

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D 358	Continued From page 30 -There was an entry for Tresiba flextouch 100 units/ml inject 25 units daily scheduled for 7:30am. -The Tresiba was documented as not administered for 4 occurrences out of 8 opportunities. -On 09/20/24 at 7:30am, the Tresiba was documented as not administered due to "no safety tips for insulin administration." -On 09/21/24 at 7:30am, the Tresiba was documented as not administered due to "no safety tips waiting on order this afternoon." -On 09/24/24 at 7:30am, the Tresiba was documented as not administered due to "patient refused medication." -On 09/27/24 at 7:30am, the Tresiba was documented as not administered due to "patient refused medication." -On 09/20/24 at 5:00pm, Resident #3's documented fingerstick blood sugar (FSBS) was 165. -On 09/21/24 at 8:00am, Resident #3's documented FSBS was 160. -On 09/21/24 at 12:00pm, Resident #3's documented FSBS was 186. -On 09/21/24 at 5:00pm, Resident #3's documented FSBS was 175. -On 09/24/24 at 12:00pm, Resident #3's documented FSBS was 318. -On 09/27/24 at 12:00pm, Resident 3's there was no documented FSBS. -Resident #3's blood sugar range was 53-318 for September 2024. Interview with a medication aide (MA) on 11/07/24 at 10:42am revealed: -Resident #3's Tresiba could not be administered on two occasions (09/20/24 and 09/21/24) because there were no safety needles available to administer the medication.	D 358		

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-The pharmacy did not have the order for the safety needles on the eMAR, so the staff had been not been able to request a refill of the safety needles.
-She had worked the morning of 09/20/24 and realized there were no safety needles available.
-She had faxed the order for the safety needles to the pharmacy on the afternoon of 09/20/24.
-The pharmacy was located in a different state.
-Resident #3's safety needles were not delivered until 09/21/24.
-There was no other way to get the safety needles.
-She contacted the family to see if they a supply of the safety needles and they did not.

Telephone interview with the facility's contracted pharmacy on 11/07/24 at 11:16am revealed they had dispensed 200 safety needles (a 60-day supply) for Resident #3's insulin administrations on 09/21/24.

Interview with the Administrator on 11/07/24 at 1:35pm revealed:
-The MAs should have been checking Resident #3's safety needle supplies and ordering the needles "ahead of time" so they would be available.
-If the MA sent the order for the safety needles to the pharmacy on 09/20/24, a new supply of safety needles should have arrived to the facility on the evening pharmacy delivery.

Telephone interview with Resident #3's PCP on 11/08/24 at 9:25am revealed:
-Resident #3 not having received the daily doses of Tresiba on 09/20/24 and 09/21/24 could have caused Resident #3's blood sugar to be higher.
-Resident #3's blood sugars routinely ran below 200.

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2. Review of Resident #4's current FL2 dated 03/15/24 revealed:
-Diagnoses included dysphagia (swallowing difficulty) and cerebral infarction (stroke).

Review of Resident #4's record revealed an order for buspirone HCL 10mg twice daily.

Review of Resident #4's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for buspirone HCL 10mg at 9:00am and 8:00pm.
-There was documentation buspirone HCL 10mg was not administered on 09/01/24 at 9:00am with the reason documented as "waiting on pharmacy".
-There was documentation buspirone HCL 10mg was not administered on 09/01/24 at 8:00pm with the reason documented as "out of medication".
-There was documentation buspirone HCL 10mg was not administered on 09/02/24 at 8:00pm with the reason documented as "waiting on pharmacy".
-There was documentation buspirone HCL 10mg was not administered on 09/03/24 at 9:00am with the reason documented as "medication not on cart".
-There was documentation buspirone HCL 10mg was not administered on 09/04/24 at 9:00am with the reason documented as "waiting on pharmacy".

Review of Resident #4's October 2024 eMAR revealed:
-There was an entry for buspirone HCL 10mg at 9:00am and 8:00pm.
-There was documentation buspirone HCL 10mg

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was not administered on 10/19/24, 10/20/24, or 10/23/24 at 9:00am or 8:00pm with the reason documented as "medication not on cart".
-There was documentation buspirone HCL 10mg was not administered on 10/21/24 at 9:00am and 10/22/24 at 8:00pm with the reason documented as "medication not on cart".

Telephone interview with a medication aide (MA) on 11/08/24 at 2:59pm revealed if other MAs documented Resident #4's buspirone as not on the cart she "probably" accidentally documented she administered the medication when it was not available, which was easy to do.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/06/24 at 8:43am revealed:
-Resident #4's buspirone was never sent with the facility's batch medications and could only be filled with a refill request from the hospice registered nurse (RN).
-The facility requested a refill on 08/30/24 and they were informed the hospice RN needed to submit a new prescription.
-A 15-day supply was dispensed on 09/04/24, 09/18/24, 10/02/24 and then not again until 10/23/24.

Telephone interview with Resident #4's hospice RN on 11/07/24 at 9:55am revealed:
-She was responsible for reordering Resident #4's buspirone which was used to treat her anxiety.
-She came to the facility every week and when she was there she asked the MA if they needed her to reorder medications.
-If they did not bring it to her attention she would not know they were running low.
-Only the MA would know the supply on hand

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because they administered the medication and she did not have access to the medication cart.
-Not getting buspirone regularly was a problem because the medication needed to remain in the blood stream to be effective.
-Resident #4 had a long history of depression and anxiety and missing doses would negatively affect her mood.

Interview with the Administrator on 11/07/24 at 1:16pm revealed:
-She expected the MAs to inform the hospice RN if Resident #4 needed a medication refill.
-The MAs had been trained properly but she could not speak for the agency MAs.
-She expected the MAs to administer medications as ordered and document accurately if they were out of a medication.

____

The facility failed to administer a medication for behaviors to Resident #3 for 19 days increasing the risk of anxiety, agitation, and aggression with staff and to Resident #4 who was not administered anxiety medications for four days in September 2024 and five days in October 2024 putting her at risk of increased anxiety. These failures were detrimental to the health and welfare of the residents and constitutes a Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/07/24 for this violation.

THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 23, 2024.

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D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the prescribed times for 2 of 2 sampled residents (#8 and #9) including medications to treat pain (#8) and to treat high blood pressure, low thyroid levels, depression, high cholesterol levels, and low vitamin B and calcium levels (#9). The findings are: Review of the facility's census report dated 11/05/24 revealed: -The facility's current census was 70 residents. -There were 56 residents currently residing in the assisted living (AL) of the facility. -There were 14 residents currently residing in the Memory Care Unit. 1. Review of Resident #8's current FL2 dated 05/15/24 revealed diagnoses including periprosthetic fracture of femur and osteoporosis. Interview with Resident #8 on 11/05/24 at 10:35am revealed:	D 364		

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-She had called for the medication aide (MA) at 10:00am to bring her medications as she had another appointment at 11:00am.
-The staff that administered medications on the first floor also worked on the third floor every shift.
-The residents on the first floor were a "lost annex" because the staff were always on the third floor.
-She routinely called the MA at 10:00am if the medications had not been delivered.

Observation on the AL side of the facility on 11/05/24 at 11:00am revealed a medication aide (MA) was administering medications on the 100 hall.

Interview with the MA on 11/05/24 at 11:00am revealed:
-She was still administering the 8:00am medications to the residents on the 100 hall.
-There was usually one MA assigned to administer medications to the residents on the first and the third floor on the same shift.
-She usually started administering medications at 7:00am and she usually finished around 11:00am.
-She had to administer other medications on the first floor before returning back to the third floor again.
-She rushed to get all the medications administered on the first floor and moved back and forth from the first floor residents to the third floor residents.

Review of Resident #8's primary care provider (PCP) order dated 05/15/24 revealed there was an order for hydrocodone-acetaminophen 5-325mg (used to treat pain) one tablet twice daily scheduled at 6:00am and 2:00pm.

Review of Resident #8's September 2024

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electronic medication administration record (eMAR) from 09/07/24-09/30/24 revealed there was an entry for hydrocodone-acetaminophen 5-325mg one tablet twice daily scheduled at 6:00am and 2:00pm.

Review of Resident #8's September 2024 eMAR variance report from 09/07/24-09/30/24 revealed the scheduled 6:00am dose of hydrocodone-acetaminophen 5-325mg was documented as administered late on 09/16/24 at 8:37am and on 09/27/24 at 8:18am.

Review of Resident #8's October 2024 eMAR revealed there was an entry for hydrocodone-acetaminophen 5-325mg one tablet twice daily scheduled at 6:00am and 2:00pm.

Review of Resident #8's October 2024 eMAR variance report from 10/01/24-10/31/24 revealed
-The scheduled 6:00am dose of hydrocodone-acetaminophen 5-325 was documented as administered late on 10/07/24 at 7:21am and on 10/12/24 at 7:08am.
-The scheduled 2:00pm dose of hydrocodone-acetaminophen 5-325mg was documented as administered late on 10/05/24 at 5:52pm, 10/07/24 at 8:18am, 10/23/24 at 3:10pm, and 10/27/24 at 3:23pm.

Review of Resident #8's November 2024 eMAR revealed there was an entry for hydrocodone-acetaminophen 5-325mg one tablet twice daily scheduled at 6:00am and 2:00pm.

Review of Resident #8's November 2024 eMAR variance report from 11/01/24-11/07/24 revealed there were no documented administrations of hydrocodone-acetaminophen 5-325mg outside of the one hour before or one hour after timeframe.

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Interview with a MA on 11/07/24 at 11:15am revealed:
-The MA was responsible for administering medications on the first and third floors during her 12-hour shift "today."
-She MA administered medications on the first floor and then returned to the third floor to continue to administer medications.
-Then the MA would return to the first floor to administer more medications.
-The MA scheduled for any given shift covered the first and third floor routinely.
-The MA routinely started administering medications early every shift and rotated the entire shift from third floor to the first floor, administering medications.
-The medications were "sometimes late."
-There was one MA and one personal care aide (PCA) scheduled every shift to cover the second floor due to population of residents who lived on the second floor.

Observation on the AL first floor on 11/07/24 at 11:45am revealed:
-There was no staff present on the floor.
-There were multiple residents walking through the halls of the first floor.

Telephone interview with Resident #8's primary care provider (PCP) on 11/08/24 at 3:25pm revealed:
-She had no concerns with Resident # 8's medications being administered late six times in the 62-day sample period.
-She had no concerns with Residents #8's medications that were ordered to be administered one time per day were administered late a few days within a sampled timeframe.

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Interview with the Administrator on 11/07/24 at 2:00pm revealed:
-She was not aware medications were being administered late.
-There were current staffing challenges which made it difficult to assign one MA to only work on the first floor.
-Medications in AL were scheduled to be administered at 7:00am, 8:00am, 9:00am, and 10:00am.
-The Health and Wellness Director (HWD) had suggested to change the administration times of the medications.
-They currently had three Registered Nurses (RNs) reviewing variance reports to figure out why medications were being administered outside the one hour before one hour after timeframe.

2. Review of Resident #9's current FL2 dated 07/24/24 revealed diagnoses included hypertension, hypothyroidism, major depressive disorder, anxiety, hyperlipidemia, and vitamin deficiency.

Interview with Resident #9 upon initial tour of the facility on 11/05/24 at 9:55am revealed:
-He took two medications routinely in the morning.
-The medication aide (MA) had not yet administered his morning medications.
-His medications were administered "haphazardly."
-He was supposed to get some of his morning medication before he ate breakfast.
-He guessed the staff put all his morning medications together and gave them to him at once.
-The MAs could not tell him what medications they administered to him.
-He had no way of knowing if he got the correct

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medications or not.

Review of Resident #9's physician's orders dated 07/24/24 revealed:
-There was an order for amlodipine (used to treat high blood pressure) 5mg take 1 tablet daily.
-There was an order for nebivolol (used to treat high blood pressure) 10mg take 1 tablet daily.
-There was an order for Synthroid (used to treat low thyroid levels) 100mcg take 1 tablet daily.
-There was an order for atorvastatin (used to treat high cholesterol levels) 10mg take 1 tablet daily.
-There was an order for bupropion HCL XL (used to treat depression) 300mg take 1 tablet daily.
-There was an order for Caltrate 600-D plus minerals (used to supplement low calcium levels) chew 1 tablet daily.
-There was an order for vitamin B-12 (used to supplement low vitamin B levels) 1,000mcg take 1 tablet daily.
-There was an order for vitamin B1 (used to supplement low vitamin B levels) 100mg take 1 tablet daily.
-There was an order for L-Methylfolate (used to supplement low vitamin B levels) 7.5mg take 1 tablet daily.

Review of Resident #9's physician's orders dated 08/11/24 revealed there was an order for bupropion HCL XL 150mg take 1 tablet every other day.

Review of Resident #9's 09/07/24-09/30/24 electronic medication administration record (eMAR) revealed:
-There was an entry for amlodipine 5mg take 1 tablet daily at 9:00am.
-There was an entry for nebivolol 10mg take 1 tablet daily at 9:00am.

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-There was an entry for Synthroid 100mcg take 1 tablet daily at 6:00am.
-There was an entry for atorvastatin 10mg take 1 tablet daily at 9:00am.
-There was an entry for bupropion HCL XL150mg take 1 tablet every other day at 9:00am.
-There was an entry for Caltrate 600-D plus minerals chew 1 tablet daily at 9:00am.
-There was an entry for vitamin B-12 1000mcg take 1 tablet daily at 9:00am.
-There was an entry for L-Methylfolate 7.5mg take 1 tablet daily at 9:00am.

Review of Resident #9's Medication Variance Report dated 09/07/24-09/30/24 revealed:
-The scheduled 6:00am doses of Synthroid were administered on 09/07/24 at 7:36am, 09/09/24 at 7:27am, 09/10/24 at 7:23am, 09/13/24 at 7:46am, 09/16/24 at 9:30am, 09/18/24 at 11:07am, 09/19/24 at 7:16am, 09/21/24 at 8:46am, 09/24/24 at 7:39am, 09/26/24 at 7:32am, 09/27/24 at 8:11am, and 09/28/24 at 10:25am.
-The scheduled 9:00am doses of amlodipine, nebivolol, atorvastatin, bupropion, Caltrate 600-D plus minerals, vitamin B-12, vitamin B1, and L-Methtylfolate were administered on 09/07/24 at 11:17am, 09/08/24 at 10:25am, 09/09/24 at 10:27am, 09/10/24 at 10:13am, 09/12/24 at 10:45am, 09/13/24 at 11:19am, 09/14/24 at 11:29am, 09/15/24 at 10:36am, 09/18/24 at 11:07am, 09/20/24 at 11:04am, 09/22/24 at 11:35am, and 09/26/24 at 11:07am.

Review of Resident #9's October 2024 eMAR revealed:
-There was an entry for amlodipine 5mg take 1 tablet daily at 9:00am.
-There was an entry for nebivolol 10mg take 1 tablet daily at 9:00am.
-There was an entry for Synthroid 100mcg take 1

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tablet daily at 6:00am.
-There was an entry for atorvastatin 10mg take 1 tablet daily at 9:00am.
-There was an entry for bupropion HCL XL 150mg take 1 tablet every other day at 9:00am.
-There was an entry for Caltrate 600-D plus minerals chew 1 tablet daily at 9:00am.
-There was an entry for vitamin B-12 1000mcg take 1 tablet daily at 9:00am.
-There was an entry for L-Methylfolate 7.5mg take 1 tablet daily at 9:00am.
-There was documentation Resident #9 was on leave of absence from the facility from 10/06/24-10/27/24 and no medications were administered during this period.

Review of Resident #9's October 2024 Medication Variance Report revealed:
-The scheduled 6:00am doses of Synthroid from 10/01/24-10/05/24 were administered on 10/08/24 at 10:25pm.
-The scheduled 6:00am dose of Synthroid was administered on 10/28/24 at 8:21am, 10/30/24 at 1:41pm, and 10/31/24 at 7:30am.
-The scheduled 9:00am doses of amlodipine, nebivolol, Synthroid, atorvastatin, bupropion, Caltrate, vitamin B12, and L-Methylfolate from 10/01/24-10/05/24 were administered on 10/08/24 at 10:25pm.
-The scheduled 9:00am doses of amlodipine, nebivolol, Synthroid, atorvastatin, bupropion, Caltrate, vitamin B12, and L-Methylfolate were administered on 10/29/24 at 10:51am, 10/30/24 at 11:40am, 10/31/24 at 10:58am.

Review of Resident #9's 11/01/24-11/07/24 eMAR revealed:
-There was an entry for amlodipine 5mg take 1 tablet daily at 9:00am.
-There was an entry for nebivolol 10mg take 1

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tablet daily at 9:00am.
-There was an entry for Synthroid 100mcg take 1 tablet daily at 6:00am.
-There was an entry for atorvastatin 10mg take 1 tablet daily at 9:00am.
-There was an entry for bupropion HCL XL150mg take 1 tablet every other day at 9:00am.
-There was an entry for Caltrate 600-D plus minerals chew 1 tablet daily at 9:00am.
-There was an entry for vitamin B-12 1000mcg take 1 tablet daily at 9:00am.
-There was an entry for L-Methylfolate 7.5mg take 1 tablet daily at 9:00am.

Review of Resident #9's 11/01/24-11/07/24 Medication Variance Report revealed:
-The scheduled 6:00am dose of Synthroid was administered on 11/02/24 at 8:17am, 11/05/24 at 11:56am, and 11/07/24 at 7:42am.
-The scheduled 9:00am doses of amlodipine, nebivolol, Synthroid, atorvastatin, bupropion, Caltrate, vitamin B12, and L-Methylfolate were administered on 11/04/24 at 11:29am, 11/05/24 at 11:56am, 11/06/24 at 10:39am, and 11/07/24 at 11:21am.

Interview with a medication aide (MA) on 11/07/24 at 2:54pm revealed:
-She was late administering Resident #9's scheduled medications today (11/07/24) because she was assigned to administer medications to the residents residing on the first floor and third floor.
-She administered the morning scheduled medications first to the residents residing on the first floor except for Resident #9.
-She always administered Resident #9's 6:00am dose of Synthroid around 7:30am because Resident #9 had 2 other medications scheduled at 7:00am.

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-She would then go to the third floor to administer medications to other residents because 3 of the residents had diabetes and needed their fingerstick blood sugar (FSBS) checked before eating breakfast.
-After she finished administering medications on the third floor, she would return to the first floor and administer Resident #9's other scheduled morning medications.
-She had been working short staffed and administering medications to two floors at the facility for the past 2 months since another MA quit.
-The facility's policy for medication administration was to administer medication one hour before or one hour after the scheduled medication time.
-She could not always administer medications within the scheduled timeframe.
-Some residents were prescribed a lot of medications and took a long time to swallow them.

Interview with Resident #9 on 11/08/24 at 8:54am revealed:
-He moved into the facility in late July 2024.
-He was administered his morning medications late "often".
-Staff were "stretched thin" and the MA had to administer medications to 2 different floors at the facility.
-The facility had agency staff working all the time.
-He complained about his medications being administered late to the previous Executive Director (ED), but his medications were still being administered late.
-It bothered him that his medications were never given around the same time because it made it hard for him to keep up with whether he was getting the medications he needed.
-Some medications were administered on time,

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and some were "really late".

Telephone interview with Resident #9's primary care provider (PCP) on 11/08/24 at 9:24am revealed:
-She last saw Resident #9 on 11/06/24.
-She did not know some of Resident #9's medications were being administered late.
-Resident #9's medications should be administered on time.
-Resident #9 had to have his blood pressure checked daily because she had ordered parameters to hold the blood pressure medications if his blood pressure was too low.
-If Resident #9's blood pressure medications were not administered when his blood pressure was checked, his blood pressure may be too low to be administered the medications later.
-Resident #9 could fall or pass out if his blood pressure medications were administered outside the parameters she ordered.
-It was important for Resident #9's Synthroid to be administered on time for best absorption.
-If Resident #9's Synthroid was administered with other medications or food, it could decrease his thyroid stimulating hormone (TSH) level which could cause weight gain, tiredness, increased depression, fatigue, and constipation.
-She expected the facility to administer Resident #9's medications as ordered and at the scheduled times.

Interview with the ED on 11/07/24 at 4:04pm revealed:
-She had been working at the facility for about a week.
-She was not aware that Resident #9's medications were being administered late.
-The facility was short-staffed and hired agency staff to cover shifts.

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-Sometimes an MA would be assigned to work as a personal care aide (PCA) and another MA would be assigned to administer medications to the first and third floor residents.
-The facility's policy and procedures for medication administration included to administer medications one hour before or one hour after the scheduled medication times.

Interview with the Administrator on 11/07/24 at 1:18pm revealed:
-The facility was short-staffed and hired agency staff to work.
-The facility currently assigned one MA to administer medications to the first and third floor residents.
-All MAs were trained by the Health and Wellness Director (HWD) and/or other MAs to administer medications.
-The MAs were trained to administer medications one hour before or one hour after the scheduled times.
-She was not aware some of Resident #9's medications were being administered late.
-She expected the MAs to follow the facility's policy on medication administration and administer the medications within the allotted timeframe.

Attempted telephone interview with an MA on 11/07/24 at 2:47pm was unsuccessful.