Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001002	A. BUILDING: ______ B. WING ______	R 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURLINGTON CARE CENTER	2201 BURCH BRIDGE ROAD BURLINGTON, NC 27217

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on July 27, 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, record reviews, and interviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#1 and #3) who had a medication to help regulate blood sugar (#1); and an antipsychotic (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 10/15/22 revealed diagnoses included diabetes mellitus. Review of Resident #1's signed physician's order dated 06/26/23 revealed an order for Januvia 100mg (used to regulate diabetes) daily. Review of Resident #1's June 2023 medication administration record (MAR) from 06/28/23 to 06/30/23 revealed: -There was a handwritten entry for Januvia 100mg take one by mouth daily with a scheduled	D 358	MEDICATION WASN'T GIVEN BECAUSE THERE WAS A PA REQUIRED. MULTIPLE PA WAS SUBMITTED BY NP TO GET INSURANCE TO APPROVE MEDICATION BUT EACH TIME WAS DEINED. JANUVIA WAS D/C'D AND NEW MEDICATION WAS ORDERED. NOW A PA IS REQUIRED FOR THIS MEDICATION. STAFF DID IN ERROR SIGN AS MEDICATION WAS BEING GIVEN. RN WILL BE MONITORING MARS, MORE CLOSELY, TO VERIFY THIS DOESN'T OCCUR AGAIN. MEDICATION TECH WAS GIVEN TRAINING ON MAKING SURE MEDS ARE VERIFIED BEFORE ADMINSTRATION. RN WILL MONITOR MEDICATION CART ON A WEEKLY BASES AND WORK WITH MED TECHS TO MONITOR COMPLIANCE.	08/31/2023

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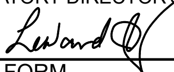
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Owner	09/01/2023

Received and Acknowledged on 09/05/23

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administration time of 8:00am.
-There was documentation Januvia 100mg was administered daily from 06/28/23 to 06/30/23.

Review of Resident #1's July 2023 MAR from 07/01/23 to 07/27/23 revealed:
-There was an entry for Januvia 100mg daily with a scheduled administration time of 8:00am.
-There was documentation Januvia 100mg was administered daily from 07/01/23 to 07/27/23.

Observation of Resident #1's medication on hand on 07/27/23 at 10:10am revealed there was no Januvia available for administration.

Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 07/27/23 at 11:06am revealed:
-The pharmacy had an order for Resident #1 for Januvia 100mg daily date 06/26/23.
-The pharmacy needed prior authorization for Januvia before dispensing the medication.
-She had faxed prior authorization forms to the Primary Care Provider (PCP) on 06/27/23. 06/28/23 and 07/14/23.
-She would check the computer several times a week to see if authorization had been given for Januvia.
-She entered the medication order into the computer so it would show on the MAR, even though the medication was not available for administration.
-She notified the Registered Nurse (RN) of the Executive Officer (EO), she could not remember which one, that Januvia had not been approved by the insurance and had not been dispensed.
-She also placed a note on the box of medications indicating Januvia was not packaged for administration because prior approval was needed and had not been received.

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D 358	Continued From page 2 Telephone interview with the Pharmacist at the facility's contracted pharmacy on 007/27/23 at 1:30pm revealed: -Januvia was used to regulate blood sugars. -If Resident #1 did not receive the medication as ordered, his blood sugar reading could increase. Interview with Resident #1 on 07/27/23 at 2:43pm revealed: -He knew he took medications for diabetes. -He did not know the name of the medications he took for his diabetes. Interview with the medication aide (MA) on 07/27/23 at 11:28am revealed: -She compared the medication with the MAR prior to administering medications. -She did sign off for Januvia on July 2023's MAR but she did not recall administering the medication. -She thought Resident #1 had Januvia on the medication cart at one time for administration and she thought it had been discontinued. -She did not know Januvia had not been dispensed from the pharmacy. -She did not recall being told by her supervisors that Januvia had not been dispensed. -The supervisors would tell the facility staff if a medication had not been dispensed because there was no prior approval. -She needed to pay more attention when she was administering medications. Interview with the Supervisor-in-Charge (SIC) on 07/27/23 at 11:29am revealed: -She would compare the medications on the medication cart to the medications listed on the MAR. -She remembered administering Januvia to	D 358		

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D 358	Continued From page 3 Resident #1 but she did not remember when. -She did not know the pharmacy had not dispensed Januvia for Resident #1. -She thought she had administered the medication. Telephone interview with the facility RN on 07/27/23 at 11:23am revealed: -The PCP would electronically send new medications orders to the pharmacy, or the facility staff would fax new medications orders to the pharmacy. -Resident #1 had a new order for Januvia. -She did not recall speaking to anyone at the facility's contracted pharmacy regarding Januvia needing prior authorization. -When a resident waited for prior authorization for a medication, she would tell the staff why the medication was not dispensed and not to document on the MAR that the medication was administered. -She reviewed the MARs monthly and each time the PCP ordered medications. -When she reviewed the MARs, she would also compare the medication with the MARs. -She did not realize Januvia was not in the facility for administration. -She expected the MAs to compare each medication on the MAR with each medication administered. -If a medication was not on the medication cart, she expected the MA to call her or the pharmacy. Telephone interview with the Executive EO on 07/27/23 at 2:50pm revealed: -Resident #1 was ordered Januvia, but it had not been approved by the insurance. -The RN should have placed a note on the MAR that the medication was pending prior authorization.	D 358		

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D 358	Continued From page 4 -It was an oversight. -The MAs were expected to compare medications with the MAR prior to administration of medications. -The MAs should notify the RN or the pharmacy if a medication is not on the medication cart and they do not know why it is not there. Attempted telephone interview with the Primary Care Provider (PCP) on 07/27/23 at 2:30pm was unsuccessful. Attempted telephone interview with the Administrator on 07/27/23 at 2:28pm was unsuccessful. 2. Review of Resident #3's FL-2 dated 01/02/23 revealed: -Diagnoses included Schizoaffective disorder, borderline mental retardation, and agitation. -There was an order for olanzapine 10mg (used to manage mood and behaviors) twice daily. Review of Resident #3's May 2023 medication administration record (MAR) from 05/05/23 to 05/31/23 revealed: -There was an entry for olanzapine 10mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation olanzapine 10mg was administered twice daily. Review of Resident #3's June 2023 MAR revealed: -There was an entry for olanzapine 10mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation olanzapine 10mg was administered twice daily.	D 358	ALL MEDICATIONS WILL BE MONITORED BY RN ON A MONTHLY BASES TO ASSURE ALL MEDICATIONS ARE GIVEN AS ORDERED. NOT SURE EXACTLY WHAT OCCURED IN THIS SITUATION. THE RESIDENT HAD NO NEW BEHAVIORS OR AGITATION.	08/31/2023

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Review of Resident #3's July 2023 MAR from 07/01/23 to 07/27/23 at 8:00am revealed:
-There was an entry for olanzapine 10mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation olanzapine 10mg was administered twice daily from 07/01/23 to 07/26/23 and on 07/27/23 at 8:00am.

Observation of Resident #3's medication on hand on 07/27/23 at 1:39pm revealed:
-There was an opened box of olanzapine 10mg that contained 21 tablets.
-The opened box of olanzapine 10mg was dispensed on 05/04/23 with 30 tablets.
-There were three unopened boxes of olanzapine 10mg on the shelf in the medication room; each box contained 30 tablets.
-One of the unopened boxes had a dispensed date of 05/04/23 and two unopened boxes had a dispensed date of 07/25/23.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/27/23 at 1:30pm revealed:
-The pharmacy had an order for Resident #1 for olanzapine 10mg twice daily dated 02/03/23.
-The pharmacy dispensed 2 boxes of 30 tablets of olanzapine 10mg on 05/04/23, 006/01/23, and 07/25/23
-Two boxes of olanzapine 10mg would last Resident #1 30 days.

Based on observation, record reviews, and interviews, there were 120 olanzapine 10mg tablets dispensed from 05/04/23 to 06/01/23 which would have been available to administered from 05/04/23 to 07/04/23. There were 51 tablets remaining that had been dispensed on 05/04/23 and 06/01/23. There should have been no

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D 358	Continued From page 6 olanzapine 10mg available to administer from 07/05/23 to 07/25/22. 60 tablets of lazonapine was received on 07/25/23. There were 60 when there should have been 57. Interview with the medication aide (MA) on 07/27/23 at 2:03pm revealed: -She had administered olanzapine 10mg to Resident #3. -She knew olanzapine was for Resident #3's behavior. -Resident #3 would curse at the staff and other residents. -Resident #3 refused his medication on Tuesday, July 25th; this is the only time from May 2023 to July 2023 that Resident #3 refused his medications when she administered medications. -The pharmacy would automatically send olanzapine 10mg every month. -It looked like the medication was not being administered as ordered. Interview with the Supervisor-in-Charge (SIC) on 07/28/23 at 2:17pm revealed: -Resident #3 did not refused his medications. -Sometimes She had to persuade him to take his medications, but he never refused. -She had not noticed any behavior problems with Resident #3. Telephone interview with the facility Registered Nurse (RN) on 07/27/23 at at 1:50pm revealed: -Resident #3's olanzapine was dispensed in a bubble pack, not in the multi-dose pack with all the medications. -The pharmacy would automatically dispense olanzapine monthly because it was a scheduled medication. -The facility staff did not have to re-order the olanzapine.	D 358		

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D 358	Continued From page 7 -Resident #3 had not refused olanzapine and had not been out of the facility and missed any doses from May to July 2023. -She could not determine if the medication was being administered as ordered. -It appeared the medication was not being administered as ordered. -She did not count medications on hand when she did medication cart audits. -She ensured the medication was available to administer. -She expected the MAs to administer the medications as ordered. -The facility staff had not voiced any concerns of behaviors to her. Telephone interview with the Executive Officer (EO) on 07/27/23 at 2:50pm revealed: -The pharmacy automatically dispenses scheduled medication each month. -Resident #3 did not refuse his medications. -She had not been notified of any behaviors from Resident #3. -She did not know why there were so many medications on hand if Resident #3 was being administered his medications as ordered. Attempted telephone interview with the Primary Care Provider (PCP) on 07/27/23 at 2:30pm was unsuccessful. Attempted telephone interview with the Administrator on 07/27/23 at 2:28pm was unsuccessful.	D 358		