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| D 000 | Initial Comments<br><br>The Adudt Care Licensure Section completed an annual survey on June 13, 2019 and June 14, 2019. | D 000 | | |
| D 131 | 10A NCAC 13F .0406(a) Test For Tuberculosis<br><br>10A NCAC 13F .0406 Test For Tuberculosis<br>(a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to assure 1 of 3 staff (Staff B) sampled had been tested for tuberculosis disease upon hire.<br><br>The findings are:<br><br>Review of Staff B's, medication aide personnel record revealed:<br>-Staff B was hired on 09/03/16.<br>-There was documentation of a TBskin test placed on 06/21/13 and read as 0mm on 06/24/19.<br>-There was documentation of a TB skin test placed on 07/13/15 and read as 0mm on 07/15/19.<br>-There was no additional documentation of a TB skin test in Staff B's personnel record. | D 131 | | |

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| D 131 | Continued From page 1<br>Attempted interview on 06/14/19 at 10:10 am with Staff B was unsuccessful.<br><br>Interview on 06/14/19 at 10:20 am with the Executive Director revealed:<br>-She was responsible for the content and accuracy of personnel records.<br>-She did not know there was no documentation of a completed TB skin test upon hire in Staff B's personnel record.<br>-The lack of TB skin test documentation in Staff B's personnel record had been overlooked.<br>-No one at the facility double-checked the personnel records. | D 131 | | |
| 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>Based on observations, interviews, and record | D 358 | | |

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reviews, the facility failed to assure medications were administered as ordered for 2 of 6 residents (#4 and #5) observed during the 8:00am medication pass on 06/14/19 regarding medication to treat memory loss and aspirin (#4) and blood pressure medication (#5).

The findings are:

The medication error rate was 10% as evidenced by the observation of 3 errors out of 29 opportunities during the 8:00am medication pass on 06/14/19.

1. Review of Resident #4's current FL2 dated 04/04/19 revealed diagnosis included dementia.

a. Review of Resident #4's current FL2 dated 04/04/19 revealed there was an order for donepezil 10 mg (used to treat memory loss) take one-half tablet (5 mg) once daily.

Observation of the 8:00 am medication pass on 06/14/19 revealed:
-At 7:12 am, the morning medication aide (MA) prepared 4 medications for administration to Resident #4.
-The MA removed one donepezil 5 mg tablet from the resident's bottle dispensed by a third party pharmacy; wiped a pill splitter located on the medication cart with an alcohol swab; and split the tablet into 2 equal pieces.
-The MA administered the 4 whole tablets and one of half a tablet (donepezil 2.5mg) to Resident #4.

Review of Resident #4's June 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for donepezil 10 mg one

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one-half tablet (5 mg) once daily scheduled for administration at 8:00 am.
-Donepezil 10 mg one-half tablet was documented as administered daily from 06/01/19 to 06/14/19.

Observation of medication on hand for administration to Resident #4 on 06/14/19 at 11:00 am revealed there was a medication bottle labeled donepezil 5 mg one tablet daily dispensed on 06/04/19 for 90 tablets with 77 whole tablets and 13 half tablets remaining.

Interview on 06/13/19 at 4:00 pm with the Administrator revealed the Executive Director was responsible for the overall operation of the facility and the Supervisor was responsible to assure medications were administered as ordered

Interview with the MA on 06/14/19 at 11:00 am revealed:
-The resident received his medication from a local veteran's pharmacy.
-The pharmacy had sent his medication cut in half previously.
-Resident #4 had recently received a new supply of medication.
-She routinely cut the donepezil tablet in half before administering the medication to Resident #4.
-She did not read the medication bottle to see the pharmacy was sending donepezil 5 mg tablets.
-The Supervisor routinely received residents' medications that were sent to the facility by mail.
-The Supervisor did not inform her Resident #4's donepezil was sent to the facility as 5 mg tablets instead of 10 mg tablets.

Interview with the Supervisor on 06/14/19 at

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11:15 am revealed:
-She did not know the local veterans pharmacy changed Resident #4's donepezil from 10 mg tablet one-half tablet to donepezil 5 mg tablets one tablet daily when the resident received his medication on 06/04/19.
-MAs were supposed to read the information on the resident eMAR and compare the medication name, strength, and directions from the medication container for each medication prior to administering the medication.
-The MA should clarify any discrepancies prior to administering medications.
-She was responsible to receive all medications mailed to the facility from third party (non-contract) pharmacies or medications brought in by family members prior to placing the medications on the medication carts for MAs to administer.
-She overlooked the change in the strength of donepezil sent by Resident #4's pharmacy.
-She would contact the contract pharmacy to correct Resident #4's eMAR to reflect the new strength and alert MAs to give one tablet of donepezil 5 mg as ordered.

Interview with the Executive Director on 06/14/19 at 11:40 am revealed the Supervisor was responsible for reviewing medication on hand, checking medication orders, and auditing medication carts for correct medications to assure residents received medications as ordered.

b. Review of Resident #4's current FL2 dated 04/04/19 revealed there was an order for aspirin 81 mg enteric coated (EC) one tablet daily. (Aspirin is used to thin the blood. Enteric coated tablets are designed to dissolve in the small intestine instead of the stomach to decrease the

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| D 358 | Continued From page 5<br>chance of gastric irritation.)<br><br>Observation of the 8:00 am medication pass on 06/14/19 revealed:<br>-At 7:12 am, the morning medication aide (MA) prepared and administered the 4 whole tablets and one of a half tablet to Resident #4.<br>-Aspirin 81 mg EC was not administered to Resident #4.<br>-Aspirin 81 mg chewable tablet was administered instead of aspirin 81mg EC.<br><br>Review of Resident #4's June 2019 electronic medication administration record (eMAR) revealed:<br>-There was an entry for aspirin 81 mg EC once daily scheduled for administration at 8:00 am.<br>-Aspirin 91 mg EC was documented as administered daily from 06/01/19 to 06/14/19.<br><br>Observation of medication on hand for administration to Resident #4 on 06/14/19 at 11:00 am revealed there was a bottle of aspirin 81 mg chewable dispensed in January 2019 on hand for administration.<br><br>Interview with the Administrator on 06/13/19 at 4:00 pm revealed the Executive Director was responsible for the overall operation of the facility and the Supervisor was responsible to assure medications were administered as ordered<br><br>Interview with the MA on 06/14/19 at 11:00 am revealed:<br>-The resident received his medication from a local veteran's pharmacy.<br>-She did not compare the medication bottle to the eMAR for Resident #4's aspirin 81 mg.<br>-She overlooked the label Resident #4 bottle for aspirin read aspirin 81 mg chew. | D 358 | | |

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| D 358 | Continued From page 6<br>-The Supervisor routinely received residents' medications that were sent to the facility by mail.<br>-The Supervisor did not inform her Resident #4's aspirin 81 mg was chewable instead of enteric coated.<br><br>Interview with the Supervisor on 06/14/19 at 11:15 am revealed:<br>-She did not know the local veterans' pharmacy changed Resident #4's aspirin 81 mg from EC to chewable.<br>-MAs were supposed to read the information on the resident eMAR and compare the medication name, strength, and directions from the medication container for each medication prior to administering the medication.<br>-The MA should inform the Supervisor of any discrepancies prior to administering medications so she could get the orders corrected.<br>-She was responsible to receive all medications mailed to the facility from third party (non-contract) pharmacies or medications brought in by family members prior to placing the medications on the medication carts for MAs to administer.<br>-She overlooked the change in the aspirin for Resident #4.<br><br>Interview with the Executive Director on 06/14/19 at 11:40 am revealed the Supervisor was responsible for reviewing medication on hand, checking medication orders, and auditing medication carts for correct medications to assure residents received medications as ordered.<br><br>2. Review of Resident #5's current FL2 dated revealed:<br>-Diagnoses included schizophrenia and heart problems. | D 358 | | |

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-There was an order for carvedilol 3.125 mg two times a day, after meals. (Carvedilol is used to treat high blood pressure and heart conditions). (Medications ordered after meals should be administered after the resident completed a meal.)

Observation of the 8:00 am medication pass on 06/14/19 revealed:
-At 7:25am, the morning medication aide (MA) prepared 6 medications, including one carvedilol 3.125 mg.
-The MA administered all medications to Resident #5 while he was seated on the bed in his room.

Interview with the MA on 06/14/19 at 7:30 am revealed:
-Resident #5 was dressed for breakfast, but breakfast was not served to the residents until 8:00 am.
-She gave Resident #5 his morning medications before breakfast if the resident was in his room when she made her way down the front hall with the medication cart.
-She administered medications outside the dining room as the residents left the dining room for residents she did not catch in their rooms prior to breakfast.

Observation of Resident #5 on 06/14/19 at 8:10 am revealed the resident was in the dining room eating breakfast.

Review of Resident #5's June 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for carvedilol 3.125 mg twice daily, after meals.
-Carvedilol 3.125 mg was scheduled for administration at 8:00 am and 6:00 pm daily.

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| D 358 | Continued From page 8<br>-Carvedilol 3.125 mg was documented as administered twice daily at 8:00 am and 6:00 pm from 06/01/19 to 06/13/19. Carvedilol was documented as administered at 8:00 am on 06/14/19.<br><br>Observation of medication on hand for administration to Resident #5 on 06/14/19 at 11:00 am revealed:<br>-There was a bingo card of carvedilol 3.125 mg labeled one tablet twice a day after meals.<br>-There were 14 tablets remaining of 25 tablets dispensed on 05/28/19.<br><br>Interview with the morning MA on 06/14/19 at 10:50 am revealed:<br>-She was responsible for administering medications from 2 separate medication carts which included medications for 26 residents during the 8:00 am medication pass.<br>-Medications appeared on the eMAR system one hour before and continued to appear for one hour after the scheduled time of administration.<br>-She focused on administering the medications within the 2 hours allotted time frame..<br>-She was supposed to compare the directions on the eMAR to the directions on the medication label and administer medications according to the directions.<br>-She knew medications ordered after meals should be administered after a resident had eaten.<br>-She overlooked Resident #5's carvedilol 3.125 mg labeled for administration after meals.<br><br>Interview with the Supervisor on 06/14/19 at 11:30 am revealed:<br>-MAs were responsible to administer medications according to the direction listed on the eMAR.<br>-Resident #5's carvedilol should be administered | D 358 | | |

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| D 358 | Continued From page 9<br>after breakfast and dinner.<br>-The morning MA must have overlooked the directions on the bingo card for carvedilol.<br>-She did not have a system for routinely observing medication administration by MAs for auditing. | D 358 | | |