STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL016018	A. BUILDING: _____ B. WING _____	R-C 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARTERET HOUSE	3020 MARKET STREET NEWPORT, NC 28570

(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 Carteret County Department of Social Services conducted a follow-up survey and complaint investigation on July 13, 2023 and July 14, 2023. The complaint investigation was initiated by the Carteret County Department of Social Services on July 5th, 2023.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the environment was free of hazards related to an oxygen tank not being secured in a resident's (#3) room. 1. Review of the facility's oxygen policy dated September 2021 revealed: -Oxygen tanks shall be secured upright at all times to prevent falling over and secured in a manner to prevent tanks from being dropped or from striking violently against each other. Review of Resident #3's Resident Register dated 11/18/19 revealed she was admitted to the facility on 11/18/19.	D 079		

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D 079	Continued From page 1 Review of Resident #3's FL2 dated 06/28/23 revealed diagnosis included chronic obstructive pulmonary disease. Review of the physician's order sheet dated 06/28/23 revealed an entry for O2 at 3 liters via nasal cannula during activities and while sleeping. Observation of Resident #3's room on 07/14/23 at 8:38am revealed: -There was a small oxygen tank in the resident's room sitting on the floor next to her bed. -The oxygen tank was sitting on the floor and was not secured in a rack, cart, holder, or to the wall. -There was an oxygen concentrator on the other side of the resident's bed. Interview with the Resident #3 on 07/14/23 at 8:40am revealed: -She thought the small oxygen tank always sat on the floor. -She used the small oxygen tank when she went out of the facility. -She had a "holster" for the small oxygen tank, but she was not sure at the moment where it was. -She was not aware the tank needed to be in a stand when it was not in the holster. Interview with a Medication Aide on 07/14/23 at 8:45am revealed: -Oxygen tanks were to always be secured in a crate or stand. -She was unaware that Resident #3's oxygen tank was on the floor unsecured in her room. -She was not sure why there was an unsecured oxygen tank sitting on the floor by Resident #3's bed. -Resident #3 used the small tank with a carrier when she left the facility.	D 079		

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D 079	Continued From page 2 Interview with the Administrator on 07/14/23 at 8:51am revealed: -All oxygen tanks were to always be secured in a crate, stand, or holder. -There should not be an oxygen tank sitting on the floor unsecured in the residents' rooms. -Resident #3 had a holster for the small oxygen tank and she was not sure why the oxygen tank was not in Resident #3's holster. -She immediately removed the oxygen tank from Resident #3's room. -All staff were responsible for assuring oxygen tanks were secured in a stand, crate or holder. -All staff were educated that oxygen must always be secured in a stand, crate, or holder. -Unsecured oxygen tanks were a safety concern because they could explode. Interview with the Executive Director/ Administrator In Training on 07/14/23 at 3:07pm revealed: -Resident #3's had been using a portable oxygen tank at night because her oxygen concentrator was broken. -The oxygen concentrator was repaired earlier today. -Oxygen tanks should never be unsecured. -Resident #3 used the small oxygen tanks in a holster when she went out of the facility. -There should never unsecured oxygen tanks on the floor in the residents' rooms. -She was aware unsecured oxygen tanks were a safety concern.	D 079		
D 368	10A NCAC 13F .1004 (k) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 368		

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D 368	Continued From page 3 (k) The facility shall have a system in place to ensure the resident is identified prior to the administration of any medication or treatment. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to correctly identify a resident (#7) during a medication pass according to the facility's medication policy resulting in the resident(#7) being administered two medications belonging to another resident (#6) and attempted administration of several other medications belonging to another resident (#6) including a blood pressure medication, a cholesterol medication, and a Parkinson's Disease medication. The findings are: Review of the facility's medication policy and procedure dated November 2018 revealed: -Five Rights-Right resident, right drug, right dose, right route, and right time are applied for each medication being administered. -Residents are identified before medication is administered. -Methods of identification include: a. Checking photograph attached to medical record. b. Calling the resident by name (except in residents with cognitive impairment). c. Having the resident verify his/her last name. d. If necessary, verifying resident identification	D 368		

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with other facility personnel.

Review of Resident #7's resident register dated 07/01/23 revealed she was admitted to the facility on 06/30/23.

Review of Resident #7's FL2 dated 06/05/23 revealed:
-Diagnosis included atrial fibrillation, cirrhosis of the liver, essential hypertension, and pre-diabetic.
-Intermittent was checked for disorientation.
-There were orders for Amlodipine 5mg once daily (used to treat hypertension), Tylenol Extra Strength 500mg-take 2 tablets every 6 hours (used to treat mild to moderate pain), Memantine 5mg 1 tablet twice daily (used to treat dementia), Metformin ER 500mg 2 tablets twice daily (used to treat high blood sugar caused by diabetes mellitus), Metoprolol Succinate ER 200mg 1 tablet daily (used to treat high blood pressure), and Xarelto 20mg 1 tablet daily (a blood thinner used to reduce the risks of strokes and blood clots).

Review of Resident #6's Resident Register dated 06/29/23 revealed she was admitted to the facility on 06/29/23.

Review of Resident #6's FL2 dated 07/07/23 revealed diagnosis included Parkinson's Disease.

Review of Resident #6 July electronic Medication Administration Record (eMAR) for 07/01/23 revealed:
-There was an entry for acetaminophen 500mg (used to treat mild to moderate pain) to be administered at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was an entry for ascorbic acid (Vitamin C) 500mg (an anti-oxidant to boost the immune

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system) to be administered at 8:00am.
-There was an entry for atorvastatin 10mg (used to treat high cholesterol) to be administered at 8:00am.
-There was an entry for biotin 5mg (a vitamin B supplement) capsule to be administered at 8:00am.
-There was an entry for carbidopa-levodopa 25-100mg (used to treat Parkinson's disease) one and a half tablets to be administered at 8:00am, 12:00pm, and 4:00pm.
-There was an entry for celecoxib 200mg (a non-steroidal anti-inflammatory used to treat pain) to be administered at 8:00am.
-There was an entry cyclosporin dropperette 0.05% ophthalmic (used to treat dry eyes) instill one drop in both eyes at 8:00am and 8:00pm.
-There was an entry for losartan 50mg (used to treat high blood pressure) 1 tablet to be administered at 8:00am.

Review of Resident #7's 07/01/23 progress notes revealed:
-There was an entry at 11:06am by the Medication Aide (MA), spoke to the doctor on call, informed him that the resident had received another residents Restasis eye drops in her eyes. He informed me that the resident will be okay and the drop will not hurt her
-There was an entry at 11:07am by the medication aide (MA), Son was in the building and informed me that the medication cup did not look like his mom's. Resident did not ingest any of the medications but did receive a drop of Restasis in each eye. I informed him the doctor said that the medication would not cause harm in any way.
-There was an entry at 12:00pm by the Resident Care Coordinator (RCC) family moved resident out on Saturday.

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D 368	Continued From page 6 Interview with Resident #7's family member on 07/13/23 at 4:01pm revealed: -Resident #7 was admitted to the facility on 06/30/23 in the late afternoon. -He provided Resident #7's medications to the facility in labeled prescription bottles. -He visited Resident #7 the morning of 07/01/23 and the MA came into Resident #7's room with a bottle of eye drops. -The MA did not call the resident by name. -He said he told the MA that Resident #7 did not use eye drops. -The MA administered the eye drops to Resident #7. -The MA left the room and returned with two medication cups of pills. -He did not recognize the pills in the medication cups. -Resident #7 placed one of the pills in her mouth. -Resident #7 was told by another family member, who was in the room, to spit the pill out and she did. -He followed the MA out to the medication cart and told her the pills given to Resident #7 were not the right pills. -He asked what medications were administered to Resident #7 and was told only supplements. -He asked for an explanation and said he only got an apology. -He asked to see the pills that were almost administered but the pills had been disposed of. -He requested a list of the medications that were almost administered and was provided with this. -He called the local police department. -He discharged Resident #7 from the facility the same day. -He did not seek medical care for Resident #7 after the medication error.	D 368		

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D 368	Continued From page 7 Interview with the MA on 07/14/23 at 9:58am revealed: -She had been a medication aide for 6 years. -She had been employed with the facility for about 4.5 years. -Staff were usually notified of new resident arrivals by text message. -Residents were identified by a photograph on their eMAR and by their first and last name. -She was the only MA for 35 residents on the day shift on 07/01/23. -She counted the controlled medications on the medication cart with the off-going MA and was told there were two new residents on the 300 hall. -She had never met the two new residents. -The new residents' names had not been placed on their doors. -She went to the 300 hall and started her medication pass on 07/01/23.. -She poured medications in two cups for Resident #6. -A family member started asking her questions and got her "off of her game". -She went into Resident #7's room thinking it was Resident's #6's room. -She did not call the resident by name and said she was in a hurry and forgot. -She administered cyclosporin eye drops, 1 drop to each eye to Resident #7. -She gave the 1st pill cup containing biotin to Resident #7. -A family member , who was in the room, said the resident did not use eye drops. -The family member present said the pills in the cup were not the correct pills and had Resident #7 spit out the pill she had placed in her mouth. -She took the medication cups from the resident and disposed of the medications in the sharps container.	D 368		

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-Resident #7's family wanted to see the pills but she advised them that she could not open the sharps container.
-Resident #7's family member called the local police department.
-The local police responded.
-She said Resident #7's family member wanted her to be arrested.
-She said the police told Resident #7's family member it was an honest mistake and not grounds for arrest.
-She said the resident's pictures on the eMARS were small and sometimes hard to see.
-Resident #7's family member asked her to contact the Executive Director(ED)/ Administrator In Training(AIT).
-She contacted the ED/AIT and she arrived about 45 minutes later.
-She apologized to Resident #7 and her family member.
-Resident #7 did not complain of any side effects from the cyclosporin eye drops.
-She notified the Primary Care Provider (PCP) that Resident #7 received the cyclosporin eye drops and was told by the PCP the cyclosporin drops would not harm the resident.
-She should have double checked Resident #7's picture, room number and name prior to administering the medications.
-She should have addressed Resident #7 by name prior to administering any medications.
-She was truly sorry for the medication error.

Interview with the Resident Care Coordinator (RCC) on 07/14/23 at 10:44am revealed:
-Resident #7 was admitted after 4:00pm on 06/30/23.
-Resident #7's family member brought her medications in labeled bottles.
-She compared the FL2 form to the medication

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bottles.
-The FL2 was faxed to the facilities contracted pharmacy.
-The contracted pharmacy created Resident #7's profile and sent the orders back to the facility for approval.
-She approved Resident #7's orders for the eMAR.
-Resident #7 had a picture on her profile.
-She was contacted by the ED/AIT around 11:30am on 07/01/23, regarding the medication error for Resident #7.
-She arrived at the facility about 12:00pm on 07/01/23 and Resident #7's family was in the process of moving her out of the facility.
-The MAs were expected to verify the residents' identity by reviewing their photograph and calling them by name.

Interview with the ED/AIT on 07/14/23 at 2:52pm revealed:
-Staff were notified of new admissions via text and this information was posted on the daily staff assignment sheet and included the new residents' name and room number.
-She was not in the facility on 07/01/23 but was contacted about the medication error with Resident #7.
-She spoke with Resident #7's family member via phone and said he was highly upset.
-She also received a call from a local law officer who had been called to the scene asking what she wanted them to do.
-She asked the law officer to place the family in a separate room in the facility and was on her way there.
-She arrived at the facility after being contacted about the medication error.
-She talked with Resident #7's family.
-A medication error report was completed, and

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the resident's PCP was contacted regarding the error.
-Resident #7's family moved her out of the facility that same day.
-The MAs were expected to observe the 5 Rights of medication administration.
-The MAs were expected to identify each resident by the photograph on their eMAR and calling them by name prior to medications being administered.

Telephone interview with Resident #7's PCP on 7/14/23 at 2:12pm revealed:
-He had never prescribed any type of eye drops to Resident #7.
-He did not feel the one-time dose of cyclosporin eye drops were of concern or caused any harm.
-He said if Resident #7 would have received the carbidopa-levodopa and losartan intended for Resident #6, she could have experienced hypotension, gait irregularity causing falls, and/or acute renal failure.
-He expected the residents to get the correct medications as ordered.

_____

The facility failed to correctly identify a resident (#7) before administering medications according to the facilities medication administration policy resulting in the resident being administered medications and attempted administering medications that belonged to another resident (#6). This failure was detrimental to the health and safety of the resident and constitutes a Type B violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/14/23 for this violation.

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D 368	Continued From page 11 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 28, 2023.	D 368		