STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043034	A. BUILDING: _____ B. WING _____	C 03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL CARE OF DUNN	217 JONESBORO ROAD DUNN, NC 28334

(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 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	In Reference to Rule # 10A NCAC 13F.1004(a)	
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	Administrator, Admin Assistance and RCC had a meeting with all med techs on duty immediately. On the polices and procedures to follow. Facility hired outside RN consulting service to hold a training with all med staff 1e hour med admin refresher course. Notified PCP got clarification order immediately.	3/15/23 3/26/23 3/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nicole Fuller — TITLE: Administrator — (X6) DATE: 4/18/23

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D 358	Continued From page 1 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	D 358	Contacted Resident's POA/ responsible party that all meds that are brought in from outside pharmacy must be checked in by RCC/SIC with proper label. Sign in medication book must be filled out and dated so that all meds are accounted for and reviewed for correct dosage and medications in bottles @ all times. 3/26/23 Notified resident responsible party to get accurate bottle in that matches the MAR + sign all meds in with RCC/SIC. 3/26/23	

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D 358	Continued From page 2 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	D 358	Administrator, Admin Assistance and RCC had meeting with med aide on the correct steps to complete med pass. (4 Rights)	3/16/23

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D 358	Continued From page 3 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.	D 358	Immediately had meeting with med techs to follow MAR for PRN time frames due to internet issues 3/15/23 NO Longer use electronic Count Keep record count Paper for Narc/Controll Sheets. Outside RN Consulting Service went over PRN Indications and accurate time frames to Follow MAR. 3/26/23	

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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	RCC will perform Cart/MAR/Med admin audit on weekly on a different med aide and turn in results via email to Administrator.	3/26/23

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D 358	Continued From page 5 -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	D 358		

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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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D 358	Continued From page 7 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	D 358		

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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		