DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-068-025**	MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	DATE SURVEY COMPLETED: 10/12/2022

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Stratford	**405 Smith Level Road, Chapel Hill, NC 27516**

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)	COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 10/11/22 to 10/12/22.	{D 000}		
(D358)	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. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 4 residents (#6) observed during the medication pass including errors with crushing medications that should not be crushed. The findings are: 1. The medication error rate was 5% as evidenced by the observation of 2 errors out of 36 opportunities during the 8:00am medication pass on 09/15/22. a. Review of Resident #6's current FL2 dated 06/29/22 revealed: -Diagnoses included vascular dementia, depression, and history of stroke. -There was an order for aspirin delayed release (EC) 81mg take one tablet daily (used to thin the blood). Observation of the medication pass on 10/12/22 at 8:05am revealed:	(D358)		

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(D358)	Continued From page 1 -The medication aide (MA) prepared 8 tablets to administer to Resident #6 including aspirin EC 81 mg. -The MA crushed Resident #6's medications including aspirin EC 81mg. -The MA administered the crushed aspirin EC 81mg tablet to Resident #6. Observation of Resident #6's medications on hand on 10/12/22 at 8:01am revealed: -There were 4 of 7 aspirin EC 81 mg tablets available for administration in a weekly bubble pack that were dispensed on 10/05/22 for the week of 10/11/22 to 10/17/22. -The pharmacy label did not indicate aspirin was to be crushed. Based on observations, record reviews, and interviews, it was determined Resident #6 was not interviewable. Refer to the interview with the medication aide (MA) observed during the medication pass on 10/12/22 at 12:08pm. Refer to the telephone interview with a pharmacist at the facility's contracted pharmacy on 10/12/22 at 11:44am. Refer to the interview with Resident #6's primary care provider (PCP) on 10/12/22 at 12:45pm. Refer to the interview with the Special Care Unit Coordinator (SCUC) on 10/12/22 at 2:20pm.	(D358)		

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(D358)	Continued From page 2 Refer to the interview with the Resident Care Coordinator (RCC) on 10/12/22 at 2:30pm. Refer to the interview with the Executive Director (ED) on 10/12/22 at 2:45pm. b. Review of Resident #6's current FL2 dated 06/29/22 revealed that there was an order for darolutamide 300mg take 2 tablets (600mg) twice daily with food and swallow tablets whole. Observation of the medication pass on 10/12/22 at 8:05am revealed: -The medication aide (MA) prepared 8 tablets to administer to Resident #6 including two tablets of Darolutamide 300mg. -The MA crushed Resident #6's medications including the two Darolutamide 300mg tablets. -The MA administered the two crushed Darolutamide 300mg tablets to Resident #6. Observation of Resident #6's medications on hand on 10/12/22 at 8:01am revealed: -There were 28 of 120 darolutamide 300mg tablets available for administration that were dispensed on 09/16/22. -The darolutamide label on the prescription bottle indicated that darolutamide tablets should be swallowed whole. Based on observations, record reviews, and interviews, it was determined Resident #6 was not interviewable.	(D358)		

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(D358)	Continued From page 3 Refer to the interview with the medication aide (MA) observed during the medication pass on 10/12/22 at 12:08pm. Refer to the telephone interview with a pharmacist at the facility's contracted pharmacy on 10/12/22 at 11:44am. Refer to the interview with Resident #6's primary care provider (PCP) on 10/12/22 at 12:45pm. Refer to the interview with the Special Care Unit Coordinator (SCUC) on 10/12/22 at 2:20pm. Refer to the interview with the Resident Care Coordinator (RCC) on 10/12/22 at 2:30pm. Refer to the interview with the Executive Director (ED) on 10/12/22 at 2:45pm. ______________________________ Interview with the MA observed during the medication pass on 10/12/22 at 12:08pm revealed: -She was not aware that aspirin 81mg EC and darolutamide 300mg could not be crushed. -She always crushed aspirin 81mg EC and darolutamide 300mg when she administered medications to Resident #6. -She thought that Resident #6's medications were able to be crushed prior to administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/12/22 at 11:44am revealed:	(D358)		

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(D358)	Continued From page 4 -Aspirin EC 81mg was dispensed on a weekly cycle fill. -If aspirin EC 81mg was crushed and administered, it would decrease the effectiveness of the medication. -She would not expect any side effects if aspirin EC 81mg was crushed and administered. -Darolutamide 300mg was not dispensed from the pharmacy but was dispensed to the facility from a different pharmacy. -If darolutamide 300mg was crushed and administered, it would decrease the effectiveness of the medication. -She would not expect any side effects if darolutamide 300mg was crushed and administered. Interview with Resident #6's primary care provider (PCP) on 10/12/22 at 12:45pm revealed: -He was not aware Resident #6's aspirin EC and darolutamide were crushed and administered during the medication pass on 10/12/22. -He would not expect any side effects to occur if aspirin EC 81mg and darolutamide 300mg were crushed and administered, but the effectiveness of the medications would be decreased. -He expected the facility to administer medications as ordered. Interview with the Special Care Unit Coordinator (SCUC) on 10/12/22 at 2:20pm revealed: -She was not aware aspirin EC and darolutamide were crushed and administered to Resident #6 by the MA during the medication pass on 10/12/22. -She expected MAs to administer medications as ordered.	(D358)		

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(D358)	Continued From page 5 -MAs were responsible to administer medications as ordered. -She audited the medication carts monthly. Interview with the Resident Care Coordinator (RCC) on 10/12/22 at 2:30pm revealed: -She was not aware aspirin EC and darolutamide were crushed and administered to Resident #6 by the MA during the medication pass on 10/12/22. -Resident #6 was able to swallow medications whole. -She had never crushed Resident #6's medications while she was on the medication cart. -MAs were responsible to administer medications as ordered. -The MAs, the Supervisors, the SCUC and herself all performed medication cart audits and they were supposed to be done weekly. -Two random resident records were audited weekly. Interview with the Executive Director (ED) on 10/12/22 at 2:45pm revealed: -She was not aware aspirin EC and darolutamide were crushed and administered to Resident #6 by the MA during the medication pass on 10/12/22. -She expected MAs to administer medications as ordered. -The MAs, the SCUC, the RCC, and herself were all responsible to ensure that medications were administered as ordered. -The RCC and the SCUC audited medication carts weekly and audited 2 resident records per week per manager on a rotational basis.	(D358)		

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