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THE STRATFORD	405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on 12/19/18-12/20/18.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure immediate follow-up with the physician regarding 1 of 5 sampled residents (Resident #1) being administered his roommate's medication and feeling lethargic, sleepy and weak. The findings are: Review of Resident #1's current FL2 dated 10/25/18 revealed diagnoses included myocardialinfarction, allergic rhinitis, atrial flutter, type II diabetes mellitus, esophageal stricture, hyperlipidemia, and coronary artery disease and macular degeneration. Review of Resident #1's hospital discharge summary report dated 12/07/18 revealed: -Resident #1 was brought to the emergency department at 6:00pm due to "drug overdose."	D 273		

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-"[Resident #1] was accidentally administered another residents medications during the morning medication pass."
-"Resident #1 complained of weakness, feeling sluggish and staff reported the resident was withdrawn."
-In the emergency department Resident #1 was "tired."
-Staff at the facility said "[Resident #1] was not administered his own medications this morning."
-"[Resident #1's] blood sugar was over 350, due to the resident not getting the morning dose of Lantus."

Interview with Resident #1's primary care practitioner (PCP) on 12/19/18 at 11:44 am revealed:
-On 12/07/18 at 4:47 pm the Memory Care Unit Coordinator (MCC) reported Resident #1 was administered his roommate's medications, which included psychotropic medications.
-The resident was feeling lethargic.
-The staff was advised to immediately send Resident #1 to emergency department.
-Prior to 4:47pm, no one from the facility called their office to notify him Resident #1 was administered his roommate's medication or that Resident #1 was not at his normal baseline.

Telephone interview with Resident #1's Guardian on 12/19/18 at 12:40 pm revealed:
-The facility staff called him after 5:00 pm on 12/07/18 to inform him that Resident #1 was going to the hospital because he was administered the wrong medications.
-No one at the facility called him in the morning on 12/07/18 to inform him that Resident #1 was administered his roommate's medication.
-The facility staff did not tell him the name of the medications administered, but informed him that

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Resident #1 was not acting at baseline.
-When he arrived at the hospital Resident #1 was tired and sleepy.
-The hospital gave the resident insulin due his blood sugar being high.

Interview with Resident #1 on 12/19/18 at 4:00 pm revealed:
-On 12/07/18 the medication aide (MA) came to the room and handed him a cup with multiple pills.
-He had observed the number of medications looked to be more than he normally was administered, but he did not question the MA and took all the medications.
-To his knowledge, he was not administered his morning Lantus.
-He did not know his medications and trusted facility staff to administer the correct medications to him.
-Between 9:15 am and 9:30 am, the MA in charge came to the room and told him that he had been administered the wrong medications.
-The MA said she would check on him throughout her shift and to let her know if he start to feel bad.
-The only thing he recalled was being sleepy and having a difficult time staying awake.
-He did not tell anyone how be felt because he could not stay awake long enough to talk to anyone.
-He slept long hours for two days and did not remember eating meals.
-The wrong medications were administered in the morning, it was around dinner time when he went to the hospital.

Interview with Resident #1's roommate on 12/19/18 at 3:55 pm revealed:
-Around 9:00am on 12/07/18 a MA came to the room to administer medications to him and his

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roommate.
-The MA in charge went to the room and told Resident #1 that he was administered the wrong medications.
-The MA told Resident #1 that she would keep an eye on him and to let her know if he felt sick.
-The MA checked on Resident #1 a few times during her shift and knew Resident #1 was tired and was not his usual baseline.
-Resident #1 slept all day and did not eat meals, which was very unusual for Resident #1.
-It was close to dinner time and Resident #1 was sleeping hard and he had a hard time waking the resident up.
-Resident #1 was administered his medications in the morning after 9:00 am, the resident was sent to the hospital at dinner time, which was 5:00 pm.

Interview with the Administrator on 12/19/18 at 3:19 pm with the Administrator revealed:
-On 12/07/18 between 5:00pm and 6:00pm he received a phone call from the MCC stating during the morning medication pass Resident #1 was administered the wrong medications.
-He did not know why the physician was not notified in the morning.
-He did not know why the MA in charge did not send Resident #1 to the hospital after the incident happened.
-"It was the facility's policy that MAs were to report incidents quick."

Interview with the first shift MA on 12/19/18 at 4:51 pm revealed:
-On 12/07/18, during the morning medication pass Resident #1's roommate and the MA informed her the MA gave the wrong medications to Resident #1.
-She told Resident #1 he was administered the wrong medications, which were his roommate's

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medications.
-She did not call Resident #1's PCP or guardian because she thought the MA that administered the medications called.
-She did not check with the MA to ensure the PCP was called.
-She had no reason why Resident #1 was not sent to the ER after he received the wrong medications.
-She had noticed that Resident #1 slept more than usual, but thought the resident was okay.

Interview with a second MA on 12/20/17 at 11:05 am revealed:
-She accidentally administered Resident #1 the wrong medications.
-She gave Resident #1 his roommate's medications, which included several psychotropic medications.
-She did not contact Resident #1's PCP or Guardian, because she thought the MA in charge was going to contact the PCP and document because it was her medication pass and she was only helping out.

Attempted telephone interview on 12/20/18 at 10:50 am with the second shift MA was not successful.

_____

The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the evening. The facility's failure placed the resident at substantial risk for serious harm and constitutes a Type A2 Violation.

_____

The facility provided a plan of protection on 01/15/19 in accordance with G.S. 131D-34 for

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D 273	Continued From page 5 this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 19, 2019.	D 273		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1 and #4) related to a resident receiving his roommate's medication (Resident #1) and a resident receiving the incorrect dosage of insulin for two months (Resident #4). The findings are:	D 358		

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1. Review of Resident #1's current FL2 dated 10/25/18 revealed:
-Diagnoses included myocardial-infarction, allergic rhinitis, atrial flutter, type II diabetes mellitus, esophageal stricture, hyperlipidemia, and coronary artery disease and macular degeneration.
-Physician's orders for medications included: Lantus 5 units at bedtime (low acting human insulin used to treat diabetes), metformin 500mg three times daily (used to treat diabetes), aspirin 81mg once a day (used as a blood thinner), acetaminophen 500mg three times daily (used to treat pain and fever), metoprolol 12.5mg once daily (used to lower blood pressure), multiple vitamin once daily (vitamin deficiency), vitamin D3 1,000 units once daily, and citrucel fiber laxative 500mg twice daily (used to treat constipation).
-The resident was intermittently disoriented.

Review of Resident #1's physician's order revealed medication orders as follows:
-A hospital summary report dated 11/26/18 with a new medication order for Humalog 4 units three times daily (long-acting human insulin used to treat diabetes) an order to increase Lantus to 14 units and to change the bedtime administration to morning administration "for better control."
-On 12/05/18 review of subsequent order that changed Humalog to 3 units three times daily.

Review of Resident #1's hospital discharge summary report (requested by the surveyor) dated 12/07/18 revealed:
-Resident #1 was brought to the emergency department at 6:00 pm due to "drug overdose."
-"[Resident #1] was accidentally administered another residents medications."
-Facility staff verbally informed the medications

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accidentally administered to Resident #1 included: omeprazole 20mg (used to treat acid reflux), tamsulosin 0.4mg (used to relax the muscle in the prostate and bladder), tizanidine 4mg (used to treat spasticity and relax muscle tone), aspirin 81mg (used to thin the blood), duloxetine 30mg (used to soften stool), and gabapentin 1200mg (used to treat nerve pain).
-After the incident "Resident #1 complained of weakness, feeling sluggish and staff reported the resident was withdrawn."
-In the emergency department Resident #1 was "tired."
-"[Resident #1] was not administered his own medications this morning.
-"[Resident #1's] blood sugar was over 350, due to the resident not getting his morning dose of Lantus."

Review of Resident #1's December 2018 electronic Medication Administration Records (eMARs) revealed:
-Medication scheduled for 8:00 am were documented as administered 12/07/18.
-An entry for Lantus 5 units once daily at 7:00 am was printed on the eMARs.
-Lantus was documented administered daily at 7:00 am from 12/01/18 through 12/1918.
-An entry for the following medications was printed on the eMARs daily at 8:00am.
-Metformin 500mg once daily at 8:00 am, acetaminophen 500mg three times at 8:00 am, aspirin 81mg once daily, daily-vite once daily at 8:00 am, fiber laxative 500mg twice daily at 8:00 am, Humalog 4 units three times daily at 8:00 am (discontinued on 12/05/18), Humalog 3 units daily three times at 8:00 am (started on 12/06/18), vitamin D3 1,000 units daily at 8:00am.
-Documentation all the above medications were administered on 12/07/18 at 7:00 am or 8:00 am.

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D 358	Continued From page 8 -There was no documentation of missed dosages of medication or medication errors documented on the eMARs or in Resident #1's record. Review of Resident #1's roommate (Resident #2) December 2018 eMARs revealed on 12/07/18 morning medications documented as administered to Resident #1 included aspirin 81mg, ciprofloxacin 250mg, duloxetine 30mg (used to treat depression), gabapentin 1200mg, omeprazole 20mg, tamsulosin 0.4mg, tizanidine 4mg and Oxycodone 30mg (used to treat pain). Interview with Resident #1's primary care practitioner (PCP) on 12/19/18 at 11:44 am revealed: -On 12/07/18 at 4:47 pm the Memory Care Unit Coordinator (MCC) reported Resident #1 was administered his roommate's medications, which included psychotropic medications. -The resident was feeling lethargic. -The staff was advised to immediately send Resident #1 to emergency department. Telephone interview with Resident #1's Guardian on 12/19/18 at 12:40 pm revealed: -The facility staff called him after 5:00 pm on 12/07/18 to inform him that Resident #1 was going to the hospital because he was administered the wrong medications. -The facility staff did not tell him the name of the medications administered, but informed him that Resident #1 was not acting at baseline. -When he arrived at the hospital Resident #1 was tired and sleepy. -Resident #1 was observed at the hospital for close to 3 hours and then discharged back to the facility. -The hospital gave the resident insulin due his blood sugar being high.	D 358		

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-To his knowledge this was the first time Resident #1 was administered the wrong medications.

Interview with Resident #1 on 12/19/18 at 4:00 pm revealed:
-On 12/07/18 the medication aide (MA) came to the room and handed him a cup with multiple pills.
-He had observed the number of medications looked to be more than he usually were administered, but he did not question the MA and took all the medications.
-To his remembrance, he was not administered his morning Lantus.
-He did not know his medications and trusted facility staff to administer the correct medications to him.
-Between 9:15 am and 9:30 am, the MA in charge came to the room and told him that he had been administered the wrong medications.
-The MA said she would check on him throughout her shift and to let her know if he start to feel bad.
-The only thing he recalled was being sleepy and having a difficult time staying awake.
-He did not mention how he was feeling to anyone because he was unable to stay awake long enough to verbalize how he was feeling.
-He slept long hours for two days and did not remember eating meals.

Interview with Resident #1's roommate on 12/19/18 at 3:55 pm revealed:
-Around 9:00 am on 12/07/18 a MA came to the room to administer medications to him and his roommate.
-He was in the bathroom when the MA came to the room, so the MA gave medications to his roommate first.
-When he came out of the bathroom the MA handed him a cup with multiple medications.

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-He knew all of his medications, the exact names, color and administration times of his medications.
-He told the MA that the medications in the cup were not his medications.
-The MA insisted they were his medications and argued with him to take the medications.
-He refused to take the medications and told the MA that he was going to see the MA in charge.
-He took the cup with the medications to the MA that was in charge and showed her the medications.
-The MA agreed with him the medications in the cup were not his correct medications.
-The MA gave him the correct medications.
The MA in charge went to the room and told Resident #1 that he was administered the wrong medications.
-The MA told Resident #1 that she was going to keep an eye on him and to let her know if he felt sick.
-The MA checked on Resident #1 a few times during her shift and knew Resident #1 was tired and sleeping more than usual.
-Resident #1 slept all day and did not eat meals, which was very unusual for Resident #1.
-It was close to dinner time and Resident #1 was sleeping hard and he had a difficult time waking the resident up.
-He went to the medication room and told the second shift MA on duty.
-The MA came to see Resident #1 and shortly afterwards sent Resident #1 to the hospital.
-Resident #1 slept hard for two days.
-This was not the first time he was accidentally given the wrong medication.
-About two months ago the same thing happened with another MA and he refused to take the medications.
-He was concerned for other residents in the facility who did not know they were administered

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D 358	Continued From page 11 the wrong medications. Interview with the Administrator on 12/19/18 at 3:19 pm revealed: -On 12/07/18 between 5:00 pm and 6:00 pm he got a phone call from the MCC stating during the morning medication pass Resident #1 was administered the wrong medications. -The MA in charge immediately knew of the medication error involving Resident #1 and his roommate, but did not report the incident to the physician or the oncoming staff. -The facility had eMARs and the resident's photo was in the computer for the MA to view before administering medications. -The MA who administered the medications was fairly new and did not know the residents. -"It was the facility's policy that MAs were to report incidents quick." -The MA was supposed to document the medication error immediately and call the resident's PCP. -The MA did not follow the facility's policy. -After the incident he "consulted" with the MA that was in charge, and reminded her to remember to review the resident's photo before administering medications, to report incidents quicker and document. -He, nor the staff documented the incident on the eMARs or in Resident #1's record. Observation of the medication cart on 12/28/18 at 12:20 pm reveled : -Lap top computers were on the top of the medication cart. -The MA typed in a resident's and a picture of the resident appeared on the screen of the computer. -A list of the resident's medications came up on the screen under the resident's picture.	D 358		

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Interview with the first shift MA on 12/19/18 at 4:51 pm revealed:
-The facility had two medications carts with computers and electronic medication administration records.
-On 12/07/18 there was a problem with the computer on one of the medication carts.
-The computer problem caused her to be behind in administering morning medications.
-She used the computer in the RCC's office which was in the front of the building, so she asked another MA on duty to help pass the medications.
-She prepared the medications in cups and gave the cups to another MA to take to residents rooms and administer the medications.
-She signed the eMARs that the medications were administered.
-Administering medications this way was not the facility's policy.
-She was behind administering medication on 12/07/18 and wanted to get the medications administered as soon as possible.
-On 12/07/18 Resident #1's roommate and the MA came to the RCC's office and told her the MA gave the wrong medications to Resident #1.
-She looked at the medications in the cup and verified the wrong medications were administered.
-She gave the roommate the correct medications.
-She did not give Resident #1 his morning medications.
-She told Resident #1 he was administered the wrong medications, which were his roommate's medications.
-She did not complete a medication error report or document the medication error.
-She did not call Resident #1's PCP or guardian.
-She checked on Resident #1 every hour for the rest of her shift to see how he was doing.
-She thought the MA that gave the wrong

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medication was going to call Resident #1's PCP and document the error.
-She did not check with the MA to ensure it was done.
-She had noticed that Resident #1 slept more than usual, but thought the resident was okay.
-Later that day, on 12/07/18, around 5:00 pm the second shift MA called her to inquire about Resident #1, and she told the MA about the medication error.

Interview with a second MA on 12/20/17 at 11:05 am revealed:
-She had worked at the facility for two-three months as a part-time MA, mostly on the third shift.
-She usually worked six-seven days per month and was not familiar with the residents and their medications.
-On 12/07/18, there was difficulty with the computers being down due to the internet.
-The MA in charge was behind in completing her morning medication pass.
-The MA asked her to assist her by taking the medications to the residents.
-The MA in charge put the medications in cups, then told her the resident name and room number to administer the medications.
-The cups were not marked, so she put Resident #1's medications in one hand and his roommate's medications in the other hand.
-She followed this process for administering medications to all the residents.
-When she got to Resident #1's room, she thought the correct medications were administered to Resident #1.
-Resident #1's roommate was in the bathroom.
-When the roommate came out of the bathroom she tried to give him the cup with the medications and he refused stating those were not his

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medications.
-She did not realize that she had mixed the medications up.
-She and the roommate, went to the MA in charge that prepared the medications and confirmed the medications in cup were Resident #1's medications.
-The MA gave the roommate the correct medications, but did not give Resident #1 anymore medications.
-She did not contact Resident #1's PCP or Guardian,.
-She also did not document the error or complete a medication error report because she thought the MA in charge was going do the notification.
-She thought the MA in charge was going to contact the PCP and document because it was her medication pass and she was only helping out.
-She was sure the other residents got the correct medications, no other residents complained their medications were incorrect.

Interview with the MCC on 12/20/18 at 12:37 pm revealed:
-It was close to 5:00pm on 12/07/18 and the MA called and informed her Resident #1's roommate came to the medication room and told her that Resident #1 was "sleeping hard" and he could hardly wake him up.
-The roommate told the MA this morning Resident #1 was administered the wrong medications.
-She called Resident #1's PCP and was informed to send the resident to the emergency department.
-She called the Administrator and informed him of the incident.
-She did not do a medication error report or document the incident.

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D 358	Continued From page 15 -She told the MA on the second shift to do the error report and document the incident. Attempt interview on 12/20/18 at 10:50 am with the second shift MA was not successful. 2. Review of Resident #4's current FL2 dated 09/07/18 revealed a diagnoses of obesity, paranoid schizophrenia, hypoventilation syndrome, shortness of breath and hypertension. Review of Resident #4's order dated 10/17/18 revealed an order for Novolog 100 units/ml, inject 5 units subcutaneously three times a day with meals. Review of Resident #4's subsequent order dated 10/24/18 revealed an order for Novolog 100 units/ml, inject 7 units subcutaneously three times a day with meals. Review of Resident #4's subsequent order dated 10/31/18 revealed an order for Novolog 100 units/ml, inject 8 units subcutaneously three times a day with meals. Review of Resident #4's subsequent order dated 12/05/18 revealed an order for Novolog 100 units/ml, inject 10 units subcutaneously three times a day with meals. Review of the October 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Novolog 100 unit/ml, inject 5 units subcutaneously three times a day after meals scheduled at 8:30 am, 1:00 pm and 6:30 pm. -Staff documented Novolog 5 units was administered from 10/17/18 at 6:30 pm through 10/18/18 at 1:00 pm.	D 358		

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D 358	Continued From page 16 -There was an entry for Novolog 100 units/ml, inject 10 units subcutaneously three times a day after meals scheduled at 8:00 am, 1:00 pm, and 6:00 pm -Staff documented Novolog 10 units was administered from 10/18/18 at 6:00 pm through 10/31/18. -There was no entry for Novolog 100 units/ml, inject 7 units subcutaneously three times a day with meals. -There was no entry for Novolog 100 units/ml, inject 8 units subcutaneously three times a day with meals. -Resident #4's blood sugars ranged from 137 - 575. Review of the November 2018 eMAR revealed: -There was an entry for Novolog 100 units/ml, inject 10 units subcutaneously three times a day after meals scheduled at 8:00 am, 1:00 pm, and 6:00 pm. -Staff documented Novolog 10 units was administered from 11/01/18 through 11/30/18. -There was no entry for Novolog 100 units/ml, inject 8 units subcutaneously three times a day with meals. -Resident #4's blood sugars ranged from 134 - 548. Review of the December 2018 eMAR revealed: -There was an entry for Novolog 100 units/ml, inject 10 units subcutaneously three times a day after meals scheduled at 8:00 am, 1:00 pm, and 6:00 pm. -Staff documented Novolog 10 units was administered from 12/01/18 through 12/06/18. -There was no entry for Novolog 100 units/ml, inject 8 units subcutaneously three times a day with meals. -Resident #4's blood sugars ranged from 134 -	D 358		

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D 358	Continued From page 17 568. Interview with a first shift medication aide (MA) on 12/20/18 at 5:00 pm revealed: -MAs could fax new orders to the pharmacy. -MAs did not have the ability to change orders on the eMAR. -She thought the Resident Care Coordinator (RCC) had the ability to change orders on the eMAR. -She thought the RCC completed eMAR audits. -She was not sure what the eMAR audit included. -She did not know Resident #4's eMAR entries for 10 units of Novolog for the months of October and November were incorrect. -She only administered medications according to the eMAR. Interview with the RCC on 12/20/18 at 5:15 pm revealed: -She did not know Resident #4 was receiving the incorrect amount of Novolog from October 2018 through December 2018. -The Novolog orders were entered into the eMAR system by the pharmacy. -She rejected the Novolog entries from 10/17/18, 10/24/18, and 10/31/18. -She manually entered the Novolog order on 10/18/18 for 10 units three times a day with meals. -She did not know why she rejected the Novolog entries and manually entered a different Novolog order. -She conducted cart audits on Monday through Thursdays. -By the end of each week every resident in the building had been audited. -During audits she reviewed medications on hand, expired medications, and compared the physician's orders to the eMAR.	D 358		

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D 358	Continued From page 18 -She missed the incorrect Novolog entries during the audit. Interview with the Regional Clinical Director on 12/20/18 at 5:30 pm revealed: -The RCC rejected the Novolog entries from 10/17/18, 10/24/18, and 10/31/18. -She did not know why the RCC rejected the Novolog entries. -The RCC manually entered a Novolog order on 10/18/18 for 10 units three times a day with meals. -When an order was rejected it did not show up on the eMAR. -When an order was manually entered by the facility staff the pharmacy would not be able to view it. Interview with the Administrator on 12/20/18 at 5:45 pm reveled: -He did not know Resident #4 was receiving the incorrect amount of Novolog from 10/18/18 through 12/05/18. -Medication cart audits were completed by RCCs everyday. -The incorrect Novolog order should have been caught during medication cart audits. -The RCCs and the Administrator were allowed access to change and enter orders in the eMAR system. Interview with Resident #4 on 12/20/18 at 6:00 pm revealed: -She was not sure what insulin she received and how many units she was receiving. -Staff administered all medications including insulin. Telephone interview with Resident #4's Primary Care Practitioner on 12/20/18 at revealed:	D 358		

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D 358	Continued From page 19 -He did not know the staff had administered Novolog 10 units three times a day with meals since 10/18/18. -It was his intention for Novolog insulin to be increased over time. -The staff had not called to inform him the Novolog was administered at the incorrect amount from October 2018 through December 2018. -Administering an increased amount of Novolog insulin could cause hypoglycemia. -He was not concerned Resident #4 was administered an increased amount of Novolog from October 2018 through December 2018 because her blood sugars remain high. _____ The facility failed to assure medications were administered as ordered by the physician for 2 of 5 sampled residents related to Resident #1 being administered his roommates medications which resulted in the resident going to the emergency room and administering the incorrect dosage of Novolog placed Resident #4 at harm for hypoglycemia. The facility's failure to assure medications were administered as ordered was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection on 12/19/18 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 3, 2019.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration	D 366		

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D 366	Continued From page 20 10A NCAC 13F .1004 Medication Administration (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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure the medication aide (MA) who prepared the medications for administration observed Resident #1 ingest his medications resulting in the resident being administered his roommate's medications. The findings are: Review of Resident #1's current FL2 dated 10/25/18 revealed: -Diagnoses included myocardial infarction, allergic rhinitis, atrial flutter, type II diabetes mellitus, esophageal stricture, hyperlipidemia, and coronary artery disease and macular degeneration. -Physician's orders for medications included: Lantus 5 units at bedtime (low acting human insulin used to treat diabetes), metformin 500mg three times daily (used to treat diabetes), aspirin 81mg once a day (used as a blood thinner), acetaminophen 500mg three times daily (used to treat pain and fever), metoprolol 12.5mg once daily (used to lower blood pressure), multiple vitamin once daily (vitamin deficiency), vitamin D3 1,000 units once daily, and citrucel fiber laxative	D 366		

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500mg twice daily (used to treat constipation).
-The resident was intermittently disoriented.

Review of a hospital discharge summary report dated 12/07/18 revealed:
-Resident #1 was brought to the emergency department at 6:00 pm due to "drug overdose."
-Resident #1 was "accidentally administered another resident's medications."
-The resident was not administered his own medications this morning.
-Resident #1's "blood sugar was over 350, due to the resident not getting his morning dose of Lantus."

Review of Resident #1's December 2018 electronic Medication Administration Records (eMARs) revealed:
-Medication scheduled for 8:00 am were documented as administered 12/07/18 by the medication aide (MA) in charge.
-An entry for Lantus 5 units once daily at 7:00 am was printed on the eMARs.
-Lantus was documented administered daily at 7:00 am from 12/01/18 through 12/1918.
-An entry for the following medications was printed on the eMARs daily at 8:00 am.
-Metformin 500mg once daily at 8:00 am, acetaminophen 500mg three times at 8:00 am, aspirin 81mg once daily, daily-vite once daily at 8:00 am, fiber laxative 500mg twice daily at 8:00 am, Humalog 4 units three times daily at 8:00 am (discontinued on 12/05/18), Humalog 3 units daily three times at 8:00am (started on 12/06/18), vitamin D3 1,000 units daily at 8:00 am.
-Documentation of all the above medications were as administered on 12/07/18 at 7:00 am or 8:00 am.
-There was no documentation of missed dosages of medication or medication errors documented

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on the eMARs or in Resident #1's record.

Interview with Resident #1's primary care practitioner (PCP) on 12/19/18 at 11:44 am revealed:
-On 12/07/18 at 4:47 pm the Memory Care Unit Coordinator (MCC) called and told the PCP that during the 8:00am medication pass Resident #1 was administered his roommate's medications, which included psychotropic medications.
-The PCP was told facility staff did not administer Resident #1 his morning medications.

Interview with Resident #1 on 12/19/18 at 4:00 pm revealed:
-On 12/07/18 he was administered his roommates medications.
-He did not receive his morning medications on 12/07/18.
-He did not receive his insulin injection on 12/07/18.
-The MA did not tell him why she did not give him the correct morning medications, but he assumed it was because he had already been administered his roommate's medications.

Interview with Resident #1's roommate on 12/19/18 at 3:55 pm revealed:
-On 12/07/18, his roommate (Resident #1) was administered his medications.
-The MA in charge informed Resident #1 he was administered the wrong medications, but did not give Resident #1 his usual morning medications.

Interview with the first shift MA on 12/19/18 at 4:51 pm revealed:
-On 12/07/18 she prepared the medications in cups and gave the cups to another MA to administer the medications to the residents.
-She signed the eMARs that the medications

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were administered.
-Administering medications this way was not the facility's policy, and she had never administered medications this way.
-She was behind administering medications on 12/07/18 and wanted to get the medications administered as soon as possible.
-On 12/07/18 Resident #1 was administered his roommate's medication and was not administered his own medications.
-She did not document on the eMAR to reflect Resident #1's medications were not administered.
-She did not have a reason why she did not document accurately on the eMARs.

Interview with a second MA on 12/20/17 at 11:05 am revealed:
-On 12/07/18, she helped the MA in charge administer morning medications.
-The MA in charge put the medications in cups, then told her the resident name and room number to administer the medications.
-She administered Resident #1 the wrong medications.
-She did not know what was documented on the eMARs, because the MA that put the medications in the cup signed the eMARs.
-To her knowledge Resident #1 was not administered his morning medication on 12/07/18.

Interview with the Administrator on 12/19/18 at 3:19 pm revealed:
-The MA in charge immediately knew of the medication error involving Resident #1 and his roommate.
-The MA was not supposed to document on the eMARs as if residents' medications were not administered.
-He had not checked the eMARs to ensure the

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D 366	Continued From page 24 MA had not documented Resident #1's medications were administered on 12/07/18 at 8:00am. -He, nor the staff documented the incident on the eMARs or in Resident #1's record. Interview with the MCC on 12/20/18 at 12:37 pm revealed: -Resident #1's roommate told the second shift MA that Resident #1 was not feeling well because he was administered the wrong medications. -She called the MA and found out Resident #1 was not administered his morning medications, but his roommate's medications. -The MA should have documented the error and completed a medication error report.	D 366		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate and in compliance with federal and state laws and rules and regulations related to health care and medication administration. The findings are:	D912		

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D912	Continued From page 25 1. Based on observations, interviews, and record reviews, the facility failed to assure immediate follow-up with the physician regarding 1 of 5 sampled residents (Resident #1) being administered his roommate's medication and feeling lethargic, sleepy and weak. [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1 and #4) related to a resident receiving his roommate's medication (Resident #1) and a resident receiving the incorrect dosage of insulin for two months (Resident #4). [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		