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WE CARE FAMILY CARE	1718 MORGANTON ROAD BURLINGTON, NC 27217

(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
C 000	Initial Comments The Adult Care Licensure Section and the Alamance County Department of Social Services conducted an annual and follow up survey with an exit date of April 13, 2023.	C 000		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled staff (A) who administered medications met the requirements related to successfully completing 5-hour and 10-hour or 15-hour medication training course and passed the state medication aide examination prior to administering medications. The findings are:	C 131		

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Observation of the medication pass on 04/13/23 at 8:06am revealed:
-Staff A called Resident #1 to the medication room and administered two eye drops to the resident.
-Staff A called Resident #2 to the medication room and obtained a fingerstick blood sugar reading (FSBS) from the resident.
-Staff A administered insulin to Resident #2.
-Staff A did not wear gloves when he administered the eye drops, checked the FSBS and administered the insulin.
-Staff A did not wash his hand before, during or after the administration of the eye drops, checked the FSBS, and administered the insulin.

Review of Staff A's personnel record revealed:
-There was documentation Staff A was hired on 06/13/06.
-There was no documentation Staff A had completed the 5-hour and 10-hour, or 15-hour medication aide (MA) training course.
-There was documentation Staff A completed the medication clinical skills checklist on 12/14/19.
-There was no documentation of an employment verification prior to hire as a MA.
-There was no documentation Staff A passed the MA written exam.

Interview with Staff A on 04/13/23 at 10:51am revealed:
-He had worked at the facility for 13 years.
-He was hired as a personal care aide (PCA).
-He was not a MA and had never taken the medication aide training course or taken the MA written exam.
-He administered eye drops to Resident #1 this morning, 04/13/23.
-He administered Resident #1's eye drops because he "wanted to get them done for the

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day".
-He learned how to administer eye drops by observing other staff administering eye drops.
-He obtained Resident #2's FSBS and administered Resident #2 his insulin injection.
-He was a diabetic and checked his FSBS and administered insulin to himself, so "he knew what he was doing".
-No one told him to administer the medications.
-The Supervisor-in-Charge (SIC) and the Administrator knew he administered eye drops, checked FSBS and administered insulin.
-He had administered eye drops, checked FSBS and administered insulin for years.

Interview with the Supervisor-in-Charge (SIC) on 04/13/23 at 11:00am revealed:
-She knew Staff A was not a MA.
-She knew he administered Resident #1's eye drops and Resident #2's insulin after checking the resident's FSBS because the task were completed when she came to work each morning.
-She thought he had been trained to administer the eye drops and insulin and check FSBS readings.

Interview with the Administrator on 04/13/23 at 3:48pm revealed:
-She knew Staff A was not a MA.
-She was aware Staff A administered eye drops and insulin and performed FSBS checks.
-Staff A had not taken the medication aide training course or taken the MA written exam.
-She knew Staff A had completed the medication clinical skills checklist but could not recall the date of completion.
-She had spoken to Staff A about taking the medication aide training course and the MA written exam, but he was not interested.

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C 131	Continued From page 3 Refer to tag .0330 10A NCAC 13G. .1004a Refer to tag .0335 10A NCAC 13G. .1004f _____ The facility failed to ensure staff, who administered medications to residents, completed the MA training requirements before administering medications including the 5-hour and 10-hour, or 15- hour training class and had passed the MA written exam within 60 days of completing the medication aide competency validation clinical skills checklist. This failure was detrimental to the health, safety and welfare of the residents to include increase opportunities for medication errors and infections and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/13/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 28, 2023.	C 131		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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.	C 330		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (#1 and #2), related to eye drops and a medication to treat an enlarged prostate (#1) and an inhaler (#2).

The findings are:

1. Review of Resident #1's current FL-2 dated 04/04/23 revealed diagnoses included schizophrenia disorder and hypertension.

a. Review of Resident #1's current FL-2 dated 04/04/23 revealed there was an order for dorzolamide-timolol 22.3-6.8 (used to treat elevated pressure in the eye) instill 1 drop in the right eye every night.

Review of Resident #1's February 2023 medication administration record (MAR) revealed:
-There was an entry for dorzolamide-timolol 22.3-6.8 instill 1 drop in the right eye twice daily with a scheduled administration time of 8:00am and 8:00pm
-There was documentation that dorzolamide-timolol was administered twice daily from 02/01/23 to 02/28/23.

Review of Resident #1's March 2023 MAR revealed:
-There was an entry for dorzolamide-timolol 22.3-6.8 instill 1 drop in the right eye twice daily with a scheduled administration time of 8:00am and 8:00pm
-There was documentation that dorzolamide-timolol was administered twice daily from 03/01/23 to 03/31/23

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Review of Resident #1's April 2023 MAR from 04/01/23 to 04/12/23 revealed:
-There was an entry for dorzolamide-timolol 22.3-6.8 instill 1 drop in the right eye twice daily with a scheduled administration time of 8:00am and 8:00pm
-There was documentation that dorzolamide-timolol was administered twice daily from 04/01/23 to 04/12/23 at 8:00am.

Observation of Resident #1's medications on hand on 04/13/23 at 11:48am revealed:
-There were two brown medication bottles, each containing a bottle of dorzolamide-timolol 22.3-6.8 eye drops in the medication cabinet in the medication room.
-The dispensed dates on the medication bottles were 06/27/22 and 09/30/22.
-Each bottle of eye drops was ¼ to ½ full.

Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 04/13/23 at 1:42pm revealed:
-The facility changed pharmacies and the previous facility faxed the current orders for Resident #1.
-The pharmacy received transfer orders from the previous pharmacy with an order date of 01/31/23.
-The pharmacy had an order for dorzolamide-timolol 22.3-6.8 instill 1 drop in the right eye twice daily.
-The pharmacy had dispensed a 10ml bottle of dorzolamide-timolol 22.3-6.8 on 02/01/23.
-A 10ml bottle should last about 75 days.

Observation of Resident #1's medications on hand on 04/13/23 at 2:00pm revealed there was no bottle dorzolamide-timolol 22.3-6.8 dispensed on 02/01/23 available for administration.

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C 330	Continued From page 6 Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/13/23 at 2:15pm revealed: -Dorzolamide-timolol was used to treat increased pressure in the eye related to glaucoma. -If the medication was not administered as ordered Resident #1 could have eye pain and blurred vision due to increased pressure. Interview with the medication aide (MA) on 04/13/23 at 3:15pm revealed: -She did not know why there was medication remaining in two bottles of eye drops that were dispensed on 06/27/22 and 09/30/22. -She did not know where the bottle of eye drops dispensed on 02/01/23 was. Interview with the Administrator on 04/13/23 at 3:47pm revealed she did not know why there were two bottles of eye drops still available for administration with dispensed dates of 06/27/22 and 09/30/22. Attempted telephone interview with Resident #1's Ophthalmologist on 04/13/23 at 2:30pm was unsuccessful. Refer to the interview with Resident #1 on 04/13/23 at 2:30pm. Refer to the interview with the MA on 04/13/23 at 3:15pm. Refer to the interview with the Administrator on 04/13/23 at 3:47pm. b. Review of Resident #1's current FL-2 dated 04/04/23 revealed there was an order for latanoprost .005% (used to treat increased	C 330		

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C 330	Continued From page 7 pressure in the eye) in one drop in the right eye every night. Review of Resident #1's February 2023, March 2023, and April 2023 from 04/01/23 to 04/12/23 medication administration record (MAR) revealed: -There was no entry for latanoprost .005% instill one drop in the right eye every night. -There was no documentation that latanoprost .005% was administered. Observation of Resident #1's medications on hand on 04/13/23 at 11:48am revealed there were no latanoprost .005% eye drops available for administration. Interview with the pharmacy technician at the facility's contracted pharmacy on 04/13/23 at 1:42pm revealed: -The pharmacy did not have an order for latanoprost eye drops. -The pharmacy accepted FL-2s as orders and would dispense medications as ordered. -The pharmacy did not receive an FL-2 dated 04/04/23 for Resident #1. -If the pharmacy had received the FL-2 dated 04/04/23, they would have questioned the latanoprost order since Resident #1 was receiving Racklatan. Interview with the Pharmacist at the facility's contracted pharmacy on 04/13/23 at 1:42pm revealed: -The pharmacy did not have an order for latanoprost .005% eye drops for Resident #1. -Resident #1 had an order for Racklatan eye drops, which contained latanoprost as one of two medications. (Racklatan was a combination of two medications, latanoprost and netarsudil).	C 330		

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C 330	Continued From page 8 Interview with the medication aide (MA) on 04/13/23 at 3:15pm revealed: -She was responsible for completing the annual FL-2 for Resident #1. -She listed latanoprost on the FL-2 dated 2023 because it was on the FL-2 dated 2022. -She did not realize Resident #1 was not taking latanoprost eye drops. -She completed Resident #1's FL-2 for 2023 by referring to the FL-2 dated 2022. -She listed the medications on the FL-2 for 2023 as they were listed on the FL-2 dated 2022. -She did not list any medications on the FL-2 for 2023 that were ordered or discontinued during the year. -She did not know she should list medications that were added during the year to the FL-2 for 2023. -She did not fax FL-2s to the pharmacy to be used as orders. Interview with the Administrator on 04/13/23 at 3:47pm revealed: -The FL-2 was completed by the MA for the Primary Care Provider to sign. -All medication that was ordered and discontinued from the FL-2 from 2022 until the FL-2 was signed by the PCP should be added or deleted to the updated FL-2 to ensure all medications were current. Attempted telephone interview with Ophthalmologist on 04/13/23 at 2:30pm. Refer to the interview with Resident #1 on 04/13/23 at 2:30pm. Refer to the interview with the medication aide (MA) on 04/13/23 at 3:15pm:	C 330		

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C 330	Continued From page 9 Refer to the interview with the Administrator on 04/13/23 at 3:47pm. c. Review of Resident #1's current FL-2 dated 04/04/23 revealed there was no order for Racklatan eye drops. Review of Resident #1's February 2023 medication administration record (MAR) revealed: -There was an entry for Racklatan eye drop instill 1 drop in the right eye every night with a scheduled administration time 8:00pm. -There was documentation that Racklatan was administered every night from 02/01/23 to 02/28/23. Review of Resident #1's March 2023 MAR revealed: -There was an entry for Racklatan eye drops instill 1 drop in the right eye every night with a scheduled administration time 8:00pm. -There was documentation that Racklatan was administered every night from 03/01/23 to 03/31/23 Review of Resident #1's April 2023 MAR from 04/01/23 to 04/12/23 revealed: -There was an entry for Racklatan eye drop instill 1 drop in the right eye every night with a scheduled administration time 8:00pm. -There was documentation that Racklatan was administered every night from 04/01/23 to 04/12/23. Observation of Resident #1's medications on hand on 04/13/23 at 11:48am revealed: -There was one brown medication bottle located in the refrigerator containing an unopened bottle of Racklatan eye drops. -The dispensed date on the brown medication	C 330		

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C 330	Continued From page 10 bottle was 04/05/23. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 04/13/23 at 1:42pm revealed: -The pharmacy had an order for Racklatan one drop to each eye at bedtime dated 01/17/23. -The pharmacy dispensed a 2.5ml bottle of Racklatan on 01/17/23 and 04/05/23. -A 2.5ml bottle of Racklatan would last 25 days. -Eye drops were not on cycle fill; the facility would have to call the pharmacy to refill the medication. The pharmacy accepted FL-2s as orders and would dispense medications as ordered. -The pharmacy did not receive an FL-2 dated 04/04/23 for Resident #1. -If the pharmacy had received the FL-2 dated 04/04/23, they would have questioned why the Racklatan was not listed. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/13/23 at 2:15pm revealed: -Racklatan was used to reduce the elevated pressure in the eye due to glaucoma. -If the medication was not administered as ordered Resident #1 could have eye pain and blurred vision due to increased pressure. Interview with the medication aide (MA) on 04/13/23 at 3:15pm revealed: -She signed the MAR each morning she administered Racklatan. -She did not realize Racklatan was not listed on the FL-2 and she did not have a current order to administer Racklatan. -She was responsible for completing the annual FL-2 for Resident #1. -She completed Resident #1's FL-2 for 2023 by referring to the FL-2 dated 2022.	C 330		

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-She listed the medications on the FL-2 for 2023 as they were listed on the FL-2 dated 2022.
-She did not list any medications on the FL-2 for 2023 that were ordered or discontinued during the year.
-She did not list Racklatan as one of the medications Resident #1 was receiving because it was not on the FL-2 dated 2022.
-She did not know she should list medications that were added during the year to the FL-2 for 2023.
-She did not fax FL-2s to the pharmacy to be used as orders.

Interview with the Administrator on 04/13/23 at 3:47pm revealed:
-The FL-2 was completed by the MA for the Primary Care Provider to sign.
-All medication that was ordered from the FL-2 from 2022 until the FL-2 was signed by the PCP should be added to the updated FL-2 to ensure all medications were current.

Attempted telephone interview with Resident #1's Ophthalmologist on 04/13/23 at 2:30pm.

Refer to the interview with Resident #1 on 04/13/23 at 2:30pm.

Refer to the interview with the medication aide (MA) on 04/13/23 at 3:15pm:

Refer to the interview with the Administrator on 04/13/23 at 3:47pm.

_____

Interview with Resident #1 on 04/13/23 at 2:30pm revealed:
-He received eye drops once or twice a day.
-He did not know how many different eye drops he received and did not know the name of the

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eye drops.
-He thought the eye drops were to help his vision.
-He did not have any problems with blurred vision.

Interview with the medication aide (MA) on 04/13/23 at 3:15pm revealed:
-She administered Resident #1 his eye drops once or twice a day.
-Resident #1 would ask for his eye drops if he had not received them.

Interview with the Administrator on 04/13/23 at 3:47pm revealed:
-She did not audit the medications in the medication room.
-She expected eye drops to be administered as ordered.

d. Review of Resident #1's current FL-2 dated 04/04/23 revealed there was no order for tamsulosin (used to relax muscle in the prostate gland)

Review of Resident #1's February 2023 medication administration record (MAR) revealed:
-There was an entry for tamsulosin 0.4mg every morning with a scheduled administration time of 8:00am.
-There was documentation that tamsulosin was administered daily from 02/01/23 to 02/28/23.

Review of Resident #1's March 2023 MAR revealed:
-There was an entry for tamsulosin 0.4mg every morning with a scheduled administration time of 8:00am.
-There was documentation that tamsulosin was administered daily from 03/01/23 to 03/31/23

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C 330	Continued From page 13 Review of Resident #1's April 2023 MAR from 04/01/23 to 04/12/23 revealed: -There was an entry for tamsulosin 0.4mg every morning with a scheduled administration time of 8:00am. -There was documentation that tamsulosin was administered daily from 04/01/23 to 04/12/23. Observation of Resident #1's medications on hand on 04/13/23 at 11:48am revealed: -There was a multi-dose pack in the medication cabinet in the medication room that contained a 7-day supply of medications for Resident #1. -Tamsulosin 0.4mg was in each morning multi-dose pack to be administered. Interview with Resident #1 on 04/13/23 at 2:30pm revealed he took several oral medications but could not recall the name of them. Telephone interview with the pharmacy technician from the facility's contracted pharmacy on 04/13/23 at 1:42pm revealed: -The pharmacy had an order for tamsulosin 0.4mg daily. -The pharmacy dispensed tamsulosin 0.4mg in the weekly multi-dose pack to be administered each morning at 8:00am. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/13/23 at 2:15pm revealed tamsulosin was used to treat an enlarged prostate gland. Interview with the medication aide (MA) on 04/13/23 at 3:37pm revealed: -She knew tamsulosin was in the morning multi-dose pack for Resident #1. -She signed the MAR each morning she administered tamsulosin.	C 330		

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C 330	Continued From page 14	C 330		

-She did not realize tamsulosin was not listed on the FL-2 and she did not have a current order to administer tamsulosin.
-She was responsible for completing the annual FL-2 for Resident #1.
-She completed Resident #1's FL-2 for 2023 by referring to the FL-2 dated 2022.
-She listed the medications on the FL-2 for 2023 as they were listed on the FL-2 dated 2022.
-She did not list any medications on the FL-2 for 2023 that were ordered or discontinued during the year.
-She did not list tamsulosin on the FL-2 dated 04/04/23.
-She did not know she should list medications that were added during the year to the FL-2 for 2023.
-She did not fax FL-2s to the pharmacy to be used as orders.

Interview with the Administrator on 04/13/23 at 3:47pm revealed:
-The FL-2 was completed by the MA for the Primary Care Provider to sign.
-All medications that were ordered from the FL-2 from 2022 until the FL-2 for 2023 was signed by the PCP should be added to the updated FL-2 to ensure all medications were current.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/13/23 at 2:30pm was unsuccessful.

2. Review of Resident #2's current FL-2 dated 02/04/22 revealed diagnoses of schizoaffective disorder, diabetes mellitus, hyperlipidemia, and hypertension.

Review of Resident #2's signed physician orders dated 01/31/23 revealed there was an order for

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C 330	Continued From page 15 Advair 250/50 1 puff by mouth twice daily. Review of Resident #1's February 2023 medication administration record (MAR) revealed: -There was an entry for Advair 250/50 1 puff by mouth twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was no documentation that Advair was administered twice daily from 02/01/23 to 02/28/23. Review of Resident #1's March 2023 MAR revealed: -There was an entry for Advair 250/50 1 puff by mouth twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation that Advair was administered twice daily from 03/01/23 to 03/31/23. Review of Resident #1's April 2023 MAR from 04/01/23 to 04/12/23 revealed: -There was an entry for Advair 250/50 1 puff by mouth twice daily with a scheduled administration time of 8:00am and 8:00pm -There was documentation that Advair was administered twice daily from 04/01/23 to 04/11/23 and at 8:00am on 04/12/23. Observation of Resident #2's medications on hand on 04/13/23 at 11:48am revealed: -Each resident had an individual basket that contained their medications in the medication cabinet in the medication room. -There was no Advair 250/50 Discus in Resident #2's basket available for administration. -There were three unopened Advair 250/50 inhalers in a basket with no name that contained extra medications for several residents. -The dispensed dates on the three unopened	C 330		

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C 330	Continued From page 16 Advair 250/50 inhalers were 09/22/21, 05/12/22, and 11/03/22. Interview with Resident #2 on 04/11/23 at 3:37pm revealed: -He received an albuterol inhaler when he was short of breath or wheezing. -He was not administered Advair Diskus inhaler. -He did not recall the last time he was administered Advair Diskus inhaler. -When he became short of breath, he would ask for and be given his albuteral inhaler. -He did not require his albuteral inhaler often, maybe two to three times a month. Telephone interview with the pharmacy technician from the facility's contracted pharmacy on 04/13/23 at 1:42pm revealed: -The pharmacy had an order for Advair 250/50 Diskus one puff twice a day dated 01/31/23. -Advair 250/50 Diskus was not on cycle fill; the facility would have to notify the pharmacy and request the medication be dispensed. -The facility had not notified the pharmacy to dispense Advair 250/50 Diskus for Resident #2. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/13/23 at 2:15pm revealed: -Advair inhaler was used for residents who had a problem breathing due to a respiratory diagnosis. -If Resident #2 did not receive Advair Inhaler as ordered he could have difficulty breathing. Interview with the medication aide (MA) on 04/13/23 at 2:15pm revealed: -Resident #2 had too many changes with his inhalers. -She did not realize the Advair inhaler was to be administered twice daily.	C 330		

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C 330	Continued From page 17 -She thought the Advair inhaler was changed to as needed. -She did not realize she documented Advair was administered in March 2023 and April 2023. Interview with the Administrator on 04/13/23 at 3:48pm reveled: -She expected the MAs to compare medication administered with the MAR. -If a medication was not available to administer that was listed on the MAR, the MA should call the pharmacy. -She expected medications to be administered as ordered. Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 04/13/23 at 4:46pm was unsuccessful.	C 330		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed	C 335		

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C 335	Continued From page 18 in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the resident's name and the name and strength of each medication prepared, and protected from contamination and spillage for 3 of 3 residents (#1, #2 and #3). The findings are: Observation during the tour of the facility on 04/13/23 at 8:02am revealed: -There were place settings on the dining room table with a souffle cup of medications at each setting. -Each souffle cup contained multiple medications. -The medications cups were not labeled with the name and strength of the medications. -The medications were not sealed; the medication cups did not have a covering.	C 335		

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C 335	Continued From page 19 -A resident's last name was written on the side of the souffle cup. Observation during the tour of the facility on 04/13/23 at 8:05am revealed the facility staff removed the souffle cups full of medications from the dining room table and placed them in the medication room. Interview with a resident on 04/13/23 at 8:09am revealed -His medication was placed on the dining room table in white cups each morning. -He took his medication each morning when eating breakfast. Interview with another resident 4/13/23 at 8:15am revealed: -Each resident's medication was placed on the dining room table each morning. -The medication was placed in a white cup and was sitting next to each resident's plate. -He took his morning medication before he ate breakfast each morning. -He did not recall if the medication aide (MA) was in the dining room when he took his medications. Interview with a facility staff on 04/13/23 at 10:51am revealed: -The MA prepared the resident's morning medications the evening before by placing the pills in a souffle cup. -He would place the souffle cup with the resident' medications on the dining room table each morning. -He removed the souffle cups of medications from the medication room the morning of 04/13/23 and placed them on the dining room table for the residents to take at breakfast. -After the survey team entered the home, he	C 335		

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C 335	Continued From page 20 called the MA at 8:05am and was told to remove the souffle cups from the table and place them back in the medication room. Interview with the MA/Supervisor-in-Charge (SIC) on 04/13/23 at 11:00am revealed: -She prepared the resident's morning medications the evening before. -She put each resident's pills in a white cup with the resident's name written on the side of the cup. -She placed the cup of pills in the locked cabinet in the medication room. -The facility staff telephoned her this morning, 04/13/23, and informed her the survey team was in the facility. -She asked the facility staff about the prepared pills in the white cup and was told they were placed on the dining room table. -She asked the facility staff to remove them and place them back in the locked cabinet in the medication room until breakfast was served. Interview with the Administrator on 04/13/23 at 3:48pm revealed: -The MA prepared resident's morning medications the evening before. -The facility staff member would administer the prepared medications each morning with breakfast. -She was not aware the souffle cups of medications were not labeled with the name and strength of the medications that were prepared in advance. -She would inform the MA to identify each medication that was prepared the evening before and placed in the souffle cup.	C 335		
C 353	10A NCAC 13G .1006 (b) Medication Storage	C 353		

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C 353	Continued From page 21 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications for 2 of 3 residents (#1 and #2) were stored in a locked container in the refrigerator. The findings are: Observation of the kitchen on 04/13/23 between 8:10am - 8:15am revealed: -There were no facility staff in the kitchen. -A resident entered the kitchen without supervision of the facility staff. -The refrigerator in the kitchen was not locked. -The refrigerator contained various food items for residents and staff. -There was a ziplock bag in the refrigerator door which contained a brown, medication bottle. -The brown, medication bottle contained an unopened bottle of Racklatan (used to reduce elevated eye pressure) drops. -There was a plastic container with a lid on the first shelf of the refrigerator. -The plastic container contained a box with 2 unused Levemir (used to control high blood sugar) insulin pens. 1. Review of Resident #1's current FL-2 dated 04/04/23 revealed: -Diagnoses included schizophrenia disorder and hypertension. -There was no order for Racklatan eye drops	C 353		

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C 353	Continued From page 22 listed. Review of Resident #1's signed FL-2 dated 03/23/22 revealed there was an order for Racklatan eye drops at night. Interview with the medication aide (MA)/Supervisor-in-charge on 0413/23 at 11:00am revealed: -She knew Resident #1's eye drops were kept in the refrigerator until they were opened. -She was not aware the medications in the refrigerator had to be locked. Refer to the interview with the Administrator on 04/13/23 at 3:48pm. 2. Review of Resident #2's current FL-2 dated 02/04/22 revealed: -Diagnoses of schizoaffective disorder, diabetes mellitus, hyperlipidemia, and hypertension. -There was an order for Levemir 10 units subcutaneously twice daily. Interview with the medication aide (MA)/Supervisor-in-charge on 0413/23 at 11:00am revealed: -She knew Resident #2's unused insulin pens were kept in the refrigerator until they were used. -She was not aware the medications in the refrigerator had to be locked. Refer to the interview with the Administrator on 04/13/23 at 3:48pm. _____ Interview with the Administrator on 04/13/23 at 3:48pm revealed: -She knew there were residents in the home that were ordered medications that had to be refrigerated until opened.	C 353		

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C 353	Continued From page 23 -She thought the medications were in a locked box. -There used to be a locked box in the refrigerator for medications. -She did not know the locked box for medications was no longer in the refrigerator. -She expected the medications in the refrigerator to be secured in a locked box.	C 353		