STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 000	Initial Comments The Adult Care Licensure Section and the Forsyth County Department of Social Services conducted an annual survey on 09/02/15 and 09/03/15.	D 000		
D 281	10A NCAC 13F .0903 (d) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (d) The facility shall assure action is taken in response to the licensed health professional review and documented, and that the physician or appropriate health professional is informed of the recommendations when necessary. This Rule is not met as evidenced by: Based on record review and interview the facility failed to assure action was taken in response to the licensed health professional support (LHPS) reviews and recommendations for physical therapy evaluation for 1 of 5 sampled residents (Resident #1). The findings are: Record review revealed Resident #1 was admitted to the facility on 6/20/15. Review of Resident #1's current FL2 dated 7/23/15 revealed diagnoses that included chronic kidney disease, edema, hypertension, shortness of breath, chronic gouty arthropathy and anemia. Review of Resident #1's previous FL2 dated 5/23/15 revealed additional information: -She needed assistance in bathing.	D 281		

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D 281	Continued From page 1 -She was semi-ambulatory with a handwritten entry for walker. -She was incontinent of bladder with a handwritten entry for "wears undergarment". Review of Resident #1's LHPS review completed on 8/12/15 revealed a recommendation to request a physical therapy evaluation, gait transfers and safety due to a recent fall. Review of Resident #1's record revealed: -There was no documentation that physical therapy (PT) had been contacted. -There was no physician order for PT. -There was documentation of Resident #1 having 2 unwitnessed falls on 7/02/15 and 8/31/15 as follows: 1. Resident #1 had an unwitnessed fall in the bathroom on 7/02/15. The resident denied hitting her head and refused to be sent to the hospital. -Resident #1's physician ordered the facility to continue to monitor and advise of changes (dated 7/06/15). 2. Resident #1 was found on the bathroom floor calling for help on 8/31/15 at 5:55 pm. She had a "large bump on the left side of head but is lying on her right side". -911 was contacted and transported Resident #1 to the hospital. Interview with the LHPS nurse on site on 9/2/15 at 3:00 pm revealed: -She was not the nurse who completed the current LHPS dated 8/12/15. -She had worked for the company "for a while" but had only worked at this facility for a few weeks. -She reviewed the residents' records, assessed the residents, and made recommendations that were entered on the LHPS form.	D 281		

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-She put the completed LHPS sheets in the Resident's record for the Resident Care Director (RCD) and facility to follow-up on.

Interviews 9/02/15 at 3:10 pm with the RCD revealed:
-Resident #1 had been hospitalized for observation and complaints of back pains since 8/31/15.
-The RCD reviewed the LHPS recommendations and forwarded them to the physician for orders to follow-up, but could not recall if she had sent the current recommendations to the physician .
-She thought PT had been contacted and would call them to verify.

An interview on 9/03/2015 at 12:20 pm with Resident #1's primary care physician office representative revealed:
-No record of the current LHPS recommendation form on file.

A second interview with the RCD on 9/03/15 at 12:40 pm revealed:
-PT had never been contacted to arrange therapy for Resident #1.
-A contracted PT company came to the facility to perform ordered therapy treatments.

Telephone interview on 9/03/15 at 12:10 pm with Resident #1's family member revealed:
-He was aware of Resident #1's fall on 7/02/15.
-Resident #1 had been in the hospital since 8/31/15 for observation after a fall.
-He was not aware that the LHPS review recommended a PT evaluation.
-PT was not discussed with him since Resident #1's admission to the facility.
-He stated that the hospital physician was recommending PT after discharge from the

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D 281	Continued From page 3 hospital at either the facility or at a rehab facility. Resident #1 was not available for interview on 9/02/15 or 9/03/15.	D 281		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have a therapeutic diet menu for 2 of 2 residents (Residents #7 and #9) with physician ordered diets (Chopped Meats and Ground Meat). The findings are: Review of facility's therapeutic menus during initial tour on 09/02/15 at 10:15 am revealed: -There were diets listed for Regular/Chopped Meats and Regular/Puree Meat. -There were no therapeutic menus for any of the physician ordered therapeutic diets. A. Review of Resident #7's current FL2 dated 07/21/15 revealed: -Diagnoses included Muscle Weakness, Moderate to Severe Arthritis and Osteoarthritis. -An order for a Chopped Meats diet . Review of the regular diet menu posted for lunch	D 296		

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D 296	Continued From page 4 on 09/02/15 revealed: -Garlic Pepper Pork Loin -Baked Sweet Potato Half -Cauliflower -Whole Wheat Roll -Margarine -Chocolate Chip Cookie Observation on 09/02/15 from 12:05 pm to 12:45 pm of the lunch meal revealed Resident #7 did not eat in the dining room. Interview with a Personal Care Aide (PCA) on 09/02/15 at 12:30 pm revealed: -Resident #7 did not come to the dining room very often -Resident #7 had refused to come to the dining room on 09/02/15 for the lunch meal. -Resident #7 would sometimes decide to eat her lunch in her room around 2:00 pm. Interview with Resident #7 on 09/02/15 at 2:15 pm revealed: -The staff brought her a pork tenderloin sandwich. -Stated "I only ate a couple of bites because I don't like pork." It could not be determined if the meal was appropriate for a chopped meats diet because there was not chopped meats menus available for staff guidance. Interview with the Dietary Aide on 09/02/15 at 2:35 pm revealed: -The PCA had taken Resident #7 a meal tray but she was not aware what was served on it. Refer to Dietary Manager interview on 09/02/15 at 10:55 am.	D 296		

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D 296	Continued From page 5 B. Review of Resident #9's current FL2 dated 07/21/15 revealed: -Diagnoses included Mental Retardation, Chronic Paranoid Schizophrenia Disorder and Hydrocephalus with shunt. Review of Resident #9's subsequent physician orders revealed: -A signed order on 08/20/15 for a ground meats diet. Review of the regular diet menu posted for lunch on 09/02/15 revealed: -Garlic Pepper Pork Loin -Baked Sweet Potato Half -Cauliflower -Whole Wheat Roll -Margarine -Chocolate Chip Cookie Observation on 09/02/15 from 12:05 pm to 12:45 pm of the lunch meal revealed Resident #9 did not eat lunch due to not feeling well. Review of the regular diet menu posted for dinner on 09/02/15 revealed: -Veal Piccata -Tricolor Spiral Pasta -Zucchini Onion Saute -Whole Wheat Bread -Margarine -Fruit Cup Observation on 09/02/15 from 5:05 pm to 5:40 pm of the dinner meal revealed Resident #9 was served the following: -Salisbury Steak cut into 1"x 1/2" pieces -Pasta Noodles -Wheat Roll	D 296		

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D 296	Continued From page 6 Observation of the dinner meal on 09/02/15 from 5:05 pm to 5:40 pm revealed Resident #9 consumed 100% of the meal without any difficulties. It could not be determined if the meal was appropriate for a ground meat diet because there were no ground meat therapeutic diet menus available for staff guidance. Refer to Dietary Manager interview on 09/02/15 at 10:55 am. Interview with Dietary Manager interview on 09/02/15 at 10:55 am revealed the following: -Had been in his role for 2 1/2 months. -The only menu used in the kitchen was the "week at a glance". -He was not aware of a therapeutic diet menu signed by a Registered Dietitian. -He had only talked to the corporate Registered Dietitian once over the phone.	D 296		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, record review and interview of staff, the facility failed to maintain an accurate and current listing of residents with physician ordered therapeutic diets for 3 of 3	D 309		

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sampled residents prescribed a therapeutic diet for guidance of food service staff (Residents #2, #9 and #10) for a Mechanical Soft, Ground Meats and Regular diet.

The findings are:

A. Review of Resident #2's current FL2 dated 8/20/15 revealed:
-Diagnoses including Dementia and hypertension.
-A diet order for mechanical soft.

Review of the facility therapeutic diet listing revealed that Resident #2 was not on the list.

Interview with Dietary Manager on 09/03/15 at 1:50 pm revealed:
-Resident #2's diet order of a mechanical soft diet was not told to the dietary staff.
-Dietary staff was not aware of Resident #2's therapeutic diet.
-The Resident Care Coordinator was responsible for making dietary aware of new diet orders.

Refer to interview with Dietary Manager on 09/03/15 at 1:50 pm.

Refer to interview with the RCC on 09/03/15 at 2:10 pm.

Observation of the lunch meal on 09/02/15 from 12:10 pm - 12:45 pm revealed Resident #2 was served a shredded pork loin, baked sweet potato, greenbeans and a wheat roll.

Observation of the lunch meal on 09/02/15 from 12:10 pm - 12:45 pm revealed Resident #2 consumed 100% of the meal without any difficulty.

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D 309	Continued From page 8 Observation of the lunch meal on 09/02/15 from 12:10 pm - 12:45 pm revealed it could not be determined if Resident #2 was served the correct diet due to no therapeutic menu available for mechanical soft diet. B. Review of Resident #9's current FL2 dated 07/21/15 revealed: -Diagnoses included Mental Retardation, Chronic Paranoid Schizophrenia Disorder and Hydrocephalus with shunt. Review of Resident #9's subsequent physician orders revealed: -A signed order dated 08/20/15 for a ground meats diet. Review of the facility therapeutic diet listing revealed that Resident #9 was to have a puree meats diet. Observation of the lunch meal on 09/02/15 from 12:10 pm - 12:45 pm revealed it could not be determined if Resident #9 was served the correct diet due to no therapeutic menu available for ground meats diet. Observation on 09/02/15 from 5:05 pm to 5:40 pm of the dinner meal revealed Resident #9 was served the following: -Salisbury Steak cut into 1"x 1/2" pieces -Pasta Noodles -Wheat Roll Observation on 09/02/15 from 5:05 pm to 5:40 pm of the dinner meal revealed Resident #9 consumed 75% of the meal without any difficulty. Refer to interview with Dietary Manager on 09/03/15 at 1:50 pm.	D 309		

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D 309	Continued From page 9 Refer to interview with the RCC on 09/03/15 at 2:10 pm. C. Review of Resident #10's current FL2 dated 6/18/15 revealed: -Diagnoses included Pneumonia, Organism, Vascular Dementia, Atrial Fibrillation. -A physician's order for a chopped meat diet. Review of Resident #10's subsequent physician orders revealed: -A signed order dated 07/16/15 for a regular diet. Review of the facility therapeutic diet listing revealed that Resident #10 was to have a chopped meats diet. Observation of the lunch meal on 09/02/15 from 12:10 pm - 12:45 pm revealed Resident #10 was served the correct physician ordered diet. Refer to interview with Dietary Manager on 09/03/15 at 1:50 pm. Refer to interview with the RCC on 09/03/15 at 2:10 pm. Interview with Dietary Manager on 09/03/15 at 1:50 pm revealed: -There are weekly meetings between the Dietary Manager and the Resident Care Coordinator to discuss changes in diet. -The last meeting was thought to be the week of 08/24/15. -It was the responsibility of the RCC to provide updated diet orders to the dietary department. Interview with the RCC on 09/03/15 at 2:10 pm revealed:	D 309		

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D 309	Continued From page 10 -It was the RCC responsibility to update the dietary department of new diet orders. -The department mangers meet monthly and discuss the diet order changes. -Stated she can not recall the last meeting, "it's been awhile".	D 309		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure medication orders were clarified for 1 of 6 residents sampled, who was prescribed lisinopril. (Resident #12). The findings are: 1. Review of Resident #12's current FL2 dated 8/20/15 revealed: -Diagnoses including Dementia and hypertension. -An order for lisinopril 10 mg daily [used to lower blood pressure (BP)]. -An order for BP checks every 2 weeks.	D 344		

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Review of Resident #12's previous FL2 dated 2/17/15 revealed lisinopril 10 mg daily was ordered.

Review of Resident #12's Resident Register revealed an admission date for 6/15/11.

Observation of the medication pass on 9/03/15 at 8:55 am by a Medication Aide (MA) on the 200 hall medication cart revealed:
-The contract pharmacy pre-packaged the resident's medications in bingo cards with one pill in each punch out bubble.
-The MA used the electronic Medication Administration Record (eMAR) to compare medications to the pre-packaged card and the eMAR prior to administering the medication.
-The MA administered one lisinopril 20mg medication and one nasal spray medication to Resident #12.
-The MA immediately documented administration of the 8:00 am medications on the September 2015 eMAR.

Review of Resident #12's signed physician's order dated 7/16/15 revealed an order for lisinopril 10 mg daily.

Review of physician orders from a physician office visit dated 7/17/15 revealed an order to "increase lisinopril to 20 mg daily".

Review of Resident #12's September 2015 eMAR revealed:
-An entry for lisinopril 20 mg daily scheduled for administration at 8:00 am.
-Documentation as administered by staff on 9/03/15 at 8:00 am.

Review of Resident #12's record revealed no

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documentation that the Resident's physician was contacted to clarify the lisinopril 10 mg and lisinopril 20 mg orders.
Resident #12's BP was checked, per request of the surveyor, by a MA on 9/03/15 at 1:25 pm with a reading of 143/91.

Interview on 9/02/15 at 10:00 am with the RCD revealed:
-The new owners of the facility required all residents to have new FL2's written and signed by the physician. These were faxed to the facility pharmacy.
-The RCD or Supervisor which is the MA on the first hall cart, checked the orders and entered changes in the eMAR system.
-"The new FL2's were generated by the RCD, the Supervisor and the regional representative from the new facility owner, from MAR review, records and orders."

Observation on 9/03/15 at 8:55 am with a MA revealed:
-The facility used an eMAR screen to administer medications.
-She used the medications displayed as a reference to administer medications to Resident #12.
-The eMAR showed Resident #12 was on lisinopril 20 mg.

Interview on 9/03/15 at 8:55 am with a MA revealed:
-The facility used an eMAR screen to administer medications.
-She used the medications displayed as a reference to administer medications to Resident #12.
-The resident had been on lisinopril 10 mg a few months ago, but she thought the change came

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D 344	Continued From page 13 after a physician's visit a few weeks ago. Interview on 9/03/15 at 10:00 am with Resident #12's primary physician's office representative revealed: -The most recent office visit was 7/17/15 and lisinopril was increased to 20 mg daily. -A new order for lisinopril 20 mg daily would be faxed to the facility. -Based on record review and observation of Resident #12 on 9/03/15, it was determined Resident #12 was not interviewable. Interview on 9/03/15 at 12:50 pm with the facility Administrator (with the RCD present) revealed: -The facility recently went through a change in ownership, and in preparing for the change, FL2's were re-written starting in June 2015 on all residents. -"The target date was 6/28/15 but the take-over dates kept changing" which caused confusion in what system to use for MARs and pharmacies. -The FL2's were faxed to the facility's contract pharmacy after being signed by physician. -Any subsequent orders were also faxed to the facility's contract pharmacy by the Medication Aide receiving the order. -The change in ownership occurred 7/9/15. -The facility has "been on 4 different systems for MARs, and two for pharmacies". -"With the changes, if a MA noticed anything wrong in the medication entry, they were to call the eMAR company system to enter the corrections in the system as the facility had no administrative rights to make the changes". -Each eMAR company had their own system for handling orders. -The eMAR system was frequently down in July 2015 during one change and the eMAR	D 344		

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D 344	Continued From page 14 "company told us they could not access any data, that there were cross-over issues in the system". -The facility used paper MARs for the first part of August since the system kept going down. -The current eMAR system has been in effect since 8/20/15. -The contract pharmacy covering the facility changed 9/01/15. Based on observation, record review and interviews the facility failed to contact Resident #12's physician for clarification for orders written on 7/17/15 and 8/20/15 for lisinopril.	D 344		
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 B VIOLATION Based on observation, interview, and record review, the facility failed to assure administration of medications were in accordance with physician's orders for 1 of 6 residents (Resident #3) observed during the medication pass on 9/02/15, and 2 of 5 sampled residents (Resident #1 and #3). The findings are:	D 358		

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D 358	Continued From page 15 A. Review of Resident #1's current FL-2 dated 7/23/15 revealed: -Diagnoses including chronic kidney disease, edema, hypertension, and shortness of breath. -An order for Lasix 80mg daily (a diuretic to reduce blood pressure and water retention). Review of Resident #1's previous FL-2 dated 5/23/15 revealed an order for Lasix 80mg. Review of Resident #1's record revealed no subsequent physician's order since 7/23/15 regarding changes to Lasix order. Review Resident #1's Resident Register revealed an admission date of 6/20/15. Review of Resident #1's July 2015 electronic medication administration record (eMAR) revealed: -An entry for Lasix 80 mg daily scheduled for administration at 8:00 am daily. -Documentation by staff that Lasix 80 mg was administered at 8:00 am daily on 7/01, 7/3 to 7/06, 7/08, 7/09, 7/11 and 7/13. -Lasix 80 mg was not documented as administered on 7/2, 7/7, 7/10, 7/12, 7/14, 7/15, and from 7/18 to 7/31. Interview on 9/02/15 at 10:00 am with the Resident Care Director (RCD) revealed: -The facility used a combination of eMARs and paper MARs to document medication administration in due to a transition from one contract pharmacy to another contract pharmacy experienced during the change to a new facility owner. -During this transition, the eMAR system had experienced multiple malfunctions.	D 358		

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D 358	Continued From page 16 -The facility used paper MARs to supplement the eMAR for documentation of Resident #1's Lasix. Review of Resident #1's August 2015 paper MAR for the dates from 8/1/15 to 8/19/15 revealed: -An entry for Furosemide (Lasix) 80 mg daily. -Documentation that Lasix 80 mg was administered daily from 8/1/15 to 8/14/15. -A handwritten notation of "discontinued 8/14/15". -A handwritten entry for Lasix 80 mg "take one tablet by mouth daily prn (as needed) pedal edema" dated 8/14/15. -No documentation on the Lasix 80 mg "prn" as being administered. Review of Resident #1's August 2015 eMAR for the dates from 8/20/15 to 8/31/15 revealed: -An entry for furosemide (Lasix) 80 mg daily at 8:00 am. -Documentation by staff that Lasix 80mg was held on 8/20/15 at 8:00 am. -Documentation by staff that Lasix 80 mg was administered by staff from 8/21/15 to 8/31/15 at 8:00 am. Review of Resident #1's record revealed: -She had been hospitalized since 8/31/15 for evaluation after a fall. -July 2015 weight was 229.2#. -August 2015 weight was 237.8#. Review of Resident #1's LHPS dated 8/12/15 revealed: -An assessment of "very tight edema both lower extremities, ankles and feet". -An assessment of "respirations are regular and unlabored". Interview on 9/02/15 at 9:45 am and 11:55 am with a first shift MA revealed:	D 358		

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D 358	Continued From page 17 -She had been employed at the facility since June 2014 as a MA and a supervisor. -They had been using the current eMAR system for two weeks. Interview at 11:55 am revealed that a regional representative with the new facility owner was present when the new system "went live and looked at the old MAR and made sure it was correct in the system". Telephone interview on 9/3/15 at 12:10 pm with Resident #1's family member revealed: -He was aware Lasix was changed to prn by their physician "because his mother was going to the bathroom too much". -He had "personally handed the physician's prescription to the facility MA" after a visit to the primary care physician on 8/14/15 for a urinary tract infection (UTI). -He was not aware the Lasix was changed back to daily. -She had been in the hospital since 8/31/15 for observation after a fall. Interview on 9/03/15 at 12:15pm with the facility's pharmacy for Resident #1 revealed: -The current order in their system was Lasix 80 mg daily. -No subsequent orders for Lasix were received after 7/22/15. Interview on 9/03/15 at 12:20 pm with Resident #1's primary care physician's representative revealed: -A notation that Lasix 80 mg was first written 1/27/15 for 90 tabs with one refill that was sent to Resident #1's pharmacy. -No record of any change to the Lasix order on file.	D 358		

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D 358	Continued From page 18 -Resident #1 did have an appointment on 8/14/15 for a UTI. Interview on 9/03/15 at 1:15 pm with the RCD revealed: -She "cannot find an order for Lasix dated 8/14/15 to discontinue and change order to prn". -She asked a MA who said "she saw the prescription but does not know where the order was put". -She would call Resident #1's physician's office for an order for the file. Refer to interview on 9/02/15 at 10:00 am with the RCD. Refer to interview on 9/03/15 at 12:50 with the facility Administrator. B. Review of Resident #3's current FL2 dated 8/10/15 revealed: -Diagnoses included osteoporosis, lupus, rheumatoid arthritis, hypertension, hypothyroidism, constipation, and gastroesophageal reflux disease (GERD). -An order for multivitamin one tablet daily. Review of Resident #3's previous FL2 dated 4/06/15 revealed an order for Multivitamin one tablet daily. Review of Resident #3's Resident Record revealed an admission date of of 5/20/11. Observation of the medication pass on 9/02/15 at 9:45 am by a Medication Aide (MA) on the 100 hall medication cart revealed: -The contract pharmacy pre-packaged the resident's medications in bingo cards with one pill	D 358		

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in each punch out bubble.
-The MA used the electronic medication administration record (eMAR) to compare medications to the pre-packaged card prior to administering the medication.
-The MA administered 7 oral medications and one eye drop medication to Resident #3 in the resident's room while she was sitting upright in a chair.
-The MA stated she did not have one of the scheduled medications available on the medication cart to administer at this time (Beta-Carotene, a multivitamin), but would order it from the facility's new pharmacy.
-The MA immediately documented administration of the 8:00 am medications on the September 2015 eMAR at 9:55 am.

Interview with a MA for the 100 hall medication cart on 9/02/15 at 9:55 am and 10:35 am revealed:
-She would contact the facility's pharmacy provider and request the Beta-Carotene for Resident #3.
-She would notify the surveyor when medication was received. (MA did not inform the surveyors of medication administration prior to end of the day on 9/02/15).
-The facility's contracted pharmacy was en-route to deliver the requested medication.
-"The new eMAR system had no drop down box to document when a resident's medications were not available" on hand. "I usually chart it as withheld per physicians order. That is supposed to be changing."

Interview with Resident Care Director (RCD) on 9/02/15 at 10:00 am revealed:
-If a medication was late," we were to check with the physician to see if it could be given outside

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the ordered parameters".
-The facility's contracted pharmacy changed on 9/01/15.

Review of Resident #3's September 2015 eMAR revealed:
-An entry for Thera Beta-Carotene was listed.
-The Thera Beta-Carotene was scheduled for 8:00 am and was documented as "withheld per physician orders" on 9/02/15; it was documented as administered on 9/01/15.
-There was no entry for multivitamin order on the eMAR.

Review of medications on hand for administration for Resident #3, on the 100 hall medication cart on 9/02/15 at 5:00 pm with a second shift MA, revealed:
-A pre-packaged bingo card labeled "Multivitamin" with 2 tablets remaining of 30 tablets dispensed on 8/03/15, plus a full card of 30 tablets.
-A pre-packaged bingo card with 25 tablets remaining of 26 tablets dispensed on 9/02/15 by facility's new contract pharmacy labeled "Thera-beta Carotene (Multiple Vitamin Tab)".

Second interview with MA on 9/03/15 at 11:10 am revealed:
-She was the MA on the 100 hall medication cart on 9/02/15 during the medication pass observation.
-She did not recognize that Resident #3's multivitamin and Thera-Beta Carotene were the same medication. "They were not identified on the eMAR as the same".
-She was now aware the multivitamin was on site 9/02/15 for the 8:00 am medication pass and could have been administered.

Interview with Resident #3 on 9/03/15 at 1:35 pm

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D 358	Continued From page 21 revealed: -She did not know her medications. -She "takes what they give me". Refer to interview on 9/2/15 at 10:00 am with the RCD. Refer to interview on 9/03/15 at 12:50 pm with facility Administrator and resident care director (RCD). C. Review of Resident #3's current FL2 dated 8/10/15 revealed diagnoses included osteoporosis, lupus, rheumatoid arthritis, hypertension, hypothyroidism, constipation, and gastroesophageal reflux disease (GERD). Review of Resident #3's Resident Record revealed an admission date of of 5/20/11. 1. Review of Resident #3's current FL2 dated 8/10/15 revealed an order for Durezol 0.05% ophthalmic drops one drop in left eye 4 times a day for 56 days (eight weeks) starting 6/09/15. (Durezol is a topical steroidal ophthalmic drop used to treat inflammation and pain after eye surgery.) Review of Resident #3's record revealed signed physician orders dated 7/21/15 with an order for Durezol 0.05% ophthalmic drops one drop in left eye 4 times a day for 56 days (eight weeks) starting 6/09/15. Continued review of Resident #3's record revealed a subsequent physician's order, from an office visit, dated 8/04/15 to restart Durezol to the left eye 4 times a day for 4 weeks.	D 358		

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D 358	Continued From page 22 Review of Resident #3's electronic Medication Administration Record (eMARs) for June 2015 and July 2015 revealed: - Durezol one drop to the left eye 4 times a day starting 6/09/15 was listed on the eMAR and scheduled for administration at 8:30 am. 12:00 PM, 4:00 pm, and 8:00 pm daily. - Administration was documented daily from 6/09/15 to 7/31/15. Review of Resident #3's paper Medication Administration Record (MAR) and eMAR for August 2015 revealed: - Durezol one drop to the left eye 4 times a day starting 6/09/15 was listed on the eMAR and scheduled for administration at 8:30 am, 12:00 pm, 4:00 pm, and 8:00 pm daily. - Administration was documented daily from 8/01/15 to 8/05/15. - "Discontinued 8/05/15" was handwritten on the paper MAR. - No documentation for restarting Durezol ophthalmic drops subsequent to the physican's order day dated 8/04/15 on the August 2015 paper MAR from 08/05/15 to 8/19/15. - No documentation for Durezol ophthalmic drops on the August 2015 eMAR from 08/20/15 to 8/31/15. Review of Resident #3's eMAR for September 2015 revealed no documentation for Durezol one drop to the left eye 4 times a day on the September 2015 eMAR from 9/01/15 thru 9/03/15. Review of Resident #3's medication on hand for administration on 9/02/15 at 4:50 pm revealed no Durezol ophthalmic solution was available for administration.	D 358		

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D 358	Continued From page 23 Interview on 9/02/15 at 11:00 am with a first shift medication aide revealed: - The facility had experienced several different systems for documenting administration of resident's medications in the last 3 months. - The facility used eMARs, computer generated paper MARs, and finally eMARs again from July 2015 to September 2015. - She was not responsible for entering medications orders on the MARs; the pharmacy provider, the Resident Care Director (RCD), and Supervisors entered orders. - The RCD, a Lead Supervisor, and the regional representative had coordinated switching to the various MAR systems. - She administered medications according to the medications listed on the MAR or eMAR. Telephone interview on 9/03/15 at 11:30 am with a representative at Resident #3's Opthalmologist's office revealed: - Resident #3 had been visiting the office for multiple appointments for cataracts. - Resident #3 should have completed the 4 weeks (28 days) of Durezol ophthalmic drops as ordered on 8/04/15. Telephone interview on 9/03/15 at 12:12 pm with the contract pharmacy provider revealed: - Resident #3 was dispensed Durezol ophthalmic solution in 5 milliliters quantities on 6/08/15, 7/03/15 and 7/24/15. - The pharmacy had no documentation for receiving the physician's order dated 8/04/15 to restart Durezol to the left eye 4 times a day for 4 weeks. Interview on 9/03/15 at 1:15 pm with the RCD revealed: - EMARs and MARs were reviewed by the RCD,	D 358		

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a Supervisor, and a regional representative during the pharmacy transitions.
- She was responsible to assure accuracy of the resident's MARs and eMARs compared to the FL2s and current orders.
- She and the regional representative had been working on reviewing some resident's MARs and eMARs but the facility did not have a system in place to review all the medications administration records since the current transition on 9/01/15.
- The contract Consultant Pharmacist was on site 9/02/15 and 9/03/15 to assist with review of resident's medications.

Interview on 9/03/15 at 1:30 pm with Resident #3 revealed:
- She had been going to an eye specialist for her cataracts and glaucoma.
- She had several different eye drops starting in June 2015.
- She did not know the names of her eye drops but was aware the physican had changed the drops a few times.
- She was not aware she should have been receiving Durezol ophthalmic drops from 8/04/15 to 9/01/15.
- She stated her left eye was staying red and hurting.
- She stated she would like to have the Durezol drops if the drops would help the discomfort.

Refer to interview on 9/2/15 at 10:00 am with the Resident Care Director (RCD).

Refer to interview on 9/03/15 at 12:50 pm with facility Administrator.

2. Review of Resident #3's current FL2 dated 8/10/15 revealed an order for Combigan ophthalmic solution one drop in both eyes 2 times

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D 358	Continued From page 25 a day for 28 days (starting 7/08/15). (Combigan is a combination ophthalmic drops used to lower the intraocular pressure.) Review of Resident #3 record revealed: - Physicians' orders from an office visit dated 7/07/15 for Combigan ophthalmic drops in each eye 2 times a day for 4 weeks. - A return visit scheduled in 4 weeks (8/04/15). Continued review of Resident #3's record revealed signed physician orders dated 7/21/15 with an order for Combigan ophthalmic solution 1 drop in each eye 2 times a day for 28 days starting 7/08/15. Review of Resident #3's electronic Medication Administration Record (eMAR) for July 2015 revealed: - Combigan ophthalmic solution was listed on the eMAR and scheduled for administration at 8:30 am and 5:00 pm. - Administration was documented at 8:30 am and 5:00 pm daily from 7/08/15 to 7/31/15 (24 days). Review of Resident #3's paper Medication Administration Record (MAR) for August 2015 revealed: - Combigan ophthalmic solution was listed on the eMAR and scheduled for administration at 8:00 am and 4:00 pm. - Administration was documented at 8:00 am and 4:00 pm daily from 8/01/15 to 8/19/15 (19 days). Based on documentation on the July 2015 and August 2015 eMARs, Combigan was administered 15 days longer than ordered. Review of Resident #3's medication on hand for administration on 9/02/15 at 4:50 pm revealed no	D 358		

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D 358	Continued From page 26 Combigan ophthalmic solution was available for administration. Interview on 9/02/15 at 11:00 am with a first shift medication aide revealed: - The facility had experienced several different systems for documenting administration of resident's medications in the last 3 months. - The facility used eMARs, computer generated paper MARs, and finally eMARs again from July 2015 to September 2015. - She was not responsible for entering medications orders on the MARs. - The Resident Care Director (RCD), a Supervisor, and regional representative had coordinated switching to the various MAR systems. - She administered medications according to the medications listed on the MAR or eMAR. Telephone interview on 9/03/15 at 11:30 am with a representative at Resident #3's physician's office (ophthalmic) revealed: - Resident #3 had been visiting the office for multiple appointment. - Resident #3 should have completed the Combigan drops at the prescribed time. Telephone interview on 9/03/15 at 12:12 pm with the contract pharmacy provider revealed Resident #3 was dispensed Combigan ophthalmic solution in 5 milliliters quantity on 7/07/15 and 7/30/15. Interview on 9/03/15 at 1:15 pm with the RCD revealed: - Medication Aides documented administration of Resident #3's Combigan ophthalmic solution on a previous electronic MAR system in July 2015. - Medication Aides documented administration of	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034100	A. BUILDING: _____ B. WING _____	09/03/2015

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D 358	Continued From page 27	D 358		

resident's medications, including Resident #3's Combigan ophthalmic drops, on paper MARs from 8/01/15 to 8/20/15 when the current electronic MAR system was implemented.
- She became aware Resident #3's Combigan ophthalmic solution was not discontinued on 8/04/15 as ordered when medications were reviewed on 8/20/15 to transition from paper MAR to eMARs.
- The Combigan ophthalmic solution order for 4 weeks beginning 7/08/15 was overlooked and continued on the eMAR for longer than 8/04/15 (28 days).
- Combigan ophthalmic solution was discontinued when the facility changed medication administration documentation system on 8/20/15.

Interview on 9/03/15 at 1:30 pm with Resident #3 revealed:
- She had been going to an eye specialist for her eyes.
- She had several different eye drops starting in June 2015.
- She did not know the names of her eye drops but was aware the physican had changed the drops a few times.
- She was not aware how long she was supposed to use Combigan.

Refer to interview on 9/2/15 at 10:00 am with the Resident Care Director (RCD).

Refer to interview on 9/03/15 at 12:50 pm with facility Administrator.

Interview on 9/02/15 at 10:00 am with the RCD revealed:
-The new owners of the facility required all residents to have new FL2's written and signed by the physician. These were faxed to the facility

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D 358	Continued From page 28 pharmacy. -The RCD or Supervisor which is the MA on the first hall cart, checked the orders and entered changes in the eMAR system. -"The new FL2's were generated by the RCD, the Supervisor and the regional representative from the new facility owner, from MAR review, records and orders. " Interview on 9/03/15 at 12:50 pm with the facility Administrator (with the RCD present) revealed: -The facility recently went through a change in ownership, and in preparing for the change, FL2's were re-written starting in June 2015 on all residents. -"The target date was 6/28/15 but the take-over dates kept changing" which caused confusion in what system to use for MARs and pharmacies. -The FL2's were faxed to the facility's contract pharmacy after being signed by physician. -Any subsequent orders were also faxed to the facility's contract pharmacy by the Medication Aide receiving the order. -The change in ownership occurred 7/9/15. -The facility has "been on 4 different systems for MARs, and two for pharmacies". -"With the changes, if a MA noticed anything wrong in the medication entry, they were to call the eMAR company system to enter the corrections in the system as the facility had no administrative rights to make the changes". -Each eMAR company had their own system for handling orders. -The eMAR system was frequently down in July 2015 during one change and the eMAR "company told us they could not access any data, that there were cross-over issues in the system". -The facility used paper MARs for the first part of August since the system kept going down. -The current eMAR system has been in effect	D 358		

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D 358	Continued From page 29 since 8/20/15. -The contract pharmacy covering the facility changed 9/01/15. The facility provided a Plan of Protection on 9/03/15 as follows: - Beginning immediately all residents will be administered (medications) according to physician's orders. - Beginning immediately all resident's orders will be clarified. - RCD will be responsible to monitoring to ensure compliance. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 18, 2015.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding medication administration. The findings are: Based on observation, interview, and record	D912		

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D912	Continued From page 30 review, the facility failed to assure administration of medications were in accordance with physician orders for 2 of 5 sampled residents (Resident #1 and #3) and 2 of 6 residents (Resident #3 and #12) observed during medication pass on 9/02/15 and 9/03/15. [Refer to Tag 0358, 10A NCAC 13F .1004(a) (Type B Violation).]	D912		