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AMERICARE ADULT HOMES # 2	103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 11/21/23.	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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 residents (#1, #2, #3) sampled including errors with medications used to treat lung disease and breathing problems (#1, #3), eye drops for infection, pain, and inflammation (#2), a controlled substance for moderate to severe pain (#1), an antibiotic for infection (#3), a potassium supplement (#3), a medication for inflammation (#3), and a medication for cough and congestion (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 01/12/23 revealed diagnoses included chronic obstructive pulmonary disease, chronic back pain, type 2 diabetes, hypertension, coronary artery disease, hyperlipidemia, debility, chronic	D 358		

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D 358	Continued From page 1 kidney disease, and depression. a. Review of Resident #1's current FL-2 dated 01/12/23 revealed an order for Budesonide 0.5mg/2ml, inhale 1 vial via nebulizer two times a day. (Budesonide is used to treat inflammation of the airways in lung disease.) Review of Resident #1's physician's order sheet dated 05/24/23 revealed an order for Budesonide 0.5mg/2ml, inhale 1 vial via nebulizer every 12 hours, morning and bedtime. Review of Resident #1's November 2023 medication administration record (MAR) revealed: -There was a handwritten entry for Budesonide 0.5mg/2ml, use 1 vial via nebulizer every 12 hours scheduled for 8:00am and 8:00pm. -Budesonide was documented as not administered from 11/01/23 at 8:00am - 11/08/23 at 8:00am (15 missed doses) due to the medication being on order. Observation of Resident #1's medications on hand on 11/21/23 at 12:26pm revealed: -There was a supply of Budesonide 0.5mg/2ml inhalation suspension dispensed on 11/08/23. -There were 11 of 30 vials remaining. Interview with a medication aide (MA) on 11/21/23 at 12:17pm revealed: -He was not sure why Resident #1 ran out of Budesonide, but he thought it was because they had a hard time getting it when they recently switched to a different pharmacy provider (could not recall date). -The resident sometimes complained of shortness of breath. Attempted telephone interviews with a second MA	D 358		

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D 358	Continued From page 2 on 11/21/23 at 4:23pm and 5:37pm were unsuccessful. Telephone interview with a pharmacist at the facility's current pharmacy provider on 11/21/23 at 3:48pm revealed: -They started servicing the facility on 11/01/23. -They received an order for Resident #1's Budesonide on 11/08/23 and dispensed a 30-day supply on that same day. -They did not receive an order for Budesonide prior to 11/08/23. Telephone interview with a pharmacist at the facility's former pharmacy provider on 11/21/23 at 4:41pm revealed: -Budesonide was backordered through the pharmacy's supplier so the last 30-day supply they dispensed was on 06/22/23. -They outsourced the prescription to a back-up pharmacy on 07/25/23, who was able to get the medication from their supplier. -He did not know if the facility obtained the medication from the back-up pharmacy. Interview with the Administrator on 11/21/23 at 1:19pm revealed: -She did a medication cart audit last week and realized that Resident #1 did not have any Budesonide available for administration. -The MAs were responsible for ordering medications. -They had recently changed pharmacy providers and she thought this may have caused the delay in getting Budesonide ordered for the resident. -Resident #1 had problems with being short of breath. -She noticed Resident #1 was short of breath on 11/08/23, when the resident was getting out of the facility van and walking back to the facility.	D 358		

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D 358	Continued From page 3 Interview with Resident #1 on 11/21/23 at 12:54pm revealed: -The facility ran out of his Budesonide when they changed pharmacies recently (could not recall date). -He had shortness of breath when he did not receive the Budesonide. -He had to use his Albuterol inhaler (used as rescue inhaler to treat acute episode of shortness of breath) more often while he was out of the Budesonide. Telephone interview with Resident #1's primary care provider (PCP) on 11/22/23 at 9:40am revealed: -Resident #1 should receive Budesonide as ordered because he had a history of chronic obstructive pulmonary disease. -Not receiving Budesonide could cause shortness of breath, making it hard for the resident to breathe. b. Review of Resident #1's physician's order dated 07/20/23 revealed an order for Xtampza ER 13.5mg twice a day. (Xtampza ER is a controlled substance used to treat moderate to severe pain.) Review of Resident #1's order from the orthopedic provider dated 10/06/23 revealed an order to increase Xtampza ER to 18mg twice a day. Review of Resident #1's orthopedic visit notes dated 11/08/23 revealed: -The resident had lumbar spine pain with spinal stenosis, degenerative disc disease, and facet joint arthritis. -There was an order to continue Xtampza ER	D 358		

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18mg twice a day.
-Documentation by the Administrator at the bottom of the visit notes indicated the order was faxed to the pharmacy, written on the medication administration record (MAR), and a copy was put in the Resident Care Coordinator's (RCC) book on 11/08/23.

Review of Resident #1's electronic prescription from the orthopedic provider dated 11/14/23 revealed:
-There was an order for Xtampza ER 18mg take 1 capsule every 12 hours as needed for 30 days.
-The prescription was written for a quantity of 60 capsules (30-day supply) with no refills.

Review of Resident #1's November 2023 MAR revealed:
-There was a handwritten entry for Xtampza ER 18mg take 1 tablet 2 times daily scheduled at 8:00am and 8:00pm.
-Xtampza ER 18mg was documented as not administered due to being on order on 11/04/23 at 8:00am and 8:00pm, 11/05/23 at 8:00am, and 11/15/23 at 8:00pm, for a total of 4 missed doses.
-There was a computer printed entry for Xtampza ER 13.5mg 1 capsule 2 times a day for pain scheduled at 8:00am and 8:00pm.
-The entry for Xtampza ER 13.5mg was marked through with "ordered changed" (no date specified) and none was documented as administered in November 2023.
-The order dated 11/14/23 for Xtampza ER 18mg 1 capsule every 12 hours as needed was not transcribed onto the November 2023 MAR.

Review of Resident #1's controlled substance (CS) count sheets for Xtampza ER 13.5mg revealed:
-There was a handwritten CS count sheet for

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Xtampza ER 13.5mg with a quantity of 8 capsules received but no date received noted.
-There were 8 of 8 Xtampza ER 13.5mg capsules documented as administered from 8:00pm on 10/11/23 - 8:00am on 10/15/23, leaving a balance of 0.
-There was a second CS count sheet for Xtampza ER 13.5mg with a quantity of 30 capsules with a dispense date of 09/14/23.
-There were 10 Xtampza ER 13.5mg capsules documented as administered from 8:00pm on 10/15/23 - 8:00am on 10/20/23, leaving a balance of 20 capsules.
-The other 20 capsules were documented as administered from 8:00pm on 11/05/23 - 8:00am on 11/15/23, leaving a balance of 0.
-There were 38 doses of Xtampza ER 13.5mg documented as administered from 10/11/23 - 11/15/23 when Xtampza ER 18mg was ordered and should have been administered.

Review of Resident #1's CS count sheets for Xtampza ER 18mg revealed:
-There was a CS count sheet for Xtampza ER 18mg with a quantity of 30 capsules with a dispense date of 10/18/23.
-There were 22 Xtampza ER 18mg capsules documented as administered from 8:00pm on 10/20/23 - 8:00am on 10/31/23, leaving a balance of 8 capsules.
-There was a second handwritten CS count sheet for Xtampza ER 18mg with a quantity of 8 capsules but no dispense date.
-These 8 capsules were documented as administered from 8:00pm on 10/31/23 - 8:00am on 11/04/23, leaving a balance of 0.
-There was a third CS count sheet for Xtampza ER 18mg with a quantity of 60 capsules and a dispense date of 11/14/23.
-There was no Xtampza ER 18mg documented

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on the CS count sheet after 8:00am on 11/15/23 until 11:00am on 11/17/23.
-There were 9 of 60 capsules documented as administered from 11:00am on 11/17/23 - 8:00am on 11/21/23, leaving a balance of 51.

Observation of Resident #1's medications on hand on 11/21/23 at 12:33pm revealed:
-There was a supply of Xtampza ER 18mg capsules dispensed on 11/14/23.
-There were 51 of 60 capsules remaining.
-There were no Xtampza ER 13.5mg capsules available for administration.

Interview with a medication aide (MA) on 11/21/23 at 12:17pm revealed:
-Resident #1 had ran out of Xtampza ER 18mg in November 2023.
-He was not sure why the resident ran out but it may have been because the facility recently switched pharmacy providers.
-The resident complained of back and leg pain when he did not receive the Xtampza ER.
-He could not explain why he documented and administered Xtampza ER 13.5mg after the order changed to 18mg on 10/06/23.

Attempted telephone interviews on 11/21/23 at 4:23pm and 5:37pm with a second MA who documented the administration of Xtampza ER 13.5mg instead of 18mg were unsuccessful.

Telephone interview with a pharmacist at the facility's former pharmacy provider on 11/21/23 at 4:41pm revealed:
-They dispensed 30 Xtampza ER 13.5mg capsules each on 07/20/23, 08/18/23, and 09/14/23.
-They dispensed 30 Xtampza ER 18mg capsules on 10/18/23.

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-They had not received any orders for Xtampza ER since 10/18/23.

Telephone interview with a pharmacist at the facility's current pharmacy provider on 11/21/23 at 3:48pm revealed:
-They started servicing the facility on 11/01/23.
-They received an order for Xtampza ER 18mg on 11/14/23.
-They did not have Xtampza ER 18mg on hand on 11/14/23.
-They sent a supply of 60 Xtampza ER 18mg capsules to the facility on 11/16/23.

Interviews with the Administrator on 11/21/23 at 1:19pm and 5:45pm revealed:
-The MAs were responsible for transcribing new orders and order changes onto the MARs.
-The RCC was responsible for checking behind the MAs to ensure order changes and new orders were implemented correctly.
-The RCC position was currently vacant at the facility.
-She was responsible for checking behind the MAs in the absence of a RCC.
-She was not aware Resident #1's Xtampza ER had not been administered as ordered.
-The Xtampza ER 13.5mg capsules should have been sent back to the pharmacy when the dosage was increased to 18mg in October 2023.
-The MAs should not have administered the Xtampza ER 13.5mg capsules when the 18mg was not available.

Telephone interview with a call center representative at Resident #1's orthopedic provider on 11/21/23 at 2:34pm revealed:
-The resident's orthopedic provider was unavailable for interview.
-According to their records, Resident #1's

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Xtampza ER was increased from 13.5mg to 18mg on 10/06/23 due to increasing right leg pain.

Telephone interview with Resident #1's primary care provider (PCP) on 11/22/23 at 9:40am revealed:
-Resident #1 was receiving Xtampza ER 13.5mg prior to seeing the orthopedic provider.
-Not receiving Xtampza ER 18mg as ordered could cause the resident to have breakthrough pain.

Interview with Resident #1 on 11/21/23 at 12:54pm revealed:
-He took Xtampza ER mostly for lower back pain.
-When he received the Xtampza ER, his pain level was usually "5" (moderate pain) when he was walking and either no pain or "not too bad" usually when he was sitting.
-The facility had recently run out of his Xtampza ER (could not recall dates).
-His pain level was at "10" (severe pain) when he did not receive the pain medication.

2. Review of Resident #2's current FL-2 dated 05/10/23 revealed diagnoses included hypertension, heart failure, pacemaker, venous insufficiency, osteoarthritis of hip, and abnormalities with gait immobility.

a. Review of Resident #2's signed physician's order dated 10/26/23 revealed an order for Tobramycin 0.3% eye drops one drop in operative eye 4 times daily starting 2 days prior to surgery on 11/13/23. (Tobramycin 0.3% eye drops are to prevent and treat bacteria before and after cataract surgery.)

Review of Resident #2's November 2023

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medication administration record (MAR) revealed:
-There was an entry for Tobramycin 0.3% instill one drop in operative eye 4 times daily, start 2 days before surgery, start on 11/11/23 at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-Surgery was scheduled for 11/13/23.
-There was documentation that Tobramycin 0.3% was administered on 11/11/23 through 11/20/23 4 times a day at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was no documentation that Tobramycin had been administered on 11/21/23 at 8:00am.

Resident #2 was transferred to the hospital emergency department (ED) for a low-grade fever around 12:00pm on 11/21/23 and was unavailable for interview.

Observation of Resident #2's medications on hand on 11/21/23 at 2:00pm revealed an opened and labeled prescription bottle that contained a small amount of liquid. from the facility's contracted pharmacy for Tobramycin 0.3% dispensed on 11/08/23 instill one drop 4 times a day in operative eye starting 2 days before to surgery.

Interview with a medication aide (MA) on 11/21/23 at 12:55pm revealed:
-Blanks on the MAR meant the medication was not given.
-He was supposed to document on the back of the MAR the reason the medication was not administered.
-He did not document on the back of the MAR the reason the medication was not administered on 11/21/23 at 8:00am.
-He did not verify the physician order dated 11/20/23 because he forgot.
-He placed the order that was incomplete in the

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resident's record and did not notify the Administrator, the order stated "grey cap 1x daily and Steroid 3x daily for right eye only tomorrow."
-He was trained to verify all orders that were incomplete.

Interview with the Administrator on 11/21/23 at 2:23pm revealed:
-When a resident returned from an appointment or the hospital all documents should be reviewed before placed in a resident's record.
-Resident #2's medication should have been given as ordered.
-The MAs had been trained to verify all orders were complete orders before placing the order in the record.
-The MAs had been trained to not leave any blanks on the MAR without documenting the reason on the back of the MAR.
-The MAs were responsible for reviewing all physician orders and if they were incomplete should have them verified with the physician who wrote them.

Telephone interview with Resident #2's optometrist's eye technician on 11/21/23 at 4:30pm revealed:
-Tobramycin was used to treat and prevent eye infections before and after cataract surgery.
-Resident #2 had surgery on 11/13/23.
-New medication orders were sent with Resident #2 after his follow up appointment on 11/20/23.

b. Review of Resident #2's signed physician's order dated 10/26/23 revealed an order for Ketorolac 0.5% eye drops one drop in operative eye 4 times daily starting 2 days prior to surgery on 11/13/23. (Ketorolac 0.5% eye drops are used to treat eye swelling and pain before and after cataract surgery.)

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D 358	Continued From page 11 Review of Resident #2's November 2023 medication administration record (MAR) revealed: -There was an entry for Ketorolac 0.5% instill one drop in operative eye 4 times daily, start 2 days before surgery on 11/11/23 at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Surgery was scheduled for 11/13/23. -There was documentation that Ketorolac 0.5% was administered on 11/11/23 through 11/20/23 4 times a day at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was no documentation that Ketorolac had been administered on 11/21/23 at 8:00am. Resident #2 was transferred to the hospital emergency department (ED) for a low-grade fever around 12:00pm on 11/21/23 and was unavailable for interview. Observation of Resident #2's medications on hand on 11/21/23 at 2:00pm revealed an opened and labeled prescription bottle that contained a small amount of liquid from the facility's contracted pharmacy for Ketorolac 0.5% dispensed on 11/08/23 instill one drop in operative eye starting 2 days prior to surgery. Interview with a medication aide (MA) on 11/21/23 at 12:55pm revealed: -Blanks on the MAR meant the medication was not given. -He was supposed to document on the back of the MAR the reason the medication was not administered. -He did not document on the back of the MAR the reason the medication was not administered on 11/21/23 at 8:00am. -He did not verify the physician order dated 11/20/23 because he forgot.	D 358		

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-He placed the order that was incomplete in the resident's record and did not notify the Administrator, the order stated "grey cap 1x daily and Steroid 3x daily for right eye only tomorrow."
-He knew that he was supposed to verify all others that were incomplete.

Interview with the Administrator on 11/21/23 at 2:23pm revealed:
-When a resident returned from an appointment or the hospital all documents should be reviewed before placed in a resident's record.
-Resident #2's medication should have been given as ordered.
-The MAs had been trained to verify all orders were complete orders before placing the order in the record.
-The MAs had been trained to not leave any blanks on the MAR without documenting the reason on the back of the MAR.
-The MAs were responsible for reviewing all physician orders and if they were incomplete have them verified with the physician who wrote them.

Telephone interview with Resident #2's optometrist's eye technician on 11/21/23 at 4:30pm revealed:
-Ketorolac drops was used to reduce swelling and pain in the eye before and after cataract surgery.
-Resident #2 had surgery on 11/13/23.
-New medication orders were sent with Resident #2 after his follow up appointment on 11/20/23.

c. Review of Resident #2's signed physician's order dated 10/26/23 revealed an order for Prednisolone 1% eye drops one drop in operative eye 4 times daily starting 2 days prior to surgery on 11/11/23. (Prednisolone 1% eye drops are used to prevent and treat inflammation and

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swelling in the eye before and after cataract surgery.)

Review of Resident #2's November 2023 medication administration record (MAR) revealed:
-There was an entry for Prednisolone 1% instill one drop in operative eye 4 times daily.
-There was documentation that Prednisolone 1% was administered on 11/11/23 through 11/20/23.
-There was no documentation that Prednisolone 1% had been administered on 11/21/23 at 8:00am.

Resident #2 was transferred to the hospital emergency room (ED) for a low-grade fever around 12:00pm on 11/21/23 and was unavailable for interview.

Observation of Resident #2's medications on hand on 11/21/23 at 2:00pm revealed an opened and labeled prescription bottle that contained a small amount of liquid from the facility's contracted pharmacy for Prednisolone 1% dispensed on 11/08/23 instill one drop in operative eye starting 2 days prior to surgery.

Interview with a medication aide (MA) on 11/21/23 at 12:55pm revealed:
-He had forgotten Resident #2 had eye drops.
-Blanks on the MAR meant the medication was not given.
-He was supposed to document on the back of the MAR the reason the medication was not administered.
-He did not document on the back of the MAR the reason the medication was not administered on 11/21/23 at 8:00am.
-He did not verify the incomplete physician order dated 11/20/23 because he forgot.
-He placed the order that was incomplete in the

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resident's record and did not notify the Administrator, the order stated "grey cap 1x daily and Steroid 3x daily for right eye only tomorrow."
-He knew that he was supposed to verify all others that were incomplete.

Interview with the Administrator on 11/21/23 at 12:35pm revealed:
-When a resident returned from an appointment or the hospital all documents should be reviewed before placed in a resident's record.
-Resident #2's medication should have been given as ordered.
-The MAs had been trained to verify all orders were complete orders before placing the order in the record.
-The MAs had been trained to not leave any blanks on the MAR without documenting the reason on the back of the MAR.
-The MAs were responsible for reviewing all physician orders and if they were incomplete should have them verified with the physician who wrote them.

Telephone interview with Resident #2's optometrist's eye technician on 11/21/23 at 4:30pm revealed:
-Prednisolone 1% was used to treat and prevent eye inflammation and swelling when having cataract surgery.
-Resident #2 had surgery on 11/13/23.
-New medication orders were sent with Resident #2 after his follow up appointment on 11/20/23.

3. Review of Resident #3's current FL-2 dated 10/10/23 revealed diagnoses including chronic obstructive pulmonary disease, hypertension, hyperlipidemia, and Vitamin D deficiency.

a. Review of Resident #3's hospital emergency

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department (ED) after visit summary dated 11/18/23 at 7:02pm revealed:
-Reason for Resident #3's visit was flu-like symptoms.
-Diagnoses from visit was chronic obstructive pulmonary disease (COPD) exacerbation.
-A prescription for Azithromycin 250mg once daily for 4 days on 11/18/23 was sent to a local pharmacy for the facility to pick up (Azithromycin is an antibiotic for infections.)
-Resident #3 was administered Azithromycin before discharge from the ED on 11/18/23 at 6:39pm.

Review of Resident #3's November 2023 medication administration record (MAR) revealed:
-There was an entry for Azithromycin 250mg once daily for 4 days dispensed on 11/20/23.
-Azithromycin 250mg was documented as administered at 8:00am on 11/20/23 and 11/21/23.
-Resident #3 went 37 hours between receiving the first and second dose of Azithromycin.

Observation of Resident #3's medications on hand on 11/21/23 at 2:15pm revealed there were 2 tablets of Azithromycin 250mg available for administration.

Interview with the medication aide (MA) on 11/21/23 at 12:55pm revealed:
-The prescription was sent from the local ED to the facility's previous pharmacy on 11/18/23.
-The MA had tried to call the previous pharmacy but could not get through to talk with anyone on 11/19/23.
-The MA did not notify the Administrator or Resident #3's provider that the medication was not available.
-The MA did not review the after visit summary

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from the ED and see that the prescription was sent to a local pharmacy for pickup.
-The MA did not know that a prescription could have been sent to a backup pharmacy for pickup so the medication could be started as directed.

Interview with the Administrator on 11/21/23 at 1:15pm revealed:
-She did not know until 11/20/23 that Azithromycin 250mg was not available on 11/19/23.
-She called their contracted pharmacy on 11/20/23 and picked up the Azithromycin.
-The MAs have been trained to review all documents sent from the hospital or provider for new orders and prescriptions.
-The MAs should have called the contracted pharmacy about the medication.

Telephone interview with the current contracted pharmacist on 11/21/23 at 4:00pm revealed that Azithromycin 250mg once daily for 4 days was dispensed on 11/20/23 after the facilty called requesting it.

Attempted telephone interview with the Resident' #3's primary care provider (PCP) on 11/21/23 at 4:13pm was unsuccessful.

Interview with Resident #3 on 11/21/23 at 5:40pm revealed:
-He did not know the names of his medications.
-He did not know if he was receiving his new medications.
-He had not felt any better since going to the ED on 11/18/23; he was still coughing, congested, and short of breath.

b. Review of Resident #3's hospital emergency department (ED) after visit summary dated 11/18/23 at 7:02pm revealed:

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-A prescription for Prednisone 20mg two tablets once daily for 4 days on 11/18/23 was sent to a local pharmacy for the facility to pick up. (Prednisone is used to treat inflammatory conditions.)
-Resident #3 was administered Prednisone before discharge from the ED on 11/18/23 at 6:40pm.

Review of Resident #3's November 2023 medication administration record (MAR) revealed:
-There was an entry for Prednisone 20mg two tablets once daily for 4 days dispensed on 11/20/23.
-Prednisone 20mg was documented as administered at 8:00am on 11/20/23 and 11/21/23.
-Resident #3 went 37 hours between receiving the first and second dose Prednisone.

Observation of Resident #3's medications on hand on 11/21/23 at 2:15pm revealed there were 2 tablets in two bubbles for a total of 4 tablets from the facility's contracted pharmacy dispensed on 11/20/23.

Interview with the medication aide (MA) on 11/21/23 at 12:55pm revealed:
-The prescription was sent from the local ED to the facility's previous pharmacy on 11/18/23.
-The MA had tried to call the previous pharmacy but could not get through to talk with anyone on 11/19/23.
-The MA did not notify the Administrator or Resident #3's provider that the medication was not available.
-The MA did not review the after visit summary from the ED and see that the prescription was sent to a local pharmacy for pickup.
-The MA did not know that a prescription could

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have been sent to a backup pharmacy for pickup so the medication could be started as directed.

Interview with the Administrator on 11/21/23 at 1:15pm revealed:
-She did not know until 11/20/23 that the Prednisone 20mg was not available.
-She called their contracted pharmacy on 11/20/23 and picked up the Prednisone.
-The MAs had been trained to review all documents sent from the hospital or provider for new orders and prescriptions.
-The MA should have called the current contracted pharmacy about the medication.

Telephone interview with the facility's currently contracted pharmacist on 11/21/23 at 4:00pm revealed that Prednisone 20mg two tablets once daily for 4 days was dispensed on 11/20/23 after the facilty called requesting it.

Interview with Resident #3 on 11/21/23 at 5:40pm revealed:
-He did not know the names of his medications.
-He did not know if he was receiving his new medications.
-He had not felt any better since the ED visit on 11/18/23.

Attempted telephone interview with Resident #3's primary care provider (PCP) on 11/21/23 at 4:13pm was unsuccessful.

c. Review of Resident #3's current FL-2 dated 10/10/23 revealed an order for Potassium Chloride ER 10meq one tablet daily on Monday and Friday. (Potassium Chloride is a potassium supplement used to treat low potassium levels.)

Review of Resident #3's November 2023

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D 358	Continued From page 19 medication administration record (MAR) revealed: -There was an entry for Potassium Chloride ER 10meq one tablet two times a week in the morning on Monday and Friday. -Potassium Chloride ER 10meq was documented as administered on 11/01/23, 11/02/23, 11/03/23, 11/04/23, 11/05/23, 11/06/23, and 11/17/23 (Friday) at 8:00am. -There was a line through the dates 11/07/23 through 11/16/23. -There was no documentation on the back of the MAR for the line. -There was no documentation on the MAR on 11/20/23 (Monday) that the medication was administered at 8:00am. -There was no documentation on the back of the MAR for 11/20/23. Observation of Resident #3's medications on hand on 11/21/23 at 2:15pm revealed there were no Potassium Chloride ER 10meq in the medication cart. Interview with the medication aide (MA) on 11/21/23 at 12:55pm revealed: -He had not called the pharmacy to check on why the Potassium Chloride ER 10meq had not been delivered. -The MAR was left blank when a resident was out of the facility, the medication had been reordered, or medication was not available for administration. -He had been trained to document an explanation on the back of the MAR. -He had not ordered the medication because he did not have time. -He had not notified the Administrator or the medical provider that Resident #3 was out of the Potassium Chloride ER 10meq.	D 358		

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Interview with the Administrator on 11/21/23 at 1:15pm revealed:
-She did not know that Resident #3 was out of medications.
-She did not know why the medication was documented as administered every day instead of on Monday and Friday.
-It was not acceptable for a MA to delay ordering medications because they said they did not have time, they worked two weeks on and two weeks off.
-The MAs had been trained on the process of reordering medications before the medications ran out.
-Medications were to be ordered before they ran out to ensure there were medications as ordered in the medication cart.

Interview with Resident #3 on 11/21/23 at 5:40pm revealed:
-He did not know the names of his medications.
-He did not know if any medications had been missed or late.

Telephone interview with the facility's previously contracted pharmacist on 11/21/23 at 4:55pm revealed the Potassium Chloride ER 10meq each Monday and Friday was dispensed on 09/05/23 for a 90-day supply of 24 tablets.

Telephone interview with the facility's currently contracted pharmacist on 11/21/23 at 4:00pm revealed:
-Potassium Chloride 10meq each Monday and Friday was dispensed on 10/12/23 for a one-month supply of 8 tablets.
-An order was requested today, 11/21/23, from the facility for Potassium Chloride 10meq.

Attempted telephone interview with Resident #3's

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primary care provider (PCP) on 11/21/23 at 4:13pm was unsuccessful.

Attempted telephone interviews with a second MA on 11/21/23 at 4:23pm and 5:37pm were unsuccessful.

d. Review of Resident #3's current FL-2 dated 10/10/23 revealed an order for Advair 250-50 Diskus one puff two times daily morning and bedtime. (Advair is used to treat chronic obstructive pulmonary disease.)

Review of Resident #3's November 2023 medication administration record (MAR) revealed:
-There was an entry for Advair Diskus 250-50mcg one puff two times daily at 8:00am and 8:00pm.
-Advair Diskus 250-50mcg was documented as administered on 11/01/23 through 11/06/23 at 8:00am and 8:00pm and on 11/17/23 at 8:00am.
-There was a line through the dates 11/07/23 through 11/16/23 at 8:00am and 11/07/23 through 11/15/23 at 8:00pm.
-There was no documentation on the back of the MAR for the line.
-There was no documentation on the MAR for 11/16/23 through 11/20/23, left blank, and 11/18/23 through 11/20/23, left blank.
-There was no documentation on the back of the MAR for explanation of the blanks.

Observation of Resident #3's medications on hand on 11/21/23 at 2:15pm revealed there was no Advair Diskus 250-50mcg in the medication cart.

Interview with the medication aide (MA) on 11/21/23 at 12:55pm revealed:
-The MAR was left blank when a resident was out of the facility, the medication had been ordered,

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or medication was not available for administration.
-Circled initials on the MAR meant that Resident #3's medication was not available for administration.
-He thought that the medication had already been ordered and did not order it until 11/19/23.
-He had not notified the Administrator or the medical provider that Resident #3 was out of the Advair Diskus 250-50mcg inhaler.

Interview with the Administrator on 11/21/23 at 1:15pm revealed:
-She did not know that Resident #3 was out of medications.
-Resident #3 brought several Advair inhalers with him when he was admitted on 11/01/22 but they did not document the number.
-The MAs had been trained on the process of reordering medications before they ran out.
-Medications were to be ordered before they ran out to ensure there were medications as ordered in the medication cart.

Interview with Resident #3 on 11/21/23 at 5:40pm revealed:
-He had two inhalers that he had to ask for, he described on inhaler as a "round one" (referring to Advair Diskus) the he used once every other day.
-The round inhaler helped him when he used it the last time, which was several days ago.

Telephone interview with the facility's previously contracted pharmacist on 11/21/23 at 4:55pm revealed the Advair Diskus 250-50mcg one puff twice daily was last dispensed on 03/21/23 for a 90-day supply.

Telephone interview with the facility's currently

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contracted pharmacist on 11/21/23 at 4:00pm revealed:
-They had not dispensed Advair Diskus 250-50mcg for Resident #3.
-An order was requested today, 11/21/23, from the facility for Advair Diskus 250-50mcg.

Attempted telephone interview with Resident #3's primary care provider (PCP) on 11/21/23 at 4:13pm was unsuccessful.

e. Review of Resident #3's current FL-2 dated 10/10/23 revealed an order for Mucous Relief DM 30-600mg one tablet twice daily. (Mucous Relief DM is used for cough and congestion.)

Review of Resident #3's November 2023 medication administration record (MAR) revealed:
-There was an entry for Mucous Relief DM 30-600mg one tablet twice daily.
-Mucous Relief DM 30-600mg was documented as administered on11/01/23 through 11/06/23 at 8:00am and 8:00pm, 11/17/23 and 11/18/23 at 8:00am and 11/16/23 through 11/19/23 at 8:00pm with the initials circled on 11/19/23.
-There was a line through the dates 11/07/23 through 11/16/23 at 8:00am and 11/07/23 through 11/15/23 at 8:00pm.
-There was no documentation on the back of the MAR for the line, the blanks, or the circled initials.

Observation of Resident #3's medications on hand on 11/21/23 at 2:15pm revealed there was one Mucous Relief DM 30-600mg tablet in the medication cart.

Interview with the medication aide (MA) on 11/21/23 at 12:55pm revealed:
-The MAR was left blank when a resident was out of the facility, or the medication had been

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ordered.
-He had been trained to document an explanation on the back of the MAR.
-He was not sure why he documented on the MAR on 11/19/23 at 8:00pm and circled his initials instead of at 8:00am on 11/09/23.
-He had checked in the reorder book on 11/19/23 to see if the Mucous Relief DM 30-600mg had been reordered and it had not been ordered.
-He found one Mucous Relief DM tablet in the wrong place on the medication cart on 11/19/23 and had not administered it to Resident #3.
-He did not know why he had not administered the medication when he found it on 11/19/23.
-He had not notified the Administrator or the medical provider that the resident was out of the Mucous Relief 30-600mg.

Interview with the Administrator on 11/21/23 at 1:15pm revealed:
-She did not know that Resident #3 was out of medications.
-The MAs had been trained on the process of reordering medications before the medications ran out.
-Medications were to be ordered before they ran out to ensure there were medications as ordered in the medication cart.
-She did not know why the medication was not given when the MA found it on 11/19/23.

Interview with Resident #3 on 11/21/23 at 5:40pm revealed he continued to have cough and congestion.

Telephone interview with the facility's previously contracted pharmacist on 11/21/23 at 4:55pm revealed the Mucous
Relief DM 30-600mg twice daily had been dispensed on 10/27/23 for a 10-day supply and

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AMERICARE ADULT HOMES # 2	103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(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 358	Continued From page 25 on 10/31/23 for a 10-day supply. Telephone interview with the facility's currently contracted pharmacist on 11/21/23 at 4:00pm revealed: -They had not dispensed any Mucous Relief DM for Resident #3. -An order was requested today, 11/21/23, from the facility for Mucous Relief DM. Attempted interview with Resident #3's primary care provider (PCP) on 11/21/23 at 4:13pm was unsuccessful. f. Review of Resident #3's current FL-2 dated 10/10/23 revealed an order for Ipratropium-Albuterol 0.5ml/3mg inhaled via nebulizer every 6 hours as needed. (Ipratropium-Albuterol nebulizer solution is used to treat and prevent breathing problems.) Review of Resident #3's November 2023 medication administration record (MAR) revealed: -There was an entry for Ipratropium-Albuterol 0.5ml/3mg via nebulizer every 6 hours as needed. -There was no documentation that Ipratropium-Albuterol 0.5ml/3mg via nebulizer had been administered. Observation of Resident #3's medications on hand on 11/21/23 at 2:15pm revealed there was not any Ipratropium-Albuterol 0.5ml/3mg in the medication cart. Interview with the medication aide (MA) on 11/21/23 at 5:45pm revealed: -He did not know where Resident #3's nebulizer was. -He had never used the nebulizer.	D 358		

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D 358	Continued From page 26 Interview with the Administrator on 11/21/23 at 5:57pm revealed: -She did not know Resident #3 was out of the Ipratropium-Albuterol used in his nebulizer. -She did not know where Resident #3's nebulizer was located. -She requested a new one today, 11/21/23. Interview with Resident #3 on 11/21/23 at 5:40pm revealed: -He continued to have cough, congestion, and shortness of breath. -The nebulizer improved his breathing when used. -He could not remember the last time he used the nebulizer. Telephone interview with the facility's previously contracted pharmacist on 11/21/23 at 4:55pm revealed the Ipratropium-Albuterol 0.5ml/3mg was last dispensed on 07/14/23 for a 30-day supply. Telephone interview with the facility's currently contracted pharmacist on 11/21/23 at 4:00pm revealed: -They had not dispensed any Ipratropium-Albuterol 0.5ml/3mg for Resident #3. -An order was requested today, 11/21/23, from the facility for Ipratropium-Albuterol 0.5ml/3mg. Attempted telephone interview with Resident #3 's primary care provider (PCP) on 11/21/23 at 4:13pm was unsuccessful. _____ The facility failed to administer medications as ordered to 3 of 3 residents sampled. Resident #1, who was diagnosed with chronic obstructive pulmonary disease, missed 15 doses of a nebulizer medication used to treat and prevent	D 358		

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D 358	Continued From page 27 symptoms of lung disease due to the medication being unavailable. Resident #1 experienced shortness of breath when the nebulizer medication was not administered. Resident #1 missed 4 doses and was administered 38 doses of the wrong strength of a controlled substance used to treat moderate to severe pain. Resident #1 experienced severe pain in his lower back when he missed the doses of pain medication. Resident #2 did not receive eye drops for pain, inflammation, and infection for cataract surgery as ordered. Resident #3 had a delay in receiving an antibiotic for infection and a medication for inflammation after a hospital visit for an exacerbation of chronic obstructive pulmonary disease (COPD). Resident #3 who had COPD did not receive an inhaler and nebulizer treatments as ordered due to the medications being unavailable. The failure of the facility to administer medications as ordered placed residents at substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/21/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 21, 2023.	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;	D 367		

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D 367	Continued From page 28 (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 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 3 sampled residents (#1) including inaccurate documentation for a controlled substance used to treat moderate to severe pain. The findings are: Review of Resident #1's current FL-2 dated 01/12/23 revealed diagnoses included chronic obstructive pulmonary disease, chronic back pain, type 2 diabetes, hypertension, coronary artery disease, hyperlipidemia, debility, chronic kidney disease, and depression. Review of Resident #1's physician's order dated 07/20/23 revealed an order for Xtampza ER 13.5mg twice a day. (Xtampza ER is a controlled substance used to treat moderate to severe pain.)	D 367		

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D 367	Continued From page 29 Review of Resident #1's order from the orthopedic provider dated 10/06/23 revealed an order to increase Xtampza ER to 18mg twice a day. Review of Resident #1's orthopedic visit notes dated 11/08/23 revealed: -The resident had lumbar spine pain with spinal stenosis, degenerative disc disease, and facet joint arthritis. -There was an order to continue Xtampza ER 18mg twice a day. -Documentation by the Administrator at the bottom of the visit notes indicated the order was faxed to the pharmacy, written on the medication administration record (MAR), and a copy was put in the Resident Care Coordinator's (RCC) book on 11/08/23. Review of Resident #1's electronic prescription from the orthopedic provider dated 11/14/23 revealed: -There was an order for Xtampza ER 18mg take 1 capsule every 12 hours as needed for 30 days. -The prescription was written for a quantity of 60 capsules (30-day supply) with no refills. Review of Resident #1's controlled substance (CS) count sheets for Xtampza ER 13.5mg revealed there were 19 doses of Xtampza ER 13.5mg documented as administered in November 2023 when Xtampza ER 18mg was ordered and should have been administered. Review of Resident #1's November 2023 MAR revealed: -There was a handwritten entry for Xtampza ER 18mg take 1 tablet 2 times daily scheduled at 8:00am and 8:00pm.	D 367		

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D 367	Continued From page 30 -Xtampza ER 18mg was documented as administered on 35 occasions from 11/01/23 - 11/21/23 with 19 of those occasions being when Xtampza ER 13.5mg was documented as administered on the CS count sheet. -There was a computer printed entry for Xtampza ER 13.5mg 1 capsule 2 times a day for pain scheduled at 8:00am and 8:00pm. -The entry for Xtampza ER 13.5mg was marked through with "ordered changed" (no date specified) and none was documented as administered in November 2023. -The MAR did not accurately reflect the strength of Xtampza ER that was actually administered. -The order dated 11/14/23 for Xtampza ER 18mg 1 capsule every 12 hours as needed was not transcribed onto the November 2023 MAR. Observation of Resident #1's medications on hand on 11/21/23 at 12:33pm revealed: -There was a supply of Xtampza ER 18mg capsules dispensed on 11/14/23. -There were 51 of 60 capsules remaining. -There were no Xtampza ER 13.5mg capsules available for administration. Interview with a medication aide (MA) on 11/21/23 at 12:17pm revealed: -Resident #1 had ran out of Xtampza ER 18mg in November 2023. -He could not explain why he documented he administered Xtampza ER 18mg on the MAR when 13.5mg was administered when the 18mg was unavailable. Attempted telephone interviews on 11/21/23 at 4:23pm and 5:37pm with a second MA who documented the administration of Xtampza ER 13.5mg on the MAR instead of 18mg were unsuccessful.	D 367		

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D 367	Continued From page 31 Interviews with the Administrator on 11/21/23 at 1:19pm and 5:45pm revealed: -The MAs were responsible for transcribing new orders and order changes onto the MARs. -The RCC was responsible for checking behind the MAs to ensure order changes and new orders were correct on the MARs. -The RCC position was currently vacant at the facility. -She was responsible for checking behind the MAs in the absence of the RCC. -She was not aware the MAs documented administration of Xtampza ER 18mg on the MAR when they actually administered the wrong strength, Xtampza ER 13.5mg. -Documentation on the MARs should be accurate and reflect the medication actually administered to the resident.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered in accordance with infection control measures by 1 of 1 medication aide observed during the 8:00am medication pass on 11/21/2023, who did not sanitize his hands between the removal of gloves,	D 371		

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D 371	Continued From page 32	D 371		

preparation, administration of medications to each resident to prevent the transmission of disease and infection, to prevent cross-contamination, and provide a safe and sanitary environment for residents.

The findings are:

Review of the facility's undated Personal Protective Equipment (PPE) Policy and Procedures revealed:
-Hand hygiene was the cornerstone of preventing infection transmission.
-Wearing gloves and changing them between patient contact did not replace the need for hand washing.
-Failure to change gloves between patient contact was an infection control hazard.
-You should perform hand hygiene immediately after removing PPE.
-If your hands became visibly contaminated during PPE removal, wash hands before continuing to remove PPE.
-Wash your hands thoroughly with soap and warm water or, if soap and water were not immediately available, use an alcohol-based hand sanitizer until hands could be washed with soap and warm water.

Observation of the medication aide (MA) on 11/21/2023 between 8:05am and 8:50am revealed:
-The MA was ungloved and at the medication cart in the facility hallway.
-There was a bottle of alcohol-based hand sanitizer on the top of the medication cart.
-The MA prepared the medications for a resident by punching the medication from the bubble cards into his ungloved hands and placed the medication in a medication cup.

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D 371	Continued From page 33 -He documented on the paper medication administration record (MAR) using an ink pen before giving the prepared medications. -He used his key to lock the medication cart. -He administered the prepared medications to a resident and returned to the medication cart. -He used his key to unlock the medication cart. -He did not wash his hands with soap and water or use hand sanitizer. -He put a glove on both hands. -He pulled the medication cards for a second resident. -He prepared the medications for the second resident by punching the medications from the bubble cards into a gloved hand and placed the medications into a medication cup. -He removed his gloves, did not sanitize his hands and picked up the bubble cards he dropped on the floor. -He documented on the paper MAR using an ink pen before giving the prepared medications. -He used his key to lock the medication cart. -He spilled the cup of medication on top of the medication cart, picked them up with his bare hands and placed the medication back into the medication cup. -He administered the prepared medications to a resident and returned to the medication cart. -He used his key to lock the medication cart. -He did not wash his hands with soap and water or use hand sanitizer. -He pulled the medication cards for a third resident. -The MA prepared the medications for the third resident by punching the medications from the bubble cards into his hands and placed the medications into a medication cup. -He documented on the paper MAR using an ink pen before giving the prepared medications. -He used his key to lock the medication cart.	D 371		

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D 371	Continued From page 34 -He pulled the medication cards and two small bottles for a fourth resident after unlocking the medication cart with his keys. -He did not wash his hands with soap and water or use hand sanitizer. -The MA prepared the medications for the fourth resident by punching the medications from the bubble cards into his hands and placed the medications into a medication cup. -He documented on the paper MAR using an ink pen before giving the prepared medications. -He gloved his left hand, picked up the medication cup and two small bottles of medication and went to a resident's room. -He provided the resident with the medication in the cup and then held the resident's right eye open with his gloved hand and placed drops from both small bottles of medication. -He returned to the medication cart and locked the medication cart with the gloved hand. -He did not remove the glove from his left hand, wash his hands with soap and water, or sanitize them before leaving the building. Interview with the MA on 11/21/2023 at 10:13am revealed: -He had worked for the facility for three months and trained as a MA when he was hired. -He was trained by the Administrator and another MA. -He knew he was to change gloves and/or wash hands with soap and water or hand sanitizer each time before passing medication to a resident. -He did not know that he needed to dispose of medication because it was dropped on the top of the medication cart. -He had infection control training during the MA course and when the nurse performed his skills check off.	D 371		

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D 371	Continued From page 35 Interview with the Administrator on 11/21/2023 at 12:05pm revealed: -The MA had been trained to wash his hands with soap and water or hand sanitizer before putting on gloves and/or preparing medications. -Medications were to be disposed of and not administered to a resident if they fell on top of the medication cart. -The MAs are supposed to wear a pair of gloves when administering eye drops. -MAs should wash their hands before and after using gloves. -She expected all staff to use proper hand hygiene.	D 371		