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
	HAL080138	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTONWOOD AT PROVIDENCE	11945 PROVIDENCE ROAD CHARLOTTE, NC 28277

(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 and the Mecklenburg County Department of Social Services conducted an annual survey and complaint investigation on 11/08/22 to 11/09/22. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 10/12/22.	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 and in accordance with the facility's policies for 1 of 4 residents (#6) observed during the medication pass including errors with a nasal spray used for congestion and a medication for overactive bladder. The findings are: Review of the facility's Medication Administration policy and procedure, dated 08/20, revealed: -Medications shall be administered according to the prescribing licensed practitioner and physician medication orders. -Medication aides (MA) shall check to verify the "right dose" for administration by comparing the	D 358		

Reviewed and Acknowledged Susan Shinn, MSW 1/9/23

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D 358	Continued From page 1 information on the electronic medication administration record (eMAR) with what is written on the pharmacy label. -MA is to check with the pharmacists' recommendations to ensure medications can be crushed or altered for administration. 1. The medication error rate was 24% as evidenced by the observation of 2 errors out of 28 opportunities during the morning medication passes on 11/08/22. Review of Resident #6 current FL-2 dated 09/19/22 revealed diagnoses included dementia, spondylosis, and urinary urge incontinence. a. Review of Resident #6's current FL-2 dated 09/19/22 revealed there was an order for Flonase 50mcg, install 2 sprays in each nostril once a day (Flonase is a nasal spray used to treat nasal congestion and allergies). Observation of the morning medication pass on 11/08/22 at 8:59am revealed: - The medication aide (MA) administered Flonase 1 spray in each nostril to Resident #6 instead of 2 sprays in each nostril as ordered. -The MA did not offer or attempt a second spray in either nostril. Review of Resident #6's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Flonase spray 50mcg with instructions to install 2 sprays in each nostril once daily, scheduled for administration at 8:00am. -Flonase spray 50mcg was documented as administered on 11/08/22 at 8:00am.	D 358		

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D 358	Continued From page 2 Observation of medications on hand for Resident #6 on 11/08/22 revealed there was one bottle of Flonase nasal spray with instructions to use 2 sprays in each nostril daily. Interview with the MA on 11/08/22 at 1:55pm revealed: -She administered Resident #6's Flonase dose off of memory and did not check the label to ensure she was administering the correct dosage. -She gave Resident #6 1 spray in each nostril when administering her Flonase. -She should have referred to the electronic medication administration record (eMAR) and pharmacy label on the medication to see how many sprays Resident #6 was ordered. -She was not aware of Resident #6 having any nasal congestion. Interview with the Special Care Coordinator (SCC) on 11/08/22 at 2:15pm revealed: -She expected MAs to administer medications as ordered, -It was the MAs responsibility to refer to the instructions on the eMAR and pharmacy label for administration including number of sprays for Resident #6's Flonase. Interview with the Resident Care Coordinator (RCC) on 11/08/22 at 2:30pm revealed it was the MAs responsibility to administer the medications as ordered, including the proper number of sprays for Resident #6's Flonase order. Interview with the Administrator on 11/09/22 at 2:30pm revealed he expected medications to be administered as ordered including correct dosage of medication.	D 358		

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D 358	Continued From page 3 Based on observations, interviews, and record reviews, it was determined that Resident #6 was not interviewable. b. Review of Resident #6's current FL-2 dated 09/19/22 revealed there was an order for Mirabegron ER 25mg, take one tablet by mouth daily with instruction *do not crush* (Mirabegron ER is an extended-release medication that may be used to treat overactive bladder. Mirabegron ER is extended release and should not be crushed or chewed.) Observation of the morning medication pass on 11/08/22 at 8:59am revealed: -The medication aide (MA) prepared morning medications for Resident #6, including one Mirabegron ER 25mg tablet. -The MA crushed all of Resident #6's oral medications, including the Mirabegron ER 25mg, mixed them in applesauce and administered them to the resident at 8:59am. Review of Resident #6's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Mirabegron ER 25mg, take one tablet by mouth daily **Do Not Crush**, scheduled for administration at 8:00am. - Mirabegron ER 25mg, take one tablet by mouth daily **Do Not Crush** was documented as administered on 11/08/22 at 8:00am. -There was an entry 'may crush medications unless contraindicated' scheduled for 12:00am-7:00am, 7:00am-3:00pm, and 3:00pm-11:00pm. -'May crush medications unless contraindicated' was documented as done on 11/08/22 at 7:00am-3:00pm.	D 358		

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D 358	Continued From page 4 Observation of medications on hand for Resident #6 on 11/08/22 revealed there was a supply of Mirabegron ER tablets dispensed on 10/26/22 with instructions stating DO NOT CRUSH on the medication label. Interview with the MA on 11/08/22 at 1:55pm revealed: -The medications that are not able to be crushed have special instructions on the eMAR and on the pharmacy printed label. -She did not check the Mirabegron ER label or eMAR instructions because she was used to crushing all of Resident #6's medications including her Mirabegron. -She should have checked the eMAR and pharmacy label before crushing Resident #6's medications. Interview with the Special Care Coordinator (SCC) on 11/08/22 at 2:15pm revealed: -The MA should have checked on the eMAR and pharmacy label to ensure that medications were appropriate to crush prior to crushing and administering them. -Resident #6's Mirabegron ER had instructions on the eMAR and on the pharmacy label not to crush the medication. Interview with the Resident Care Coordinator (RCC) on 11/08/22 at 2:30pm revealed she expected the MA not to crush extended-release medications. Interview with the Administrator on 11/09/22 at 2:30pm revealed he expected medications to be administered as ordered, including ER medications that should not be crushed. Based on observations, interviews, and record	D 358		

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D 358	Continued From page 5 reviews, it was determined that Resident #6 was not interviewable.	D 358		

Plan of Correction: Waltonwood at Providence
RE: Annual Survey
Charlotte- Mecklenburg County
HAL-060-138
Administrator: John Ficker

D358 - Regarding the alleged deficient practice of failure to prepare and administer medications, prescription and non-prescription, and treatments by staff 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, as evidenced by:

a) The medication aide (MA) administered Flonase 1 spray in each nostril to Resident #6 instead of 2 sprays in each nostril as ordered.

&

b) The MA crushed all of Resident #6's oral medications, including the Mirabegron ER 25mg (noted **DO NOT CRUSH**), mixed them in applesauce and administered them to the resident at 8:59am.

Plan of Correction as follows-

- On 11/09/22, resident #6 was assessed by a licensed Registered Nurse with no adverse effects noted. Resident #6's primary care provider notified of medication errors and resident assessment with no new orders received.

- On 11/09/22, the Medication Aide was re-trained by the Resident Care Manager (RN) on the rights of medication administration, physician orders for medication administration, and pharmacy instructions related to use of medications.

- All Medication Aides will be educated by 12/30/2022 by the Regional Director of Resident Care or the Resident Care Manager on the rights of medication administration, physician orders for medication administration, and pharmacy instructions related to use of medications. Newly hired Medication Aides will be educated upon hire to ensure medications are administered in accordance with physician orders, facility policies, and pharmacy instructions. On-going medication administration education and in-services will be provided quarterly by Regional Director of Resident Care or Resident Care Manager.

- The Regional Director of Resident Care or The Resident Care Manager will audit medication administration weekly for any errors completed by 1/26/2023. Quarterly audits will remain in place after completion date.

- The Regional Director of Resident Care or The Resident Care Manager and Executive Director will review the findings of medication administration audits during monthly Quality Assurance committee meetings.

- Executive Director will audit quarterly to ensure compliance of Plan of Correction.

Administrator
1-5-23