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
	FCL060019	A. BUILDING: ______ B. WING ______	R 03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY HARBOUR ADULT LIVING	**908 TOM HUNTER ROAD CHARLOTTE, NC 28213**

(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
C 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a follow-up survey on March 3 - 4, 2016 with an exit conference via telephone on March 8, 2016.	C 000		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure implementation of the application of ace wraps and smoking cessation intervention as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL2 dated 12/10/15 revealed diagnoses included chronic obstructive pulmonary disease, deep vein thrombosis, schizoaffective disorder, and tardive dyskinesia. Review of the Resident Register revealed Resident #1 was admitted to the facility on 09/28/10. Review of a Resident #1's primary care	C 249		

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C 249	Continued From page 1 physician's office visit note dated 1/4/16 revealed: -Resident #1 had plus 3 right lower extremity edema and plus 2 left lower extremity edema. -Resident #1 had a history of deep vein thrombosis and pulmonary embolism. -Resident #1 was on the medication Xarelto (Xarelto is a blood thinner used to treat and prevent blood clots). -Despite medications of Lasix (Lasix is a diuretic that treats fluid retention) and potassium chloride (used to treat low blood levels of potassium), Resident #1 continued to have lower extremity edema. -Resident #1 had refused to wear support hose and anti-embolic stockings. Review of physician orders dated 1/4/16 revealed: -There was an order for ace wraps for four hours twice a day to the right lower extremity. -Elevate lower extremities as much as possible and walking exercises. Review of a Resident #1's Hematologist office visit note dated 2/29/16 revealed: -Resident #1 had chronic deep vein thrombosis of the right lower leg, so it was expected she would have some swelling there. -Resident #1 still smoked about one pack of cigarettes per day. Review of the Hematologist's orders dated 2/29/16 revealed: -Smoking cessation strongly advised and directions to "call 1-800-QUIT now". -Repeat ultrasound of lower extremities if swelling worsens or becomes more painful. Review of Resident #1's record revealed: -There was no documentation of the facility	C 249		

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C 249	Continued From page 2	C 249		

arranging for smoking cessation intervention.
-There was no documentation of resident refusals to participate in smoking cessation intervention.
-There was no documentation of notification of the physician that the referral for smoking cessation intervention had not been arranged.
-There was not a discontinue order for the ace wraps or the smoking cessation intervention.

Interview on 3/3/16 at 2:10pm with Resident #1 revealed:
-She did not have the wraps for her legs and did not want the wraps for her legs.
-She would not use wraps for her legs even though the doctor wanted her to do this.
-She did elevate her legs during the day.

Interview with Resident #1 on 3/4/16 revealed:
-She refused to wear the Ted hose previously and she would also not wear the wraps the doctor ordered for her legs
-Resident #3 stated she did not like the wraps.
-She did elevate her legs often, when she was home.

Observations during the survey of Resident #1 revealed:
-On 3/3/16 at 9:00am, Resident #1 was sitting outside smoking a cigarette.
-On 3/3/16 at 12:35pm, Resident #1 was sitting outside smoking a cigarette.
-On 3/3/16 at 1:55pm, Resident #1 was sitting outside smoking a cigarette.
-Resident #1 was not observed to elevate her legs for three observations when she was in her room.
-On 3/4/16, Resident #1 was out of the facility.

Attempted interview with Resident #1's primary care physician was unsuccessful prior to exit.

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C 249	Continued From page 3 Interview on 3/4/16 at 8:45 am with the Administrator revealed: -Resident #1 told the physician during the office visit on 1/4/16, she did not want to wear the ace wraps the physician was prescribing. -She was aware the doctor wrote the order for the ace wraps to be applied to her right lower leg twice a day for four hours. -Because Resident #1 told the doctor she would not wear the ace wraps, the facility had not obtained the ace wraps. -The Resident Care Coordinator (RCC) was responsible for following up on physician's orders. -Resident #1 was "a chain smoker" and she did not think the resident would agree to Smoking Cessation interventions. -The facility had not made a referral to the smoking cessation program as ordered by the physician because they did not think the resident would participate. -She did not think Resident #1 had purchased the ace wraps. -She did not know if the facility should purchase the ace wraps if Resident #1 refused to wear them. -She was not sure if Resident #1's insurance would cover the ace wraps if ordered through the contract pharmacy. -She could "go to the drugstore" and purchase ace bandages for Resident #1. -The facility had not attempted to get the resident to use the ace wraps. -Resident #1 would inform the facility if her legs were swollen. -The facility staff did not routinely check Resident #1's legs for edema. -The facility had a Licensed Health Professional Support (LHPS) Registered Nurse (RN) who came to the facility every quarter and "she looked	C 249		

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C 249	Continued From page 4 at Resident #1's legs then." -There was no documentation in Resident #1's record of observations of Resident #1's lower extremities or attempts to obtain ace wraps. -The facility informed the physician, during Resident #1's office visit on 2/29/16, the resident refused to wear ace wraps.	C 249		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 observations, record reviews, and interviews, the facility failed to assure Advair (used to treat asthma and COPD, Mirtazapine (used to treat depression), Thiamine (is a vitamin of the B complex), Ibuprophen (used to treat fever, pain, or inflammation), and Primidone (used to treat seizure disorders) were administered as ordered by a licensed prescribing practitioner for 3 of 4 sampled residents (Residents #1, #2, and #4). The findings are: A. Review of Resident #1's current FL2 dated 12/10/15 revealed:	C 330		

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C 330	Continued From page 5	C 330		

-Diagnoses included chronic obstructive pulmonary disease (COPD), deep vein thrombosis, schizoaffective disorder, and tardive dyskinesia.
-There was an order for Advair 250/50 Diskus inhale one puff (frequency not noted).
-There was an order for Mirtazapine 45mg one tablet at bedtime.

Review of the Resident Register revealed Resident #1 was admitted to the facility on 09/28/10.

Review of physician's orders dated 1/19/16 revealed:
-There was an order to decrease Advair to 100/50 one puff every 12 hours.
-There was an order on 1/19/16 for Thiamine 100mg every morning.
-There was an order on 1/19/16 to decrease Mirtazapine to 30mg at bedtime.

Review of Resident #1's January 2016 Medication Administration Record (MAR) revealed:
-There was an entry for Mirtazapine 45mg take one once daily at bedtime.
-Documentation revealed Mirtazapine had been administered at bedtime daily during the month of January 2016.
-No change in dosage to Mirtazapine 30mg was noted on the MAR.
-There was an entry for Advair 250/50 inhale one puff twice daily.
-Documentation revealed Advair had been administered at 8 am and 8 pm daily during the month of January 2016.
-Thiamine 100mg every morning had not been added to the January 2016 MAR for administration as ordered.

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C 330	Continued From page 6 Review of Resident #1's February 2016 MAR revealed: -There was an entry for Mirtazapine 45mg take one once daily at bedtime. -Documentation revealed Mirtazapine had been administered at bedtime daily during the month of February 2016. -There was no change in dosage to Mirtazapine 30mg noted on the February 2016 MAR. -There was an entry for Advair 250/50 inhale one puff twice daily. -Documentation revealed Advair had been administered at 8 am and 8 pm daily during the month of February 2016. -Thiamine 100mg every morning had not been added to the February 2016 MAR for administration as ordered. Review of Resident #1's March 2016 MAR revealed: -There was an entry for Mirtazapine 45mg one tablet daily at bedtime. -Documentation revealed Mirtazapine had been administered at bedtime on 3/1/16, 3/2/16, and 3/3/16. -There was an entry for Advair 250/50 one puff twice daily. -Documentation revealed Advair had been administered every 12 hours at 8:00am and 8:00pm on 3/1/16, 3/2/16, and 3/3/16. -Thiamine 100mg every morning had not been added to the March 2016 MAR for administration as ordered. Observation of Resident #1's medications on hand for the resident on 3/3/16 at 3:50 pm revealed: -There was a bubble pack with a label for Mertazapine 45mg once a day at bedtime	C 330		

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C 330	Continued From page 7	C 330		

dispensed 30 tablets on 2/2/16.
-There was an Advair inhaler with a label for Advair 250/50 diskus inhale one puff twice daily dispensed on 2/29/16 for 60 puffs.
-No Thiamine was on hand for Resident #1.

Review of the facility's "Medication Administration and Orders" policy (undated) revealed:
-"Be sure the Medication Administration Record (MAR) matches current physician orders."
-If there was a change in the resident's medication be sure "the MAR is updated to reflect the instructions of the new order."

Resident #1 was unavailable for interview on 3/4/16 as she was out of the facility.

Interview on 3/3/16 at 3:30pm with the Medication Aide (MA) revealed:
-She filed new orders in the resident's records.
-"Nine times out of 10, the doctor's office sends the orders directly to the pharmacy."
-The MA or the Administrator was responsible for contacting the pharmacy to assure they had received new orders by the licensed prescribing practitioner.
-The Administrator had taken Resident #1 to the physician's office on 1/19/16.
-The Administrator or the MA either took new orders to the pharmacy or faxed it to the pharmacy "if they don't already have it."
-The MA did not recall seeing the new orders for the change in dosages for Mirtazapine and Advair or the new order for Thiamine.
-The MA did not know if the Administrator had faxed the orders written on 1/19/16 to the pharmacy.

Interview with the Pharmacist on 3/4/16 at 11:45am revealed:

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C 330	Continued From page 8 -On 3/3/16, the Pharmacist had received by fax from the facility, the orders dated 1/19/16 for Resident #1. -The orders included changing the Mirtazapine dosage from 45mg to 30mg at bedtime, changing the Advair from 250/50 inhale one puff twice daily to 100/50 one puff every 12 hours, and a new order for Thiamine 100mg every morning. -It was the responsibility of the physician's office to send new orders directly to the pharmacy. -The pharmacy had not received the new orders from the physician's office. -The facility should have, and did not, contact the pharmacy to assure the pharmacy had received the new orders dated 1/19/16. -If the facility had sent the pharmacy a copy of the orders written on 1/19/16 by the physician, the pharmacy would have filled it. -The pharmacy filled the orders on 3/3/16 and they would be delivered to the facility on 3/4/16. -The Pharmacist did quarterly medication reviews at the facility. -The Pharmacist had requested the physician to consider dosage reduction for the Mirtazapine during the quarterly review in January 2016. -Mirtazapine was a psychotropic drug and she often requested consideration of dose reductions from the physician for psychotropic drugs to see if the resident could tolerate a lower dose. Interview with the Administrator on 3/4/16 at 8:30am revealed: -She was aware of the new orders written by Resident #1's physician on 1/19/16. -She took Resident #1 to the doctor for the appointment on 1/19/16. -She was not aware the orders had not been implemented by the facility. -She did not know how the MA "missed the new orders."	C 330		

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C 330	Continued From page 9	C 330		

Continued From page 9

-The MA was responsible for assuring the pharmacy received a copy of any new physician's orders.
-She thought the MA had previously faxed the order to the pharmacy after the appointment on 1/19/16.
-The MA faxed the orders dated 1/19/16 for Resident #1 to the pharmacy on 3/3/16.
-The MA or the Administrator would contact Resident #1's physician to inform the physician the orders for changes in Resident #1's medications written on 1/19/16 had not been administered as ordered.
-When medications were delivered to the facility, the MA checked the medications with the MAR, but not to the Physician's orders.
-The Administrator was going to have the MA begin to review MAR's with physician orders monthly when the MAR's for the new month were received from the pharmacy.

Refer to interview with the Administrator on 3/4/16 at 8:45am.

B. Review of Resident #4's current FL2 dated 12/5/15 revealed:
-Diagnoses included bipolar disorder, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and schizoaffective disorder.
-There was an order for Ibuprofen 800 mg take 1 tablet three times a day.

Review of Resident #4's Resident Register revealed an admission date of 8/2/05.

Observation on 3/3/16 at 1:55pm revealed:
-Resident #4 was administered Ibuprofen 800mg one tablet at 1:55pm by a MA.
-Resident #4's March 2016 MAR was not available to the MA for review prior to

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C 330	Continued From page 10	C 330		

Continued From page 10

administration of the medication because the Administrator had taken the MAR book to her office on 3/3/16 to copy the MARs.

Review of Resident #4's March 2016 MARs when made available on 3/3/16 at 2:45pm revealed:
-There was a computer entry for Ibuprofen 800mg take one tablet three times daily.
-Ibuprofen 800mg was scheduled to be administered at 8:00am, 12:00noon, and 4:00pm.

Interview with the Pharmacist on 3/4/16 at 2:30pm revealed:
-Administering Ibuprofen 800 mg at 1:55pm and then again at 4:00pm was not an appropriate time frame between dosages.
-If Ibuprofen 800 mg was administered too close together (not at the designated times), "they are asking for gastrointestinal problems."

Attempted interview with Resident #4's physician was unsuccessful by exit.

Interview with Resident #4 on 3/3/16 at 9:15 am revealed:
-The resident had lived at the facility for 12 years.
-The resident received medications in the mornings, at 2:00pm in the afternoons, and at night.
-The Administrator usually gave the morning and night medications.
-The MA gave the 2:00pm medications.
-The resident had no concerns about getting her medications on time.
-There had been no changes in her medications recently.

Interview with the MA on 3/3/16 at 2:00pm revealed:
-The MA gave Resident #4 the Ibuprophen 800

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C 330	Continued From page 11	C 330		

mg tablet at 2:00pm every day because the resident was usually at the day program at 12:00 noon when the Ibuprofen was scheduled.
-Resident #4 was at the facility today, but the MA still administered the Ibuprophen 800mg one tablet at 1:55pm.
-She did not have Resident #4's March MAR to refer to today, because the Administrator took it with her this morning to her office to make copies of each residents' MARs.
-The pharmacist had told her previously it was "okay" to change medicines scheduled at 12:00 noon to 2:00pm.

Interview with the Administrator on 3/4/16 at 8:45am revealed:
-Resident #4 attended a day program and did not return to the facility until 2:00pm.
-The MA administered medications to Resident #4 at 2:00pm each day when she returned to from the day program.
-If the MA had a question about when to administer medications, the MA had contacted the pharmacist for assistance.

Refer to interview with the Administrator on 3/4/16 at 8:45am.

C. Review of Resident #2's current FL2 dated 12/5/15 revealed:
-Diagnoses included anemia, chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis, hyperlipidemia, hypertension, personality disorder, sleep apnea, and type 2 diabetes mellitus.
-There was an order for Primidone 50mg take 1 tablet three times a day.

Review of Resident #2's Resident Register revealed an admission date of 3/2/1998.

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C 330	Continued From page 12 Observation on 3/3/16 at 2:10pm revealed: -Resident #2's March 2016 MAR was not available to the MA for review prior to administration of the medication because the Administrator had taken the MAR book to her office on 3/3/16 to copy the MARs. -Resident #2 was administered Primidone 50mg one tablet at 2:10pm by the MA. Review of Resident #2's March 2016 MAR when made available on 3/3/16 at 2:45pm revealed: -There was an entry for Primidone 50mg tablets take 1 tablet three times a day. -Primidone 50mg was scheduled to be administered at 8:00am, 12:00noon, and 4:00pm. -A hand-written entry of "2pm" was written over the "12N" time. Interview with Resident #2 at 3:15pm on 3/4/16 revealed either the MA or the Administrator administered medications to the resident. Attempted interview with Resident #2's physician was unsuccessful by exit. Interview with the MA on 3/3/16 at 2:00pm revealed: -The MA gave Resident #2 the Primidone 50mg tablet at 2:00pm every day because the resident was usually at the day program at 12:00 noon when the Primidone was scheduled. -She did not have Resident #2's March MAR to refer to today because because the Administrator had taken the MAR book to her office on 3/3/16 to copy the MARs. -"The Primidone is all he gets at 2:00." -The pharmacist had told her previously it was okay to change medicines scheduled at 12:00 noon to 2:00pm.	C 330		

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	FCL060019	A. BUILDING: ______ B. WING ______	R 03/08/2016

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SHADY HARBOUR ADULT LIVING	908 TOM HUNTER ROAD CHARLOTTE, NC 28213

(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
C 330	Continued From page 13 Interview with the MA on 3/4/16 at 12:10am revealed: -She gave the Primidone to Resident #2 at 2:00pm each day. -She did not think she gave the next dose of Primidone at 4:00pm "because I don't have any 4:00 medicines to give." -She thought she gave the Primidone at 8:00pm "because I don't have any 4:00 medicines to give." -She had not thought about if giving the medication that close together was acceptable. Interview with the Pharmacist on 3/4/16 at 2:35pm revealed: -Administering Primidone 50mg at 1:55pm and then again at 4:00pm was not an appropriate time frame between dosages. -The shortened time frame did not allow the body enough time to absorb the medication before the second dose was administered at 4:00pm. Interview with the Administrator on 3/4/16 at 8:45am revealed: -Resident #2 attended a day program and did not return to the facility until 2:00pm. -The MA administered medications to Resident #2 at 2:00pm each day when he returned from the day program. Refer to interview with the Administrator on 3/4/16 at 8:45am. ______________________ Interview with the Administrator on 3/4/16 at 8:45am revealed: -The MA could contact the pharmacist when there was a question about how or when medications were to be administered. -She was not aware medications were not being administered as prescribed by the physician.	C 330		

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C 330	Continued From page 14 -She had taken the Residents' MARs to her office on 3/3/16 to copy "so we will have copies to take to the physicians when we take residents to physician appointments." -She took the MARs to copy each month at her office when the new MARs were received from the pharmacy. -She preferred to make copies at her office because they printed in color. -The facility did have a copier that printed black and white. -She had not thought about printing a copy for the MA to use on the day she took the original MARs to copy. -The MA would "just write down what she gave on a piece of paper" and then transfer it to the MAR when she returned it to the facility. On 3/4/16, the Administrator submitted a Plan of Protections as follows: -The Medication Aide (MA) will review with the pharmacy, all records to compare orders to the MARs. -Ongoing, the facility will ensure that all doctors' orders were faxed or communicated to the pharmacy to ensure implementation of doctors' orders. -The MA and the Administrator would be responsible for this action. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 22, 2016.	C 330		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration	C 341		

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C 341	Continued From page 15	C 341		

(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observation, interviews, and record reviews, the facility failed to assure all medications administered to residents were documented as administered immediately following administration and were not predocumented as being administered for 3 of 3 sampled residents (Resident #2, #3, and #4).

The findings are:

Review of the facility policy "Medication Administration and Orders" revealed "When administering medications, initial the MAR [Medication Administration Record] immediately after you give the medication."

Observation of staff on 3/3/16 at 2:30pm revealed the Medication Aide (MA) left the facility and returned at 2:50pm with the March MARs.

A. Review of Resident #4's current FL2 dated 12/5/15 revealed:
-Diagnoses included bipolar disorder, chronic obstructive pulmonary disease (COPD), gastroesophageal reflux, and schizoaffective disorder.
-There was an order for Ibuprofen (used to treat pain, fever, and inflammation) 800 mg take 1

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C 341	Continued From page 16	C 341		

tablet three times a day.
-There was an order for Spiriva (used to improve breathing related to asthma or COPD) 18 mcg inhale contents of 1 capsule using handihaler every day.
-There was an order for Trazadone (used to treat depression)100mg take two tablets daily at bedtime.
-There was an order for Symbicort 160/4.5 (used to prevent bronchospasms related to COPD) inhale two puffs twice daily.
-There was an order for Amitiza (used to treat constipation) 8 Mcg take one tablet twice daily.
-There was an order for Potassium Citrate ER (used to treat low blood levels of potassium) 10mg take two tablets in the am and one in the pm.

Review of Resident #4's Resident Register revealed an admission date of 8/2/05.

Review of Resident #4's March 2016 MAR on 3/4/16 at 10:30am revealed:
-Spiriva 18 mcg inhale contents of 1 capsule using handihaler once daily (8:00pm) was documented as administered on 3/4/16 at 8:00pm by the MA.
-Trazadone 100mg take 2 tablets daily at 8:00pm was documented as administered on 3/4/16 at 8:00pm by the MA.
-Symbicort 160/4.5 inhale two puffs twice daily (8:00am and 8:00pm) was documented as administered on 3/4/16 at 8:00pm by the MA.
-Amitiza 8 Mcg take one twice daily (8:00am and 8:00pm) was documented as administered on 3/4/16 at 8:00pm by the MA.
-Ibuprofen 800mg take one three times daily (8:00am, 12:00N, and 4:00pm) was documented as administered on 3/4/16 at 12:00N and 8:00pm by the MA.

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C 341	Continued From page 17	C 341		

-Potassium Citrate Er 10mg take two tablets at 8:00 am and 8:00pm was documented as administered on 3/4/16 at 8:00pm by the MA.
-The Spiriva, Trazadone, Symbicort, Amitiza, Ibuprofen, and Potassium Citrate Er were documented as administered prior to medication being administered by the MA for the 8:00pm doses.

Observation on 3/3/16 at 1:55pm revealed:
-Resident #4 was administered Ibuprofen 800mg 1 tablet at 1:55pm by the MA.
-Resident #4's March 2016 MAR was not available to the MA for review and documentation of the administration of the medication on 03/03/16 at 2:00pm.

Interview with Resident #4 on 3/3/16 at 9:15 am revealed:
-The resident had lived at the facility for 12 years.
-The resident received medications in the mornings, at 2:00pm in the afternoons, and at night.
-The Administrator usually gave the morning and night medications.
-The MA gave the 2:00pm medications.
-The resident had no concerns about getting her medications on time.
-There had been no changes in her medications recently.

Refer to interview with the MA on 3/3/16 at 11:50pm

Refer to interview with the MA on 3/3/16 at 2:00pm.

Refer to interview with the MA on 3/4/16 at 3:00pm.

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	FCL060019	A. BUILDING: ______ B. WING ______	R 03/08/2016

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C 341	Continued From page 18	C 341		

Refer to interview with the Administrator on 3/4/16 at 8:45am.

Refer to telephone interview with the Administrator on 3/4/16 at 2:45pm.

Refer to telephone interview with the Administrator on 3/4/16 at 3:25pm.

B. Review of Resident #2's current FL2 dated 12/5/15 revealed:
-Diagnoses included anemia, chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis, hyperlipidemia, hypertension, personality disorder, sleep apnea, and type 2 diabetes mellitus.
-There was an order for Primidone 50mg (used to treat seizure disorders) take one tablet three times a day.
-There was an order for Olanzapine(used to treat mental disorders) 10mg take one tablet daily at bedtime.
-There was an order for Tamsulosin HCl (used to treat urination symptoms of an enlarged prostate) 0.4mg take one tablet daily at bedtime.
-There was an order for Asmanex Twisthaler (used to treat asthma symptoms) 220 Mcg inhale one puff by mouth twice daily.
-There was an order for Gemfibrozil (used to treat high cholesterol and triglyceride levels) 600mg take one tablet by mouth twice daily.

Review of Resident #2's Resident Register revealed an admission date of 3/2/1998.

Review of Resident #2's March 2016 MAR on 3/4/16 at 10:40am revealed:
-Primidone 50 mg take one tablet three times daily (8:00am, 12:00pm, and 4:00pm)
-The 12:00pm scheduled time for Primidone

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C 341	Continued From page 19 50mg had been marked through and 2:00pm written on the MAR. -The Primidone 50mg was documented as administered on 3/4/16 at 2:00pm and 4:00pm by the MA. -Olanzapine 10mg take one daily at 8:00pm was documented as administered on 3/4/16 at 8:00pm by the MA. -Tamsulosin Hcl 0.4mg take one tablet daily at 8:00pm was documented as administered on 3/4/16 at 8:00pm by the MA. -Asmanex Twisthaler 220 Mcg inhale one puff by mouth twice daily (8:00am and 8:00pm) was documented as administered on 3/4/16 at 8:00pm. -Gemfibrozil 600mg take one tablet by mouth twice daily (8:00am and 8:00pm) was documented at administered on 3/4/16 at 8:00pm by the MA. -The Primidone, Olanzapine, Tamsulosin HCl, Asmanex Twisthaler, and Gemfibrozil were documented as administered prior to being administered on 3/4/16 by the MA for the 8:00pm doses. Observation of medication administration on 3/3/16 at 2:10pm revealed: -Resident #2 was administered Primidone 50mg one tablet at 2:10pm by the MA. -Resident #2's March 2016 MAR was not available to the MA for review and documentation of the administration of the medication on 03/03/16 at 2:00pm. Interview with the MA on 3/3/16 at 2:10pm revealed "The Primidone is all he gets at 2:00 o'clock." Interview with Resident #2 at 3:15pm on 3/4/16 revealed:	C 341		

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C 341	Continued From page 20 -Either the MA or the Administrator administered medications to the residents. -The Administrator administered 8pm medications to him the night of 3/3/16. -Resident #2 had received medications twice on 3/4/16 at 3:15pm. Review of Resident #2's March MAR when made available on 3/3/16 at 2:45pm revealed: -There was an order for Primidone 50mg tablets take 1 tablet three times a day. -Primidone 50mg was scheduled to be administered at 8:00am, 12:00noon, and 4:00pm. -A hand-written entry of "2pm" was written over the "12N" time. -No other medications were scheduled for 2:00pm. Refer to interview with the MA on 3/3/16 at 11:50pm Refer to interview with the MA on 3/3/16 at 2:00pm. Refer to interview with the MA on 3/4/16 at 3:00pm. Refer to interview with the Administrator on 3/4/16 at 8:45am. Refer to telephone interview with the Administrator on 3/4/16 at 2:45pm. Refer to telephone interview with the Administrator on 3/4/16 at 3:25pm. C. Review of Resident #3's current FL2 dated 12/17/15 revealed: -Diagnoses included alcoholism, aortic valve stenosis, chronic hepatitis C, depression,	C 341		

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C 341	Continued From page 21	C 341		

gastroesophageal reflux, and hypertension.
-An order for Famotidine 20mg take one tablet twice daily.
-An order for Acetaminophen 325mg take two tablets twice daily.
-An order for Bupropion Hcl SR 200mg take one tablet twice daily.
-An order for Buspirone Hcl 15mg take two tablets twice daily.
-An order for Trazadone 100mg take one tablet at bedtime.

Review of Resident #3's March 2016 MAR on 3/3/16 at 3:30pm revealed:
-Famotidine 20mg take one twice daily (8:00am and 8:00pm) was documented as administered on 3/3/16 at 8:00pm by the MA.
-Acetaminophen 325mg take two twice daily (8:00am and 8:00pm) was documented as administered on 3/3/16 at 8:00pm by the MA.
-Bupropion HCl SR 200mg take one twice daily (8:00am and 8:00pm) was documented as administered on 3/3/16 at 8:00pm by the MA.
-Buspirone HCl 15mg take one twice daily (8:00am and 8:00pm) was documented as administered on 3/3/16 at 8:00pm by the MA.
-Trazadone 100mg take one at bedtime (8:00pm) was documented as administered on 3/3/16 at 8:00pm by the MA.
-The Famotidine, Acetaminophen, Bupropion HCl, Buspirone HCl, and Trazadone were documented as administered prior to being administered on 3/3/16 by the MA for the 8:00pm doses.

Review of Resident #3's March 2016 MAR on 3/4/16 at 2:30pm revealed:
-Famotidine 20mg take one twice daily (8:00am and 8:00pm) was documented as administered on 3/4/16 at 8:00pm by the MA.

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C 341	Continued From page 22 -Acetaminophen 325mg take two twice daily (8:00am and 8:00pm) was documented as administered on 3/4/16 at 8:00pm by the MA. -Bupropion Hcl SR 200mg take one twice daily (8:00am and 8:00pm) was documented as administered on 3/4/16 at 8:00pm by the MA. -Buspirone Hcl 15mg take one twice daily (8:00am and 8:00pm) was documented as administered on 3/4/16 at 8:00pm by the MA. -Trazadone 100mg take one at bedtime (8:00pm) was documented as administered on 3/4/16 at 8:00pm by the MA. -The Famotidine, Acetaminophen, Bupropion HCl, Buspirone HCl, and Trazadone were documented as administered prior to being administered on 3/4/16 by the MA for the 8:00pm doses. Observation of medication administration on 3/3/16 at 2:20pm revealed: -Resident #3 was administered Buspirone HCL SR 200mg at 2:20pm by the MA. -Resident #3's March 2016 MAR was not available to the MA for review prior to administration of the medication because the Administrator had taken the MAR book to her office on 3/3/16 to copy the MARs. Refer to interview with the MA on 3/3/16 at 11:50pm Refer to interview with the MA on 3/3/16 at 2:00pm. Refer to interview with the MA on 3/4/16 at 3:00pm. Refer to interview with the Administrator on 3/4/16 at 8:45am.	C 341		

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C 341	Continued From page 23 Refer to telephone interview with the Administrator on 3/4/16 at 2:45pm. Refer to telephone interview with the Administrator on 3/4/16 at 3:25pm. ______________________ Interview with the MA on 3/3/16 at 11:50pm revealed: -Her normal works hours at the facility were 2:00pm to 8:00pm. -She did not have the March MAR for all of the residents because the Administrator took the MARs with her this morning to make copies of each residents' MARs. -The Administrator took the MARs to copy monthly when they received new MARs from the pharmacy. -The copies were used to take to residents' physician visits. -She was expecting the MARs to be returned this afternoon or tonight when the Administrator returned to the facility. Interview with the MA on 3/3/16 at 2:00pm revealed: -"We only have 5 residents so it is not hard to remember who gets medicines and when." -There were 3 residents who received medications at 2:00pm when they returned from the day program. -She would write down "on a piece of paper" what she administered to the residents and then initial on the March MAR when the MAR was returned to the facility. documented as administered prior to being administered on 3/4/16 by the MA for the 8:00pm doses. -She did not realize she had documented the	C 341		

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C 341	Continued From page 24	C 341		

scheduled 8:00pm medications prior to being administered on 3/3/16 for Residents #2, #3, and #4.
-She kept getting the date "mixed up thinking it was the 4th instead of the 3rd."

Interview with the MA on 3/4/16 at 3:00pm revealed:
-She did not realize she had documented the scheduled 8:00pm medications prior to being administered on 3/4/16 for Residents #2, #3, and #4.
-She was thinking today was the 5th instead of the 4th.

Interview with the Administrator on 3/4/16 at 8:45am revealed:
-The policy of the facility was for the MA to document on the MAR immediately following the administration of the medication.
-The Administrator took the MARs to her office monthly, when they received new MARs from the pharmacy, to make copies of them.
-She used the copies to take to phycian appointments with the residents.
-The MA would write down what she administered until the MARs were returned to the facility and then would document on the MARs.
-She had not thought about making a copy of the MAR to leave for the MA to refer to and document on until the original MARs were returned to the facility.

Telephone interview with the Administrator on 3/4/16 at 3:25pm revealed:
-The MA administered 8:00pm medications on 3/3/16.
-The Administrator rarely administered 8pm medications.
-The MA would usually stay at the home and

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C 341	Continued From page 25 administer the 8pm medications, even if the Administrator was at the facility in time to administer the medications.	C 341		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 comliance with relevant federal and state laws and rules and regulations regarding medication administration. The findings are: Based on observations, record reviews, and interviews, the facility failed to assure Advair (used to treat asthma and COPD, Mirtazapine (used to treat depression), Thiamine (is a vitamin of the B complex), Ibuprophen (used to treat fever, pain, or inflammation), and Primidone (used to treat seizure disorders) were administered as ordered by a licensed prescribing practitioner for 3 of 4 sampled residents (Residents #1, #2, and #4). [Refer to Tag 0330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation).]	C 912		