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	HAL092143	A. BUILDING: _____ B. WING _____	R 12/09/2021

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(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 and Wake County Department of Social Services conducted an annual, follow up and complaint investigation survey on December 7 - 9, 2021. The complaint investigation was initiated by the Wake County Department of Social Services on November 19, 2021.	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 5 residents (#6, #7) observed during the medication passes evidenced by errors which included a medication to treat a breathing condition (#6) and a supplement used to treat a low potassium level (#7); and for 2 of 5 residents sampled (#1, #4) which included a medication to treat a low thyroid hormone level (#4) and a medication to treat dementia (#1). The findings are: 1. The medication error rate was 6% as evidenced by the observation of 2 errors out of 30	D 358		

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D 358	Continued From page 1 opportunities during the 8:00am medication pass on 12/08/21. a. Review of Resident #7's signed FL-2 dated 11/16/21 revealed diagnoses included hypertension, end stage renal failure, and anemia. Review of Resident #7's signed physician order report dated 11/16/21 revealed there was an order for Breo Ellipta 100-25mcg inhale 1 puff by mouth every day at 8:00am. (Breo Ellipta is a medication used to treat chronic obstructive pulmonary disease and asthma in adults). Observation of Resident #7's 8:00am medication pass on 12/08/21 revealed: -The medication aide (MA) prepared and administered medications to Resident #7 at 7:40am. -Breo Ellipta was not administered or offered to Resident #7 when he received his other medications. -The Breo Ellipta cartridge counter was on 0 which indicated no more puffs were left. -The MA stopped the medication pass and went to the overstock medication room to see if the medication was available. -The medication was not available in the overstock medication room. -The MA notified the Resident Care Director (RCD) after the morning medication pass that the medication needed to be refilled by the pharmacy. Review of Resident #7's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Breo Ellipta 100-25mcg inhale 1 puff by mouth every day at 8:00am on 12/08/21.	D 358		

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-The Breo Elipta was documented as administered on 12/08/21 at the 8:00am medication pass.

Interview with Resident #7 revealed on 12/10/21 at 9:30am revealed:
-He did not know the names of the medications he received.
-He used an inhaler every day.
-He was not experiencing any shortness of breath.

Interview with the MA on 12/08/21 at 11:32am revealed:
-Resident #7's Breo Ellipta was entered on the current December 2021 eMAR 100-25mcg inhale 1 puff by mouth every day at 8:00am.
- She did not administer the Breo Ellipta to Resident #7 because the medication cartridge did not contain any more puffs to be administered.
-She thought she had documented that the medication was unavailable on the eMAR.
-She notified the RCC after the morning medication pass that the medication needed to be refilled.
-The RCC sent a refill request to the pharmacy on 12/08/21 around 11:30am.
-MAs were responsible for placing medication refill requests with the pharmacy.
-She thought that medication cart audits were done every other night by the MAs on the evening shift.
-She did not know why no one noticed that the Breo Ellipta counter was on zero.

Interview with the RCD on 12/08/21 at 11:38 revealed:
-The MAs were responsible for sending medication refill requests to the pharmacy.
-She expected medication refill requests to be

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sent to the pharmacy when there was less than a 7-day supply in the medication cart.
-Medication cart audits were done weekly.
-The medication refill request was submitted to the pharmacy today around 8:30am.

Interview with the Administrator on 12/10/21 at 8:22am revealed:
-She expected the MAs to look in the overstock medication room if the medication was not available on the cart.
-If the medication was not in the facility, she expected the MA to finish the medication pass and notify the RCC who would submit the refill request to the pharmacy.
-It was the responsibility of MAs to ensure medications were available on the cart.
-Medication cart audits were done weekly.
-The MAs were responsible for ensuring at least a 7-day supply of medication was in the cart.
-Resident #7's Breo Ellipta was important for better breathing.

Attempted telephone interview with the primary care provider (PCP) on 12/09/21 at 11:42am was unsuccessful.

b. Review of Resident #6's signed FL-2 dated 08/31/21 revealed diagnoses included Alzheimer's disease, coronary artery disease, hyperlipidemia, and hypertension.

Review of Resident #6's signed physician order dated 08/31/21 revealed:
-There was an order for Potassium Chloride ER 10 mEq 1 tablet by mouth every day at 8:00am. (Potassium Chloride was used to treat a low potassium level).
-There was an order that all medications may be given by mouth and/or crushed (check do not

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D 358	Continued From page 4 crush list) and placed in applesauce or pudding. Observation of Resident #6's 8:00am medication pass revealed: -The medication aide (MA) prepared and administered Resident #6's medications at 8:15am. -The Potassium Chloride ER was crushed with the other medications and placed in applesauce and administered to the resident. Observation of the medication cart on 12/10/21 at 10:00am revealed there was no do not crush list on the medication cart where Resident #6's medications were stored. Observation of Resident #6's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Potassium Chloride ER 1 tablet by mouth every day at 8:00am. -There was a separate entry that all medications can be given my mouth and/or crushed (check do no crush list) and placed in applesauce or pudding. -There was documentation the Potassium Chloride ER was administered at the 8:00am medication pass. Interview with the MA on 12/08/21 at 11:29am revealed: -She was aware that the Potassium Chloride ER should not be crushed. -She crushed the medication because Resident #6 could not swallow pills whole and it was the only way she could get the resident to take the medication. -She had not contacted the primary care provider (PCP) regarding an alternative form of the medication.	D 358		

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D 358	Continued From page 5 -She had not notified the Resident Care Director (RCD) or the Administrator regarding an alternative form of the medication. -She did not know why the Potassium Chloride ER should not be crushed. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/08/21 at 3:11pm revealed: -It was the responsibility of the facility and the prescriber to include do no crush instructions on the medication order. -It was best practice to not crush Potassium Chloride ER because it is an extended release medication which means the medication is released slowly in the body over time. Interview with the RCD on 12/10/21 at 11:50am revealed: -She was aware that Potassium Chloride ER should not be crushed. -The medications should have been dissolved and placed in some applesauce or pudding before administering to Resident #6. -She was aware the Potassium Chloride was on the do not crush list. -She was not sure of the potential impact on Resident #6 when the Potassium Chloride ER was crushed. Interview with the Administrator on 12/10/21 at 8:22am revealed: -There were do not crush lists on all medication carts. -The MAs have been trained on the medications that were not supposed to be crushed. -She expected MAs to administer medication according to the do not crush list. -It was important to follow the no crush list for medications for the safety of the residents.	D 358		

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D 358	Continued From page 6 Attempted telephone interview with the primary care provider (PCP) on 12/10/21 at 11:00am was unsuccessful. Based on observation, interviews, and record reviews it was determined that Resident #6 was not interviewable. 2. Review of Resident #4's FL-2 dated 02/15/21 revealed a diagnosis included hypothyroidism. Review of a physician's order dated 10/27/21 revealed: -Discontinue Levothyroxine 100 mcg. -Start Levothyroxine 112 mcg. Review of Resident #4's November 2021 electronic medication administration record (eMAR) revealed there was documentation Levothyroxine was administered at 6:15am from 11/01/21- 11/30/21. Review of Resident #4's December 2021 eMAR revealed: -There was documentation Levothyroxine 112 mcg was administered at 6:15am from 12/01/21-12/05/21 and 12/07/21. -There was documentation Levothyroxine 112 mcg was unavailable on 12/06/21 and 12/08/21. Observation of Resident #4's medications on hand on 12/08/21 at 3:00pm revealed there was no Levothyroxine 112 mcg in the medication cart. Interview with a medication aide (MA) on 12/08/21 at 3:18pm revealed: -He was not aware Resident #4's Levothyroxine 112 mcg was not in the medication cart. -The MAs were responsible for reordering	D 358		

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medications for the residents in the facility a week before the medications were out.
-The MAs were to inform the Resident Care Director (RCD) or the Memory Care Director (MCD) when a resident's medication was reordered and almost out.
-The RCD and the MCD were responsible for completing weekly medication cart audits.

Interview with a second MA on 12/09/21 at 11:30am revealed:
-She was aware Resident #4's Levothyroxine 112 mcg was not available.
-She was not certain if she sent a refill order to the pharmacy.
-The MAs were responsible for conducting a medication cart audit on every shift.
-The medication cart audit was to determine if residents had all their medications in the cart.
-The MAs were responsible for reordering the residents' medication.
-She could not remember when she last completed a medication cart audit.

Interview with the Administrator on 12/08/21 at 3:35pm revealed:
-The MAs were responsible for reordering medications for the residents in the facility.
-She expected the MAs to reorder medications immediately before the residents' medication was out.
-The RCD and MCD were responsible for ensuring the medication orders were placed.

Telephone interview with a pharmacy technician on 12/09/21 at 9:40am revealed:
-A 30-day supply of Levothyroxine 112 mcg was dispensed for Resident #4 on 10/27/21.
-The 30-day supply of Levothyroxine 112 mcg that was dispensed on 10/27/21 should have

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been completed by 11/27/21.

Attempted telephone interview to the Primary Care Provider (PCP) on 12/08/21 at 9:48am and 12/09/21 at 8:26am was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.

3. Review of Resident #1's current FL-2 dated 06/29/21 revealed:
-Diagnosis included Alzheimer's dementia.
-There was an order for donepezil 10mg daily. (Donepezil is used to treat symptoms of dementia.)

Review of a medication pharmacy review for Resident #1 dated 07/09/21 revealed:
-A recommendation to change donepezil to 10mg daily at bedtime.
-The primary care provider (PCP) signed the order and dated it 07/13/21.

Observation of medications on hand for Resident #1 on 12/09/21 at 9:45am revealed donepezil 10mg was packaged in a seven-day multidose pack (MDP) with morning medications for each day.

Review of August, September, October, November and December 2021 electronic medication administration records (eMARs) revealed:
-An entry for donepezil 10mg daily at bedtime scheduled for 8:00pm.
-Documentation doses were administered 08/01/21 through 12/06/21 at 8:00pm.

Telephone interview with a pharmacy technician

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from the facility's contracted pharmacy on 12/09/21 at 11:10am revealed:
-The current order for donepezil for Resident #1 was 10mg daily at bedtime from a physician's orders form dated 08/13/21.
-The pharmacy included donepezil in the morning MDP for Resident #1 because the order was for once daily.
-The pharmacy must have missed the bedtime directive since the donepezil continued to be dispensed in the morning MDP.
-The pharmacy did not change the donepezil to the bedtime MDP when the order was changed on 08/13/21.

Interview with a medication aide (MA) on 12/09/21 at 10:51am revealed:
-She was trained to scan the MDP and the computer system logged each medication in the MDP that was administered.
-She was also trained to review the list of medications on the MDP and compare to the eMAR.
-She had never noticed the smaller print "at bedtime" on the computer screen for the donepezil.
-She saw that it read donepezil 10mg daily and administered the donepezil with morning medications.

Interview with the Resident Care Director (RCD) on 12/09/21 at 10:58am revealed:
-She was responsible for ensuring follow up on pharmacy review recommendations.
-For the recommendation for Resident #1 signed by the PCP on 07/13/21, she changed the scheduled time to 8:00pm and faxed the signed order to the pharmacy.
-The pharmacy would have changed the MDP to include the donepezil in the 8:00pm pack and

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remove it from the 8:00am pack.
-MAs were responsible for scanning MDP prior to administration.
-Medications that were not supposed to be in the pack would cause a notification box to pop up on the eMAR.
-The notification box would not let the MA go any further until they clicked on the notification which would prompt removal of any medications that were not supposed to be in there.
-No one had reported any concerns related to Resident #1's MDPs and the administration time of donepezil.

Interview with the Administrator on 12/09/21 at 11:05am revealed:
-The RCD was responsible for follow up on pharmacy review recommendations and then checking eMARs to ensure orders were updated.
-MAs should have notified the RCD and/or the pharmacy that the donepezil was still in the morning MDP.
-The MA should have also placed a sticker on the morning MDP pack alerting other MAs about the donepezil.

Attempted telephone interview with a second shift medication aide (MA) on 12/09/21 at 11:25am was unsuccessful.