STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0490	A. BUILDING: _____ B. WING _____	C 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA MEADOWS HEALTH CTR	500 CAROLINA MEADOWS CHAPEL HILL, NC 27517

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L 000	INITIAL COMMENTS A licensure and complaint investigation survey was conducted from 10/14/25 through 10/16/25. Event ID#NFM711. The following intakes were investigated: NC00215707, NC00219483, NC00232682, NC00212009, and NC00212331. 3 of 16 complaint allegations resulted in deficiency.	L 000		
L 091	.2306(D)(1) MEDICATION ADMINISTRATION 10A-13D.2306 (d) The facility shall ensure that procedures aimed at minimizing medication error rates include the following: (1) All medications or drugs and treatments shall be administered and discontinued in accordance with signed medical orders which are recorded in the patient's medical record. Such orders shall be complete and include drug name, strength, quantity to be administered, route of administration, frequency and, if ordered on an as-needed basis, a stated indication for use. This Rule is not met as evidenced by: Based on record reviews and facility staff, Nurse Practitioner (NP) and Medical Doctor (MD) interviews, the facility failed to administer an anticoagulant medication twice daily to a resident for the entire 3-month course of treatment recommended for a pulmonary embolism. After receiving the anticoagulant medication twice daily for 31 days, the medication order was changed to once daily dosing and continued for 41 days before the error was discovered and corrected to	L 091		

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twice daily dosing. This deficient practice occurred for 1 of 3 residents whose medications were reviewed (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 7/14/21 with diagnoses which included essential thrombocythemia (a chronic blood disorder characterized by an abnormally high platelet count), a right upper lobe (RUL) lung tumor, and vascular dementia.

The resident's electronic medical record (EMR) included a Monthly Assessment dated 10/5/23. Resident #1 was described as alert but confused. She was assessed to be non-ambulatory and bed/chair bound. She was able to feed herself with a fair appetite reported but was dependent on staff for personal hygiene, bathing, and transfers.

Resident #1 was hospitalized on 10/23/23 with a return to the facility on 10/25/23.

A 10/26/23 physician's Progress Note authored by the facility's Medical Director (who was also the resident's physician) reported Resident #1 was hospitalized after a pulmonary embolism (a clot that is blocking an artery in the lung, thereby restricting blood flow to a part of the lung) was identified on an outpatient computerized tomography (CT) scan performed for the surveillance of her RUL lung tumor. The physician noted Eliquis (an anticoagulant medication) was initiated as 2.5 milligrams (mg) twice daily for Resident #1 after discussion with hematology (a medical specialty for diagnosing and treating blood-related disorders). It was recommended that a trough level of Eliquis (the

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lowest concentration of a medication in a patient's bloodstream, measured just before the next scheduled dose) be drawn at 5 days from initiation (10/30/23 before the morning dose) with hematology following the resident for further management.

A review of Resident #1's Physician's Orders, October 2023 Medication Administration Record (MAR), and November 2023 MAR revealed that Eliquis was scheduled and administered twice daily from 10/25/23 through 11/8/23.

A physician's Progress Note dated 11/8/23 reported the physician discussed the results of Resident #1's Eliquis trough level with hematology, with no dose adjustment recommended for the Eliquis.

Resident #1's EMR also included a Nurse Practitioner (NP) Progress Note dated 11/8/23 and authored by NP #1. The NP note included, in part: "[Hematologist] recommends no dose adjustment for the apixaban (Eliquis)."

An NP Progress Note dated 11/14/23 and authored by NP #2 reported Resident #1 was seen by hematology on 11/13/23 with several recommendations made, including: " ...Eliquis long-term, 2.5 mg q 12 [every 12 hours] until Jan [January] 24, 2023 [2024]. Then 2.5 mg once daily empirically long-term." The note also indicated, "New orders written to decrease Eliquis to 2.5 mg daily on 1/25/24."

The Physician's Orders in Resident #1's EMR were reviewed and revealed that an order was input into facility's computer system on 11/14/23. This order had a start date of 11/25/23 for 2.5 mg Eliquis to be given by mouth one time daily. It

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indicated the ordering provider was NP #2.

A physician's Progress note dated 11/18/23 read in part, "Currently remains on 2.5 mg BID [twice daily] with dose reduction in January."

A review of Resident #1's November 2023, December 2023, and January 2024 MARs indicated that 2.5 mg Eliquis was administered twice daily from 11/1/23 through 11/24/23 (indicative of the resident receiving a total of 31 days of Eliquis with twice daily dosing). The MARs also revealed the dose of Eliquis decreased from twice daily dosing to once a day dosing on 11/25/25. Once daily dosing of the Eliquis continued through 1/5/24 (reflecting 41 days of Eliquis given only once a day).

On 1/5/24, a physician Progress Note reported the physician contacted Resident #1's family member to discuss a communication with the resident's hematologist regarding the dosing of her Eliquis. The physician indicated the initial recommendation and order made was to give 2.5 mg Eliquis twice daily until 1/24/24 with a long-term order intended to decrease the dosing of Eliquis to 2.5 mg given once daily, effective on 1/25/24.

A review of Resident #1's physician orders and January 2024 MAR revealed a new order was written by the physician to administer 2.5 mg Eliquis twice daily from 1/5/24 to 1/17/24.

Resident #1's EMR included an NP Progress Note authored by NP #1 and dated 1/17/24. This note indicated hematology made a new recommendation and an order was subsequently written on 1/17/24 for Resident #1 to continue to receive 2.5 mg Eliquis twice daily until 2/29/24,

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and then 2.5 mg Eliquis to be given only once a day thereafter with no end date.

Resident #1's January 2024 and February 2024 MARs revealed the resident was administered 2.5 mg Eliquis given twice daily through 2/29/24 before a decrease to once daily dosing was implemented (in accordance with the physician's orders).

An interview was conducted on 10/16/24 at 9:26 AM with the facility's Medical Director (who was also the resident's physician). During the interview, concern related to the dosing schedule of Resident #1's Eliquis was expressed, and an inquiry made as to whether the 11/14/23 Eliquis order to decrease the dosing from twice daily to once a day on 11/25/23 was a medication error. In response, the physician stated, "We acknowledge that the dosing was an error." She confirmed that order should have indicated the 2.5 mg Eliquis twice daily dosing needed to continue until 1/24/24 before being decreased to once a day on 1/25/24 (not 11/25/23). When the error was identified on 1/5/24, the physician reported she contacted both the hematologist and the resident's family member to inform them. The physician reported that at the time this error was discovered, the actual cause of the transcription error for the Eliquis dosing could not be determined. Upon further inquiry, the physician reported she was confident that the error did not cause any harm to Resident #1. The physician added that she also had a conversation with the resident's hematologist, and he also confirmed there was no harm to the resident.

An interview was conducted on 10/16/25 at 12:13 PM with NP #2. NP #2 was the provider identified as having written the 11/14/23 order which

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L 091	Continued From page 5 specified when Resident #1's Eliquis dose should be decreased from twice daily dosing to once a day dosing. The NP confirmed she intended for Resident #1 to continue twice daily dosing of Eliquis through 1/24/24 with a decrease to once daily dosing of the Eliquis on 1/25/24. During the interview, the NP stated that she wasn't involved in the transcription process for this order (the process of converting an order into the facility's electronic format). The NP reported she did not input the order herself into the computer system. NP #2 recalled the physician and previous Director of Nursing (DON) managed the situation when the dosing error for Resident #1's Eliquis was discovered. Upon inquiry, NP #2 described the process involved for implementing a provider order. The NP reported that when she had an order to put in for Resident #1 (in consultation with the hematologist and/or physician), she would write the order on a Physician's Order Sheet, flag it as a new order, and then let the nurses know of the new order so it could be put into the resident's EMR. The facility's former DON was not available for an interview. On 10/16/25 at 9:50 AM, an interview was conducted with the facility's Administrator. During the interview, the Administrator was informed of the concern identified about Resident #1's Eliquis dosing. When asked, the Administrator reported he was not aware of the facility having a plan of correction related to this situation.	L 091		