STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092143	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZEBULON HOUSE	551 PONY ROAD ZEBULON, NC 27597

(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 and Wake County Department of Social Services conducted an annual and follow up and survey on August 9-10, 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 interviews and record reviews the facility failed to administer medications as ordered for 1 of 5 residents (#1) observed during the medication pass including errors with medications used to treat constipation and a medication used to prevent too much phosphate in the blood for people receiving dialysis and for 1 of 5 sampled residents (#1) including medications that were to be administered prior to procedures to prevent allergic reactions. The findings are: 1. The medication error rate was 6% as evidenced by 2 errors out of 29 opportunities during the 8:00am medication pass on 08/09/23. Review of Resident #1's current FL2 dated 03/01/23 revealed diagnoses included type II diabetes and chronic kidney disease.	D 358		

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D 358	Continued From page 1 a. Review of Resident #1's current FL2 dated 03/01/23 revealed there was a physician's order to administer sevelamer carbonate 800mg three times each day. (Sevelamer carbonate is a medication used to prevent high phosphate levels in the blood.) Review of a physician's order dated 05/09/23 revealed sevelamer carbonate 800mg, two tablets were to be administered three times daily prior to each meal. Review of a physician's order dated 07/13/23 revealed sevelamer carbonate 800mg, three tablets were to be administered three times with each meal. Observation of the 8:00am medication pass on 08/09/23 revealed sevelamer 800mg, 3 tablets were not administered. Review of Resident #1's medication administration record (MAR) for August 2023 revealed: -There was an entry for sevelamer carbonate 800mg, three tablets to be administered three times daily with meals. -There was documentation sevelamer carbonate 800mg, three tablets was administered at 8:00am. Interview with the medication aide (MA) on 08/09/23 at 11:15am revealed: -Third shift staff usually administered the sevelamer carbonate to Resident #1. -She did not administer sevelamer carbonate to Resident #1 during the medication pass that morning. -She accidentally documented the administration	D 358		

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D 358	Continued From page 2	D 358		

of the sevelamer that morning.

Telephone interview with the Registered Nurse for Resident #1's primary care provider (PCP) on 08/10/23 at 11:15am revealed:
-Sevelamer carbonate was used to prevent high phosphorus levels in people receiving dialysis.
-High phosphorus levels could cause muscle spasms but symptoms were minimal.

Interview with the Resident Care Coordinator on 08/10/23 at 10:20am revealed:
-Medications scheduled for 8:00am should be administered by the first shift MA.
-She expected all medications to be administered as ordered.

Interview with the Administrator on 08/10/23 at 11:38am revealed:
-She expected all medications to be administered using the 5 Rights of medication administration: Right medication, Right dose, Right resident, Right time and Right dose.
-First shift MAs were expected to administer 8:00am medications.

b. Review of Resident #1's current FL2 dated 03/01/23 revealed a physician's order for lactulose 15ml to be administered daily on Monday, Wednesday, Friday and Sunday. (Lactulose is medication used to treat constipation.)

Observation of the 8:00am medication pass on Wednesday 08/09/23 revealed lactulose 15ml was not offered or administered.

Review of Resident #1's medication administration record (MAR) for August 2023 revealed:

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D 358	Continued From page 3	D 358		

-There was an entry for lactulose 15ml to be administered daily on Monday, Wednesday, Friday and Sunday.
-There was documentation lactulose 15ml was not administered because the resident refused.

Interview with the medication aide (MA) on 08/09/23 at 11:15am revealed Resident #1 refused laxatives often and, when Resident #1 refused one laxative that am during the medication pass, she assumed the refusal of the lactulose as well.

Interview with Resident #1 on 08/09/23 at 2:48pm revealed:
-She was not offered lactulose during the morning medication pass.
-She was offered another laxative and would have refused the lactulose if it was offered because she did not need them.

Interview with the Resident Care Coordinator on 08/10/23 at 10:20am revealed:
-Lactulose 15ml should have been offered to Resident #1 even if she refused the medication.
-Refusal of a medication could not be assumed.

Interview with the Administrator on 08/10/23 at 11:38am revealed all scheduled medications should be offered as ordered and refusals documented on the mediation administration record with reason.

2. Review of Resident #1's current FL2 dated 03/01/23 revealed diagnoses included type II diabetes and chronic kidney disease.

Review of Resident #1's primary care provider (PCP) progress note dated 07/12/23 at 7:20am revealed Resident #1 had a arteriovenous shunt

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D 358	Continued From page 4	D 358		

in her right upper arm.

Review of Resident #1's primary care provider (PCP) progress note dated 08/08/23 at 7:19am revealed:
-Resident #1's right arm had increased swelling.
-Resident #1's dialysis clinic reported they were unable to complete dialysis treatment that morning due to a partially clogged port.

Review of Resident #1's progress note dated 08/08/23 at 11:02am revealed Resident #1 had an appointment the following morning (08/09/23) at 7:15am at a local access center.

Review of a physician's order dated 08/08/23 revealed an order for Prednisone 20mg, 2 tablets to be administered at 7:00pm and 11:00pm on 08/08/23 and 2 tablets on 08/09/23 prior to procedure.

Interview with Resident #1 on 08/09/23 at 2:48pm revealed:
-She had an appointment that morning but was unable to go because she did not get the medication she was suppose to have before that procedure.
-The procedure was to clear the dialysis shunt that was clogged.
-She was allergic to something that was used during the procedure that caused her to itch and the medication she was suppose to receive was to prevent the reaction.
-The appointment was rescheduled for 08/10/23.

Telephone interview with the scheduling coordinator for Resident #1's local access center on 08/10/23 at 9:56am revealed:
-Resident #1 had an appointment scheduled for 08/09/23 but the facility called to inform them

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D 358	Continued From page 5 Resident #1 did not receive the medication that was to be administered pre-procedure. -The procedure was to clear clots at access for dialysis. -Resident #1 could receive dialysis as schedule on 08/10/23 following the procedure. Telephone interview with Resident #1's Registered Nurse (RN) with the local access center on 08/10/23 at 11:26am revealed: -Resident #1 had a mild allergy to the contrast dye used during procedures that caused itching. -Resident #1 was able to have procedure and continue dialysis the same day. Telephone interview with the RN at Resident #1's dialysis clinic on 08/10/23 at 11:03am revealed: -Resident #1 went in for dialysis after an appointment at the access clinic that morning. -There were no missed or delayed dialysis appointments for Resident #1. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 08/10/23 at 10:03am revealed an order written on 08/08/23 for Resident #1 to receive pre-procedure medications was received on 08/09/23 at 12:00pm and the sent to the back-up pharmacy to be filled. Telephone interview with the pharmacist at the facility's back-up pharmacy on 08/10/23 revealed: -The pharmacy received an order for Resident #1 written 08/08/23 for Prednisone 20mg, to administer 2 tablets at 7:00pm and 11:00pm the night before the procedure and 2 tablets the morning of the procedure on 08/09/23. -Six tablets of Prednisone 20mg was dispensed on 08/09/23.	D 358		

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D 358	Continued From page 6 Interview with the transportation staff on 08/10/23 at 11:58am revealed: -She transported Resident #1 to dialysis on 08/08/23 and dialysis could not be completed because the access was clogged . -She returned to the facility with a medication prescription that she gave to the medication aide and scheduled the appointment with the access clinic for 08/09/23. -She did not inform the Resident Care Coordinator (RCC) of the appointment or the medication order. -The medication aide was responsible for faxing the order to the pharmacy. Interview with the medication aide (MA) on 08/10/23 at 12:04pm revealed: -Transportation staff laid Resident #1's prednisone order on the medication cart on 08/08/23 when she returned with Resident #1 from dialysis. -She gave the order to the RCC who was responsible for faxing the order to the pharmacy. Interview with the Resident Care Coordinator (RCC) on 08/10/23 at 10:20am revealed: -Resident #1 received dialysis 3 times each week. -Resident #1's dialysis clinic reported on 08/08/23 they were unable to complete dialysis due to Resident #1's port being partially clogged. -Resident #1 was suppose to have a procedure on 08/09/23 but Resident #1 did not receive pre-procedure medication as prescribed so the procedure was rescheduled for 08/10/23. -Transportation staff gave her the prescription for pre-procedure medications when she returned with the resident on 08/08/23 and are usually able to get the medication on the same day. -The RCC was not aware of the appointment and	D 358		

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D 358	Continued From page 7 order for medications until the morning of 08/09/23 because she did not look at the paper the transportation staff gave her until 08/09/23 and the transportation staff did not tell her about the appointment. -She should have looked at the paper the transportation staff gave her and faxed the order to the pharmacy when it was received on 08/08/23. Interview with the Administrator on 08/10/23 at 11:38am revealed: -The appointment for Resident #1 on 08/09/23 was not a routine appointment but an appointment to clear clots from a dialysis shunt. -She was not aware of the appointment until 08/09/23 when the RCC told hr it was missed due the medication not being administered. -The transportation staff should have told the RCC about the appointment and the medication orders. -It was the RCC's responsibility to fax the order to pharmacy.	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 medications or treatments as needed (PRN) and	D 367		

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D 367	Continued From page 8	D 367		

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 the medication administration record was accurate for 1 of 5 sampled residents (#1) for a medication used to prevent high phosphorus levels in the blood.

The findings are:

Review of Resident #1's current FL2 dated 03/01/23 revealed:
-Diagnoses included type II diabetes and chronic kidney disease.
-There was a physician's order to administer sevelamer carbonate 800mg three times each day. (Sevelamer carbonate is a medication used to prevent high phosphorus levels in the blood.)

Review of a physician's order dated 05/09/23 revealed sevelamer carbonate 800mg, two tablets were to be administered three times daily prior to each meal.

Review of a physician's order dated 07/13/23 revealed sevelamer carbonate 800mg, three tablets were to be administered three times with each meal.

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D 367	Continued From page 9 Observation of the 8:00am medication pass on 08/09/23 revealed sevelamer 800mg, 3 tablets were not administered. Review of Resident #1's medication administration record (MAR) for August 2023 revealed: -There was an entry for sevelamer carbonate 800mg, three tablets to be administered three times daily with meals. -There was documentation sevelamer carbonate 800mg, three tablets was administered at 8:00am. Interview with the medication aide (MA) on 08/09/23 at 11:15am revealed: -Third shift staff usually administered the sevelamer carbonate to resident #1. -She did not administer sevelamer carbonate to Resident #1 during the medication pass that morning. -She accidentally documented the administration of the sevelamer that morning. Interview with the Resident Care Coordinator on 08/10/23 at 10:20am revealed: -Medications should be documented as administered only when it was administered and if a medication is not administered there should be documentation as to why. -It was important for MARs to be accurate to know if medications were administered or not. -Providers need to have an accurate MAR to review if an incident was to occur or they may need to adjust medications. Interview with the Administrator on 08/10/23 at 11:38am revealed she expected documentation of medications administered and not administered to be accurate so providers would	D 367		

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D 367	Continued From page 10 know how and if any adjustment to medications is needed.	D 367		