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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on September 15, 2021 - September 16, 2021.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 5 residents (#4, #5, #6) observed during the medication pass including errors with a supplement (#4,); fat soluble vitamin (#6); urinary antispasmodic (#4); histamine 2 blocker, prostatic hypertrophic agent, (#5), bronchodilator, inhaled corticosteroid (#5, #6); and an antiarrhythmic (#6); and 1 of 3 residents (#3) sampled for record review for a supplement and laxative. The findings are: Review of the facility's Medication Policies and Procedures on 09/16/21 revealed: -Medications will be administered in accordance with the prescribing practitioner's orders. -Using the medication administration record (MAR), one at a time check the directions and	D 358		

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strength of each medication against the label on each dose. Perform the check three times.
-Instruct the resident to inhale deeply while depressing the inhaler canister, have resident to hold their breath then exhale slowly, wait 1 minute between each puff, wait 5 minutes between different types of inhalers.
-Rinse mouth with water or as physician orders after the inhalant.

1. The medication error rate was 21% as evidenced by the observation of 9 errors out of 41 opportunities during the 12:00pm medication pass on 09/15/21 and 8:00am medication pass on 09/16/21.

a. Review of Resident #4's current FL-2 dated 09/09/21 revealed:
-Diagnoses included gastric esophageal reflux disease (GERD), liver cirrhosis, spina bifida, neurogenic bladder, and urinary tract infection.
-There was an order for Potassium Chloride 1 tablet daily (a supplement used to treat low amounts of Potassium in the blood).
-The dosage was not documented.
-There was an order for Toviaz Extended Release (ER) 4mg daily (a medication used to treat urinary spasms. ER medications are absorbed in the stomach slowly and released in the bloodstream at a slower even rate . ER medications cannot be crushed or chewed because it releases all the medication at once which increases side effects).

Review of Resident #4's previous physician order sheet dated 08/12/21 revealed there was an order for Potassium Chloride 20 milliequivalent (mEq) ER daily; do not crush.

Review of Resident #4's previous physician's order dated 10/15/20 revealed there was an order

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to crush all medications and administer in food/liquid.

Observation of the 8:00am medication pass on 09/16/21 revealed:
-The Resident Care Coordinator/medication aide (RCC/MA) clicked on Resident #4's electronic medication administration record (eMAR) profile.
-The RCC/MA pulled Resident #4's medications from the medication cart and placed them on top of the cart.
-The RCC/MA looked at the pharmacy label on Resident #4's Potassium Chloride 20mEq ER pill pack and popped the medication into a paper medication cup.
-The RCC/MA crushed Resident #4's Potassium Chloride 20 mEq and mixed the crushed medication in applesauce and other medications.
-The RCC/MA looked at the pharmacy label on Resident #4's Toviaz ER pill pack and popped the medication into a paper medication cup.
-The RCC/MA crushed Resident #4's Toviaz ER and mixed the crushed medication in applesauce with the Potassium Chloride and other medications.
-The RCC/MA fed Resident #4 the applesauce which contained the crushed Potassium Chloride ER and crushed Toviaz ER.
-Resident #4 ate the applesauce with crushed medications.
-The RCC/MA clicked on each of Resident #4's medications that populated on the eMAR during the 8:00am medication pass on 09/16/21.
-The RCC/MA clicked on the administered tab on the eMAR.

Review of Resident #4's September 2021 electronic MAR (eMAR) revealed:
-There was an entry for Potassium Chloride 20mEq 1 tablet daily to be administered at

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8:00am; do not crush.
-Potassium Chloride 20mEq was documented as administered on 09/16/21 at 8:00am.
-There was an entry for Toviaz ER 4mg daily to be administered at 8:00am; do not crush.
-Toviaz ER 4mg was documented as administered on 09/16/21 at 8:00am.

Interview with the RCC/MA on 09/16/21 at 1:15pm revealed:
-She compared the instructions on Resident #4's eMAR to the pharmacy label for Potassium Chloride ER and Toviaz ER which indicated do not crush the medications.
-She crushed Resident #4's Potassium Chloride ER and Toviaz ER because the resident had an order to crush the medications.
-Resident #4 would hold pills in his mouth if the medications were not crushed for administration.
-She always crushed Resident #4's Potassium Chloride ER and Toviaz ER for administration.

Interview with Resident #4's Primary Care Provider (PCP) on 09/16/21 at 10:30am revealed:
-Resident #4 would hold pills in his mouth if not crushed for administration.
-Potassium Chloride ER should not be crushed for administration to Resident #4 because it would taste bad.
-She had no other concerns of crushed Potassium Chloride ER being administered to Resident #4.
-Toviaz ER should not be crushed for administration because of the pharmacokinetics (the way a medication moves through the body).
-She did not know what the outcome to Resident #4 would be for administering crushed Toviaz ER.

Telephone interview with the facility's contracted pharmacist on 09/16/21 at 3:15pm revealed:

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-Potassium Chloride should not be crushed for administration to Resident #4 because it was an ER medication.
-Administering crushed Potassium Chloride ER would cause Resident #4 to absorb all the medication at once instead of slowly over time.
-Administering crushed Potassium Chloride ER to Resident #4 placed the resident at risk for arrhythmia which could cause a heart attack (cardiac muscle damage caused by lack of blood flow).
-Toviaz ER should not be crushed for administration to Resident #4 because it was an ER medication.
-Administering crushed Toviaz ER would cause Resident #4 to absorb all the medication at once instead of slowly over time.
-Toviaz ER was used to treat Resident #4's overactive bladder.
-Administering crushed Toviaz ER to Resident #4 placed the resident at risk for dry mouth and constipation.

Interview with the Administrator on 09/16/21 at 3:55pm revealed she expected the RCC/MA to have followed the instructions documented in Resident #4's eMAR and on the resident's medication pharmacy label.

Interview with Resident #4 on 09/16/21 at 4:30pm revealed his mouth was always dry and he had not experienced constipation.

Refer to interview with the Administrator on 09/16/21 at 3:55pm.

b. Review of Resident #5's current FL-2 dated 10/22/20 revealed there was an order for Flomax 0.4mg one capsule daily 30 minutes after a meal (used to treat an enlarged prostate which can

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obstruct the flow of urine).

Review of Resident #5's physician order sheet dated 08/12/21 revealed there was an order for Flomax 0.4mg 1 capsule daily give 30 minutes after a meal.

Observation of the 8:00am medication pass on 09/16/21 revealed:
-The RCC/MA prepared Resident #5's Flomax for administration.
-At 7:51am the MA administered Resident #5's Flomax to the resident in the common living room.

Review of Resident #5's September 2021 eMAR revealed:
-There was an entry for Flomax 0.4mg one capsule daily give 30 minutes after a meal.
-Flomax was documented as administered on 09/16/21 at 8:00am.

Interview with the MA on 09/16/21 at 1:15pm revealed:
-Breakfast was served to the residents around 8:30am today, 09/16/21.
-She administered Flomax to Resident #5 prior to breakfast because she was nervous.

Interview with Resident #5's PCP on 09/16/21 at 10:30am revealed:
-Resident #5 had benign prostate hypertrophy (BPH) which blocks the flow of urine.
-Flomax was ordered to treat Resident #5's BPH.
-It was possible Flomax was to be administered 30 minutes after a meal to help decrease gastrointestinal (GI) upset.

Based on observations, interviews, and record reviews it was determined Resident #5 was not

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D 358	Continued From page 6 interviewable. Refer to interview with the Administrator on 09/16/21 at 3:55pm. c. Review of Resident #5's physician order sheet dated 08/12/21 revealed there was an order for Pepcid 40mg 1 tablet daily (used to treat and prevent ulcers of the stomach and intestines). Observation of the 8:00am medication pass on 09/16/21 revealed the RCC/MA did not administer Pepcid to Resident #5. Review of Resident #5's September 2021 eMAR revealed: -There was an entry for Pepcid 40mg one tablet daily to be administered at 8:00am. -Pepcid was documented as administered on 09/16/21 at 8:00am. Interview with the RCC/MA on 09/16/21 at 12:00pm revealed: -Resident #5's Pepcid did not populate for administration during the 8:00am medication pass. -She administered Pepcid to Resident #5 during the 9:00am medication pass. Interview with Resident #5's PCP on 09/16/21 at 10:30am revealed: -Pepcid was ordered for Resident #5 to treat gastrointestinal upset such as abdominal pain and belching. -Not administering Pepcid to Resident #5 would cause abdominal pain and belching. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.	D 358		

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D 358	Continued From page 7 Refer to interview with the Administrator on 09/16/21 at 3:55pm. d. Review of Resident #5's physician order sheet dated 08/12/21 revealed there was an order for Trelegy Ellipta 200-62.5-25 inhale 1 puff daily (an inhaled corticosteroid used to treat and prevent wheezing and shortness of breath) with the use of an aero chamber (a plastic tube with a mouthpiece and valve used to control deliver of an inhaled medication into the lungs). Observation of the 8:00am medication pass on 09/16/21 revealed the RCC/MA did not administer Trelegy Ellipta to Resident #5. Review of Resident #5's September 2021 eMAR revealed: -There was an entry for Trelegy Ellipta 200-62.5-25 inhale 1 puff daily with the use of an aero chamber to be administered at 8:00am. -There was documentation Trelegy Ellipta was administered on 09/16/21 at 8:00am. Interview with the RCC/ MA on 09/16/21 at 12:00pm revealed: -Resident #5's Trelegy Ellipta did not populate for administration during the 8:00am medication pass. -She administered Trelegy Ellipta to Resident #5 during the 9:00am medication pass. Interview with Resident #5's PCP on 09/16/21 at 10:30am revealed: -Trelegy Ellipta was ordered to treat Resident #5's COPD. -Resident #5 was always short of breath. -Not administering Ellipta to Resident #5 could cause COPD exacerbation (severe symptoms of	D 358		

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breathlessness requiring emergency treatment).

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.

Refer to interview with the Administrator on 09/16/21 at 3:55pm.

e. Review of Resident #6's current FL-2 dated 05/20/21 revealed:
-Diagnoses included acute diastolic congestive heart failure, atrial fibrillation, and moderate to severe pulmonary hypertension.
-There was an order for Digoxin 0.25mg daily (used to treat heart failure and atrial fibrillation).

Observation of the 8:00am medication pass on 09/16/21 revealed:
-The RCC/MA placed a pulse oximetry device [(SpO2) a device that measures the percent of oxygen in the blood. Some devices will measure the heart rate (HR)] on Resident #6's finger.
-The residents SpO2 was 93% and HR was 82 beats per minute (bpm).
-The RCC/MA documented "93" on a piece of paper. She did not document the HR.
-The RCC/MA clicked on Resident #6's eMAR profile, pulled the residents medications from the medication cart and placed them on top of the cart.
-The RCC/MA looked at the pharmacy label of Resident 6's Digoxin and popped the Digoxin from the pill pack into a white paper cup.
-The RCC/MA was prompted to assess Resident #6's HR prior to administration.
-The RCC/MA administered the Digoxin to Resident #6.
-The RCC/MA assessed Resident #6's HR at 92 bpm.

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D 358	Continued From page 9 -The RCC/MA clicked on Digoxin in Resident #6's eMAR then clicked administered. Review of Resident #6's Digoxin pill pack revealed there was documentation to hold for HR less than 60. Review of Resident #6's September 2021 eMAR revealed: -There was an entry for Digoxin .025mg 1 tablet daily. Hold for HR less than 60 to be administered at 8:00am. -Digoxin was documented as administered on 09/16/21 at 8:00am. -The resident's HR was documented as 92 on 09/16/21 at 8:00am. Interview with the RCC/MA on 09/16/21 at 1:30pm revealed: -She did not assess Resident #6's HR prior to being prompted during the 8:00am medication pass today. -She would normally assess Resident #6's HR prior to administering Digoxin to the resident. Interview with Resident #6's PCP on 09/16/21 at 10:30am revealed: -Resident #6 was hospitalized in May 2021 for heart failure exacerbation. -Heart failure could cause a decrease in HR. -She did not know why Resident #6's HR should be assessed prior to administration of Digoxin. -She recommended cardiology be consulted as to why a HR should be assessed prior to administration of Digoxin. Telephone interview with the facility's contracted pharmacist on 09/15/21 at 3:15pm revealed: -Digoxin could cause a decreased HR and was to be held for a HR <60.	D 358		

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D 358	Continued From page 10 -A heart rate less than 60 could be dangerous. Interview with the Administrator on 09/16/21 at 3:55pm revealed she expected Resident #6's heart rate to have been assessed prior to administering Digoxin as ordered. Refer to interview with the Administrator on 09/16/21 at 3:55pm. f. Review of Resident #6's current FL-2 dated 05/20/21 revealed there was an order for Advair Diskus (an oral steroid used to treat wheezing and shortness of breath. Rinse mouth after use and spit out to prevent fungal infections of the mouth and throat) 1 puff twice daily. Review of Resident #6's previous FL-2 dated 03/04/21 revealed there was an order for Advair Diskus 250/50 1 puff twice daily rinse mouth after use. Review of Resident #6's omission order clarification dated 05/27/21 revealed an order for Advair Diskus 250/50 1 puff twice daily. Observation of the 8:00am medication pass on 09/16/21 revealed: -Resident #6 was sitting in a chair located in the medication room. -The RCC/MA removed Resident #6's Advair Diskus from the medication cart and prepared the dose. -The RCC/MA gave the Advair Diskus to Resident #6 for self-administration. -Resident #6 inhaled the Advair Diskus. -The RCC/MA gave Resident #6 a cup of water. -Resident #6 drank the water as he exited the medication room. -The RCC/MA did not prompt Resident #6 to rinse	D 358		

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his mouth and/or spit out the water.

Review of Resident #6's September 2021 eMAR revealed:
-There was an entry for Advair Diskus 250/50 1 inhalation BID rinse mouth after use to be administered at 8:00am and 8:00pm.
-Advair Diskus was documented as administered on 09/16/21 at 8:00am.

Interview with the RCC/MA on 09/16/21 at 1:15pm revealed:
-She did not have Resident #6 rinse his mouth after administering Advair Diskus.
-She should have prompted Resident #6 to rinse his mouth after administering Advair Diskus to prevent a fungal infection.
-There was no reason why she did not prompt Resident #6 to rinse his mouth after administering Advair Diskus.

Interview with Resident #6's PCP on 09/16/21 at 10:30am revealed:
-She expected the RCC/MA to prompt Resident #6 to rinse his mouth after each administration of Advair Diskus.
-Not rinsing the mouth after administering Advair Diskus could cause mouth sores.

Observation of Resident #6 on 09/16/21 at 8:02 am revealed there were no sores to the resident's mouth or lips.

Refer to interview with the Administrator on 09/16/21 at 3:55pm.

g. Review of Resident #6's current FL-2 dated 05/20/21 revealed there was an order for Albuterol inhale 2 puffs every 6 hours prn wheezing.

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D 358	Continued From page 12 Review of Resident #6's omission order clarification dated 05/27/21 revealed there was an order for Albuterol 2 buffs twice daily. Observation of the 8:00am medication pass on 09/16/21 at 8:00am revealed: -At 8:00am the RCC/MA placed the Albuterol to Resident #6's mouth, pressed the device once, and the resident inhaled. -The RCC/MA removed the Albuterol from Resident #6's mouth and returned the medication to the medication cart drawer. -The RCC/MA clicked on the Albuterol in the eMAR and clicked administrated. Review of Resident #6's September 2021 eMAR revealed: -There was an entry for Albuterol inhale 2 puffs BID for wheezing/shortness of breath to be administered at 8:00am and 8:00pm. -Albuterol was documented as administered on 09/16/21 at 8:00am. Interview with the RCC/MA on 09/16/21 at 1:15pm revealed: -She did not administer 2 individual puffs of Albuterol to Resident #6 during the 09/16/21 8:00am medication pass. She did not know why. -She administered 1 dose of the albuterol inhaler to Resident #6. Interview with Resident #6's PCP on 09/16/21 at 10:30am revealed: -She expected the MA to have administered 2 individual doses of Albuterol to Resident #6. -The MA should have administered 1 dose of Albuterol to Resident #6, had him inhale the medication, wait between doses, then administer the second dose.	D 358		

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D 358	Continued From page 13 Refer to interview with the Administrator on 09/16/21 at 3:55pm. h. Review of Resident #6's physician's order dated 09/02/21 revealed there was an order for Vitamin D3 5000 units daily (a fat-soluble vitamin that helps the body absorb calcium and phosphorus). Observation of the 8:00am medication pass on 09/16/21 revealed Vitamin D3 was not administered to Resident #6. Review of Resident #6's September 2021 eMAR revealed: -There was an entry for Vitamin D3 5000 units daily to be administered at 8:00am. -Vitamin D3 was documented as administered on 09/16/21 at 8:00am. Obsevation of Resident #6's medications on hand on 09/16/21 at 1:02pm revealed the RCC/MA was unable to locate Vitamin D3 for the resident. Interview with the RCC/MA on 09/16/21 at 1:02pm revealed: -She could not locate Vitamin D3 on the medication cart for Resident #6. -She thought she administered Vitamin D3 to Resident #6 during the 8:00am medication pass today. -She documented on Resident #6's eMAR she administered Vitamin D3 to the resident during the 8:00am medication pass today. -Her process for administering medications was to compare the eMAR to the pharmacy label on the pill packs, pop the medication from the pill pack into a medication cup, administer the medications to the resident, click on the	D 358		

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medications that populated on the resident's eMAR, then click administer.

Interview with Resident #6's PCP on 09/16/21 at 10:30am revealed:
-Vitamin D3 was prescribed for the resident to aide in preventing dementia.
-She had no concerns if the resident was not administered Vitamin D3.

Interview with the Administrator on 09/16/21 at 3:55pm revealed:
-The RCC/MA was not to document a medication was administered if it was not.
-The RCC/MA was responsible for faxing medication orders to the pharmacy, copy the order, place the original in the resident's record and place a copy in a folder until pharmacy entered the order in the eMAR and delivered the medication.
-The RCC/MA receiving the medication would compare the order to the eMAR and to the pharmacy label on the received medication then shred the order copy.
-She would do random cart audits comparing the orders in the resident's record to the medication on the medication cart and in the eMAR.
-She last performed a random cart audit 2 - 3 weeks ago.

Refer to interview with the Administrator on 09/16/21 at 3:55pm.

2. Review of Resident #3's current FL-2 dated 03/04/21 revealed diagnoses included: Alzheimer's disease, dementia, bradycardia, generalized weakness, gastroesophageal reflux disease (GERD), hypertension (HTN), hypothyroidism and urinary tract infection (UTI).

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D 358	Continued From page 15 a. There was an order for Vitamin D3 25mcg 2 tablets once a day. (Vitamin D3 is a supplement that helps with calcium absorption.) Observation of Resident #3's medications on hand on 09/16/21 at 10:50am revealed there was an over the counter bottle of Vitamin D3 125mcg in the medication cart labeled with the resident's name with no administration directions. Review of Resident #3's July 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D3 25mcg 2 tablets once a day scheduled at 8:00am. -Vitamin D3 was documented as administered from 07/01/21 - 07/31/21. Review of Resident #3's August 2021 eMAR revealed: -There was an entry for Vitamin D3 25mcg 2 tablets once a day scheduled at 8:00am. -Vitamin D3 was documented as administered from 08/01/21 - 08/31/21. Review of Resident #3's September 2021 eMAR revealed: -There was an entry for Vitamin D3 25mcg 2 tablets once a day scheduled at 8:00am. -Vitamin D3 was documented as administered from 09/01/21 - 09/15/21. Interview with the Resident Care Coordinator/medication aide (RCC/MA) on 09/16/21 at 10:50am revealed: -The Vitamin D3 belonged to Resident #3 and was supplied by the family. -She was not aware that the over the counter Vitamin D3 on hand did not match the orders on Resident #3's eMAR.	D 358		

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D 358	Continued From page 16 Interview with the Administrator on 09/16/21 at 12:10pm revealed: -It was the responsibility of the MA to ensure that medications supplied by the family matched the resident's eMAR. -It was the responsibility of the MA to notify the resident's primary care provider (PCP) for order clarification. Telephone interview with Resident #3's primary care provider (PCP) on 09/16/21 at 4:30pm revealed: -Resident #3's family supplied the resident's over-the-counter (OTC) medications. -She was not aware that the family supplied Vitamin D3 125mcg instead of the ordered Vitamin D3 25mcg. Based on observations, record review, and interviews it was determined that Resident #3 was not interviewable. Refer to interview with the Administrator on 09/16/21 at 3:55pm. b. Review of Resident #3's physician's orders dated 08/12/21 revealed there was an order for Senna-Plus 8.6-50mg 1 tablet twice a day. (Senna-Plus is a combination of laxative and stool softener used to treat constipation.) Observation of Resident #3's medications on hand on 09/16/21 at 10:50am revealed there was a bottle of Senna 8.6mg in the medication cart that was not labeled with the resident's name. Review of Resident #3's July 2021 electronic medication administration record (eMAR) revealed:	D 358		

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-There was an entry for Senna-Plus 8.6-50mg 1 tablet twice a day scheduled at 9:00am and 9:00pm.
-Senna-Plus was documented as administered from 07/01/21 - 07/31/21.

Review of Resident #3's August 2021 eMAR revealed:
-There was an entry for Senna-Plus 8.6-50mg 1 tablet twice a day scheduled at 9:00am and 9:00pm.
-Senna-Plus was documented as administered from 08/01/21 - 08/31/21.

Review of Resident #3's September 2021 eMAR revealed:
-There was an entry for Senna-Plus 8.6-50mg 1 tablet twice a day scheduled at 9:00am and 9:00pm.
-Senna-Plus was documented as administered from 09/01/21 - 09/15/21.

Interview with the Resident Care Coordinator/medication aide (RCC/MA) on 09/16/21 at 10:50am revealed:
-The Senna belonged to Resident #3 and was supplied by the family.
-She was not aware that the Senna on hand did not match the orders on Resident #3's eMAR.
-She was not aware of Resident #3 having any constipation or diarrhea.

Telephone interview with Resident #3's primary care provider (PCP) on 09/16/21 at 4:30pm revealed:
-Resident #3's family supplied the resident's over-the-counter (OTC) medications.
-She was not aware that the family supplied Senna instead of Senna-Plus.
-Resident #3 had no complaints of diarrhea or

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D 358	Continued From page 18 constipation. Interview with the Administrator on 09/16/21 at 12:10pm revealed: -It was the responsibility of the MA to ensure that medications supplied by the family matched the resident's eMAR. -It was the responsibility of the MA to notify the resident's PCP for order clarification. Based on observations, record review, and interviews it was determined that Resident #3 was not interviewable. Refer to interview with the Administrator on 09/16/21 at 3:55pm. _____ Interview with the Administrator on 09/16/21 at 3:55pm revealed: -She expected all medications to be administered per physician's order. -She expected the MA to click on the resident's individual medication in the eMAR, compare the medication information on the eMAR to the pharmacy label on the medication to be sure they match, place the medication in the medication cup, repeat the process until all scheduled medications were compared and prepared, administer the medications to the resident, then click administered on the eMAR.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent	D 371		

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cross-contamination and provide a safe and sanitary environment for staff and residents.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews the facility failed to ensure infection control measures were implemented during the morning medication pass on 09/16/21 by the Resident Care Coordinator/medication aide observed who failed to wash or sanitizer her hands and/or wear gloves prior to preparing and after administering medications and inhalants to four residents.

The findings are:

Review of the facility's Medication Policies and Procedures revealed:
-Facility staff will administer medications in accordance with infection control measures.
-Wash hands or use appropriate hand cleaner before and after administering oral inhalants.

Observation of the medication cart on 09/16/21 at 7:35am revealed:
-There was a bottle of hand sanitizer on the cart.
-There were gloves available.

Observation of the Resident Care Coordinator/medication aide (RCC/MA) during the 8:00am medication pass on 09/16/21 revealed:
-At 7:30am, she removed Albuterol and an aero chamber from the medication cart, placed the Albuterol in the aero chamber, walked in the common living room, and placed the aero chamber in a resident's mouth.
-The resident pursed his lips around the

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mouthpiece of the aero chamber and inhaled.
-The RCC/MA removed the Albuterol and aero chamber from the resident's mouth, returned to the medication room, and placed the Albuterol while still in the aero chamber on top of the medication cart.
-She did not wear gloves during the administration.
-She did not wash her hands or use hand sanitizer after the administration.
-She touched the keyboard, the medication cart, opened the bottom drawer of the medication cart and removed another resident's bubble pack of medications.
-At 7:48am, she popped 15 medications from the bubble packs for the second resident, crushed 2 of the medications and mixed them in applesauce, separated a capsule and sprinkled the granules in the applesauce, and fed the second resident the crushed medications in the applesauce.
-She did not wear gloves or perform hand hygiene before or after administering the second resident's medications.
-She did not wear gloves when she separated the capsule and sprinkled the granules in the applesauce.
-At 7:51am, she removed a bubble pack from the medication cart, popped 1 medication from a bubble pack and administered to the first resident.
-She did not perform hand hygiene before or after administering the first resident's medication.
-At 8:00am, she popped 14 medications from the bubble packs and administered to a third resident.
-She removed an oral inhalant and placed to the third resident's mouth for administration.
-Her fingers touched the resident's bottom lip while she pressed the inhalant to administer the

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dose and the resident inhaled.
-She removed the inhalant, returned it to the medication cart, and removed another oral inhalant for the third resident.
-She primed the oral inhalant and gave it to the third resident to administer.
-She took the oral inhalant from the third resident and returned it to the medication cart.
-She did not wear gloves or perform hand hygiene before or after administering the third resident's medications.
-She removed a nasal inhalant and provided to a fourth resident for self-administration.
-The resident removed the cap, placed the inhalant in her nose, administered the medication, capped the inhalant, and returned it to the RCC/MA.
-The RCC/MA took the nasal inhalant from the resident and returned the inhalant to the medication cart.
-She did not perform hand hygiene before or after administration.

Observation of the first resident's mouth on 09/16/21 at 7:30am revealed :
-There were pale yellow to cream colored scabs over the resident's top and bottom lips.
-The corners of the resident's mouth were red and swollen.

Interview with the first resident's Primary Care Provider (PCP) on 09/16/21 at 10:30am revealed:
-The sores on the resident's lips were because of chapped lips.
-She expected hand sanitizer to be used between resident medication pass.
-She did not expect the RCC/MA to wear gloves when administering oral inhalants if she sanitized between residents.
-She did not respond when asked her

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expectations when the RCC/MA did not sanitize between residents when administering oral inhalants.

Review of the first resident's current FL-2 dated 10/22/20 revealed diagnoses included human papillomavirus (HPV) infection (a group of viruses that infects the skin or moist areas of the body transmitted through direct contact which could lead to oral and respiratory lesions).

Interview with the RCC/MA on 09/16/21 at 1:25pm revealed:
-She should sanitize her hands before and after each resident medication administration to prevent the spread of germs.
- She did not know why she did not sanitize or wash her hands before and after each resident medication pass during the 09/16/21 8:00am medication pass observation.
-She should wear gloves when administering breathing treatments to decrease the spread of germs to residents.
-She did not know why she did not wear gloves when administering breathing treatments to two residents during the 09/16/21 8:00am medication pass.
-Normally she would wear gloves when administering breathing treatments and perform hand hygiene before and after each resident medication pass.
-Facility Infection Control classes were provided yearly by the Licensed Health Professional Support (LHPS) nurse.
-She received an Infection Control class provided by the facility but did not remember the date or the year.

Interview with the Administrator on 09/16/21 at 9:30am revealed:

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D 371	Continued From page 23 -Hand sanitizer and gloves were on the medication cart and to be used before and after each resident medication administration to prevent cross contamination of germs and infections. -There were no residents who resided in the facility who had communicable disease. -There were no residents who resided in the facility who had mouth sores. -She expected gloves to be worn when administering oral inhalants to prevent cross contamination and infection. -The last Infection Control class was provided in January 2021. -She did random medication pass observations monthly to ensure staff were following infection control guidelines. -The last infection control observation was 09/14/21. There were no concerns. Telephone interview with the LHPS nurse on 09/16/21 at 3:40pm revealed: -She last provided an Infection Control class for facility staff around June 2021. -She had not performed MA skills validations since taking over the LHPS role because the MA's employed were already validated by the previous LHPS nurse. -She expected MAs to sanitize their hands before beginning and after performing a medication pass to decrease cross contamination between residents. -MAs were expected to wear gloves when administering oral inhalants to decrease cross contamination and exposure to mucus membranes, open sores, and blood. _____ The facility failed to ensure infection control measures were implemented during the 8:00am medication pass on 09/16/21 when the RCC/MA	D 371		

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D 371	Continued From page 24 observed failed to wash or sanitize her hands prior to preparing and after administering oral and nasal inhalants and oral medications to multiple residents and failed to wear gloves when administering oral inhalants to 2 residents. Her fingers touched the lips of a resident and she was exposed to another resident who had sores on the upper and bottom lips when administering an oral inhalant. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 16, 2021 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 31, 2021.	D 371		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records that accurately reconciled the receipt, disposition, and administration of controlled substances for 3 of 3 sampled	D 392		

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residents (#2, #3, #4) related to pain medications.

The findings are:

1. Review of Resident #4's current FL-2 dated 09/09/21 revealed:
-Diagnoses included chronic back pain, liver cirrhosis, spina bifida, neurogenic bladder, and urinary tract infection.
-There was an order for Morphine Sulfate 15mg/0.75ml (used to treat sever pain) orally every 6 hours (hrs.).

Observation of Resident #4's medications on hand on 09/15/21 at 2:45pm revealed there were 81 prefilled syringes of Morphine Sulfate 15mg/0.75ml.

Review of the pharmacy label for Resident #4's Morphine on 09/16/21 revealed on 09/09/21, the pharmacy dispensed 67.5 milliliters (ml) of Morphine Sulfate (90 prefilled syringes of 0.75ml) to administer every 6 hrs.

Review of Resident #4's September 2021 electronic medication record (eMAR) revealed:
-There was an entry for Morphine Sulfate 20mg/ml concentrate give 1 prefilled syringe (0.75ml = 15mg) every 6 hrs.
-The first dose of Morphine was administered on 09/13/21 at 12:00pm.
-There were 9 doses administered from 09/13/21 at 12:00pm - 09/15/21 at 12:00pm.
-There was a total of Morphine 6.75ml administered to Resident #4 from 09/13/21 at 12:00pm - 09/15/21 at 12:00pm.

Review of Resident #5's Morphine Sulfate controlled substance (CS) log for September 2021 revealed:

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-Morphine 0.75ml was documented as administered on 09/13/21 at 12:00pm and 6:00pm.
-Morphine 0.75ml was documented as administered on 09/14/21 at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-Morphine 0.75ml was documented as administered on 09/15/21 at 12:00am, 6:00am, and 12:00pm.
-The remaining control substance count started with 66 with a remaining count of 58.
-The CS log did not match the total number of prefilled Morphine syringes or ml remaining.
-The CS log should show a remaining balance of 60.75ml or 81 prefilled syringes.

Interview with the Resident Care Coordinator/medication aide (RCC/MA) on 09/15/21 at 2:50pm revealed:
-She began the CS log for Resident #4's Morphine Sulfate on 09/13/21.
-She thought the 67.5 documented on the pharmacy label was the number of prefilled syringes delivered for Resident #4.
-She did not count the prefilled syringes prior to administering the first dose of Morphine to Resident #4.
-She would deduct each syringe from the documented remaining amount with each administration to Resident #4.

Refer to interview with the Administrator on 09/16/21.

2. Review of Resident #3's current FL-2 dated 03/04/21 revealed:
-Diagnoses included: Alzheimer's Disease, dementia, bradycardia, generalized weakness, gastroesophageal reflux disease (GERD), hypertension (HTN), hypothyroidism and urinary

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tract infection (UTI).
-There was an order for Ultram 50mg administer ½ tablet twice a day. (Ultram is a narcotic medication used to treat moderate to severe pain.)

Observation of Resident #3's medications on hand on 09/16/21 at 10:50am revealed:
-The pharmacy dispensed 30 whole tablets of Ultram 50mg on 08/29/21.
-The 30 whole tablets of Ultram 50mg tablets were split in half tablets.
-There were #30 ½ tablets of Ultram (15 whole tablets) that remained from the #60 ½ tablets of Ultram (30 whole tablets) that were dispensed on 08/29/21.

Review of Resident #3's control substance (CS) log for Ultram on 09/16/21 at 10:50am revealed:
-There was documentation on 09/15/21 at 9:00pm where ½ tablet of Ultram was documented as administered and 14½ tablets remained.
-There was documentation on 09/16/21 at 9:00am where 1 tablet of Ultram was documented as administered and 19 tablets remained.

Review of Resident #3's July 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Ultram 50mg administer ½ tablet twice a day scheduled at 9:00am and 9:00pm.
-Ultram was documented as administered from 07/01/21 - 07/31/21.

Review of Resident #3's August 2021 eMAR revealed:
-There was an entry for Ultram 50mg administer

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D 392	Continued From page 28 ½ tablet twice a day scheduled at 9:00am and 9:00pm. -Ultram was documented as administered from 08/01/21 - 08/31/21. Review of Resident #3's September 2021 eMAR revealed: -There was an entry for Ultram 50mg administer ½ tablet twice a day scheduled at 9:00am and 9:00pm. -Ultram was documented as administered from 09/01/21 - 09/15/21. Based on observations, record reviews, and interviews it was determined that Resident #3 was not interviewable. Interview with the Resident Care Coordinator/medication aide (RCC/MA) on 09/16/21 at 10:50am revealed: -The MAs counted narcotics on the medication cart at the change of each shift. -She counted the narcotics with another MA at the start of her shift on 09/16/21. -She incorrectly documented the amount of Ultram remaining on Resident #3's CS log on 09/16/21. Refer to interview with the Administrator on 09/16/21 at 12:10pm. 3. Review of Resident #2's current FL-2 dated 04/15/21 revealed diagnoses included amyotrophic lateral sclerosis (ALS), bipolar disorder, and dementia. Review of Resident #2's physicians order dated 08/29/21 revealed there was an order for Lorcet 5/325 every 6 hours as needed for pain (used to relieve moderate to severe pain).	D 392		

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D 392	Continued From page 29 Review of Resident #2's medication on hand on 09/16/21 for Lorcet 5/325 revealed: -On 08/29/21 there were 30 tablets dispensed. -There were 16 tablets remaining. -There was documentation to administer 1 tablet every 6 hours as needed for pain. Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Lorcet 5/325 one tablet every 6 hours as needed for pain. -Lorcet was documented administered on 08/30/21 at 10:51am, 4:45pm, and 11:35pm. -Lorcet was documented administered on 08/31/21 at 5:36pm and 11:10pm. -Lorcet was documented administered 5 times for the month of August 2021. Review of Resident #2's September 2021 eMAR revealed: -There was an entry for Lorcet 5/325 one tablet every 6 hours as needed for pain. -Lorcet was documented as administered on 09/02/21 at 9:14am. -Lorcet was documented as administered on 09/03/21 at 8:58am, 5:42pm, and 11:35pm. -Lorcet was documented as administered on 09/04/21 at 3:19pm. -Lorcet was documented as administered on 09/12/21 at 12:06am. -Lorcet was documented as administered on 09/15/21 at 9:07am. -Lorcet was documented as administered 7 times for the month of September 2021. Review of Resident #2's Lorcet 5/325 controlled substance (CS) log on 09/16/21 revealed: -Lorcet was documented administered on	D 392		

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08/30/21 at 11:36. There was no am or pm documented.
-Lorcet was documented administered on 08/31/21 at 7:00 and 5:30 (there was no am or pm documented) and at 11:30pm.
-Lorcet was documented administered on 09/01/21 at 6:00pm.
-Lorcet was documented administered on 09/02/21 at 9:15 (there was no am or pm documented).
-Lorcet was documented administered on 09/03/21 at 9:00am, 5:30 (there was no am or pm documented) and 11:30pm.
-Lorcet was documented administered on 09/04/21 at 1:30 (there was no am or pm documented) and 7:30pm.
-Lorcet was documented administered on 09/12/21 at 12:00pm.
-Lorcet was documented administered on 09/15/21 at 9:00am.
-Lorcet was documented administered 4 times in August 2021.
-Lorcet was documented administered 9 times for the month of September 2021.
-The CS log did not match the dates and times of administration documented on the residents August 2021 eMAR.
-The CS log did not match the dates and times of administration documented on the residents September 2021 eMAR.

Interview with the Resident Care Coordinator/medication aide (RCC/MA) on 09/16/21 at 1:25pm revealed:
-Her signature was documented on Resident #2's Lorcet CS log for the dates 08/31/21, 09/03/21, 09/04/21, 09/12/21, and 09/15/21.
-She did not remember administering Resident #2 Lorcet in August 2021.
-She did not remember administering Resident

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D 392	Continued From page 31 #2 Lorcet in September 2021. -She did not know why Resident #2's eMAR did not match the Lorcet CS log for August 2021 or September 2021. -She would administer CSs, document administered in the eMAR, then document on the CS log. Interview with the Administrator on 09/16/21 at 1:50pm revealed: -She did not know why the dates Lorcet was documented on Resident #2's eMAR as administered did not match the dates documented on the CS log. -There was no reason the documented dates and times of administration in the eMARs should not match the CS log. -She expected the MA who administered the CS to document on the CS log. Refer to interview with the Administrator on 09/16/21 at 12:10pm. _____ Interview with the Administrator on 09/16/21 at 12:10pm revealed: -It was the responsibility of the MAs to count all narcotics on the medication cart at the change of each shift. -It was the responsibility of the MAs to notify the Administrator and the primary care provider (PCP) of incorrect narcotic counts.	D 392		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and	D912		

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D912	Continued From page 32 regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration. The findings are: Based on observations, interviews, and record reviews the facility failed to ensure infection control measures were implemented during the morning medication pass on 09/16/21 by the Resident Care Coordinator/medication aide observed who failed to wash or sanitizer her hands and/or wear gloves prior to preparing and after administering medications and inhalants to four residents. . [Refer to Tag 371, 10A NCAC 13F .1004(n) Medication Administration (Type B Violation)].	D912		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening	D992		

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procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 1 of 2 sampled staff (B) prior to hire.

The findings are:

Review of Staff B's medication aide (MA) personnel record revealed:
-Staff B was hired 05/23/18.
-There was no documentation Staff B completed the examination and screening for the presence of controlled substances.

Interview with the Administrator on 09/16/21 at

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D992	Continued From page 34 1:29pm revealed: -The new staff signed a consent form for drug testing upon hire, but the drug screens were not done. -She completed drug testing for employees randomly and as needed. -She was not aware of the state regulations related to drug testing new employees.	D992		