STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNDATION SENIOR LIVING	1437 AVERSBORO ROAD GARNER, NC 27529

(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 an annual survey October 22-23, 2024.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) in residents' bathrooms as evidenced by 7 of 9 fixtures with water temperatures ranging from 94.3 to 118.8 degrees F. The findings are: Review of the facility's census on 10/22/24 revealed there were 23 residents residing in the facility. Observation of the water temperatures in the facility on 10/22/24 from 8:50am to 10:16am revealed: -The water temperature in the sink in room 118 was 94.3 degrees Fahrenheit (F). -The water temperature in the sink in room 119 was 117.5 degrees F. -The water temperature in the sink in room 215	D 113	Administrator immediately put up "Caution: Hot Water" signs for elevated water temperatures. Administrator immediately contacted Maintenance department to adjust hot water temperatures to a minimum of 100 degrees F and not exceeding 116 degrees F. Maintenance technician immediately began adjusting temperatures to a minimum of 100 degrees F and not exceed 116 degrees F and is testing all fixtures to assure water temperatures are correct. Maintenance/Administrator will check water temperatures weekly to assure all fixtures used by residents maintain a a minimum of 100 degrees F and not exceed 116 degrees F. Compliance Director will review temperature logs at least monthly to assure water temperatures are being checked regularly and will test water temps randomly ongoing.	12/7/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director 12/04/24

Reviewed and acknowledged on 12/05/24 by JL

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D 113	Continued From page 1 was 118.8 degrees F. -The water temperature in the sink in room 224 was 97.7 degrees F. -The water temperature in the shower in room 224 was 98.3 degrees F. Second observation of the water temperatures in the facility on 10/23/24 from 8:29am to 10:16am revealed: -The water temperature in the sink in room 117 was 106.2 degrees F. -The water temperature in the sink in room 118 was 112.8 degrees F. -The water temperature in the sink in room 119 was 113.5 degrees F. -The water temperature in the sink in room 121 was 114.3 degrees F. -The water temperature in the sink in room 215 was 115.3 degrees F. -The water temperature in the shower in room 224 was 99.1 degrees F. Interview with the resident in room 118 on 10/22/24 at 9:15am revealed: -She had lived at the facility for approximately 2 years. -There have been problems with the water temperature since she was admitted to the facility. -The water in her bathroom was always either too hot or too cold. -Sometimes the water in her shower did not feel warm. Interview with the resident in room 114 on 10/22/24 at 9:30am revealed: -She had lived at the facility for approximately 1.5 years. -The water in her bathroom sink and in her shower took a long time to get warm.	D 113		

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D 113	Continued From page 2 -Sometimes when the water was running in the sink or shower, the water felt warm at first but did not stay warm. -The water temperature seemed to vary frequently and was not consistent. Interview with the resident in room 224 on 10/22/24 at 10:00am revealed: -She had lived at the facility for 5 months. -There had been problems with the water temperature since she was admitted to the facility. -The water in the sink was always cold. -The water in the shower did not get hot. Interview with the resident in room 215 on 10/22/24 at 10:16am revealed: -He had not noticed the water in his bathroom being too hot. -He was able to adjust the hot and cold water if he felt the water was too warm. -He had not been burned by the hot water in his room. Confidential interview with a medication aide (MA) revealed: -She had worked at the facility for 2 years. -Most of the time, the water in residents' rooms did not seem to get hot enough. -The facility had been trying to get the water temperatures regulated the entire time she had worked at the facility. Interview with the Maintenance Director on 10/22/24 at 3:28pm revealed: -He came to the facility 2 times each week. -He checked water temperatures weekly and recorded them on a temperature log. -He thought the water temperature should be between 110 and 116 degrees F.	D 113		

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D 113	Continued From page 3 -No residents had complained to him about water temperatures. -Each resident room had a mixing valve in the bathroom, and he had replaced some of the mixing valves. -If there was an issue with the water temperature being too hot or too cold when he checked the water temperatures each week, and he adjusted the mixing valve at that time. Review of the facility's August 2024 water temperature logs revealed: -On 08/08/24, 4 fixtures were checked and temperatures ranged from 111.7 degrees F to 115.3 degrees F. -On 08/12/24, 19 fixtures were checked and temperatures ranged from 111.2 degrees F to 117.7 degrees F. -On 08/20/24, 10 fixtures were checked and temperatures ranged from 111.6 degrees F to 116 degrees F. -On 08/08/24, 12 fixtures were checked and temperatures ranged from 111.6 degrees F to 115.7 degrees F. Review of the facility's September 2024 water temperature logs revealed: -On 09/04/24, 9 fixtures were checked and temperatures ranged from 111.2 degrees F to 115.9 degrees F. -On 09/09/24, 11 fixtures were checked and temperatures ranged from 113.4 degrees F to 115.5 degrees F. -On 09/16/24, 12 fixtures were checked and temperatures ranged from 111.4 degrees F to 115.9 degrees F. -On 09/23/24, 11 fixtures were checked and temperatures ranged from 110.8 degrees F to 115.9 degrees F.	D 113		

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D 113	Continued From page 4 Review of the facility's October 2024 water temperature logs revealed: -On 10/01/24, 6 fixtures were checked and temperatures ranged from 111 degrees F to 115.9 degrees F. -On 10/07/24, 12 fixtures were checked and temperatures ranged from 107.1 degrees F to 115.9 degrees F. -On 10/14/24, 12 fixtures were checked and temperatures ranged from 110 degrees F to 115.9 degrees F. Interview with the Administrator on 10/22/24 at 10:56am revealed: -The facility had a Maintenance Director who visited the facility 2-3 times each week. -The Maintenance Director checked water temperatures weekly and recorded the temperatures on a log. -The facility had some high water temperatures in August 2024, but the maintenance director replaced the mixing valves in those rooms. -She was aware the water temperatures in residents' rooms should be 100 degrees F to 116 degrees F. -Water temperatures out of the range were a safety concern for residents.	D 113		
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	D 358		

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D 358	Continued From page 5 and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 2 residents (#1, #5) observed during the medication pass including medications used to treat high blood sugar (#5) and medication used to treat hypothyroidism (#1), a medication used to prevent strokes or heart attacks (#1), and a medication used to treat asthma (#1). The findings are: The medication error rate was 14% as evidenced by 4 errors out of 28 opportunities during the 8:00am medication pass on 10/23/24. a. Review of Resident #5's current FL2 dated 08/05/24 revealed diagnoses included type 2 diabetes mellitus and end stage renal disease. Review of Resident #5's primary care provider's (PCP) order dated 08/22/24 revealed there was an order for Humalog Kwikpen 6 units subcutaneously three times daily, 15 minutes before meals (Humalog is a rapid acting injectable medication used to lower blood sugar levels). According to the manufacturer, the Humalog Kwikpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles prior to administration. Observation of the 8:00am medication pass on 10/23/24 from 7:28am to 7:56am revealed: -The medication aide (MA) prepared Resident #5's medications and entered his room at 7:50am.	D 358	Administrator retrained medication aides on medication administration, diabetic training and medications errors. For any med error identified, the PCP will be notified and med error report completed. Administrator/Designee will observe a minimum of two medication passes weekly x4, will observe a minimum of 3 medication passes monthly x3 and then randomly thereafter to ensure medication is administered as ordered by the physician.	12/7/2024

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D 358	Continued From page 6 -The MA checked Resident #5's blood sugar with a continuous glucose monitoring device and obtained a blood sugar reading of 149. -At 7:54am, the MA donned gloves, cleaned an area on Resident #5's right upper arm with an alcohol pad, dialed the Humalog Kwikpen to 6 units, and injected the Humalog into Resident #5's right upper arm. -The MA did not perform a 2-unit air shot prior to dialing the Humalog Kwikpen to 6 units to ensure no air bubbles were present and insulin was flowing from the pen. Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog Kwikpen inject 6 units subcutaneously three times a day, hold insulin for blood sugar less than 70 scheduled for 7:30am, 11:30am, and 4:30pm. -Humalog Kwikpen was documented as administered on 56 of 67 opportunities from 10/01/24 to 10/23/24. Interview with the MA on 10/23/24 at 11:48am revealed: -She had worked at the facility as a MA for 2 years. -She recalled having some online training about insulin pens since she started working at the facility. -She was not aware that Resident #5's insulin pen should be primed with 2 units before each administration. -She thought insulin pens were primed only when the pen was first opened. -She was aware that priming the insulin pen helped to remove air bubbles. -She was not aware that priming the pen with 2 units before administering the prescribed dose	D 358		

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D 358	Continued From page 7 ensured the correct dose of insulin was administered. Interview with the Administrator on 10/23/24 at 12:01pm revealed: -MAs should prime insulin pens before administering to ensure there were no air bubbles and that the full dose of insulin was administered. -Resident #5 may not get the full dose of insulin ordered if the insulin pen was not primed before the insulin was administered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/23/24 at 2:42pm revealed: -The 2-unit air shot used to prime insulin pens helped to expel air bubbles. -Priming the insulin pen helped ensure the correct dose was administered. Telephone interview with Resident #5's primary care provider (PCP) on 10/23/24 at 12:31pm revealed: -The facility staff should prime Resident #5's insulin pen with 2 units of insulin prior to administering the scheduled 6-unit dose of Humalog. -Resident #5 may not receive the correct dose of Humalog if the facility staff did not prime the insulin pen prior to administration. Based on observations and interviews on 10/23/24 Resident #5 was not interviewable. b. Review of Resident #1's current FL2 dated 09/13/24 revealed: -There was an order for Levothyroxine 88mcg, take 1 tablet every day for low thyroid hormone. Do not take within 4 hours of calcium or iron containing products (Levothyroxine is a	D 358		

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D 358	Continued From page 8 medication used to treat an underactive thyroid gland). -There was an order for Caltrate 600mg+D, take 1 tablet twice a day for supplement (Caltrate 600mg+ D is a calcium and vitamin supplement used to prevent or treat vitamin and mineral deficiencies). Observation of the 8:00am medication pass on 10/23/24 from 7:28am to 7:56am revealed: -The medication aide (MA) began preparing Resident #1's medication at 7:28am. -Resident #1 received 16 oral medications, including Levothyroxine 88mcg and Caltrate 600mg+D at 7:40am. -The MA completed Resident #1's medication administration at 7:46am. Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed: There was an entry for Levothyroxine 88mcg, take 1 tablet every day for low thyroid hormone. Do not take within 4 hours of calcium or iron containing products, scheduled at 8:00am. -There was an entry for Caltrate 600mg+D, take 1 tablet twice a day for supplement scheduled at 8:00am and 8:00pm. -Levothyroxine 88mcg was documented as administered at 8:00am from 10/01/24 to 10/23/24. -Caltrate 600mg+D was documented as administered at 8:00am and from 10/01/24 to 10/23/24 and at 8:00pm from 10/01/24 to 10/22/24. Interview with Resident #1 on 10/23/24 at 3:25pm revealed: -She had taken Levothyroxine for a while but was unsure how long.	D 358		

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D 358	Continued From page 9 -She took a large pill that needed to be chewed, and she thought that it was a calcium tablet. -The staff always administered these 2 medications at the same time each morning. Interview with the MA on 10/23/24 at 11:48am revealed: -The facility's contracted pharmacy entered medication orders on the eMAR and scheduled the medications at the appropriate time. -She followed the directions on the eMAR when administering medications to residents. -She was unsure if she saw the entry on the eMAR about Levothyroxine 88mcg, do not take within 4 hours of calcium. -She was unsure why the Levothyroxine 88mcg and Caltrate 600mg+D were scheduled at the same time if the medications should not be given together. Interview with the Administrator on 10/3/24 at 12:01pm revealed: -The facility's contracted pharmacy entered orders on the facility's eMARs. -MAs should read and follow the instructions on the eMAR when administering medications to residents. -If the MAs had a question about orders, the MAs could ask the Administrator or call the pharmacy for clarification. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/23/24 at 2:42pm revealed: -The pharmacy entered the facility's medication orders into the eMAR system. -Levothyroxine should not be taken with other medications so Levothyroxine could be better absorbed. -Taking Caltrate at the same time as	D 358		

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D 358	Continued From page 10 Levothyroxine could interfere with the absorption of Levothyroxine and affect thyroid levels. Interview with Resident #1's primary care provider (PCP) on 10/23/24 at 11:20am revealed: -If Resident #1's eMAR instructed staff not to administer Levothyroxine and Caltrate 600mg+D within 4 hours of each other, the medications should not be taken at the same time. -The facility staff should follow the instructions on the eMAR when administering medications. c. Review of Resident #1's current FL2 dated 09/13/24 revealed: -Diagnoses included asthma, hypothyroidism, hypertension, and anxiety. -There was an order for Symbicort 160-4.5mcg aerosol inhaler inhale 2 puffs by mouth twice a day for asthma. Observation of the 8:00am medication pass on 10/23/24 from 7:28am to 7:56am revealed: -The medication aide (MA) prepared Resident #1's medications and entered Resident #1's room at 7:39am. -The MA handed Resident #1 the Symbicort inhaler and Resident #1 inhaled the first puff, then the second puff approximately 10 seconds later. -The MA offered Resident #1 some water and an empty cup and asked her to rinse her mouth. -The MA did not give Resident #1 any prompting or instructions regarding the inhaler's administration. Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Symbicort 160-4.5mcg aerosol inhaler inhale 2 puffs by mouth twice a day for asthma scheduled at 8:00am and 8:00pm.	D 358		

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D 358	Continued From page 11 -Symbicort 160-4.5mcg was documented as administered at 8:00am from 10/01/24 to 10/23/24 and at 8:00pm from 10/01/24 to 10/22/24. Interview with Resident #1 on 10/23/24 at 3:25pm revealed: -She had asthma and that was why she used an inhaler each day. -The facility staff usually brought the inhaler with her morning medications, and she did 2 quick puffs of the inhaler each morning. -The facility staff had not instructed her to breathe in through her mouth and out through her nose or to wait for a minute in between puffs. Interview with the MA on 10/23/24 at 11:48am revealed: -Resident #1 preferred to hold her inhaler and administer the puffs with staff supervision rather than the staff administering the puffs for her. -She thought when administering an inhaler, there should be 3 minutes in between puffs. -She had attempted previously to instruct Resident #1 to wait in between puffs and breathe in, but Resident #1 always did the puffs together and did not wait. Interview with the Administrator on 10/23/24 at 12:01pm revealed MAs should encourage residents to wait 1 minute in between puffs when administering inhalers to residents. Interview with a pharmacist at the facility's contracted pharmacy on 10/23/24 at 2:42pm revealed: -Staff should wait a minimum of 30 seconds to 1 minute in between puffs when administering Symbicort aerosol inhalers. -When the puff was inhaled, the resident should	D 358		

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D 358	Continued From page 12 take a breath in and then breathe out of their nose if needed. -Encouraging the resident to breathe in and waiting in between each puff ensured the medication was being administered properly and would work more efficiently. Interview with Resident #1's primary care provider (PCP) on 10/23/24 at 11:30am revealed the MA should encourage Resident #1 to wait 1 minute in between each puff of Symbicort 160-4.5mcg aerosol inhaler. d. Review of Resident #1's current FL2 dated 09/13/24 revealed: -Diagnoses included asthma, hypothyroidism, hypertension, and anxiety. -There was an order for Aspirin 81mg chew 1 tablet twice a day. Observation of the 8:00am medication pass on 10/23/24 from 7:28am to 7:56am revealed: -The medication aide (MA) began preparing Resident #1's medication at 7:28am. -Resident #1 received 16 oral medications, including Aspirin 81mg at 7:40am. -The MA did not prompt Resident #1 to chew the Aspirin 81mg tablet. -Resident #1 placed Aspirin 81mg in her mouth and swallowed the tablet with water. Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 81mg chew 1 tablet twice a day scheduled for 8:00am and 8:00pm. -Aspirin 81mg was documented as administered at 8:00am from 10/01/24 to 10/23/24 and at 8:00pm from 10/01/24 to 10/22/24.	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 Interview with Resident #1 on 10/23/24 at 3:25pm revealed: -She was unsure if she was taking Aspirin 81mg. -She knew what some of her medications were but was not sure about all the medications. -She only had one medication that she chewed, and it was a large calcium tablet. -She did not chew any other medications; she swallowed the rest of her medications whole with water. Interview with the Administrator on 10/23/24 at 12:01pm revealed: -MAs should read and follow the instructions on the eMAR when administering medications to the residents. -If the eMAR gave instructions, the MAs should follow what was on the eMAR. -If MAs had questions about instructions on the eMAR, they should ask the Administrator or contact the pharmacy for clarification. Interview with a pharmacist at the facility's contracted pharmacy on 10/23/24 at 2:42pm revealed: -If Aspirin 81mg is chewed rather than swallowed, the medication may be absorbed faster. -If Aspirin 81mg is swallowed, the medication would be absorbed slower but would still be effective. -The facility staff should follow the instructions on the eMAR and administer medications according to those instructions. Telephone interview with Resident #1's primary care provider (PCP) on 10/23/24 at 11:20am revealed facility staff should follow the instructions on Resident #1's eMAR regarding Resident #1's Aspirin 81mg order.	D 358		

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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 that electronic medication administration records (eMAR) were complete and accurate to include current order and documentation of doses documented for 1 of 3 sampled residents (#1) related to a medication for pain that was being administered but not documented on the MAR. The findings are: Review of Resident #1's current FL-2 dated 09/13/24 revealed diagnoses included	D 367	Administrator audited all MARs to ensure they are accurate per physicians orders Lead SIC/Designee will audit all MARs monthly to ensure they are accurate per physicians orders. Administrator will audit MARs randomly thereafter to ensure they are accurate as per physicians orders.	12/7/2024

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D 367	Continued From page 15 hypertension, asthma, anxiety disorder, hypothyroidism, and encephalopathy. Review of Resident #1's Resident Register revealed she was admitted on 10/13/23. Review of Resident #1's physician's order dated 09/13/24 revealed there was an order for Oxycodone 5mg to be administered one tablet every 4 hours as needed for chronic back pain. (Oxycodone is a medication used to relieve pain.) Observation of Resident #1's medications on hand on 10/23/24 at 10:30am revealed: -There was a medication card dispensed on 10/21/24 that contained 30 Oxycodone tablets. -There were 28 Oxycodone 5mg tablets remaining. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/22/24 at 4:31pm revealed: -The Oxycodone 5mg was not on cycle refill; refills had to be requested when needed. -A quantity of 10 Oxycodone 5mg tablets was dispensed on 08/23/24 to be administered 1 every 4 hours as needed for chronic back pain. -The most recent prescription for a quantity of 30 Oxycodone 5mg was signed and dispensed on 10/21/24. Review of Resident #1's eMAR for October 2024 revealed there was a computerized entry for Oxycodone 5mg to be administered one tablet every 4 hours as needed for chronic back pain with no documentation of administration from 10/01/24 to 10/23/24. Review of Resident #1's first controlled substance (CS) log revealed:	D 367		

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D 367	Continued From page 16 -It was labeled Oxycodone TAB 5mg, take one tablet every 4 hours as needed for chronic back pain. -10 tablets were received on 08/24/24. -There was documentation Oxycodone 5mg was administered at 7:00am on 10/08/24. -There was documentation Oxycodone 5mg was administered at 7:30 (am or pm not listed) on 10/12/24. -There was documentation Oxycodone 5mg was administered at 7:00am on 10/13/24. Review of Resident #1's 2nd CS log revealed: -It was labeled Oxycodone TAB 5mg, take one tablet every 4 hours as needed for back pain. -30 tablets were dispensed on 10/21/24. -There was documentation Oxycodone 5mg was administered at 4:00pm on 10/22/24. -There was documentation Oxycodone 5mg was administered at 7:44 (am or pm not listed) on 10/23/24. Interview with the medication aide (MA) on 10/23/24 at 2:35pm revealed: -She administered the Oxycodone on 10/08/24,10/12/24 and 10/13/24 to Resident #1; the initials on the controlled substance log were her initials. -She did not realize she had not documented the medication was administered on the eMAR. -She probably forgot to click the button in the eMAR system to show that the medication was administered. -She was responsible for documenting the medication was administered on both the eMAR and the CS log. Interview with the Administrator on 10/23/24 at 3:18pm revealed: -The MA was responsible for documenting on the	D 367		

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D 367	Continued From page 17 eMAR when a medication was administered. -The MA was responsible for signing the medications out on the CS log. -When a controlled medication was pulled, the MA was supposed to sign the medication out on the CS log. -She was not aware the administration of the Oxycodone for Resident #1 was not documented on the eMAR for 10/08/24, 10/12/24 and 10/13/24. -She tried to do chart audits once per month. -During chart audits, she never compared the eMAR to the CS log. -Resident #1's last chart audit was 08/2024. -She did not know why the administration of Oxycodone to Resident #1 was not documented on the eMAR.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure implementation of infection control measures during the medication pass as evidenced by a medication aide who handled a residents' oral medication with ungloved hands while preparing medications for administration. The findings are:	D 371		

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D 371	Continued From page 18 Review of the facility's undated medication administration policy revealed facility staff will administer medications in accordance with infection control measures. Observation of the 8:00am medication pass on 10/23/24 from 7:28am to 7:56am revealed: -The medication aide (MA) began preparing a residents' medication at 7:28am. -The MA pushed the residents' Levothyroxine 88mcg tablet out of the unit dose card into her bare hand and then placed the medication into a plastic medication cup (Levothyroxine is a medication used to treat an underactive thyroid gland). -The MA administered the residents' medications at 7:40am. Interview with the MA on 10/23/24 at 11:48am revealed: -She had been working at the facility for 2 years. -She was aware that she should not touch the residents' medications while she was preparing the medications. -She was unsure why she pushed the residents' Levothyroxine 88mcg tablet out of the packaging and into her hand before placing the tablet in the cup. -Medications should not be touched without gloves due to the risk for contamination. Interview with the Administrator on 10/23/24 at 12:01pm revealed: -MAs should not touch medications while preparing medications. -The medication should be removed from the unit dose card directly into the cup. -If medications were touched by staff during preparation, this was an infection control issue.	D 371	Administrator/Pharmacy Staff retrained Medication Aides on infection control measures while administering medications to residents. Administrator/Designee will observe a minimum of two medication passes weekly x4, will observe a minimum of 3 medication passes monthly x3 and then randomly thereafter to ensure medication is administered as ordered by the physician.	12/7/2024

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D 371	Continued From page 19 Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/23/24 at 2:42pm revealed: -The facility's staff should not handle any medications without gloves. -The medications should be removed from the unit dose packaging directly into the cup. -The facility staff should not handle medications with ungloved hands as an infection control measure.	D 371		
D 377	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications were stored securely as evidenced by a bottle of a medication used to treat decreased appetite or pain being left on top of the medication cart unsecured and unsupervised and over the counter medications that were stored in a resident's room who did not have an order to self-administer medications including medications used to treat allergies and pain. The findings are: Review of the facility's undated Storage of Medications policy: -All medications, prescription and non-prescription administered by facility staff including those requiring refrigeration would be	D 377	Administrator/Designee retrained medication aides on ensuring medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration. Administrator/SIC will monitor daily to assure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration. Administrator/Compliance Director will conduct random monitoring through observations to ensure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration.	12/7/2024

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D 377	Continued From page 20 kept locked except when staff responsible for medication administration were in close proximity and could see the medications. -All medication storage areas including medication carts would be kept clean, well-lighted, well-ventilated and medications would be stored in an orderly manner. -No medication would be stored in the bathroom, kitchen or utility room. -Accessibility to locked storage areas would be allowed only to persons responsible for medication administration, the Administrator or person in charge. -Medications intended for topical or external use except for ophthalmic, otic and trans-dermal medications would be stored separately from oral or injectable medications. -Medications would not be stored with cleaning agents and hazardous chemicals. -Medications requiring refrigeration would be stored between 36°F and 46°F. -Medications would not be stored in a refrigerator with non-medication items unless stored in a separate container. The container would be locked if the refrigerator did not contain a lock. -The facility would not keep on hand a stock of prescription medications for general use except for the following: irrigation solutions in single unit quantities exceeding 4ml and related diagnostic agents; vaccines and water and normal saline for injections. -First aid supplies would be immediately available, secure out of sight of residents and visitors unless they are being used by staff. -Self-administer medications that were kept in a resident's room would be stored in a safe and secure manner. 1. Observation of the facility from 7:22am to 7:26am revealed:	D 377		

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D 377	Continued From page 21 -The medication cart was near the end of the right 1st floor hallway. -There was a bottle of a residents' Marinol capsules on top of the medication cart (Marinol is a synthetic form of tetrahydrocannabinol (THC), which is an ingredient found in marijuana and can be used to treat pain or stimulate appetite). -There were no staff members near the medication cart. -There were no residents near the medication cart. -At 7:26am, the medication aide (MA) exited a residents' room, approached the medication cart, and secured the medication in the medication cart. Interview with the MA on 10/23/24 at 11:48am revealed: -She normally put all medications in the medication cart and locked the cart before walking away from the cart. -She left the residents' Marinol on top of the medication cart this morning by accident. -The residents' Marinol was usually stored in the refrigerator in the medication storage room, and she did not take the medication back to the medication room. -Medications should be stored where residents do not have access to them. Interview with the Administrator on 10/23/24 at 12:01pm revealed: -Medications should not be left unattended and on top of the medication cart. -Medications should be secured when unattended.	D 377		

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D 377	Continued From page 22 2. Review of Resident #4's current FL-2 dated 07/18/24 revealed: -Diagnoses included atrial fibrillation with rapid ventricular response, coronary artery disease, hypertension, depression, status post traumatic subarachnoid hemorrhage, status post klebsiella pneumonia and history of urinary tract infection. -There was an order for Aspirin low dose chew 81mg, 1 tablet every day. -There was an order for Metoprolol tartrate 25mg, 1 tablet 2 times a day. -There was an order for Macrobid 100mg, 1 tablet every day. -There was an order for Senna plus 8.6-50mg, 2 tablets at bedtime. -There was an order for Venlafaxine 75mg ER, 1 caplet every day. -There was an order for Acetaminophen 325mg, 2 tablets every 4 hours as needed. -There was an order for Artificial Tears, instill 1gtt into each eye every 8 hours as needed. -There was an order for Bisacodyl 5mg, 2 tablets every 24 hours as needed. -There was an order for Polyethylene glycol powder, mix 17 grams (one capful) in 4 to 8 ounces of beverage of choice every 12 hours as needed. -There was no order for allergy relief 25mg. -There was no order for 8 hour arthritis pain relief 650mg. -There was no order for glucosamine chondroitin. -There was no order for calcium antacid. -There was no order for Blu-Emu. -There was no order to allow Resident #4 to self-administer his medications. Observation of Resident #1's room on 10/22/24 at 9:12am revealed: -He was sitting in the recliner watching television. -He lived in a private room.	D 377		

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D 377	Continued From page 23 -There was a bottle of allergy relief 25mg on the table beside the recliner that expired 10/2018. (Allergy relief 25mg is used to treat allergy symptoms such as rash and itching.) -There was bottle of 8 hour arthritis pain relief 650mg on the table beside the recliner. (8 hour arthritis pain relief 650mg is used to treat minor arthritis pain.) -There was a bottle of Glucosamine Chondroitin on the table beside the recliner. (Glucosamine Chondroitin is used to treat joint pain and osteoarthritis.) -There was a bottle of Calcium Antacid on the bedside side table across the room. (Calcium antacid is used to treat heartburn, indigestion, or other conditions cause by too much stomach acid.) -There was a jar of Blue Emu on the bedside side table across the room. (Blue Emu is a topical pain relief product used to treat pain.) Interview with Resident #4 on 10/22/24 at 9:12am revealed: -He took the allergy relief 25mg once or twice a week for itching caused by nervousness. -He took the 8 hour arthritis pain relief 650mg, 2 pills daily for arthritis pain. -He took the Glucosamine Chondroitin once daily for joint health, when he thought about taking it. -He took the calcium and acid for indigestion as needed and sometimes did not need it for 6 months. -He used the Blue Emu as needed for body pain; he sometimes went months without using it but other times he needed it 2 to 3 times per week. -He had been living at the facility for about one year and had been keeping all the medications in his room on the table by his chair so he would not have to hunt for them. -Although the allergy relief pills expired 10/2018,	D 377		

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D 377	Continued From page 24	D 377		

they still work.
-He did not have a physician's order to take the medications that he had in his room.
-He was unsure if staff knew he took the medications.
-His family member gave him the allergy relief medication and she ordered the Calcium antacid and blue emu off the Internet.
-He bought the Tylenol and Glucosamine Chondroitin from the store.
-He did not need a prescription to buy the medication.

Review of physician's orders dated 10/23/24 revealed:
-Resident would like to have the following orders all to keep at bedside and self administer.
-Tylenol 650mg 2 tablets every morning.
-Benadryl 25mg 2 tablets as needed every day for itching.
-Simethicone 80mg 1 tablet every 6 hours as needed for gas.
-Blue Emu super strength, apply topically three times a day as needed to painful areas.
-Glucosamine Chondroitin dietary supplement 2 tablets every morning.
-Allergy nasal mist, use one spray in each nostril every day as needed for allergies.
-Systane lubricant eye drops, instill 1gtt in each eye every day for dry eyes.

Interview with the Pharmacist at Resident #4's pharmacy on 10/23/24 at 3:20pm revealed:
-There was a prescription for Banophen (another name for allergy relief 25mg) on his profile but they had not filled it. (On profile meant there was a list of over the counter (OTC) medications used to treat minor illnesses for the resident, if needed.)
-New orders were received today, 10/23/24, for

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D 377	Continued From page 25 Tylenol 650mg, Benadryl 25mg twice daily as needed for itching, Simethicone 80mg, 1 every 6 hours as needed for gas, Blue Emu, 3 times daily as needed for painful areas, Glucosamine Chondroitin, nasal mist, 1 spray in each nostril daily for allergies, and Systane eye drops, 1 drop in each eye daily as needed. -There were no orders for allergy relief, arthritis 8 hour, Glucosamine Chondroitin or Bue Emu prior to today, 10/23/24. -Resident #4 did not have a self-administer order for any of his prescription medications. -There was no self-administer order sent with the prescriptions that were sent over today, 10/23/24, for the OTC medications. -None of the OTC medications would interact with Resident #4's prescription medications. Interview with the medication aide (MA) on 10/23/24 at 4:10 PM revealed: -She had not noticed any OTC medications in Resident #4's room. -She had not observed Resident #4 take any OTC medications. -Resident #4 had a self-administer order when he first moved in but it was discontinued. -Resident #4 did not have a self-administer order yesterday, 10/22/24. Interview with the Administrator on 10/23/24 at 3:18pm revealed: -Resident #4 did not have a self-administer order prior to 10/23/24. -A self-administer order was obtained today, 10/23/24, because the resident told her he had medications on his night stand that the Surveyor observed. -She was not aware Resident #4 had OTC medications in his room. -She was aware Resident #4 had the Blue Emu in	D 377		

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FOUNDATION SENIOR LIVING	1437 AVERSBORO ROAD GARNER, NC 27529

(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 377	Continued From page 26 his room, but she thought it was lotion. -Resident #4 did not have orders for the OTC medications in his room. -Resident #4 signed out and went to the store and bought whatever he wanted. -Resident #4 now knew that he had to let staff know if he bought any medications that were not prescribed. -Resident #4 locked his room door at night and when he went to take a shower but did not lock his door when he left the room. -Her concern with Resident #4 having OTC medications that were not prescribed and not secured was that a confused resident could get to the medication. Telephone interview with the Practice Manager at Resident #4's PCP office on 10/23/24 at 3:42pm revealed: -Resident #4 did not have a self-administer order. -The PCP signed standing orders 6/10/24 for Benadryl 25mg, 1 every four hours as needed. -Resident #4 did not have orders for Glucosamine Chondroitin, Calcium antacid or Blue Emu.	D 377		