STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013007	A. BUILDING: _____ B. WING _____	R 03/10/2016

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CAREMOOR RETIREMENT CENTER	4876 CAREMOOR PLACE KANNAPOLIS, NC 28081

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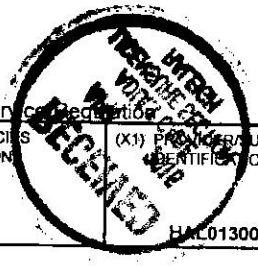
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on March 9-10, 2016.	{D 000}		
{D 309}	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an 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, the facility failed to maintain an accurate and current listing of residents with physician ordered therapeutic diets (regular with ground meats and cardiac with mechanical soft) for 2 of 7 sampled residents (Residents #1 and #9). The findings are: Observation on 3/09/16 at 10:15 am in the kitchen revealed: -A posted therapeutic diet list that included residents to be served chopped meats, regular ground/mechanical soft diets, pureed, cardiac and no concentrated sweets. Observation on 10/06/15 at 11:50 am in the kitchen revealed: -There were 25 color coded note cards posted on a bulletin board that included the residents' names, therapeutic diets, likes and dislikes, date of birth and admission date. A. Review of Resident #1's current FL2 dated	{D 309}		

Addendum:
Based on the telephone call with Anita Linker on 4/13/16, all complete dates of 3/09/16 will be changed to 3/11/16.
Reviewed and Accepted with revisions.
4/14/16 fw



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{D 309}	Continued From page 1 9/03/15 revealed: -Diagnoses included a stroke with right hemiparesis and aphasia, irritable bowel syndrome, gastric esophageal reflux disease, and dysphagia. -An order for a cardiac diet with chopped meats. Review of Resident #1's record revealed: -A physician's diet order dated 1/09/16 for a cardiac diet with chopped meats and "no egg whites, prefers whole egg". -A facility printed physician's order form signed and dated 2/08/16 for "please chop up all foods for a mechanical soft consistency". Cardiac diet was not specified. Review of the diet list posted in the kitchen revealed: -Resident #1 was listed to have a cardiac diet with regular eggs and chopped meats. -Resident #1 was not listed on the resident diet list to receive a soft-mechanical diet. Review of the therapeutic diet menu for regular, mechanical soft diet revealed residents were to be served 3 oz meatloaf with gravy, 1/2 c. garlic mashed potatoes, 1/2 c. green beans, 1 roll, and 1 slice chocolate cake. Cardiac diets were to be served 1/2 slice. Observation of the lunch meal on 3/09/16 at 12:00 pm revealed: -Resident #1 was served meatloaf and gravy, 1/2 c. mashed potatoes, 1/2 c. green beans, applesauce, roll, cake with icing, water and milk. -Margarine was offered, but refused. -Resident #1 consumed 10% of the meal. -Resident #1 had no difficulties swallowing her meal.	{D 309}	-Pharmacy was notified and was told to reprint new Physician's orders + send to facility ASAP. Pharmacy was also told not to print anymore Diets on the Physician's orders ever again. Manager + RCC will check over printed physician's orders more closely + more often. Physician's orders are done every 6 months. updated new Diet Orders for residents who had regular diets with Chopped meat. But left off the Chopped meat staff will cut up meat at table.	3/9/16 4/5/16

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{D 309}	Continued From page 2 Interview with Resident #1 on 3/09/16 at 12:30 pm revealed: -She did not have lower teeth, but had upper dentures. -The kitchen staff usually chopped all her meats, but "I'm allowed to have eggs however I want them". -The kitchen staff did not cut up other food served, but the serving staff would cut the food at the table if she asked them too. -She had no problems eating what was served, and usually had a good appetite. Interview with the Supervisor/Manager of employees on 3/09/16 pm at 3:25 pm revealed -Resident #1 was on a mechanical soft diet at one time since her stroke, but had an order from 1/09/16 for a cardiac with chopped meats. -She was not aware the facility printed physician's order form dated 2/08/16 referenced a mechanical soft consistency order. "These forms were printed by the pharmacy for the physician to sign." She did not look at this form as a diet order, and had not noticed this entry before, so the kitchen had not been updated. Refer to interview on 3/09/16 at 10:15 am with the Dietary Manager (DM). Refer to interview on 3/09/16 at 12:30 pm with the Director of Operations (DO). Refer to interview on 3/09/16 at 3:25 pm with the Supervisor/Medication Aide. Refer to interview on 3/10/16 at 8:00 am with the DM. B. Review of Resident #9's current FL2 dated 2/24/16 revealed:	{D 309}	printed Physician's orders Are updated every 6 months Manager + RCC will Check over printed Physician's orders to make sure that there Are no diet orders listed on them. Pharmacy was notified on 3/9/16 And was told to reprint Physician's order + send to facility ASAP for Res. #1. And for future Reference, do not put Any more diets on the Physician's orders. Manager + RCC will Check Diet Cards in Kitchen weekly As well As Dietary manager.	3/9/16

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{D 309}	Continued From page 3 -Diagnoses included dementia, hypertension, and history or stroke. -A diet order was illegible on this FL2. Review of Resident #9's record on 3/9/16 revealed: -An admission date of 2/23/16. -An FL2 dated 4/17/15 (from a previous facility Resident #9 had lived at) which had a diet order of "regular with ground meats". -There was no separate facility printed physician's diet order form in Resident #9's record. Review of the diet list posted in the kitchen on 3/09/16 at 10:05 am revealed: -Resident #9 was listed to have a regular, ground mechanical diet. -Resident #9 was not listed on the resident diet list to receive a regular, ground meat diet. Review of the diet order book posted in the kitchen revealed a copy of Resident #9's previous FL 2 dated 4/17/15 (from the previous facility) which had a diet order of "regular with ground meats". Review of the therapeutic diet menu for regular with ground meats revealed residents were to be served 3 oz meatloaf with gravy, 1/2 c. garlic mashed potatoes, 1/2 c. green beans, 1 roll, and 1 slice chocolate cake. Interview on 3/10/16 at 8:00 am with the Supervisor/Manager of employees revealed: -The facility only served a regular chopped diet or a regular ground, mechanical diet. -She would contact Resident #9's physician to clarify the diet order. Based on observations, record review and	{D 309}	Manager did a new facility diet order on Res. #9 for regular diet with Chopped meat, Ensure Drink-1 can PO BID @ 8AM + 5PM. + faxed it to the DR. office Manager + RCC will Check over FL-2 on new Admissions thoroughly + will make sure Dietary Manager gets a copy + understands the FL-2 (or can read it clearly).	3/10/16

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{D 309}	Continued From page 4 interview, it was determined Resident #9 was not interviewable. Attempted telephone interview on 3/10/16 at 11:00 am with Resident #9's responsible party was unsuccessful. Attempted telephone interview on 3/10/16 at 11:00 am with Resident #9's primary care physician's office was unsuccessful. Review of a facility diet order sheet for Resident #9 provided by the facility on 3/11/16, revealed a diet order dated 3/10/16 for regular with chopped meats. Supplement drink twice a day. Refer to interview on 3/09/16 at 10:15 am with the Dietary Manager (DM). Refer to interview on 3/09/16 at 12:30 pm with the Director of Operations (DO). Refer to interview on 3/09/16 at 3:25 pm with the Supervisor/Manager of employees. Refer to interview on 3/10/16 at 8:00 am with the DM. Interview with the DM on 3/09/16 at 10:15 am revealed -He had worked at the facility for 4 years as the DM. -The Medication Aides (MA) would bring the diet orders to the kitchen. A copy was put in the "diet orders" book. -He would make any changes on the posted resident diet list and diet cards hung on the bulletin board for staff reference. Interview with the DO on 3/09/16 at 12:30 pm	{D 309}		

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{D 309}	Continued From page 5 revealed: -She had worked at the facility for 6 years and was the Assistant Administrator or DO. -The MAs were to send copies of diet orders to the DM, who updated the kitchen diet records. Interview with the Supervisor/Manager of employees on 3/09/16 pm at 3:25 pm revealed: -She had worked at the facility for 17 years, and had been the "Manager over the employees" for 1 year. -She was also a certified nursing assistant and a MA, and "did whatever else needed to be done". -Diet orders were updated every 6 months. Interview with the Dietary Manager (DM) on 3/10/16 at 8:00 am revealed: -If a diet was ordered mechanical soft, all meats and other necessary foods were ground. -Soft foods were not ground.	{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.	D 344		

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D 344	Continued From page 6 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to clarify unclear or conflicting medication orders for 3 of 5 sampled residents (#2, #4, and #5.) The findings are: A. Review of Resident #5's current FL2 dated 3/7/16 revealed: -Diagnoses included dementia, congestive heart failure, anxiety, and a history of AV block. - A medication order for KCL (potassium chloride) 20 mEq, 1 daily. (KCL is a medication used to treat low potassium levels.) Review of Resident #5's record revealed: -A prior medication order dated 3/13/15 for KCL 20 mEq, 1/2 tablet daily. -A signed physician's order sheet dated 7/10/15 for KCL 20 mEq, 1/2 tablet daily. -A medication order dated 7/31/15 to increase the KCL to 80 mEq daily for two days, then 40 mEq daily thereafter. -A basic metabolic panel (BMP) dated 7/30/15 indicated a potassium level of 2.7 mmol/L with a normal range of 3.5 to 5.1.) -A repeat BMP dated 8/7/15 with a potassium level of 3.9 mmol/L. Review of Resident #5's Medication Administration Records (MARs) for February and March 2016 revealed: -An entry for KCL, 20 mEq, 2 tablets daily with a scheduled administration time of 8am. -40 mEq of KCL had been documented as administered daily the entire month of February 2016 and from 3/1/16 through 3/10/16.	D 344	Resident Care Coordinator did new FL-2 on Res. #5 with correct dosage of Potassium And faxed to DR office Manager also did a phone order for Clarification of potassium Order + faxed it to the DR. office. Manager + RCC will take their time when doing or updating new FL-2 or transcribing medication to the MARS or FL2.	3/10/16

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D 344	Continued From page 7 Observation of Resident #5's medications on hand on the afternoon of 3/10/16 revealed: -A bubble pack of KCL 20 mEq, labeled two tablets daily, with a dispense date of 2/5/16. Reviews of Resident #5's record revealed: -No order to change Resident #5's KCL order back to 40 mEq per day from the FL2 order dated 3/7/16 of KCL 20 mEq per day. -No attempts by facility staff to clarify the KCL order with Resident #5's physician. Interview with Resident #5 on 3/9/16 at 10:20 am revealed she believed she received her medications as ordered by her physician. -Interview with the Manager (Resident Care Coordinator [RCC]) on 3/10/16 at 11:20 am revealed: -She completed new FL2s for the physician to sign from the current MARs. -The RCC and Medication Aides check the new MARs for accuracy when the come in from the pharmacy. -The RCC could not explain the discrepancy between the dose of KCL on the FL2 dated 3/7/16 and the dose documented as administered from the MAR. Interview with the Pharmacist at the provider pharmacy on 3/10/16 at 12:03 pm revealed: -The most recent order they had for Resident #5's KCL was dated 10/13/15 for 20 mEq, two tablets daily. -The most recent KCL dispensed for Resident #5 was for 60 tablets on 3/4/16. -The facility doesn't always fax new FL2s to the pharmacy. B. Review of Resident #4's current FL2 dated	D 344		

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D 344	Continued From page 8 9/3/15 revealed: -Diagnoses of dementia, diabetes type 2, and depression. -A medication order for Lorazepam 1mg daily, and every 8 hours as needed. (Lorazepam is a medication used to treat anxiety disorders and acute seizures.) -An admission date of 10/20/14. Review of Resident #4's record revealed: -A subsequent handwritten order dated 2/8/16 on a physician's order sheet for Lorazepam 0.5 mg, 1 daily, and one 8 hours after first dose as needed for agitation or anxiety. -A prescription from Resident #4's primary care physician dated 1/18/16 for Lorazepam 1 mg every morning, and one tablet 8 hours after the first dose as needed. -No documentation of an attempt to clarify Resident #4's order for Lorazepam. Review of Resident #4's Medication Administration Records (MARs) for February and March 2016 revealed: -An entry for Lorazepam 1 mg every morning with a scheduled administration time of 8:00 am. -A separate entry for Lorazepam 1 mg, may repeat in 8 hours as needed. Observation or Resident #4's medications on hand on the afternoon of 3/10/16 revealed: -Several bubble packs of Lorazepam 1 mg labeled, 1 tablet every morning, and 1 tablet eight hours after first dose as needed with a dispense date of 2/4/16. Interview with a Pharmacist and the provider pharmacy on 3/10/16 at 12:03 pm revealed: -Resident #4's family provides her medications,	D 344		

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D 344	Continued From page 9 but the most recent order they have on file was for Lorazepam 1 mg every morning, and 1 mg 8 hours after first dose as needed dated 9/4/15. Interview with Resident #4 on 3/10/16 at 11:40 am revealed she was not sure what medications she took. Interview with Resident #4's responsible party on 3/10/16 at 12:05 pm revealed: -She was unaware of any changes in Resident #4's Lorazepam dose from 1mg. -The last refill she obtained for Resident #4 was on 2/1/16 for 100 tablets of 1mg. -As far as she knows, Resident #4 received her medications as ordered from her physician. Interview with the Resident Care Coordinator and Supervisor/Medication Aide on 3/10/16 at 2:10 pm revealed: -Resident #4 was on Lorazepam 0.5 mg at one time, but it was changed to 1 mg, (unsure of date.) -Neither could explain the discrepancy between the order for Lorazepam 0.5 mg dated 2/8/16, and the documentation of administration of 1 mg tablets. -The physician's order sheet (POS) dated 2/8/16 with the order for Lorazepam 0.5 mg may have been handwritten because the computer generated POS was incomplete. Interview with the Director of Operations on 3/10/16 at 1:10 pm revealed: -The RCC and MA check the MARs monthly for accuracy. -She was not sure why Resident #4's Lorazepam was changed to 0.5 mg on the POS without an order. C. Review of Resident #2's current FL 2 dated	D 344	Manager did a phone order to clarify order on Ativan for res. # 4 + faxed it to the DR. When Checking over the printed physician's orders + MARS, If a medication is left off + the medication is a Active current order + it has not been DIC'd Manager + RCC will notify the Pharmacy to have them reprint a new one with that medication on it instead of Manager RCC or med Tech having to write it in. That way we can prevent future errors like this from Happening Again.	3/10/16

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D 344	Continued From page 10 3/07/16 revealed: -Diagnoses included advanced dementia with constant disorientation, depression, manic depression psychosis, and hypertension. -A medication order for Mirtazapine 15 mg at bedtime (used to treat depression). Review of Resident #2's record revealed: -A physician's order dated 7/10/15 for Mirtazapine 15 mg 1/2 tablet (7.5 mg) at bedtime. -A computer printed physician's order form signed and dated 2/08/16 with an order for Mirtazapine 15 mg 1/2 tablet (7.5 mg) at bedtime. -Record review revealed no documentation was sent to the physician clarifying the dosage change. -No documention or physician's order was found in the record for when or why the Mirtazapine dose was changed. Review of Resident #2's Medication Administration Record (MAR) for January 2016 revealed: -An entry for Mirtazapine 15 mg, 1/2 tablet (7.5 mg) at bedtime. -Mirtazapine 7.5 mg was documented as administered at 8 pm from 1/01/16 to 1/31/16. Review of Resident #2's Medication Administration Record (MAR) for February 2016 revealed: -An entry for Mirtazapine 15 mg, 1/2 tablet (7.5 mg) at bedtime. -Mirtazapine 7.5 mg was documented as administered at 8 pm from 2/01/16 to 2/29/16. Review of Resident #2's Medication Administration Record (MAR) for March 2016 revealed: -An entry for Mirtazapine 15 mg, 1/2 tablet (7.5	D 344		

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D 344	Continued From page 11 mg) at bedtime. -Mirtazapine 7.5 mg was documented as administered at 8 pm from 3/01/16 to 3/08/16. -No dose change notations were documented for dosage change ordered on 3/07/16. Interview on 3/09/16 at 3:00 pm with the facility's contract pharmacist revealed: -According to the pharmacy records, an order for Resident #2 originated 7/10/15 for Mirtazapine 7.5 mg at bedtime. -There was no copy of Resident #2's FL 2 dated 3/07/16 in their system. Interview on 3/09/16 at 3:30 pm with a Supervisor/Medication Aide revealed: -She had worked at the facility as a Medication Aide (MA), Care Aide (CA) and Supervisor since 2009. -Resident #2's current FL2 listed Mirtazapine 15 mg at bedtime. That was "a transcription error. It should be 1/2 tablet (7.5 mg)". -The Supervisor/Medication Aide or Supervisor/Manager of employees transcribed a new FL2 to be signed by the physician. "The physician expected our staff to transcribe meds correctly." -The MA, or Supervisor/Manager of employees compared the new FL2 to the MARs. The FL2 was faxed to the pharmacy only if there were changes noted by the physician. -She would fax a clarification request to the physician. Review of a physician's order faxed to the facility on 3/09/16 revealed an order for Mirtazapine 7.5 mg at bedtime. Interview on 3/10/16 at 2:00 pm with the Director of Operations (DO) revealed:	D 344	-RCC did new FL-2 on Res. #2 that listed the correct dosage of Mirtazapine 15 mg TAKE 1/2 tab (7.5mg) PO At Bedtime. RCC and manager faxed it to the Dr. office. RCC + manager will encourage med techs to slow down when transcribing meds to the MAR. Manager + RCC will send copies of updated FL-2 to the pharmacy everytime we update them	3/10/16

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D 344	Continued From page 12 -She had been the Assistant Administrator or DO at the facility for 6 years. -She expected documentation on the MAR to be accurate and the MA to clarify orders with the physician as necessary. Based on observations, record reviews and interviews with staff, it was determined Resident #2 was not interviewable. Interview on 3/10/16 at 9:45 am with Resident #2's responsible party revealed: -They were satisfied with the care provided by the facility. -The facility "took care of anything related to medications", and the family had no concerns. -Resident #2 never appeared over or under medicated when they visited.	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: Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 1 of 5 (#1) sampled residents regarding Lactaid tablets.	{D 358}		

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{D 358}	Continued From page 13 The findings are: Review of Resident #1's current FL2 dated 9/3/15 revealed: -Diagnoses included stroke with right sided weakness, irritable bowel syndrome, gastroesophageal reflux disease, possible bipolar disorder, and dysphagia. -A medication order for Lactaid chewable tablets, 3 tablets with first bite of dairy. (Lactaid is an enzyme used to treat lactose intolerance.) -An admission date of 5/2/13. Review of Resident #1's record revealed a subsequent order on a physician's order sheet dated 2/8/16 for Lactaid chew/swallow 3 tablets with first bite of dairy (each time dairy is eaten.) Review of Resident #1's Medication Administration Records (MARs) for January, February, and March 2016 revealed: -An entry for Lactaid tablets, Chew/swallow 3 tablets with first bite of dairy(each time dairy is eaten) with an notation of prn (as needed) under the hour of administration. -No Lactaid documented as administered. Observation of Resident #1's medications on hand on the afternoon of 3/9/16 revealed a partial box of Lactaid tablets with the resident's name handwritten on the box. Interview with a Supervisor/Medication Aide on 3/9/16 at 3:00 pm revealed: -The (MAs) only gave Resident #1 her Lactaid when she requested it. -She doesn't ask for the Lactaid often. -Resident #1 asked for milk routinely. -The MA believed the pm designation on the MAR meant the residents had to ask for the	{D 358}		

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{D 358}	Continued From page 14 medication. Interview with Resident #1 on 3/9/16 at 3:25 pm revealed: -She doesn't ask for her Lactaid because "staff are so busy," and she didn't want to bother them. -She had a glass of milk every day. -Sometimes the milk gave her an upset stomach. Interview with the Director of Operations on 3/10/16 at 1:10 pm revealed: -They did not have a specific policy on administering medications like Lactaid. -Resident #1 should have gotten the Lactaid with her dairy regardless if she asked for it or not. Interview with a Registered Nurse at Resident #1's physician's office on 3/10/16 at 1:15 pm revealed: -She should have gotten the Lactaid when she consumed dairy. -They would rewrite the order to make it more clear to the staff about when to administered Resident #1's Lactaid. The facility received a clarification order from Resident #1's physician dated 3/10/16 for Lactaid tablets that stated, "Take three tablets three times a day with meals at 8 am, 12 noon, and 5 pm, and may have prn too."	{D 358}	If its not a PRN order Manager did a phone order for Res. #1 LACtaid TAbs, to take 3 tabs PO TID ō meals + may take it PRN too. Resident #1 Has since refused to take her scheduled doses @ 8A, 12p + 5pm. 7 days in a row. The Order has been D/C'd as of 3/24/16. She stated no one is gonna force her ~~from~~ error AR to take it if she don't want it. Manager + RCC will Check orders, + MARS more closely + more often (weekly) will go thru Charts monthly.	3/9/16
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	{D 367}		

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{D 367}	Continued From page 15 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure Medication Administration Records (MARs) were accurate and complete for 4 of 5 sampled residents (#1, #2, #3, and #4) with physician's orders for Lorazepam (Resident #1 and Resident #2), hydromorphone (Resident #3), Sodium Hypochlorite Solution for wound care (Resident #3), and Fish Oil (Resident #4.) The findings are: A. Review of Resident #2's current FL2 dated 3/07/16 revealed: -Diagnoses included advanced dementia with constant disorientation, depression, manic depressive psychosis. -An order for Lorazepam (Ativan) 1 mg every 6 hours as needed (used to treat anxiety). Review of Resident #2's January 2016 MAR revealed:	{D 367}		

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{D 367}	Continued From page 16 -An entry for Lorazepam 1 mg every 6 hours as needed for anxiety. -Lorazepam was documented as administered 36 times on the front of the MAR from 1/01/16 to 1/31/16. -Lorazepam was documented as administered for anxiety on the back of the MAR with dates and times matched to dates on the front except on 1/03/16, and 1/19/16. -Lorazepam was documented as administered on the MAR, but not signed out on the controlled substance record 3 times: 1/04/16 am (time not specified), 1/10/16 at 10:00 pm, and 1/26/16 8:00 am. -Lorazepam was documented as administered on the back of the MAR, but not on the front of the MAR and not on the controlled substance record 2 times: on 1/18/16 at 8:00 am and 1/18/16 at 8:00 pm. -There was no documentation on the back of the MAR for the Lorazepam dose administered on 1/19/16 at 8:00 am. Review of Resident #2's controlled substance record for Ativan 1 mg from 1/01/16 to 1/31/16 revealed: -Ativan 1 mg was signed out on the controlled substance record, but not documented as administered on the January 2016 MAR 6 times: on 1/12/16 at 5:00 pm, 1/16/16 at 8:00 am, 1/17/16 at 8:00 am, 1/21/16 at 5:00 pm, 1/24/16 at 5:00 pm, and 1/27/16 at 8:00 am. -An entry on 1/10/16 at 5:00 pm, was crossed out with "error" marked on the controlled substance record, but was documented as administered on the front of the MAR, but not the back of the MAR. Review of Resident #2's February 2016 MAR revealed:	{D 367}		

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{D 367}	Continued From page 17 -An entry for Lorazepam 1 mg every 6 hours as needed for anxiety. -Lorazepam was documented as administered 14 times on the front of the MAR from 2/01/16 to 2/29/16. -Lorazepam was documented as administered for anxiety on the back of the MAR with dates and times matched to dates on the front of the MAR except on 2/25/16 and 2/29/16. Review of Resident #2's controlled substance record for Ativan 1 mg from 2/01/16 to 2/29/16 revealed: -Ativan 1 mg was signed out on the controlled substance record, but not documented as administered on the February 2016 MAR 11 times: 2/03/16 at 8 :00 am, 2/04/16 at 8:00 am, 2/06/16 at 8:00 am, 2/07/16 at 8:00 am, 2/10/16 at 8 am, 2/21/16 at 5:00 pm, 2/23/16 at 5:00 pm, 2/26/16 at 5:00 pm, 2/27/16 at 8:00 am and 2/27/16 at 5:00 pm. Review of Resident #2's March 2016 MAR revealed: -An entry for Lorazepam 1 mg every 6 hours as needed for anxiety. -Lorazepam was documented as administered 2 times on the front of the MAR from 3/01/16 to 3/09/16. -Lorazepam was documented as administered for anxiety on the back of the MAR with dates and times matched to dates on the front. Review of Resident #2's controlled substance record for Ativan 1 mg from 2/01/16 to 2/29/16 revealed: -Ativan 1 mg was signed out on the controlled substance record, but not documented as administered on the March 2016 MAR 2 times: on 3/01/16 at 8:00 am and 3/03/16 at 5 pm.	{D 367}	-Med Tech/SIC did a medication error report + faxed it to the Physician's office (Not enough of documentation on MARS. Manager + RCC will check over MARS for PRN's given + make sure All documentation is noted in all Areas + do more taining with the staff (med Tech) + go over how important it is to do documentation.	3/9/16 -3/25/16

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{D 367}	Continued From page 18 Observation of Resident #2's medication on hand on 3/09/16 at 2:00 pm revealed Ativan 1 mg was available for administration and the narcotic count was accurate. Based on observations, record review and interviews with staff, it was determined Resident #2 was not interviewable. Interview on 3/10/16 at 9:45 am with Resident #2's responsible party revealed: -They were satisfied with the care provided by the facility. -The facility "took care of anything related to medications", and the family had no concerns. -Resident #2 never appeared over or under medicated when they visited. Refer to interview on 3/09/16 at 3:30 pm with the Supervisor/Medication Aide. Refer to interview on 3/10/16 at 10:00 am with the Supervisor/Medication Aide. Refer to interview on 3/10/16 at 12:10 pm with the Manager. Refer to interview on 3/10/16 at 2:00 pm with the Director of Operations (DO). B. Review of Resident #3's current FL 2 dated 5/27/16 revealed: -Diagnoses included chronic pain, osteomyelitis, coronary artery disease, and history of diskitis. Review of Resident #3's Resident Register revealed an admission date of 5/12/15. 1. Review of Resident #3's record revealed:	{D 367}		

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{D 367}	Continued From page 19 -A physician's order dated 5/14/15 for hydromorphone 2 mg every 6 hours prn (as needed) pain (a medication used to treat moderate to severe pain). -A "physician's move-in prescriptions/verification of orders" sheet signed and dated 10/22/15 for hydromorphone 2 mg every 6 hours prn pain. -A subsequent physician's order dated 1/19/16 for hydromorphone 2 mg every 6 hours prn pain. -No physician's order to discontinue hydromorphone. -There was no documentation that the facility staff had contacted Resident #3's physician when hydromorphone was not on the January 2016 Medication Administration Record (MAR). Review of Resident #3's December 2015 MAR revealed: -An entry for hydromorphone 2 mg every 6 hours as needed for pain. -Hydromorphone was documented as administered on the front of the MAR 3 times from 12/01/15 to 12/31/15: 12/07/15, 12/08/15, and 12/17/15. -Hydromorphone was documented on the back of the MAR 4 times: on 12/07/15 at 10:50 pm, 12/08/15 at 9:45 pm, 12/17/15 at 8 am, and 12/17/15 at 9:00 pm. Review of Resident #3's Controlled Substance Record for hydromorphone 2 mg from 12/01/15 to 12/31/15 revealed: -Hydromorphone 2 mg was signed out on the controlled substance record, but not documented as administered on the December 2015 MAR 19 times: on 12/02/16 at 8:00 pm, 12/03/16 at 8:00 am, 12/03/16 at 8:00 pm, 12/07/16 at 5:00 pm, 12/07/16 at 10:50 pm, 12/08/16 at 9:45 pm, 12/11/16 at 8:00 pm, 12/12/16 at 8:00 am, 12/12/16 at 8:00 pm, 12/13/16 at 8:00 am,	{D 367}	Manager And RCC will do more training with med techs. on documenting on MARS + anywhere else documentation is needed. Manager And RCC will do frequent Checks on MARS (weekly) + Check Orders in Charts monthly.	3/25/16

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{D 367}	Continued From page 20 12/13/16 at 8:00 pm, 12/16/16 at 8:00 am, 12/17/16 at 9:00 pm, 12/21/16 at 8:00 am, 12/21/16 at 8:00 pm, 12/22/16 at 8:00 pm, 12/23/16 at 1:20 am, 12/26/16 at 8 pm, and 12/27/16 at 9 pm. -The last documentation of hydromorphone 2 mg signed out on the controlled substance record was on 12/27/15 at 9:00 pm. Observation of Resident #3's medication on hand on 3/10/16 at 2:00 pm revealed hydromorphone 2 mg was available for administration and the narcotic count was accurate. Review of Resident #3's MARs for January, February and March 2016 revealed: -No entry for hydromorphone on the MAR. Interview on 3/10/16 at 10:20 am with the facility's contracted pharmacist revealed: -Hydromorphone needed a "hard script" in order for it to be renewed for Resident #3. -They had a copy of an order dated 1/19/16 to continue hydromorphone, so would not have contacted the facility or the physician for a hard script. -The facility staff had not requested a refill for Resident #3's hydromorphone since it was last dispensed on 5/15/15. -She had not noticed the hydromorphone had "dropped off the system" when she performed a pharmacy review on 12/23/15. Interview on 3/10/16 at 10:30 am with Resident #3's physician's representative revealed: -The facility contacted the office for any concerns and needs regarding Resident #3. -The last office visit documented in the office record was dated 1/19/16 with a note to continue hydromorphone for chronic pain.	{D 367}	Pharmacy was notified regarding why Hydromorphone order was not listed on the MAR, Pharmacy stated she would fax manager a copy of what she found in their system. manager also had her to send a new printed MAR with the Hydromorphone listed on it. Manager + RCC will do more frequent checks thru MAR weekly + follow-up with Pharmacy.	3/10/16

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{D 367}	Continued From page 21 -There was no record of a "hard script" requested by the facility or pharmacy for Resident #3's hydromorphone. Review of a faxed letter dated 3/10/16 from the facility's contracted pharmacist provided by the facility on 3/10/16 revealed: -The faxed letter was a letter of explanation with an "attachment of a copy of a note. It was attached to a deleted prescription in (Resident #3's) profile and documented 'We destroyed script (for hydromorphone) due to script being on file for 6 months or longer. This was done on 12/21/2016'." -The pharmacist wrote "the hard copy on file in their system was dated 5/14/15. Hard copies for controlled substances are only valid for 6 months after the original written date." -The pharmacist wrote "when a prescription is deleted in our system, we are still able to view it in the patient profile, but it does not show up on reports, including MARs." Interview on 3/10/16 at 1:15 pm with Resident #3 revealed: -She came to the facility in May 2015 after recovering from a stroke. -She had gotten better and had not needed her hydromorphone medication since December 2015. -The facility administered her medications as necessary, and she had never run out of medications. Refer to interview on 3/09/16 at 3:30 pm with the Supervisor/Medication Aide. Refer to interview on 3/10/16 at 10:00 am with the Supervisor/Medication Aide.	{D 367}		

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{D 367}	Continued From page 22 Refer to interview on 3/10/16 at 12:10 pm with the Manager. Refer to interview on 3/10/16 at 2:00 pm with the Director of Operations (DO). Review of faxed physician's order signed and dated 3/11/16 and sent by the facility on 3/11/16 revealed an order to discontinue hydromorphone. 2. Review of Resident #3's record revealed: -A physician's order dated 9/14/15 for Sodium Hypochlorite 0.057% topical liquid to leg wound 3 times per week, and to be administered on Monday, Wednesday and Friday (a medication used as a disinfectant to promote healing in wound care). -A physician's order dated 10/20/15 for Sodium Hypochlorite 0.057% topical liquid to leg wound 3 times per week, and to be applied on Monday, Wednesday and Friday. Review of Resident #3's December 2015 MAR revealed: -An handwritten entry for Sodium Hypochlorite 0.057% applied topically 3 times per week and scheduled for application at 8:00 am every Monday, Wednesday and Friday. -Documented as applied at 8:00 am daily from 12/02/15 to 12/28/15. -No documentation was recorded on the front or back of the MAR for the scheduled treatment on Wednesday, 12/30/15. -No documentation on the back of the MAR as for the reason Sodium Hypochloride was not applied on 12/30/15. Review of Resident #3's January 2016 MAR , February 2016 MAR and March 2016 MAR revealed:	{D 367}		

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{D 367}	Continued From page 23 -No entry for Sodium Hypochlorite 0.057% on the MAR. Further review of Resident #3's record revealed: -A physician's visit report dated 1/19/16 that documented "right lower extremity wound completely healed over with good skin", but no discontinue order for Sodium Hypochlorite. -A pharmacy review was completed on 12/23/15 and contained no documentation about Sodium Hypochlorite. -There was no documentation that staff had contacted the physician to clarify the order when Sodium Hypochlorite was not on Resident #3's January 2016 MAR. Interview on 3/10/16 at 10:00 am with the Supervisor revealed: -Resident #3 no longer was on Sodium Hypochlorite since her wound was healed. -She did not find a discontinued order in Resident #3's record. Interview on 3/10/16 at 10:20 am with the facility's contracted pharmacist revealed: -She had seen a note in Resident #3's record that the wound was healed, so "she would have stopped the Sodium Hypochlorite". -There was no order in the pharmacy's system that Sodium Hypochlorite was discontinued, so it should have remained on the MAR until the order was received. -The facility faxed MARs to the pharmacy if they were incorrect so that it could be corrected in the system. Interview on 3/10/16 at 10:30 am with Resident #3's physician's representative revealed: -The facility contacted the office for any concerns and needs regarding Resident #3.	{D 367}	Manager faxed a phone order to the DR. to D/C Sodium Hypochlorite due to leg wound Being healed + Had the Hydromorphone order D/C'd due to Resident not taking it. Manager + RCC will go over physician's progress notes that the physician's fax back over to facility About their visits with the residents because the DR. may make Changes to these forms as well, so we can prevent future errors	3/10/16

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{D 367}	Continued From page 24 -The last office visit documented in the office record was dated 1/19/16 with a note on file that "right lower extremity wound completely healed over with good skin". -She would not expect to need to continue Sodium Hypochlorite treatment if the wound was healed. -Resident #3's primary care physician was "not the physician who originally ordered the Sodium Hypochlorite treatment, so would not have discontinued it". Interview on 3/10/16 at 1:15 pm with Resident #3 revealed: -She came to the facility in May 2015 after recovering from a stroke. -She had a "right leg wound that has been healed awhile". -She had been treated with a liquid solution under a dressing until it was healed. She no longer received or needed the treatment, and did not recall the name of the medication. -The facility administered her medications as necessary, and she had never run out of medications. Review of faxed physician's order signed and dated 3/11/16 and sent by the facility on 3/11/16 revealed an order to discontinue Sodium Hypochlorite. Refer to interview on 3/09/16 at 3:30 pm with the Supervisor/Medication Aide. Refer to interview on 3/10/16 at 10:00 am with the Supervisor/Medication Aide. Refer to interview on 3/10/16 at 12:10 pm with the Manager.	{D 367}		

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{D 367}	Continued From page 25 Refer to interview on 3/10/16 at 2:00 pm with the Director of Operations (DO). C. Review of Resident #5's current FL2 dated 3/7/16 revealed: -Diagnoses included dementia, anxiety, and congestive heart failure. -A medication order for Lorazepam 0.5 mg, 1 tablet three times a day as needed for anxiety. (Lorazepam is a medication used to treat anxiety disorders and acute seizures.) -An admission date of 3/2/15. Review of Resident #5's record revealed a prior order for Lorazepam 0.5 mg, 1 every 8 hours as needed for anxiety and agitation. Review of Resident #5's Medication Administration Record (MAR) for February 2016 revealed 42 doses of prn (as needed) doses of Lorazepam 0.5 mg tablets. Review of Resident #5's narcotic count sheet for February 2016 revealed 56 doses of Lorazepam 0.5 mg documented as administered including the following doses not documented on the MAR for February 2016: -2/1/16, 8am and 5pm. -2/2/16, 8am. -2/4/16, 8am. -2/7/16, 3pm. -2/11/16, 8am and 3pm. -2/18/16, 3pm. -2/19/16, 3pm. -2/22/16, 8pm. -2/23/16, 3pm and 8pm. -2/27/16, 3pm, and 8pm. Review of Resident #5's Medication Administration Record (MAR) and narcotic count sheet for March 2016 revealed 18 doses of prn	{D 367}		

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{D 367}	Continued From page 26 (as needed) doses of Lorazepam 0.5 mg tablets documented as administered. Observation of Resident #5's medications on hand on the afternoon of 3/10/16 revealed the narcotic count was accurate for the Lorazepam 0.5 mg. Refer to interview on 3/09/16 at 3:30 pm with the Supervisor/Medication Aide. Refer to interview on 3/10/16 at 10:00 am with the Supervisor/Medication Aide. Refer to interview on 3/10/16 at 12:10 pm with the Manager. Refer to interview on 3/10/16 at 2:00 pm with the Director of Operations (DO). D. Review of Resident #1's current FL2 revealed: -Diagnoses included stroke with right sided weakness, anxiety, irritatable bowel syndrome, and possible bipolar. -An admission date of 5/3/13. Review of Resident #1's record revealed: -A medication order for Lorazepam 0.5 mg daily as needed on a on a signed physician's order sheet dated 2/8/16. (Lorazepam is a medication used to treat anxiety disorders and acute seizures.) -A prior order for Lorazepam 0.5 mg daily as needed dated 11/16/15. Review of Resident #1's Medication Administation Record (MAR) for December 2015 revealed no prn (as needed) Lorazepam 0.5 mg documented as administered.	{D 367}		

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{D 367}	Continued From page 27 Review of the December 2015 narcotic count sheet for Resident #1's Lorazepam 0.5 mg revealed: -Two doses of Lorazepam 0.5 mg were documented as administered, one on 12/4/15 at 12 noon, and one on 12/6/15 at 6:30 pm. Review of Resident #1's Medication Administation Record (MAR) for January 2016 revealed 4 doses of prn Lorazepam 0.5 mg documented as administered. Review of the January 2016 narcotic count sheet for Resident #1's Lorazepam 0.5 mg revealed: -5 doses of Lorazepam 0.5 mg were documented as administered, on 1/3/16 at 1:52 am, 1/4/16 at 8am, 1/9/16 at 10am, 1/16/16 at 6:30pm, and 1/18/16 at 1pm. Review of the February and March 2016 MARs and narcotic count sheets for Resident #1's Lorazepam 0.5mg revealed no doses documented as administered. Observation of Resident #1's medications on hand on the afternoon of 3/10/16 revealed the narcotic count was accurate for the Lorazepam 0.5mg. Interview with Resident #1 on 3/9/16 at 9:53 am revealed: -She believed she received her medications as ordered by her doctor. -She never ran out of her medications. Refer to interview on 3/09/16 at 3:30 pm with the Supervisor/Medication Aide. Refer to interview on 3/10/16 at 10:00 am with the Supervisor/Medication Aide.	{D 367}	Manager + RCC will check MARS weekly + do more training with Staff (Med Techs) on Documentation + transcribing Medications to the MARS.	3/25/16

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{D 367}	Continued From page 28 Refer to interview on 3/10/16 at 12:10 pm with the Manager. Refer to interview on 3/10/16 at 2:00 pm with the Director of Operations (DO). E. Review of Resident #4's current FL2 dated 9/3/15 revealed: -Diagnoses included dementia, hypertension, diabetes, and elevated blood lipids. -An admission date of 10/20/14. -A medication order for Fish Oil capsules 1200 mg, 1 daily. (Fish Oil is used as a nutritional supplement for a variety of conditions included elevated triglycerides.) Review of Resident #4's Medication Administration Record for March 2016 revealed: -A computer generated entry for Fish Oil capsules 1200 mg, 1 capsule daily, with a scheduled administration time of 8 am. -A handwritten entry for Fish Oil capsules 1200 mg, 1 capsule daily, with a scheduled administration time of 8 am. -Both entries for Fish Oil 1200 mg had been initialed as administered daily from 3/1/16 through 3/10/16. Interview with Resident #4 on 3/10/16 at 11:40 am revealed she was not sure what medications she was taking. Interview with Resident #4's responsible party on 3/10/16 at 12:05 pm revealed: -She buys the Fish Oil for Resident #4. -She last purchased Fish Oil for Resident #4 on 9/25/15 for 200 capsules. -Resident #4 should be getting one 1200 mg fish oil capsule daily.	{D 367}	This was an oversite And Manager + RCC will Check Mars thoroughly And will limit who compares the MARS monthly to just Manager RCC + Head Med Tech Manager did a phone order + faxed it to the Dr. to Clarify Fish Oil Order.	3/10/16

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{D 367}	Continued From page 29 -She believed Resident #4 was getting her medications as ordered by her physician. Observation of Resident #4's medications on hand on the afternoon of 3/10/16 revealed: -A partially filled bottle of Fish oil capsules 1200 mg with Resident #4's name hand written on the label. -Approximately 10% of the Fish Oil capsules remained in the bottle. Interview with the Supervisor/Medication Aide on 3/10/16 at 2:10 pm revealed: -She was not sure why the Fish Oil was hand written on he March 2016 MAR. -She only gave one capsule a day. -The Medication Aides were just filling in the blanks. Interview with the Director of Operations on 3/10/16 at 1:10 pm revealed she as not sure what happened with the Fish Oil documentation on the MAR. Refer to interview on 3/09/16 at 3:30 pm with the Supervisor/Medication Aide. Refer to interview on 3/10/16 at 10:00 am with the Supervisor/Medication Aide. Refer to interview on 3/10/16 at 12:10 pm with the Manager. Refer to interview on 3/10/16 at 2:00 pm with the Director of Operations (DO). Interview on 3/09/16 at 3:30 pm with the Supervisor/Medication Aide revealed: -She had worked at the facility as the Care Aide	{D 367}		

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{D 367}	Continued From page 30 (CA), Medication Aide (MA) and Supervisor since 2009. -If a resident needed a controlled prn (as needed) medication, the MA signed the medication out on the controlled substance record, documented as administered on the front of the MAR, and documented on the back of the MAR when and why the medication was administered. -If a MA forgot to sign the MAR at the time of administering a medication, "they were to sign the MAR by the end of their shift to be accurate or it counts as an error". Interview on 3/10/16 at 10:00 am with the Supervisor/Medication Aide revealed: -The Medication Aide (MA), Supervisor, or Manager reviewed MARs. They compared the old ones to the new ones to make sure they were correct. If a medication was not on the new MAR at the "change-over", they faxed the old MAR to the pharmacy so it could be corrected in the system so the MARS were accurate. Interview on 3/10/16 at 12:10 pm with the Manager revealed: -She had worked at the facility as CNA, MA for 17 hears, and had been the Manager for 1 year. -She did "whatever needed to get done". -The facility did not use the title Resident Care Coordinator. -If a medication was a scheduled controlled medication, the MA signed the medication out on the controlled substance record and documented the medication as administered on the front of the MAR. -If a medication was a prn, the MA should also document on the back of the MAR as to the reason and time the medication was given. Interview on 3/10/16 at 2:00 pm with the Director	{D 367}		

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{D 367}	Continued From page 31 of Operations (DO) revealed: -She had been the Assistant Administrator or DO at the facility for 6 years. -She expected documentation on the MAR to be accurate.	{D 367}		