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
	HAL026068	A. BUILDING: ______ B. WING ______	R 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA FAYETTEVILLE	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

(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 a follow-up survey on 05/13/25 - 05/14/25.	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: FOLLOW-UP TO UNABATED TYPE A1 VIOLATION Based on these findings, the previously Unabated Type A1 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 residents (#6, #7) observed during the medication pass including medications used to treat or prevent vitamin deficiencies (#6, #7); and for 1 of 5 sampled residents (#2) including a medication used to treat or prevent mineral deficiency and a medication used to treat muscle spasms. The findings are: 1. The medication error rate was 6% as evidenced by 2 errors out of 30 opportunities during the 8:00am/9:00am medication pass on	D 358	DHW or Designee will observe random medication passes two times a week for four weeks and then randomly thereafter. Med pass observation form will be completed. Any issues will be immediately addressed, corrected and reported to the Executive Director. DHW or ED will ensure continued education and med pass observations are conducted as part of the community QA process. DHW or designee will conduct additional training to Medication staff to include discontinuing of medication orders , removing of medications from the med cart at the time of order processing and review of the routes of medication administration. Med cart audits will be completed by the DHW/RCC or designee weekly to ensure all discontinued medications have been removed and only medications currently on MAR are in the medication cart.	7/1/2025

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin Jabor	Area Executive Director	6/23/2025

Reviewed and acknowledged 07/02/25 KC

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05/13/25.

a.. Review of Resident #6's current FL2 dated 10/01/24 revealed diagnoses included gastroesophageal reflux disease, benign prostatic hypertrophy, insomnia, osteoporosis, gastrointestinal perforation, and diverticulosis.

Review of Resident #6's primary care provider's (PCP) order dated 05/09/25 revealed:
-There was an order to discontinue Vitamin B12 (Vitamin B12 is a medication used to treat or prevent vitamin deficiencies).
-There was an order to continue Vitamin B Complex daily (Vitamin B Complex is a medication used to prevent or treat vitamin deficiencies).

Observation of the assisted living (AL) 8:00am/9:00am medication pass on 05/13/25 from 8:46am to 9:16am revealed:
-The medication aide (MA) began preparing Resident #6's medications at 8:47am.
-The MA removed Vitamin B12 1000mcg from the medication cart and punched 1 tablet from a unit dose package into a medication cup.
-The MA prepared 3 additional oral medications for Resident #6, which did not include Vitamin B Complex.
-The MA administered Resident #6's oral medications at 8:52am.

Observation of Resident #6's medications on hand on 05/13/25 at 12:50pm revealed:
-There was a unit dose package of Vitamin B Complex with a quantity of 31 tablets dispensed 04/29/25 with 20 tablets remaining.
-There was a unit dose package of Vitamin B12 1000mcg with a quantity of 31 tablets dispensed 04/29/25 with 23 tablets remaining.

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Review of Resident #6's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin B12 1000mcg 1 tablet daily scheduled for 9:00am, which was discontinued on 05/07/25.
-There was an entry for Vitamin B Complex 1 tablet once daily scheduled for 9:00am.
-Vitamin B Complex was documented as administered daily at 9:00am from 05/01/25 to 05/13/25.

Interview with the MA on 05/13/25 at 12:52pm revealed:
-She administered medications according to the instructions on the eMAR.
-She was unsure why she administered Vitamin B12 during the morning AL medication pass on 05/13/25.
-If she had questions about the residents' medications or eMARs, she usually asked the Health and Wellness Director (HWD).
-The facility did not currently have a HWD.
-There was another nurse currently assisting the facility and she could ask that nurse if she had questions about the residents' medications.

Interview with the Regional Director of Resident Care (RDRC) on 05/14/25 at 3:02pm revealed:
-The facility did not currently have a HWD.
-She was assisting the facility with medications and medication orders until the new HWD started at the facility.
-MAs should follow the eMAR when administering medications to residents.
-MAs should check the medication label to the resident's eMAR 3 times to ensure they were administering the correct medication.
-Resident #6's Vitamin B12 was discontinued,

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and she thought the medication was removed from the cart.
-The MA should have administered Resident #6's Vitamin B Complex instead of the Vitamin B12.

Interview with the Administrator on 05/13/25 at 1:04pm revealed:
-The residents' medications should be administered as ordered by their PCP.
-MAs should administer medications according to the instructions on the residents' eMARs.
-If MAs had questions about medication orders, they should contact the pharmacy or the RDRC.

Interview with a pharmacist at the facility's contracted pharmacy on 05/14/25 at 9:40am revealed:
-The facility staff should follow the instructions on the residents' eMARs and administer the residents' medications according to the eMAR.
-Resident #6 had a current order for Vitamin B Complex one tablet daily.
-Resident #6's Vitamin B12 was discontinued on 05/07/25.
-When a resident's medication was discontinued, the medication should be removed from the medication cart and returned to the pharmacy.

Based on observations, interviews, and record reviews, it was determined that Resident #6 was not interviewable.

Attempted telephone interview with Resident #6's PCP on 05/14/25 at 9:30am was unsuccessful.

b. Review of Resident #7's current FL2 dated 10/01/24 revealed diagnoses included dementia and hypertension.

Review of Resident #7's primary care provider's

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(PCP) orders dated 04/23/25 revealed there was an order for Vitamin B12 + Folic Acid 2500mg take 1 tablet sublingually (under the tongue) once daily (Vitamin B12 + Folic Acid is a medication used to treat or prevent vitamin deficiencies).

Observation of the Special Care Unit (SCU) 9:00am medication pass on 05/13/25 from 9:19am to 9:35am revealed:
-The medication aide (MA) began preparing Resident #7's medications at 9:20am.
-The MA punched 3 oral medications from unit dose packaging into a medication cup, including Vitamin B12 + Folic Acid 2500 mcg.
-The MA approached Resident #7 and handed Resident #7 the medication cup containing 4 tablets.
-The MA did not prompt Resident #7 to place Vitamin B12 + Folic Acid 2500 mcg under her tongue.
-Resident #7 placed all 4 tablets from the cup into her mouth and swallowed the medications with water at 9:23am.

Review of Resident #7's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin B12 + Folic Acid 2500mg take 1 tablet sublingually (under the tongue) once daily scheduled for 9:00am.
-Vitamin B12 + Folic Acid 2500mg was documented as administered daily at 9:00am from 05/01/25 to 05/13/25.

Interview with the MA on 05/13/25 at 12:37pm revealed:
-She started working at the facility in January 2025.
-When she administered medications to residents, she checked the residents' medication

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labels and compared them to the residents' eMARs.
-She followed the instructions on the residents' eMAR when she administered medications to residents.
-She saw the instructions on Resident #7's eMAR to administer Vitamin B12 + Folic Acid 2500 mcg sublingually.
-She was aware that sublingually meant for the medication to be administered under the tongue.
-She did not prompt Resident #7 to put Vitamin B12 + Folic Acid 2500 mcg under her tongue because Resident #7 would not put the medication under her tongue.
-Resident #7 always put the Vitamin B12 + Folic Acid 2500 mcg tablet in her mouth with her other medications and swallowed all the tablets every time she administered Resident #7's medications.
-She had been administering Resident #7's Vitamin B12 + Folic Acid 2500 mcg with her oral medications and not prompting her to take it sublingually since she started working at the facility.
-If she had any questions about the residents' medications or orders, she notified the Special Care Coordinator (SCC).
-She had not notified the SCC that Resident #7 would not take Vitamin B12 + Folic Acid 2500 mcg sublingually as ordered.
-She had not notified Resident #7's PCP that Resident #7 would not take Vitamin B12 + Folic Acid 2500 mcg sublingually as ordered.

Interview with the SCC on 05/13/25 at 12:42pm revealed:
-MAs should administer residents' medications according to the instructions on the residents' eMARs.
-She was not aware Resident #7 was not taking her Vitamin B12 + Folic Acid 2500 mcg

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sublingually.
-None of the MAs had reported any concerns about Resident #7 taking her medications.
-If a medication was ordered sublingually, the MA should instruct the resident to place the medication under the tongue.
-Medications should be administered to the residents as their PCP ordered them.
-If medications were not administered as the PCP ordered the medications, it was an error.
-MAs should report any concerns about the residents' medications to her so she could notify their PCP.

Interview with the Regional Director of Resident Care (RDRC) on 05/14/25 at 3:02pm revealed:
-MAs should follow the instructions on the residents' eMARs when administering medications to residents.
-If a resident had an order for medication to be administered sublingually, the MA should place the medication in a separate medication cup and instruct the resident to place the medication under their tongue.
-If MAs had concerns or issues with medication administration, they should report it to the SCC or Health and Wellness Director (HWD).

Interview with the Administrator on 05/13/25 at 1:04pm revealed:
-MAs should administer medications according to the residents' eMARs.
-The resident's medications should be administered as ordered by the resident's PCP.
-If MAs had questions about medication orders, they should contact the pharmacy, SCC, or the RDRC.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/14/25 at

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9:40am revealed:
- Vitamin B12 + Folic Acid 2500 mcg was a vitamin supplement.
- Vitamin B12 + Folic Acid 2500 mcg was absorbed faster when administered sublingually.
-Resident #7's Vitamin B12 + Folic Acid 2500 mcg should have been administered under the tongue to be most effective.
-The facility staff should follow the instructions on the residents' eMARs when administering medications to residents.

Based on observations, interviews, and record reviews, it was determined that Resident #7 was not interviewable.

Attempted telephone interview with Resident #7's PCP on 05/14/25 at 9:30am was unsuccessful.

2. Review of Resident #2's current FL2 dated 04/24/25 revealed diagnoses included dementia, fibrosis of the lung, gastroesophageal reflux disease, idiopathic osteoarthritis, cardiomyopathy, and presence of prosthetic heart valve.

a. Review of Resident #2's after visit summary from a local hospital dated 04/24/25 revealed:
-Resident #2 was admitted to the hospital from 04/20/25 to 04/24/25.
-There was an order to discontinue Potassium Chloride 10mEq daily.

Review of Resident #2's primary care provider's (PCP) order dated 05/05/25 revealed there was an order to discontinue Potassium Chloride 10mEq as ordered on discharge from hospital-the medication was still on the medication administration record (MAR).

Review of Resident #2's April 2025 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Potassium Chloride 10mEq 1 tablet daily scheduled for 8:00am.
- Potassium Chloride 10mEq was documented as administered at 8:00am from 04/01/25 to 04/19/25.
-Potassium Chloride 10mEq was documented as "-" at 8:00am from 04/20/25 to 04/24/25.
- Potassium Chloride 10mEq was documented as not administered on 04/25/25 at 8:00am with the reason "Resident was still at the hospital" at 2:06pm on 04/25/25.
-The stop date on the first entry for Potassium Chloride 10mEq was 04/25/25 and the entry was discontinued.
-There was a second entry for Potassium Chloride 10mEq 1 tablet daily scheduled for 8:00am.
-Potassium Chloride 10mEq was documented as "-" at 8:00am from 04/20/25 to 04/25/25.
-There was no documentation that Potassium Chloride 10mEq was administered from 04/26/25 to 04/29/25.
- Potassium Chloride 10mEq was documented as administered at 8:00am on 04/30/25.

Review of Resident #2's May 2025 eMAR revealed:
-There was an entry for Potassium Chloride 10mEq 1 tablet daily scheduled for 8:00am.
- Potassium Chloride 10mEq was documented as administered at 8:00am from 05/01/25 to 05/05/25.
-Potassium Chloride 10mEq was discontinued on the eMAR 05/05/25.

Attempted telephone interview with Resident #2's PCP on 05/14/25 at 12:31pm was unsuccessful.

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D 358	Continued From page 9 Refer to interview with Resident #2 on 05/14/25 at 2:28pm. Refer to interview with a medication aide (MA) on 05/14/25 at 10:36am. Refer to interview with the SCC on 05/14/25 at 2:32pm. Refer to interview with the Regional Director of Resident Care on 05/14/25 at 3:02pm. Refer to interview with the Administrator on 05/14/25 at 3:29pm. Refer to telephone interview with a nurse from Resident #7's PCP office on 05/14/25 at 12:22pm. Refer to telephone interview with a pharmacist at the facility's contacted pharmacy on 05/14/25 at 9:40am. b. Review of Resident #2's after visit summary from a local hospital dated 04/24/25 revealed: -Resident #2 was admitted to the hospital from 04/20/25 to 04/24/25. -There was an order to discontinue Baclofen 5mg (Baclofen is a medication used to treat muscle spasms). Review of Resident #2's primary care provider's (PCP) order dated 05/05/25 revealed there was an order to discontinue Baclofen as ordered on discharge from hospital-the medication was still on the medication administration record (MAR). Review of Resident #2's April 2025 electronic medication administration record (eMAR) revealed:	D 358		

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-There was an entry for Baclofen 5mg 1 tablet three times daily scheduled for 9:00am, 1:00pm, and 5:00pm.
- Baclofen 5mg was documented as administered at 9:00am and 1:00pm from 04/01/25 to 04/19/25, and at 5:00pm from 04/01/25 to 04/18/25.
-Baclofen 5mg was documented as "-" at 9:00am and 1:00pm from 04/20/25 to 04/24/25, and at 5:00pm from 04/19/25 to 04/24/25.
-Baclofen 5mg was documented as not administered on 04/25/25 at 9:00am with the reason "Resident was still at the hospital" at 2:06pm on 04/25/25.
-Baclofen 5mg was documented as administered at 1:00pm on 04/25/25.
-The stop date on the first entry for Baclofen 5mg was 04/25/25 and the entry was discontinued.
-There was a second entry for Baclofen 5mg 1 tablet three times daily scheduled for 8:00am, 12:00pm, and 5:00pm.
-Baclofen 5mg was documented as "-" at 8:00am from 04/20/25 to 04/25/25, at 12:00pm from 04/20/25 to 04/24/25, and at 5:00pm from 04/19/25 to 04/24/25.
-There was no documentation that Baclofen 5mg was administered at 8:00am and 12:00pm on 04/26/25 and 04/27/25, and 5:00pm from 04/25/25 to 04/27/25.
-On 04/28/25, Baclofen 5mg scheduled for 8:00am, 12:00pm, and 5:00pm was documented as not administered with the reason "incorrect order start date".
-Baclofen 5mg was documented as administered on 04/29/25 at 8:00am and 12:00pm.
-Baclofen 5mg was documented as medication not available at 5:00pm on 04/29/25.
-Baclofen 5mg was documented as administered at 8:00am, 12:00pm, and 5:00pm on 04/30/25.

Review of Resident #2's May 2025 eMAR

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revealed:
-There was an entry for Baclofen 5mg 1 tablet three times daily scheduled for 8:00am, 12:00pm, and 5:00pm
-Baclofen 5mg was documented as administered at 8:00am and 12:00pm from 05/01/25 to 05/05/25, and at 5:00pm from 05/01/25 to 05/04/25.
-Baclofen 5mg was discontinued on the eMAR 05/05/25.

Attempted telephone interview with Resident #2's PCP on 05/14/25 at 12:31pm was unsuccessful.

Refer to interview with Resident #2 on 05/14/25 at 2:28pm.

Refer to interview with a medication aide (MA) on 05/14/25 at 10:36am.

Refer to interview with the Special Care Coordinator (SCC) on 05/14/25 at 2:32pm.

Refer to interview with the Regional Director of Resident Care (RDRC) on 05/14/25 at 3:02pm.

Refer to interview with the Administrator on 05/14/25 at 3:29pm.

Refer to telephone interview with a nurse from Resident #7's PCP office on 05/14/25 at 12:22pm.

Refer to telephone interview with a pharmacist at the facility's contacted pharmacy on 05/14/25 at 9:40am.

Interview with Resident #2 on 05/14/25 at 2:28pm revealed:
-She was in the hospital in April 2025.

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TERRABELLA FAYETTEVILLE	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

(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
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-She was unsure if she had any medication changes after her hospitalization.
-The facility staff administered her medications each day, but she was unsure of the names of all her medications.

Interview with a medication aide (MA) on 05/14/25 at 10:36am revealed:
-When residents returned from the hospital or primary care provider's (PCP) office with new medication orders, the MAs gave the new orders to the Special Care Coordinator (SCC) or the Administrator.
-The SCC or Administrator was responsible for sending new medication orders to the pharmacy.
-The pharmacy entered the medication orders on the residents' eMARs.
-If there were any questions about medication orders, she contacted the pharmacy or the SCC.
-She was unsure if Resident #2 had any new medication orders when she returned from the hospital in April 2025.

Interview with the SCC on 05/14/25 at 2:32pm revealed:
-She was responsible for sending residents' new medication orders to the pharmacy.
-The pharmacy entered new medication orders on the residents' eMARs.
-She checked the eMAR and order for accuracy either the day she sent the order to the pharmacy or the next morning when she came into work.
-She sent Resident #2's medication orders to the pharmacy when Resident #2 returned from the hospital in April 2025.
-Resident #2's Baclofen 5mg and Potassium Chloride 10mEq were still on the eMAR when she checked the eMAR again.
-She contacted the pharmacy on 04/25/25 and asked them to discontinue Resident #2's

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Baclofen 5mg and Potassium Chloride 10mEq.
-She thought the pharmacy would remove the medications from the eMAR since they had the orders to discontinue the medications.
-She noticed the orders were still on Resident #2's eMAR 3-4 days later, so she called the pharmacy again and asked them to discontinue Resident #4's Baclofen and Potassium Chloride 10mEq.
-She thought the pharmacy would remove the medications from Resident #2's eMAR so she got busy and did not call the pharmacy back.
-She was unsure if the MAs administered Baclofen 5mg and Potassium Chloride 10mEq to Resident #2 after the medications were discontinued on the eMAR.
-If the medications were documented on the eMAR, Resident #2 probably received Baclofen 5mg and Potassium Chloride 10mEq.
-If she had any concerns about the medication orders or eMAR, she contacted the pharmacy or reported the concerns to the Administrator.

Interview with the Regional Director of Resident Care (RDRC) on 05/14/25 at 3:02pm revealed:
-Either she, the SCC, Health and Wellness Director (HWD), or Administrator sent new medication orders to the pharmacy via electronic fax.
-The facility did not currently have a HWD.
-The pharmacy entered all new medication orders on the residents' eMARs.
-The pharmacy placed an alert on the order, so the MAs would be aware that the order was new.
-After the pharmacy entered the new orders into the eMAR system, either she, the SCC, or HWD verified the orders were correct on the eMAR.
-She was unsure why the pharmacy did not remove Resident #2's Baclofen 5mg and Potassium Chloride 10mEq from the eMAR.

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-If the orders were not removed from the eMAR system, the MAs would continue to administer the medications.

Interview with the Administrator on 05/14/25 at 3:29pm revealed:
-The SCC, RDRC, or HWD were responsible for sending new medication orders to the pharmacy.
-The facility did not currently have a HWD.
-The pharmacy entered medication orders into the facility's eMAR system.
-The SCC, RDRC, or HWD were responsible for checking the residents' medication orders after the pharmacy entered the orders to ensure accuracy.
-If the MAs noticed any issues or had questions about orders, they should contact the SCC or RDRC.
-She was unsure why Resident #2's Baclofen 5mg and Potassium Chloride 10mEq orders were not removed from the eMAR if there was an order to discontinue them.
-If the pharmacy did not discontinue the orders, the MAs would administer the medications to Resident #2 because the order was still on eMAR.

Telephone interview with a nurse from Resident #2's PCP office on 05/14/25 at 12:22pm revealed:
-Resident #2 saw the PCP for a follow-up visit on 05/05/25.
-Resident #2's PCP wrote an order to discontinue Baclofen 5mg and Potassium Chloride 10mEq on 05/05/25 because the orders were still on Resident #2's eMAR.
-The PCP office had the after visit summary from the hospital dated 04/24/25 with the orders to discontinue Baclofen 5mg and Potassium Chloride 10mEq.
-She did not see why Resident #2's Baclofen 5mg

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D 358	Continued From page 15 and Potassium Chloride 10mEq were discontinued in the records the office had from Resident #2's hospitalization in April 2025. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/14/25 at 9:40am revealed: -The facility sent all new medication orders to the pharmacy and the pharmacy entered the orders into the facility's eMAR system. -The pharmacy received Resident #2's order to discontinue Baclofen 5mg and Potassium Chloride 10mEq on 04/25/25. -It appeared the orders for Baclofen 5mg and Potassium Chloride 10mEq were reentered on Resident #2's eMAR by mistake. -Another order to discontinue Baclofen 5mg and Potassium Chloride 10mEq was received on 05/05/25 and the orders were discontinued on Resident #2's eMAR. -The pharmacy dispensed 90 tablets of Baclofen 5mg for Resident #2 on 05/01/25 and 03/21/25. -The pharmacy dispensed 31 tablets of Potassium Chloride 10mEq for Resident #2 on 04/29/25, and 30 tablets of Potassium Chloride 10mEq on 03/27/25. -He was unsure why Resident #2's orders for Baclofen 5mg and Potassium Chloride 10mEq were discontinued, so he was unsure if Resident #2 would have any side effects if she continued to receive the medications after the medications were discontinued.	D 358		
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	D 371	DHW or designee will re-educate Med-Techs on infection control measures to include wearing gloves if medications are to be touched.	7/1/2025

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D 371	Continued From page 16 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 and interviews, the facility failed to ensure implementation of infection control measures during the medication pass as evidenced by a medication aide (MA) who handled a resident's oral medication with ungloved hands while preparing medications for administration. The findings are: Observation of the 8:00am/9:00am medication pass on 05/13/25 from 8:46am to 9:35am revealed: -The medication aide (MA) began preparing a resident's medications at 9:02am. -The MA was removing medications from the unit dose package into a medication cup and the resident's Spironolactone 25mg fell from the package and onto the medication cart (Spironolactone is a medication used to treat fluid retention). -The MA picked up the Spironolactone 25mg tablet from the top of the medication cart with ungloved hands and placed the tablet into a plastic medication cup. -The MA continued to prepare the resident's medications. -The MA mixed the resident's medications with applesauce. -The MA entered the resident's room at 9:09am and began administering the resident's medications at 9:10am.	D 371	Education will also include disposal of medications that have been dropped or touched without the use of gloves. DHW/RCC or designee will observe infection control measures during random medication observations two times a week for four weeks then randomly thereafter. Med pass observation form will be completed to include use of proper infection control measures. DHW/RCC or designee will ensure Infection control measures observations are conducted as part of the community QA process.	

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Interview with the MA on 05/13/25 at 12:52pm revealed:
-MAs were supposed to use hand sanitizer before and after administering medications to residents.
-If a resident's medications needed to be handled, she wore gloves because some medications could not be touched.
-The medications should be removed from the unit dose packaging and directly into the medication cup.
-She should not have touched the resident's Spironolactone 25mg tablet during the medication pass this morning.
-She should have discarded the tablet and prepared another tablet from the unit dose package.
-She was unsure why she did not discard the Spironolactone 25mg tablet when it was dropped on the medication cart.

Interview with the Regional Director of Resident Care (RDRC) on 05/14/25 at 3:02pm revealed:
-MAs should wear gloves if they needed to touch a resident's medications.
-The MA should have discarded the tablet dropped on the medication cart during the 8:00am/9:00am medication pass on 05/13/25.
-When the MAs had to discard a tablet, the pharmacy should be notified so the tablet could be replaced.

Interview with the Administrator on 05/13/25 at 1:04pm revealed:
-MAs should not touch medications with ungloved hands when preparing medications for administration.
-The medication should be removed from the unit dose package directly into the medication cup.
-The MA should have discarded the dropped tablet and prepared another tablet for the

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D 371	Continued From page 18 resident. -When a tablet must be discarded, the MA should notify the pharmacy and reorder a replacement tablet. -The MA dropping the medication on the medication cart and handling the medication without gloves were infection control issues. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/13/25 at 2:02pm revealed facility staff should wear gloves if medications were handled.	D 371		