| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL001134 | A. BUILDING: _____ B. WING _____ | 06/25/2015 |

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| THE OAKS OF ALAMANCE | 1670 WESTBROOK AVENUE BURLINGTON, NC 27215 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on June 23-25, 2015. | D 000 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 5 residents (#3) sampled for review related to errors with medications for hypertension, symptoms of urinary tract infections, nasal allergies, low vitamin D levels, cough and congestion. The findings are:<br><br>Review of Resident #3's current FL-2 dated 05/12/15 revealed diagnoses included dementia, diabetes mellitus type II, hypothyroidism, coronary artery disease, prostate cancer, congestive heart failure, hypertension, and peripheral vascular disease.<br><br>A. Review of Resident #3's current FL-2 dated 05/12/15 revealed:<br>- Order for Metoprolol 25mg take ½ tablet every 12 hours. (Metoprolol is for heart/blood | D 358 | | |

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pressure.)
- Order for Vitamin D 1000 units take 2 tablets once daily. (Vitamin D is a supplement for low Vitamin D levels.)

Review of physician's order sheet verified and signed by the Veteran's Administration Nurse Practitioner (VA NP) dated 05/12/15 revealed:
- NP verified the Metoprolol was decreased from 25mg 1 tablet twice a day to 25mg ½ tablet twice a day.
- NP verified the Vitamin D was increased from 1 tablet daily to 2 tablets daily.

Review of the May 2015 medication administration records (MARs) revealed:
- Metoprolol 25mg ½ tablet was documented as ordered from 05/13/15 - 05/31/15.
- A handwritten entry for Vitamin D 1000 units 2 tablets twice daily instead of once daily as ordered.
- Vitamin D 1000 units 2 tablets twice daily at 8:00 a.m. and 8:00 p.m. was documented as administered from 05/13/15 - 05/31/15.

Review of the June 2015 MARs revealed:
- Computer printed entry for Metoprolol 25mg 1 tablet twice daily.
- Metoprolol 25mg 1 tablet was documented twice a day at 10:00 a.m. and 8:00 p.m. from 06/01/15 - 06/24/15 instead of ½ tablet as ordered.
- Computer printed entry for Vitamin D 1000 units 1 tablet once daily.
- Vitamin D 1000 units 1 tablet daily at 10:00 a.m. was documented as administered from 05/13/15 - 05/31/15 instead of 2 tablets daily as ordered.

Review of medications on hand for Resident #3

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| D 358 | Continued From page 2<br>on 06/24/15 revealed:<br>- One supply of Metoprolol 25mg tablets with directions to take 1 tablet every 12 hours.<br>- One supply of Vitamin D 1000 units tablets with directions to take 2 tablets once daily.<br><br>Interview with a medication aide on 06/24/15 at 4:20 p.m. revealed:<br>- She gave one whole Metoprolol 25mg tablet as indicated on the directions on the current MAR.<br>- She gave 1 Vitamin D 1000 unit tablet as indicated on the directions on the current MAR.<br>- She had not noticed the directions on the Vitamin D label did not match the instructions on the MAR.<br>- The VA NP comes to the facility to see Resident #3 and the NP faxes orders to the VA pharmacy.<br>- The medication aide on duty was supposed fax a copy of the orders to the facility's primary pharmacy so they can add any new orders or order changes to the next month's MARs.<br><br>Review of the April 2015 - June 2015 MARs revealed:<br>- Blood pressure ranged from 110/76 - 142/80 in April 2015.<br>- Blood pressure ranged from 111/76 - 135/69 in May 2015.<br>- One blood pressure recorded on 06/17/15 was 132/96.<br><br>Review of Resident #3's record revealed no Vitamin D levels noted in the record.<br><br>Interview with a pharmacist at the primary pharmacy on 06/25/15 at 4:40 p.m. revealed:<br>- Resident #3 did not get any medications from them but they provided MARs based on orders received from the facility. | D 358 | | |

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| D 358 | Continued From page 3<br>- The pharmacy did not receive the order dated 05/12/15 with changes in the directions for the Metoprolol and the Vitamin D.<br><br>Interview with Resident #3's family member on 06/25/15 at 3:45 p.m. revealed:<br>- The resident's medications were filled at a local VA pharmacy.<br>- The facility usually reorders the resident's medications and the medications are mailed to the facility from the VA pharmacy.<br>- The most current list of medications she had from the VA listed Metoprolol 25mg ½ tablet twice daily.<br>- The Vitamin D order was for 1000 units 2 tablets once daily.<br><br>Interview with the Administrator on 06/25/15 at 3:45 p.m. revealed:<br>- Medication aides on duty were responsible for making sure the MARs and medication labels matched.<br>- If something did not match, there were supposed to stop and clarify the orders.<br>- She was currently trying to contact the VA NP regarding Resident #3's medications.<br><br>Attempts to contact the VA NP during the survey were unsuccessful.<br><br>Based on observation, interview, and record review, Resident #3 was not interviewable due to diagnoses of dementia.<br><br>B. Review of a physician's visit form for Resident #3 dated 05/15/15 revealed:<br>- The Veteran's Administration Nurse Practitioner (VA NP) saw the resident at the facility on Friday, 05/15/15.<br>- The VA NP wrote an order for Guaifenesin | D 358 | | |

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400mg 3 times a day for 14 days. (Guaifenesin is for cough and congestion.)
- The VA NP wrote an order for Chromolyn Nasal Spray, 1 spray in each nostril 3 times a day. (Chromolyn Nasal Spray is used to treat symptoms of nasal allergies.)

Review of the May 2015 medication administration record (MAR) revealed:
- Handwritten entry dated 05/17/15 for Guaifenesin 400mg 3 times a day for 14 days.
- The first dose of Guaifenesin was not documented as administered until Wednesday morning, 05/20/15.
- A note on the back of the MAR indicated the Guaifenesin came in on 05/20/15.
- Handwritten entry for Chromolyn Nasal Spray 1 spray in each nostril 3 times a day at 10:00 a.m., 2:00 p.m., and 6:00 p.m.
- Chromolyn was documented as being "ordered" from 05/15/15 - 05/18/15 and the first dose was administered on 05/19/15.

Review of medications on hand on 06/24/15 revealed:
- Two supplies of Guaifenesin were available.
- One supply was dispensed on 11/03/15 for "prn" (as needed) administration.
- One supply was dispensed on 05/19/15 for the order to give 3 times a day for 14 days.
- One bottle of Chromolyn Nasal Spray dispensed on 05/15/15.

Interview with a medication aide on 06/24/15 at 4:00 p.m. revealed:
- Medication aide on duty at the time an order was received was responsible for ordering and implementing new orders.
- If they were unable to get Resident #3's medications from the VA pharmacy, they were

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supposed to use the back-up pharmacy.
- She was unsure why there was a delay in getting Resident #3's medications that were ordered on 05/15/15.
- There may have been a delay because of the weekend.
- She was unsure why the Chromolyn Nasal Spray was not administered since it was dispensed on 05/15/15.

Interview with Resident #3's family member on 06/25/15 at 3:45 p.m. revealed:
- The resident's medications were filled at a local VA pharmacy.
- The facility usually reorders the resident's medications and the medications are mailed to the facility from the VA pharmacy.
- The VA NP came to the facility one Friday in May 2015 and discontinued some orders and wrote some new orders.
- The VA NP faxes the orders to the VA pharmacy and the medications were supposed to be sent via overnight mail.
- The resident was having problems with cough and congestion.
- There was a delay in starting the medications and she was told by staff it was because they did not have a blank MAR to write the orders on.
- The facility nurse who worked at the facility when the orders were received no longer works at the facility.

Interview with the Administrator on 06/25/15 at 3:45 p.m. revealed:
- She was aware there had been some problems with Resident #3's medications in May 2015.
- There had been some staff turnover during that time and the facility had recently hired a new nurse and they are working on medication

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systems.
- Resident #3's medications are ordered through the VA pharmacy but staff were supposed to use the back-up pharmacy if they were unable to get the medications from the VA.
- She was currently trying to contact the VA NP regarding Resident #3's current medications.

Based on observation, interview, and record review, Resident #3 was not interviewable due to diagnoses of dementia.

Attempts to contact the VA NP during the survey were unsuccessful.

C. Review of a physician's visit form for Resident #3 dated 05/15/15 revealed:
- The Veteran's Administration Nurse Practitioner (VA NP) saw the resident at the facility on Friday, 05/15/15.
- The VA NP wrote an order for AZO take 2 tablets every morning. (AZO is used to relieve symptoms of urinary tract infections such as pain, irritation, discomfort, and urgency. The active ingredient in AZO that exerts this effect is phenazopyridine.)

Review of the May 2015 medication administration record (MAR) revealed:
- The order for AZO dated 05/15/15 was not transcribed onto the MAR.
- There was no documentation any AZO was administered as ordered from 05/15/15 - 05/31/15.

Review of the June 2015 MARs revealed entry for AZO take 2 tablets every morning was documented as administered at 10:00 a.m. from 06/01/15 - 06/24/15.

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| D 358 | Continued From page 7<br><br>Review of medications on hand on 06/24/15 revealed:<br>- There was no AZO on hand.<br>- There was a box of AZO Cranberry on hand. (AZO Cranberry is a natural product that contains cranberry powder and other supplements but does not contain phenazopyridine, the active ingredient in AZO. AZO and AZO Cranberry are not the same product.)<br><br>Interview with a medication aide on 06/24/15 at 4:00 p.m. revealed:<br>- Resident #3's medications either come from the VA pharmacy or the family brings in the medications.<br>- The AZO Cranberry in the cart would have been brought in by the family since there was no label by the VA pharmacy.<br>- She had not noticed the box was labeled as AZO Cranberry instead of plain AZO.<br>- She thought the resident had some plain AZO at one time but she was not sure.<br><br>Interview with Resident #3's family member on 06/25/15 at 3:45 p.m. revealed:<br>- The resident's medications were filled at a local VA hospital.<br>- The facility usually reorders the resident's medications and the medications are mailed to the facility from the VA pharmacy.<br>- She brought in the AZO Cranberry tablets for Resident #3 since it was over-the-counter.<br>- She did not realize AZO Cranberry did not have the same active ingredient as AZO.<br>- The resident has a suprapubic catheter that is changed by a local home health agency.<br>- The resident has a history of chronic urinary tract infections.<br>- The resident was currently being treated with an antibiotic for a urinary tract infection. | D 358 | | |

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| D 358 | Continued From page 8<br>- She thought the resident's symptoms were getting better since he had started the antibiotics.<br><br>Interview with the Administrator on 06/25/15 at 3:45 p.m. revealed:<br>- She was unaware the medication brought by Resident #3's family did not match the orders on file.<br>- There was no current system to track and document medications brought by families to make sure the correct medications were brought.<br>- She was currently trying to contact the VA NP regarding Resident #3's current medications.<br><br>Based on observation, interview, and record review, Resident #3 was not interviewable due to diagnoses of dementia | D 358 | | |