STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092161	A. BUILDING: _____ B. WING _____	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTONWOOD CARY PARKWAY	750 SE CARY PARKWAY CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 9 - 11, 2022.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 5 residents (#6, #7, #8) observed during the medication passes including errors with a medication used to treat and prevent constipation (#6), a medication used to lower the risk of heart attacks and strokes (#8), and a nasal spray used to treat and prevent allergy symptoms (#7). The findings are: The medication error rate was 10% as evidenced by the observation of 3 errors out of 28 opportunities during the 8:00am and 9:00am medication passes on 03/10/22. 1. Review of Resident #8's current FL-2 dated 03/31/21 revealed: -Diagnoses included dementia, abnormal gait, and weight loss.	D 358		

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D 358	Continued From page 1 -There was an order for Enteric Coated Aspirin 81mg, take 1 tablet daily, and do not crush. (Aspirin may prevent unwanted blood clotting and decrease the risk of heart attacks and strokes. Enteric Coated Aspirin has a special coating to prevent stomach irritation and reduce the risk of stomach bleeding. Enteric Coated Aspirin should not be crushed or chewed to maintain the protective coating of the tablet.) -There was an order to crush crushable medications and put in applesauce, pudding or yogurt. Observation of the 9:00am medication pass on 03/10/22 revealed: -The medication aide (MA) prepared morning medications for Resident #8, including one Enteric Coated Aspirin 81mg tablet. -The MA crushed all of Resident #8's oral medications, including the Enteric Coated Aspirin, mixed them in applesauce and administered them to the resident at 9:32am. Observation of Resident #8's medications on hand on 03/10/22 revealed: -There was a supply of Enteric Coated Aspirin 81mg tablets dispensed on 02/27/22. -The medication card label included "DO NOT CRUSH" instructions. Review of Resident #8's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Enteric Coated Aspirin 81mg, take 1 tablet once daily and "DO NOT CRUSH" instructions scheduled for 9:00am. -Enteric Coated Aspirin was documented as administered daily from 03/01/22 to 03/10/22 at 9:00am. -There was an entry to crush crushable	D 358		

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D 358	Continued From page 2	D 358		

medications and put in applesauce, pudding or yogurt.
-Crush crushable medications was documented as completed daily from 03/01/22 to 03/10/22 at the 7:00am to 3:00pm timeframe.

Interview with the MA on 03/10/22 at 1:13pm revealed:
-The facility did not have a Do Not Crush (DNC) list available to use as a guide.
-Resident's medication cards and eMAR entries included DNC instructions.
-Resident #8 was not able to swallow her pills and needed all her pills crushed and usually mixed with applesauce.
-She was aware Resident #8's Aspirin was enteric coated and labeled with DNC instructions.
-She always crushed Resident #8's Enteric Coated Aspirin because there was an order to crush her medications.
-After reviewing the eMAR, Resident #8's Enteric Coated Aspirin should not be crushed because the crush order specified "crushable medications".

Interview with the Wellness Coordinator on 03/10/22 at 1:36pm revealed:
-The facility did not have a list of DNC medications available for the MAs.
-Medication card labels included DNC instructions so the MAs would know what medications should not be crushed.
-Crushable medication instructions meant to crush only medications that could be crushed.
-The MAs were expected to contact the PCP if the resident was unable to swallow a whole pill and the pill was a DNC medication.
-The MA should have requested the PCP to change Resident #8's Enteric Coated Aspirin to a chewable Aspirin.

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D 358	Continued From page 3 Interview with the Associate Executive Director (ED) on 03/10/22 at 1:48pm revealed: -The facility did not have a DNC list for the MAs because the medication cards and eMAR entries were labeled with DNC instructions by the pharmacy. -The MAs were expected to follow the physician's orders when administering crushed medications. -Crushing DNC medications increased the risk of improper absorption of the medication and risked irritation to the resident's stomach. -The MA should have contacted Resident #8's PCP to request the order be changed to a chewable Aspirin. Telephone interview with Resident #8's PCP on 03/11/22 at 12:00pm revealed: -She expected Enteric Coated Aspirin to be administered as ordered and the DNC instructions to be followed. -Resident #8 had not complained of any stomach irritation to her knowledge. Based on observations, interviews and record reviews, it was determined Resident #8 was not interviewable. 2. Review of Resident #7's current FL-2 dated 11/24/21 revealed diagnoses included late onset Alzheimer's disease, dementia, anxiety, hypertension, hypothyroidism, osteoarthritis, neuralgia, and chronic pain. Review of Resident #7's physician's orders dated 12/06/21 revealed an order for Flonase nasal spray 50mcg, instill 2 sprays into each nostril once daily. (Flonase is used to treat allergy symptoms.)	D 358		

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D 358	Continued From page 4 Observation of the 9:00am medication pass on 03/10/22 revealed: -The medication aide (MA) administered Resident #7's Flonase nasal spray at approximately 9:16am. -The MA administered 1 spray into the left nostril and 1 spray into the right nostril instead of 2 sprays into each nostril as ordered. -The MA did not offer or attempt to administer the resident a second spray needed into each nostril. Review of Resident #7's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Flonase nasal spray 50mcg, instill 2 sprays into each nostril once daily. -Flonase nasal spray 50mcg was scheduled for administration once a day at 9:00am. -Flonase nasal spray 50mcg was documented as administered once a day from 03/01/22 to 03/10/22 at 9:00am. Interview with the MA on 03/10/22 at 1:13pm revealed: -After reviewing the eMAR during the interview, the MA acknowledged the resident should have received 2 sprays in both nostrils. -She had not noticed she only administered 1 spray into each nostril during the 9:00am medication pass. -She did not know why she only administered 1 spray into each nostril. -She usually administered 2 sprays into each of Resident #7's nostrils to every morning. Interview with the Wellness Coordinator on 03/10/22 at 1:36pm revealed: -The MAs were trained to read the eMARs and medication labels and follow the instructions.	D 358		

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D 358	Continued From page 5 -The MA should have administered 2 sprays of the Flonase nasal spray into each nostril as ordered. Interview with the Associate Executive Director (ED) on 03/10/22 at 1:48pm revealed: -The MA was expected to follow the physician's orders when administering Resident #7's nasal spray. -Not receiving the full dose of Flonase increased Resident #7's risk for allergy symptoms. Telephone interview with Resident #7's primary care provider (PCP) on 03/11/22 at 12:00pm revealed she expected Flonase to be administered to the resident as ordered. Based on observations, interviews and record reviews, it was determined Resident #7 was not interviewable. 3. Review of Resident #6's current FL-2 dated 12/22/21 revealed diagnoses included dementia, and myasthenia gravis. Review of Resident #6's medication clarification orders dated 01/05/22 revealed an order for Citrucel fiber powder ½ tablespoon in 8 ounces of water for seven days, then 1 tablespoon in 8 ounces of water daily (Citrucel is a soluble fiber powder used to treat and prevent constipation.) Observation of the 8:00am medication pass on 03/10/22 revealed: -Directions for no scoop dosing was printed on the Citrucel canister label. -The directions were to measure a heaping tablespoon (one dose) of the powder and mix with water. -The medication aide (MA) used a white plastic	D 358		

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spoon to scoop the Citrucel powder from the container.
-There was a clear plastic medication cup with 2 tablespoons, 1 tablespoon, 1 teaspoon and ½ teaspoon measurements imprinted on the side.
-The MA poured the powder from the spoon into a plastic medication cup to just above the 1 teaspoon mark.
-The MA removed a small amount of powder from the medication cup so that the amount of powder in the cup was 1 teaspoon.
-The MA mixed the Citrucel powder in the water and gave it to the resident to take with her oral solid medications at 8:33am.
-The resident drank all the water with the Citrucel but a full dosage of 1 tablespoon was not prepared and administered to the resident as ordered.

Review of Resident #6's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Citrucel fiber therapy powder mix 1 tablespoonful in 8oz of water and drink by mouth once daily with a scheduled administration time of 8:00am.
-Citrucel was documented as administered daily from 03/01/22 to 03/10/22 at 8:00am.

Observation of the MA on 03/10/22 at 1:26pm revealed:
-The MA read the eMAR Citrucel order aloud and incorrectly read 1 teaspoon where 1 tablespoon was written in the order instructions.
-The MA demonstrated where she measured the amount of Citrucel powder to be administered to Resident #6 by pointing to the 1 teaspoon mark on the medication cup.

Interview with the MA on 03/10/22 at 1:26pm

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D 358	Continued From page 7 revealed: -Resident #6's Citrucel did not contain a manufacturer's scoop for measuring the powder. -She had measured the Citrucel incorrectly and should have measured the Citrucel to the 1 tablespoon mark on the medication cup. -She had measured the resident's Citrucel to the 1 teaspoon mark since starting at the facility a month ago. -Resident #6 had no complaints of constipation to her knowledge. Interview with the Wellness Coordinator on 03/10/22 at 1:36pm revealed: -The MAs were trained to read the eMARs and medication labels and follow the instructions. -The MA should have measured the Citrucel powder to the 1 tablespoon mark on the plastic medication cup. Interview with the Associate Executive Director (ED) on 03/10/22 at 1:48pm revealed the MAs were expected to accurately measure medication dosages and follow the physician's orders. Telephone interview with Resident #6's primary care provider (PCP) on 03/11/22 at 12:00pm revealed she expected Citrucel to be administered to the resident as ordered. Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.	D 358		