STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL006007	A. BUILDING: _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 completed a follow-up survey 03/01/23 - 03/02/23.	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: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents related to two medications used to treat an eye infection (Resident #4). The findings are: Review of the facility's medication administration policy dated September 2021 revealed: -The facility utilized a preferred pharmacy that provided medications in a multi-dose packaging system except when antibiotics or psychotropics were ordered. -All medications administered, handled, and stored were documented on the electronic medication administration record (eMAR). -A new medication order for an antibiotic shall be started no later that 9:00am the following day and all efforts should be made to start antibiotics at	D 358		

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D 358	Continued From page 1	D 358		

the next scheduled dose.
-All new orders were reviewed by the Special Care Coordinator (SCC) and faxed to the contracted pharmacy and scanned into the computer system.
-The SCC would wait for pharmacy to enter the medication into the electronic medication system, review the order, and approve the order for administration.
-Staff completed medication cart audits weekly and check to make sure all medications were available using a copy of the physician orders.
-Medication errors included wrong doses, missed doses, missed documentation, or not initiating orders.

Review of Resident #4's current FL2 dated 12/27/22 revealed:
-Diagnoses included dementia and osteoporosis.
-The resident was intermittently disoriented.

Review of a physician's order dated 01/27/23 revealed:
-Start Gentamicin (an antibiotic) one drop left eye four times daily.
-Continue Maxitrol Ointment (an antibiotic and steroid combination) in left eyelid every night.

Review of Resident #4's January, February and March 2023 eMAR revealed:
-There was not an entry for Gentamicin one drop left eye four times daily.
-There was not an entry for Maxitrol Ointment in left eyelid every night.

Observation of Resident #4's medications on hand on 03/01/23 at 3:29pm revealed there were no Gentamicin drops or Maxitrol Ointment on the medication cart.

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D 358	Continued From page 2 Interview with the medication aide (MA) on 03/01/23 at 4:10pm revealed: -There were no Gentamicin drops or Maxitrol Ointment on the medication cart for Resident #4. -There was not an order on the eMAR to administer Gentamicin drops or Maxitrol Ointment for Resident #4. Interview with the SCC on 03/01/23 at 3:51pm revealed: -Resident #4 had conjunctivitis (an eye infection). -She was aware that Resident #4 had been administered eye drops a few weeks ago. -She was not aware of the order on 01/27/23 for Resident #4 to be administered Gentamicin or Maxitrol. -The facility had a transportation aide (TA) who took Resident #4 to her eye appointment on 01/27/23. -The TA was supposed to write a progress note about any medication changes. -The TA was supposed to fax any scripts from the eye appointment to the pharmacy. -The TA was supposed to place any paperwork for medication orders in a file designated for orders to be put in the computer by the SCC. -Apparently, the TA had placed the paperwork in the "to be filed" file. -The medication order from the physician visit on 01/27/23 was never placed in the computer. Observation of Resident #4 on 03/01/23 at 5:16pm revealed her eyes were clear with no redness, cloudiness or drainage. Interview with Resident #4 on 03/01/23 at 5:16am revealed: -Her eyes did not burn or itch. -Her eyes were not causing her any discomfort. -She had an eye infection but thought it was	D 358		

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D 358	Continued From page 3 getting better. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/01/23 at 4:30pm revealed: -Gentamicin was an antibiotic used for eye infections. -Maxitrol was a combination antibiotic and steroid used for eye infections. -If Gentamicin and Maxitrol were not administered as ordered, the eye infection could potentially get worse. -The pharmacy has not received an order from the facility dated between 01/27/23 and 03/01/23 for Gentamicin eye drops or Maxitrol eye Ointment. Telephone interview with an Optometrist office Representative on 03/02/23 at 1:44pm revealed: -The optometrist who saw Resident #4 on 01/27/23 diagnosed her with "other conjunctivitis." -Resident #4's eye infection could have gotten worse without the medication but would not have caused vision loss. -The optometrist wanted Resident #4 to start the Gentamicin and Maxitrol as soon as possible. -The optometrist would follow up with an eye exam on 03/09/23 for Resident #4. Interview with the Administrator on 03/02/23 at 2:06pm revealed: -If there was a question about medications to be given, the MA should get a clarification order. -The SCC was responsible to follow up and make sure medication orders were followed. -The medication order for Resident #4 was missed. -He expected medications to be given as ordered. _____ The facility failed to ensure two medications were	D 358		

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D 358	Continued From page 4 available and administered as ordered to a resident (#4) who had been diagnosed with an eye infection and prescribed an antibiotic and a steroid on 01/27/23. The facility's failure was detrimental to the health and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/01/23. CORRECTION DATE FOR THE VIOLATION SHALL NOT EXCEED APRIL 16, 2023.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the medication aide (MA) observe a resident (Resident #2) take their medication and document on the electronic medication administration record (eMAR) immediately following administration of medications to the resident. The findings are:	D 366		

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D 366	Continued From page 5 Review of the facility's medication administration policy dated September 2021 revealed medication errors included wrong doses, missed doses, missed documentation, or not initiating orders. Review of Resident #2's current FL2 dated 07/20/22 revealed: -Diagnoses included dementia, high blood pressure and depression. -Orientation was documented as constantly disoriented. -There was an order for losartan (used to treat high blood pressure) 100mg tablet daily. -There was an order for sertraline (used to treat depression) 50mg tablet daily. Observation during the initial facility tour on 03/01/23 at 10:00am revealed on Resident #4's bedside table there was a plastic medication cup setting on Resident #2's bedside table containing one green tablet and one yellow tablet. Interview with Resident #2 on 03/01/23 at 10:00am revealed: -She had already taken all her morning medication on 03/01/23. -She did not want to take those 2 tablets because they were not hers. -She did not want to take someone else's medication. Observation of Resident #2 on 03/01/23 at 10:08am revealed: -Resident #2 was walking down the hallway with the plastic medication cup in her hand. -Resident #2 gave the plastic medication cup to the medication aide (MA). -The plastic medication cup contained one green tablet and one yellow tablet.	D 366		

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D 366	Continued From page 6 -Resident #2 told the MA she did not want to take the medications. Interview with MA on 03/01/23 at 10:09am revealed: -She administered medications to Resident #2 in the dining room the morning of 03/01/23. -She observed Resident #2 take her medications. -Resident #2 pour the medication in her hand and then place the medication in her mouth. -She usually checked to make sure Resident #2 had taken all her medications. -She did not verify she had taken all her medications on the morning of 03/01/23. -She usually left the empty medication cup with Resident #2 because Resident #2 would throw the medication cup away as she left the dining room after her breakfast. -She did not observe Resident #2 throw her medication cup away on 03/01/23 after breakfast. -She was not sure what the two medications were that Resident #2 had brought to her. -She documented on the eMAR all of Resident #2's morning medications on 03/01/23 had been administered. Observation of Resident #2's medications on hand on 03/01/23 at 3:29pm revealed: -There was a picture of each medication on the outside of the multi-dose package containing Resident #2's medication. -The MA verified the two tablets in the medication cup were losartan and sertraline. Interview with the Special Care Coordinator (SCC) on 03/02/23 at 8:07am revealed: -All MAs were aware they were not supposed to leave medications with a resident. -The MA should have observed Resident #2 swallow all her medications.	D 366		

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D 366	Continued From page 7 -If a resident did not take all their medications, the medication should be removed and not left with the resident. -Resident #2 had a history of pouring medications into her hand and "pocketing" some of her medication or "cheeking" (keeping the medication in her mouth but not swallowing) the medication. -The MA should pay very close attention when Resident #2 took her medication because of her history of pocketing or cheeking her medication and not swallowing it. Interview with Administrator on 03/02/23 at 2:06pm. -The MAs should always observe residents take all their medication. -Medications should never be left with the resident. -Oral medications should be documented on the eMAR after the MA observed the resident swallow them.	D 366		
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; (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;	D 367		

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D 367	Continued From page 8 (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, record review and interviews, the facility failed to ensure electronic medication administration records (eMAR) were accurate for 1 of 5 sampled residents (Resident #2) related to a medication used to treat high blood pressure and a medication used to treat depression. The findings are: Review of the facility's medication administration policy dated September 2021 revealed medication errors included wrong doses, missed doses, missed documentation, or not initiating orders. Review of Resident #2's current FL2 dated 07/20/22 revealed: -Diagnoses included dementia, high blood pressure and depression. -There was an order for losartan (used to treat high blood pressure) 100mg tablet daily. -There was an order for sertraline (used to treat depression) 50mg tablet daily. Observation during initial tour on 03/01/23 at 10:00am revealed on Resident #2's bedside table there was a plastic medication cup with one green tablet and one yellow tablet.	D 367		

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D 367	Continued From page 9 Interview with MA on 03/01/23 at 10:09am revealed: -She administered medications to Resident #2 the morning of 03/01/23 between 7:40am and 7:50am. -She observed Resident #2 pour the medication in her hand and place the medication in her mouth. -She did not verify Resident #2 had taken all her medications on the morning of 03/01/23. -She documented on the eMAR all medications were administered to Resident #2 the morning of 03/01/23. Review of the eMAR for the 8:00am administration on 03/01/23 revealed: -There was documentation losartan 100mg tablet was administered. -There was documentation sertraline 50mg tablet was administered. Interview with the Special Care Coordinator (SCC) on 03/02/23 at 8:07am revealed if a resident was not observed taking their medication the MAs should not document their medication was administered on the eMAR. Interview with the Administrator on 03/02/23 at 2:06pm revealed the MAs could only check off medication on the eMAR that they witnessed the resident take.	D 367		