STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL009025	A. BUILDING: _____ B. WING _____	R 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLADEN ASSISTED LIVING	714 BLADEN STREET BLADENBORO, NC 28320

(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 on 05/04/22 - 05/05/22.	{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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 2 residents (#5, #6) observed during the medication passes including errors with an eye medication for dry eyes (#5) and two topical creams for rashes (#6). The findings are: The medication error rate was 9% as evidenced by the observation of 3 errors out of 33 opportunities during the 8:30am medication pass on 05/04/22 and the 9:30am medication pass on 05/05/22. 1. Review of Resident #5's current FL-2 dated 10/20/21 revealed: -Diagnoses included dementia, severe mental retardation, Parkinson's disease, and diabetes. -The resident was intermittently disoriented and ambulatory.	{D 358}		

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{D 358}	Continued From page 1 Review of Resident #5's optometrist's order dated 02/08/22 revealed an order for artificial tears as needed twice daily to treat dry eye syndrome (used to lubricate dry eyes and help maintain moisture). Review of Resident #5's May 2022 electronic administration medication record (eMAR) revealed: -There was an entry for artificial tears solution 1.4% use as directed as needed into each eye twice daily wait 3 to 5 minutes between eye drops. -There was documentation artificial tears was administered at 8:30am on 05/04/22. -The dosage and reason for administration was not documented. Review of Resident #5's artificial tears administration label on 05/04/22 revealed there were instructions to use as directed as needed into each eye twice daily. Observation of the medication pass on 05/04/22 at 9:25am revealed: -The Special Care Coordinator/medication aide (SCC/MA) administered artificial tears 1 drop each into Resident #5's left and right eyes while the resident sat in a rocking chair located in her room. -The artificial tears ran from the bottom of Resident #5's right and left eyes down the resident's cheeks. Interview with the SCC/MA on 05/04/20 at 11:15am revealed: -The Resident Care Coordinator (RCC) or the SCC faxed physician orders to the pharmacy, pharmacy entered the orders, the RCC or the SCC compared the original orders to the orders	{D 358}		

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{D 358}	Continued From page 2	{D 358}		

entered by pharmacy to ensure the orders matched then accepted the orders so the orders would transfer to the eMAR.
-She read Resident #5's eMAR artificial tears administration instructions on 05/04/22 during the 8:30am medication pass as to administer twice daily as a scheduled administration.
-When administering medications, she compared the eMAR administration instructions to the medication's administration label instructions to ensure they both matched.
-She always administered artificial tears to Resident #5 as a scheduled medication during medication passes.

Interview with the RCC on 05/04/22 at 12:00pm revealed:
-She reviewed Resident #5's artificial tears order dated 02/08/22 and sent the order to pharmacy.
-She expected the MA to compare medication administration label instructions to the eMAR to ensure both matched when administering medications.

Interview with the Administrator on 05/04/22 at 12:15pm revealed he expected the MA to notify the RCC the artificial tears administration label needed clarification prior to administering because the dosage was not documented.

Interview with a pharmacy technician for the facility's contracted pharmacy on 05/05/22 at 12:11pm revealed:
-There was a current order for artificial tears 1.4% use as directed as needed each eye twice daily.
-On 03/28/22, artificial tears was sent to the facility.
-It was the responsibility of the facility to call Resident #5's ordering provider for clarification.

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{D 358}	Continued From page 3 Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. 2. Review of Resident #6's current FL-2 dated 02/01/22 revealed: -Diagnoses included autoimmune deficiency, diabetes, psoriasis, and schizophrenia. -The resident was intermittently disoriented and ambulatory. a. Review of Resident # 6's current FL-2 dated 02/01/22 revealed: -There was an order for Benadryl gel 2% apply to affected areas four times daily (an antihistamine used to treat itch and pain associated with minor skin irritations or rashes). -The location of administration was not documented Review of Resident #6's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Benadryl gel 2% apply to affected area four times daily. -The location of administration was not documented. -There was documentation Resident #6 refused the Benadryl gel at 9:30am on 05/05/22. Observation of the medicaiton pass on 05/05/22 at 8:35am revealed: -The MA asked Resident #6 if she wanted Benadryl cream. -Resident #6 told the MA she did not want Benadryl cream. -The MA did not attempt to administer Benadryl cream to Resident #6 without asking the resident. Observation of Resident #6 on 05/05/22 at	{D 358}		

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{D 358}	Continued From page 4 10:53am revealed there was a red, raised rash from the elbow to the hands and fingers on the right and left arms. Interview with Resident #6 on 05/05/22 at 10:48am revealed: -She had a rash on both forearms and hands. -Sometimes the rash itched. -The MA asked her if she wanted her creams during today's medication pass and she refused because the rash did not itch today. Interview with the MA on 05/05/22 at 8:50am revealed: -Resident #6 had a rash to both forearms at times. -She asked Resident #6 if she wanted the Benadryl cream and the resident refused during the 9:30am medication pass on 05/02/22. -She should have attempted to administer the medication to the resident without asking because it was a scheduled medication. -She knew where to administer the cream because Resident #6 had a rash to her arms. Interview with the Administrator on 05/05/22 at 1:53pm revealed he expected the MA to have attempted to administer the scheduled medication instead of asking because it was a scheduled medication. b. Review of Resident #6's dermatologist order dated 02/11/22 revealed: -There was an order for Triamcinolone cream 0.14% twice daily to rash (a glucocorticoid used to treat redness, itching, swelling, or other discomforts caused by skin conditions). -The location of the rash was not documented. Observation of the medication pass on 05/05/22	{D 358}		

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{D 358}	Continued From page 5 at 8:35am revealed the medication aide (MA) did not administer Triamcinolone cream to Resident #6. Review of Resident #6's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Triamcinolone cream 0.1% apply to rash twice daily. -The location of the rash was not documented. -There was documentation the resident refused Triamcinolone cream at 9:30am on 05/05/22. Observation of Resident #6 on 05/05/22 at 10:53am revealed a red, raised rash from the elbow to the hands and fingers on the right and left arms. Interview with Resident #6 on 05/05/22 at 10:48am revealed: -She had a rash on both forearms and hands. -Sometimes the rash itched. -The MA asked her if she wanted her creams during today's medication pass and she refused because the rash did not itch today. Interview with the MA on 05/05/22 at 8:50am revealed: -She did not attempt to administer Triamcinolone cream to Resident #6 because the resident refused the Triamcinolone cream when she asked the resident if she wanted another medication cream during the 9:30am medication pass on 05/05/22. -She should have attempted to administer the medication without asking because it was a scheduled medication. -She knew where to administer the cream because Resident #6 had a rash to her arms.	{D 358}		

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{D 358}	Continued From page 6 Interview with the Administrator on 05/05/22 at 1:53pm revealed he expected the MA to have attempted to administer the scheduled medications instead of asking.	{D 358}		