STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CARTERET LANDING	221 FRIENDLY ROAD MOREHEAD CITY, NC 28557

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D 000	Initial Comments The Adult Care Licensure Section and the Carteret County Department of Social Services conducted an annual survey on October 19, 2021 to October 21, 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 for 2 of 3 residents (#6, #7) observed during the medication passes including errors leaving a medication at the bedside unsupervised (#6) and the administration of a nasal spray and inhaler (#7); and for 1 of 5 sampled residents (#1) for record review including errors with a blood pressure medication and an antibiotic eye drop (#1). The findings are: 1.The medication error rate was 9% as evidenced by the observation of 3 errors out of 32 opportunities during the 8:00am medication pass on 10/20/21. a.Review of Resident #6's current FL-2 dated 12/08/21 revealed:	D 358		

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D 358	Continued From page 1 -Diagnoses included essential tremor, muscle weakness (generalized), dysphagia, unsteadiness on feet, and lack of coordination. -The resident was intermittently disoriented, semi-ambulatory, and had wandering behaviors. -There was an order for Miralax 17 grams (used to treat constipation), give once daily mixed in 8 ounces of water. Review of a physician's progress note for Resident #6 dated 12/29/20 revealed she had been prescribed Miralax 17 grams to treat constipation. Interview with Resident #6 on 10/20/21 at 7:46am revealed: -She had a bowel movement sometime earlier that morning (10/20/21) or late last evening (10/19/21). -She sometimes struggled with constipation. Observation of a medication aide (MA) on 10/20/21 at 7:46am revealed: -The MA prepared and administered Resident #6's morning pills allowing the resident to swallow the pills using a small sip of the prepared Miralax. -Resident #6 handed the Miralax back to the MA after swallowing her pills. -The MA left the Miralax on the bedside table near the resident on a beverage coaster. -The MA did not encourage Resident #6 to finish the Miralax. -The MA left the room and continued to administer other residents' medications leaving Resident #6 unsupervised with the unfinished Miralax. Review of Resident #6's October 2021 electronic medication administration record (eMAR) revealed:	D 358		

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D 358	Continued From page 2 -There was an entry for Miralax 17gm, give with 8 ounces of water each day. -The Miralax 17gm was documented as administered on 10/20/21. Interview with the MA on 10/20/21 at 7:51am revealed: -She normally left Resident #6's Miralax at her bedside because she would not drink the whole cup at once. -She normally went back about one-and one-half hours after administration of Resident #6's Miralax to make sure she drank it all. Second interview with the MA on 10/20/21 at 11:35am revealed: -She was not supposed to leave medications unsupervised at a resident's bedside. -She was to observe resident's swallow their medications before leaving the room to ensure they received the full dose as ordered and no one else consumed the medication. -She normally left Resident #6's Miralax at her bedside because she trusted the resident to take it appropriately. -She checked on Resident #6 about one hour after the administration of her Miralax this morning, 10/20/21, and the cup was empty, and the resident stated she drank it. Interview with the Health and Wellness Director (HWD) on 10/20/21 at 11:36am revealed: -MAs were expected to follow the 6 rights of medications administration (right resident, medication, time, dose, route, and documentation) to administered medications accurately. -MAs were expected to observe residents take their medications before leaving the room. -MAs were not permitted to leave medications at	D 358		

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the bedside for residents to take later.
-MAs were usually good at following this rule except for the administration of Miralax and Metamucil.
-The MA should have encouraged Resident #6 to drink all her Miralax before walking out of the room.

Interview with the Resident Care Coordinator (RCC) on 10/21/21 at 11:02am revealed:
-MAs were expected to administer medication using the 6 rights and compare the label instructions to the eMAR order three times before administration.
-She expected MAs to administer medications accurately and safely to residents.
-She expected MAs to observe a resident completely take a medication prior to walking out of the resident's rooms and not leave medication at the bedside.

Interview with the Administrator on 10/21/21 at 11:06am revealed:
-MAs were expected to administer medication using the 6 rights and compare the label instructions to the eMAR order three times before administration.
-He expected MAs to administer medications accurately and safely to residents.
-He expected MAs to observe a resident completely take a medication prior to walking out of the resident's rooms and not leave medication at the bedside.

Interview with Resident #6's Primary Care Provider (PCP) on 10/21/21 at 10:30am revealed:
-She expected the facility MAs to administer medications according to the 6 rights in an accurate and safe manner.
-She expected medications to be administered as

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ordered and the instructions verified against the original order.
-She expected the MAs to observe residents take their medication prior to leaving the room because most residents in the facility had cognitive impairment; and to ensure the full dose of the medication was taken by the resident as prescribed, and that no one else took the medication.

b. Review of Resident #7's current FL-2 dated 05/11/21 revealed:
-Diagnoses included hypothyroidism.
-There was an order for Albuterol inhaler (used to prevent or treat spasm of the airway), inhale 2 puffs twice daily.
-There was an order for Breo Ellipta inhaler (used to treat chronic obstructive pulmonary disease (COPD) and asthma), inhale 1 puff daily, rinse mouth after use.

Review of a physician's progress note for Resident #7 dated 07/06/21 revealed:
-The resident was diagnosed with chronic obstructive pulmonary disease (COPD).
-The resident was to continue taking the Albuterol and Breo Ellipta inhaler as prescribed to treat the COPD.

Observation of a medication aide (MA) on 10/20/21 from 9:03am-9:04am revealed:
-The MA provided Resident #7 a cup of water and an empty cup prior to the administration of his inhalers.
-The MA then administered Resident #7's Albuterol at 9:03am.
-Resident #7 rinsed his mouth with water and spit into the empty cup without prompting after taking the Albuterol.
-The MA then administered Resident #7's Breo

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D 358	Continued From page 5 Ellipta inhaler at 9:04am. -Resident #7 did not rinse his mouth with water and the MA did not prompt him to do so after taking the Breo Ellipta. -Resident #7 handed the water and empty cup back to the MA and the MA then left the room. Review of Resident #7's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Albuterol, inhale 2 puffs twice daily. -There were no instructions for the resident to rinse his mouth after using the Albuterol. -The Albuterol was documented as administered on 10/20/21. -There was an entry for Breo Ellipta, inhale 1 puff daily, rinse mouth after use. -The Breo Ellipta was documented as administered on 10/20/21. Interview with Resident #7 on 10/20/21 at 11:08am revealed he did not want to be interviewed. Interview with the MA on 10/20/21 at 11:09am revealed: -She was expected to administer medications to residents per the six medication rights (right resident, medication, time, dose, route, and documentation). -She was expected to ensure accurate administration of medications by comparing the medication label to the order in the eMAR three times prior to administering a medication. -She did not realize the medication label on the Breo Ellipta said to rinse after using. -Resident #7 normally rinsed his mouth after the use of both of his inhalers and she did not usually have to prompt him to do so.	D 358		

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-She was unsure why it was important for residents to rinse their mouth after using Breo Ellipta.
-She was nervous during the medication pass observation and should have slowed down and read the medication labels more closely to administer the Breo Ellipta accurately by having the resident rinse his mouth after use.

Interview with the Health and Wellness Director (HWD) on 10/20/21 at 11:36am revealed:
-MAs were expected to follow the 6 rights of medications administration to administered medications accurately.
-Directions for administering Resident #7's inhaler were on the medication label and on the order in the eMAR.
-The MAs are expected to compare the instructions on a medication label to the instructions on the order in the eMAR three times before administering the medication to a resident.
-She expected MAs to read and follow directions when administering medications to ensure accuracy.

Interview with the Resident Care Coordinator (RCC) on 10/21/21 at 11:02am revealed:
-MAs were expected to administer medication using the 6 rights and compare the label instructions to the eMAR order three times before administration.
-She expected MAs to administer medications accurately and safely to residents.
-She expected the MA to prompt Resident #7 to rinse his mouth after taking his Breo Ellipta as ordered.

Interview with the Administrator on 10/21/21 at 11:06am revealed:
-MAs were expected to administer medication

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using the 6 rights and compare the label instructions to the eMAR order three times before administration.
-He expected MAs to administer medications accurately and safely to residents.
-He expected the MA to prompt Resident #7 to rinse his mouth after taking his Breo Ellipta as ordered.

Interview with Resident #7's Primary Care Provider (PCP) on 10/21/21 at 10:30am revealed:
-She expected the facility MAs to administer medications according to the 6 rights in an accurate and safe manner.
-She expected medications to be administered as ordered and to verify the instructions on the medication label against the original order prior to administration.
-It was concerning to her that Resident #7's Breo Ellipta had not been administered correctly because she had personally witnessed a medication error with another resident just two weeks prior.
-It was important for the MAs to take their time to follow an order correctly when administering medications.
-She expected the MA to prompt the Resident #7 to rinse his mouth after using Breo Ellipta.
-It was important for Resident #7's to rinse his mouth after using his Breo Ellipta to prevent thrush (yeast) and mouth irritation.

c. Review of Resident #7's current FL-2 dated 05/11/21 revealed:
-Diagnoses included hypothyroidism.
-There was an order for Flonase nasal spray 50mcg (used to treat symptoms of hay fever or allergies), inhale 2 sprays in each nostril every day.

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D 358	Continued From page 8 Observation of a medication aide (MA) on 10/20/21 at 9:04am revealed: -The MA administered 1 spray of Flonase nasal spray in each nostril to Resident #7 at 9:04am. -The MA then left Resident #7's room. -Review of Resident #7's October electronic medication administration record (eMAR) revealed: -There was an entry for Flonase 50mcg, inhale 2 puffs in each nostril daily. -Flonase 50mcg was documented as administered as ordered on 10/20/21. Interview with Resident #7 on 10/20/21 at 11:08am revealed he did not want to be interviewed. Interview with the MA on 10/20/21 at 11:09am revealed: -She did not give 2 sprays in each nostril of Flonase to Resident #7 that morning, 10/20/21, because she was nervous during the observation of the medication pass. -She normally administered Resident #7's Flonase with two sprays each time she administered it. -She should have slowed down and read the medication labels more closely to administer the Flonase accurately. Interview with the Health and Wellness Director (HWD) on 10/20/21 at 11:36am revealed: -MAs were expected to follow the 6 rights of medications administration (right resident, medication, time, dose, route, and documentation) to administered medications accurately. -Directions for administering Resident #7's nasal spray were on the medication label and the order	D 358		

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in the eMAR.
-The MAs were expected to compare the instructions on a medication label to the instructions on the order in the eMAR three times before administering a medication to a resident.
-She expected MAs to read and follow directions when administering medications to ensure accuracy.

Interview with the Resident Care Coordinator (RCC) on 10/21/21 at 11:02am revealed:
-MAs were expected to administer medication using the 6 rights and compare the label instructions to the eMAR order three times before administration.
-She expected MAs to administer medications accurately and safely to residents.

Interview with the Administrator on 10/21/21 at 11:06am revealed:
-MAs were expected to administer medication using the 6 rights and compare the label instructions to the eMAR order three times before administration.
-He expected MAs to administer medications accurately and safely to residents.

Interview with Resident #7's Primary Care Provider (PCP) on 10/21/21 at 10:30am revealed:
-She expected the facility MAs to administer medications according to the 6 rights in an accurate and safe manner.
-She expected medications to be administered as ordered and the instructions on the medication label verified against the original order prior to administering medications.
-It was concerning to her that Resident #7's Flonase had not been administered correctly because she had personally witnessed a medication error with another resident just two

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weeks prior.
-It was important for the MAs to take their time to follow an order correctly when administering medications.

2. Review of Resident #1's current FL-2 dated 05/14/21 revealed diagnoses included history of a cerebral vascular accident (CVA), anxiety, and impaired cognition.

a.Review of Resident #1's current FL-2 dated 05/14/21 revealed an order for Midodrine 2.5mg (used to increase low blood pressure), give one tablet three times daily.

Review of a physician's order for Resident #1 dated 05/21/21 and 10/08/21 revealed an order for Midodrine 5mg, give three times daily.

Review of a physician's order for Resident #1 dated 10/15/21 revealed an order for Midodrine 10mg, give three times daily.

Review of Resident #1's October 2021 electronic medication administration record (eMAR) on 10/19/21 revealed:
-There was an entry for Midodrine 5mg, give one tablet three times daily.
-The Midodrine 5mg was administered daily 10/01/21-10/19/21.
-There was no entry or documentation of administration of Midodrine 10mg beginning 10/15/21 as ordered.

Observation of Resident #1's medications on hand on 10/20/21 at 11:20am revealed there was no Midodrine 10mg available to the resident.

Interview with the Health and Wellness Director (HWD) on 10/20/21 at 11:36am revealed:

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D 358	Continued From page 11 -She did not know why the Midodrine 10mg order was not active and implemented on Resident #1's eMAR as of 10/15/21, but she would research it and find out. -It was her or the MA's responsibility to process new orders for residents when received. -Processing an order for a medication entailed faxing a signed order to the pharmacy, ensuring the fax was received by the pharmacy, then placing a copy of the order in the MAs new order notebook. -When the pharmacy sent the medication to the facility, it was the MAs responsibility to compare the medication to the order in the new order notebook prior to placing the medication on the cart for administration. -There was no audit process in place by management to ensure an order was completed or accurate. Interview with the Resident Care Coordinator (RCC) on 10/20/21 at 12:00pm revealed: -She was unsure why Resident #1's Midodrine had not been increased to 10mg on 10/15/21 as ordered. -It was the MA's, HWD's, or her responsibility to process orders when received for residents. -It was the HWD's responsibility to ensure accuracy of orders when received, then fax the order to the pharmacy. -The pharmacy would then enter the order onto the resident's eMAR once it was received from the facility. -Once a medication was received by the facility, it was the MA's responsibility to compare the medication received to the original order in the new order book and to the order on the eMAR to ensure accuracy before administering the medication. -She expected medication to be administered	D 358		

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D 358	Continued From page 12 accurately and safely to residents. Interview with the RCC on 10/21/21 at 9:45am revealed: -The Midodrine order had been missed by the pharmacy and the facility had not realized it. -The facility had not realized that Resident #1's Midodrine had not been increased to 10mg as ordered on 10/15/21. -There was no audit process in place by management to ensure MAs did not miss orders that the pharmacy may have overlooked. -Catching a mistake overlooked or missed by the pharmacy took critical thinking from the MAs but the facility should have caught the pharmacy's oversight of Resident #1's Midodrine 10mg not being implemented. Review of an email correspondence dated 10/21/21 between the RCC and the facility's contracted pharmacy provider revealed: -The pharmacy had received the order to increase Resident #1's Midodrine to 10mg on 10/15/21. -The pharmacy technician and pharmacist missed the order for Resident #1's Midodrine 10mg and realized it when it had been brought to their attention that day, 10/21/21. Interview with the Administrator on 10/21/21 at 11:06am revealed: -He expected MAs to administer medication accurately and safely to residents. -He expected the facility staff responsible to implement and process orders to ensure accuracy in a timely manner. Interview with Resident #1's Primary Care Provider (PCP) on 10/21/21 at 10:30am revealed: -She expected the facility MAs to administer	D 358		

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medications according to the 6 rights in an accurate and safe manner.
-She expected medications to be administered as ordered and for the instructions on the medication label to be verified against the original order prior to administration.
-She had not been made aware that Resident #1's Midodrine had not been increased as ordered on 10/15/21 and she expected the facility to have caught the mistake without it being brought to their attention and reported to her.
-It was concerning to her that Resident #1's Midodrine had not been increased as ordered on 10/15/21 because she ordered the increase in the Midodrine to treat the resident's orthostatic hypotension (low blood pressure when rising from a lying or sitting position that could cause one to pass out).
-The resident had been having syncopal episodes (passing out) due to her orthostatic hypotension and had recently experienced multiple falls due to the condition.
-The Midodrine was ordered and increased to treat the resident's orthostatic hypotension and prevent further injury or complications.

b. Review of a physician's order for Resident #1 dated 10/12/21 revealed an order for Tobramycin/Dexamethasone 0.3/0.1% eye drops, instill two drops in the right eye every 6 hours x5 days to treat conjunctivitis.

Review of Resident #1's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Tobramycin/Dexamethasone 0.3/0.1% eye drops, instill two drops in the right eye every 6 hours x5 days to treat conjunctivitis.
-The Tobramycin/Dexamethasone 0.3/0.1% eye

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL016022	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARTERET LANDING	221 FRIENDLY ROAD MOREHEAD CITY, NC 28557

(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 358	Continued From page 14	D 358		

drops were documented as administered for an equivalent of 6 days instead of 5 days from 10/13/21-10/19/21.
-The resident received a total of 24 doses instead of 20 doses between 10/13/21-10/19/21.

Interview with the Health and Wellness Director (HWD) on 10/20/21 at 11:36am revealed:
-It was her or the MA's responsibility to process new orders for residents when received.
-Processing an order for medication entailed faxing a signed order to the pharmacy, ensuring the fax was received by the pharmacy, then placing a copy of the order in the MAs new order notebook.
-When the pharmacy sent the medication to the facility, it was the MAs responsibility to compare the medication to the order in the notebook prior to placing the medication on the cart for administration.

Interview with the Resident Care Coordinator (RCC) on 10/20/21 at 12:00pm revealed:
-She was unaware that Resident #1's Tobramycin had been administered for 6 days instead of 5 days as ordered until it had been brought to her attention that day, 10/20/21.
-Resident #1's Tobramycin had been administered incorrectly and was considered a medication error; she would make sure it was reported to the resident's primary care provider.
-The days of administration for Resident #1's Tobramycin must have been miscalculated and the error was missed.
-It was the MA's, HWD's, or her responsibility to process orders when received for residents.
-It was the HWD's responsibility to ensure accuracy of orders when received, then fax the order to pharmacy.
-The pharmacy would then enter the order onto

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D 358	Continued From page 15	D 358		

the resident's eMAR when it was received from the facility.
-Once a medication was received at the facility, it was the MA's responsibility to compare the medication received to the original order in the new order book and to the order on the eMAR to ensure accuracy before administering a medication prior to administration.
-She expected medication to be administered accurately and safely to residents.

Interview with the RCC on 10/21/21 at 9:45am revealed:
-There was no audit process in place by management to ensure MAs did not miss inaccurate orders that the pharmacy may have overlooked.
-Catching a mistake overlooked or missed by the pharmacy took critical thinking from the MAs but the facility should have caught Resident #1's Tobramycin error.

Interview with the RCC on 10/21/21 at 11:02am revealed:
-MAs were expected to administer medication using the 6 rights and compare the label instructions to the eMAR order three times before administration.
-She expected MAs administer medication accurately and safely to residents.

Interview with the Administrator on 10/21/21 at 11:06am revealed:
-MAs were expected to administer medication using the 6 rights and compare the label instructions to the eMAR order three times before administration.
-He expected MAs to administer medication accurately and safely to residents.

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D 358	Continued From page 16 Interview with Resident #1's Primary Care Provider (PCP) on 10/21/21 at 10:30am revealed: -She expected the facility MAs to administer medications according to the 6 rights in an accurate and safe manner. -She expected medications to be administered as ordered and the instructions on the medication label to be verified against the original order. -She had not been made aware that Resident #1's Tobramycin had been administered for 6 days instead of 5 days and she expected the facility to have caught the mistake without it being brought to their attention and reported to her. -It was concerning to her that Resident #1's Tobramycin had not been administered as ordered because receiving antibiotics longer than ordered or needed could lead to antibiotic resistance (when the infection no longer responds to antibiotics for treatment). -Antibiotics should only be used for the minimum amount of time needed. -Resident #1's Tobramycin should have been stopped after 5 days of administration as the order had been written. -It was important for MAs to take their time and follow orders correctly when administering medications.	D 358		