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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 06/23/22 to 06/24/22.	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 3 of 7 residents (#4, #6, #7) observed during the mediation passes including errors with a laxative to treat constipation, a nasal steroid to treat allergies (#7), an inhaled bronchodilator (#4, #7), and medications to treat urinary spasms, severe potassium loss, and an eye medication for dry eyes (#6). The findings are: Review of the facility's Medication Administration Policy dated September 2021 revealed: -All routine medications shall be started with the next regular scheduled dose following the next regular pharmacy delivery if ordered before 5:00pm. -Routine medication orders received after 5:00pm shall be started no later than the regularly scheduled dose following the regular pharmacy	D 358		

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delivery of the next business day.

The medication error rate was 18% as evidenced by the observation of 7 errors out of 38 opportunities during the 7:00am to 9:00am medication pass on 06/23/22 and 8:00am to 9:00am medication pass on 06/24/22.

1. Review of Resident #7's current FL-2 dated 06/03/22 revealed:
-Diagnoses included urinary tract infection (UTI), sepsis, irritable bowel syndrome without diarrhea, and hypertension, chronic obstructive pulmonary disease (COPD), and asthma.

a. Review of Resident #7's current FL-2 dated 06/03/22 revealed there was an order for Miralax 17g mixed in 4 to 8 ounces of liquid daily for constipation (used to treat constipation).

Review of Resident #7's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax 17g mix with 4 to 8 ounces of liquid for constipation to be administered daily at 9:00am.
-There was documentation Miralax was administered to the resident on 06/23/22 at 9:00am.

Observation of the medication pass on 06/23/22 at 9:13am revealed:
-The MA removed Resident #7's Miralax from the medication cart drawer, compared the eMAR to the Miralax label, prepared the Miralax, then clicked prep in the eMAR.
-At 9:17am, the MA entered Resident #7's room and handed the Miralax to the resident who was sitting in a chair.
-Resident #7 took one swallow of the Miralax and

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the MA exited the room with the resident holding the cup of Miralax.
-The MA returned to the medication cart and documented the Miralax had been administered to Resident #7.
-The MA rolled the medication cart to the next resident's room due for medication administration.
-The MA did not observe Resident #7 drink the Miralax.

Interview with Resident #7 on 06/23/22 at 9:30am revealed:
-Miralax was used to treat her constipation.
-She drank all the Miralax after the MA walked out of the room.
-The MA did not normally observe her drink the Miralax during medication passes.
-She was not constipated.

Interview with the MA on 06/23/22 at 12:14pm revealed:
-She forgot Resident #7 was due Miralax during the 9:00am medication pass this morning, 06/23/22, until the resident reminded her during the medication pass.
-She returned to the medication cart and prepared Resident #7's Miralax.
-She returned to Resident #7's room and administered Miralax to the resident.
-She did not observe Resident #7 take the scheduled Miralax this morning, 06/23/22, because did not want to be late with the medication pass.

Interview with the Administrator on 06/23/22 at 1:09pm revealed:
-The MAs were to observe residents take their medications to ensure the medications were taken.

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-The MAs were to document medications when administered after observing the resident take their ordered medications in order to accurately document.

b. Review of Resident #7's current FL-2 dated 06/03/22 revealed there was an order for Advair Diskus 250/50mcg inhale one puff twice daily (used to treat COPD).

Review of Resident #7's June 2022 eMAR revealed:
-There was an entry for Advair Diskus blister with device; 250-50mg/dose inhale one puff twice daily, rinse mouth after use to be administered at 9:00am and 7:00pm.
-There was documentation Advair Diskus was administered to the resident on 06/23/22 at 9:00am.

Observation of the medication pass on 06/23/22 at 9:13am revealed:
-The MA prepared and administered nine oral medications to Resident #7 in the resident's room.
-The MA returned to the medication cart located in the hallway outside of the residents' room, and documented medications were administered.
-The MA did not prepare and did not administer Resident #7 the ordered Advair diskus during the medication pass.

Interview with the MA on 06/23/22 at 9:50am revealed Resident #7 had been administered all ordered medications due during the 9:00am medication pass today.

Interview with the Resident on 06/23/22 at 12:00pm revealed she could not remember if the MA administered her the Advair diskus today,

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D 358	Continued From page 4 06/24/22. A second interview with the MA on 06/23/22 at 12:14pm revealed: -She forgot to administer Resident #7 the ordered Advair diskus during the 9:00am medication pass this morning (06/23/22). -This morning (06/23/22), she realized when she administered and documented topical medications after the 9:13am medication pass for Resident #7, that she had not administered the ordered Advair diskus to the resident. -She then administered the Advair to Resident #7. Interview with the Administrator on 06/23/22 at 1:09pm revealed: -Medications populated in the eMARs under resident's names at the scheduled time when due. -Most pills/tablets/capsules were in prefilled packets and the MAs scanned the packets when they prepared the medications for administration. -Inhaled and other medications such as cough syrups, eye drops and ointments were not prefilled and could not be scanned to prepare for administration. -The MA had to review the eMAR and pull the medications for administration that were not prefilled in medication packets. -The MAs were to administer medications to the resident at the times they were due to be administered. c. Review of Resident #7's current FL-2 dated 06/03/22 revealed there was an order for Flonase 50mcg inhale one spray each nostril twice daily for allergies (used to treat allergies). Review of Resident #7's June 2022 eMAR revealed:	D 358		

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-There was an electronic entry for 50mcg/actuation, inhale one spray in each nostril twice daily for allergies to be administered at 9:00am and 8:00pm.
-There was documentation Flonase was administered on 06/23/22 at 9:00am.

Observation of the medication pass on 06/23/22 at 9:13am revealed:
-The MA prepared and administered nine oral medications to Resident #7 in the resident's room.
-The MA returned to the medication cart located in the hallway outside of the residents' room, and documented medications were administered and proceeded to the next resident.
-The MA did not prepare and did not administer Resident #7 the ordered Flonase during the medication pass.

Interview with the MA on 06/23/22 at 9:50am revealed Resident #7 had been administered all ordered medications due during the 9:00am medication pass today.

A second interview with the MA on 06/23/22 at 12:14pm revealed:
-She forgot to administer Resident #7 the ordered Flonase during the 9:00am medication pass this morning (06/23/22).
-This morning (06/23/22), she realized when she administered and documented topical medications after the 9:13am medication pass for Resident #7, that she had not administered the ordered Flonase to the resident.
-She then administered the Flonase to Resident #7.

Interview with the Administrator on 06/23/22 at 1:09pm revealed:

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-Medications populated in the eMARs under resident's names when due.
-Pills/tablets/capsules were in prefilled packets and the MAs scanned the packets when preparing the medications for administration.
-Inhaled and other medications such as cough syrups, eye drops, and ointments were not prefilled and could not be scanned to prepare or administration.
-The MA reviewed the eMAR and pulled the medications from the medication cart that were not prefilled in medication packets to administer.
-Medications were to be administered by the MAs at the ordered times.

2. Review of Resident #4's current FL-2 dated 11/22/21 revealed:
-Diagnoses included chronic obstructive pulmonary disorder (COPD).
-There was an order for Spiriva inhale contents of one capsule daily, rinse mouth with water and spit after.

Review of Resident #4's physician order sheet dated 05/15/22 revealed there was an order for Spiriva 18mcg inhale the contents of one capsule (taking two separate inhalations via Handihaler) daily, rinse mouth with water and spit after each use (used to treat COPD).

Review of Resident #4's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Spiriva 18mcg inhale the contents of one capsule, taking two separate inhalations, daily, rinse mouth with water and spit after each use to be administered at 9:00am.
-Spiriva was documented as administered at 9:00am on 06/23/22.

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D 358	Continued From page 7 Observation of the 9:00am medication pass on 06/23/22 revealed: -The MA prepared and administered three oral medications to Resident #4. -Spiriva was not administered to Resident #4 during the 9:00am medication pass on 06/23/22. Interview with the MA on 06/23/22 at 9:50am revealed Resident #4 had been administered all ordered medications due during the 9:00am medication pass today. Interview with the MA on 06/23/22 at 12:42pm revealed: -Resident #4's Spiriva was ordered for administration in the mornings. -She stated during the 9:00am medication pass today (06/23/22) Resident #4 had been administered all her medications due because she was only referring to oral medications. -She administered Spiriva to Resident #4 this morning after the 9:00am medication pass. Interview with the Administrator on 06/23/22 at 1:09pm revealed: -Medications populated in the eMARs under resident's names when due. -Pills/tablets/capsules were in prefilled packets and the MAs scanned the packets when preparing the medications for administration. -Inhaled and other medications such as cough syrups, eye drops, and ointments were not prefilled and could not be scanned to prepare or administration. -The MA reviewed the eMAR and pulled the medications from the medication cart that were not prefilled in medication packets to administer. -Medications were to be administered by the MAs at the ordered times.	D 358		

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D 358	Continued From page 8 3. Review of Resident #6's current FL-2 dated 12/22/21 revealed: -Diagnosis included dementia and hypokalemia. -The resident was incontinent of bladder and bowel. a. Review of Resident #6's Primary Care Provider's (PCP) progress note dated 05/27/22 revealed: -The resident was being seen via telehealth for complaints of painful urination. -Diagnoses included urinary tract infection (UTI). -The resident was treated in the emergency department (ED) on 05/06/22 for a UTI. -The resident was previously prescribed antibiotics for UTI and yeast infection but still reported painful urination. -There was an order for Pyridium 100mg one tablet three times daily to start when delivered by pharmacy (used to treat symptoms of a UTI). Review of Resident #6's PCP visit note dated 06/16/22 revealed: -Diagnoses included urinary incontinence and overactive bladder. -There was an order for Pyridium 100mg three times daily with a start date of 05/27/22. Review of the facility's physician order request form for Resident #6 dated 05/24/22 revealed: -The resident experienced UTI symptoms (an infection of the bladder and/or tubes leading to the bladder. Symptoms include painful and/or burning urination and urinary frequency). -The symptoms were not documented. -Macrodantin 100mg twice daily for 7 days was orderd on 05/24/22 (an antibiotic used to treat UTIs). -Diflucan 150mg for a total of 2 doses was ordered on 05/24/22 (used to treat fungal	D 358		

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infections).

Review of the facility's physician order request form for Resident #6 dated 05/29/22 revealed:
-The resident complained of severe urinary pain.
-The resident was sent to the local hospital per her request.

Review of Resident #6's local hospital ED visit information sheet dated 05/26/22 revealed diagnoses included a UTI.

Review of the facility's physician order request form for Resident #6 dated 06/19/22 revealed:
-The resident's urine was cloudy.
-The resident's genital was red and the resident complained of burning during urination.
-An antifungal cream and urinalysis and culture (a urine laboratory test that can diagnose a UTI) were ordered.

Review of the facility's physician order request form for Resident #6 dated 06/22/22 revealed:
-The resident's urinalysis was documented as positive without documentation of bacteria present.
-Cipro 500mg twice daily for 14 days was ordered on 06/22/22 (used to treat infections such as UTIs).
-Macrodantin 500mg one tablet at bedtime for 90 days; start once Cipro was completed was ordered on 06/22/22.

Review of Resident #6's facility record on 06/24/22 at 9:30am revealed there was not a urinalysis report.

Review of Resident #6's June 2022 electronic medication administration report (eMAR) revealed:

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-There was not an entry for Pyridium 100mg three times daily.
-There was no documentation Pyridium was administered to the resident.

Observation of the 8:00am to 9:00am medication pass on 06/24/22 revealed:
-The medication aide (MA) administered 14 medications to Resident #6.
-Pyridium was not administered to Resident #6.

Observation of Resident #6's mediations on hand on 06/24/22 at 12:42pm revealed Pyridium was not available for administration to the resident.

Interview with the Resident Care Coordinator (RCC) on 06/24/22 at 11:00am revealed:
-Both she and the MA/Supervisor (MA/S) were responsible for new order processing.
-She did not know Resident #7 had an order for Pyridium.
-PCP visit notes were received by the facility via fax.
-The MA/S received the PCP visit notes from the fax and reviewed for orders.
-The MA/S faxed the orders to the pharmacy and gave to the RCC after faxed.
-The RCC reviewed the resident's eMARs and compared to the faxed documentation every day to be certain the medication was entered on the eMAR by the pharmacy.
-After pharmacy entered the medication in the eMAR, she documented a check mark or her initials on the order to indicate the order had been completely processed.
-Resident #7's PCP visit notes with the Pyridium order was not documented with a check or her initials.
-She was dependent on the MA/S to retrieve orders and PCP visit notes from the fax and

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process them.
-She did not remember discussing Resident #7's Pyridium order with the PCP.
-She did not know how Resident #7's Pyridium order was missed by the MA/S and her.

Interview with the Administrator on 06/24/22 at 12:20pm revealed:
-She did not know anything about Resident #7's Pyridium order.
-The RCC was responsible for reviewing PCP visit notes and orders daily.
-The MA retrieved the orders and PCP visit notes from the fax, reviewed the documentation for orders, copied the order, filed and flagged the copy in the resident's facility record, and placed the original in a hot box system.
-The RCC and MA/S were responsible for checking the hot box daily to ensure orders were processed and complete.
-Once the order was complete, the RCC or MA/S pulled the copy from the resident's facility chart and filed the original document.

Telephone interview with Resident #6's PCP on 06/24/22 at 11:25am revealed:
-Resident #6 had chronic UTIs.
-She prescribed Pyridium 100mg three times daily on 05/27/22 to treat painful urination associated with UTIs.
-The Pyridium order was still active.
-Missing doses of Pyridium would cause the resident to have painful urination.
-She did not know the facility had not administered the ordered Pyridium to the resident.

Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable.

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