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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on June 22, 2016 and June 23, 2016.	D 000		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.	D 363		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared for administration in advance were kept enclosed in a sealed container that identified the name and strength of each medication prepared and the resident's name for 3 of 3 residents (Residents #4, #5 and #6) observed during the morning (8:00 am) medication pass and 1 of 3 sampled residents (Resident #1).

The findings are:

Observations on 06/23/16 at 7:45 am of the medication storage closet revealed a stack of four muffin trays labeled Breakfast, Lunch, Supper, and Bedtime.

The Breakfast muffin tray contained white, plastic, containers with lids. All of the plastic containers were labeled with residents' names and listed medication names and dosages.

The Lunch muffin tray contained white, plastic, containers with lids. All of the plastic containers were labeled with residents' names and listed medication names and dosages.

The Supper muffin tray contained white, plastic, containers with lids. All of the plastic containers were labeled with residents' names and listed medication names and dosages.

The Bedtime muffin tray contained white, plastic, containers with lids. All of the plastic containers were labeled with residents' names and listed medication names and dosages.

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Observation on 06/23/16 at 7:45 am of part of the morning medication pass process revealed:
-The Supervisor was observed passing medications for 3 residents.
-The Supervisor prepared one resident's medications at a time from the bubble packages and/or pharmacy dispensed containers and administered the medications to the resident prior to preparing the next resident's medications.
-The Supervisor administered medications.
-The book containing all the residents' Medication Administration Records (MARs) lay opened on the counter throughout the medication pass and the Supervisor documented administration of each resident's medication prior to moving to the next.

A. Review of Resident #4's current FL-2 dated 11/09/15 revealed diagnoses included depression, benign prostatic hyperplasia (BPH), schizophrenia, and microscopic hematuria.

Further review of the FL-2 dated 11/09/15 revealed the medication orders included Abilify (treats schizophrenia), ferrous sulfate (iron supplement), loxapine (treats schizophrenia), Flomax (treats BPH), vitamin B-12 (vitamin supplement), Zyprexa (treats schizophrenia), Cogentin (antipsychotic), Lamictal (treats mental disorders), melatonin (treats sleep disorders), and mirtazapine (treats mental disorders).

Review of Resident #4's record revealed a previous physician's order dated 05/06/15 prescribing vitamin D-2 50,000 units once a week.

Review of Resident #4's record revealed a previous physician's order dated 08/20/15 to discontinue vitamin D-2 50,000 units once a

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D 363	Continued From page 3 week. Review of Resident #4's record revealed signed physician's orders dated 06/02/16 ordering Abilify, ferrous sulfate, loxapine , Flomax, vitamin B-12, Zyprexa, Cogentin, Lamictal, and melatonin. Observation on the 8:00 am medication pass on 06/23/16 at 7:45 am revealed: -The Supervisor/Medication Aide retrieved a white plastic container with lid from the Breakfast muffin tray. -Resident #4 was administered one Abilify 15 mg, one ferrous sulfate 65 mg, two loxapine 50 mg, two Flomax 0.4 mg, and one vitamin B-12 1,000 mcg. -Resident #4 was not administered vitamin D-2 50,000 units. Observation of the medication storage container revealed: -The container was labeled with Resident #4's name and breakfast. -A label that listed medications, with the strengths on the label, was affixed to the container. -The container was labeled for medications as follows: Abilify 15 mg, ferrous sulfate 65 mg, loxapine 50 mg , Flomax 0.4 mg, vitamin B-12 1,000 mcg. -The label included vitamin D-2 50,000 units once a week but a physician's order dated 08/20/15 was to discontinue the vitamin D-2 50,000 units once a week. Review of Resident #4's June 2016 Medication Administration Record (MAR) revealed: -Abilify 15 mg was listed and scheduled for administration at 8:00 am. -Ferrous sulfate 65 mg was listed and scheduled for administration at 8:00 am.	D 363		

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D 363	Continued From page 4 -Loxapine 50 mg 2 capsules=100mg was listed and scheduled for administration at 8:00 am. -Flomax 0.4 mg 2 capsules daily was listed and scheduled for administration at 8:00 am. -Vitamin B-12 1,000 mcg daily was listed and scheduled for administration at 8:00 am. -Vitamin D-2 50,000 units once a week was not listed on the MAR. Interview on 6/23/16 at 2:20 pm with Resident #4 revealed he depended on staff to administer medications as ordered and had no problems with his medications Refer to interview on 6/23/16 at 8:15 am with the Supervisor/Medication Aide. Refer to interview on 6/23/16 at 3:15 pm with the Lead Medication Aide (LMA). Refer to interview on 06/23/16 at 4:04 pm with the full-time Supervisor/MA. Refer to interview on 06/23/16 at 4:50 pm with a Co-Administrator. B. Review of Resident #5's current FL-2 dated 08/18/15 revealed diagnoses included gait abnormality, gastric esophageal reflux disease (GERD), history of peripheral edema, encephalopathy, elevated triglycerides, chronic schizophrenia. Further review of the FL-2 dated 08/18/15 revealed the medication orders included aspirin 325 mg (treats circulation), Atorvastatin 20 mg (treats elevated cholesterol), benztropine mesylate 0.5 mg (antipsychotic), famotidine 20 mg (treats GERD), multivitamin (vitamin supplement), olanzapine 10 mg (treats	D 363		

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schizophrenia), vitamin D 2,000 units (vitamin supplement), and divalproex sod extended release 500 mg (treats seizures or mental disorders).

Review of Resident #5's record revealed a physician's order dated 09/24/15 ordering ginkgo biloba 60 mg 2 capsules twice a day. (Ginkgo biloba is used to improve memory.)

Review of Resident #5's record revealed signed physician's orders dated 02/03/16 ordering aspirin 325 mg, atorvastatin 20 mg, benztropine mesylate 0.5 mg, famotidine 20 mg, multivitamin, olanzapine 10 mg, vitamin D 2,000 units, ginkgo biloba 60 mg, and divalproex sod extended release 500 mg.

Observation of the 8:00 am medication pass on 06/23/16 at 7:45 am revealed:
-The Supervisor/Medication Aide retrieved a white plastic container with lid from the Breakfast muffin tray.
-Resident #5 was administered aspirin 325 mg, atorvastatin 20 mg, benztropine mesylate 0.5 mg, famotidine 20 mg, multivitamin, olanzapine 10 mg, vitamin D 2,000 units, and divalproex sod extended release 500 mg.
-Resident #5 was administered 2 ginkgo biloba 60 mg tablets.

Observation of the medication storage container revealed:
-The container was labeled with Resident #5's name and breakfast.
-A label that listed medications, with the strengths on the label, was affixed to the container.
-The container was labeled for medications as follows: aspirin 325 mg, atorvastatin 20 mg, benztropine mesylate 0.5 mg, famotidine 20 mg,

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multivitamin, olanzapine 10 mg, vitamin D 2,000 units, and divalproex sod extended release 500 mg.
-Ginkgo Biloba was not listed on the resident's container label.

Review of Resident #5's June 2016 Medication Administration Record (MAR) revealed:
-Aspirin 325 mg one tablet daily was listed and scheduled for 8:00 am.
-Atorvastatin 20 mg one tablet daily was listed and scheduled for 8:00 am.
-Benztropine mesylate 0.5 mg one tablet in the morning was listed and scheduled for 8:00 am.
-Famotidine 20 mg one tablet daily was listed and scheduled for 8:00 am.
-Multivitamin one tablet daily was listed and scheduled for 8:00 am.
-Olanzapine 10 mg one tablet daily was listed and scheduled for 8:00 am.
-Vitamin D 2,000 units one capsule daily was listed and scheduled for 8:00 am.
-Divalproex sod extended release 500 mg one tablet twice a day was listed and scheduled for 8:00 am.
-Ginkgo biloba 60 mg 2 capsules twice a day was listed and scheduled for 8:00 am.

Based on observation and record review, Resident #5 received 2 ginkgo biloba 60 mg capsules as ordered but the medication was not listed on the pre-poured medications label for the resident.

Interview on 6/23/16 at 2:40 pm with Resident #5 revealed he depended on staff to administer medications as ordered and had no problems with his medications

Refer to interview on 6/23/16 at 8:15 am with the

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D 363	Continued From page 7 Supervisor/Medication Aide. Refer to interview on 6/23/16 at 3:15 pm with the Lead Medication Aide (LMA). Refer to interview on 06/23/16 at 4:04 pm with the full-time Supervisor/MA. Refer to interview on 06/23/16 at 4:50 pm with a Co-Administrator. C. Review of Resident #6's current FL-2 dated 04/12/16 revealed diagnoses included hypertension, fracture of humerus proximal right closed with symptoms post open reduction internal fixation right proximal humerus 03/30/15, hypertension, schizophrenia, abnormal aortic aneurysm, and iliac artery aneurysm, bilateral. Further review of the FL-2 dated 04/12/16 revealed the medication orders included labetalol 200 mg (used to treat heart conditions), clonidine 0.3 mg (used to treat high blood pressure), fluphenazine 5 mg (antipsychotic), Zoloft 25 mg (used to treat mental disorders), and rivastigmine 3 mg (used to treat dementia). Observation of the 8:00 am medication pass on 06/23/16 at 7:45 am revealed: -The Supervisor/Medication Aide retrieved a white plastic container with lid from the Breakfast muffin tray. -Resident #6 was administered labetalol 200 mg, clonidine 0.3 mg, fluphenazine 5 mg, Zoloft 25 mg, and rivastigmine 3 mg. Observation of the medication storage container revealed: -The container was labeled with Resident #6's name and breakfast.	D 363		

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D 363	Continued From page 8 -A label that listed medications, with the strengths on the label, was affixed to the container. -The container was labeled for medications as follows: labetalol 400 mg, clonidine 0.3 mg, fluphenazine 5 mg, and Zoloft 25 mg. -Rivastigmine 3 mg was not listed on the label of medications contained in the plastic container. Review of Resident #6's June 2016 Medication Administration Record (MAR) revealed: _Labetalol 200 mg take 2 tablets twice a day was listed and scheduled for administration at 8:00 am. -Clonidine 0.3 mg was listed and scheduled for administration at 8:00 am. -Fluphenazine 5 mg 2 tablets=10 mg twice a day was listed and scheduled for administration at 8:00 am. -Zoloft 25 mg was listed and scheduled for administration at 8:00 am. -Rivastigmine 3 mg one capsule daily was listed and scheduled for administration at 8:00 am. Based on observation and record review, Resident #6 received one Rivastigmine 3 mg as ordered but the medication was not listed on the pre-poured medications label for the resident. Interview on 6/23/16 at 2:40 pm with Resident #6 revealed he had no problems with his medications. Refer to interview on 6/23/16 at 8:15 am with the Supervisor/Medication Aide. Refer to interview on 6/23/16 at 3:15 pm with the Lead Medication Aide (LMA). Refer to interview on 06/23/16 at 4:04 pm with the full-time Supervisor/MA.	D 363		

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D 363	Continued From page 9 Refer to interview on 06/23/16 at 4:50 pm with a Co-Administrator. D. Review of Resident #1's current FL-2 dated 01/15/16 revealed: -Diagnoses included diabetes Mellitus Type II, gastroesophageal reflux disease (GERD), schizophrenia-undifferentiated, hypertension, and hyperlipidemia. -Medications ordered included: fish oil 4000 units (vitamin supplement), vitamin B-12 1,000 mcg, vitamin D-3 2,000 units (vitamin supplement), Protonix 40 mg (treats GERD), Diamox 250 mg (treats glaucoma), Paxil 20 mg (treat mental disorders), lithium carbonate extended release 300 mg (treat mental disorders), metformin 1,000 mg (treat diabetes), clozapine 300 mg (treat schizophrenia), and docusate sodium 100 mg (treat constipation). Review of Resident #1's record revealed a physician's order dated 04/21/16 to decrease metformin 1,000 mg twice a day to metformin 500 mg twice a day. Observation of the medication storage containers revealed: -There was a breakfast container for Resident #1. -The container was labeled with the resident's name and the name and dosages of his morning medications. -Review of the label revealed the medications and dosages did not match the current orders. The following discrepancies were identified between the container label and the resident's current orders: - Vitamin B-12 1,000 mcg, and vitamin D-3 2,000 units did not appear on the container label.	D 363		

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D 363	Continued From page 10 -Metformin 1,000 mg appeared on the label and it was changed on 04/21/16 to metformin 500 mg. Interview on 06/23/16 at 1:40 pm with Resident #1 revealed: -He routinely received his medications on time. -He received medications from the pre-poured plastic containers a couple times a week, when the relief Medication Aide was working. -He was aware of most of his medication by the look of the tablet. -He received all of his medications each day, as far as he knew. Refer to interview on 6/23/16 at 8:15 am with the Supervisor/Medication Aide. Refer to interview on 6/23/16 at 3:15 pm with the Lead Medication Aide (LMA). Refer to interview on 06/23/16 at 4:04 pm with the full-time Supervisor/MA. Refer to interview on 06/23/16 at 4:50 pm with a Co-Administrator. Interview on 6/23/16 at 8:15 am with the Supervisor/Medication Aide (MA) revealed: -The full-time Supervisor/MA was scheduled to have one or two day shifts off each week. -She worked once or twice a week from 7:00 am until 7:00 pm. -The full-time Supervisor/MA prepared medications each night to be administered at breakfast, lunch, and supper the next day. -She administered the breakfast, lunch and supper medications from the white plastic containers. -She routinely consulted the MAR for controlled medications, since they were not pre-poured, and	D 363		

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added them to the medications in the plastic containers which had been prepared by the Supervisor.
-She administered the medications to each resident and documented the medications on the residents' MARs.
-She had no way of verifying the medications in the containers and relied on the full-time Supervisor/MA to prepare the correct medications.
-She documented whatever was scheduled on the MAR because she assumed what was scheduled was in the white container.
-The labels on the white containers were supposed to be kept current by the full-time Supervisor/MA.
-The full-time Supervisor/MA should let the Lead Medication Aide (LMA) know which resident needed a label changed and the LMA would generate a corrected label.
-She was not aware of a system for routine audits and correction for the residents' medication containers.

Interview on 6/23/16 at 3:15 pm with the Lead Medication Aide (LMA) revealed:
-The full-time Supervisor/MA was responsible to make handwritten corrections to the labels on the white medication containers used for pre-pouring medications, and to request new labels.
-She was responsible to generate labels for the residents' medication containers used for pre-pouring medications.
-She did not have a system in place to routinely audit the residents' current medications compared to the white containers used to pre-pour residents' medications.
-She depended on the full-time Supervisor/MA to keep the tract of any need corrections and place a request for a label update in the area

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designated for label changes located in the main office.
-She was not aware of any residents who currently needed medication container label changes.

Interview on 06/23/16 at 4:04 pm with the full-time Supervisor/MA revealed:
-She prepared medications for the residents' breakfast, lunch, and dinner the night before the relief MA worked.
-She used the residents' MARs to prepare the medications for the appropriate times.
-She did not prepare any control medications or liquids ahead of time.
-She was certain all the medications prepared were current medications for each resident.
-She had not recently audited the residents' plastic medication containers she used for pre-pouring medications for accuracy of the labels.
-She was aware of the requirement by the facility policy to have pre-poured medications correctly labeled but stated she had not had time recently to get all the labels updated.

Interview on 06/23/16 at 4:50 pm with a Co-Administrator revealed:
-She was not aware residents' white plastic containers to be used in the pre-pouring of medications were not labeled correctly.
-The full-time Supervisor/MAs and other Medication Aide staff had been trained and retrained for the importance of having current labels that were accurate for the medications to be pre-poured.
-She did not have a system in place to routinely audit the residents' MARs compared to the pre-pour containers except a few random audits performed by the LMA.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/PIERCE VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 363	Continued From page 13 -The pre-pour white containers for all of the facility's residents had been corrected by the LMA today when the MA notified the Co-Administrator of the labels not matching.	D 363		