DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-059-017**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/19/2022

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
McDowell Assisted Living	**5235 NC 226 South, Marion, NC 28752**

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)	COMPLETE DATE
{D 0000}	Initial Comments The Adult Care Licensure Section conducted an annual survey from 10/18/22 to 10/19/22. 10A NCAC 13F .1004(a) Medication Administration	{D 0000}		
(D 0358)	10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and nonprescription, 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. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed practicing prescriber for 1 of 5 sampled residents (#4) related to an order for levothyroxine. The findings are: 1. Review of Resident #4's current FL2 dated 04/07/22 revealed: -Diagnoses included a history of cerebrovascular accident (CVA), hyperlipidemia, and hyponatremia. -There was an order for levothyroxine 150mcg take one tablet daily (used to treat low levels of thyroid hormone). Review of Resident #4's signed physician's orders dated 07/27/22 revealed: -There was an order to discontinue levothyroxine 150mcg take one tablet daily. -There was an order to begin levothyroxine 125mcg	(D 0358)		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

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)	COMPLETE DATE
(D 0358)	Continued From page 1 take one tablet daily. Review of Resident #4's signed physician's orders dated 09/22/22 revealed: -There was an order to discontinue levothyroxine 125mcg take one tablet daily. -There was an order to begin levothyroxine 100mcg take one tablet daily. Review of Resident #4's September 2022 electronic Medication Administration Record (eMAR): -There was an entry for levothyroxine 125mcg take one tablet daily and scheduled for 6:30am. -Levothyroxine 125mcg was documented as administered from 09/01/22 to 09/22/22 at 6:30am. -There was an entry for levothyroxine 100mcg take one tablet daily that started on 09/23/22. -Levothyroxine 100mcg was documented as administered from 09/23/22 to 09/30/22 at 6:30 am. Review of Resident #4's October 2022 eMAR revealed: -There was an entry for levothyroxine 100mcg take one tablet daily for 6:30am. -Levothyroxine 100mcg was documented as administered daily from 10/01/22 to 10/19/22 at 6:30 am. -There was no entry for levothyroxine 125mcg take one tablet daily on the eMAR. Observation of Resident #4's medications on hand on 10/19/22 at 7:40am revealed: -There was a medication bubble pack labeled levothyroxine 125mcg take one tablet daily that was	(D 0358)		

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)	COMPLETE DATE
(D 358)	Continued From page 2 dispensed on 09/23/22 with 1 of 28 tablets that remained. -The levothyroxine 125mcg medication bubble pack was delivered with the facility's cycle fill of medications according to the label on the medication package. -There was another medication bubble pack labeled levothyroxine 100mcg take one tablet daily that was dispensed on 09/22/22 with 1 of 28 tablets that remained. Based on review of the eMARs, observation of Resident #4's medications on hand, pill count and interview with the pharmacy revealed, there should have been 28 of 28 tablets remaining in the levothyroxine 125mcg bubble pack because the order was discontinued on 09/22/22 and 28 tablets of levothyroxine 125mcg were dispensed to the facility on 09/23/22. Levothyroxine 100mcg was dispensed to the facility on 09/22/22. There was 1 of 28 tablets that remained in both the levothyroxine 125mcg and levothyroxine 100mcg bubble packs which indicated levothyroxine 125mcg was not discontinued as ordered on 09/22/22. Resident #4 was administered both the levothyroxine 125mcg and 100mcg doses instead of the ordered dose of levothyroxine 100mcg. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/19/22 at 10:20am revealed: -Levothyroxine 100mcg take one tablet daily was Resident #4's current medication order on file at the pharmacy. -There were 28 tablets of levothyroxine 100mcg	(D 0358)		

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)	COMPLETE DATE
(D 358)	Continued From page 3 dispensed to the facility on 09/22/22. -Levothyroxine 125mcg take one tablet daily was Resident #4's previous medication order that was discontinued by the provider on 09/22/22. -There were 28 tablets of levothyroxine 125mcg that were filled on 09/16/22 and delivered to the facility with the cycle fill of medications on 09/23/22. -A normal cycle fill of medications was a 28-day supply. -Sometimes providers would send orders directly to the pharmacy and sometimes the facility would fax new medication orders to the pharmacy. Telephone interview with Resident #4's primary care provider (PCP) on 10/19/22 at 10:40am revealed: -She was not aware that Resident #4 was administered both the discontinued 125mcg and ordered 100mcg doses of levothyroxine daily from 09/23/22 to 10/18/22 until she was notified by the facility on 10/19/22. -She expected the facility to administer medications as ordered. -Possible side effects of too much levothyroxine included anxiety and increased heart rate. -When she wrote a new medication order, she wrote the order down, gave it to the facility, and the facility faxed the order to the pharmacy. -She wrote an order for Resident #4 to have a thyroid stimulating hormone (TSH) level lab draw done on 10/19/22 after the facility notified her of the medication error. Interview with a medication aide (MA) on 10/19/22 at 9:40am revealed: -She was not aware that Resident #4 was administered	(D 358)		

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)	COMPLETE DATE
(D 358)	Continued From page 4 both the discontinued order of levothyroxine 125mcg daily and the ordered amount of 100mcg levothyroxine daily from 09/23/22 to 10/18/22. -Her normal process for administering medications was to check a resident's medication orders on the computer screen first, pop the medications from the bubble pack into a medication cup, administer the medications and document medication administration. -The facility used to have medication scanners to scan medications into the computer, but they no longer had scanners. -MAs documented all medication administration by manual entry, meaning that they physically clicked a computer mouse to document administration on the eMAR system. -Most medications were sent to the facility from the pharmacy on a cycle fill every 28 days. -The last cycle fill date was on 09/23/22 and the next cycle fill date would be on 10/20/22. -She thought that Resident #4's PCP changed the medication order for levothyroxine right before the medication cycle fill was sent to the facility on 09/23/22. -The old, discontinued order for levothyroxine 125mcg was sent to the facility along with the rest of Resident #4's medications with the cycle fill on 09/23/22. -She thought that Resident #4 was administered both the 125mcg daily and 100mcg daily dosages of levothyroxine from 09/23/22 to 10/18/22. -She thought the first shift MA normally audited the medication carts and the medication orders every 28 days when the cycle fill of medications arrived in the facility.	(D 358)		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

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)	COMPLETE DATE
(D 358)	Continued From page 5 -Both MAs and the RCC were responsible to administer medications as ordered by the provider. -When a provider wrote a new medication order, the provider would write down the new order and give it to the Resident Care Coordinator (RCC), the RCC would fax the new order to the pharmacy, and the pharmacy would enter the new medication order into the eMAR system. Interview with a second MA on 10/19/22 at 12:30pm revealed: -She was not aware Resident #4 was administered both the 125mcg and 100mcg doses of levothyroxine from 09/23/22 to 10/18/22. -She and the RCC did medication cart audits every 28 days when the cycle fill of medications was delivered from the pharmacy to the facility. -She thought the discontinued medication bubble pack of levothyroxine 125mcg that was delivered to the facility was missed during the last medication cart audit on 09/23/22. -Her normal process for administering medications was to open the eMAR, take the medication out of the medication cart, pop the medication into a medication cup, administer the medication to the resident, and document administration. -MAs were responsible to administer medications as ordered. -Resident #4 had not complained of any increased heart rate or anxiety. Interview with Resident #4 on 1:50pm revealed: -He thought that he was administered all his medications according to his provider's orders,	(D 358)		

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-059-017**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/19/2022

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
McDowell Assisted Living	**5235 NC 226 South, Marion, NC 28752**

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)	COMPLETE DATE
(D 358)	Continued From page 6 including levothyroxine. -He had not experienced any anxiety or felt like his heart rate was increased in the last month. Telephone interview with the Resident Care Coordinator (RCC) on 10/19/22 at 12:48pm revealed: -She was not aware Resident #4 was administered both the 125mcg and 100mcg doses of levothyroxine daily from 09/23/22 to 10/18/22. -Resident #4's PCP was notified once the error of levothyroxine administration was discovered and had ordered labs to be drawn on 10/19/22. -Medication cart audits were done when the cycle fill of medications was delivered to the facility. -The last medication cycle fill was 09/23/22. -The first shift MA did the medication cart audits. -MAs were responsible to administer medications as ordered. Interview with the Administrator on 10/19/22 at 2:00pm revealed: -She was not aware Resident #4 was administered both 125mcg levothyroxine and 100mcg levothyroxine from 09/23/22 to 10/18/22 daily instead of the ordered dose of 100mcg levothyroxine daily. -She expected MAs to administer medications as ordered by the PCP. -MAs were responsible to administer medications as ordered. -The RCC did medication cart audits with each cycle fill of medication that arrived at the facility, and sometimes the MA on duty would help with the medication cart audit.	(D 358)		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-059-017**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/19/2022

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
McDowell Assisted Living	**5235 NC 226 South, Marion, NC 28752**

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)	COMPLETE DATE
(D 358)	Continued From page 7 -The facility immediately notified the provider once the medication error was discovered on 10/19/22.	(D 358)		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE