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CARDINAL CARE OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and a complaint investigation survey from March 14 - 15, 2023. The complaint investigation was initiated by the Harnett County Department of Social Services on March 2, 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 2 of 4 residents (#1, #9) observed during the medication pass including errors with a medication used to treat underactive thyroid disease (#9) and vitamin supplements (#1); and for 1 of 5 residents (#2) sampled for record review for a medication for anxiety and agitation (#2). The findings are: 1. The medication error rate was 8% as evidenced by 3 errors out of 35 opportunities during the 7:00am/8:00am medication pass on 03/15/23. a. Review of Resident #9's current FL-2 dated 01/17/23 revealed diagnoses included dementia,	D 358		

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type 2 diabetes mellitus, hypertension, and chronic kidney disease - stage 3.

Review of Resident #9's hospital discharge summary dated 03/10/23 revealed an order for Levothyroxine 25mcg 1 tablet every morning before breakfast, give at 7:30am or at least 30 minutes before breakfast. (Levothyroxine is used to treat underactive thyroid disease.)

Observation of the 7:00am/8:00am medication pass on 03/15/23 revealed:
-Resident #9 was in the dining room and had eaten approximately 25% of her breakfast meal.
-The medication aide (MA) had the resident come out of the dining room and go to the medication cart at 7:55am.
-The MA prepared and administered one Levothyroxine 25mcg tablet with the resident's other morning medications at 8:05am.
-Levothyroxine was not administered before breakfast or at least 30 minutes before breakfast as ordered.

Review of Resident #9's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Levothyroxine 25mcg take 1 tablet every day scheduled for 7:30am.
-Levothyroxine was not documented as administered from 03/01/23 - 03/10/23 due to the resident being in the hospital.
-Levothyroxine was documented as administered daily from 03/11/23 - 03/15/23.

Observation of Resident #9's medications on hand on 03/15/23 at 12:53pm revealed:
-There was a supply of Levothyroxine 25mcg tablets dispensed on 02/17/23.
-Instructions on the Levothyroxine medication

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label was to take 1 tablet every day.

Interview with the MA on 03/15/23 at 12:41pm revealed:
-If a medication was ordered to be administered before breakfast, she usually tried to administer it around 7:30am because the residents ate breakfast around 8:00am.
-She offered no explanation for administering Resident #9's Levothyroxine after the resident had started eating breakfast on 03/15/23.

Based on observations, interviews, and record reviews, it was determined that Resident #9 was not interviewable.

Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 1:28pm revealed:
-Resident #9's Levothyroxine should be administered on an empty stomach as ordered.
-Levothyroxine should be administered before the resident ate breakfast

Telephone interview with Resident #1's primary care provider (PCP) on 03/15/23 at 4:53pm revealed:
-Resident #1's Levothyroxine should be administered on an empty stomach to make sure there was proper absorption of the medication.
-She had no concerns about the resident's current thyroid levels.

b. Review of Resident #1's current FL-2 dated 01/27/23 revealed:
-Diagnoses included vascular dementia, hyperlipidemia, chronic obstructive pulmonary disease, and gout.
-There was an order for Preservision AREDS Formula take 1 capsule twice a day.
(Preservision AREDS Formula is a vitamin and

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mineral supplement for eye health. AREDS Formula contains beta-carotene but AREDS 2 Formula contains lutein and zeaxanthin instead of beta-carotene. AREDS and AREDS 2 are not the same product.)

Observation of the 7:00am/8:00am medication pass on 03/15/23 revealed:
-The medication aide (MA) prepared Resident #1's morning medications for administration, including one Preservision AREDS 2 tablet and administered it to the resident at 7:36am.
-The resident was administered one Preservision AREDS 2 tablet instead of Preservision AREDS as ordered.

Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Preservision AREDS 1 tablet twice a day scheduled for 7:00am and 7:00pm.
-Preservision AREDS was documented as administered from 03/01/23 - 03/15/23 at 7:00am.

Observation of Resident #1's medications on hand on 03/15/23 at 12:41pm revealed:
-There was no supply of Preservision AREDS Formula on hand for the resident.
-There was a supply of Preservision AREDS 2 Formula in the original manufacturer container.
-The resident's first and last names were written on the bottle with a black marker.
-There was no pharmacy label on the AREDS 2 bottle.

Interview with the MA on 03/15/23 at 12:41pm revealed:
-Resident #1's family member usually brought the resident's medication to the facility.

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D 358	Continued From page 4 -She had seen AREDS 2 on the Preservision label but she did not realize AREDS 2 was different than AREDS. Interview with Resident #1 on 03/15/23 at 1:11pm revealed: -Her family member picked up her medications at a local pharmacy and brought the medications to the facility. -She took vitamins but she was not sure how many or which vitamins she usually received. Attempted telephone interview with Resident #1's family member on 03/15/23 at 4:51pm was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 1:28pm revealed: -The MAs were supposed to read the eMARs and match it with the medication label. -The MAs were supposed to check any medications brought to the facility by the resident's family to make sure they matched the current order. -If the eMAR and a medication label did not match, the MAs should notify her and let the family know they brought the wrong medication. -She had not been notified of any issues with Resident #1's medications. Interview with the Administrator on 03/15/23 at 1:28pm revealed: -The MAs were supposed to match the eMAR and medication labels when administering medications. -The MAs should contact the RCC or the primary care provider (PCP) if something did not match. Telephone interview with Resident #1's PCP on 03/15/23 at 4:53pm revealed:	D 358		

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-The MAs should match the medication label with the eMARs when administering medications.
-She was not concerned about any adverse effects from Resident #1 receiving AREDS 2 instead of AREDS.

c. Review of Resident #1's current FL-2 dated 01/27/23 revealed an order for Vitamin B6 100mg take 2 and ½ tablets once daily. (Vitamin B6 is a vitamin supplement.)

Observation of the 7:00am/8:00am medication pass on 03/15/23 revealed:
-The medication aide (MA) prepared Resident #1's morning medications for administration, including one Vitamin B6 100mg tablet with Calcium Carbonate 160mg and administered it to the resident at 7:36am.
-The resident was administered one Vitamin B6 100mg tablet instead of 2 and ½ tablets and the tablet also contained Calcium Carbonate.

Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin B6 100mg take 2 and ½ tablets once daily scheduled for 7:00am and 7:00pm.
-Vitamin B6 100mg was documented as administered from 03/01/23 - 03/15/23.

Observation of Resident #1's medications on hand on 03/15/23 at 12:48pm revealed:
-There was a supply of Vitamin B6 100mg with Calcium Carbonate 160mg tablets in the original manufacturer container.
-The resident's name was handwritten on the lid of the container.
-There was no pharmacy label on the bottle.
-There was no supply of plain Vitamin B6 100mg

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D 358	Continued From page 6 tablets on hand. Interview with the MA on 03/15/23 at 12:41pm revealed: -Resident #1's family member usually brought the resident's medication to the facility. -She had not noticed the Vitamin B6 100mg tablets also contained Calcium Carbonate 160mg in each tablet. -She usually administered 1 tablet of the Vitamin B6 because she had not noticed the instructions on the eMAR were to administer 2 and ½ tablets. Interview with Resident #1 on 03/15/23 at 1:11pm revealed: -Her family member picked up her medications at a local pharmacy and brought the medications to the facility. -She took vitamins but she was not sure how many or which vitamins she usually received. Attempted telephone interview with Resident #1's family member on 03/15/23 at 4:51pm was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 1:28pm revealed: -The MAs were supposed to administered medications as ordered. -The MAs were supposed to read the eMARs and match it with the medication label. -The MAs were supposed to check any medications brought to the facility by the resident's family to make sure they matched the current order. -If the eMAR and a medication label did not match, the MAs should notify her and let the family know they brought the wrong medication. -She had not been notified of any issues with Resident #1's medications.	D 358		

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Interview with the Administrator on 03/15/23 at 1:28pm revealed:
-The MAs were supposed to match the eMAR and medication labels when administering medications.
-The MAs should contact the RCC or the primary care provider (PCP) if something did not match.
-The MAs should triple check the eMARs and label and administer medications as ordered.

Telephone interview with Resident #1's PCP on 03/15/23 at 4:53pm revealed:
-The MAs should match the medication label with the eMARs when administering medications.
-She was not concerned about Resident #1 receiving the wrong dosage of Vitamin B6 or the extra Calcium Carbonate.
-She would have the resident's calcium levels checked at her next visit.

2. Review of Resident #2's current FL-2 dated 01/27/23 revealed:
-Diagnoses included vascular dementia and anxiety disorder.
-There was an order for Lorazepam 0.5mg 1 tablet every 8 hours as needed (prn) for anxiety and agitation. (Lorazepam is used to treat anxiety and agitation.)

Review of Resident #2's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet every 8 hours prn for anxiety/agitation.
-Lorazepam 0.5mg was documented as administered twice on 01/30/23 at 10:41am and 5:32pm, only 6 hours and 51 minutes apart.
-Lorazepam 0.5mg was documented as administered twice on 01/31/23 at 6:14pm and

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D 358	Continued From page 8 8:21pm, only 2 hours and 7 minutes apart. Review of Resident #2's electronic controlled substance (CS) record for January 2023 revealed: -There were two doses of Lorazepam 0.5mg documented as administered on 01/30/23 at 10:41am and 5:32pm with both doses declined from the CS inventory. -There were two doses of Lorazepam 0.5mg documented as administered on 01/31/23 at 6:14pm and 8:21pm with both doses declined from the CS inventory. Review of Resident #2's medications on hand on 03/15/23 at 4:17pm revealed: -There was a supply of Lorazepam 0.5mg tablets dispensed on 12/06/22 with 2 of 30 tablets remaining. -There was a supply of Lorazepam 0.5mg tablets dispensed on 02/28/23 with 30 of 30 tablets remaining. Interview with a medication aide (MA) on 03/15/23 at 4:33pm revealed: -She did not recall administering Resident #2's prn Lorazepam less than every 8 hours apart. -Sometimes the eMAR system did not show the date and time a prn medication was last administered. -The prn Lorazepam should be administered if needed at least 8 hours apart. Interview with Resident #2 on 03/15/23 at 4:43pm revealed she thought she received Lorazepam but she was not sure how often. Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 5:30pm revealed: -She was not aware Resident #2's prn	D 358		

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D 358	Continued From page 9 Lorazepam was documented as administered more often than every 8 hours. -The MAs should wait the correct number of hours apart to administer the prn Lorazepam. Interview with the Administrator on 03/5/23 at 5:27pm revealed the MAs should follow the prn Lorazepam order. Telephone interview with Resident #2's primary care provider (PCP) on 03/15/23 at 4:53pm revealed: -Resident #2's prn Lorazepam should be administered according to the order. -Receiving Lorazepam too soon between dosages could cause sedation.	D 358		