Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063011	A. BUILDING: _____ B. WING _____	R 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARA PLANTATION OF CARTHAGE	820 S. MCNEILL STREET CARTHAGE, NC 28327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 04/30/24 to 05/01/24.	{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: FOLLOW-UP TO TYPE A2 VIOLATION. The Type A2 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 7 residents (#6, #7, #8) observed during the medication pass including errors with an inhaler for breathing problems and a topical gel for pain and inflammation (#6), rapid-acting insulin used to lower blood sugar and a medication used to aid in digestion (#7), and a medication used to treat movement disorders (#8). The findings are: The medication error rate was 20% as evidenced by 5 errors out of 25 opportunities during the 9:00am, 11:30am, and 12:00pm medication passes on 04/30/24.	{D 358}	On 5/7/24 the AIC contacted the pharmacy to provide one on one training during med pass with each MA. Training dates are: 5/28/24 6/4/24 The UCC will monitor and document one MA med pass per week to ensure proper med administration. The UCC will report any issues to the AIC.	6/4/24

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kathy Huffman, Adm TITLE 6/27/24 (X6) DATE

Reviewed and Acknowledged PHR 06/28/2024

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{D 358}	Continued From page 1 a. Review of Resident #6's current FL-2 dated 12/31/23 revealed: - Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease and osteoarthritis. -There was an order for Symbicort 160-4.5mcg inhaler, inhale 2 puffs twice daily, rinse mouth after each use. (Symbicort is used to treat chronic obstructive pulmonary disease). -According to the manufacturer, before using a Symbicort inhaler the first time, it will need to be primed. To prime Symbicort, hold it in the upright position; shake the inhaler well for 5 seconds; hold the inhaler facing away from you and press down firmly and fully on the top of the counter on the Symbicort inhaler to release a test spray; then shake it again for 5 seconds and release a second test spray. This ensures a full dose of medication is released. -According to the manufacturer, rinsing the mouth after use will help prevent fungal infections of the mouth and throat. Observation of the 9:00am medication pass on 04/30/24 revealed: -The medication aide (MA) removed a Symbicort inhaler from the medication cart for Resident #6. -The counter on the Symbicort inhaler was pointing to the red area indicating the inhaler was empty. -The MA retrieved a new unopened box with a Symbicort inhaler from the medication room for Resident #6. -The MA did not prime the new Symbicort inhaler prior to attempting to administer it to the resident. -The MA did not shake the inhaler or do the required test sprays prior to using the inhaler the first time. -The MA placed the mouthpiece in Resident #6's	{D 358}		

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{D 358}	Continued From page 2 mouth and said "deep breath" while pressing the inhaler 2 quick times in a row at 8:45am. -No sound was heard with the first press of the inhaler and no medication was released from the inhaler. -There was a short quick mist sound heard with the second press but the resident did not inhale and the medication vapors came back out of the resident's mouth. -The MA did not wait between puffs. - According to Guidelines for the Medication Administration Clinical Skills Checklist, waiting at least 1 minute between puffs may permit additional puffs to penetrate the lungs better. -The Symbicort inhaler was not primed and did not release medication for the first puff and did not release a full dose of medication for the second puff. -The vapors came back out of the resident's mouth so the medication did not go into the resident's lungs. -The MA did not instruct or offer for the resident to rinse his mouth after administering the Symbicort inhaler. Review of Resident #6's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Symbicort 160-4.5mcg inhaler, inhale 2 puffs by mouth twice daily; rinse mouth after each use. -Symbicort inhaler was scheduled for 9:00am and 9:00pm. -Symbicort inhaler was documented as administered from 04/01/24 - 04/30/24 at 9:00am. Interview with the MA on 04/30/24 at 04/30/24 at 12:35pm revealed: -She did not recall being trained on how to prime inhalers.	{D 358}		

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{D 358}	Continued From page 3 -She did not know she needed to prime the Symbicort inhaler before the first use. -She did not notice that no medication came out of the new Symbicort inhaler when she pressed it the first time. -She had the resident rinse his mouth later after he finished taking a nebulizer treatment around 9:00am. -Resident #6 usually became short of breath after walking and sometimes when he was sitting still. Interview with Resident #6 on 04/30/24 at 2:43pm revealed: -He usually received Symbicort inhaler each day, but he was not sure how often or how many puffs he received. -He could not remember if he rinsed his mouth with water after using the inhaler. -He did not get short of breath too often and denied any current shortness of breath. Interview with the Unit Care Coordinator (UCC) on 04/30/24 at 2:15pm revealed: -The MAs had been trained and checked off on how to properly administer inhalers. -She was not sure if the training included how to prime new inhalers for use. -Resident #6 had chronic obstructive pulmonary disease and got short of breath at times especially when he was walking. Telephone interview with Resident #6's primary care provider (PCP) on 05/01/24 at 11:51am revealed: -The MAs should be educated on how to properly prime and use inhalers. -Not receiving the full dose of Symbicort could cause Resident #6 to develop a cough or worsening of his lung disease including shortness of breath.	{D 358}		

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{D 358}	Continued From page 4 b. Review of Resident #6's current FL-2 dated 12/31/23 revealed: -There was an order for Voltaren 1 % Gel, apply 4 grams topically to both knees twice a day, **use dosing card**. (Voltaren Gel is a topical gel used to treat pain and inflammation). -Voltaren Gel is supplied with a plastic dosing card with markings for 2 grams and 4 grams that should be used to measure the proper dose. Observation of the 9:00am medication pass on 04/30/24 revealed: -The medication aide (MA) squeezed a dime-sized amount of Voltaren 1% Gel onto her gloved hand and applied the Voltaren Gel to both of Resident #6's knees at 8:46am. -The MA did not use a dosing card to measure 4 grams of Voltaren Gel as ordered. Review of Resident #6's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Voltaren 1% Gel, apply 4 grams topically to both knees twice a day scheduled for 9:00am and 9:00pm. -Voltaren 1% Gel was documented as administered from 04/01/24 - 04/30/24 (9:00am). Observation of Resident #6's medications on hand on 04/30/24 at 12:31pm revealed: -There was a tube of Voltaren 1% Gel dispensed on 02/26/24. -Instructions were to apply 4 grams topically to both knees twice a day, **use dosing card**. -The tube of Voltaren Gel was not in a box and there was no dosing card with the tube. Interview with Resident #6 on 04/30/24 at 2:43pm revealed:	{D 358}		

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{D 358}	Continued From page 5 -He usually got Voltaren Gel on both knees, and he thought it helped with his pain. -His knees hurt when he walked a lot. Interview with the MA on 04/30/24 at 12:35pm revealed: -There was supposed to be a dosing card with Resident #6's Voltaren Gel but she did not see the dosing card that morning, 04/30/24. -She "eye balled" the amount of Voltaren Gel she administered that morning based on what she thought would equal 4 grams. -There was a dosing card with Resident #6's Voltaren Gel on Sunday, 04/28/24, when she worked but she was not sure where it was now. -She could contact the pharmacy to get a new dosing card. -Resident #6 complained of pain in his knees when he walked too much. Interview with the Unit Care Coordinator (UCC) on 04/30/24 at 2:15pm revealed: -Voltaren 1% Gel came with a plastic dosing card marked with 2 grams and 4 grams. -The MAs should use the plastic dosing card to measure the correct dosage of Voltaren Gel. -If a resident's dosing card was missing, the MAs should check in the medication overstock to see if there was one located in there. -If not, the MAs should let her know and either she or the MA could order a new dosing card from the pharmacy. -Without using the dosing card, the resident could receive too much or too little of the medication. -Resident #6 had not complained to her of knee pain in a long time but she could tell the resident was more active and walked faster when he received the Voltaren Gel. Telephone interview with Resident #6's primary	{D 358}		

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{D 358}	Continued From page 6 care provider (PCP) on 05/01/24 at 11:51am revealed: -The MAs should use the dosing card to measure the correct dosage of Voltaren Gel. -If the full amount of Voltaren Gel was not administered, it may not be as effective at relieving the resident's pain. c. Review of Resident #7's current FL-2 dated 11/02/23 revealed: -Diagnoses included dementia, type 2 diabetes mellitus, and unspecified disease of the pancreas. -There was an order for Zenpep DR 40,000 units, take 4 capsules with each meal and 2 capsules with snacks. (Zenpep is a medication that contains digestive enzymes used to aid in the digestion of food). -Zenpep should be administered with food to exert the proper effects. Observation of the 12:00pm medication pass on 04/30/24 revealed: -Resident #7 was sitting in the lounge area of the facility. -The medication aide (MA) prepared and administered 4 Zenpep DR 40,000 units capsules to Resident #7 at 11:36am. -Resident #7 was served lunch at 12:01pm. -Resident #7's Zenpep DR was administered before the meal instead of with the meal as ordered. Review of Resident #7's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Zenpep DR 40,000 units, take 4 capsules with each meal and 2 capsules with snacks. -Zenpep was scheduled to be administered at	{D 358}		

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{D 358}	Continued From page 7 8:00am, 10:00am, 12:00pm, 2:30pm, 4:30pm, and 7:00pm. Observation of Resident #7's medication on hand on 04/30/24 at 1:55pm revealed there was a supply of Zenpep DR 40,000 units with instructions to take 4 capsules with each meal and 2 capsules with snacks. Attempted telephone interviews with the MA on 04/30/24 at 1:39pm and 2:50pm were unsuccessful. Interview with the Unit Care Coordinator (UCC) on 04/30/24 at 2:15pm revealed: -If a medication was ordered with meals, it should be administered with the meal while the resident was sitting down with the meal in front of them eating. -Resident #7 should have received the Zenpep while he was eating lunch instead of before lunch. Telephone interview with Resident #7's primary care provider (PCP) on 05/01/24 at 11:51am revealed: -Resident #7's Zenpep should be administered with the meal. -Not receiving Zenpep with the meal could cause the resident to have some issues with digesting food and with abdominal pain. Interview with Resident #7 on 04/30/24 at 2:04pm revealed: -He usually received his medications before he ate lunch. -He denied any current problems with digestion or stomach pain. d. Review of Resident #7's physician's order dated 02/13/24 revealed:	{D 358}		

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{D 358}	Continued From page 8 -There was an order for Novolog insulin before meals and at bedtime according to the following sliding scale: 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than (>) 400 = give 10 units and call the provider. (Novolog is rapid-acting insulin used to lower blood sugar). -According to the manufacturer, the Novolog Flexpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles. Once the needle is inserted into the skin, the dose knob should be pushed all the way in and held for at least 6 seconds to ensure the full amount is injected. Review of Resident #7's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog Flexpen inject 4 times a day before meals and at bedtime with sliding scale: 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; > 400 = give 10 units and call the provider. -Novolog insulin was scheduled at 7:45am, 11:45am, 4:15pm, and 9:00pm. -The resident's blood sugar ranged from 60 - 495 from 04/01/24 - 04/30/24. Observation of the 11:30am/12:00pm medication pass on 04/30/24 revealed: -Resident #7's blood sugar was 205 at 11:37am. -The medication aide (MA) dialed 4 units on the Novolog Flexpen and administered insulin into Resident #7's left abdomen at 11:39am. -The MA did not perform a 2-unit air shot prior to dialing the insulin pen to 4 units to ensure no air bubbles were present and to ensure insulin was	{D 358}		

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{D 358}	Continued From page 9 flowing from the pen. -The MA held the insulin pen in the skin for only 3 seconds and removed the pen needle from the skin. -The MA did not hold the insulin pen in the skin for at least 6 seconds after injecting the needle and pressing the button to allow time for the full amount of insulin to be injected. -A stream of insulin ran out of the injection site and down the resident's abdomen. Attempted telephone interviews with the MA on 04/30/24 at 1:39pm and 2:50pm were unsuccessful. Interview with Resident #7 on 04/30/24 at 2:04pm revealed: -The MAs administered insulin to him every day when he needed it. -The MAs usually injected the insulin into his skin and pull the needle out immediately. -When his blood sugar was low, he felt thirsty and hungry. -He could not recall if he had symptoms when his blood sugar was high. Interview with the Unit Care Coordinator (UCC) on 04/30/24 at 2:15pm revealed: -The MAs had been trained and checked off on the proper use of insulin pens. -The MAs were supposed to prime the insulin pen with a 2-unit air shot to get the bubbles out. -She thought the MAs should hold the injection in the skin for at least 15 seconds. -She was concerned that not administering Resident #7's Novolog Flexpen correctly could cause the resident's blood sugar to be too high or too low. Interview with the Administrator-in-Training (AIT)	{D 358}		

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{D 358}	Continued From page 10 on 04/30/24 at 2:53pm revealed: -The MAs had been trained by the facility's contracted nurse. -The MAs should use proper technique when administering insulin pens. Telephone interview with Resident #7's primary care provider (PCP) on 05/01/24 at 11:51am revealed: -The MAs should use the proper technique for Resident #7's Novolog Flexpen to ensure the correct dosage was administered. -Not receiving the full amount of insulin could cause the resident's blood sugar to go up and cause hyperglycemia including symptoms such as dry mouth. e. Review of Resident #8's current FL-2 dated 07/03/23 revealed: -Diagnoses included dementia, degenerative disease of basal ganglia, and Hallervorden-Spatz disease (a neurological disorder that causes issues with movement). -There was an order for Sinemet 10/100mg 1 tablet 3 times a day with meals. (Sinemet is used to treat movement disorders). -Taking Sinemet with food may decrease gastrointestinal side effects. Review of Resident #8's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Sinemet 10/100mg 1 tablet 3 times a day with meals. -Sinemet was scheduled to be administered at 8:00am, 12:00pm, and 4:30pm. Interview with the medication aide (MA) on 04/30/24 at 11:35am revealed lunch was usually served at 12:00pm.	{D 358}		

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{D 358}	Continued From page 11 Observation of the 12:00pm medication pass on 04/30/24 revealed: -Resident #8 was sitting in a common area of the facility. -The MA prepared and administered Sinemet 10/100mg to Resident #8 at 11:43am. -Resident #8 was served dessert at 11:58am and started eating dessert at that time. -Resident #8 was served lunch at 12:01pm. -Resident #8's Sinemet was administered before a meal instead of with a meal as ordered. Observation of Resident #8's medication on hand on 04/30/24 at 1:57pm revealed there was a supply of Sinemet 10/100mg dispensed on 03/01/24 with instructions to take 1 tablet 3 times a day with meals. Attempted telephone interviews with the MA on 04/30/24 at 1:39pm and 2:50pm were unsuccessful. Interview with the Unit Care Coordinator (UCC) on 04/30/24 at 2:15pm revealed: -If a medication was ordered with meals, it should be administered with the meal while the resident was sitting down with the meal in front of them eating. -Resident #8 should have received the Sinemet while she was eating lunch instead of before lunch. Telephone interview with Resident #8's primary care provider (PCP) on 05/01/24 at 11:51am revealed: -Resident #8's Sinemet should be administered with the meal. -Not receiving Sinemet with the meal could cause the resident to have gastrointestinal side effects.	{D 358}		

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{D 358}	Continued From page 12 Based on observations, interviews, and record review, it was determined that Resident #8 was not interviewable.	{D 358}		