

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: fci079113	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2021
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NAME OF PROVIDER OR SUPPLIER HARRISONS CARING HANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 814 LINDSEY STREET REIDSVILLE, NC 27320
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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 04/06/21.	C 000		
C 341	<p>10A NCAC 13G .1004 (i) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure staff documented the administration of medications immediately following the administration for 3 of 3 sampled residents (#1, #2, #3).</p> <p>The findings are:</p> <p>Observation on 04/06/21 between 8:09 am and 8:37 am revealed a medication aide (MA) administered medications which included an inhaler to 2 of the residents and a nasal spray for one resident in the facility without documenting on the MARs immediately after medication administration prior to administering the next resident's medication.</p> <p>1. Review of Resident #1's current FL2 dated</p>	C 341		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 341	<p>Continued From page 1</p> <p>09/30/20 revealed: -Diagnoses included schizoaffective disorder, bipolar disorder with psychotic features, epilepsy, post traumatic stress disorder, chronic obstructive pulmonary disease (COPD), and tardive dyskinesia. -There was an order for gabapentin (used to treat seizures) 300mg three times daily, hydroxyzine (used to treat anxiety) 50mg twice daily, ingreza (used to treat tardive dyskinesia) 80mg daily, lamotrigine (used to treat seizures) 25mg twice daily, levetiracetam (used to treat seizures) 750mg twice daily, zonisamide (used to treat seizures) 200mg twice daily, and amantadine (used to treat tardive dyskinesia) 100mg twice daily.</p> <p>Review of physician's orders dated 3/10/21 revealed orders for mag oxide(used to treat low magnesium levels) 400mg daily, vitamin B-12 (used to treat vitamin B deficiency) 1,000mcg daily, vitamin D3(used to treat vitamin D deficiency) 5,000IU daily, anora ellipta (treatment of COPD) 62.5-25mcg inhale one puff by mouth daily, buspirone (used to treat anxiety) 15mg three times daily, celecoxib (used to treat pain and swelling) 100mg daily, and esomeprazole (used to treat acid reflux) 40mg daily scheduled for 8:00 am.</p> <p>Review of Resident #1's April 2021 medication administration record (MAR) revealed there were entries for gabapentin 300mg three times daily, hydroxyzine 50mg twice daily, ingreza 80mg daily, lamotrigine 25mg twice daily, levetiracetam 750mg twice daily, mag oxide 400mg daily, vitamin B-12 1,000mcg daily, vitamin D3 5,000IU daily, zonisamide 200mg twice daily, amantadine 100mg twice daily, anora ellipta 62.5-25mcg inhale one puff by mouth daily, buspirone 15mg</p>	C 341		

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C 341	<p>Continued From page 2</p> <p>three times daily, celecoxib 100mg daily, and esomeprazole 40mg daily scheduled for 8:00 am.</p> <p>Observation of the Medication Aide (MA) on 04/06/21 at 8:09 am revealed:</p> <ul style="list-style-type: none"> -The MA had color coded packs of medications she punched Resident #1's morning medications from the blister packs. -She did not look at the MARs to compare the medications to the order. - At 8:12 am, the MA called Resident #1 over to the medication cart and handed her a medication cup with medications in it. -The MA administered Resident #1's medications but did not document medication administration on the MAR after the resident took the medication. -Then, the MA pulled another resident's medication from the cart. -At 8:37 am, she documented the medications she had administered. <p>Refer to interview on 04/06/21 at 8:18 am with the MA.</p> <p>Refer to interview on 04/06/21 at 8:50 am with the Administrator.</p> <p>2. Review of Resident #2's current FL2 dated 07/22/20 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included schizoaffective disorder, borderline personality disorder, asthma, intellectual disabilities, impaired glucose tolerance, and hypertension. -There was an order for breo ellipta (used to treat asthma) inhaler 1 puff daily, fluvoxamine (used to treat personality disorder) 50mg twice daily, haloperidol (used to treat schizoaffective disorder) 5mg twice daily, lisinopril (used to treat high blood pressure) 20mg daily, metformin (used 	C 341		

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C 341	<p>Continued From page 3</p> <p>to treat high blood sugar levels) 500mg twice daily, and vitamin D3 (used to treat vitamin D deficiency) 2,000IU daily.</p> <p>Review of physician's orders dated 3/19/21 revealed orders for bydureon (used to lower elevated blood sugar levels) 2mg inject weekly and omeprazole (used to treat acid reflux) 40mg daily.</p> <p>Review of Resident #2's April 2021 medication administration record (MAR) revealed there were entries for breo ellipta inhaler 1 puff daily, bydureon 2mg inject weekly, fluvoxamine 50mg twice daily, haloperidol 5mg twice daily, lisinopril 20mg daily, metformin 500mg twice daily, omeprazole 40mg daily, and vitamin D3 2,000IU daily scheduled for 8:00 am.</p> <p>Observation of the Medication Aide (MA) on 04/06/21 at 8:13 am revealed:</p> <ul style="list-style-type: none"> -The MA had color coded blister packs of medications she punched Resident #2's morning medications from the blister packs. -She did not look at the MARs to compare the medications to the order. -At 8:15 am, the MA called Resident #2 over to the medication cart and handed her a medication cup with medications in it. -The MA administered Resident #2's medications but did not document medication administration on the MAR after the resident took the medication. -Then, the MA pulled another resident's medication from the cart. -At 8:37 am, she documented the medications she had administered. <p>Refer to interview on 04/06/21 at 8:18 am with the MA.</p>	C 341		

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C 341	<p>Continued From page 4</p> <p>Refer to interview on 04/06/21 at 8:50 am with the Administrator.</p> <p>3. Review of Resident #3's current FL2 dated 11/23/20 revealed: -Diagnoses included schizophrenia and hypertension. -There was an order for amlodipine (used to treat high blood pressure) 5 mg daily, finasteride (used to treat enlarged prostate) 5mg daily, fluticasone (used to treat allergies) 50mcg 1 spray each nostril daily, hydralazine (used to treat high blood pressure) 50mg three times daily, isosorbide (used to treat high blood pressure) 30mg daily, lithium (used in treatment of schizophrenia) 450mg every 12 hours, tamsulosin (used to treat enlarged prostate) 0.4mg daily, vitamin B-12 (used to treat vitamin B deficiency) 100mcg daily, vitamin D3 (used to treat vitamin D deficiency) 50 mcg daily, and Spiriva (used to treat chronic obstructive pulmonary disease) inhale one capsule daily.</p> <p>Review of Resident #3's April 2021 medication administration record (MAR) revealed there were entries for amlodipine 5 mg daily, finasteride 5mg daily, fluticasone 50mcg 1 spray each nostril daily, hydralazine 50mg three times daily, isosorbide 30mg daily, lithium 450mg every 12 hours, tamsulosin 0.4mg daily, vitamin B-12 100mcg daily, vitamin D3 50 mcg daily, and Spiriva inhale one capsule daily scheduled for 8:00 am.</p> <p>Observation of the Medication Aide (MA) on 04/06/21 at 8:30 am revealed: -The MA had color coded blister packs of medications she punched Resident #3's morning medications from the blister packs.</p>	C 341		

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C 341	<p>Continued From page 5</p> <p>-She did not look at the MARs to compare the medications to the order.</p> <p>-At 8:37 am, the MA called Resident #3 over to the medication cart and handed her a medication cup with medications in it.</p> <p>-The MA administered Resident #3's medications but did not document medication administration on the MAR after the resident took the medication.</p> <p>-At 8:37 am, she documented the medications she had administered.</p> <p>Refer to interview on 04/06/21 at 8:18 am with the MA.</p> <p>Refer to interview on 04/06/21 at 8:50 am with the Administrator.</p> <p>_____ Interview with the MA on 04/06/21 at 8:18 am revealed:</p> <p>-She did not document on the MAR after each resident because she was nervous.</p> <p>-She knew the resident's medications by color and each color coded medication blister pack was for specific medication administration times.</p> <p>-She usually used the MARs for guidance to identify the residents and medications to be administered to the residents, but did not know why she did not check the MARs before she punched the medications.</p> <p>-She was trained to check the medications three times with the MAR before administering medication.</p> <p>-She was trained to document medication administration after each resident.</p> <p>Interview with the Administrator on 04/06/21 at 8:50 am revealed:</p> <p>-The MA had been properly trained and attended the medication aide training class.</p>	C 341		

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C 341	Continued From page 6 -The MA knew she was supposed to compare the residents' medications with the MARs and document immediately after administration of medication to each resident. The MA was very nervous. -She expected the MA to use the MARs to compare the medications listed on the MARs three times before administering medication to residents and to document medication administration immediately after each resident took their medications.	C 341		
C 356	10A NCAC 13G .1006 (e) Medication Storage 10A NCAC 13G .1006 Medication Storage (e) Medications intended for topical or external use, except for ophthalmic, otic and transdermal medications, shall be stored in a designated area separate from the medications intended for oral and injectable use. Ophthalmic, otic and transdermal medications may be stored with medications intended for oral and injectable use. Medications shall be stored apart from cleaning agents and hazardous chemicals. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure medications were maintained in a safe manner under locked security and direct supervision of staff in charge of medication administration. The findings are: Observation of the medication cart in the hallway on 04/06/21 at 7:59 am revealed:	C 356		

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C 356	<p>Continued From page 7</p> <ul style="list-style-type: none"> -The medication cart was observed unlocked and unsupervised by a medication aide (MA). -All drawers were full of medications and were accessible to whomever walked by. -There were two residents sitting on the couch in the living room just past the medication cart and staff was in the kitchen. <p>Interview with the medication aide (MA) on 04/06/21 at 8:05 pm revealed:</p> <ul style="list-style-type: none"> -She had been in the medication cart earlier and forgot to lock it back -The medication cart was usually kept locked. -She did not believe any of the residents would bother the medications. -She had been instructed to never leave the medication cart unlocked if she was not there to watch it. <p>Interview with the Administrator on 04/06/21 at 8:50 am revealed:</p> <ul style="list-style-type: none"> -She was made aware the MA left the medication cart unlocked and unsupervised in the hallway. -The medication cart should always be kept locked and supervised. -She expected the medication cart to be locked when unsupervised. 	C 356		