STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096004	A. BUILDING: _____ B. WING _____	R 03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYNE COUNTY REST VILLA NO 2	305 SOUTH VANCE STREET EUREKA, NC 27830

(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 conducted an annual and follow up survey on March 21-22, 2023.	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 by the primary care provider (PCP) for 3 of 3 sampled residents (#1, #2 and #3) including a bronchodilator inhaler (#1), an antibiotic lotion (#2) and an antipsychotic (#3). The findings are: 1. Review of Resident #3's current FL-2 dated 12/23/22 revealed diagnoses included diabetes mellitus, hypertension, depression, and dementia. Review of Resident #3's physician's orders dated 03/02/23 revealed an order for Zyprexa 2.5mg twice daily. (Zyprexa is an antipsychotic used to treat mood and mental disorders.) Review of Resident #3's February 2023 electronic administration records (eMAR) revealed: -There was an entry for Zyprexa 2.5mg one tablet	D 358	* all MA's will be retrained by the facility RN on the 6 RIGHTS in given Medication. The training will Include But not Limited	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Lorraine Best TITLE Adm. (X6) DATE 4/20/2023

Reviewed and acknowledged 2 May 2023

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D 358	Continued From page 1 twice daily at 8:00am and 8:00pm. -There was documentation all doses of Zyprexa were administered from 8:00pm on 02/23/23 until 8:00pm on 02/28/23. Review of Resident #3's March 2023 eMAR revealed: -There was an entry for Zyprexa 2.5mg one tablet twice daily at 8:00am and 8:00pm. -There was documentation all doses of Zyprexa were administered from 8:00am on 03/01/23 until 8:00am on 03/21/23. Observations of Resident #3's medications on hand on 03/22/23 at 11:35am revealed: -There was a prescription bottle with a Veteran's Administration (VA) pharmacy label which included Resident #3's name and instructions for Zyprexa 5mg one half tablet twice daily. -The pharmacy label indicated 90 tablets were dispensed on 03/08/23. -The medication aide (MA) emptied the Zyprexa tablets onto a tissue and counted 54 whole tablets. Interview with the MA on 03/22/23 at 11:35am revealed: -She had administered one Zyprexa tablet from the prescription bottle that morning (03/22/23) because the order on the eMAR was for one tablet. -She did not previously know the order on the eMAR was for Zyprexa 2.5mg one tablet twice daily while the prescription bottle label was for Zyprexa 5mg one half tablet twice daily. -She did not know Resident #3 was supposed to receive one half tablet to equal 2.5mg. -She did not have a pill cutter on the medication cart. -She was responsible for notifying the Resident	D 358	to the following on how to read physican orders to compare orders on the medication cart by checking doses when and how to administer the correct dose. RCC will Review New orders for accuracy, check medication package for accuracy before adding medication to	

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D 358	Continued From page 2 Care Coordinator (RCC)/Manager of any medication errors. -The RCC/Manager notified the primary care provider (PCP). Interview with Resident #3 on 03/22/23 at 11:59am revealed: -He took many medications, but he did not know the names of them. -He remembered seeing his PCP and a mental health provider (MHP). -He remembered recently starting new medications, but he did not know the name of the medication or what it was for. -He was feeling okay and was not experiencing any side effects such sleepiness, nervousness, anxiety, or nausea. Telephone interview with Resident #3's PCP on 03/22/23 at 1:37pm revealed: -Zyprexa was used to treat agitation and aggression and was normally prescribed by a MHP. -He prescribed a low dose of Zyprexa for Resident #3 due to behavior changes and the resident had not yet been seen by a MHP. Interview with the RCC/Manager on 03/22/23 at 2:12pm revealed: -She was responsible for checking the pharmacy label on medications mailed to the facility by the VA against the order and eMAR. -The Zyprexa did not arrive by mail. -Resident #3 went to the VA and filled the prescription order. -She was not sure if she or the MA on duty checked the prescription bottle before it was placed on the cart. -Normally, she would have ensured the order on the eMAR for tablet strength and the bottle	D 358	med. Carts. RCC will audit medication Cart Weekly to ensure medication are on hand and being administered as ordered. 5/9/23	

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D 358	Continued From page 3 matched or she would have ensured all tablets in the bottle were halved before placing them on the medication cart. Refer to interview with the Resident Care Coordinator (RCC)/Manager on 03/22/23 at 12:15pm. 2. Review of Resident #2's current FL-2 dated 03/22/23 revealed diagnoses included hypothyroidism, hyperlipidemia, benign prostate hypertrophy, obesity, obstructive sleep apnea, gastro-esophageal reflux disease, schizophrenia, and panniculus. Review of Resident #2's physician order dated 01/25/23 revealed an order for metronidazole lotion topically to face every day. (Metronidazole is used to treat adult acne.) Review of Resident #2's January, February, and March 2023 electronic treatment administration record (eTAR) revealed: -There was an entry for metronidazole lotion topically to face every day at 8:00am. -There was documentation doses of metronidazole lotion were administered daily from 01/27/23 through 03/22/23. Observations of Resident #2's medications on hand on 03/22/23 at 11:15am revealed: -There was a manufacturer's bottle of metronidazole with a prescription label which included Resident #2's name and instructions to apply daily. -The label indicated 2 fluid ounces were dispensed on 01/25/23 and the bottle was nearly full. -There was a second bottle of a different prescription antibiotic lotion with instructions to	D 358		

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D 358	Continued From page 4 apply twice daily. Interview with the medication aide (MA) on 03/22/23 at 11:15am revealed: -Resident #2 did not like to have both of the medicated lotions applied to his face at the same time. -She normally applied the metronidazole lotion when she administered noon medications. -She did not work every day and could not say how the bottle remained nearly full for 2 months. Interview with Resident #2 on 03/22/23 at 12:59pm revealed: -He used a lotion on his face every morning and evening. -He did not know the name of the lotion or what it was used for. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/22/23 at 1:08pm revealed: -The pharmacy had an order for metronidazole lotion topically to the face every day dated 01/25/23 for Resident #2. -The pharmacy dispensed 59 milliliters (ml) of metronidazole once for Resident #2 on 01/25/23. Telephone interview with Resident #2's primary care provider (PCP) on 03/22/23 at 1:37pm revealed: -Metronidazole was used to treat facial rosacea (acne). -Resident #2 always had some level of rosacea on his face. Refer to interview with the Resident Care Coordinator (RCC)/Manager on 03/22/23 at 12:15pm.	D 358		

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D 358	Continued From page 5 3. Review of Resident #1's current FL-2 dated 11/17/22 revealed diagnoses included chronic obstructive pulmonary disease, hypertension, diabetes type 2, mild retardation, and schizophrenia. Review of Resident #1's physician's orders dated 11/17/21 revealed an order for Spiriva 18 MCG CP-Handihaler daily at 9:00 AM. Review of Resident #1's January, February, and March 2023 electronic administration medication records (eMAR) revealed Spiriva was documented as administered from 01/01/23 through 03/21/23 once daily at 9:00 AM. Observations of Resident #1's medications on hand on 03/22/23 at 11:45am revealed: -There was a manufacturer's bottle of Spiriva with a prescription label which included Resident #1's name and instructions to inhale contents of one capsule via Handihaler by mouth daily. -The dispense date on the medication that was being used was 01/31/23 and was a 30 cap supply, with ten capsules remaining. -There was a second box of Spiriva capsules in the medication cart dated 03/14/23 that was unopened. Interview with the medication aide (MA) on 03/22/23 at 11:45am revealed: -Resident #1 should be getting a capsule of Spiriva daily. -She reported she was unsure if Resident #1 was given the Spiriva inhaler daily, she gave it to him on the days she passed medications. Interview with Resident #1 on 03/22/23 at 1:30pm revealed: -He was given his inhaler every morning.	D 358		

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D 358	Continued From page 6 -He did not recall missing any doses of Spiriva. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/22/23 at 1:15pm revealed: -The pharmacy had an order for Spiriva 18 MCG CP-Handihaler daily dated 07/14/22 for Resident #1. -The pharmacy dispensed a 30-day supply to the facility on 12/20/22, 01/31/23 and 03/14/23. Telephone interview with Resident #1's primary care provider (PCP) on 03/22/23 at 1:40pm revealed: -Spiriva was prescribed for Resident #1's diagnosis of COPD and wheezing. -He preferred Resident#1 to take the Spiriva every day. Refer to interview with the Resident Care Coordinator (RCC)/Manager on 03/22/23 at 12:15pm. Interview with the Resident Care Coordinator (RCC)/Manager on 03/22/23 at 12:15pm revealed: -Medication aides (MAs) were responsible for administering medications according to the orders on the electronic medication and treatment administration records. -MAs were responsible for comparing the medication label against the orders on the electronic medication administration record (eMAR) before administering medications to the resident. -MAs were responsible for contacting the primary care provider (PCP) for clarification of discrepancies between the medication label and the eMAR. -The MA was responsible for reporting medication	D 358		

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D 358	Continued From page 7 errors to her. -She contacted the PCP when she was at the facility. -MAs were responsible for notifying the PCP of medication errors when she was not at the facility.	D 358		