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 10/05/2023

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 completed a follow -up survey on October 04, 2023 and October 05, 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 ensure medications were administered as ordered for 2 of 6 residents (#6, #7) observed during the medication pass including errors with a medication used to treat diabetes (#5) and a medication to treat dry eyes (#7); and for 1 of 5 residents (#2) sampled for record review for a medication used to treat moderate to severe pain (#2). The findings are: 1. The medication error rate was 7% as evidenced by 2 errors out of 27 opportunities during the 8:00am medication pass on 010/05/23. a. Review of Resident #6's current FL-2 dated 09/12/23 revealed: -Diagnoses included diabetes mellitus type 2. -There was an order for Toujeo Solostar U-300 IU/MC pen, inject 35 units once a day	D 358		

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subcutaneously. (Toujeo is a long-acting insulin used to lower blood sugar).

Review of Resident #6's Resident Register revealed an admission date of 09/11/23.

Review of a handwritten order sheet for Resident #6 dated and signed by the Primary Care Provider (PCP) dated 09/12/23 revealed an order for Toujeo Solostar 35 units every day.

Review of Resident #'s October 2023 medication administration record (MAR) revealed:
-There was an entry for Toujeo Solostar U-300 insulin pen inject 35 units once a day scheduled for 8:00am.
-The resident's blood sugar ranged from 191 - 333 from 10/01/23 10/05/23.

Observation of the 8:00am medication pass on 010/05/23 revealed:
-The MA performed a finger stick blood sugar (FSBS) on Resident #6 at 7:39am.
-Resident #6's blood sugar was 206 at 7:39am.
-The MA attempted to dial the Toujeo Solostar U-300 insulin pen dose selector to 35 units.
-The Toujeo Solostar U-300 insulin pen dose selector stopped at 13 units.
-There was no other Toujeo Solostar U-300 insulin pen on the medication cart.
-The MA left the medication cart to look for another Toujeo Solostar U-300 insulin.
-The MA returned without a Toujeo Solostar insulin pen.
-Resident #6 did not receive Toujeo Solostar insulin.

Interview with the MA on 10/05/23 at 7:42am revealed:
-There were no additional Toujeo Solostar insulin

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pens in the facility for Resident #6.
-She planned to call the pharmacy to order more Toujeo Solostar Insulin pens for Resident #6.

Resident #6 was unavailable for interview on 10/05/23 at 10:46am.

Second interview with the MA on 10/05/23 at 11:52am revealed:
-The MAs were responsible for re-ordering the residents' medications.
-She thought the night shift MA did medication cart audits.
-The MAs re-ordered medication by selecting the re-supply option beside the medication on the residents' MAR or called the contracted pharmacy for medication refills.
-She preferred to call the contracted pharmacy for refills.
-She had contacted the pharmacy to re-order Toujeo for Resident #6.
-She thought Resident #6 required a new prescription for the Toujeo since he was recently admitted to the facility.

Interview with a pharmacist from the facility's contracted pharmacy on 10/05/213 at 12:12pm revealed:
-There was no record Toujeo had been dispensed by their pharmacy.
-An order for Toujeo was received for Resident #6 from the facility 10/05/23.
-The Toujeo order for Resident #6 was forwarded to the local back up pharmacy.

Based on observations,interviews and record review, it was determined Resident #6 was not interviewable.

Interview with the Resident Care Coordinator

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D 358	Continued From page 3 (RCC) on 10/05/23 at 1:03pm revealed: -The MAs were responsible for re-ordering medications for the residents. -Medications should be re-ordered when there is a 1.5 to 2 week supply remaining. The MAs called the contracted pharmacy and re-ordered medications and documented on the progress notes. Interview with the Administrator on 10/05/23 at 1:05pm revealed: -The night shift MA did medication cart audits weekly for each resident. -Resident #6 was a recent admission and the Toujeo pens came with him to the facility. -The MAs were expected to monitor and re-order the residents' medications so their medications would be available. Interview with Resident #6's primary care provider (PCP) on 10/05/23 at 12:59pm revealed: -She treated Resident #6 for diabetes. -Toujeo was ordered to help control his blood sugar. -Missing the Toujeo dose could cause Resident #6's blood sugar to be elevated. -She was not concerned about the one missed dose of Toujeo since Resident #6 received sliding scale insulin and finger stick blood sugars before meals and at bedtime. b. Review of Resident #7's current FL-2 dated 03/07/23 revealed diagnoses included macular degeneration and vision loss both eyes. . Review of Resident #7's physician's order dated 03/07/23 revealed an order for lubricant eyes	D 358		

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drops (carboxymethylcellulose sodium) Over the Counter (OTC) drops, 0.5%, ophthalmic, instill 1 drop in the left eye three times a day (carboxymethylcellulose sodium is used to treat dry eyes).

Review of Resident #7's September and October 2023 Medication Administration Records (MAR) revealed:
-There was an entry for carboxymethylcellulose sodium (OTC) drops 0.5% ophthalmic, instill 1 drop in the left eye three times daily at 8:00am, 12:00pm and 5:00pm.
-Carboxymethylcellulose sodium (OTC) drops 0.5% were documented as administered 10/01/23 through 10/04/23 at 8:00am, 12:pm and 5:00pm and on 10/05/23 at 8:00am.

Observation of the 8:00am medication pass on 10/05/23 revealed:
-The medication aide (MA) removed a 0.5 fluid ounce (15ml) bottle of Refresh Tears Lubricant Eye Drops (Refresh Tears is a brand name for carboxymethylcellulose sodium eye drops) from the medication cart.
-The bottle of Refresh Tears had no opened date written on it.
-The bottle of Refresh Tears had no name written on it but did have Resident #7's initials written on it..
-The MA did not administer Refresh Tears to Resident #7.

Interview with the MA on 10/05/23 at 8:11am revealed:
-Resident #7 had one bottle of Refresh Tears on the medication cart.
-The bottle of Refresh Tears was almost empty.
-The bottle of Refresh Tears should have the resident's name on it.

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-The bottle of Refresh Tears should have an opened date on it.
-Resident #7's family supplied Refresh Tears.
-There were no additional bottles of Refresh Tears available for Resident #7 on the medication cart.
-Resident #7 was told on 10/05/23 at the morning medication pass that he was out of Refresh Tears and to tell his family member that he needed more.

Interview with Resident #7 on 10/05/23 at 10:48am revealed:
-He had a radiation burn to his left eye and used lubricating drops for dry eyes.
-The MA did not return and administer Refresh Tears this am.
-His family supplied his Refresh Tears.
-The MAs notified him when he was low on Refresh Tears, and he would notify his family member.
-He has not been told until this am that he needed more Refresh Tears.

Second Interview with the MA on 10/05/23 at 11:52am revealed:
-Resident #7's family member supplied Refresh Tears for him.
-Resident #7 should have been notified that he was getting low on Refresh Tears.
-The MAs notified Resident #7 and he notified his family when his Refresh Tears were getting low.
-The third shift MA did medication cart audits for each resident weekly.
-She did not return and administer Refresh Tears to Resident #7.
-Resident #7 should have been notified that he needed more Refresh tears.

Interview with a representative with the facility's

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contracted pharmacy provider on 10/05/23 at 12:12pm revealed carboxymethylcellulose sodium (OTC) 0.5% drops had never been dispensed from their pharmacy for Resident #7.

Attempted telephone interview with Resident #7's family member on 10/05/23 at 12:29pm was unsuccessful.

Interview with the Resident Care Coordinator (RCC) on 10/05/23 at 1:03pm revealed:
-The MAs were responsible for re-ordering medications for the residents.
-Medications should be re-ordered when there is a 1.5 to 2 week supply remaining.
-If a residents' family member supplied medications, the MAs were to notify the resident's family member when a medication ran low.
-The MA should notify the resident's family member of the need for more medication prior to running out.

Interview with the Administrator on 10/05/23 at 1:05pm revealed:
-The night shift MA did medication cart audits weekly for each resident.
-The MAs were expected to monitor and re-order the residents' medications so their medications would be available.
-Resident #7's family member should have been contacted for Refresh Tears when the last bottle was opened.

Interview with Resident #7's Primary Care Provider on 10/05/23 at 12:59pm revealed:
-Carboxymethylcellulose sodium (OTC) 0.5% drops were ordered for Resident #7 to treat dry eyes.
-Resident #7 could experience dry eyes without the eye drops.

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D 358	Continued From page 7 c. Review of Resident #2s current FL2 dated 06/06/23 revealed: -Diagnosis included chronic low back pain. -There was an order for tramadol 50mg one by mouth every 4 hours as needed for pain (tramadol is used to treat moderate to severe pain). Review of Resident #2's Resident Register revealed an admission date of 06/05/23. Review of Resident #2's signed physician's order dated 06/26/23 revealed an order for Tramadol 50mg take one tablet by mouth every 4 hours as needed for pain. There was a physician's order dated 07/10/23 to change the Tramadol order to Tramadol 50mg one every 12 hours as a scheduled dose. Review of Resident #2's September 2023 Medication Administration Record revealed: -There was an entry for Tramadol 50mg take one tablet twice daily at 6:00am and 6:00pm. -There was documentation Tramadol was administered at 6:00am and at 6:00pm 09/01/23 through 09/14/23. -There was documentation Tramadol was not administered on 09/15/23 at 6:00pm with exception noted as phone order sent to primary care provider (PCP) for new prescription. -There was documentation Tramadol was not administered on 09/16/23 at 6:00am with the exception noted as reorder meds. -There was documentation Tramadol was not administered on 09/16/23 at 6:00pm, 09/17/23 at 6:00am and 6:00pm and 9/18/23 at 6:00am with exception noted as obtaining discontinue scheduled and put on prn (as needed).	D 358		

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-There was documentation Tramadol was not administered on 09/18/23 at 6:pm with the exception noted as new script sent to doctor from the pharmacy.
-There was documentation Tramadol was not administered on 09/19/23 at 6:00am and 6:00pm and on 09/20/23 at 6:00am with the exception documented as waiting on delivery.
-Tramadol was documented as administered on 09/20/23 at 6:00pm.
-There was documentation Tramadol was not administered on 09/21/23 at 6:00am with the exception documented as obtaining discontinue scheduled and put on prn (as needed).

Interview with Resident #2 on 10/04/23 at 3:40pm revealed:
-She took Tramadol twice daily for pain.
-She had "unadulterated body pain and crinkly bones".
-She had 5 back surgeries.
-She did not remember being out of the Tramadol.

Observation of Resident #2's medications on hand on 10/04/23 at 11:51am revealed a labeled prescription bottle from a local retail pharmacy for tramadol 50mg #120 take 1 tablet by mouth every 6 hours as needed for pain, dispensed 09/18/23 with 92 tablets remaining.

Interview with a representative from Resident #2's local retail pharmacy on 10/04/23 at 4:09pm revealed:
-Tramadol, take one every 6 hours prn, #120 tablets, was dispensed on 07/18/23 for a 30-day supply.
-No prescription was received in August.
-A new prescription was received at the pharmacy on 09/18/23 for tramadol 50mg #120 1 po q6hrs

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prn for a 30-day supply.
-The facility requested the tramadol refill on 09/20/23.
-The tramadol prescription was picked up on 09/21/23.

Interview with the Resident Care Coordinator (RCC) on 10/05/23 at 1:03pm revealed:
-The MAs were responsible for re-ordering medications for the residents.
-Medications should be re-ordered when there is a 1.5 to 2 week supply remaining.
The MAs called the contracted pharmacy and re-ordered medications and documented on the progress notes.

Interview with the Administrator on 10/05/23 at 1:05pm revealed:
-The night shift MA did medication cart audits weekly for each resident.
-The MAs were expected to monitor and re-order the residents' medications so their medications would be available.

Interview with a nurse at Resident #2's Primary Care Provider's (PCP) office on 10/05/23 at 3:09pm revealed:
-Resident #2 last received Tramadol #120 one by mouth every 6 hrs prn for a 30-day supply on 02/11/23 from their office.
-The order for Tramadol was changed to Tramadol 50mg one every 12 hours on 07/10/23.
-She thought the most recent Tramadol refills may have come from Resident #2's pain management provider.

Attempted telephone interview with Resident #2's pain management provider on 10/05/23 at 2:59pm was unsuccessful.