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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the New Hanover Department of Social Services conducted an annual and follow-up survey as well as a complaint investigation on 04/09/24 and 04/10/24. The complaint investigations were initiated on 02/27/24 and on 03/13/24 by the New Hanover County Department of Social Services. | D 000 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered for 2 of 6 residents (#6, #7) observed during the medication passes at 8:00am on 04/09/24 and 04/10/24 including errors with an antacid medication (#7) and a medication used to treat high blood pressure (#6); and for 1 of 5 residents (#1) sampled for record review for a medication used to treat cancer.<br><br>The findings are:<br><br>1. The medication error rate was 6% as evidenced by 2 errors out of 26 opportunities during the 8:00am medication passes on 04/09/24 and 04/19/24. | D 358 | | |

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| D 358 | Continued From page 1<br><br>a. Review of Resident #6's current FL-2 dated 08/15/23 revealed diagnoses included dementia with agitation, atrial flutter, unspecified protein-calorie malnutrition, bronchiectasis, and difficulty walking.<br><br>Review of physician orders for Resident #6 dated 12/05/23 revealed:<br>-There was an order for metoprolol succinate (a time released medication used to treat chest pain, heart failure, and high blood pressure) extended release (ER) 25mg tablet daily for atrial flutter.<br>-There was a physician's order that medications that were appropriate to crush may be crushed and placed in applesauce, pudding, yogurt, or juice.<br><br>Observation of the medication aide (MA) from 7:33am to 7:34am on 04/10/24 revealed:<br>-The medication aide (MA) prepared four medications for administration to Resident #6 which included the metoprolol succinate ER 25mg tablet.<br>-The MA placed the metoprolol succinate tablet and a second tablet in a clear plastic bag and crushed the two tablets.<br>-The MA poured the crushed medications in a coffee cup with the remaining two medications and filled the cup half-full of coffee.<br><br>Observation of Resident #6's medications on hand at 7:33am on 04/10/24 revealed:<br>-There was a blister pack pharmacy labelled medication container for metoprolol succinate ER 25mg tablet daily.<br>-There were printed instructions for "DO NOT CRUSH" in the lower right-hand corner of the pharmacy prepared medication label. | D 358 | | |

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| D 358 | Continued From page 2<br><br>Interview with the MA on 04/10/24 at 7:34am revealed:<br>-She always crushed Resident #6's medications and mixed all of the residents' medications with coffee to make sure Resident #6 took her medications.<br>-Resident #6 always drank her coffee.<br>-There was a physician's order to crush Resident #6's medications.<br><br>Interview with a second MA on 04/10/24 at 3:15pm.<br>-She had to crush Resident #6's medication for administration.<br>-She was "pretty sure" there was a physician's order to crush Resident #6's medications and mix the medications with her food.<br>-She was not sure if there was a list on the memory care unit for medications that were not to be crushed.<br>-The MAs had to crush residents' medications on the special care unit (SCU) and mix the medications with the resident's food or drink.<br>-Resident #6 took her medication fine when mixed in the resident's food.<br><br>Observation of the MA on 04/10/24 at 3:20pm revealed she looked through the controlled substance book and found the printed list for medications that should not be crushed.<br><br>Interview with the Nurse/Resident Care Director (RCD) on 04/10/24 at 4:00pm revealed:<br>-She became aware on the morning of 04/10/24 that the MAs were crushing Resident #6's metoprolol extend release tablet.<br>-Resident #6 would usually drink her coffee and medications were mixed in her coffee.<br>-There was a list of medications on the memory | D 358 | | |

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care unit that were not to be crushed.
-The MAs needed to be aware of medications that could not e crushed.

Telephone interview with the Primary Care Provider (PCP) for Resident #6 on 04/10/24 at 4:25pm revealed:
-She wanted Resident #6 to be administered the Metoprolol Succinate to get the whole dose.
-With Resident #6's atrial flutter, the resident may have more of an irregular heart rate that could cause decreased cardiac effects such as worsening cardiac disease.
-The resident's atrial flutter could be uncontrolled.
-There was a risk for stroke or heart attack.
-The MAs should put the metoprolol succinate tablet in applesauce to administer to Resident #6.

Refer to the interview with the Administrator on 04/10/24 at 8:57am.

b. Review of Resident #7's current FL-2 dated 11/15/23 revealed diagnoses included vascular dementia, hypothyroidism, anemia, anxiety, syncope, traumatic heart disease, and biliary acute pancreatitis.

Review of physician orders for Resident #7 dated 11/15/23 revealed:
-There was an order for antacid calcium (used to treat indigestion) 1000mg three times a day.
-There was no physician's order for Resident #7 to keep medications at the bedside or self-administer medications.

Observation of the medication aide (MA) at 8:39am on 04/09/24 revealed the medication aide (MA) prepared eleven medications for administration to Resident #7 which did not include any antacid calcium tablets.

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| D 358 | Continued From page 4<br><br>Review of Resident #7's medication administration records (MARS) on 04/09/24 revealed:<br>-There was a printed entry for antacid calcium 1000mg tablet chew and swallow one tablet three times a day for indigestion "+PT HAS+" and scheduled for administration at 8:00am, 12:00pm, and 5:00pm daily.<br>-There was documentation of administration for the 8:00am scheduled dosage for 04/09/24 by the MA.<br><br>Observation of Resident #7's medications at 12:29pm on 04/09/24 revealed there was no antacid calcium on hand and available for administration.<br><br>Interview with the MA on 04/09/24 at 12:20pm revealed:<br>-Resident #7 "normally" had her own antacid calcium tablets.<br>-Resident #7 self-administered the antacid calcium medication.<br>-The MA was not sure if Resident #7 got the antacid calcium the morning of 04/09/24.<br>-The MA did not remember asking Resident #7 if she had taken the antacid calcium.<br>-The MA documented administration of the antacid calcium when he signed the MAR for the other medications administered.<br><br>Interview with the Administrator on 04/09/24 at 12:30pm revealed the facility would need a physician's order for Resident #7 to self-administer the antacid calcium medication.<br><br>Interview with the Administrator on 04/10/24 at 8:57am revealed:<br>-Resident #7's physician had been contacted | D 358 | | |

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about an order for the resident to self-administer the antacid calcium.
-She expected the MAs not to document administration of medication until the MAs observed the resident consume the medication.

Interview with Resident #7 on 04/10/24 at 9:03am revealed:
-She kept the antacid calcium in her room.
-She took the medication three times a day.
-She put the antacid calcium in the medication cup herself.
-A family member bought the antacid calcium for her.
-She did not know where the antacid calcium container was currently.
-She may have already taken the last of the antacid calcium tablets.

Telephone interview with the nurse for the Primary Care Provider (PCP) on 04/10/24 at 4:40pm revealed:
-The PCP's office was contacted on 04/09/24 and again on 04/10/24 requesting a physician's order for Resident #7 to self-administer the antacid calcium.
-The PCP had not signed the order for Resident #7 to self-administer medication.
-She was not aware of a physician's order for Resident #7 to self-administer any medication.
-She had reviewed Resident #7's physician orders as far back as 12/08/23 an did not find an order for Resident #7 to self-administer medication.
-There was a current physician's order for Resident #7 for Tums (calcium antacid) 1000mg with each meal three times a day.

Refer to the interview with the Administrator on 04/10/24 at 8:57am.

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| D 358 | Continued From page 6<br><br>Interview with the Administrator on 04/10/24 at 8:57am revealed she expected the MAs to administer medications as ordered by the physician.<br><br>2. Review of Resident #1's current FL-2 dated 12/20/23 revealed:<br>-Diagnoses included memory deficits, prostate cancer, uncontrolled type 2 diabetes mellitus, hyperlipidemia, hypertension, cerebral vascular accident, and camurati-engelmann disease.<br>-The resident was intermittently disordered and wandered.<br>-The resident's recommended level of care was special care unit.<br>-There was no order for darolutamide (used to treat prostate cancer).<br><br>Review of a physician encounter for Resident #1 dated 03/21/24 revealed:<br>-The resident was being seen for evaluation of prostate adenocarcinoma.<br>-The primary visit diagnosis was prostate cancer metastatic to bone.<br>-The resident received an order from the provider for darolutamide 300mg twice daily.<br><br>Review of Resident #1's March 2024 and April 2024 electronic medication administration records (eMARs) revealed there was no entry for darolutamide 300mg to be administered.<br><br>Review of Resident #1's progress notes printed on 04/09/24 revealed no documentation regarding the resident's order for darolutamide. (Darolutamide is a androgen receptor inhibitor used to treat prostate cancer.)<br><br>Review of a morning stand up/at risk form dated | D 358 | | |

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04/01/24 revealed:
-Resident #1's prostate cancer had returned.
-The Veteran Affairs (VA) was to send Resident #1's new medication.
-It was noted that follow up was needed.
-The Administrator and Memory Care Director (MCD) were noted to be in attendance, but the Resident Care Director (RCD) was not in attendance.

Observation of medications on hand for Resident #1 on 04/09/24 at 4:08pm revealed darolutamide was not on hand to be administered.

Interview with a medication aide (MA) on 04/09/24 at 4:15pm revealed:
-Resident #1 had a history of prostate cancer.
-She was not aware of an order for darolutamide for Resident #1 and had not administered that medication to the resident.

Telephone interview with a nurse at the oncologist office of the provider on who saw Resident #1 on 04/10/24 at 12:16pm revealed:
-The resident was seen on the office on 03/21/24 as a follow up visit from being seen on 03/13/24.
-During the office visit on 03/21/24, the resident was informed that the cancer had already metastasized to the bone.
-Resident #1 was ordered darolutamide 300mg one twice daily.
-The provider sent an order for the darolutamide was sent to a VA pharmacy on 03/21/24.
-When the provider ordered darolutamide for Resident #1, the intent was that the resident would receive the medication as ordered.
-The provider had no knowledge that Resident #1 had not received the darolutamide as ordered.
-Missing the darolutamide was not ideal as the medication was not a life-or-death situation, but

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| D 358 | Continued From page 8<br>the intent was for Resident #1 to receive the medication.<br><br>Second telephone interview with a nurse at the oncologist office of the provider on who saw Resident #1 on 04/10/24 at 2:48pm revealed:<br>-The facility had not contacted their office prior to 04/10/24 to let the office know that Resident #1's darolutamide had not been filled and that the resident had not received the medication as ordered.<br>-She would expect the facility to notify the provider if there was a delay in getting the darolutamide order filled after 3 to 5 days.<br>-She sent a note to the provider on 04/10/24 to make him aware of the delay with Resident #1's darolutamide and that the resident had not received the medication as ordered.<br><br>Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 04/10/24 at 2:33pm revealed:<br>-The facility would send Resident #1's medication to their pharmacy to be packaged into blister packs once the medications were filled by the VA pharmacy.<br>-The pharmacy was not aware of an order for darolutamide for Resident #1.<br><br>Telephone interview with Resident #1's responsible party (RP) on 04/10/24 at 4:43pm revealed:<br>-Resident #1's medications were filled at the VA pharmacy and sent to the facility.<br>-She was aware Resident #1 had not received a medication ordered by the physician on 03/21/24 but could not recall the name of the medication.<br>-The facility was responsible for getting Resident #1's medications. | D 358 | | |

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| D 358 | Continued From page 9<br><br>Interview with the MCD on 04/10/24 at 1:28pm revealed:<br>-Resident #1's medications were filled at the VA pharmacy and then sent to the facility's contracted pharmacy to be repackaged into blister packs.<br>-She was aware Resident #1 had received an order on 03/21/24 for darolutamide and that the resident had not received the medication.<br>-Resident #1's RP was suppose to follow up with the VA pharmacy about sending he darolutamide, but she had not followed up with the VA pharmacy or Resident #1's responsible party.<br>-She had not followed up with Resident #1's RP or the VA pharmacy regarding Resident #1's darolutamide being filled.<br><br>Interview with the RCD on 04/10/24 at 1:48pm revealed:<br>-She was not aware Resident #1 had an order for darolutamide and that it had not been filled.<br>-Some of Resident #1's medications came from a VA pharmacy and were repackaged by facility's contracted pharmacy, which could have caused a delay in getting the darolutamide.<br>-The MCD would have been responsible for any follow up regarding Resident #1's darolutamide, which would include calling the VA pharmacy and notifying the provider that there had been a delay in getting the darolutamide.<br>-She would expect the MCD to document any follow up efforts or notification to the provider of the delay regarding Resident #1's darolutamide in the residents' progress notes.<br>-She would have expected the MCD to notify her of the delay regarding Resident #1's darolutamide after several days of the resident not having the medication on hand to be administered.<br><br>Interview with the Administrator on 04/10/24 at | D 358 | | |

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| D 358 | Continued From page 10<br><br>3:55pm revealed:<br>-During a stand-up meeting on 04/01/24, she learned for the first time there was a delay with Resident #1's darolutamide, as the order had not been filled the pharmacy.<br>-According to the MCD, the MCD had followed up with the pharmacy and provider regarding the delay with getting the darolutamide order filled.<br>-She was not aware until 04/09/24 when Resident #1's progress notes were printed that the MCD had not documented any follow up efforts with the pharmacy or notification with the provider regarding the darolutamide for Resident #1 not being filled.<br>-She would expect the MCD to document any follow up efforts and communication to the provider regarding the delay with Resident #1's darolutamide.<br>-If the resident had an active order, she would expect the resident to receive the medication as ordered. | D 358 | | |
| D 366 | 10A NCAC 13F .1004 (i) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION | D 366 | | |

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Based on observations, interviews, and record reviews, the facility failed to ensure medication aides who administered medications actually observed a resident in the memory care unit (Resident #6) taking their medications during the 8:00am medication pass on 04/10/24 before documenting the medication administration, and a resident (#3) whose medications were found left at the bedside on 04/09/24.

The findings are:

Review of the facility's Administration of Medications policy dated September 2020 revealed:
-All medications must be checked against the physician's order to ensure it is the right medication, right resident, right dosage, right time, and the right route.
-Proper documentation of each medication was to be done at the time of administration.

1. Review of Resident #6's current FL-2 dated 08/15/23 revealed:
-Diagnoses included dementia with agitation, atrial flutter, psychiatric disorder, unspecified protein-calorie malnutrition, bronchiectasis, and difficulty walking.
-The resident was constantly disoriented.
-The recommended and current level of care was special care unit.

Review of physician orders dated 08/15/23 revealed:
-There was an order for metoprolol (used to treat hypertension and heart disorders) 25mg tablet daily.
-There was an order for quetiapine fumarate (used to treat behaviors) 25mg tablet two times a day.

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-There was an order for tamsulosin (used to treat urinary symptoms) 0.4mg capsule daily.
-There was an order for polyethylene glycol 3350 (generic for Miralax used to treat constipation) 17grams in 8 ounces of water daily.

Observations of the 8:00am medication pass in the special care unit (SCU) on 04/10/24 from 7:33am through 7:47am revealed:
-The medication aide (MA) began preparing Resident #6's morning medications for administration which included polyethylene glycol powder 17gms, metoprolol succinate ER (extended release) 25mg tablet, quetiapine fumarate 25mg tablet, and tamsulosin HCL 0.4mg capsule.
-The MA measured the polyethylene glycol powder, crushed the metoprolol succinate extended release tablet and quetiapine fumarate, and emptied the content from the tamsulosin HCL capsule in a drinking cup.
-The MA mixed all of Resident #6's medications in a coffee cup and filled the cup half full of black coffee.
-At 7:37am, the MA sat the cup of coffee mixed with the medications on the dining room table in front of Resident #6 and instructed the resident to drink her coffee.
-At 7:38am, the resident picked up the cup of coffee mixed with medications and looked inside the cup. The resident did not drink from the cup and placed the cup back on the table.
-At 7:39am, the MA returned to the medication cart, in a room next to the dining room, and began preparing medications for another resident seated in the dining room. The personal care aide (PCA) remained in the dining room with the residents that included four residents seated at a second table, two residents seated in the common area, and one resident walking around

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in the dining room.
-At 7:40am, the resident walking around in the dining room positioned herself next to Resident #6 and leaned toward Resident #6 who continued seated at the table with the cup of coffee mixed with medications.
-At 7:41am, Resident #6 got up from the table and exited the dining room, leaving the cup of coffee mixed with medications on the dining room table.
-At 7:42am, the MA removed the cup of coffee mixed with medications from the dining room table and placed it on top of the refrigerator. The MA approached another resident seated in the dining room at another table and administered the resident medications.
-At 7:44am, the MA left the dining room and medication room area. A second PCA came into the dining room, removed Resident #6's cup of coffee mixed with medications from the top of the refrigerator, went to the sink and prepared to pour the cup of coffee mixed with medications down the sink drain when the surveyor intervened.
-At 7:46am, the MA entered the dining room.

Interview with the MA on 04/10/24 at 7:46am and 7:53am revealed:
-She had already documented the administration of medication for Resident #6's 8:00am medications.
-Resident #6 "usually" drank her coffee.
-She did not know why the resident would not drink her coffee on 04/10/24.
-The PCA should not have removed Resident #6's cup of coffee mixed with medication from the top of the refrigerator.
-She had not told either of the PCA's there were medications mixed in Resident #6's cup of coffee on top of the refrigerator because she did not think to tell them.

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-At 7:47am, the MA removed Resident #6's cup of coffee mixed with medications from the top of the refrigerator and relocated it in the medication room on top of the medication cart.
-She did not know why she did not stay with Resident #6 and the cup of coffee mixed with medications.
-She was trained that after medication was prepared for administration, the MA was supposed to stay with the medications until the resident had swallowed them.

Interview with the Administrator on 04/10/24 at 8:57am revealed:
-The MAs were expected to remain with the resident's medications until the residents consumed the medications.
-The MAs were not supposed to document administration of medications for a resident until the MA observed the resident consume the medication.

2. Review of Resident #5's current FL-2 dated 11/14/24 revealed:
-Diagnoses included hypotension, heart failure with decreased ejection fraction, paroxysmal atrial fibrillation, adult failure to thrive and a history of a cerebrovascular accident (stoke).
-She was intermittently disoriented.
-There was an order for enteric coated aspirin 81mg to be administered each day. (Aspirin is a medication used to thin the blood and prevent a stroke.)
-There was an order for metoprolol extended release (ER) 25mg to be administered each day. (Metoprolol is a medication used to treat high blood pressure.)
-There was an order for senna plus, 1 tablet to be administered each day. (Senna Plus is a medication used to treat constipation.)

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-There was an order for sertraline 25mg to be administered each day. (Sertraline is a medication used to treat depression.)
-There was an order for torsemide 20mg to be administered twice daily. (Torsemide is a medication used to treat fluid retention in people with congestive heart failure.)

Observation of Resident #5 on 04/09/24 at 9:21am revealed:
-She was lying in bed but sat up on the side of the bed upon entry.
-She looked to her bedside table, grabbed a medication cup and put the pills in her mouth and swallowed with a drink of water.

Interview with Resident #5 on 04/09/24 at 9:21am revealed:
-There were 5 pills in the cup.
-She did not remember what the medications were but she thought one was for constipation.
-She rarely got up for breakfast and medications were always brought to her in her room between 8:30am and 9:00am.
-Only 1 medication aide (MA) watched her take her medication.
-She lost her ability to remember things since her stroke but she always remembered to take her medication.

Review of Resident #5's electronic medication administration record (eMAR) for April 2024 revealed:
-There was a computerized entry for enteric coated aspirin 81mg to be administered each day for heart health and scheduled for 10:00am.
-There was documentation enteric coated aspirin 81mg was not administered on 04/09/24 with the exception note stated "medication not given".
-There was a computerized entry for metoprolol

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ER 25mg to be administered each day for the heart and scheduled for 10:00am.
-There was documentation metoprolol ER 25mg was not administered on 04/09/24 with the exception note stated "medication not given".
-There was a computerized entry for senna plus tablet, 1 tablet to be administered each day for constipation and scheduled for 8:00am.
-There was documentation senna plus tablet, 1 tablet was not administered on 04/09/24 with the exception note stated "medication not given".
-There was a computerized entry for sertraline 25mg to be administered each day for constipation and scheduled for 8:00am.
-There was documentation sertraline 25mg was not administered on 04/09/24 with the exception note stated "medication not given".
-There was a computerized entry for torsemide 20mg to be administered each day for constipation and scheduled for 8:00am.
-There was documentation torsemide 20mg was not administered on 04/09/24 with the exception note stated "medication not given".
-There was no documentation of the reason the medication was not administered.

Interview with the medication aide (MA) on 04/09/24 at 9:50am revealed:
-He left Resident #5's medications scheduled for 8:00am and 10:00am at her beside that morning.
-The medications scheduled for 8:00am that were left were sertraline 25mg, torsemide 20mg and senna plus.
-The medications scheduled for 10:00am that were left were metoprolol 25mg and aspirin 81mg.
-There was no order for Resident #5 to self administer her medications.
-He was not suppose to leave medications at the bedside for residents to take but he did not think

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anything of it that morning; he was busy, there was a lot going on that morning and he assumed she would take it.
-He documented the medications were administered on the eMAR without ensuring the medications were taken by Resident #5.
-Resident #5 did not like men and he could not do his job as he completely as he should due to Resident #5's boundaries with men.
-He could not wait for her to take her medications because there were timeframes to medication administration.
-He did not always leave the medications at the bedside; sometimes he would throw them away and document the resident refused.
-He thought he may have told the Resident Care Director about Resident #5 not wanting men in her room sometimes.
-He had not reported to anyone that he left medications at the bedside.
-He had not discussed alternative strategies on how to administer medications to Resident #5 to ensure she took the medications.

Telephone interview with Resident #5's family member on 04/10/24 at 3:23pm revealed:
-Resident #5's memory was not good and she would get confused.
-She would forget to take her medications when she lived alone.
-The facility staff administered her medications to make sure she took them.
-Resident #5 might forget to take her medications if they were left for her at the bedside to take.

Telephone interview with Resident #5's primary care provider (PCP) on 04/10/24 at 3:58pm revealed:
-Resident #5's cognition was modestly abnormal.
-Staff should administer her medications and

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| D 366 | Continued From page 18<br>watch her take them to ensure she is taking medications as prescribed.<br>-Resident #5 had a history of stroke and heart failure and the medications were prescribed to control her blood pressure to prevent another stroke and exacerbation of her heart failure.<br><br>Interview with the Resident Care Director (RCD) on 04/09/24 at 10:59am revealed:<br>-She was not aware the MA was experiencing any difficulty with administering medications to Resident #5.<br>-She was not aware Resident #5's medications were left at her bedside.<br>-MAs were expected to administer medications and watch the resident take the medication prior to documenting the administration on the eMAR.<br>-The documentation for the 8:00am and 10:00am scheduled medications was changed to show that the medications were not administered after she learned the medication was not observed to be taken by the MA.<br><br>Interview with the Administrator on 04/10/24 at 4:30pm revealed:<br>-Resident #5 had good days and bad days but her memory was 'spotty".<br>-She was aware Resident #5 did not like men in her room and the MA had been told to call her to the door to administer medications.<br>-It was important to watch the residents take their medications to ensure they were taken as prescribed.<br>-Medications should never be left at the bedside or unattended due to safety concerns that another resident could get them and it could be harmful to them.<br><br>_____<br>The facility failed to ensure a medication aide observed residents take their medication for 2 | D 366 | | |

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| D 366 | Continued From page 19<br>residents (#6, #5). Resident #6, who was living on a special care unit, had multiple medications mixed into her coffee which was left unattended in the dining room during breakfast meal service in the presence of other residents during the observation of the medication administration process and Resident #5, who was living on the assisted living unit with intermittent disorientation and a history of stroke, with multiple medications that were left at her bedside unattended .The facility's failure to ensure medications were swallowed and administered safely was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/10/24 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 8, 2024. | D 366 | | |
| D 371 | 10A NCAC 13F .1004(n) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record review, the facility failed to ensure infection control measures were implemented during the medication pass on 04/09/24 as evidenced by a | D 371 | | |

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medication aide (MA), who prepared to administer medication dropped on the floor to a resident.

The findings are:

Review of the facility's Infection Prevention and Control policy and procedure dated 10/23/20 and updated 01/2021 revealed:
-The facility would implement a comprehensive infection prevention and control program.
-The facility would assure all facility team members were trained in the facility's infection control program.

Observations of the medication aide (MA) administering medications during the 9:00am medication pass on 04/09/24 from 8:39am to 8:55am revealed:
-At 8:39am, the MA began preparing lisinopril (used to treat hypertension) 2.5mg tablet and torsemide (used to treat fluid retention and hypertension) 20mg tablet for administration to a resident by placing the two tablets in a separate plastic medication cup from the remaining oral medications for administration to the resident.
-The MA entered the resident's room at 8:50am with medications stacked in three plastic cups, two medication containers of creams, and one cup of water.
-The MA placed each plastic cup and medication container on the table in front of the resident.
-At 8:54am, the MA completed the application of creams to the residents' lower legs and feet. The MA prepared to rise from the kneeled position when the MA knocked over the medication cup containing the lisinopril 2.5mg tablet and torsemide 20mg tablet, and the two tablets fell on the carpeted room floor.
-The MA immediately picked up the lisinopril

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| D 371 | Continued From page 21<br><br>2.5mg tablet and torsemide 20mg tablet with a gloved hand and returned them to the medication cup on the tablet.<br>-At 8:55am, the MA prepared to administer the lisinopril 2.5mg tablet and torsemide 20mg tablet retrieved from the floor when the surveyor intervened.<br>-The MA returned to the medication cart and disposed of the two tablets that fell on the floor.<br><br>Interview with the MA at 8:55am revealed:<br>-He had never dropped a pill before and he "kinda" knew the policy when a medication was dropped.<br>-The MA "could redo them".<br>-The MA used the "five second rule" because the pills had not been on the floor longer than five seconds.<br><br>Interview with the Nurse/Resident Care Director (RCD) on 04/09/24 at 11:00am revealed:<br>-The facility did not have a "five second rule" for medications.<br>-Medications dropped on the floor should be thrown away. | D 371 | | |