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
	fcl079113	A. BUILDING: _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISONS CARING HANDS	814 LINDSEY STREET REIDSVILLE, NC 27320

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 04/06/21.	C 000	MA has been retrained by Registered Nurse on Administering medication to one resident at a time and retrained to document as soon as administration of medication is given and before going to the next resident.	4/20/21
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .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 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). The findings are: 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. 1. Review of Resident #1's current FL2 dated	C 341		

reviewed and accepted with addendum 05/07/21 Jo Scarlett

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C 341	Continued From page 1 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, ingrezza (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. 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. 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, ingrezza 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	C 341	MA has been retrained by RN on the correct way to administer, and document medication.	4/20/21

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C 341	Continued From page 2 three times daily, celecoxib 100mg daily, and esomeprazole 40mg daily scheduled for 8:00 am. Observation of the Medication Aide (MA) on 04/06/21 at 8:09 am revealed: -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. Refer to interview on 04/06/21 at 8:18 am with the MA. Refer to interview on 04/06/21 at 8:50 am with the Administrator. 2. Review of Resident #2's current FL2 dated 07/22/20 revealed: -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	MA was retrained on how to compare the residents medications on the blister packs to the MAR's. MA was retrained to check and compare the residents medication to the MAR's and to document the medications was given on the MAR only after it has been given to the resident and before going to the next resident.	4/7/21 By Administrator 4/20/21 By RN

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C 341	Continued From page 3 to treat high blood sugar levels) 500mg twice daily, and vitamin D3 (used to treat vitamin D deficiency) 2,000IU daily. 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. 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. Observation of the Medication Aide (MA) on 04/06/21 at 8:13 am revealed: -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. Refer to interview on 04/06/21 at 8:18 am with the MA.	C 341	MA was retrained on how to compare the residents medications to the MAR's and to document immediately after the resident has taken their medication. This is to be done per resident.	4/20/21

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C 341	Continued From page 4 Refer to interview on 04/06/21 at 8:50 am with the Administrator. 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. 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. 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.	C 341	MA's is retrained to look at MAR and compare 3 x's before administering medication per resident and document immediately after administering per resident.	4/7/21 By administrator 4/20/21 By RN

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C 341	Continued From page 5 -She did not look at the MARs to compare the medications to the order. -At 8:37 am, the MA called Resident #3 over to the medication cart and handed her a medication cup with medications in it. -The MA administered Resident #3's medications but did not document medication administration on the MAR after the resident took the medication. -At 8:37 am, she documented the medications she had administered. Refer to interview on 04/06/21 at 8:18 am with the MA. Refer to interview on 04/06/21 at 8:50 am with the Administrator. Interview with the MA on 04/06/21 at 8:18 am revealed: -She did not document on the MAR after each resident because she was nervous. -She knew the resident's medications by color and each color coded medication blister pack was for specific medication administration times. -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. -She was trained to check the medications three times with the MAR before administering medication. -She was trained to document medication administration after each resident. Interview with the Administrator on 04/06/21 at 8:50 am revealed: -The MA had been properly trained and attended the medication aide training class.	C 341	MA has been retrained by RN on administering medication to one resident at a time and retrained to document as soon as administration of medication is given	4/20/21

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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	administrator talked with the MA and explained that being nervous is not an excuse to not do what you have been trained to do. Administrator will show MA the correct way to administer medication and document on the MAR. Administrator will monitor daily for the first week. then weekly to ensure that proper procedure is being done and will do this for thirty days and will continue to monitor once a month after. all hazadous chemicals and cleaning agents are stored in a locked cabinet away from medication cart and residents.	4/6/21 4/7/21 Beginning 4/7/21 Beginning 4/14/21
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	Continued From page 7 -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. Interview with the medication aide (MA) on 04/06/21 at 8:05 pm revealed: -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. Interview with the Administrator on 04/06/21 at 8:50 am revealed: -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	Administrator talked with the MA's about the importance of making sure the med cart stays locked. They where told to double check to make sure the cart is locked. Never assume that a resident will not bother the med cart or medications. Administrator put up signs on the board above the med cart and laminated labels near the lock and also on the drawer that the MAR book goes in as a reminder to lock the med cart.	4/6/21 4/6/21

Addendum via telephone conversation with Ms. Harrison

the medication cart will be monitored randomly by the MAs and by Administrator each time they go to the kitchen or commom area and the Administrator will check daily for a month and weekly ongoing.

5/7/21 Jo Scarlett, RN