

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL004003 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/06/2025 |
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| NAME OF PROVIDER OR SUPPLIER MEADOWVIEW TERRACE OF WADESBORO | STREET ADDRESS, CITY, STATE, ZIP CODE 123 ANSON HIGH SCHOOL ROAD WADESBORO, NC 28170 |
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| {D 000} | Initial Comments The Adult Care Licensure Section and Anson County Department of Social Services conducted a follow-up survey on March 5-6, 2025. | {D 000} | | |
| {D 367} | <p>10A NCAC 13F .1004(j) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:</p> <ol style="list-style-type: none"> (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and 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). <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were accurate for 1 of 6 sampled residents (#6) related to a medication used to prevent or treat blood clots.</p> | {D 367} | | |

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| Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| {D 367} | <p>Continued From page 1</p> <p>The findings are:</p> <p>Review of Resident #6's current FL2 dated 07/03/24 revealed diagnoses included atrial fibrillation, heart failure, type 2 diabetes mellitus, hyperlipidemia, and hypertension.</p> <p>Review of Resident #6's primary care provider's (PCP) order dated 01/23/25 revealed there was an order for Eliquis 5mg take one tablet two times daily (Eliquis is a medication used to prevent or treat blood clots).</p> <p>Observation of the 8:00am medication pass on 03/06/25 from 7:22am to 8:06am revealed:</p> <ul style="list-style-type: none"> -The medication aide (MA) began preparing Resident #6's medications at 7:41am. -The MA emptied Resident #6's 8:00am medications from a blister pack into a plastic medication cup. -There were 16 tablets and capsules in the cup, including one Eliquis 5mg tablet. -The MA entered Resident #6's room and administered Resident #6's oral medications at 7:46am. <p>Observation of Resident #6's medications on hand 03/06/25 at 9:42am revealed:</p> <ul style="list-style-type: none"> -Resident #6's medications were packaged in multi-dose blister packs. -The blister packs were labeled as morning, evening, and bedtime. -Resident #6's medications were filled by a local pharmacy. -Resident #6 had 3 days of medication blister packs labeled morning and each contained one tablet of Eliquis 5mg. -Resident #6 had 4 days of medication blister packs labeled bedtime and each contained one | {D 367} | | |

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| {D 367} | <p>Continued From page 2</p> <p>tablet of Eliquis 5mg.</p> <p>Review of Resident #6's March 2025 electronic medication administration record (eMAR) revealed there was no entry for Eliquis 5mg one tablet two times daily.</p> <p>Interview with Resident #6 on 03/06/25 at 10:45am revealed:</p> <ul style="list-style-type: none"> -He was admitted to the facility in February 2024. -He had atrial fibrillation (Atrial fibrillation is an irregular heart rhythm). -He had been taking Eliquis for at least 5 years. -He only stopped taking the medication when he had dental work or other procedures. -He last had dental work a few months ago. -The staff administered his medications, and he took Eliquis in the morning and at night. -He ordered his own medications from a local pharmacy. -He had seen a provider at the facility a few times when he was first admitted to the facility. -He now saw a PCP at a medical office in a nearby town. -His current PCP had not discontinued his Eliquis. -He had to take Eliquis and could not go without the medication because of his heart. <p>Interview with the MA on 03/06/25 at 9:45am revealed:</p> <ul style="list-style-type: none"> -When residents saw their PCP and had new medication orders, the Resident Care Coordinator (RCC) sent the medication orders to the facility's contracted pharmacy. -The facility's contracted pharmacy entered the residents' medication orders into the eMAR system. -When she administered medications, she checked the resident's eMAR with the medication label and followed the instructions on the | {D 367} | | |

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| {D 367} | <p>Continued From page 3</p> <p>resident's eMAR.</p> <ul style="list-style-type: none"> -Resident #6 ordered his medications from a local pharmacy and did not use the facility's contracted pharmacy. -She had not noticed that Resident #6's 8:00am blister pack included Eliquis 5mg. -She did not see Eliquis 5mg listed on Resident #6's current medications on the eMAR. -She was unsure why Resident #6's eMAR did not have an Eliquis order listed if the medication was in his blister pack of medications. -She was unsure if Resident #6 was supposed to be taking Eliquis. -She thought Resident #6 took Eliquis at one time, but his PCP stopped the medication because Resident #6 had a tooth extraction. -She was unsure if Resident #6's PCP restarted Resident #6's Eliquis after his tooth extraction. -She administered Eliquis 5mg to Resident #6 because she did not realize the medication was in Resident #6's blister pack of 8:00am medications. -If she had any concerns about medications or the eMAR, she reported the concerns to the RCC. <p>Interview with the RCC on 03/06/25 at 12:34pm revealed:</p> <ul style="list-style-type: none"> -She was responsible for sending new medication orders to the facility's contracted pharmacy. -The facility's contracted pharmacy entered all medication orders into the facility's eMAR system. -She checked the medication orders and approved the orders in the facility's eMAR when the pharmacy entered the medication orders. -She and the MAs completed medication cart audits every 1-2 weeks to ensure residents' medications were available on the medication cart. -Sometimes the medication cart audit consisted of reviewing the residents' eMARs. | {D 367} | | |

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| {D 367} | <p>Continued From page 4</p> <ul style="list-style-type: none"> -She was unsure why Resident #6's Eliquis order was not on his current eMAR. -Resident #6 had been taking Eliquis for a while, so the order should have been on his eMAR. -Resident #6 had switched PCPs and pharmacies since he was admitted, so that may have resulted in the Eliquis order being taken off Resident #6's eMAR. -The MA should review the label on the blister pack and match the label to the resident's eMAR when administering medications. -If the MA did not see Eliquis on Resident #6's eMAR, the MA should not have administered Eliquis to Resident #6. -The MA should have read the label on Resident #6's blister pack and made sure each medication was on Resident #6's eMAR. -If the MA noticed the medication label did not match the eMAR, the MA should report it to her, and she would contact the resident's PCP. -If a medication was discontinued and still in the resident's medication blister pack, the MA should notify her, so they could dispose of the medication and not administer the medication to the resident. <p>Interview with the Administrator on 03/06/25 at 12:51pm revealed:</p> <ul style="list-style-type: none"> -The MAs or RCC sent all medication orders to the facility's contracted pharmacy. -The facility's contracted pharmacy entered medication orders into the eMAR system. -The RCC was responsible for checking the residents' medication orders for accuracy. -When the MAs administered medications, the MA should be checking the label on the blister pack and comparing the label to the resident's eMAR. -All medications administered to residents should have an order and the medication order should | {D 367} | | |

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| {D 367} | <p>Continued From page 5</p> <p>be on the resident's current eMAR.</p> <ul style="list-style-type: none"> -The MA should not have administered Resident #6's Eliquis if the medication was not on Resident #6's eMAR. -The MA should have verified Resident #6's Eliquis order with Resident #6's PCP. -The MA should have read the label on Resident #6's blister pack and made sure each medication on the label was on Resident #6's eMAR. <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/06/25 at 10:11am revealed:</p> <ul style="list-style-type: none"> -The facility faxed medication orders to the pharmacy and the pharmacy entered medication orders into the facility's eMAR system. -The pharmacy had not dispensed Resident #6's Eliquis since April 2024. -The pharmacy had an order to discontinue Resident #6's Eliquis dated 05/01/24. -The facility's staff should be following instructions on the residents' eMARs and administering medications as ordered on the eMAR. -Eliquis was a medication used to prevent blood clots, so it was important for the medication to be given as it was ordered by the residents' PCP. <p>Telephone interview with a pharmacist at Resident #6's contracted pharmacy on 03/06/25 at 10:29am revealed:</p> <ul style="list-style-type: none"> -The pharmacy had been filling prescriptions for Resident #6 since 2017. -The pharmacy did not dispense any medications for Resident #6 in February 2024, March 2024, or April 2024. -The pharmacy started filling prescriptions for Resident #6 again in May 2024 and delivered his medications to the facility. -The pharmacy had orders for Resident #6's Eliquis 5mg one tablet two times daily dated | {D 367} | | |

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| {D 367} | <p>Continued From page 6</p> <p>05/06/24 with 4 refills, 09/25/24 with 3 refills, and 01/23/25 with 3 refills.</p> <p>-The pharmacy had no record of Resident #6's Eliquis being discontinued at any time since the pharmacy resumed dispensing his medications in May 2024.</p> <p>D 371 10A NCAC 13F .1004(n) Medication Administration</p> <p>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.</p> <p>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.</p> <p>The findings are:</p> <p>Observation of the 8:00am medication pass on 03/06/25 from 7:22am to 8:06am revealed:</p> <ul style="list-style-type: none"> -The medication aide (MA) began preparing a resident's medication at 7:28am. -The MA removed a unit dose card of Lorazepam 0.5mg from the controlled substances drawer of the medication cart (Lorazepam is a medication used to treat anxiety or agitation). -The MA punched one Lorazepam 0.5mg tablet | {D 367} | | |

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| D 371 | <p>Continued From page 7</p> <p>from the card into her bare hand, then placed the tablet in a plastic medication cup.</p> <p>-The MA continued preparing the resident's medications and administered the resident's oral medications at 7:35am.</p> <p>Interview with the MA on 03/06/25 at 9:45am revealed:</p> <p>-When preparing medications to be administered, she usually held the cup under the unit dose card and punched the tablet out of the card and into the cup.</p> <p>-She was aware that she should not touch the resident's medications with her bare hands.</p> <p>-This morning, 03/06/25, she punched the resident's Lorazepam 0.5mg out of the card and into her hand and then placed the tablet in the cup.</p> <p>-She was afraid if she attempted to punch the Lorazepam 0.5mg tablet out of the card and into the cup, the medication would not go into the cup and would fall on the floor.</p> <p>-She should have placed the unit dose card over the plastic cup and punched the tablet out of the card and into the medication cup instead of handing the medication with her bare hands.</p> <p>Interview with Resident Care Coordinator (RCC) on 03/06/25 at 12:34pm revealed:</p> <p>-MAs were not supposed to touch the residents' medications when preparing the medications for administration.</p> <p>-MAs were supposed to remove the medications from the unit dose packaging directly into the medication cup and not touch the medication.</p> <p>-The MA should not have touched the resident's medication with bare hands.</p> <p>-There was risk of contamination if the medications were handled with bare hands.</p> | D 371 | | |

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| D 371 | <p>Continued From page 8</p> <p>Interview with the Administrator on 03/06/25 at 12:51pm revealed:</p> <ul style="list-style-type: none"> -MAs should not handle residents' medications with their bare hands when medications were prepared for administration. -The medication should be removed from the unit dose card and placed directly into the cup. -The MA should not have touched the medication with her bare hands. <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/06/25 at 10:11am revealed:</p> <ul style="list-style-type: none"> -The facility's staff should not handle any medications without gloves. -The medications should be removed from the unit dose packaging directly into the cup. -The facility staff should not handle medications with ungloved hands due to the risk of spreading germs or contaminating the medication. | D 371 | | |