Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039016	A. BUILDING: _____ B. WING _____	01/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on-site on 01/10/22-01/11/22..	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or conclusions, set forth in the statement of deficiencies, theplan of correction is perpared soley as a matter of compliance with the law.	
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 1 of 5 residents sampled for record review including errors with an eye drop and a topical cream for pain (#4). The findings are: 1. Review of Resident #4's current FL2 dated 12/14/21 revealed diagnoses included history of falls, hypothyroidism, myasthenia, history of ventricular tachycardia, gout, osteoarthritis, hypertension, atherosclerotic disease and sick sinus syndrome. a. Review of Resident #4's physician's orders dated 12/14/21 revealed there was an order for Restasis 0.05% (used to treat dry eyes) instill one drop in each eye every 12 hours. Review of Resident #4's physician's orders dated	D 358	10A NCAC 13F .1004(a) Medication Administration Community will assure that all medications and treatments are administered as ordered Community RCC will conduct medication cart audits no less than twice weekly for four weeks, then weekly thereafter Medication cart audits shall include review of all prescription,non-prescription, and treatments. Audits will also include quantity on hand, prescibed dates and availablity of medications and/or treatments . Any discrepancies found during audits will be immediately corrected and followed with completion of Medication Error reports and notification to Physician shall be completed. Community ED will review and inital all medication cart audits weekly ED and RCC will discuss any refusals of medications and/or treatments as well as any discrepancies found during audits. to assure proper follow-up.	2/15/2022 2/15/2022 2/15/2022 2/15/2022

Reviewed and acknowledged on 02/11/22
Janet Thornburg JT

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D 358	Continued From page 1 10/05/21 revealed there was an order for Restasis 0.05% instill one drop in each eye every 12 hours. Review of Resident #4's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Restasis 0.05% instill one drop in each eye every 12 hours with a scheduled administration time of 8:00am and 8:00pm. -There was documentation that Restasis 0.05% was administered twice daily at 8:00am and 8:00pm from 11/01/21 to 11/30/21. -There were exceptions documented that Resident #4 refused administration of Restasis 0.05% on 11/07/21 and 11/21/21 at 8:00am. Review of Resident #4's December 2021 eMAR revealed: -There was an entry for Restasis 0.05% instill one drop in each eye every 12 hours with a scheduled administration time of 8:00am and 8:00pm. -There was documentation that Restasis 0.05% was administered twice daily at 8:00am and 8:00pm from 12/01/21 to 12/31/21. -There were exceptions documented that Resident #4 refused administration of Restasis 0.05% on 12/08/21 at 8:00am and on 12/25/21 at 8:00pm. -There was no documentation of administration of Restasis 0.05% on 12/09/21 at 8:00pm and 12/10/21 at 8:00am and 8:00pm. Review of Resident #4's January 2022 eMAR revealed: -There was an entry for Restasis 0.05% instill one drop in each eye every 12 hours with a scheduled administration time of 8:00am and 8:00pm. -There was documentation that Restasis 0.05% was administered twice daily on 01/01/22 to	D 358	Continued from page 1 In addition, to scheduled cart audits community Area Clinical Director (ACD), RN will do random medication cart audits no less than monthly, to include checking for dispense dates. Area Clinical Director will review findings of audits with community ED and/or RCC. Community ED, RCC and/or ACD will conduct medication pass observations with different medication techs, observating/monitoring at least one medication/treatment pass weekly for next four weeks, then randomly there after. Community Medication Staff have received training in the following: - Medicaition Administration, including proper dosing, six rights of medication administration, refusals and documentation -Medication Errors Training conducted by ACD, RN	2/15/2022 2/15/2022 2/14/2022

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D 358	Continued From page 2 01/09/22 at 8:00am and 8:00pm and on 01/10/22 at 8:00am. -There were no exceptions documented. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 01/11/22 at 10:55am revealed: -There was an order for Restasis 0.05% instill one drop in each eye every 12 hours dated 10/01/21. -The pharmacy dispensed Restasis 60 single use vials on 10/05/21. -The pharmacy dispensed Restasis 60 single use vials on 12/09/21. -The pharmacy did not dispense Restasis 0.05% in November 2021. -The pharmacy did not receive a re-order for Restasis 0.05% in November 2021. -Restasis 0.05% 60 single use vials would last 30 days. -Restasis was used for dry eyes. Observation of Resident #4's medication on hand on 01/11/22 at 9:30 am revealed: -There was a box labeled Restasis 0.05% with 30-single use vials. -The directions were to instill one drop in each eye every 12 hours. -The pharmacy label showed a dispensed date of 12/09/21. -There were two handwritten open dates on the box, 12/11/21 and 01/06/22. -There were 27-single use vials in the box. Interview with Resident #4 on 01/11/22 at 11:08am revealed: -She knew she received eye drops once a day. -The eye drops were for dry, itchy eyes. -Her eyes were not itchy today, 01/11/22.	D 358		

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D 358	Continued From page 3 Interview with a medications aide (MA) on 01/11/21 at 11:10am revealed: -She administered Restasis this morning between 8:00am and 9:00am. -She did not know what the medication was used for. -She did not know why there were so many vials left in the box on the cart. Interview with a second MA on 01/11/22 at 11:38am revealed: -She administered Restasis every morning to Resident #4 when she passed meds on her hall. -She thought she received Restasis once a day. -She did not know what Restasis was used for. -She did not know why there were so many vials left in the box on the cart. Refer to interview with the Resident Care Coordinator on 01/11/22 at 11:10am. Refer to interview with the Administrator on 01/11/21 at 11:30am. b. Review of Resident #4's physician's orders dated 12/14/21 revealed there was an order for diclofenac sodium 1% (used to treat pain) apply 3 grams topically to right knee three times a day. Review of Resident #4's physician's orders dated 10/13/21 revealed there was an order for Restasis 0.05% instill one drop in each eye every 12 hours. Review of Resident #4's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for diclofenac sodium gel 1% with a scheduled administration time of 8:00am, 2:00pm and 8:00pm.	D 358		

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D 358	Continued From page 4 -There was documentation that diclofenac sodium gel 1% was administered three times daily at 8:00am, 2:00pm and 8:00pm from 11/01/21 to 11/30/21. -There were exceptions documented that Resident #4 refused administration of diclofenac sodium gel 1% on 11/07/21 and 11/21/21 at 8:00am. -There was no documentation of administration of diclofenac sodium gel 1% on 11/30/21 at 8:00pm. Review of Resident #4's December 2021 eMAR revealed: -There was an entry for diclofenac sodium gel 1% with a scheduled administration time of 8:00am, 2:00pm and 8:00pm. -There was documentation that diclofenac sodium gel 1% was administered three times daily at 8:00am, 2:00pm and 8:00pm from 12/01/21 to 12/31/21. -There were exceptions documented that Resident #4 refused administration of diclofenac sodium gel 1% on 12/08/21 at 8:00am and 12/25/21 at 8:00pm. -There were exceptions documented that Resident #4 was out of the facility and was not administered diclofenac sodium gel 1% on 12/21/21 and 12/30/21 at 2:00pm Review of Resident #4's January 2022 eMAR revealed: -There was an entry for diclofenac sodium gel 1% with a scheduled administration time of 8:00am, 2:00pm and 8:00pm. -There was documentation that diclofenac sodium gel 1% was administered three times daily on 01/01/22 to 01/09/22 at 8:00am, 2:00pm and 8:00pm and on 01/10/22 at 8:00am. -There were no exceptions documented.	D 358		

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D 358	Continued From page 5 Telephone interview with the Pharmacist at the facility's contracted pharmacy on 01/11/22 at 10:55am revealed: -There was an order for diclofenac sodium 1% gel apply 3 grams topically to right knee three times a day dated 10/01/2021. -The pharmacy dispensed diclofenac sodium, one tube, on 10/12/21. -The pharmacy dispensed diclofenac sodium, one tube, on 11/30/21. -The pharmacy did not dispense diclofenac sodium in December 2021 or January 2022. -Diclofenac sodium had not been re-ordered from the pharmacy during December 2021 and January 2022. -Diclofenac sodium, one tube, should last about 15 days. -Diclofenac sodium was used to treat pain related to arthritis. Observation of Resident #4's medication on hand on 01/11/22 at 9:30 am revealed: -There was a box labeled diclofenac sodium 1% gel. -The directions were to apply 3 grams topically to right knee three times a day. -The pharmacy label showed a dispensed date of 11/30/21. -There was a dosing scale with measurements from 2 to 4 grams for the MAs to use. -The diclofenac sodium tube was ½ full. Interview with Resident #4 on 01/11/22 at 11:08am revealed: -The staff would rub cream on my right knee every morning. -She did not think the medication helped. -She complained of her right knee hurting. Interview with a medication aide (MA) on 01/11/22	D 358		

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D 358	Continued From page 6 at 11:10am revealed: -She administered diclofenac sodium to Resident #4 this morning between 8:00am and 9:00am. -She would administer the medication again this afternoon. -The medication helps with pain in Resident #4's right knee. -She used the dosing scale to measure the medication. -She did not know why there was a half of tube still left on the medication cart if it was dispensed on 11/30/21. -She did not know how long a tube of diclofenac sodium cream should last. Interview with a second MA on 01/11/22 at 11:38am revealed: -Diclofenac sodium was administered to Resident #4 twice a day. -She only received 1 gram of medication at each administration -She donned her gloves and placed a dime size of medication on her finger. -Sometimes she would place medication in a medication cup. -She had not noticed the dozing scale in the medication box. -The medication was used for pain in Resident #4's right knee. -She did not know why diclofenac sodium had not been re-ordered since 11/30/2. Interview with the Administrator on 01/11/22 at 11:30am revealed she only required a small, thin amount of diclofenac cream to be applied to her right knee. Refer to interview with the Resident Care Coordinator on 01/11/22 at 11:10am.	D 358		

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D 358	Continued From page 7 Refer to interview with the Administrator on 01/11/21 at 11:30am. Interview with the Resident Care Coordinator (RCC) on 01/11/22 at 11:10am revealed: -The medications carts were audited at least weekly. -She would audit the medication carts. -During the audit she would make sure all medications were available for administration. -Medications such as creams and eye drops were re-ordered when the medication got low. -Resident #4 was not being administered her medications as ordered. -The doctor's orders should be followed. Interview with the Administrator on 01/11/22 at 11:30am revealed: -The medication carts were audited weekly to see what medications needed to be re-ordered. -The MAs need to follow the doctor's orders as written.	D 358		