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| AMERICARES ADULT HOMES # 2 | 103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on 11/20/24 - 11/22/24. | D 000 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>TYPE A1 VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination and follow-up for 1 of 3 sampled residents (#1) including failing to obtain follow-up lab work to determine the levels of a medication for mood disorders; failing to coordinate physical therapy; failing to notify the primary care provider (PCP) of multiple low blood pressures; failing to coordinate a podiatry referral; failing to coordinate speech therapy; and failing to report a 25-pound weight loss to the PCP.<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 10/31/24 revealed:<br>-Diagnoses included schizoaffective disorder - bipolar type, coronary artery disease, thyroid gland disease, stage 2 chronic obstructive pulmonary disease, asthma, and depression.<br>-The resident was ambulatory and required assistance with bathing and dressing.<br><br>a. Review of Resident #1's primary care provider (PCP) progress note dated 09/16/24 revealed an | D 273 | | |

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order for a podiatry referral for follow-up and treatment of large calluses to great toe of both feet.

Review of Resident #1's facility progress notes for September 2024 - November 2024 revealed no documentation the resident had been seen by a podiatrist as ordered on 09/16/24.

Observation of Resident #1 on 11/21/24 at 3:35pm revealed:
-The resident's toenails on both feet were yellowish brown and extremely thick.
-The fourth and fifth toenails on the right foot were long and curved over the top of the toes.
-The resident's left foot had 4 toes; the second toe had been amputated.
-There was a reddened area approximately 1.5cm in diameter with a darker colored center on top of his left foot.
-There were two open areas approximately 1cm and 0.25cm in diameter on top of his left foot with reddened skin around the open areas.
-There was a tan raised area of skin on the underside of the right great toe.
-There was a tan and brown raised area covering the right side of the left great toe that extended onto the toenail and to the underside of the toe.
-There was a dime-sized tan raised area on the inner foot near the heel on his right foot.
-There was a tan and brown raised area approximately the size of a quarter on the underside of the left foot near the outer edge of the left side of his foot.

Interview with Resident #1 on 11/21/24 at 3:33pm revealed:
-The tan and brown raised areas on his feet were calluses and they had been on his feet at least 6 months.

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| D 273 | Continued From page 2<br>-The second toe on his left foot was removed about 15 years ago when he stumped it.<br>-He was not diabetic, so he was not sure why the toe never healed.<br>-He denied pain but had discomfort in his feet when he wore shoes and when he walked at times.<br>-He did not recall when he last saw a podiatrist.<br><br>Interview with the Resident Care Coordinator (RCC) on 11/21/24 at 12:30pm revealed:<br>-He was responsible for giving referrals to the Transporter so she could set up the appointments.<br>-He did not recall seeing the podiatry referral for Resident #1 in September 2024.<br>-He was responsible for following up to make sure referral appointments were scheduled.<br>-He must have overlooked the podiatry referral for Resident #1.<br><br>Interview with the facility's Transporter on 11/21/24 at 12:23pm revealed:<br>-The RCC usually put referrals in her folder or texted them to her.<br>-She would then call and make appointments.<br>-She usually took the residents to their appointments.<br>-She was not aware of a podiatry referral for Resident #1 in September 2024, so no podiatry appointment had been made.<br><br>Interview with the Administrator on 11/21/24 at 12:02pm revealed:<br>-The RCC was responsible for forwarding referral for outside appointments to the facility's Transporter.<br>-The facility's Transporter was responsible for setting up appointments for referrals and taking the residents to the appointments. | D 273 | | |

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| D 273 | Continued From page 3<br>-The Transporter just told her that she never received a podiatry referral for Resident #1, so no appointment was made.<br><br>Telephone interview with front office staff at Resident #1's podiatrist's office on 11/21/24 at 11:48am revealed:<br>-They did not receive a podiatry referral for the resident in September 2024.<br>-If they had received a referral, they would have called and set up an appointment.<br>-If a referral had been received in September 2024, they would have been able to schedule the appointment at least by November 2024.<br>-An appointment was made on 11/21/24 for Resident #1 to see the podiatrist on 01/02/25 at 2:30pm.<br>-No appointments had been made prior to that time.<br><br>Second interview with the Administrator on 11/22/24 at 8:45am revealed:<br>-She contacted and had a virtual visit completed yesterday evening with a triage provider.<br>-The provider ordered an antibiotic for the open wounds on Resident #1's foot.<br><br>Telephone interview with Resident #1's PCP on 11/22/24 at 1:40pm revealed:<br>-She was concerned about Resident #1's calluses when she wrote the order for a podiatry referral in September 2024.<br>-The resident had a history of foot wounds and could develop more wounds.<br>-If the podiatry referral had been done it could have prevented the calluses from getting so large and causing the resident discomfort.<br><br>b. Review of Resident #1's FL-2 dated 04/23/24 revealed: | D 273 | | |

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-There was an order for Amlodipine 5mg 1 tablet once daily in the morning. (Amlodipine lowers blood pressure.)
-There was an order to check blood pressure once daily and call physician if systolic blood pressure (SBP) is greater than 190 or diastolic blood pressure (DBP) is less than 60.

Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Amlodipine 5mg and it was documented as administered daily at 8:00am from 09/01/24 - 09/24/24.
-The resident was documented as being in the hospital from 09/25/24 - 09/30/24.
-There was an entry to check blood pressure every day, call physician if SBP was greater than 190 or if DBP was less than 60.
-The daily blood pressure check was scheduled at 8:00am.
-The resident's blood pressure ranged from 68/38 - 168/52 from 09/01/24 - 09/24/24.
-The resident's DBP was less than 60 on 12 of 24 occasions from 09/01/24 - 09/24/24.
-The resident's DBPs less than 60 included: 105/54 on 09/03/24; 115/54 on 09/08/24; 168/52 on 09/11/24; 91/45 on 09/12/24; 91/40 on 09/14/24; 90/48 on 09/15/24; 85/53 on 09/16/24; 68/38 on 09/18/24; 82/55 on 09/19/24; 111/58 on 09/21/24; 97/55 on 09/23/24; and 107/57 on 09/24/24.
-There was no documentation to indicate the physician was notified as ordered for any of the 12 occasions the resident's DBP was less than 60.

Review of Resident #1's October 2024 eMAR revealed:
-There was an entry for Amlodipine 5mg and it

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was documented as administered daily at 8:00am from 10/04/24 - 10/09/24 and from 10/15/24 - 10/31/24.
-The resident was documented as being in the hospital from 10/01/24 - 10/03/24 and from 10/10/24 - 10/14/24.
-There was an entry to check blood pressure every day, call physician if SBP was greater than 190 or if DBP was less than 60.
-The daily blood pressure check was scheduled at 8:00am.
-The resident's blood pressure ranged from 68/54 - 141/73 from 10/01/24 - 10/31/24.
-The resident's DBP was less than 60 on 8 of 21 occasions from 10/01/24 - 10/31/24.
-The resident's DBPs less than 60 included: 101/53 on 10/07/24; 84/56 on 10/17/24; 68/54 on 10/18/24; 84/58 on 10/19/24; 94/59 on 10/23/24; 81/59 on 10/27/24; 80/54 on 10/28/24; and 98/58 on 10/31/24.
-There was no documentation to indicate the physician was notified as ordered for any of the 8 occasions the resident's DBP was less than 60.

Review of Resident #1's November 2024 eMAR revealed:
-There was an entry for Amlodipine 5mg and it was documented as administered daily at 8:00am from 11/01/24 - 11/04/24 and 11/07/24 - 11/20/24.
-The resident was documented as being in the hospital from 11/05/24 - 11/06/24.
-There was an entry to check blood pressure every day, call physician if SBP was greater than 190 or if DBP was less than 60.
-The daily blood pressure check was scheduled at 8:00am.
-The resident's blood pressure ranged from 83/55 - 146/69 from 11/01/24 - 11/21/24.
-The resident's DBP was less than 60 on 4 of 19 occasions from 11/01/24 - 11/21/24.

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| D 273 | Continued From page 6<br>-The resident's DBPs less than 60 included: 99/53 on 11/03/24; 83/55 on 11/07/24; 92/54 on 11/14/24; and 90/51 on 11/19/24.<br>-There was no documentation to indicate the physician was notified as ordered for any of the 4 occasions the resident's DBP was less than 60.<br><br>Review of Resident #1's progress notes for September 2024 - November 2024 revealed no documentation to indicate the physician was notified on any occasion when the resident's DBP was less than 60.<br><br>Review of Resident #1's hospital discharge summary dated 10/14/24 revealed:<br>-The resident was admitted to the hospital on 10/08/24.<br>-The resident presented to the hospital emergency room (ER) from the radiation oncology office secondary to hypotension (low blood pressure) and near syncopal episode (fainting).<br>-The resident's blood pressure in the office was 78/50.<br>-The resident's principal discharge diagnosis was hypotension.<br><br>Interview with Resident #1 on 11/21/24 at 3:33pm revealed:<br>-The facility staff checked his blood pressure daily.<br>-He was not sure how his blood pressure was because he did not get the results.<br>-He denied any current symptoms of lightheadedness or dizziness.<br><br>Interview with the medication aide (MA) on 11/21/24 at 1:31pm revealed:<br>-Resident #1's blood pressure was usually low.<br>-He did not call the primary care provider (PCP) | D 273 | | |

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about any of the resident's low blood pressures because he was not aware of the parameter.
-He had not noticed the instructions on the eMAR to notify the PCP if the blood pressure was low.

Telephone interview with Resident #1's PCP on 11/22/24 at 1:40pm revealed:
-There had been no notifications by the facility regarding low blood pressures for the resident.
-They should have notified her about the low blood pressures.
-If she had known the resident was having consistently low blood pressures, she would have them to hold his blood pressure medication.
-She may also have ordered a medication to increase and stabilize his blood pressure.

Review of Resident #1's PCP Triage Note dated 11/22/24 revealed:
-The PCP was notified that the state inspection team identified multiple episodes of hypotension (low blood pressure) possibly due to chemotherapy and radiation treatment and the resident was still receiving Amlodipine.
-The PCP noted the resident had completed chemotherapy recently and radiation treatment this week.
-The resident's blood pressure would likely improve some.
-There was an order to discontinue Amlodipine 5mg 1 tablet daily in the morning.
-There was an order to start Amlodipine 5mg 1 tablet every morning; hold Amlodipine if SBP is less than 110.

c. Review of Resident #1's accident/incident report dated 09/21/24 at 11:00pm revealed:
-On 09/21/24 at 12:00pm, staff entered the resident's room to remind him to come to lunch.
-The resident reported he had fallen the previous

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night about 11:00pm when he was trying to get some water and bumped his head.
-The resident had a bruise on his head.
-The resident was instructed to let staff know when he had a fall.
-The resident was instructed to use his walker more because he was prone to falls.
-The Administrator noted on the form that the resident was checked out by the primary care provider (PCP) but no date was noted.

Review of Resident #1's accident/incident report dated 09/22/24 at 5:30am revealed:
-Staff received a phone call from a female (no name given) and was told that Resident #1 had fallen in the bathroom.
-When staff entered the resident's room, the resident was in bed.
-The resident reported he fell, bumped his head, and crawled back to bed.
-The resident's chemotherapy had made him weak and he could not use his hand because he was weak.
-Emergency Medical Services (EMS) was called and EMS checked the resident.
-The resident refused to go to the hospital.
-The resident was also seen by the PCP but no date was documented.

Review of Resident #1's accident/incident report dated 10/15/24 at 10:35am revealed:
-The resident was using the bathroom and when the resident was getting ready to walk out of the bathroom, he lost his balance and fell on the floor, bumping his head.
-EMS was called and the resident was transported to the hospital.
-The resident returned to the facility with no broken bones.
-The resident was to follow-up with the PCP on

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the next visit to the facility.
-The Administrator requested an order for a personal alarm by the PCP.

Review of Resident #1's accident/incident report dated 10/26/24 at 6:30am revealed:
-The resident was found on the floor in the bathroom.
-The resident stated he hurt his knee.
-EMS was called and the resident was taken to the hospital.
-The resident returned to the facility that same evening with no report of any fractures.
-The resident would be seen by the PCP on next visit to the facility.

Review of Resident #1's accident/incident report dated 11/02/24 at 1:13pm revealed:
-The resident had fell off the bed but caught himself.
-EMS was called but the resident refused to go to the hospital.
-The Administrator noted the resident was seen by the PCP (no date provided).

Review of Resident #1's hospital after visit summary dated 11/06/24 revealed:
-The resident was admitted to the hospital on 11/04/24.
-The resident's diagnoses included decrease of all blood cells and systemic inflammatory response syndrome.
-There was an outpatient referral for physical therapy (PT).

Review of Resident #1's provider visit notes and progress notes for November 2024 revealed no documentation of the resident receiving PT services as ordered on 11/06/24.

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| D 273 | Continued From page 10<br><br>Interview with Resident #1 on 11/21/24 at 3:33pm revealed:<br>-He had not received PT recently.<br>-His family member said he needed to receive PT services.<br>-The chemotherapy and radiation made him unsteady on his feet.<br><br>Interview with the Resident Care Coordinator (RCC) on 11/21/24 at 12:30pm revealed:<br>-He was responsible for referrals.<br>-He signed the paper with Resident #1's PT referral but he did not recall seeing the referral.<br>-The PT referral was not done, and the resident did not have PT in September 2024 because he overlooked it.<br><br>Interview with the Administrator on 11/21/24 at 10:45am revealed:<br>-The RCC was responsible for implementing any orders on hospital discharge papers including referrals.<br>-The RCC was responsible for sending the order to the PT provider and setting up for the PT to be done at the facility.<br>-She was responsible for checking behind the RCC and she did audits every week.<br>-She had not audited Resident #1's record since he returned to the facility on 11/06/24 so she was unaware of the PT referral.<br><br>Telephone interview with Resident #1's PCP on 11/22/24 at 1:40pm revealed:<br>-She was not aware that the resident's PT order had not been sent to the PT provider.<br>-The resident needed PT because he was weak from chemotherapy and radiation treatments and needed PT to help prevent falls.<br><br>d. Review of Resident #1's current FL-2 dated | D 273 | | |

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| D 273 | Continued From page 11<br><br>10/31/24 revealed:<br>-There was an order for Lithium Carbonate 300mg 1 capsule once daily in the morning.<br>-There was an order for Lithium Carbonate 600mg 1 capsule every evening.<br>(Lithium Carbonate is used to treat mood disorders. Lithium Carbonate works best if the amount of drug in the body is kept at a constant level. Too much Lithium can cause nausea, diarrhea, shaking of hands, dizziness, twitching, seizures, trouble speaking, confusion, and increase in the amount of urine. Lithium blood levels should be checked to ensure levels stay in the therapeutic range to be effective and to avoid side effects.)<br><br>Review of Resident #1's hospital after visit summary dated 11/06/24 revealed:<br>-The resident was admitted to the hospital on 11/04/24.<br>-The resident's diagnoses included decrease of all blood cells and systemic inflammatory response syndrome.<br>-Changes were made to the resident's Lithium Carbonate dosing; it was lowered due to levels being elevated.<br>-The resident's Lithium level would need to be checked in the next 2 to 3 days.<br>-There was an order for Lithium 150mg 1 capsule daily and 600mg every evening.<br><br>Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed:<br>-There was an entry for Lithium Carbonate 300mg 1 capsule once daily in the morning for mood scheduled at 8:00am.<br>-Lithium Carbonate 300mg was documented as administered at 8:00am from 09/01/24 - 09/24/24.<br>-Lithium Carbonate 300mg was documented as | D 273 | | |

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not administered from 09/25/24 - 09/30/24 due to the resident being in the hospital.
-There was an entry for Lithium Carbonate 600mg 1 capsule every evening for mood stabilization scheduled at 8:00pm.
-Lithium Carbonate 600mg was documented as administered at 8:00pm from 09/01/24 - 09/23/24.
-Lithium Carbonate 600mg was documented as not administered from 09/24/24 - 09/30/24 due to the resident being in the hospital.

Review of Resident #1's October 2024 eMAR revealed:
-There was an entry for Lithium Carbonate 300mg 1 capsule once daily in the morning for mood scheduled at 8:00am.
-Lithium Carbonate 300mg was documented as administered at 8:00am from 10/04/24 - 10/08/24.
-Lithium Carbonate 300mg was documented as not administered from 10/01/24 - 10/03/24 and from 10/09/24 - 10/14/24 due to the resident being in the hospital and on 10/16/24 due to the resident being out of the facility.
-There was an entry for Lithium Carbonate 600mg 1 capsule every evening for mood stabilization scheduled at 8:00pm.
-Lithium Carbonate 600mg was documented as administered at 8:00pm from 10/03/24 - 10/07/24, 10/14/24 - 10/21/24, and 10/23/24 - 10/31/24.
-Lithium Carbonate 600mg was documented as not administered from 10/01/24 - 10/02/24, 10/08/24 - 10/13/24 and 10/22/24 due to the resident being in the hospital.

Review of Resident #1's November 2024 eMAR revealed:
-There was an entry for Lithium Carbonate 300mg 1 capsule once daily in the morning for mood scheduled at 8:00am.
-Lithium Carbonate 300mg was documented as

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administered at 8:00am from 11/01/24 - 11/04/24 and 11/07/24, then noted to be discontinued.
-Lithium Carbonate 300mg was documented as not administered at 8:00am from 11/05/24 - 11/06/24 due to the resident being in the hospital.
-There was an entry for Lithium Carbonate 150mg 1 capsule every day for mood scheduled at 8:00am.
-Lithium Carbonate 150mg was documented as administered at 8:00am from 11/08/24 - 11/20/24.
-There was an entry for Lithium Carbonate 600mg 1 capsule every evening for mood stabilization scheduled at 8:00pm.
-Lithium Carbonate 600mg was documented as administered at 8:00pm from 11/01/24 - 11/03/24 and from 11/06/24 - 11/19/24.
-Lithium Carbonate 600mg was documented as not administered from 11/04/24 - 11/05/24 due to the resident being in the hospital.

Review of Resident #1's lab results and progress notes for November 2024 revealed no documentation that a Lithium level had been drawn as ordered on 11/06/24.

Interview with Resident #1 on 11/21/24 at 3:33pm revealed:
-He had lab work drawn frequently for some of his medications.
-He was not sure when a Lithium level was last drawn.

Interview with the Resident Care Coordinator (RCC) on 11/21/24 at 12:30pm revealed:
-He overlooked the order for Resident #1's Lithium level to be rechecked.
-He thought the resident's mental health provider (MHP) did lab work for residents.

Interview with the Administrator on 11/21/24 at

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| D 273 | Continued From page 14<br><br>10:40am revealed:<br>-The RCC was responsible for implementing orders for lab work.<br>-The RCC was supposed to fax the order to the lab provider or call the lab provider.<br>-The lab provider came to the facility to draw the blood, and they usually called the facility the day before they came to the facility.<br>-Resident #1's follow-up Lithium level was not done.<br>-She usually checked behind the RCC every week, but she overlooked the order for Resident #1's Lithium level to be rechecked.<br>-The resident's mood had been fine; the resident had no behaviors or agitation currently.<br><br>Review of Resident #1's MHP visit form dated 11/21/24 revealed:<br>-There was another order to schedule a blood draw for Lithium level.<br>-The resident's morning Lithium Carbonate dose to be held the morning of the blood draw.<br><br>Attempted telephone interview with Resident #1's MHP on 11/22/24 at 2:16pm was unsuccessful.<br><br>e. Review of Resident #1's primary care provider (PCP) visit note dated 07/29/24 revealed:<br>-There was an order for the resident to have a mechanical soft/chopped meat diet.<br>-There was an order for a referral to speech therapy (ST) for a swallowing evaluation.<br><br>Review of Resident #1's facility progress note dated 07/29/24 revealed:<br>-The PCP changed the resident's diet due to the resident not being able to eat his food/swallow properly.<br>-The problem just occurred, and it was reported immediately. | D 273 | | |

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| D 273 | Continued From page 15<br><br>Review of Resident #1's progress notes and provider notes for July 2024 - November 2024 revealed no documentation that the resident had been evaluated for ST.<br><br>Interview with Resident #1 on 11/22/24 at 2:53pm revealed:<br>-He did not recall having any ST services.<br>-It sometimes felt like something was rubbing in his throat when he swallowed and it was uncomfortable.<br>-He denied choking on his food or drink.<br><br>Interview with the Administrator on 11/21/24 at 10:45am revealed:<br>-Resident #1 sometimes refused the mechanical soft/chopped meats diet; it depended on the meal.<br>-She had not observed the resident coughing or choking when he ate.<br>-The RCC was responsible for implementing any orders on hospital discharge papers including referrals.<br>-The RCC was responsible for sending the order to the ST provider and setting up for the ST to be done at the facility.<br>-She was responsible for checking behind the RCC and she did audits every week.<br>-She did not know why the ST referral was not done.<br><br>Telephone interview with a representative from the ST provider on 11/22/24 at 3:42pm revealed they never received the ST referral from July 2024 for Resident #1 so ST never evaluated the resident.<br><br>Telephone interview with Resident #1's PCP on 11/22/24 at 1:40pm revealed she was concerned | D 273 | | |

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that the resident was not evaluated by ST because there was a potential for the resident to aspirate which could cause pneumonia.

f. Review of Resident #1's primary care provider (PCP) visit note dated 08/19/24 revealed an order to weigh the resident each month and record the results.

Review of Resident #1's current FL-2 dated 10/31/24 revealed an order to check weight once monthly and record for monitoring.

Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry to check weight once monthly and record for monitoring.
-Weight checks were scheduled at 8:00am.
-The resident's weight was documented as 200 pounds on 09/20/24.

Review of Resident #1's October 2024 eMAR revealed:
-There was an entry to check weight once monthly and record for monitoring.
-Weight checks were scheduled at 8:00am.
-The resident's weight was documented as 180 pounds on 10/20/24.

Review of Resident #1's November 2024 eMAR revealed:
-There was an entry to check weight once monthly and record for monitoring.
-Weight checks were scheduled at 8:00am.
-The resident's weight was documented as 175 pounds on 11/19/24.

Review of Resident #1's facility progress notes for September 2024 - November 2024 revealed no

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documentation that the resident's primary care provider (PCP) was notified of the 25-pound weight loss from 09/20/24 - 11/19/24.

Interview with Resident #1 on 11/21/24 at 3:33pm revealed:
-He had recently completed chemotherapy and radiation treatments and had lost some weight but he was not sure how much.
-He did not know if his PCP was aware of the weight loss.

Interview with Resident Care Coordinator (RCC) on 11/21/24 at 12:30pm revealed:
-The facility's contracted PCP was at the facility last Monday.
-He did not discuss Resident #1's weight loss with the PCP because he was not aware he was supposed to do so.

Interview with the Administrator on 11/21/24 at 10:45am revealed:
-The RCC was responsible for notifying the PCP of any significant weight changes.
-The RCC should notify the PCP of weight changes each month when the monthly weights were completed.

Telephone interview with Resident #1's PCP on 11/22/24 at 1:40pm revealed:
-Resident #1 had recently completed chemotherapy and radiation so some weight loss was expected.
-She was not aware of the amount of weight the resident had since September 2024.
-The facility just sent notification in the last couple of days about the resident's recent weight loss.
-If she had known sooner, she may have made changes in his diet or supplement orders.

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| D 273 | Continued From page 18<br><br>The facility failed to ensure health care referral and follow-up for Resident #1. Resident #1 had a history of foot wounds and staff failed to coordinate a podiatry referral resulting in discomfort to the resident and the resident requiring antibiotics for infection to open wounds on his foot. Resident #1 had a history of multiple falls, including head injuries requiring evaluation and treatment at the hospital but staff failed to coordinate physical therapy services to prevent further falls. The facility failed to notify the primary care provider (PCP) of multiple low blood pressures resulting in a hospitalization for low blood pressure. Resident #1 did not receive speech therapy services as ordered after having swallowing problems while receiving chemotherapy and radiation treatments, putting the resident as risk for aspiration and pneumonia. The facility failed to obtain follow-up lab levels for a medication for mood disorders after the dosage was decreased in the hospital due to the levels being too high. Resident #1's 25-pound weight loss in two months was not reported to the PCP. The failure of the facility to provide health care referral and follow-up resulted in serious physical harm and neglect and constitutes a Type A1 Violation.<br><br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/21/24 for this violation.<br><br>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 22, 2024. | D 273 | | |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service | D 310 | | |

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| D 310 | Continued From page 19<br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure nutritional supplements were served as ordered to 1 of 2 sampled residents (#1) who had orders to receive nutritional supplements.<br><br>The findings are:<br><br>Observation of the food supply on 11/21/24 at 1:12pm revealed there were 3 cans of a nutritional supplement in the storage closet near the kitchen.<br><br>Review of Resident #1's current FL-2 dated 10/31/24 revealed:<br>-Diagnoses included schizoaffective disorder - bipolar type, coronary artery disease, thyroid gland disease, stage 2 chronic obstructive pulmonary disease, asthma, and depression.<br>-The resident was ambulatory and required assistance with bathing and dressing.<br>-There was an order for a nutritional supplement, drink 1 can 3 times a day with meals.<br><br>Review of Resident #1's monthly weight log for July 2024 - November 2024 revealed:<br>-On 07/19/24, the resident weighed 220 pounds.<br>-On 08/18/24, the resident weighed 208 pounds.<br>-On 09/16/24, the resident weighed 200 pounds.<br>-On 10/20/24, the resident weighed 186 pounds.<br>-On 11/11/24, the resident weighed 170 pounds. | D 310 | | |

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| D 310 | Continued From page 20<br><br>Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed:<br>-There was an entry for a nutritional supplement drink 1 can 3 times a day with meals scheduled at 8:00am, 12:00pm, and 5:00pm.<br>-The nutritional supplement was documented as administered from 09/01/24 - 09/24/24 except on 4 occasions when the resident was either out of the facility, at chemotherapy, or in the hospital.<br>-The resident was documented as being in the hospital from 09/25/24 - 09/30/24.<br><br>Review of Resident #1's October 2024 eMAR revealed:<br>-There was an entry for a nutritional supplement drink 1 can 3 times a day with meals scheduled at 8:00am, 12:00pm, and 5:00pm.<br>-The nutritional supplement was documented as administered from 10/01/24 - 10/31/24 except on 25 occasions when the resident was either out of the facility, at chemotherapy, or in the hospital.<br><br>Review of Resident #1's November 2024 eMAR revealed:<br>-There was an entry for a nutritional supplement drink 1 can 3 times a day with meals scheduled at 8:00am, 12:00pm, and 5:00pm.<br>-The nutritional supplement was documented as administered from 11/01/24 - 11/20/24 (8:00am) except on 7 occasions when the resident was either out of the facility or in the hospital.<br>-The resident's nutritional supplement was documented as not given on 11/10/24 and 11/11/24 at 4:00pm due to not having any in the facility.<br><br>Observation of Resident #1's lunch meal served on 11/20/24 from 12:03pm to 12:15pm revealed:<br>-Resident #1's was served beef vegetable soup, | D 310 | | |

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peanut butter and jelly sandwich, peaches, water, and tea.
-He consumed 75% of the beef vegetable soup, 100% of the peanut butter and jelly sandwich, 0% of the peaches, 75% of the water, and 100% of the tea.
-He was not served or offered a nutritional supplement with his meal.

Interview with the medication aide (MA) on 11/20/24 revealed he gave Resident #1 a nutritional supplement in his room after lunch.

Interview with Resident #1 on 11/22/24 at 2:53pm revealed:
-He usually received a nutritional supplement at least twice a day and he usually drank them when received.
-He could not recall what time he usually received the nutritional supplements.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/21/24 at 12:10pm revealed:
-The pharmacy charged a miscellaneous fee for nutritional supplements, so most facilities did not order the supplements through the pharmacy.
-They dispensed 24 cans of a nutritional supplement for Resident #1 on 08/20/24, which was an 8-day supply.
-The facility had not requested any refills for the nutritional supplement since 08/20/24.

Interview with the Resident Care Coordinator (RCC) on 11/21/24 at 12:30pm revealed:
-The facility ordered nutritional supplements from their contracted food supplier, not from the pharmacy.
-The facility got a food supply ordered delivered every Tuesday.

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| D 310 | Continued From page 22<br>-He did not know why Resident #1 ran out of his nutritional supplements in November 2024.<br>-The resident usually drank the nutritional supplements because the resident had lost some weight while taking chemotherapy treatments.<br><br>Interview with the Administrator on 11/21/24 at 1:33pm revealed:<br>-Resident #1 ran out of nutritional supplements in November 2024 for 2 days.<br>-They were trying to switch and start getting the supplements from the pharmacy instead of the facility's contracted food supplier.<br><br>Telephone interview with Resident #1's primary care provider (PCP) on 11/22/24 at 1:40pm revealed:<br>-The resident was ordered nutritional supplements to help with his appetite and weight loss from recent chemotherapy and radiation treatments.<br>-The resident needed the nutritional supplements to help prevent further weight loss. | D 310 | | |
| D 344 | 10A NCAC 13F .1002(a) Medication Orders<br><br>10A NCAC 13F .1002 Medication Orders<br>(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:<br>(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;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or | D 344 | | |

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clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure that medication and treatment orders were clarified for 2 of 3 sampled residents (#1, #2) including a medication that lowers blood pressure (#1), a medication used for anxiety (#2), and an order for blood pressure parameters (#2).

The findings are:

1. Review of Resident #1's current FL-2 dated 10/31/24 revealed:
-Diagnoses included schizoaffective disorder - bipolar type, coronary artery disease, thyroid gland disease, stage 2 chronic obstructive pulmonary disease, asthma, and depression.
-There was an order for Amlodipine 5mg 1 tablet once daily in the morning. (Amlodipine lowers blood pressure.)

Review of Resident #1's prior hospital after visit summary dated 10/03/24 revealed:
-The resident was admitted to the hospital on 09/24/24 with anemia, requiring a blood transfusion.
-The resident was discharged from the hospital on 10/03/24.
-There were instructions to stop taking Amlodipine.

Review of Resident #1's physician's orders revealed no documentation the resident's primary care provider (PCP) was contacted to clarify whether the resident should take Amlodipine or stop taking it.

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Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed:
-The resident was documented as being in the hospital from 10/01/24 - 10/03/24 and from 10/10/24 - 10/14/24.
-There was an entry for Amlodipine 5mg and it was documented as administered daily at 8:00am from 10/04/24 - 10/09/24 and from 10/15/24 - 10/31/24.
-The resident continued to be administered Amlodipine after it was stopped on 10/03/24 and before the current FL-2 dated 10/31/24.
-The resident's blood pressure ranged from 68/54 - 141/73 from 10/01/24 - 10/31/24.

Review of Resident #1's November 2024 eMAR revealed:
-The resident was documented as being in the hospital from 11/05/24 - 11/06/24.
-There was an entry for Amlodipine 5mg and it was documented as administered daily at 8:00am from 11/01/24 - 11/04/24 and 11/07/24 - 11/20/24.
-The resident's blood pressure ranged from 83/55 - 146/69 from 11/01/24 - 11/21/24.

Review of Resident #1's hospital discharge summary dated 10/14/24 revealed:
-The resident was admitted to the hospital on 10/08/24.
-The resident presented to the hospital emergency room (ER) from the radiation oncology office secondary to hypotension (low blood pressure) and near syncopal episode (fainting).
-The resident's blood pressure in the office was 78/50.
-The resident's principal discharge diagnosis was hypotension.
-Amlodipine was included on the list of

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| D 344 | Continued From page 25<br>medications.<br><br>Review of Resident #1's physician's orders revealed no documentation the resident's PCP was contacted to clarify the Amlodipine.<br><br>Interview with Resident #1 on 11/21/24 at 3:33pm revealed:<br>-He was not sure what medications he received for blood pressure.<br>-The facility staff checked his blood pressure daily.<br>-He was not sure how his blood pressure was because he did not get the results.<br>-He denied any current symptoms of lightheadedness or dizziness.<br><br>Interview with the Resident Care Coordinator (RCC) on 11/21/24 at 12:30pm revealed:<br>-He had not noticed the instructions on Resident #1's after visit summary on 10/03/24 to stop taking Amlodipine.<br>-He should have contacted the provider to clarify the order.<br><br>Interview with the Administrator on 11/21/24 at 10:45am revealed:<br>-The RCC was responsible for processing hospital discharge paperwork and contacting the providers for any clarification needed.<br>-She was responsible for checking behind the RCC.<br>-She overlooked the discrepancy with Resident #1's Amlodipine.<br><br>Telephone interview with Resident #1's PCP on 11/22/24 at 1:40pm revealed:<br>-No one at the facility had contacted her to clarify whether Resident #1 needed to stop taking Amlodipine | D 344 | | |

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| D 344 | Continued From page 26<br>-By continuing the Amlodipine, the resident could have continued to have low blood pressure that required hospitalization.<br><br>2. Review of Resident #2's current FL-2 dated 11/18/24 revealed diagnoses included type 2 diabetes, hypertension, chronic obstructive pulmonary disease, depression, chronic kidney disease, chronic back pain, and hyperlipidemia.<br><br>Review of Resident #2's Resident Register revealed an admission date of 04/01/19.<br><br>a. Review of Resident #2's FL2 dated 11/18/24 revealed there was an order to check blood pressure (BP).<br><br>Review of Resident #2 progress note dated 11/04/24 revealed:<br>-There was an order to check blood pressure (BP) once a day and to notify the primary care provider (PCP) if the BP was greater than 200 or less than 90.<br>-It was electronically signed by the PCP on 11/12/24.<br><br>Review of Resident #2's November 2024 electronically medication administration record (eMAR) BP check revealed:<br>-On 11/13/24, BP was documented as 140/83.<br>-On 11/14/24, BP was documented as 129/81.<br>-On 11/15/24, BP was documented as 117/62.<br>-On 11/16/24, BP was documented as 138/80.<br>-On 11/17/24, BP was documented as 124/77.<br>-On 11/18/24, BP was documented as 124/88.<br>-On 11/19/24, BP was documented as 131/78.<br>-On 11/20/24, BP was documented as 109/68.<br><br>Interview with the Resident Care Coordinator (RCC) on 11/22/24 at 2:40pam revealed: | D 344 | | |

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-He could not recall why he did not clarify the BP parameters for Resident #2.
-He believed that if either number, the systolic BP or the diastolic BP, reached greater than 200 or less than 90 he was to notify the PCP, but he did not get clarification.
-He was responsible for getting physician orders clarified.

Telephone interview with Resident #2's PCP on 11/22/24 at 1:40pm revealed
-The parameters were if the systolic BP number was less than 90 or over 200 to contact her.
-The systolic was the top number on the BP reading.
-She was not contacted for clarification.
-She was not notified of any concerns.

Interview with the Administrator on 11/22/24 at 2:05pm revealed:
-The MAs could not notify the PCP without knowing the parameters.
-She did not know why the BP parameters were not clarified.
-The RCC was responsible for reviewing all orders and clarifying the orders.
-The BP parameters were overlooked, and she was ultimately responsible for making sure all medication orders were clarified.

b. Review of Resident #2's hospital discharge summary dated 09/25/24 revealed there was an order for Hydroxyzine Pamoate 25mg, take 1 capsule three times daily (Hydroxyzine Pamoate is an antihistamine that can be used to treat anxiety).

Review of Resident #2's Rehabilitation Center order summary report dated 10/21/24 revealed Hydroxyzine Pamoate was not listed on the

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| D 344 | Continued From page 28<br>medications ordered.<br><br>Review of Resident #2's October 2024 electronic medication administration record (eMAR) revealed there was no entry for Hydroxyzine Pamoate,1 capsule three times daily (8:00am, 3:00pm, 8:00pm) on 10/23/24 through 10/31/24.<br><br>Review of Resident #2's November 2024 eMAR revealed there was no entry for Hydroxyzine Pamoate,1 capsule three times daily (8:00am, 3:00pm, 8:00pm) on 11/01/24 through 11/12/24.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/21/24 at 12:55pm revealed:<br>-Hydroxyzine Pamoate was a medication used to treat anxiety.<br>-On 10/22/24, Hydroxyzine Pamoate,1 capsule three times daily, was not on Resident #2's medication list faxed to the pharmacist and per the administrator the pharmacy was told to go by the list faxed and discontinued the medication.<br>-A new order was faxed to the pharmacy for Resident #2 on 11/12/24 for Hydroxyzine Pamoate 25mg, take 1 capsule three times daily.<br><br>Interview with the Administrator on 11/22/24 at 2:05pm revealed:<br>-The Rehabilitation Center removed Hydroxyzine Pamoate when Resident #2 returned to the facility on 10/22/24.<br>-The medication fell through the cracks and got overlooked because she went by what the Rehabilitation Center faxed.<br>-There was no clarification of the medication order.<br>-She and the Resident Care Coordinator (RCC) were responsible for clarifying medications when a resident returned to the facility. | D 344 | | |

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| D 344 | Continued From page 29<br>-The mental health provider (MHP) wrote a new prescription for the medication on 11/12/24.<br><br>Attempted telephone interview with Resident #2's family member on 11/22/24 at 12:05pm was unsuccessful.<br><br>Attempted telephone interview with Resident #2's MHP on 11/22/24 at 2:55pm was unsuccessful. | D 344 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE A1 VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#1, #2) sampled including errors with a nicotine patch (#2); and errors with an antibiotic for infection, an antipsychotic, a medication used to prevent nausea after chemotherapy treatments, an oral solution used to treat mouth sores caused by chemotherapy and radiation, and a medication used to treat thyroid disease (#1).<br><br>The findings are: | D 358 | | |

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1. Review of Resident #1's current FL-2 dated 10/31/24 revealed diagnoses included schizoaffective disorder - bipolar type, coronary artery disease, thyroid gland disease, stage 2 chronic obstructive pulmonary disease, asthma, and depression.

a. Review of Resident #1's hospital discharge summary dated 07/11/24 revealed an order to continue taking Clozapine 100mg 1 tablet every morning and 2 tablets (200mg) at bedtime. [Clozapine is an antipsychotic used to treat treatment-resistant schizophrenia. Clozapine can cause severe neutropenia [low absolute neutrophil count (ANC) levels], which can lead to serious and fatal infections. ANC is a blood test used to measure neutrophils in the blood. Neutrophils are a type of white blood cell that help the body fight infection. Anyone taking Clozapine is required to have a baseline ANC level before treatment and regular monitoring during treatment. Other warnings for Clozapine include orthostatic hypotension (low blood pressure when standing), bradycardia (slow heart rate), syncope (fainting), seizure, and heart-related side effects.]

Review of Resident #1's lab results dated 09/05/24 revealed the resident's ANC level was 254 (reference range was 1500 - 7800).

Review of Resident #1's mental health provider (MHP) visit note dated 09/06/24 revealed:
-There was an order to discontinue all Clozapine - effective immediately.
-The resident should be sent to the hospital for evaluation due to an extremely low ANC.

Review of Resident #1's hospital emergency room (ER) after visit summary dated 09/06/24 revealed:

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-The resident had small cell lung cancer and was receiving chemotherapy.
-The resident was diagnosed with chemotherapy-induced neutropenia.
-The resident was prescribed an antibiotic (used to treat and prevent infections).

Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Clozapine 100mg 1 tablet in the morning for schizophrenia scheduled at 8:00am.
-Clozapine 100mg was documented as administered daily at 8:00am from 09/01/24 - 09/09/24.
-The stop date listed was 09/06/24.
-Clozapine 100mg in the morning continued to be documented as administered from 09/07/24 - 09/09/24, 3 days after it was discontinued.
-There was an entry for Clozapine 100mg 2 tablets (= 200mg) at bedtime for schizophrenia scheduled at 8:00pm.
-Clozapine 200mg was documented as administered daily at 8:00pm from 09/01/24 - 09/06/24.
-The stop date listed was 09/06/24.

Interview with the Administrator on 11/21/24 at 10:45am revealed:
-The medication aide (MA) who documented administering the Clozapine to Resident #1 after it was ordered to be discontinued on 09/06/24 no longer worked at the facility.
-The MA should not have administered the Clozapine after it was discontinued.

Review of Resident #1's MHP visit note dated 10/02/24 revealed:
-The MHP noted she was restarting Clozapine

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and the resident's blood levels were to be drawn weekly by hematology or oncology to monitor the resident's ANC levels.
-There was an order to start Clozapine 25mg 1 tablet twice daily for 3 days then discontinue.
-There was an order to then start Clozapine 25mg 1 tablet daily and 2 tablets at bedtime for 3 days then discontinue.
-There was an order to then start Clozapine 50mg 1 tablet twice daily for 3 days then discontinue.
-There was an order to then start Clozapine 50mg 1 tablet daily and 2 tablets at bedtime for 30 days, then MHP would review and assess need to increase maintenance dose.

Review of Resident #1's current FL-2 dated 10/31/24 revealed an order for Clozapine 50mg 1 tablet every morning and 2 tablets (100mg) at bedtime.

Review of Resident #1's October 2024 eMAR revealed:
-There was an entry for Clozapine 25mg 1 tablet 2 times a day for 3 days for mood scheduled for 8:00am and 8:00pm.
-Clozapine 25mg 2 times a day was documented as not administered on 10/02/24 - 10/03/24 (8:00am) due to the resident being in the hospital.
-Documentation for 10/03/24 (8:00pm) - 10/05/24 was blank with no Clozapine documented as administered and no reason indicated.
-The entry indicated a stop date of 10/07/24 for Clozapine 25mg 1 tablet 2 times a day for 3 days.
-There was a second entry for Clozapine 25mg 1 tablet every morning for 3 days for mood scheduled for 8:00am.
-Clozapine 25mg 1 tablet every morning for 3 days was documented as not administered from 10/08/24 - 10/14/24 due to the resident being in the hospital.

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| D 358 | Continued From page 33<br>-Clozapine 25mg 1 tablet in the morning for 3 days was documented as administered on 4 days at 8:00am including 10/15/24 and 10/17/24 - 10/19/24.<br>-There was third entry for Clozapine 25mg 2 tablets (50mg) at bedtime for 3 days for mood scheduled for 8:00pm.<br>-Clozapine 25mg 2 tablets at bedtime for 3 days was documented as not administered from 10/07/24 - 10/13/24 due to the resident being in the hospital.<br>-Clozapine 25mg 2 tablets a bedtime for 3 days was documented as administered from 10/14/24 - 10/19/24, a total of 6 days instead of 3 days.<br>-There was a fourth entry for Clozapine 50mg 1 tablet 2 times a day for 3 days for mood scheduled for 8:00am and 8:00pm.<br>-Clozapine 50mg 1 tablet 2 times a day for 3 days was documented as administered from 8:00pm on 10/16/24 - 8:00pm on 10/19/24, a total of 3.5 days instead of 3 days.<br>-There was a fifth entry for Clozapine 50mg 1 tablet every morning for schizophrenia scheduled at 8:00am.<br>-Clozapine 50mg 1 tablet every morning at 8:00am was documented as administered on 10/17/24, 10/18/24, and 10/20/24 - 10/31/24.<br>-There was a sixth entry for Clozapine 50mg 2 tablets (100mg) at bedtime for schizophrenia scheduled at 8:00pm.<br>-Clozapine 50mg 2 tablets at bedtime was documented as administered on 10/21/24 and 10/23/24 - 10/31/24.<br>-Clozapine was documented as administered on multiple entries on the eMAR from 10/16/24 - 10/29/24 when the dosage ordered was 50mg twice a day.<br>-There was a total of 75mg of Clozapine documented as administered at 8:00pm on 10/16/24. | D 358 | | |

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| D 358 | Continued From page 34<br>-There was a total of 125mg of Clozapine documented as administered at 8:00am on 10/17/24 and 10/18/24.<br>-There was a total of 100mg of Clozapine documented as administered at 8:00pm on 10/17/24 and 10/18/24.<br>-There was a total of 75mg of Clozapine documented as administered at 8:00am on 10/19/24.<br>-There was a total of 100mg of Clozapine documented as administered at 8:00pm on 10/19/24.<br><br>Interview with the MA on 11/21/24 at 1:31pm revealed:<br>-The pharmacy usually entered medication orders into the eMAR system.<br>-He was not sure if Resident #1 was being weaned off or on the Clozapine in October 2024.<br>-He was the MA working in the facility in October 2024 when there were multiple doses documented as administered on multiple days.<br>-He administered Clozapine for each entry that "popped up" on the eMAR each day even if it was multiple entries.<br>-He was not aware some of the entries should not have been active at that time.<br>-He was just going by what came up on the eMAR system.<br><br>Review of Resident #1's lab results dated 11/01/24 revealed:<br>-The resident's ANC level was 244 (reference range was 1500 - 7800).<br>-There was a handwritten note dated 11/04/24 at the bottom of the page indicating the resident was sent to the hospital due to the lab results.<br><br>Review of Resident #1's MHP electronic prescription dated 11/08/24 at 2:26pm revealed | D 358 | | |

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| D 358 | Continued From page 35<br>an order for Clozapine 50mg 1 tablet every morning and 2 tablets (100mg) at bedtime.<br><br>Review of Resident #1's MHP visit note dated 11/08/24 at 2:46pm revealed an order to hold all Clozapine due to awaiting updated blood work.<br><br>Review of Resident #1's MHP visit note dated 11/11/24 revealed an order to resume Clozapine with continued weekly lab draws.<br><br>Review of Resident #1's November 2024 eMAR revealed:<br>-There was an entry for Clozapine 50mg 1 tablet every morning scheduled at 8:00am.<br>-Clozapine 50mg 1 tablet was documented as administered at 8:00am from 11/01/24 - 11/04/24, 11/07/24 - 11/08/24, and 11/13/24 - 11/20/24.<br>-Clozapine 50mg 1 tablet at 8:00am was documented as not administered from 11/05/24 - 11/06/24 due to the resident being in the hospital and from 11/09/24 - 11/12/24 due to the medication being on hold per physician's order.<br>-Clozapine should have been resumed on 11/11/24 instead of being held.<br>-There was a second entry for Clozapine 50mg 2 tablets (=100mg) at bedtime scheduled at 8:00pm.<br>-Clozapine 50mg 2 tablets (100mg) was documented as administered at 8:00pm from 11/01/24 - 11/03/24, 11/06/24 - 11/07/24, and 11/12/24 - 11/19/24.<br>-Clozapine 50mg 2 tablets at 8:00pm was documented as not administered from 11/04/24 - 11/05/24 due to the resident being in the hospital and from 11/08/24 - 11/11/24 due to the medication being on hold per physician's order.<br>-Clozapine should have been resumed on 11/11/24 instead of being held. | D 358 | | |

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| D 358 | Continued From page 36<br><br>Review of Resident #1's pharmacy dispensing records dated 09/01/24 - 11/21/24 revealed:<br>-There were 6 Clozapine 50mg tablets dispensed on 10/10/24.<br>-There were 15 Clozapine 25mg tablets dispensed on 10/10/24.<br>-There were 90 Clozapine 50mg tablets dispensed on 10/12/24.<br>-There were 90 Clozapine 50mg tablets dispensed on 11/11/24.<br><br>Observation of Resident #1's medications on hand on 11/21/24 at 1:16pm revealed:<br>-There was a supply of Clozapine 50mg tablets dispensed on 11/11/24 with instructions to take 1 tablet every morning.<br>-There was 1 tablet packaged in each bubble of the medication card.<br>-There was a supply of Clozapine 50mg tablets dispensed on 11/11/24 with instructions to take 2 tablets (=100mg) at bedtime.<br>-There were 2 tablets packaged in each bubble of the medication card.<br>-There was a total of 90 Clozapine 50mg tablets dispensed on 11/11/24 and there were 62 of 90 tablets remaining.<br><br>Interviews with Resident #1 on 11/21/24 at 3:33pm and 11/22/24 at 2:53pm revealed:<br>-He saw a MHP and took medication for schizophrenia.<br>-He had to get lab work related to his medication.<br>-He was not sure how often or what dosage of the medication he received.<br>-He had recently finished chemotherapy and radiation treatments and he felt tired.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/22/24 at 12:27pm revealed: | D 358 | | |

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-The pharmacy staff usually entered medication orders into the eMAR system and the facility staff had to approve the orders to activate them.
-The facility staff also had access to enter orders into the eMAR system.
-The pharmacy received and entered the discontinue order for Clozapine on 09/06/24.
-She was not sure why it continued on the eMAR unless there was a delay in the facility staff approving the order.
-She was not sure why there were several orders for Clozapine entered into the eMAR system that were active at the same time, unless there was a delay by facility staff approving some of the orders.

Interview with the Resident Care Coordinator (RCC) on 11/21/24 revealed:
-He supervised the MAs and sometimes administered medications.
-He usually did record audits for all residents once a week.
-He compared medications on hand with the eMAR and the medication orders.
-He saw multiple entries on the eMAR for Resident #1's Clozapine in October 2024 but he thought that was the way the physician ordered it.
-When asked about comparing the eMAR to the physician's orders, the RCC did not respond.

Interview with the Administrator on 11/21/24 at 10:45am revealed:
-The RCC and MAs were responsible for sending medication orders to the pharmacy
-The pharmacy usually entered orders into the eMAR system.
-Either she or the RCC or the MAs had to review and approve orders in the eMAR system prior to the orders becoming active.
-She was not sure why Clozapine continued to be

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administered after it was discontinued on 09/06/24.
-The MA should have notified her of the RCC when he saw multiple orders for Clozapine in the eMAR system.
-The MA should not have administered multiple doses of Clozapine to the resident in October 2024.

Attempted telephone interview with Resident #1's MHP on 11/22/24 at 2:16pm was unsuccessful.

b. Review of Resident #1's hospital emergency room (ER) after visit summary dated 09/06/24 revealed:
-The resident had small cell lung cancer and was receiving chemotherapy.
-The resident was diagnosed with chemotherapy-induced neutropenia.
-The resident was prescribed an antibiotic (used to treat and prevent infections.)

Review of Resident #1's hospital prescription order dated 09/06/24 revealed an order for Levofloxacin 500mg 1 tablet once a day for 5 days. (Levofloxacin is an antibiotic used to treat and prevent infections.)

Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Levofloxacin 500mg take 1 tablet every for 5 days for infection.
- Levofloxacin was scheduled to be administered at 8:00am.
-Documentation for Levofloxacin 500mg was blank from 09/06/24 - 09/09/24.
-The first dose of Levofloxacin 500mg was documented as administered at 8:00am on 09/10/24.

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| D 358 | Continued From page 39<br>- Levofloxacin 500mg was documented as administered daily from 09/10/24 - 09/15/24, 6 days instead of 5 days.<br>-There was no reason for the delay in starting the antibiotic documented on the eMAR.<br><br>Observation of Resident #1's medications on hand on 11/21/24 at 1:16pm revealed there was no Levofloxacin on hand.<br><br>Review of Resident #1's pharmacy dispensing records dated 09/01/24 - 11/21/24 revealed there were 5 Levofloxacin 500mg tablets dispensed on 09/09/24.<br><br>Interviews with Resident #1 on 11/21/24 at 3:33pm and 11/22/24 at 2:53pm revealed he recalled going to the hospital several times, but he was not sure if he had been prescribed an antibiotic.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/21/24 at 12:10pm revealed:<br>-The pharmacy received the Levofloxacin order (dated 09/06/24) on 09/09/24.<br>-The ordered was entered into the eMAR system to start on 09/10/24.<br><br>Interview with the Administrator on 11/21/24 at 10:45am revealed:<br>-The RCC was responsible for faxing medication order to the pharmacy.<br>-If the RCC was not available, the medication aide (MA) on duty was responsible for faxing medication orders to the pharmacy.<br>-The facility's contracted pharmacy staff put orders into the eMAR system and either the RCC or MAs had to approve orders prior to the orders becoming active in the eMAR system. | D 358 | | |

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-The facility's contracted pharmacy usually delivered medications to the facility each week night.
-If an order was received on a weekend, there was someone on call at the pharmacy and they could get the medication the next day.
-She did not know why there was a delay in getting Resident #1's Levofloxacin.
-It should have been started no later than the next day after it was ordered.
-She usually did record audits weekly, but she had not audited Resident #1's record because the resident was in the hospital last week.
-The MA who was on duty at the time of the Levofloxacin order dated 09/06/24 no longer worked at the facility.
-The MA should have sent the order to the pharmacy when it was received on 09/06/24.

Telephone interview with a registered nurse (RN) at Resident #1's radiation provider's office on 11/22/24 at 2:36pm revealed:
-Resident #1 received chemotherapy and radiation for lung cancer.
-The resident's low ANC levels caused by chemotherapy and the resident's antipsychotic medications put the resident at more at risk for infections, especially since the resident lived in close quarters with other residents in the facility.
-The delay in starting Levofloxacin caused the resident to be at risk for infection and sepsis (infection in the blood).

Telephone interview with Resident #1's primary care provider (PCP) on 11/22/24 at 1:40pm revealed:
-Resident #1 had lung cancer and had received chemotherapy and radiation that put the resident at higher risk for infections.
-The resident also received an antipsychotic that

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could lower blood counts and put the resident at risk of infections.
-The delay in receiving Levofloxacin put the resident at risk of infections.

Attempted telephone interview with Resident #1's MHP on 11/22/24 at 2:16pm was unsuccessful.

c. Review of Resident #1's physician's order dated 07/04/24 revealed there was an order for Olanzapine 5mg take 1 tablet in the evening on days 1 to 4 of chemotherapy to prevent nausea. (Olanzapine is an antipsychotic that may be used to prevent nausea and vomiting caused by chemotherapy.)

Review of a handwritten list of dates of chemotherapy for Resident #1 revealed:
-The first cycle was 07/30/24, 07/31/24, and 08/01/24.
-The second cycle was 08/20/24, 08/21/24, and 08/22/24.
-The third cycle was 09/10/24, 09/11/24, and 09/12/24.
-The fourth cycle was 10/22/24, 10/23/24, and 10/24/24.

Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Olanzapine 5mg take 1 tablet in the evening on days 1 to 4 of chemotherapy to prevent nausea.
-The entry was marked as prn (as needed) rather than scheduled for 4 doses as ordered.
-No Olanzapine was documented as administered.

Review of Resident #1's October 2024 eMAR revealed:

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| D 358 | Continued From page 42<br>-There was an entry for Olanzapine 5mg take 1 tablet in the evening on days 1 to 4 of chemotherapy to prevent nausea.<br>-The entry was marked as prn (as needed) rather than scheduled for 4 doses as ordered.<br>-No Olanzapine was documented as administered.<br><br>Observation of Resident #1's medications on hand on 11/21/24 at 1:15pm revealed:<br>-There was a supply of Olanzapine 5mg dispensed on 07/03/24 with instructions to take 1 tablet in the evening x 4 doses, on days 1 to 4 of chemotherapy to prevent nausea.<br>-There were 12 of 12 tablets of the supply dispensed on 07/03/24 remaining.<br>-There was a supply of Olanzapine 5mg dispensed on 07/30/24 with instructions to take 1 tablet in the evening x 4 doses, on days 1 to 4 of chemotherapy to prevent nausea.<br>-There were 12 of 12 tablets of the supply dispensed on 07/30/24 remaining.<br>-There were no other supplies of Olanzapine available for administration.<br><br>Interviews with Resident #1 on 11/21/24 at 3:33pm and 11/22/24 at 2:53pm revealed:<br>-He had recently finished with chemotherapy and radiation treatments.<br>-He did not recall having nausea and vomiting but he did recall being weak and unsteady on his feet when he was receiving treatments.<br><br>Interview with the medication aide (MA) on 11/21/24 at 1:31pm revealed:<br>-The pharmacy usually entered medication orders into the eMAR system.<br>-Resident #1 took chemotherapy about 3 times a week for 12 sessions starting sometime around July 2024. | D 358 | | |

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| D 358 | Continued From page 43<br>-The resident also took about 30 radiation treatments.<br>-He could not recall administering any Olanzapine to the resident and did not recall seeing the order on the eMAR.<br>-The resident never complained of nausea to him.<br>-He recalled the resident vomiting one time in the dining room (could not recall date) but could not recall if it was on a day the resident received chemotherapy.<br>-He did not document when the resident vomited.<br><br>Interview with the Resident Care Coordinator (RCC) on 11/21/24 revealed:<br>-He supervised the MAs and sometimes administered medications.<br>-He usually did record audits for all residents once a week.<br>-He compared medications on hand with the eMAR and the medication orders.<br>-The pharmacy usually entered orders into the eMAR system and the facility had to approve the orders.<br>-He usually approved the orders and he must have overlooked that Olanzapine was set up as a prn medication in the eMAR system.<br>-The resident never reported any nausea to his knowledge.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/22/24 at 12:27pm revealed:<br>-The pharmacy only dispensed Olanzapine 5mg tablets twice, on 07/03/24, and 07/30/24 with 12 tablets each time.<br>-There had been no requests by the facility to refill the Olanzapine since it was last dispensed on 07/30/24.<br>-A pharmacy technician entered the order into the eMAR system as a prn (as needed) medication | D 358 | | |

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but it should have been scheduled on the eMAR in accordance with chemotherapy days.
-The facility staff who approved the order should have changed it to a scheduled medication.

Telephone interview with a registered nurse (RN) at Resident #1's chemotherapy provider's office on 11/22/24 at 2:43pm revealed:
-Olanzapine was ordered to be taken during Resident #1's chemotherapy treatments because there was a high risk of the chemotherapy causing nausea.
-Olanzapine should have been administered to prevent nausea for the comfort of the resident

d. Review of Resident #1's physician's order dated 10/03/24 revealed an order for Magic Mouthwash 10ml twice a day for 5 days. (Magic Mouthwash is used to treat mouth sores caused by chemotherapy and radiation.)

Review of Resident #1's physician's order dated 10/22/24 revealed an order for Magic Mouthwash swish, gargle, and spit out 5ml every 6 hours as needed for mouth or throat pain.

Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed:
-There was no entry for Magic Mouthwash 10mls twice a day for 5 days.
-There was no Magic Mouthwash documented as administered twice a day as ordered on 10/03/24.
-There was an entry for Magic Mouthwash swish, gargle, and spit out 5ml every 6 hours as needed (prn) for mouth or throat pain.
-The prn Magic Mouthwash was documented as administered on one occasion on 10/30/24.

Observation of Resident #1's medications on

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hand on 11/21/24 at 1:29pm revealed:
-There was a bottle of Magic Mouthwash dispensed on 11/14/24 with instructions to swish, gargle, and spit out 5ml every 6 hours as needed for mouth or throat pain.
-There were no to other supplies of Magic Mouthwash available.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/22/24 at 12:27pm revealed:
-The pharmacy received Resident #1's Magic Mouthwash order dated 10/03/24.
-The pharmacist did not dispense it on 10/03/24 because there was an ingredient in the mouthwash that was similar to another medication the resident was allergic to.
-The pharmacist attempted to contact the provider.
-The pharmacist notified the facility (no facility staff person's name was noted) and told the facility staff person to call the pharmacy back the next day to see if they heard back from the provider.
-They did not hear back from the provider.
-The facility did not call back, so the pharmacy did not dispense the medication.

Interviews with Resident #1 on 11/21/24 at 3:33pm and 11/22/24 at 2:53pm revealed:
-He had used some Magic Mouthwash at times, but he could not recall when or how often.
-He had received chemotherapy and radiation, and he had recently finished both.
-It was sometimes uncomfortable when he swallowed because it felt like something was rubbing in his throat.
-He thought the Magic Mouthwash helped when he used it.

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| D 358 | Continued From page 46<br><br>Interview with the medication aide (MA) on 11/21/24 at 1:31pm revealed:<br>-The pharmacy usually entered medication orders into the eMAR system.<br>-He did not recall getting Magic Mouthwash for Resident #1 until later in October 2024.<br>-He did not recall speaking to anyone at the pharmacy about the 10/03/24 order for Magic Mouthwash.<br><br>Interview with the Resident Care Coordinator (RCC) on 11/21/24 revealed:<br>-He supervised the MAs and sometimes administered medications.<br>-He usually did record audits for all residents once a week.<br>-He compared medications on hand with the eMAR and the medication orders.<br>-He did not know why Resident #1 did not receive the Magic Mouthwash ordered on 10/03/24.<br>-The resident received chemotherapy 3 to 4 times a week and should have received the Magic Mouthwash.<br><br>Telephone interview with a registered nurse (RN) at Resident #1's radiation provider's office on 11/22/24 at 2:36pm revealed:<br>-Magic Mouthwash was ordered to be administered to Resident #1 because the resident's immune system was compromised and the radiation could cause thrush (a fungal infection of the mouth and throat).<br>-Magic Mouthwash was to help with the resident's discomfort related symptoms caused by radiation including making it harder to swallow, eat, and drink.<br><br>e. Review of Resident #1's physician's order dated 08/23/24 revealed an order for Levothyroxine 150mcg 1 tablet every morning | D 358 | | |

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before breakfast. (Levothyroxine is used to treat underactive thyroid disease.)

Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Levothyroxine 150mcg 1 tablet every day 1 hour prior to breakfast.
-Levothyroxine was scheduled for administration at 8:00am.
-Levothyroxine was documented as administered daily at 8:00am from 09/01/24 - 09/24/24 except on 09/16/24 when the dosage was held.
-Levothyroxine was documented as not administered from 09/25/24 - 09/30/24 due to the resident being in the hospital.

Review of Resident #1's October 2024 eMAR revealed:
-There was an entry for Levothyroxine 150mcg 1 tablet every day 1 hour prior to breakfast.
-Levothyroxine was scheduled for administration at 8:00am.
-Levothyroxine was documented as not administered from 10/01/24 - 10/03/24 and from 10/09/24 - 10/14/24 due to the resident being in the hospital and on 10/16/24 due to the resident being out of the facility for a chemotherapy treatment.
-Levothyroxine was documented as administered daily at 8:00am from 10/04/24 - 10/08/24, 10/15/24, and from 10/17/24 - 10/31/24.

Review of Resident #1's November 2024 eMAR revealed:
-There was an entry for Levothyroxine 150mcg 1 tablet every day 1 hour prior to breakfast.
-Levothyroxine was scheduled for administration at 8:00am.
-Levothyroxine was documented as not

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administered from 11/05/24 - 11/06/24 due to the resident being in the hospital.
-Levothyroxine was documented as administered daily at 8:00am from 11/01/24 - 11/04/24 and from 11/07/24 - 11/20/24.

Interviews with Resident #1 on 11/21/24 at 3:33pm and 11/22/24 at 2:53pm revealed he usually received all of his morning medications when he was eating his breakfast.

Observation of Resident #1's medications on hand on 11/21/24 at 1:20pm revealed:
-There was a supply of Levothyroxine 150mcg tablets dispensed on 11/06/24.
-The instructions were to take 1 tablet everyday 1 hour prior to breakfast.

Interview with the medication aide (MA) on 11/21/24 at 1:31pm revealed:
-Breakfast was served at 8:00am daily.
-Resident #1's medications scheduled at 8:00am were administered at 8:00am including Levothyroxine.
-He had not noticed the instructions on the eMAR and the medication label were to administer Levothyroxine one hour prior to meals.
-At one time (could not recall when), the Levothyroxine was scheduled and administered at 6:00am.

Interview with the Resident Care Coordinator (RCC) on 11/21/24 revealed:
-He supervised the MAs and sometimes administered medications.
-He usually did record audits for all residents once a week.
-He compared medications on hand with the eMAR and the medication orders.
-Resident #1 should get Levothyroxine at 7:00am.

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-He had not noticed the time was incorrect on the eMAR.

Review of Resident #1's lab results dated 09/20/24 revealed the resident's thyroid stimulating hormone (TSH) level was 1.31 (reference range = 0.35 - 4.94) on 09/20/24.

Telephone interview with Resident #1's primary care provider (PCP) on 11/22/24 at 1:40pm revealed:
-Food hindered the absorption of Levothyroxine.
-Levothyroxine should be taken on an empty stomach to maintain therapeutic range.
-If getting with food, the resident could be at risk for symptoms including heart palpitations, weight loss, and diarrhea.

2. Review of the facility's Medication Order Policy (policy not dated) revealed:
-Physician medications orders may be ordered from the pharmacy by any person designated by the facility.
-New medication orders shall include the resident's name, physician's name, name of drug, strength of drug and amount, route of administration, and time of dose limit if specified by physician such as a stop order.

Review of Resident #2's current FL-2 dated 11/18/24 revealed diagnoses included type 2 diabetes, hypertension, chronic obstructive pulmonary disease, depression, chronic kidney disease, chronic back pain, and hyperlipidemia.

Review of Resident #2's Resident Register revealed an admission date of 04/01/19.

Review of Resident #2's hospital discharge summary dated 09/25/24 revealed there was an

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| D 358 | Continued From page 50<br>order for Nicotine 21mg/24-hour patch apply 1 on the skin daily (used to treat smoking cravings).<br><br>Review of Resident #2's Rehabilitation Center order summary report dated 10/21/24 revealed an order for Nicotine patch 24-hour 21mg apply 1 patch transdermally one time a day for smoking cessation for 4 weeks and remove per schedule.<br><br>Second review of Resident #2's current FL-2 dated 11/18/24 revealed there was no order for Nicotine 21mg/24 hours patch.<br><br>Review of Resident #2's November 2024 electronic medication administration record (eMAR) revealed:<br>-There was an entry for Nicotine 21mg/24HR patch, apply 1 patch transdermally to skin once daily for smoking.<br>-Nicotine 21mg/24 hours were documented as administered at 8:00am on 11/01/24 through 11/03/24.<br>-There was no other documentation of Nicotine 21mg/ 24 hours being administered.<br><br>Observation of Resident #2's medications on hand on 11/20/24 at 10:40am revealed.<br>-There was a Nicotine transdermal system patch kit on the medication cart.<br>-There were 7 out of 28 patches sitting in their original package.<br><br>Interview with Resident #2 on 11/20/24 at 11:20am revealed:<br>-He was wearing a Nicotine patch.<br>-The medication aide (MA) placed the Nicotine patch on him that morning and every day in the last week.<br><br>Interview with the MA on 11/20/24 at 11:30am | D 358 | | |

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| D 358 | Continued From page 51<br>revealed:<br>-He applied the Nicotine patch on Resident #2's arm from 11/15/24 through 11/20/24.<br>-He was not aware the medication had been discontinued because he did not see discontinue on the cart, or on the eMARs.<br>-Resident #2 reminded him that he needed his patch to be applied, and he placed it on his arm but did not check off on the eMARs that he had applied the patch because it was not up there for him to check off and it never occurred to him that was because the order had been discontinued.<br><br>Interview with the Resident Care Coordinator (RCC) on 11/20/24 at 11:43am revealed:<br>-He was not aware Resident #2's Nicotine patch had an order to discontinue within 4-weeks.<br>-He was responsible for reviewing all orders for clarification.<br>-If the resident's order came from a Rehabilitation Center, he was to review the order, initial that he reviewed the order, then fax it to the primary care provider (PCP) for clarification.<br>-He could not recall using this method when Resident's #2's order came in from the Rehabilitation Center.<br>-He did not contact the PCP for clarification of the medication.<br>-He was responsible for making the MA aware of any medication changes.<br>-He was not aware the MA applied the nicotine patch on Resident #2's skin with no physician's order.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/21/24 at 12:55pm revealed:<br>-Nicotine Transdermal System 4-week kit was dispensed for Resident #2 on 09/25/24 and the stop date was dated 11/05/24. | D 358 | | |

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| D 358 | Continued From page 52<br>-The medication was a short order.<br>-The quantity of the medication was 28 patches.<br>-Any unused patches after the stopped dated should have been returned to the pharmacy.<br>-No patches were returned to the pharmacy.<br><br>Telephone interview with Resident #2's PCP on 11/22/24 at 1:40pm revealed:<br>-She was not aware that Rsident #2's Nicotine patch had an order to end within 4-weeks.<br>-She was not aware that MA continued to administer the medication.<br>-She did expect the staff to discontinue the patch if there was no order.<br><br>Interview with the Administrator on 11/21/24 at 11:25am revealed:<br>-She was not aware that Resident #2's medication order for Nicotine patch had been discontinued.<br>-She faxed the Nicotine patch order to the pharmacy on 10/23/24 and overlooked that it was ordered for 4-weeks only.<br>-The RCC was responsible for medication clarification, to confirm all medications were active, and to review start date and end date.<br>-When a medication was discontinued, the eMAR system alerted the MA that the medication was discontinued with a sound when, they attempted to scan the medication.<br>-She was not aware that the MA applied Resident #2's Nicotine patch from 11/15/24 to 11/21/24.<br>-She was not aware that the nicotine patch continued to be on the medication cart.<br><br>Attempted telephone interview with Resident #2's family member on 11/22/24 at 12:05pm was unsuccessful.<br><br>The facility failed to administer medications as | D 358 | | |

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| D 358 | Continued From page 53<br>ordered to Resident #1 whose antipsychotic medication was administered 3 days after it was discontinued on 09/06/24 due to the resident having severely low blood cell counts requiring treatment at the hospital. Resident #1's also received multiple doses of the antipsychotic medication on multiple days when it was restarted in October 2024 and the resident had more low blood cell counts requiring another hospital visit and putting the resident at risk of infections including sepsis (infection in the blood) as the resident was already immunocompromised from receiving chemotherapy and radiation treatments for lung cancer. There was a 4-day delay in starting an antibiotic to prevent infection in Resident #1 when his blood counts were severely low again putting the resident at risk for infections. Resident #1 did not receive any medication to prevent nausea and vomiting while receiving chemotherapy treatments. Resident #1 who complained of discomfort when swallowing did not receive a scheduled Magic Mouthwash for sore mouth and throat due to chemotherapy treatments. The failure of the facility to administer medications as ordered resulted in serious physical harm and neglect and constitutes a Type A1 Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/21/24 for this violation.<br><br>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 22, 2024. | D 358 | | |
| D 406 | 10A NCAC 13F .1009(b) Pharmaceutical Care<br><br>10A NCAC 13F .1009 Pharmaceutical Care | D 406 | | |

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| D 406 | Continued From page 54<br>(b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure follow up for a quarterly medication review for 1 of 1 sampled resident (#1) who had a recommendation.<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 10/31/24 revealed diagnoses included schizoaffective disorder - bipolar type, coronary artery disease, thyroid gland disease, stage 2 chronic obstructive pulmonary disease, asthma, and depression.<br><br>Review of Resident #1's quarterly medication review dated 09/10/24 revealed:<br>-The resident was being treated with Famotidine and Protonix. (Famotidine and Protonix are used to treat acid reflux disease.)<br>-The pharmacist made a recommendation to evaluate if the resident needed to be on both medications.<br>-The medication review recommendation was not signed by the resident's primary care provider (PCP).<br><br>Review of Resident #1's progress notes and provider visit notes dated September 2024 - November 2024 revealed no documentation the medication review recommendation had been | D 406 | | |

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| D 406 | Continued From page 55<br>forwarded to the PCP for follow-up.<br><br>Interview with the Resident Care Coordinator (RCC) on 11/20/24 at 3:49pm revealed:<br>-He was not familiar with medication review recommendations.<br>-He was not aware that he needed to follow-up on medication reviews.<br><br>Interview with the Administrator on 11/21/24 at 10:45am revealed:<br>-The RCC was responsible for following up on medication review recommendations.<br>-She did not know why Resident #1's medication recommendation from September 2024 had not been followed up.<br>-She had not had a chance to check behind the RCC to make sure recommendations were followed up.<br><br>Telephone interview with the facility's contracted Consultant Pharmacist on 11/22/24 at 11:28am revealed:<br>-She did the medication reviews on-site at the facility.<br>-She usually typed and sent the medication review recommendations to the facility in the pharmacy tote the next day.<br>-She put a note for attention to the Administrator on the medication review recommendations.<br>-She did not usually have any issues with the facility following up on medication review recommendations.<br>-She was not aware they had not followed up on the recommendation from September 2024 for Resident #1.<br><br>Telephone interview with Resident #1's PCP on 11/22/24 at 1:40pm revealed:<br>-If she had received a medication | D 406 | | |

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| D 406 | Continued From page 56<br>recommendation for Resident #1 in September 2024, she would have responded to it when she received it.<br>-She would evaluate the resident at her next visit and decide if the resident needed both medications. | D 406 | | |
| D 451 | 10A NCAC 13F .1212(a) Reporting of Accidents and Incidents<br><br>10A NCAC 13F .1212 Reporting of Accidents and Incidents<br>(a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to notify the county department of social services (DSS) of incidents/accidents for 1 of 2 sampled residents (#1) who required emergency medical and hospital evaluations for falls.<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 10/31/24 revealed diagnoses included schizoaffective disorder - bipolar type, coronary artery disease, thyroid gland disease, stage 2 chronic obstructive pulmonary disease, asthma, and depression. | D 451 | | |

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| D 451 | Continued From page 57<br><br>Review of Resident #1's facility progress note dated 10/26/24 (no time noted) revealed:<br>-The resident was found on the floor and could not get up.<br>-Emergency Medical Services (EMS) was called and the resident was taken to the hospital emergency room (ER).<br><br>Review of Resident #1's hospital after visit summary dated 10/26/24 revealed:<br>-The resident was seen for a fall with head injury.<br>-A head and neck scan were completed.<br>-The resident was diagnosed with a closed head injury.<br><br>Review of Resident #1's facility progress note dated 11/02/24 (no time noted) revealed:<br>-The resident had a fall from his wheelchair.<br>-EMS was called and EMS checked out the resident.<br>-The resident refused to go to the hospital.<br><br>Review of Resident #1's accident/incident reports for October 2024 - November 2024 revealed:<br>-There were no accident/incident reports for the resident's falls on 10/26/24 and 11/02/24.<br>-There was no documentation the county department of social services (DSS) was notified of the falls requiring EMS and/or hospital evaluation and treatment.<br><br>Interview with the medication aide (MA) on 11/21/24 at 3:23pm revealed:<br>-He thought he had filled out an accident/incident report on 10/26/24 but he could not find it.<br>-He usually gave accident/incident reports to the Administrator.<br><br>Interview with the Resident Care Coordinator | D 451 | | |

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| D 451 | Continued From page 58<br>(RCC) on 1/21/24 at 12:30pm revealed:<br>-The MA or personal care aide (PCA) on duty at the time of an accident was responsible for completing an accident/incident report.<br>-The MA or PCA then gave the report to him or the Administrator.<br>-If the MA or PCA gave the report to him, he forwarded it to the Administrator.<br>-The Administrator was responsible for notifying the county DSS of accidents/incidents.<br>-He and the Administrator were responsible for checking to make sure accident/incident reports were completed.<br>-He was not sure why there was no accident/incident reports for Resident #1's falls on 10/26/24 and 11/02/24.<br>-He thought they had been done and given go the Administrator.<br><br>Interview with the Administrator on 11/21/24 at 10:45am revealed:<br>-The accident/incident reports for Resident #1's falls on 10/26/24 and 11/02/24 were not done.<br>-The MA on duty at the time of the incident was responsible for completing the accident/incident report.<br>-The MA was supposed to give the report to the RCC or her.<br>-She was responsible for sending the accident/incident reports to the county DSS.<br>-She had staff complete accident/incident reports today, 11/21/24, for Resident #1's falls on 10/26/24 and 11/02/24.<br>-She sent those reports to the county DSS today, 11/21/24, but they should have been completed and sent on the day the falls occurred.<br><br>Telephone interview with the Adult Home Specialist (AHS) with the county DSS on 11/22/24 at 10:50am revealed: | D 451 | | |

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| D 451 | Continued From page 59<br>-The facility usually sent accident/incident reports within 24 hours of the accident/incident.<br>-The facility usually either faxed, emailed, or called.<br>-She did not receive accident/incident reports for Resident #1's falls on 10/26/24 and 11/02/24 until yesterday, 11/21/24. | D 451 | | |