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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	HWY 301 NORTH DUNN, NC 28335

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on February 8, 2023 through February 10, 2023.	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 ensure medications were administered as ordered for 1 of 4 residents (#6) observed during the medication pass including errors with a medication used to treat underactive thyroid disease and a mild pain reliever. The findings are: The medication error rate was 5% as evidenced by 2 errors out of 34 opportunities during the 7:00am medication pass on 02/09/23. Review of Resident #6's current FL-2 dated 09/19/22 revealed diagnoses included hemiplegia, essential hypertension, mixed hyperlipidemia, and cerebrovascular disease. a. Review of Resident #6's physician's order dated 11/10/22 revealed an order for	D 358		

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Levothyroxine 25mcg 1 tablet daily on an empty stomach. (Levothyroxine is used to treat underactive thyroid disease.)

Observation of the 7:00am medication pass on 02/09/23 revealed:
-The medication aide (MA) prepared and administered one Levothyroxine 25mcg tablet with the resident's other morning medications at 7:17am.
-The resident was in his room eating breakfast and had eaten approximately half of the food on his plate when his medication was administered to him.
-Levothyroxine was not administered on an empty stomach as ordered.

Review of Resident #6's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Levothyroxine 25mcg take 1 tablet daily on an empty stomach scheduled for 6:00am.
-Levothyroxine was documented as administered daily at 6:00am from 02/01/23 - 02/09/23.

Observation of Resident #6's medications on hand on 02/09/23 at 10:19am revealed:
-There was a supply of Levothyroxine 25mcg tablets dispensed on 01/01/23.
-Instructions on the Levothyroxine medication label was to take 1 tablet daily on an empty stomach.

Interview with the MA on 02/09/23 at 10:20am revealed:
-She usually administered Resident #6's Levothyroxine earlier than his other scheduled morning medications.
-She sometimes administered the Levothyroxine

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with Resident #6's other morning medications but the resident had not usually eaten breakfast yet.

Interview with Resident #6 on 02/09/23 at 10:52am revealed:
-He was not sure if he received medication for his thyroid.
-He did not think he needed medication for his thyroid.

Interview with the Resident Care Coordinator/Business Office Manager (RCC/BOM) on 02/09/23 at 11:50am revealed:
-Resident #6's Levothyroxine should be administered on an empty stomach as ordered.
-Levothyroxine was scheduled to be administered at 6:00am to ensure it was administered on an empty stomach.
-The third shift MA needed to administer the Levothyroxine at 6:00am instead of the first shift MA to make sure it was administered before breakfast.

Interview with the Administrator on 02/09/23 at 11:54am revealed the third shift MA should administer Levothyroxine since it was scheduled at 6:00am to make sure it was administered on an empty stomach.

Interview with Resident #6's primary care provider (PCP) on 02/09/23 at 11:13am revealed:
-Resident #6's Levothyroxine should be administered on an empty stomach to make sure there was proper absorption of the medication.
-Not administering Levothyroxine on an empty stomach could affect the potency of the medication.
-The resident's last thyroid levels on 11/17/22 were within normal limits.
-Resident #6 should be monitored for tremors

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and muscle weakness and be continued on the same schedule for Levothyroxine on an empty stomach.

b. Review of Resident #6's physician's order dated 01/12/23 revealed an order for Tylenol ES 500mg take 1 tablet twice a day. (Tylenol is a mild pain reliever.)

Review of Resident #6's physician's order dated 02/02/23 revealed an order to change Tylenol ES 500mg to 2 tablets twice a day.

Observation of the 7:00am medication pass on 02/09/23 revealed:
-The medication aide (MA) prepared Resident #6's morning medications for administration.
-The MA put one Tylenol ES 500mg tablet from one medication container labeled by the pharmacy with Resident #6's name into a paper medication cup.
-The MA put two Tylenol ES 500mg tablets from a second medication container labeled by the pharmacy Resident #6's name into the paper medication cup.
-The MA administered 3 Tylenol ES 500mg tablets to Resident #6 at 7:17am instead of 2 tablets as ordered.

Review of Resident #6's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Tylenol ES 500mg take 1 tablet twice a day scheduled for 7:00am and 8:00pm.
-Tylenol ES 500mg 1 tablet was documented as administered from 02/01/23 - 02/03/23 at 7:00am.
-The stop date for Tylenol ES 500mg 1 tablet twice a day was documented as 02/03/23 at 4:00pm.

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-There was a second entry for Tylenol ES 500mg take 2 tablets twice a day scheduled for 7:00am and 8:00pm.
-Tylenol ES 500mg 2 tablets was documented as administered from 8:00pm on 02/03/23 through 7:00am on 02/09/23.

Observation of Resident #6's medications on hand on 02/09/23 at 10:19am revealed:
-There was a supply of Tylenol ES 500mg tablets dispensed on 01/12/23 with instructions to take 1 tablet twice a day.
-There was a second supply of Tylenol ES 500mg tablets dispensed on 02/03/23 with instructions to take 2 tablets twice a day.

Interview with the MA on 02/09/23 at 10:20am revealed:
-She was not paying attention when she administered Tylenol from both supplies for Resident #6 that morning on 02/09/23.
-The supply of Tylenol that had been discontinued should have been removed from the medication cart when it was discontinued.
-Resident #6 should have received 2 Tylenol ES 500mg tablets instead of 3 tablets.

Interview with Resident #6 on 02/09/23 at 10:52am revealed:
-He thought he usually received 2 Tylenol tablets every day to help with foot pain.
-The Tylenol usually helped with his pain.

Interview with the Resident Care Coordinator/Business Office Manager (RCC/BOM) on 02/09/23 at 11:50am revealed:
-The MAs were supposed to read the eMARs and match it with the medication label.
-The MA on duty was responsible for removing any discontinued medication from the medication

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D 358	Continued From page 5 cart and sending it back to the pharmacy. -The medication container with the Tylenol dosage that had been discontinued should not have been available in the medication cart. -Resident #6 should have received 2 Tylenol ES 500mg tablets instead of 3 tablets. Interview with the Administrator on 02/09/23 at 11:54am revealed: -The MAs were responsible for removing any discontinued medications from the medication cart. -Resident #6 should have received 2 Tylenol ES 500mg tablets instead of 3 tablets. Interview with Resident #6's primary care provider (PCP) on 02/09/23 at 11:13am revealed: -If too much Tylenol was administered at one time, it could cause an overdose or it could cause liver issues. -Since Resident #6 received 3 Tylenol ES 500mg tablets that morning on 02/09/23, she instructed the facility staff to only administer 1 Tylenol ES 500mg tablet for the 8:00pm dose.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of	D 367		

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medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were accurate for 2 of 5 residents sampled (#4, #5) including inaccurate documentation of a muscle relaxer (#4) and a controlled substance used to treat moderate to severe pain (#5).

The findings are:

1. Review of Resident #4's current FL-2 dated 07/19/22 revealed:
-Diagnoses included lumbago with sciatica and chronic back pain.
-There was an order for Cyclobenzaprine 10mg 1 tablet by mouth every 12 hours as needed for pain and muscle spasms. (Cyclobenzaprine is a muscle relaxant used to treat muscle spasms).

Review of Resident #4's physician's orders dated 12/22/22 revealed there was an order for Cyclobenzaprine 10mg 1 tablet by mouth every 8 hours as needed for pain and muscle spasms.

Review of Resident #4's pharmacy delivery sheets dated 01/19/23 and 02/03/23 revealed:
-There were 30 Cyclobenzaprine 10mg tablets for

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Resident #4 delivered on 01/19/23.
-There were 60 Cyclobenzaprine 10 tablets for Resident #4 delivered on 02/03/23.

Observation of Resident#4's medications on hand on 02/10/23 at 12:22pm revealed:
-There was a supply of Cyclobenzaprine 10mg tablets dispensed on 02/03/23.
-There were 43 of 60 tablets remaining.

Review of Resident #4's January 2023 and February 2023 electronic medication administration records (eMARs) from 01/19/23 to 02/10/23 revealed:
-There was an entry for Cyclobenzaprine 10mg 1 tablet by mouth every 8 hours as needed for pain and muscle spasms on each of the eMARs.
-Cyclobenzaprine was documented as administered on 21 occasions from 01/19/23 to 02/10/23.

Review of Resident #4's medications on hand, pharmacy delivery sheets, and January 2023 and February 2023 eMARs revealed:
-There were 90 Cyclobenzaprine 10mg tablets dispensed from 01/19/23 to 02/10/23.
-There were 43 tablets of 90 Cyclobenzaprine 10mg tablets remaining on hand on 02/10/23 with a total of 47 being used from the supply.
-There were only 21 of 47 tablets used from supply documented as administered from 01/19/23 to 02/10/23 on the eMARs.
- The other 26 doses administered from the supply were not documented as administered on the eMARs from 01/19/23 to 02/10/23.
-The documentation on the eMARs did not accurately reflect the administration of Cyclobenzaprine to Resident #4.

Interviews with Resident #4 on 02/09/23 at

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D 367	Continued From page 8 2:40pm and 3:53pm revealed: -She went to a pain clinic for her back and leg pain. -She took 3 medications for her back and leg pain. -She took Cyclobenzaprine up to 3 times per day to control her pain. -She had to ask for the Cyclobenzaprine because it was not a scheduled medication. -She needed Cyclobenzaprine usually three times daily. -There were some days she only took it once or twice. -There was never a day that she could go without it. -She got Cyclobenzaprine when she asked for it. Interview with a medication aide (MA) on 02/09/23 at 3:05pm revealed: -Medications ordered to be administered as needed (prn) were to be returned to the pharmacy if not used. -Resident #4 never had returned or left over Cyclobenzaprine. -Resident #4 usually asked for and received Cyclobenzaprine three times every day. -Resident #4 sometimes requested Cyclobenzaprine before it was due. Interview with the Resident Care Coordinator /Business Office Manager (RCC/BOM) on 02/09/23 at 3:43pm revealed: -Resident #4 requested Cyclobenzaprine daily, usually three times per day. - The MAs must have documented administration of medication only once every 24 hours on the eMAR and did not document each dose administered on the eMAR. A second interview with the RCC/BOM on	D 367		

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02/09/23 at 4:05pm revealed:
-The eMARs were checked weekly by her or a MA.
-They did not usually count the number of prn medications on hand or compare the medication to the eMAR documentation.
-The MAs were not documenting each dose of the prn Cyclobenzaprine administered to Resident #4.
-The MAs were supposed to document each prn dose administered to the resident.

Interview with a second MA on 02/10/23 at 9:28am revealed:
-Each time a prn medication was administered, it should be "clicked off" on the eMAR.
-The MAs got busy sometimes and prn medications may not be "clicked off" on the eMARs as administered.

A third interview with the RCC/BOM on 02/10/23 at 9:43am revealed:
-Every time a prn medication was administered, it should be "clicked off" on the eMAR system.
-All prn medications should be documented on the eMAR so the next shift would know what time the medication was last administered to avoid overdosing or administering too soon.

2. Review of Resident #5's current FL-2 dated 09/08/22 revealed:
-Diagnoses included chronic pain syndrome, rheumatoid arthritis, and muscle spasms.
-There was an order for Oxycodone 10mg 1 tablet at 6:00am, 10:00am, 2:00pm, 6:00pm, and 10:00pm. (Oxycodone is a controlled substance used to treat moderate to severe pain.)

Review of Resident #5's December 2022 electronic medication administration record

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(eMAR) revealed:
-There was an entry for Oxycodone 10mg take 1 tablet at 6:00am, 10:00am, 2:00pm, 6:00pm, and 10:00pm.
-Documentation for Oxycodone was blank with no reason for the omissions on 7 occasions: at 6:00pm on 12/11/22, 12/13/22, 12/14/22, and 12/20/22; and at 10:00pm on 12/05/22, 12/13/22, and 12/26/22.

Review of Resident #5's December 2022 controlled substance (CS) records for Oxycodone revealed:
-Seven of the 7 doses of Oxycodone that were blank on the eMAR were documented as administered on the CS record including: at 6:00pm on 12/11/22, 12/13/22, 12/14/22, and 12/20/22; and at 10:00pm on 12/05/22, 12/13/22, and 12/26/22.
-The eMARs did not match the documentation on the CS records.

Review of Resident #5's February 2023 eMAR revealed:
-There was an entry for Oxycodone 10mg take 1 tablet at 6:00am, 10:00am, 2:00pm, 6:00pm, and 10:00pm.
-Documentation for Oxycodone was blank with no reason for the omissions on 3 occasions from 02/01/23 - 02/08/23: at 6:00pm on 02/06/23; and at 10:00pm on 02/01/23 and 02/06/23.

Review of Resident #5's February 2023 CS records for Oxycodone revealed:
-Three of the 3 doses of Oxycodone that were blank on the eMAR were documented as administered on the CS record including: at 6:00pm on 02/06/23; and at 10:00pm on 02/01/23 and 02/06/23.
-The eMARs did not match the documentation on

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D 367	Continued From page 11 the CS records. Interview with Resident #5 on 02/10/23 at 9:32am revealed: -She usually received Oxycodone for chronic pain at 6:00am, 10:00am, 2:00pm, 6:00pm, and 10:00pm each day. -She had not missed any doses of Oxycodone. Interview with a medication aide (MA) on 02/10/23 at 1:07pm revealed: -Resident #5 usually took the Oxycodone each time it was scheduled to be administered. -She was not sure why there were blanks/omissions on the eMARs for Resident #5's Oxycodone. -The MAs may have forgotten to "click" on the computer for the eMARs when they administered the Oxycodone. -It could also be related to problems with the internet causing documentation on the eMARs to be blank at times. Interview with the Resident Care Coordinator/Business Office Manager (RCC/BOM) on 02/10/23 at 1:09pm revealed: -The MAs were responsible for documenting medications as administered on the eMAR system when the medications were administered and taken by the resident. -She was not aware of the omissions on the eMARs for Resident #5's Oxycodone. -She was responsible for checking the eMARs for accuracy but she had not had time to check them. -There should not be any omissions on the eMARs and if a medication was not administered, there should be a reason documented on the eMARs.	D 367		