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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on January 4, 2022 - January 5, 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 for 2 of 6 residents (#6, #7) observed during the medication passes evidenced by errors which included an eye drop to treat dry eyes (#7) and an antibiotic ointment used to treat skin infections (#7); and for 1 of 5 residents sampled (#4) for record review related to an over the counter pain medication. 1. The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 12:00pm medication pass on 01/04/22 and 9:00am medication pass on 01/05/22. a. Review of Resident #6's current FL-2 dated 06/09/21 revealed: -Diagnoses included hypertension, cerebrovascular attack, and dementia. -The resident was intermittently disoriented and	{D 358}		

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had visual functional limitations.
-There was an order for Systane Balance Restoration (eye drops used to restore lubrication) instill one drop into each eye four times daily.

Review of Resident #6's subsequent physician orders dated 11/04/21 revealed there was an order for Systane Balance 0.6% instill one drop in each eye four times daily.

Review of Resident #6's previous PCP visit note dated 10/06/21 revealed:
-The resident was treated for blurred vision.
-The resident was ordered an ophthalmology referral for blurred vision.

Observation of the 12:00pm medication pass on 01/04/22 revealed:
-The MA clicked on Resident #6's electronic medication administration record (eMAR) located on top of the medication cart outside of Resident #6's room.
-She read the directions in the eMAR for Resident #6's Systane Balance Restoration eye drops.
-She removed the residents Systane Balance Restoration eye drop bottle from the medication cart.
-She read the instructions on the administration label of the resident's Systane Balance Restoration eye drops.
-She donned gloves and walked in the resident's room.
-Resident #6 was sitting in a chair located in his room.
-She provided the resident with a tissue.
-She removed the top of the Systane Balance Restoration eye drop bottle.
-She instructed Resident #6 to lean his head back.

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{D 358}	Continued From page 2 -She pulled down on Resident #6's right lower eye. -She squeezed the Systane Balance Restoration eye drop bottle and ran a continuous stream of the white liquid medication along the inside of Resident #6's right lower eye from the outer corner to the inner corner instead of one drop of the medication. -The medication ran from the resident's right eye down his cheek. -The MA pulled down Resident #6's left lower eye. -She squeezed a steady stream of the Systane into Resident #6's left lower eye from the inside corner to the outside corner instead of one drop of the medication. -The medication ran from the resident's left eye down his cheek. -Resident #6 lifted his head up after administration of the eye drops and wiped both eyes and cheeks with the tissue. -The MA did not prompt the resident to keep his head back or not to wipe the medication from his eyes. -The MA placed the lid back on the Systane bottle and exited the room. -The MA clicked in the resident's eMAR the medications had been administered. Review of Resident #6's January 2022 eMAR revealed: -There was an entry for Systane Balance 0.6% instill one drop into each eye four times daily. -There was documentation Systane Balance was administered to the resident on 01/04/21 at 12:00pm by the MA. Interview with the MA on 01/04/22 at 12:00pm revealed: -During the 12:00pm medication pass on 01/04/22, she started at one side of Resident #6's	{D 358}		

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{D 358}	Continued From page 3 lower eye and squeezed a constant stream of the Systane in the resident's eye. -She did the same process for both eyes. -She had never administered only one eye drop to Resident #6. -She would always administer Resident #6 a constant stream of the Systane eye drops across the bottom of both resident's lower eyes. Interview with Resident #6 on 01/04/22 at 12:05pm revealed: -The MA never administered only one drop in each eye when administering the Systane eye drops. -The MA would always administer a constant stream in both of his eyes. -The medication would always run out of his eyes and down his face. Second interview with the MA on 01/04/22 at 1:13pm revealed: -She looked at Resident #6 s' eMAR during the 9:00am medication pass today, 01/04/22, to verify the correct resident. -She removed Resident #6's Systane eye drops and verified the administration instructions prior to administering the medication to the resident. -The Systane administration instructions on the label stated to administer one drop in each eye four times daily. -Resident #6 told her two weeks ago one drop of Systane in each eye did not relieve his dry eyes. -She decided two weeks ago she would administer a continuous stream of Systane to the resident's lower eyes to see if it helped relieve dryness. -Resident #6 had not complained of dry eyes since she began administering the continuous stream of Systane to the resident's eyes two weeks ago.	{D 358}		

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{D 358}	Continued From page 4 -She had not notified Resident #6's PCP the resident had no relief of dry eyes with administering one drop of the Systane in each eye. Interview with the Resident Care Director (RCD) on 01/04/21 at 1:22pm revealed: -She expected the MA to read the administration instructions on the Systane label and compared the label instructions to the eMAR. -She expected the MA to administer the Systane as ordered. Telephone interview with Resident #6's current Primary Care Provider (PCP) on 01/04/21 at 3:30pm revealed: -She became the PCP for the resident in December 2021. -She expected the MA to administer medications as ordered. -There was no adverse effect for administering the resident a constant stream of Systane to both eyes. Refer to interview with the Administrator on 01/04/22 at 1:27pm. b. Review of Resident #7's current FL-2 dated 01/25/21 revealed: -Diagnoses included postherpetic polyneuropathy (nerve pain from shingles) and dementia. -The resident was intermittently disoriented. Review of Resident #7's physician order dated 07/14/21 revealed there was an order for Silver Sulfadiazine (SSD) Cream 1% apply to right breast and right axillary rash two times a day (an antibiotic cream used to treat bacterial skin infections).	{D 358}		

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{D 358}	Continued From page 5 Observation of the 9:00am medication pass on 01/05/22 revealed: -The MA clicked on Resident #7's name in the electronic medication administration record (eMAR) located on the medication cart. -The medication aide (MA) removed the SSD cream from the medication cart. -The MA entered Resident #7's room. -Resident #7 was lying in bed. -The MA prompted the resident to the need to administer her medications. -The resident sat up in bed. -The MA applied approximately 1.5-inch-long of the SSD cream to his gloved finger. -The MA applied the SSD cream to Resident #7's right upper chest not right breast or axilla. -The MA removed his gloves and exited the room. -The MA clicked in the eMAR the SSD cream was administered to the resident. Interview with the MA on 01/05/22 at 8:30am revealed he administered SSD cream to Resident #7's right upper chest to treat shingles without open lesions. Review of Resident #7's January 2022 eMAR revealed: -There was an entry for SSD cream 1% apply to right breast and right axilla rash twice a day. -There was documentation SSD cream was administered to the resident on 01/05/21 at 9:00am by the MA. Second interview with the MA on 01/05/22 at 10:52am revealed: -He applied SSD cream to Resident #7's right upper chest during the 9:00am medication pass today, 01/05/22. -He did not apply SSD cream to Resident #7's	{D 358}		

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right breast or axilla during the 9:00am medication pass today, 01/05/22.
-Normally he would apply SSD cream to Resident #7's right breast and axilla.
-He did not know why he did not apply SSD cream to Resident #7's right breast and axilla today (01/05/22) during the 9:00am medication pass.

Interview with Resident #7 on 01/05/22 at 11:25am revealed:
-The MA did not apply SSD cream to her right breast and axilla today, 01/05/22.
-Sometimes the MA would apply SSD to her right breast and axilla but not always.
-She was currently experiencing "a little" pain to the skin of her right breast and axilla.

Observation of Resident #7's right breast and axilla revealed the skin was intact without lesions or rashes.

Attempted interview with Resident #7's Primary Care Provider on 01/05/22 at 12:00pm was unsuccessful.

Refer to interview with the Administrator on 01/04/22 at 1:27pm.

2. Review of Resident #4's current FL-2 dated 09/08/21 revealed:
-Diagnoses included osteoarthritis with bilateral hip pain.
-The resident was ambulatory but required a walker for assistance.
-His medication orders included naproxen sodium 220 milligrams (mg) one tablet as needed. (Naproxen sodium is a nonsteroidal anti-inflammatory drug used to relieve mild to moderate pain and reduce swelling caused by

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{D 358}	Continued From page 7 arthritis) Review of Resident #4's physician orders dated 10/19/21 revealed an order for naproxen sodium 220 mg tablets every 12 hours as needed for pain. Observation of Resident #4's medications on hand on 01/05/22 at 10:10 am revealed naproxen sodium 220 mg tablets were not available in the medication cart. Interview with Resident #4 on 01/05/2022 at 8:00 am revealed: -He had pain in both hips that has worsened since 01/02/22 when the weather turned colder. -He requested something for pain on the evening of 01/03/22 and 01/04/22. -The medication aide (MA) told him he did not have anything ordered for his pain on both occasions. -He did not request pain medication often and tried not to take it at all. Review of the facility's Medication Management Policy dated 09/06/18 revealed: -The facility should always have an adequate supply of medication. -It was the facility's responsiblity to contact the appropriate person to order the medications. -It was unacceptable for the facility to run out of a medication. -The facilty should reorder medications from the pharmacy when down to a five day supply. Review of Resident #4's electronic medication administration record (eMAR) for November 2021 revealed: -The listed medications included naproxen sodium 220 mg to be given every 12 hours as	{D 358}		

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needed for pain.
-The start date for the naproxen sodium was 10/19/21.
-There were no doses of naproxen sodium administered to the resident during November 2021.

Review of Resident #4's eMAR for December 2021 revealed:
-The listed medications included naproxen sodium 220 mg to be given every 12 hours as needed for pain.
-The start date for the naproxen sodium was 10/19/21.
-There was one dose of naproxen sodium administered to the resident on 12/14/21 at 8:02 pm and on 12/17/21 at 8:16 pm.

Review of Resident #4's eMAR for January 2022 revealed:
-The listed medications included naproxen sodium 220 mg to be given every 12 hours as needed for pain.
-The start date for the naproxen sodium was 10/19/21.
-There were no doses of naproxen sodium administered to the resident from 01/01/22 to 01/04/22.

Interview with the MA on 01/05/22 at 10:10 am revealed:
-She did not know why Resident #4's naproxen sodium was not in the medication cart.
-The MA was responsible to order refills for medication when there were only 5-7 days of medication left in the cart.
-She requested a refill of the naproxen sodium 220 mg tablets on 01/05/22 at 10:30 am.

Interview with pharmacy representative from the

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{D 358}	Continued From page 9 facility's pharmacy on 01/05/21 at 10:34 am revealed: -On 09/27/21 five tablets of naproxen sodium 220 mg were dispensed to the facility for Resident #4. -An order clarification for the frequency of administration of the naproxen sodium 220 mg was requested from the facility on 10/07/21. -The facility faxed the order clarification for naproxen sodium 220 mg tablets to take 1 tablet by mouth every 12 hours as needed for pain to the pharmacy on 10/19/21. -There were no refills requested for the naproxen sodium between 10/19/21 and 01/04/22. -The facility requested a refill for the naproxen sodium on 01/05/22 at approximately 10:35 am. Interview with the Administrator on 01/05/22 12:42pm revealed: -She always expected all resident medications to be available on the medication cart for administration as ordered. -The MAs were expected to be aware of what medications needed to be ordered with each medication pass to ensure medications were always available. -Resident medications were to be ordered by the MAs when there were seven doses remaining. -She expected the Resident Care Director (RCD) to perform weekly medication cart audits to ensure medications were readily available for administration. -The last cart audit performed by the RCD was last night, 01/03/22. -The RCD did not tell her there were any missing medications discovered during the cart audit performed on 01/03/22. Refer to interview with the Administrator on 01/04/22 at 1:27pm.	{D 358}		

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{D 358}	Continued From page 10 Interview with the Administrator on 01/04/22 at 1:27pm revealed she expected the MAs to administer medications as ordered.	{D 358}		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the prescribed or scheduled times for 4 of 5 residents (#1, #2, #5 #4). The findings are: 1. Review of Resident #1's current FL-2 dated 09/20/21 revealed diagnoses included hypertension, dementia, cervical disc disease, gastroesophageal reflux disease (GERD), lumbar stenosis, hypothyroidism, irritable bowel syndrome (IBS) and atrial fibrillation (AFIB). a. Review of Resident #1's current physician's orders dated 09/20/21 revealed there was an order for Levothyroxine 50mcg once a day at 6:00am on an empty stomach. (Levothyroxine is a medication used to treat hypothyroidism).	D 364		

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Review of Resident #1's November 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Levothyroxine 50mcg once a day with scheduled administration time at 6:00am.
-Levothyroxine was documented as administered late on 6 occasions from 11/16/21 - 11/30/21 ranging from 1 hour and 45 minutes up to 2 hours and 56 minutes after the allowed timeframe.

Review of Resident #1's December 2021 eMAR revealed:
-There was an entry for Levothyroxine 50mcg once a day with scheduled administration time at 6:00am.
-Levothyroxine was documented as administered late on 12 occasions from 12/01/21 - 12/31/21 ranging from 1 hour and 24 minutes up to 3 hours and 23 minutes after the allowed timeframe.

Review of Resident #1's January 2022 eMAR revealed:
-There was an entry for Levothyroxine 50mcg once a day with scheduled administration time at 6:00am.
-Levothyroxine was documented as administered late on 1 occasion from 01/01/22 - 01/04/22 1 hour and 35 minutes after the allowed timeframe.

b. Review of Resident #1's current physician's orders dated 09/20/21 revealed there was an order for Lorazepam 0.5mg ½ tablet three times a day. (Lorazepam is used to treat anxiety).

Review of Resident #1's December 2021 eMAR revealed:
-There was an entry for Lorazepam 0.5mg ½ tablet every 8 hours with scheduled administration times at 6:00am, 2:00pm, and

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10:00pm.
-Lorazepam was documented as administered late on 7 occasions from 12/01/21 - 12/31/21 ranging from 1 hour and 14 minutes up to 3 hours and 23 minutes after the allowed timeframe.

Review of Resident #1's January 2022 eMAR revealed:
-There was an entry for Lorazepam 0.5mg ½ tablet every 8 hours with scheduled administration time at 6:00am, 2:00pm and 10:00pm.
-Lorazepam was documented as administered late on 1 occasion from 01/01/22 - 01/04/22 1 hour and 35 minutes after the allowed timeframe.

Refer to interview with a MA on 01/05/22 at 7:30am.

Refer to interview with a medication aide (MA) on 01/05/22 at 9:05am.

Refer to interview with a second MA on 01/05/22 at 12:31pm.

Refer to interview with the Administrator on 01/05/22 at 12:42pm.

2. Review of Resident #5's current FL-2 dated 04/13/21 revealed diagnoses included Lewy Body Dementia, Parkinson's Disease, hypertension (HTN), gastroesophageal reflux disease (GERD), hypothyroidism, depression, chronic pain, Vitamin D Deficiency, and Vitamin B-12 Deficiency.

a. Review of Resident #5's signed physician's orders dated 11/04/21 revealed there was an order for Refresh Optive Ophthalmic Solution 0.5-0.9% 1 drop into each eye four times a day. (Refresh Optive Ophthalmic Solution is a

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D 364	Continued From page 13 lubricating eye drop used to relieve dryness). Review of Resident #5's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Refresh Optive Ophthalmic Solution 0.5-0.9% solution 1 drop into each eye four times a day with scheduled administration times at 9:00am, 12:00pm, 4:00pm and 9:00pm. -Refresh Optive Ophthalmic Solution was documented as administered late on 3 occasions from 11/16/21 - 11/30/21 ranging from 1 hour and 15 minutes up to 4 hours and 34 minutes after the allowed timeframe. Review of Resident #5's December 2021 eMAR revealed: -There was an entry for Refresh Optive Ophthalmic Solution 0.5-0.9% solution 1 drop into each eye four times a day with scheduled administration times at 9:00am, 12:00pm, 4:00pm and 9:00pm -Refresh Optive Ophthalmic Solution was documented as administered late on 9 occasions from 12/01/21 - 12/31/21 ranging from 1 hour and 11 minutes up to 3 hours and 19 minutes after the allowed timeframe. b. Review of Resident #5's signed physician's orders dated 11/04/21 revealed there was an order for Oxycodone 5mg one tablet four times a day. (Oxycodone is used to treat moderate to severe pain). Review of Resident #5's November 2021 eMAR revealed: -There was an entry for Oxycodone 5mg four times a day with scheduled administration times at 8:00am, 12:00pm, 4:00pm and 8:00pm.	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025041	A. BUILDING: _____ B. WING _____	R 01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 364	Continued From page 14 -Oxycodone was documented as administered late on 3 occasions from 11/16/21 - 11/30/21 ranging from 1 hour and 15 minutes up to 4 hours and 34 minutes after the allowed timeframe. Review of Resident #5's December 2021 eMAR revealed: -There was an entry for Oxycodone 5mg four times a day with scheduled administration times at 8:00am, 12:00pm, 4:00pm and 8:00pm. -Oxycodone was documented as administered late on 10 occasions from 12/01/21 - 12/31/21 ranging from 1 hour and 11 minutes up to 3 hours and 19 minutes after the allowed timeframe. Refer to interview with a MA on 01/05/22 at 7:30am. Refer to interview with a medication aide (MA) on 01/05/22 at 9:05am. Refer to interview with a second MA on 01/05/22 at 12:31pm. Refer to interview with the Administrator on 01/05/22 at 12:42pm. 4. Review of Resident #2's current FL-2 dated 03/11/21 revealed diagnoses included anemia, and hypothyroidism. Review of Resident #2's signed physician orders dated 11/08/21 revealed: -There was an order for Ferrous Sulfate Elixir 220mg/5ml, 5ml three times a day. (Ferrous Sulfate is used to treat iron deficiency anemia) Review of Resident #2's November 2021 electronic medication administration record	D 364		

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D 364	Continued From page 15 (eMAR) revealed: -There was an entry for Ferrous Sulfate Elixir 220mg/5ml, 5ml three times a day with scheduled administrations times at 8:00am, 12:00pm and 5:00pm. -Ferrous Sulfate was documented as administered late on two occasion from 11/01/21 - 11/30/21 ranging from 1 hour and 3 minutes to 1 hour and 11 minutes after the allowed timeframe. Review of Resident #2's December 2021 eMAR revealed: -There was an entry for Ferrous Sulfate Elixir 220mg/5ml, 5ml three times a day with scheduled administrations times at 8:00am, 12:00pm and 5:00pm. -Ferrous Sulfate was documented as administered late on one occasion from 12/01/21 - 12/31/21; 1 hour and 36 minutes after the allowed timeframe. Refer to interview with a medication aide (MA) on 01/05/22 at 7:30am. Refer to interview with a MA on 01/05/22 at 9:05am. Refer to interview with a second MA on 01/05/22 at 12:31pm. Refer to interview with the Administrator on 01/05/22 at 12:42pm. 5. Review of Resident #4's current FL-2 dated 09/08/21 revealed diagnoses included type 2 diabetes mellitus, hyperlipidemia, hypertension, bilateral hip pain, osteoarthritis, malignant neoplasm of the bladder. Review of Resident #4's signed physician orders	D 364		

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D 364	Continued From page 16 dated 09/08/21 revealed: -There was an order for Metformin HCl 1000mg one tablet twice a day with meals. (Metformin HCl is used to treat high blood sugar levels) Review of Resident #4's November 2021 electronic medication administration record(eMAR) revealed: -There was an entry for Metformin HCl 1000mg twice a day with a scheduled time at 9:00am and 5:00pm. -Metformin was documented as administered late on one occasion from 11/01/21 - 11/30/21; 1 hour and 48 minutes after the allowed timeframe. Review of Resident #4's December 2021 eMAR revealed: -There was an entry for Metformin HCl 1000mg twice a day with a scheduled time at 9:00am and 5:00pm. -Metformin was documented as administered late on two occasion from 12/01/21 - 12/31/21 ranging from 1 hour and 26 minutes to 1 hour and 57 minutes after the allowed timeframe. Refer to interview with a medication aide (MA) on 01/05/22 at 7:30am. Refer to interview with a MA on 01/05/22 at 9:05am. Refer to interview with a second MA on 01/05/22 at 12:31pm. Refer to interview with the Administrator on 01/05/22 at 12:42pm. _____ Interview with a medication aide (MA) on 01/05/22 at 7:30am revealed: -Medications were to be documented in the	D 364		

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D 364	Continued From page 17	D 364		

eMAR by the MAs as soon as administered to the residents.
-The eMAR icon for administering a medication was a hand with a finger pointing up.
-The time and date a medication was administered by the MA would auto populate and timestamp the administration once the MA clicked the medication had been administered.
-The MA could administer a medication one hour before or one hour after the scheduled administration time.
-A mediation name would highlight in red on the eMAR when the medication was outside the allowed timeframe for administration indicating the medication was late.
-Sometimes medications were administered late for example if a resident fell and sustained an injury or was sick and the MA would have to stop the medication pass to care for the resident.

Interview with a second MA on 01/05/22 at 9:05am revealed:
-It was the responsibility of the MAs to document on the residents' eMAR after the medications were administered.
-It was the responsibility of the MAs to administer medications within 1 hour of the scheduled administration time.
-The resident's eMAR showed if medications were administered late and the time that the medication was administered.
-It was the responsibility of the MA to document the reason medications were not administered within the scheduled administration time frames.

Interview with a third MA on 01/05/22 at 12:31pm revealed sometimes the eMAR was down or internet slow and could not immediately chart when medications were administered.

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D 364	Continued From page 18 Interview with the Administrator on 01/05/22 at 12:42pm revealed: -She expected the MAs to always administer resident medications on time. -There was no reason a medication would be administered late. -Medications documented as administered late in the eMAR would automatically alert to an electronic health record (EHR) dashboard. -The Resident Care Director (RCD) was responsible for checking the EHR daily. -She did not know if the RCD checked the EHR daily. -She expected the RCD to notify her during the daily stand up meetings of any mediations administered late along with the reason. -Late medications would also be documented in the 24-hour shift communication book. -It was the responsibility of the Administrator to review the 24-hour shift communication book for documentation of late mediation administration. -She would not know the MAs were administering medications outside of the allowed timeframe if it was not documented in the 24-hour shift communication book.	D 364		