STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL067004	A. BUILDING: _____ B. WING _____	03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARC COMMUNITY	1241 ONSLOW PINES ROAD JACKSONVILLE, NC 28540

(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 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 30, 2022 through March 31, 2022.	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 1 of 8 residents (#5) observed during the medication passes including errors with a medication used to treat and prevent acid reflux, a medication used to treat the symptoms of an enlarged prostate, and a medication used to treat chest pain, heart failure, and high blood pressure. The findings are: The medication error rate was 12% as evidenced by the observation of 3 errors out of 25 opportunities during the 7:00am and 8:00am medication passes on 03/31/22. Review of Resident #5's FL-2 dated 02/28/22 revealed diagnoses included vascular dementia, gastroesophageal reflux disease, hypertension,	D 358	In refrence to 10A NCAC 13F .1004 Medication Administration: -On 04/01/22 RCC had meeting with all med-techs about crushing meds that aren't allowed to be crushed. RCC also posted non crushable med list up on med carts and in med room. -Rcc, primary care physician, and pharmacist went through all resident's medication list that had to be crushed and modified the medication to a equivalent medication that could be crushed or a liquid to follow all policy and procedures. -On 04/29/22 Med Admin Review of specific techniques training was held for all med-techs by RN, with Ren care consulting.	5/4/2022

Reviewed and acknowledged by [illegible] 5/23/22

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D 358	Continued From page 1 and benign prostatic hyperplasia. Review of Resident #5's Standing Orders dated 02/28/22 revealed an order for medications given by mouth may be crushed, if not otherwise noted, and/or placed in applesauce, pudding, or yogurt. Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable a. Review of Resident #5's FL-2 dated 2/28/22 revealed an order for Toprol-XL 50mg, 1 tablet every day. (Toprol-XL is used for the treatment of high blood pressure. It is designed to release the medication over a 24-hour period and should not be crushed. Too much of the medication can be released at one time if it is crushed and it can cause symptoms of low blood pressure.) Review of Resident #5's March 2022 electronic medication administration record (eMAR) on 03/31/22 revealed: -An entry for Toprol-XL 50mg, take 1 tablet every day and do not crush. -Toprol-XL 50mg was documented as administered to the resident on 03/31/22 at 7:00am. Review of Resident #5's medication packet on 03/31/22 at 7:18am revealed: -The medication packet was prefilled by the facility's contract pharmacy with the resident's medications scheduled for 7:00am on 03/31/22. -The packet label included an entry for Toprol-XL 50mg, take 1 tablet every day and "DO NOT CRUSH" instructions. Observation of the 7:00am medication pass on 03/31/22 revealed:	D 358		

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D 358	Continued From page 2 -There was a supply of one Toprol-XL 50mg tablet in a prefilled medication packet dated 03/31/22 7:00am. -The medication aide (MA) prepared morning medications for Resident #5, including one Toprol-XL 50mg tablet. -The MA crushed all of Resident #5's oral medications, including the Toprol-XL, mixed them in yogurt and administered them to the resident at 7:28am. Refer to interview with the MA on 03/31/22 at 11:12am. Refer to interview with the RCC and Administrator on 03/31/22 at 11:42am. b. Review of Resident #5's FL-2 dated 2/28/22 revealed an order for Prilosec 40mg, 1 capsule every day. (Prilosec is used for the treatment of gastroesophageal reflux disease. Each capsule contains coated pellets which stop the medicine from being broken down by the stomach acid. Crushing the pellets can cause the medication to be broken down too soon and less effective.) Review of Resident #5's March 2022 eMAR on 03/31/22 revealed: -An entry for Prilosec 40mg, take 1 capsule every day and do not crush. -Prilosec 40mg was documented as administered to the resident on 03/31/22 at 7:00am. Review of Resident #5's medication packet on 03/31/22 at 7:18am revealed: -The medication packet was prefilled by the facility's contract pharmacy with the resident's medications scheduled for 7:00am on 03/31/22. -The medication packet label included an entry for Prilosec 40mg, take 1 capsule every day and	D 358		

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D 358	Continued From page 3 "DO NOT CRUSH" instructions. Observation of the 7:00am medication pass on 03/31/22 revealed: -There was a supply of one Prilosec 40mg capsule in a packet dated 03/31/22 7:00am. -The medication aide (MA) prepared morning medications for Resident #5, including one Prilosec 40mg capsule. -The MA crushed all of Resident #5's oral medications, including the contents of the Prilosec capsule, mixed them in yogurt and administered them to the resident at 7:28am Refer to interview with the MA on 03/31/22 at 11:12am. Refer to interview with the Resident Care Coordinator (RCC) and Administrator on 03/31/22 at 11:42am. c. Review of Resident #5's FL-2 dated 2/28/22 revealed an order for Flomax 0.4mg, 1 capsule every day. (Flomax is used to treat male urinary symptoms due to benign prostatic hyperplasia, also called an enlarged prostate. Each Flomax capsule contain time-released pellets that may cause rapid drug release disrupted and serious side effects. When taken on an empty stomach, more of the medication is absorbed and could cause a greater effect and a drop in blood pressure.) Review of Resident #5's March 2022 eMAR on 03/31/22 revealed: -An entry for Flomax 0.4mg, take 1 capsule every day, do not open, give 30 minutes after a meal, and do not crush. -Flomax 0.4mg was documented as administered to the resident on 03/31/22 at 7:00am.	D 358		

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D 358	Continued From page 4 Review of Resident #5's medication packet on 03/31/22 at 7:18am revealed: -The medication packet was prefilled by the facility's contract pharmacy with the resident's medications scheduled for 7:00am on 03/31/22. -The medication packet label included an entry for Flomax 0.4mg, take 1 capsule every day and "DO NOT OPEN, GIVE 30 MINUTES AFTER A MEAL, DO NOT CRUSH" instructions. Observation of the 7:00am medication pass on 03/31/22 revealed: -There was a supply of one Flomax 0.4mg capsule in a packet dated 03/31/22 7:00am. -The MA prepared morning medications for Resident #5, including one Flomax 0.4mg capsule. -The MA crushed all of Resident #5's oral medications, including the contents of the Flomax capsule, mixed them in yogurt and administered them to the resident at 7:28am. Observation of Resident #5 on 03/31/22 at 7:45am revealed he was served and began eating his breakfast. Refer to interview with the MA on 03/31/22 at 11:12am. Refer to interview with the RCC and Administrator on 03/31/22 at 11:42am. Interview with the MA on 03/31/22 at 11:12am revealed: -The facility did not have a Do Not Crush (DNC) list available to use as a guide. -The resident's medication cards, prefilled packets and eMAR entries included DNC instructions.	D 358		

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D 358	Continued From page 5 -All residents had standing orders to crush medications and mix with yogurt, applesauce or pudding. -She usually crushed all of Resident #5's medications and administered the medications before the resident ate breakfast. -She did not read the entire medication label instructions and eMAR instructions to not open, to not crush, and/or to administer after a meal for Resident #5's Toprol-XL, Prilosec, and Flomax. Interview with the RCC and Administrator on 03/31/22 at 11:42am revealed: -The MAs were expected to follow all order instructions when administering medications to the residents. -The facility did not have a list of DNC medications available for the MAs. -Medication packet labels, medication blister card labels, and eMAR included DNC instructions so the MAs would know what medications should not be crushed. -The facility's standing order was resident's medications may be crushed unless otherwise instructed to not crush.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment;	D 367	In refrence to rule 10A NCAC 13F .1004 Medication Administration: -Med-Tech was immediately removed of med cart until further training during survey. -04/01/22 Rcc had meeting with all med techs on the proper steps to med administration. To always sign the MAR and Narc sheet to	

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D 367	Continued From page 6 (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 1 of 5 sampled residents (#2) regarding the omission of documenting administration of a sedative medication on the eMAR. The findings are Review of Resident #2's FL-2 dated 02/08/22 revealed: -Diagnoses of Alzheimer's disease, anxiety, and bipolar disorder. -There was an order for Clonazepam 0.5mg, take ½ tablet to equal 0.25mg daily as needed for agitation/anxiety. (Clonazepam is a sedative used to treat anxiety and panic disorders.) Review of Resident #2's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Clonazepam 0.5mg, take ½ tablet to equal 0.25mg daily as needed for agitation/anxiety. -There was documentation Clonazepam 0.25mg	D 367	continued- To always show your documentation -Rcc will review mars daily and weekly review resident's mars and audit narc counts, and make sure the facility is in compliance with med administration documentation . --On 04/29/22 Med Admin Review of specific techniques training was held for all med-techs by RN, with Ren care consulting.	04/29/22

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D 367	Continued From page 7 was administered to the resident on 03/06/22. -There was documentation Clonazepam 0.25mg was administered to the resident on 03/17/22. -There was a total of 2 times Clonazepam 0.25mg was documented as administered to the resident between 03/06/22 to 03/18/22. Review of Resident #2's control log for Clonazepam 0.25mg revealed: -There was documentation there were 10 doses of Clonazepam 0.25mg available on the resident's medication punch card on 02/17/22. -There was documentation Clonazepam 0.25mg was administered to the resident on 03/06/22 at 8:00am. -There was documentation Clonazepam 0.25mg was administered to the resident on 03/06/22 at 8:00pm. -There was documentation Clonazepam 0.25mg was administered to the resident on 03/07/22 at 8:00am. -There was documentation Clonazepam 0.25mg was administered to the resident on 03/07/22 at 3:00pm. -There was documentation Clonazepam 0.25mg was administered to the resident on 03/15/22 at 8:00am. -There was documentation Clonazepam 0.25mg was administered to the resident on 03/17/22 at 7:14am. -There was documentation Clonazepam 0.25mg was administered to the resident on 03/18/22 at 11:00am. -There was documentation Clonazepam 0.25mg was administered to the resident on 03/18/22 at 6:00pm. -There was a total of 8 times Clonazepam 0.25mg was documented as administered to the resident between 03/06/22 to 03/18/22.	D 367		

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D 367	Continued From page 8 Observation of Resident #2's Clonazepam 0.25mg medication punch card on 03/30/22 revealed 2 doses remained on the card. Interview with a medication aid (MA) on 03/31/22 at 11:12 revealed: -Control medications were counted and compared to the corresponding control log when the MAs changed shifts. -The resident's eMAR was not reviewed when the MAs counted the control medications during the change of shift because the medication count and control log were accurate. -She was not aware there were 8 times Clonazepam 0.25mg was not documented administered to the resident between 03/06/22 to 03/18/22 on Resident #2's March 2022 eMAR. Interview with the Resident Care Coordinator (RCC) and Administrator on 03/31/22 at 11:42 revealed: -The MAs were expected to accurately document administration of resident's medications on the eMAR. -The MA should have documented the administration of Resident #2's Clonazepam 0.25mg on the eMAR after she administered the medication. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable	D 367		
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	D 371	In reference to 10A NCAC 13F .1004 (n): -04/01/22 Rcc had meeting with all med techs the importance of infection control. Demonstrated how to	

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D 371	Continued From page 9 measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the medication pass on 03/31/22 by 1 of 1 medication aides observed who failed to wash or sanitize her hands prior to preparing and after administering multiple oral medications and insulin to residents. The findings are: Observation of a medication aide (MA) administering medications on 03/31/22 during the 7:00am to 8:00am medication pass revealed: -A bottle of hand sanitizer was setting on the top of the medication cart. -The MA prepared and administered crushed oral medications mixed with approximately 2 tablespoons of yogurt to a resident at 7:14am. -The MA returned to the medication cart and did not sanitize or wash her hands. -The MA then touched the computer keyboard and screen. -The MA prepared and administered crushed oral medications mixed with approximately 2 tablespoons of yogurt to a second resident at 7:28am. -The MA checked the blood sugar and administered insulin to the same resident at 7:31am while wearing gloves. -The MA returned to the medication cart and removed her gloves but did not sanitize or wash her hands. -The MA then touched the computer keyboard and screen.	D 371	continued- properly wash hands and had them demostrate back as she evaluated them. Explained when to use hand sanitizer and when to wash your hands. To wear gloves when feeding residents crushed meds, or coming in contact with in bodily fluids. -04/29/22 Ren care consulting, RN. trained a class on infection control and Medication Administration review on specific technique. -Rcc will observe weekly med pass to ensure med tech is using proper infection control.	04/29/22

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D 371	Continued From page 10 -The MA prepared and administered crushed oral medications mixed with approximately 2 tablespoons of yogurt to a third resident at 7:46am. -The MA returned to the medication cart and did not sanitize or wash her hands. -The MA then touched the computer keyboard and screen. -The MA prepared and administered crushed oral medications mixed with approximately 2 tablespoons of yogurt to a fourth resident at 7:52am. -The MA returned to the medication cart and did not sanitize or wash her hands. -The MA documented information in a binder labeled "Control Log". -The MA then touched the computer keyboard and screen. -The MA did not wear gloves when offering feeding assistance while administering crushed oral medications to four residents. -The MA did not sanitize or wash her hands prior to preparing the medications or after administering the medications to each resident during the 7:00am to 8:00am medication pass. Observation of the same MA administering medications on 03/31/22 from 8:30am to 9:05am revealed: -A bottle of hand sanitizer was setting on the top of the medication cart. -The MA prepared and administered crushed oral medications mixed with approximately 2 tablespoons of yogurt to a resident at 8:38am. -The MA returned to the medication cart and did not sanitize or wash her hands before she touched the computer keyboard and screen. -The MA prepared and administered crushed oral medications mixed with approximately 2 tablespoons of yogurt to a second resident at	D 371		

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D 371	Continued From page 11 8:42am. -The MA returned to the medication cart and did not sanitize or wash her hands before she touched the computer keyboard and screen. -The MA prepared and administered crushed oral medications mixed with approximately 2 tablespoons of yogurt to a third resident at 8:50am. -The MA returned to the medication cart and did not sanitize or wash her hands before she touched the computer keyboard and screen. -The MA documented information in a binder labeled "Control Log". -The MA prepared and administered crushed oral medications mixed with approximately 2 tablespoons of yogurt to a fourth resident at 9:00am. -The MA returned to the medication cart and did not sanitize or wash her hands before she touched the computer keyboard and screen. -The MA did not wear gloves when offering feeding assistance while administering crushed oral medications to four residents. -The MA did not sanitize or wash her hands prior to preparing the medications or after administering the medications to each resident during medication from 8:30am to 9:05am. Interview with the MA on 03/31/22 at 11:20am revealed: -The facility procedure related to infection prevention during administering medications was to sanitize hands or wash hands with soap and water in between residents and after removing gloves. -She did not recall omitting sanitizing her hands in between residents during the 7:00am and 8:00am medication pass this morning. Interview with the Resident Care Coordinator	D 371		

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D 371	Continued From page 12 (RCC) on 03/31/22 at 11:42am revealed: -The MAs were expected to use hand sanitizer before and after administering medications to each resident. -The MAs were expected to wash hands with soap and water after administering medications to every third resident. -The MAs were expected to wear gloves when administering crushed oral medications mixed with yogurt or pudding to residents that required feeding assistance.	D 371		